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EDITORIAL

Disease outbreaks and epidemics continue to be a threat in the Great Lakes sub-region. Capacity has been built and the legal framework (Protocol of Cooperation) provided for inter-country collaboration in epidemic response.

The goal of WHO is to support the countries to ensure that each suspected outbreak is thoroughly investigated, responded to timely to prevent unnecessary morbidity and mortality, and prevention measures for recurrence instituted. More resources are needed for this to be fully achieved.

Dr. Oladapo Walker – WR Uganda

Inter country cross border meeting on epidemic investigation and response

In May-June 2004, the WHO Regional office for Africa in collaboration with HQ conducted a consultative cross border inter country meeting in Kampala, Uganda to strengthen collaboration in surveillance, preparedness and response to epidemics in the most affected areas of the Great Lakes Region. During this meeting, key responses and interventions were highlighted including the need for strengthening mechanisms for effective management of epidemics, cross-border emergency meetings in case of epidemics, outbreak investigation and response and operationalising joint response teams.

In response to the above recommendations and the prevailing situation, specifically the cholera epidemic in the areas surrounding Lakes Albert and Edward (DR Congo/Uganda Border) and the anthrax epidemic among animals in the Queen Elizabeth National Park, a three-day cross border orientation meeting was conducted (11th – 13th November 2004) in Kasese for Uganda and DR Congo (DRC) epidemic prone districts around this area.

The orientation meeting was conducted in three days. The first day had an orientation to epidemic investigation and response (cholera and anthrax). The second had field investigations in the most affected/high risk areas. And on the third day, participants proposed various interventions/action points to address current epidemic diseases on the border areas. Through this approach, the participants did not only find it easy to appreciate what was passed onto them in a class setting, but it also generated new information to current issues of health concern.

The meeting aimed at strengthening epidemic investigation and response (EIR) in the high-risk border areas around the Lakes at Uganda and DRC borders, with emphasis on cholera and anthrax. More specifically, the meeting was intended to build capacity of the health officials on the border areas in EIR and to strengthen cross border collaboration in epidemic investigation and response.

The meeting was attended by health officers from 4 districts at Uganda-DRC border including Nebbi, Bundibugyo, Kasese, Bushenyi and officers from the DRC districts bordering Nebbi district. By the end of the meeting, district health officials had been oriented in epidemic investigation and response, areas and mechanisms for cross border collaboration in EIR were defined, joint activities and district action points for strengthening epidemic investigation and response around the border areas were identified and district specific action points for controlling cholera epidemic and spread of Anthrax to humans agreed upon.

A cross section of the participants

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Field Investigation of a cholera outbreak in Kilembe, Kasese District

During the Inter Country Cross-border Meeting on Epidemic Investigation and Response, held in Kasese, participants were constituted into 4 teams to carry out field investigations in the most affected/high risk areas, for capacity building.

One of such teams was tasked to verify a cholera outbreak in Kilembe and to establish its magnitude, associated risk factors and the capacity of the community and health facility to handle it. This was in response to a press report on 21st September 2004 describing a new cholera upsurge in Maliba Sub- county where 7 cases were reported following the rainy season.

Four sites were visited; 2 communities and 2 Cholera Treatment Centres (CTC). Former cholera patients were traced, visits made to homes of patients and non patients and to water collection points, sanitation conditions were checked and verified cholera cases registered.

The outbreak peaked in September 2004 coinciding with the rainy season, with the most affected area being Nyakasanga parish in Kasese Town Council, where 75% of the cases originated (see graph). Note that the cases corresponding to November were seen during the first 12 days (visit made on 12th/11/2004).

Fig. 1 Cholera cases seen at Kilembe Hospital, August - 12th November 2004

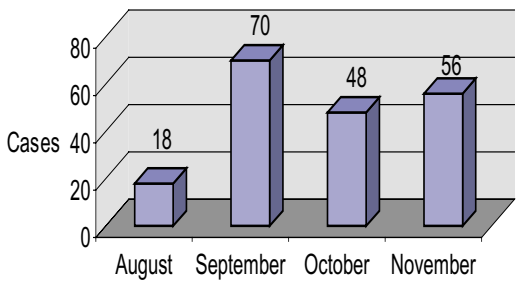
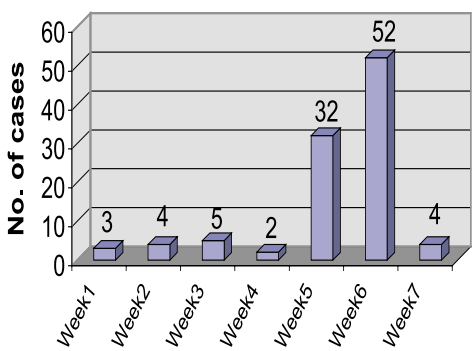


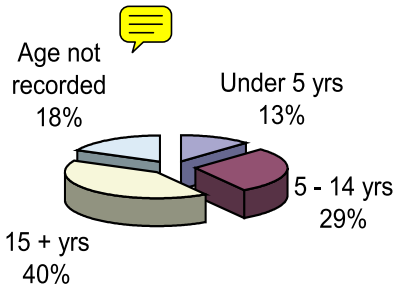
Fig. 2 shows a summary of the number of cases per week beginning 27th September 2004.

