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#### Editorial Team:

Dr. Josephine Nambooze	WHO
Dr. Nestor Ndayimirije	WHO
Dr. Jimmy Kamugisha	Min. of Health
Dr. Eddy Mukooyo	Min. of Health
Mr. Peter Kintu	WHO
Ms Diana Nakintu	WHO

#### EDITORIAL

WHO continues to support efforts geared towards strengthening the Health Management Information System and Integrated Disease Surveillance. In view of the global initiative to eradicate polio and other diseases, moreover ensuring prompt response to epidemic outbreaks, there is constant need to collect, analyse and utilise all available disease data regularly. We remain committed to supporting feedback mechanisms aimed at utilising information for action and continue to advocate for improved information technology in the districts.

In Uganda, we are using the platform of AFP Surveillance to establish a functioning IDS system. This has not been easy as there are difficulties with reporting from the districts, where all the data are generated from. However, we are encouraged that our efforts are in line with the thoughts of the Regional Director in this matter.

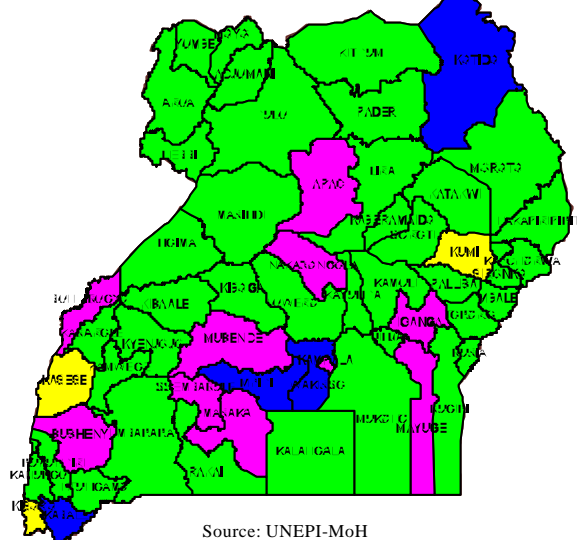
*Dr. Oladapo Walker - WR Uganda*

## Immunization Drop-out in Uganda

**D**PT3 coverage is a key Health Sector Strategic Plan (HSSP) indicator to monitor utilisation of immunisation services in Uganda. The target for the year 2005 has been set at 80%, however it is still low (<60%). One of the contributing factors to this is the high drop-out rate (DPT1-DPT3) in more than 70% of the districts, despite a significant level of access to immunisation services as reflected by the DPT1 coverage. In the few districts (18%) where access is low, the drop-out rate is still high. Some of the probable reasons behind this could be:

- communities have not internalised the usefulness of immunisation and benefits of completing the full doses for children.
- health workers do not inform or remind mothers/guardians to come back for more doses and outreach dates.
- immunisation sessions sometimes conflict with farming/family duties especially during planting seasons and this reduces attendance.
- static and outreach sessions are sometimes infrequent.
- vaccine shortage and/or cold chain breakdown.
- little involvement of local leaders, especially in following up of defaulters.

DPT Coverage/Drop-out rate in Uganda, Year 2000



Source: UNEPI-MoH

- Legend:
- High DPT1 Coverage (>65%), low drop-out rate (<10%)
  - High DPT1 Coverage (>65%), high drop-out rate (>10%)
  - Low DPT1 Coverage (<65%), low drop-out rate (<10%)
  - Low DPT1 Coverage (<65%), high Drop-out rate (>10%)

