IDS/HEALTH INFORMATION BULLETIN

WHO Country Office for Uganda
in collaboration with Great Lakes Epidemiological Bloc

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EDITORIAL

In line with the Resolution of WHO Regional Committee (RC48) for Africa and regional initiatives namely, Great Lakes Protocol of Cooperation and the East African Cooperation, most of the countries in the region have achieved the assessment of their national disease surveillance systems. Through the implementation of Integrated Disease Surveillance (IDS) Plan of Action, theUgandan Ministry of Health with technical assistance from WHO, is continuing to strengthen the Health Management Information System (HMIS).

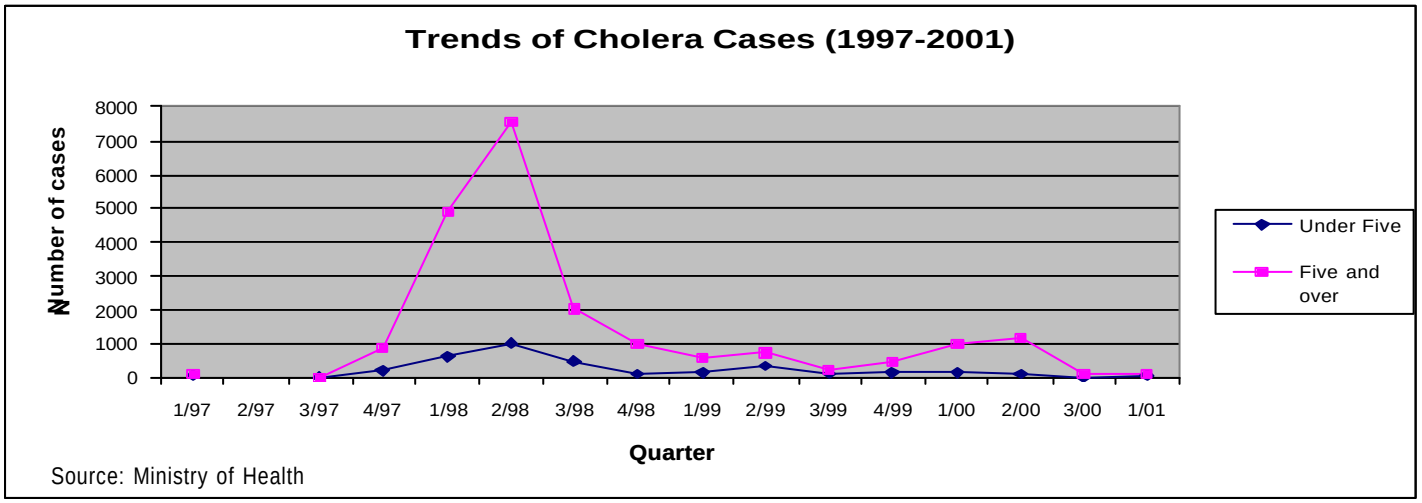
Dissemination and utilization of health information by all stakeholders in the health sector will enable them to rationally plan, mobilize and efficiently utilize the resources in order to improve detection, response, and prevention of major public health problems. WHO is committed to supporting the establishment of a feedback mechanism so that all health information collected from the districts is regularly analysed and utilised to enable effective implementation and monitoring of the Health Sector Strategic Plan 2000/01-2004/05.

The IDS/HIS bulletin will stimulate the monitoring of progress of key indicators and disease trends in Uganda and the Great Lakes sub region, in order to improve on the interventions. In addition, this bulletin will enable WHO to intensify advocacy to development partners to support MoH programmes. Comments and suggestions for improvement are welcome.

