IDS/HEALTH INFORMATION BULLETIN

WHO Country Office for Uganda

in collaboration with Great Lakes Epidemiological Bloc

June 2002 No. 5.

CONTENTS

EDITORIAL

Integrated Disease Surveillance and Response (IDSR) strategy is key for communicable disease control and response to epidemics. At the end of May 2002, Uganda hosted the 3rd regional IDSR annual taskforce meeting due to its high commitment to IDSR implementation.

In the coming months, IDSR is going to focus on the improvement of interventions and response.The initiative of the Ministry of Health to award prizes to districts with good performance in EPI activities and HMIS reporting is in the positive direction. However, there is need for more efforts in strengthening collection, analysis and utilisation of both morbidity and mortality data for better monitoring and evaluation of interventions. The experience of other Great Lakes countries may serve as an example for improvement in reporting mortality data. Improving access to essential drugs for priority diseases in the country will be the next key support intervention for IDSR.

Dr. Oladapo Walker - WR Uganda

Improving EPI Performance in Uganda

THE HEALTH SECTOR STRATEGIC PLAN (2001-05) in Uganda has put strong emphasis on immunisation for all Ugandan children below 5 years of age. DPT3 coverage is one of the key output indicators of the HSSP, with a five-year target set at 80%. The current data, however, indicates that more than half of the districts in Uganda have a DPT3 coverage of less than 80% and a DPT1-3 drop-out rate of more than 10%. Since the beginning of 2001, the Ministry of Health, with support from WHO and other partners, has initiated a programme to revitalise immunisation coverage in the country to fulfil the HSSP goals.

During the launching of the revitalisation of immunisation and home-based management of fever in Uganda in June 2002, ten districts were awarded prizes for good performance in EPI activities. The assessment criteria *(table below)* used mainly data from Integrated Disease Surveillance for the years 2000 and 2001.

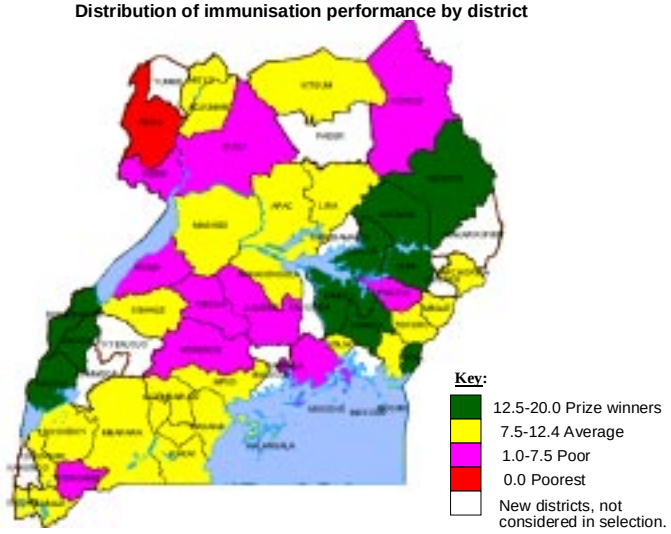
Criteria for selection of best performing districts

Number	Variable	Score
1	Districts that maintained DPT3 coverage ≥ 80% for 2000	2.5
2	Districts that maintained DPT3 coverage of ≥ 80% for 2001	2.5
3	Districts with fully immunized children from 1998/9 EPI coverage surveys of above 60%	5
4	Districts with DPT1 - 3 drop out rate < 10% for 2001	5
5	Improvement in DPT3 coverage of >10% between 2000 and 2001	5
6	District timeliness of reporting to HMIS of ≥ 80% in 2001	2.5
7	District completeness of reporting to HMIS of ≥ 80% in 2001	2.5
8	80% of stool specimens collected within 14 days for AFP cases	5
9	Measles coverage for 2001 was used as the tiebreaker	

Using this criteria, the districts in the western and eastern parts of the country appeared to be doing well in terms of immunisation coverage and IDS reporting compared with the central and northern districts.