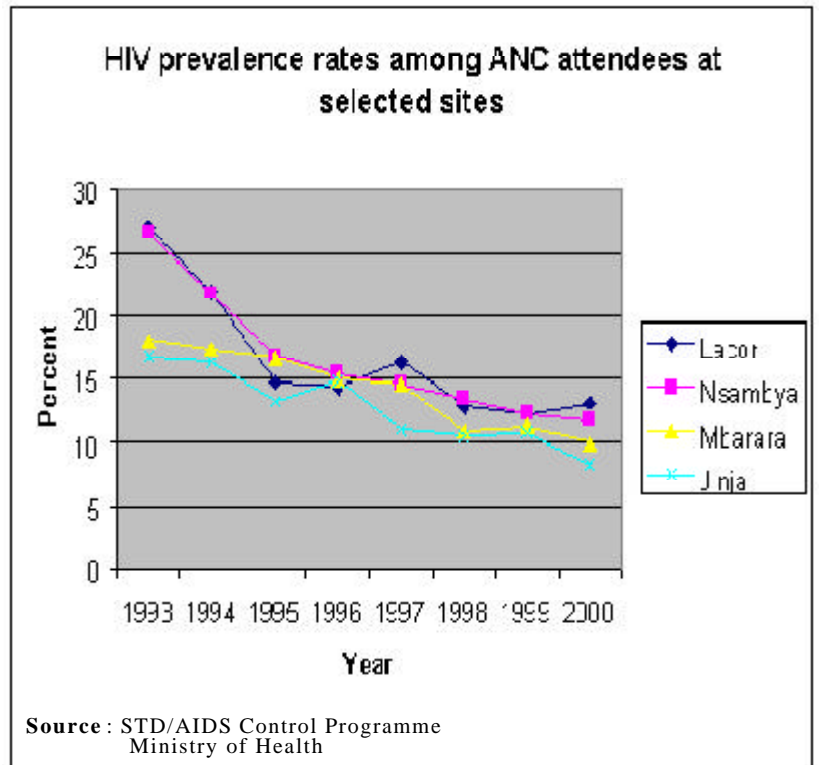
#### Some suggestions for reducing immunisation drop-out rates:

- **Social mobilisation:** train community volunteers, local groups and school children to identify defaulters and direct them to health facilities.
- **Meeting community needs:** involve communities in planning health services, integrate immunisation with other PHC services, immunise women and children at every visit to the health facility when necessary.
- **Provide health education:** distribute EPI IEC materials and organise health education sessions in communities.
- **Organise local immunisation days** and ensure full community participation. ☐