Dr. Oladapo Walker - WR Uganda

Cholera trend in Uganda

Cholera - The epidemic due to *Vibrio Cholerae type Ogawa*, started in December 1997, with a major peak (incidence of 9.4 per 10,000) observed in the second quarter of 1998. However, there has been a significant decline in the number of cases since the end of 1998 due to effective response and control. Minor out-breaks with low magnitude (0.6 per 10,000) were reported during the second quarter of 1999 and first quarter of 2000. Only 153 cases have been reported during the first quarter of 2001. The major risk factors include poor sanitation (low latrine coverage that leads to pollution of water sources), and cultural practices especially during burial ceremonies. ❑



Source: Ministry of Health

Immunization Programme

Immunization coverage - During the development of the Health Sector Strategic Plan 2001-2005, a low immunization coverage was observed in the country with baseline indices below 50%. Percentage of children below 1 year receiving 3 doses of DPT according to schedule was agreed upon as the key output indicator for monitoring of immunization.

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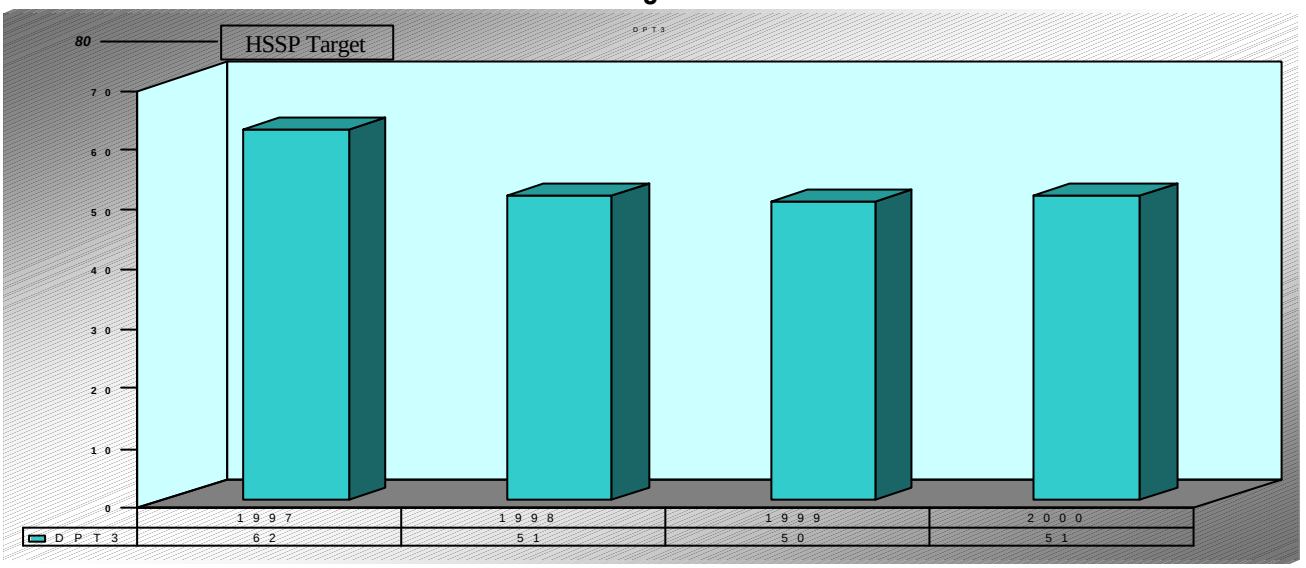
DPT3 coverage was higher in 1997 at 60%, but has declined and remained stagnant at about 50% for the last 3 years (1998-2000) which is still far below the HSSP target.