On the whole, the best district (Moroto) scored only 20 out of the total score of 30. Therefore, there is need for more effort and support in revitalising immunisation coverage and stengthening IDS across the country. ❑

Distribution of immunisation performance by district



Source: EPI Team, WHO
UNEPI, Ministry of Health

Mortality Reporting in Uganda

MORTALITY DATA from health facilities is crucial for the evaluation of the quality of case management and the performance of disease specific programmes.

Reporting on mortality data has been lacking for a long time in Uganda due to administrative and structural problems. In the past two decades, reporting tools for in-patient, including mortality data were only available for hospitals and reporting was done only on an annual basis directly to the Ministry of Health. It was also noted that the health centres with in-patient services were not required to report on mortality data. In 1993, Ministry of Health introduced the Health Management Information System (HMIS) in order to improve the reporting system but unfortunately mortality data was not captured in the HMIS tools on a monthly basis.

In 1998,during the introduction of IDSR in Uganda, the need to review HMIS was highly recognised to include in the reporting tools the priority diseases as agreed upon by the IDSR committee. In addition, this was also to respond to the increasing demand from MoH programmes and partners. After two years of fruitful work with the various programmes, the revision of HMIS tools was concluded in July 2001. The periodicity of reporting was revised from annually to monthly and through the office of the District Director of Health Services (DDHS). According to the revision, all health facilities with in-patient services were included in the reporting system. Furthermore, introduction of monthly mortality reporting would ease the work of records assistants who originally had to compile yearly totals.

So far, only few districts (5) have started reporting on mortality data.

During the dissemination of revised HMIS tools, there were no clear instructions about the changes in the channel of transmission of reports from hospitals and health centres given the fact that they were not used to reporting to the DDHSís office. In addition to this, the clinicians and record assistants from hospitals who are the source of the information were not properly sensitized on the new reporting system which demanded reporting through the DDHSís office and on a monthly basis.

Way forward:

- Encourage the use of data generated from the reporting system, especially at the service delivery level.
- Organise sensitization sessions for clinicians and record assistants on the importance of mortality data and the new mechanism for reporting.
- Disseminate clear instructions on reporting mechanisms to the DDHS by hospitals and health centres with in-patient services.
- Include mortality data in the monthly feedback to the DDHS.

Since the beginning of the year 2000, other countries in the region (Rwanda, Burundi and Tanzania) have continuously reported on mortality on a monthly basis. Although Uganda has performed very well in weekly epidemiological reporting, the MoH needs to improve on monthly mortality data reporting using the experience from other countries.

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Dysentery in Uganda

DYSENTERY continues to be one the key epidemic-potential diseases in Uganda. The Epidemiological Surveillance Division of the Ministry of Health has provided a simple case definition for bacillary dysentery to all health workers in Uganda as ëany person having diarrhoea with visible blood in the stool and usually accompanied with abdominal painí. The alert and action thresholds have been defined as ëan increasing trend in the number of cases of bloody diarrhoeaí and ëany increase in number of deaths due to bloody diarrhoeaí respectively.

During the past 3 years, high incidence levels of bacillary dysentery have been observed in the first quarter of each year. This coincides with the onset of the first rain season, and probably poor sanitation and hygiene practices in many parts of the country contribute to the prevalence of the disease. The general trend, however, indicates that cases of bacillary dysentery are on the increase in the country. A four-fold increase in the number of cases has been registered between January 1999 (2,300) and January 2002 (8,300). Current data from the weekly epidemiological reports indicate that 54 out of 56 districts are reporting dysentery cases.

The majority of the reported cases are clinically diagnosed, but this broad definition may contain other types of dysentery. Some districts send stool specimens to Regional Referral Laboratories and the Central Public Health Laboratory for confirmation. It is recommended to put more effort in processing laboratory specimens at the beginning of the outbreak in order to confirm and establish drug sensitivity.