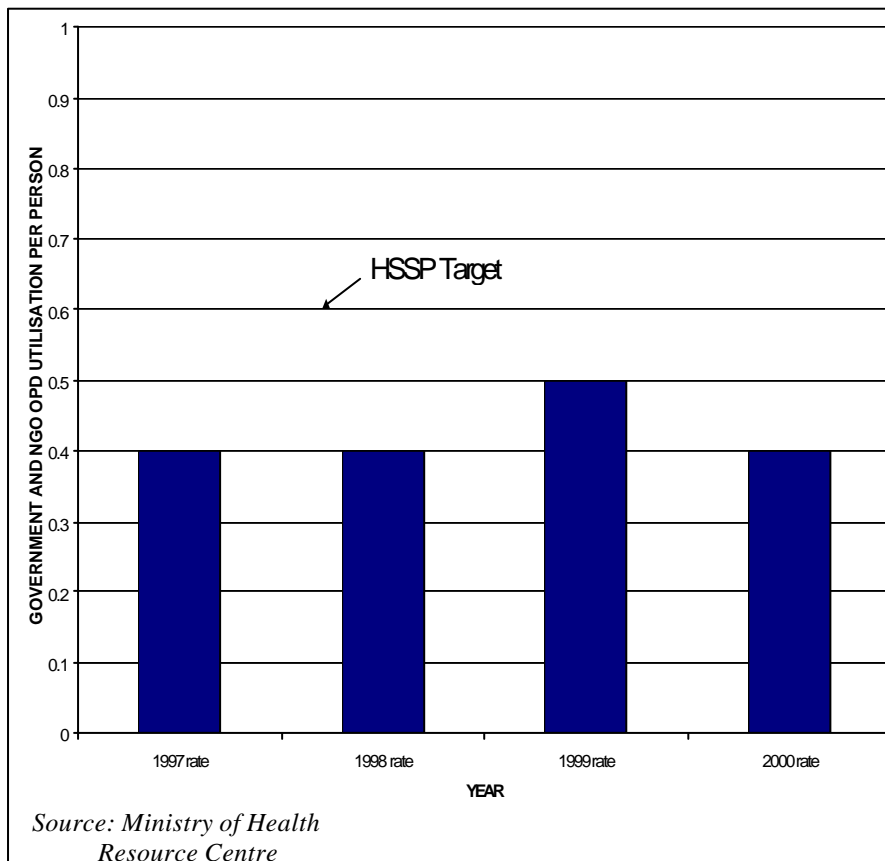
# HIV/AIDS in Uganda

Over the last seven years, HIV infection levels have continued to decline and the current weighted antenatal prevalence rate is estimated at 6.1% (*HIV/AIDS Surveillance Report, June 2001*). This trend has been very similar in all regions of the country and in other high risk population groups like STD patients. General population cohort studies in some parts of the country have also reported significant declines in HIV prevalence and incidence. By December 2000 the cumulative number of reported AIDS cases was 58,165.

All these achievements are attributed to the multi-sectoral approach in HIV/AIDS prevention and control spearheaded by the Government of Uganda and the positive response by the communities in sexual behaviour change. A general population survey was conducted in 1987 and there has been a silent debate on the necessity of validating Uganda's success story in the reduction of HIV prevalence. WHO is proposing to support yet again a second large scale population HIV serosurvey to assist this process. Despite this remarkable decline, there is a great need to intensify efforts for obtaining an effective HIV vaccine as well as curbing mother-to-child transmission to protect those not yet infected and care for those already infected. □



## Utilisation of health services



OPD utilisation was considered a key output indicator for monitoring utilisation of health services in the country during the baseline data collection for the HSSP. For both government and NGO health services, OPD utilisation was found to be only 40% per capita at all levels and age-groups. A five-year target has been set at 60%.

The trend in the past 4 years has been similar, although there appeared to be a slight improvement in 1999. Unfortunately, low rates of OPD utilisation continue to be observed in the current year due to a number of factors, most notably the essential drug stock-outs in many health units across the country. This calls for review of health policies to reflect the realities in lower health facilities. With the introduction of health sub-districts in 2000, it is hoped that services will be fully utilised by the communities. □

# Epidemic Meningococcal Disease

After a huge epidemic of meningococcal meningitis in 1991/1992 in the Great Lakes countries, there has

since been reported unconfirmed meningitis cases in Uganda. In 1997, there was a peak (incidence of 5 per 100,000 which was below the action threshold) in the third quarter of the year, then a significant decline in the trend throughout the years 1998 to 2000. A slight increase in the number of cases has been reported since the first quarter of the year 2001 and continued to rise during the first quarter of 2001 (incidence more than 2 per 100,000). Although there has been a remarkable decline in the second quarter of 2001, this unevenly constant trend is a threat to the national health services.

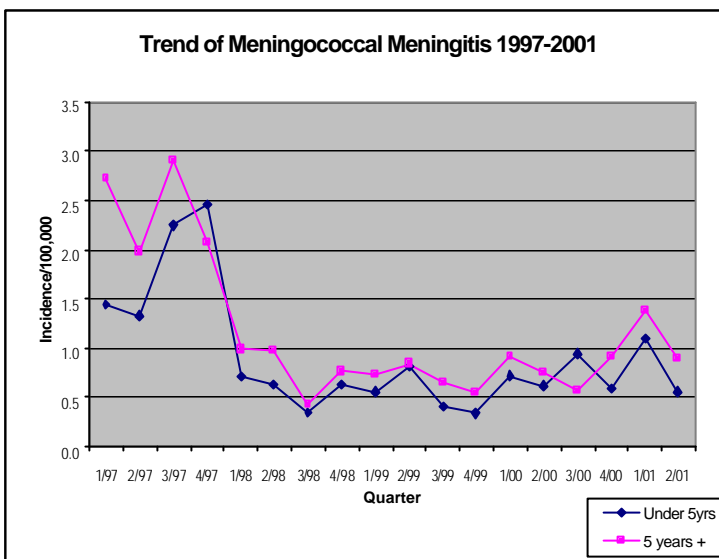
**guidelines for effective early detection and response have been distributed to all countries in the region**

(WER Vol. 75, 38, p305-312)

There is, therefore, need for confirmation and effective preparedness.