The Ministry of Health, with support from WHO and other partners, is revitalising EPI activities in the country to ensure improved immunisation coverage in all districts in line with HSSP goals. ❑

DPT3 Coverage 1997-2000

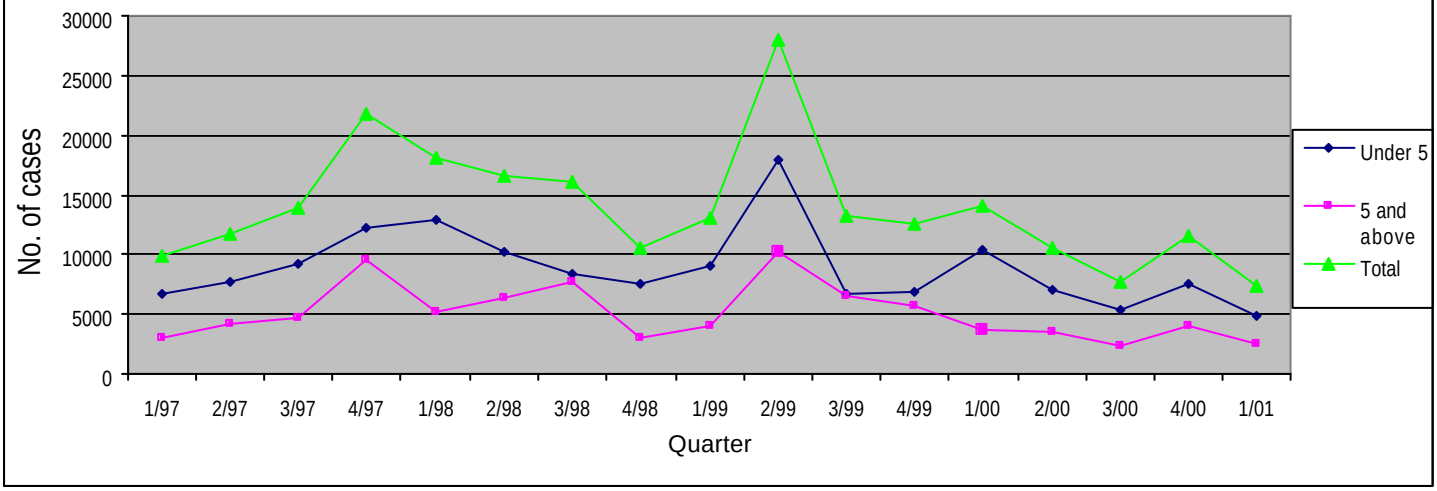


Measles outbreaks occurred with two major peaks in Uganda, one occured during the last quarter 1997 and the other during the second quarter 1999.

The trend has been similar for all age groups. However, children below the age of 5 years have continued to be the most affected through the years.

A mass campaign for measles immunization was initiated in 1999 and its effect can be seen in the sharp decline in the number of cases in year 2000 . A similar trend is continuing to be observed in the year 2001. ❑