Fig. 2 Summary of cases per week at Kilembe Mines Hospital



Demographic characteristics of the cases seen in November are as shown in Fig. 3, with males and females being affected equally.

Fig. 3 Distribution of cases by age group



The Health sub district responded by setting up CTCs in the affected areas – Kilembe & Kasese town Council (KTC) thus yielding a relatively low case fatality rate (2%). The team also found that people don't have access to safe water in Mubuku and instead use untreated water piped from Mubuku river and stream water direct from Mubuku Nyamwamba (UMOJA). The people still have poor behavioral practices like bathing, washing in the rivers from which water is fetched for home use (see photo) and latrine coverage is still very low, the village leader (Chairman Local Council I) for instance, stays in a house without a pit latrine!!); Sources of "safe water" like taps are not functional due to break down and are still limited in other areas.

The team recommended that community mobilization be intensified and health education strengthened; focus on key behavioral risk factors; promote early treatment of cases, initiate
chlorination of water at home and collection points in Mubuku and Umoja; regular water quality monitoring at the source, point of collection, and point of use (Directorate of water department -DWD); maintain water source infrastructures (DWD, Sub-County chief); monitor latrine coverage (HI, LCIII, Sub-County chief) and the HSD should consult data, analyze and use it to focus the interventions on weekly basis.

Treating at least 60,000 people onAnti retroviral Therapy by end of 2005

The Government of Uganda was one of the first countries to express commitment and request for support to access Anti-Retroviral (ARV) drugs. According to Ministry of Health Surveillance data, 1.1 million Ugandans were estimated to be living with HIV/AIDS in 2001 with 70,170 new infections in 2002. It is estimated that about 120,000 people require ART now.

In 2001, antiretroviral therapy (ART) was integrated in the Ministry of Health national program for comprehensive HIV/AIDS care after the successful piloting of the Ministry of Health-UNAIDS Drug Access initiative (DAI).

Uganda has adopted the WHO global strategy of having three million people in the developing world on ART by the end of 2005 and has committed to have at least 60,000 HIV infected people on ART by the end of 2005 (120,000 by 2007).

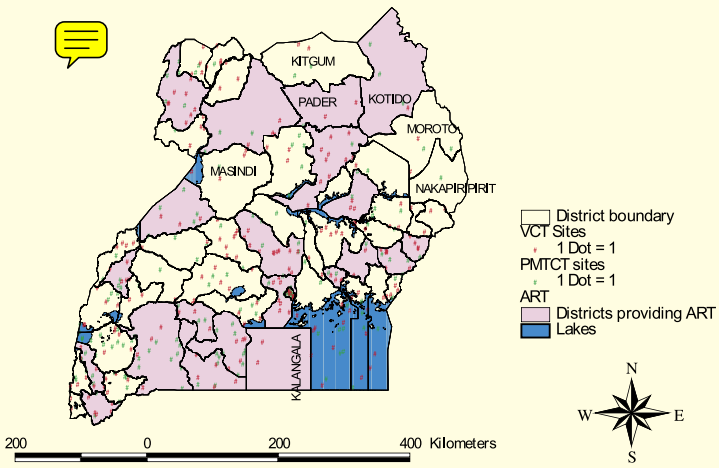
Ministry of Health in collaboration with other partners is on course to achieving this target. Massive capacity building is one major activity that has been undertaken in seven regions i.e. Masaka, Hoima, West Nile, Teso, Karamoja, Mbale and Jinja. So far, 36 districts have been covered with 667 health service providers trained in provision of comprehensive HIV/AIDS care including ART in 25 districts.

According to the MoH, expansion of ART provision was planned in 4 phases:

Phase 1: All regional Referral hospitals –by December 2003.
Phase 2: District and other hospitals (78 in all) –by December 2004
Phase 3: Health center IVs (214 in all) – to be completed by December 2006
Phase 4: Lower level facilities/community

About 42,000 people were accessing ART by the end of December 2004. Of the 112 health facilities from public and private sectors so far accredited to offer ART, 63 sites are providing antiretroviral treatment. 54 of these are public facilities, which include; 11 regional hospitals, 2 national hospitals, 25 district level hospitals, and 18 Health center IVs. There are 30 private-not-for-profit hospitals/medical centers, 18 private-for-profit medical centers/hospitals and 7 centers of excellence/research-based facilities. The public sector ART program was recently launched with ARVs for treating 2,700 adults already distributed to 26 public and private health facilities in June 2004. This includes the 11 regional referral hospitals and Mulago national referral hospital.

District coverage of VCT, PMTCT and ART



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At the end of the 3 days meeting, it was recommended that the protocol of cooperation should be disseminated to all districts, provincial and district authorities and stakeholders should be informed about the epidemic potential risk, training of health workers in the high risk areas/ zones should be intensified, active search of cases of cholera and anthrax should be done in the most affected communities for early detection and treatment, advocacy to partners for resource mobilization should be stepped up, press/news reports on outbreaks should be produced and shared with health workers, leaders and communities and capacity building for HWs and other stakeholders such as media, water and sanitation staff in this region should be supported.