Meningitis epidemics occur in the dry season within the so called "meningitis belt" stretching from Senegal to Ethiopia

and the Great Lakes region. Appropriate control measures should be put in place during the current period. Based on a similar experience in the Great Lakes region, guidelines for early detection and response have been distributed to all countries in the region to improve on preparedness. □



Source: Ministry of Health Resource Centre

# Laboratory Networking in Uganda

With WHO technical support, revitalisation of laboratory services in Uganda began during early 2001. A joint training of laboratory and surveillance focal points from satellite districts served by regional hospitals was

held, and follow up visits continue to be made. Refresher training of laboratory technicians have so far been held for 3 out of the 9 regional hospitals, and reporting to the Central Public Health Laboratory has generally improved.

A laboratory database for epidemic diseases has been set up. It will be analysed regularly and shared within the Great Lakes Region and WHO/AFRO. □

**Referrals made to Central Public Health Laboratory in 2001**

MONTH	SPECIMEN	PATHOGENS	DISTRICT
February	Stool	3 <i>V.cholerae</i> , Ogawa	Bundibugyo and Kisoro
March	Stool	2 <i>Sh.flexneri</i>	Kampala
April	Stool	6 <i>V.cholerae</i> , , Ogawa 5 <i>Sh flexneri</i> 1 <i>Sh sonnei</i>	Bundibugyo, Kisoro, Mbarara, Gulu
May	CSF	4 <i>H.influenzae</i> , 2 <i>Str.pneumoniae</i> , 1 <i>Salmonella spp</i> , 1 <i>Klebsiella</i> , 2 <i>Cryptococcus</i>	Mbale
June	Stool No report	2 <i>Sh flexneri</i> , 3 <i>V.cholerae</i> Ogawa	Rakai
July	Stool	7 <i>V.cholerae</i> , Inaba 1 <i>Salmonella typhi</i>	Arua ( index case originated from Sudan) Jinja (outbreak in a boarding school)
August	CSF Joint aspirate Blood	10 <i>Salm. Spp</i> 10 " " 6 " "	Gulu, all except one are aged less than 3 years (? Nosocomial outbreak)

# Revision of HMIS reporting formats

In order to implement the IDS plan of action and effectively monitor the implementation of the Health Sector Strategic Plan, it was agreed by MoH technical programmes and partners that HMIS reporting forms be revised to integrate several aspects and incorporate mortality data collection. WHO has supported the entire exercise from revision to printing and distribution to all districts in Uganda. The revised forms were launched in August and have started being used in all health facilities across the country.

The main advantages include:

- integration of major aspects (OPD, Immunisation, Family Planning, etc) into one reporting format thereby reducing on the workload of records assistants who previously had to fill several forms, and reducing on errors.
- health facility-based mortality data will for the first time be collected on monthly basis and it will be possible to compute case fatality rates for the different diseases regularly.
- at the MoH level, integration of reporting formats will facilitate the smooth running of the central data bank where all data for different programmes will be processed at one location.



*A cross-section of District Directors of Health Services, HMIS and Surveillance Focal Persons at the launching of the Revised HMIS Reporting tools, August 2001*

What remains to be done is to empower districts and health sub-districts to analyse and utilise the collected data for action at the lower levels. A

computer inventory survey in all districts was funded by WHO and it established the weaknesses that need to be addressed and made recommendations to meet this objective. □

# Cholera in the Great Lakes Region

The cholera situation in the great lakes countries has been improving during the last three and a half years. A huge epidemic occurred in Uganda and Tanzania during the first semester of 1998, while Burundi and Rwanda experienced outbreaks of minor magnitude. In 1999, Tanzania experienced another peak in the first semester of the year.

During 1998, the incidence rate was higher (24 per 10,000) in Uganda compared to the overall incidence rate of 11.3 per 10,000 in the region. During 1999 and 2000, the

incidence rates continuously reduced in all countries, 2.7 and 1.6 respectively. According to the case-fatality rate which reduced from 4.6% to 2.8% during 1999-2000, case management has generally improved in the region. In 2001, *vibrio cholerae inaba* was identified in addition to the existing aetiological causative agent (*ogawa*).

It is strongly recommended that appropriate sanitation measures be implemented to prevent the occurrence of cholera in the region. □