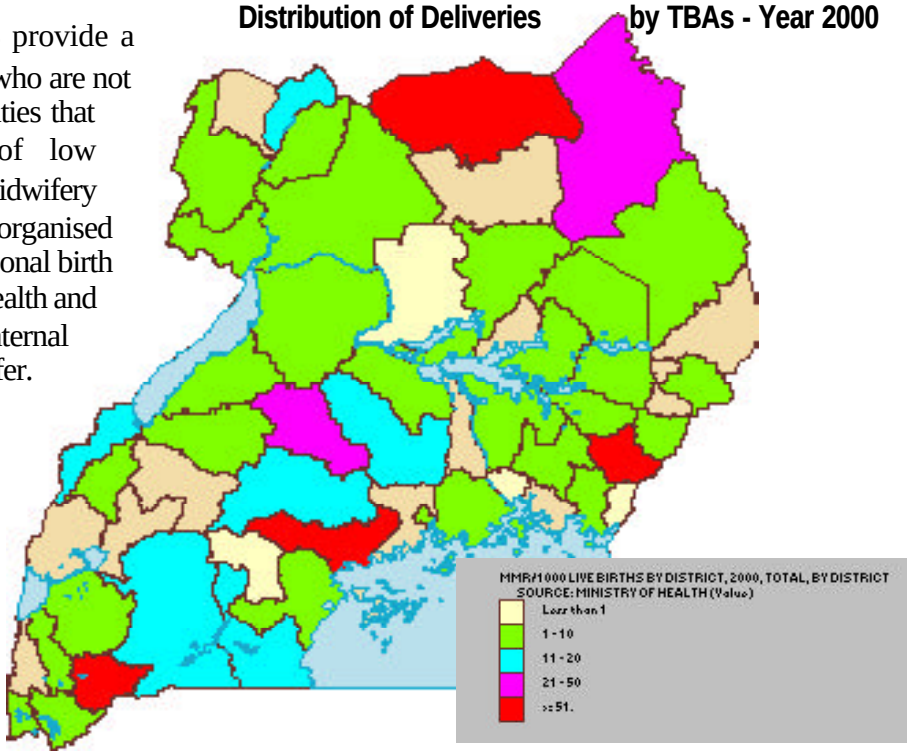
Measles Trend In Uganda 1997-2001



Traditional birth attendants provide a solution to many expectant mothers who are not able to walk long distances to health facilities that have maternity units, and also because of low numbers of trained medical personnel with midwifery skills. Several development partners have organised several training programmes for these traditional birth attendants in modern methods of maternal health and child birth to complement the existing maternal health services and improve their ability to refer.

During the year 2000, traditional birth attendants administered over 30% of the deliveries in more than half of the 45 districts, which is double the 1995 UDHS figures. These trends have serious implication on access and acceptability of maternal and new-born health services. ❑

Distribution of Deliveries by TBAs - Year 2000



Maternal mortality data that is health facility-based can be obtained from in-patient records, however, it has been difficult to get expected reports from all health facilities with in-patient services in the country (Health Centre IV and hospitals). It has been observed that district hospitals and few health centres report on maternal deaths on an annual basis, and these data are taken as a proxy to represent the district.

During the year 2000, data on maternal deaths from district hospitals and health centres distributed across the country were reported to the Ministry of Health. From this data, about a third of the districts are estimated to have a maternal mortality ratio above 1000 per 100,000 live births and are distributed randomly across the country. The official national statistics put this figure at 506 per 100,000 live births (Ref: UDHS 1995). The MoH encourages all districts to endeavour to analyse MMR data and utilize the findings for improved quality of care and community mobilisation. ❑

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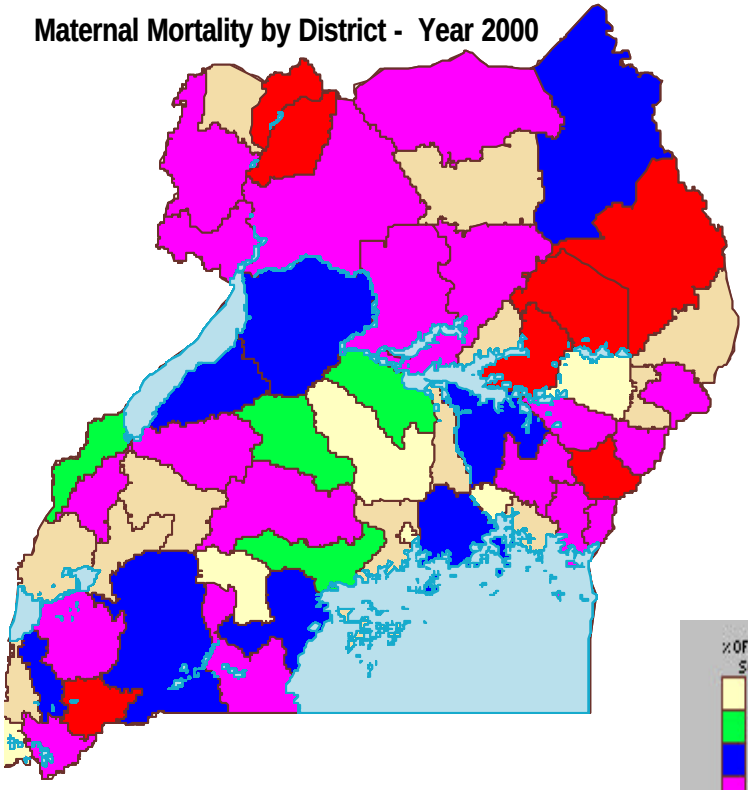
Maternal Mortality by District - Year 2000