Specific action points were also agreed upon for each of the districts/provinces, the media group, Ministry of Health and the World Health Organisation.

Community-Based DOTS: the Ugandan model of decentralized TB Care

Background

Despite adopting the internationally recommended Directly Observed Short Course (DOTS) strategy for curing and controlling tuberculosis (TB) from 1995, main indicators (case detection and treatment success rates) remained poor in the 90's in Uganda. The poor performance was attributed to several factors including poor access to TB services , high hospitalization and transport costs leading to high default rates as well as little, if any, community involvement in the planning and delivery of TB services. At the same time Uganda, like other high HIV prevalence countries, was experiencing a rise in TB notifications (of about 4-6% annually) that overcrowded and strained the already overstretched health system. There was therefore a need to decentralize TB services.

Decentralizing TB services: to what level and to whom?

As there was no blue print solution at hand, the National TB and Leprosy Programme (NTLP), supported by WHO, involved officials and communities of one district (Kiboga) in the design and piloting of a decentralized TB care model that could address these concerns. The model that came to be known as Community-Based TB Care with Directly Observed Therapy Short course (CB-DOTS) strategy was successfully piloted in Kiboga in 1998.

CB-DOTS model was associated with a number of benefits to the health system, patient/family as well as the community. First of all it halved the costs of TB care to the health services and users alike. As a result of shorter hospitalization time it decongested wards freeing space and staff for other duties. In CB-DOTS TB treatment is decentralized to the community thus positively impacting on TB indicators, reducing defaults while increasing treatment success. The default rate in Kiboga fell from 19% the previous year to 2% during the intervention year 1998 . In addition, both the service users and service providers were satisfied. Lastly, involvement of communities in the planning and delivery of TB service imparts a sense of ownership and thereby promotes sustainability of services.

CB-DOTS differs from the traditional TB care model in several ways. Patients are hospitalized for two weeks instead of 2 months as in the traditional model. Patients' only need to visit facilities on 3 occasions for follow-up sputum test (at 2, 5 and 8 months) and not 6 times for monthly drug supply as before. In CB-DOTS communities are involved in selecting and overseeing community volunteers who observe and record each day's ingestion of medication. A public health worker sensitizes the community to select a volunteer, trains the volunteer and replenishes the community volunteers drug supplies every two weeks and uses the same opportunity to update TB data.

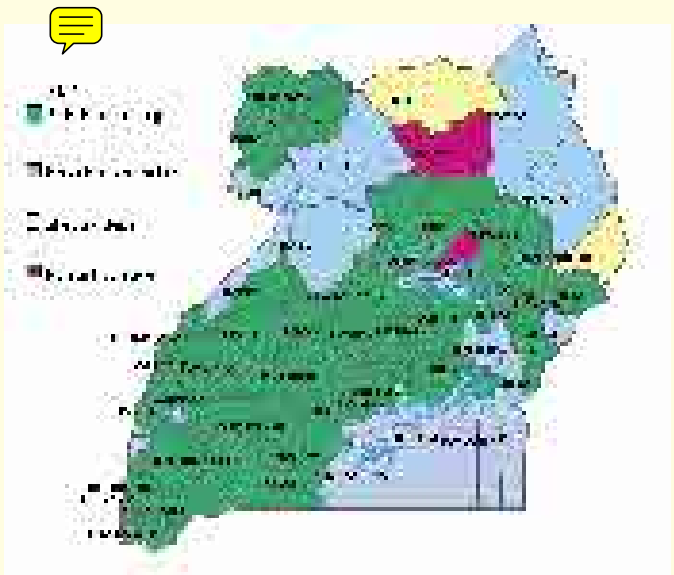
CB-DOTS from research to policy

The MOH was so satisfied with the outcome of CB-DOTS in Kiboga that the strategy was adopted as MOH policy and incorporated into the Health Sector Strategic Plan. Subsequently, the MOH planned to expand the strategy to all 56 districts in the country. WHO in turn was committed to and has supported the MOH to expand CB-DOTS to 51 districts by the end of 2004. Furthermore, WHO is committed to support the NTLP to cover the remaining districts by the end of first quarter 2005.

Steps in introducing CBDOTS to a district

Introducing CBDOTS to a district involves a number of steps. These include situation analysis to identify strengths, weaknesses and corrective measures and draw a plan of action; advocacy with district officials to raise awareness and solicit for their sustained support for TB control from them; training teams of health workers, sub-county teams and initial group of community volunteers, thus preparing the district to initiate implementation of CB-DOTS; identification/ internalization of TB referral system; and provision of transport (usually bicycles) to enable public health workers monitor TB control at community level.

CBDOTS status by end of 2004



[1]*Only 49%□*

[2]*It also improved on the accuracy of recording and reporting with a paradoxical rise in death rates as dead patients who hitherto would have been erroneously labeled defaulters would be correctly classified as dead.*

[3]*With futher support from other partners: GLRA, AIM, UPHOLD and IMC in a few districts.*