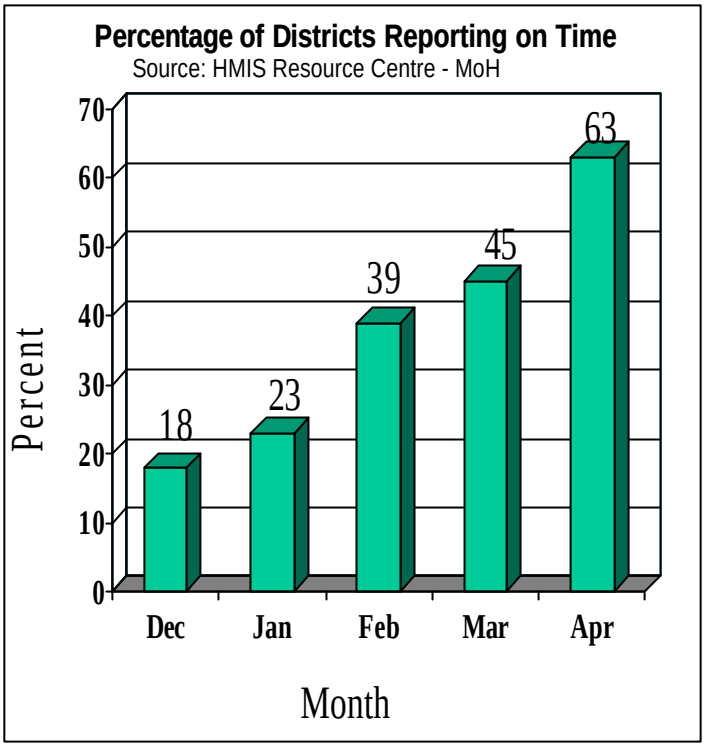
Progress in Reporting

Reporting -There have been remarkable improvements in the timeliness of monthly and weekly epidemic reporting from the districts to the Ministry of Health. This can be attributed to the concerted support from WHO to the HMIS Resource Centre and the Epidemiological Surveillance Division of the Ministry. A quarterly feedback mechanism, whereby data from districts on key indicators is analysed and sent back to the districts (with copies to political leaders), plus a regular weekly epidemic bulletin, have been catalysts in this direction.
The outstanding issues that remain to be addressed include:

- ensuring completeness of the reports
- reports on mortality data which has been lacking
- sustainability of the feedback mechanism

With support from WHO, new HMIS reporting forms have been printed and distributed to all districts. For the first time in Uganda, health facility-based mortality data will be reported to the Ministry on a monthly basis.

Our vision is to establish a district computer network capable of transmitting timely electronic reports to the Ministry and improvement in data analysis at the district level using the EpiInfo software. ❑



Malaria in the Great Lakes Region

Malaria continues to be a major disease burden in the Great Lakes Region. The most affected countries include Burundi and Uganda where a generally increasing trend has been observed over the past 2 years, with over 100,000 cases per month. Tanzania and Rwanda have constantly reported a lower number of cases monthly (incidence below 50/10000 and 140/10000 respectively).

During the last six months (Oct 2000-March 2001), malaria trend in the Great Lakes increased rapidly, with Burundi being the most affected country where the peak reached an attack rate of 1078 cases per 10000 inhabitants in November 2000. Although the Burundi trend declined in the first quarter of the year 2001, the Ugandan situation has been rising steadily (incidence of 208/10000 in March 2001) and this calls for intensified efforts to roll back malaria in the region. ❑