The epidemic trend suggests a seasonal increase and a rising magnitude which calls for indepth assessment of dysentery in order to initiate appropriate preventive measures.

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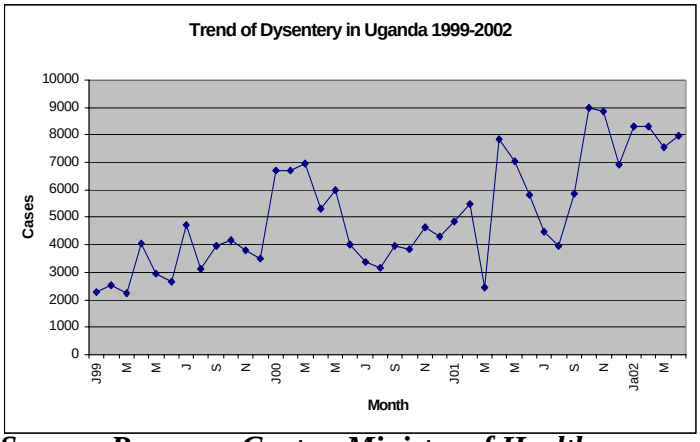

Source: Resource Centre, Ministry of Health

Current status of IDSR implementation in GL Countries

In the Great Lakes region, the introduction of Integrated Disease Surveillance and Response (IDSR) strategy started in Tanzania at the end of 1998. So far, the other countries started the implementation of this strategy in year 2000. Currently, the overall implementation level of the IDSR process is about 52%. The variables used for this estimation are the major steps for IDSR implementation, establishment of IDSR structures at country level, basic equipment and some important functions for IDSR (*see table below*).

Status of IDSR strategy implementation in GL Countries

Achievements	Burundi	DR Congo	Rwanda	Tanzania	Uganda	Remarks
1. Conducted sensitization	yes	yes	yes	yes	yes	5/5
2. Conducted assessment	no	yes	yes	yes	yes	4/5
3. Developed IDSR plan	no	yes	yes	yes	yes	4/5
4. Adapted IDSR guidelines	no	no	Yes	yes	yes	3/5
5. Adapted IDSR training modules	no	no	no	yes	no	1/5
6. Started implementation	no	no	yes	yes	yes	3/5
7. Established IDSR committee	no	no	yes	yes	yes	3/5
8. Designated IDSR focal point (provincial/ district and HF) (2)	0/2	0/2	0/2	2/2	2/2	4/10
9. Has equipment (computer, e-mail) (2)	2/2	0/2	0/2	2/2	2/2	6/10
10. Has Data Manager/stat	Yes	No	No	No	Yes	2/5
11. Has bulletin (weekly/monthly) (2)	1/2	0/2	0/2	0/2	1/2	2/10
12. Established lab networking	No	no	no	Yes	yes	2/5

On the status of IDSR implementation using the core indicators, a questionnaire was filled by MoH and the results are presented in the following table. By the end of 2002 (3 years of implementation), an indepth evaluation should be done by a joint team of WHO and MoH in the different countries in order to appreciate the level of implementation of IDSR downstream (provincial or district level).

IDSR Indicator	Burundi	DR Congo	Rwanda	Tanzania	Uganda
1. HF submitting timely surveillance reports		20%	70%	50%	61%
2. Reported outbreaks of epidemic-prone diseases notified to the next level within 2 days of surpassing the epidemic threshold in 2001		0%	100%	90%	-----
3. Cases of disease targeted for elimination/ eradication reported using case-based forms or line lists.		33%	25%	100%	50%
4. Investigated outbreaks reported with case-based data in 2001.		59.4%	100%	5%	47%
5. Districts that have current trend analysis for selected priority diseases.		60%	100%	25%	80%
6. Reported outbreaks of epidemic-prone diseases that occurred in 2001 with lab confirmation results.		54%	100%	90%	76%

Source: MoH

Way forward:

- Use the experiences and success stories to accelerate the implementation process.
- Countries with security problems (Burundi, DR Congo), could implement IDSR in relatively peaceful areas .
- Accelerate the establishment of laboratory networking.
- Conduct a formal evaluation using IDSR core indicators to assess what is happening downstream (provincial or district level) by the end of 2002. ❑

Lab Networking: Analysis of Drug Sensitivity in Uganda

Following IDSR implementation in Uganda and with support from WHO, laboratory networking has been functional since June 2001. Since then, 9 districts have sent samples to the Central Public Health Laboratory (CPHL). The samples have been processed and antibiotic sensitivity tests performed.

The following table shows the enteric bacterial pathogens reported by the CPHL from the samples. Numbers susceptible to the commonly used antimicrobial agents are also shown.

Antimicrobial Sensitivity of Enteric Bacterial Pathogens with Epidemic Potential in Uganda: 2001/2.

Pathogen	Number of samples	COT	AMP	TET	CHL	NAL	CIP	ERY
Shigella dysenteriae type 1	9 (only 3 tested)	0	0	0	2	3	3	-
Shigella Flexner	21	0	1	0	1	21	21	-
Vibrio-cholerae Inaba	9	0	0	7	0	1	7	7
Vibrio-cholerae Ogawa	24	0	0	24	0	0	24	24
Salmonella enteritidis	26	0	0	0	0	26	26	-
Salmonella typhi	3	0	0	1	3	3	3	-

Source: Central Public Health Laboratory, MoH.

Cotrimoxazole and ampicillin, easily available over the counter, are ablated from effective drugs. Other than for cholera, tetracycline is also ineffective. Although chloramphenicol showed activity against *Salmonella typhi*, its poor inhibition of *Salmonella enteritidis* is of concern, hence the need to differentiate between *Salmonella typhi* and other salmonellae whenever salmonellosis is considered as a diagnosis.

These results should contribute to formulation of an effective antibiotic policy for the Ministry of Health. ❑

COT = Cotrimoxazole
AMP = Ampicillin
TET = Tetracycline
CHL = Chlorampenicol
NAL = Nalidixic acid
CIP = Ciprofloxacin
ERY = Erythromycin

Essential Drugs and Medicines Policy in Uganda

In the 2002-2003 biennium, the WHO Country Office Essential Drugs Management programme focuses on support to the Ministry of Health (MoH) for improved capacity for the National Drug Policy (NDP) implementation and monitoring. This is in line with the WHO Global Medicines Strategy of saving lives and improving health by helping to close the gap between the potential that essential medicines have to offer and the reality that for millions of people medicines are unavailable, unaffordable, unsafe or improperly used.

WHO will support the MoH to ensure that all Ugandans can obtain the medicines they need, at a price they and the country can afford; that these medicines are safe, effective, and of assured quality; and that they are prescribed and used rationally.

This work is being guided by 4 objectives outlined below and within the framework of the drug management cycle.

- **National Drug Policy**: Implementation of the new NDP, which is basically a guide to coordination of action by all stakeholders.
- **Access to Essential Medicines**: Selection of drugs, financing, pricing and supply systems.
- **Quality and Safety of Medicines**: Standards and effective regulation by the National Drug Authority (NDA), information support.
- **Rational Use of Drugs**: Treatment guidelines, dissemination of information and training for health professionals and consumers, public and private.

THE DRUG MANAGEMENT CYCLE:

The cycle emphasises the relationships between drug selection, procurement, distribution, and use activities, which are nurtured by a strong management support system. The entire cycle will rest upon the NDP and legal framework that upholds the commitment to an effective drug supply system for Uganda.

In addition specific emphasis is being placed on improving access to essential drugs for priority diseases such as HIV/AIDS, TB, Malaria and other Childhood illnesses. ❑

Epidemic-prone Zones in the Great Lakes

Disease surveillance, preparedness and response have been improved in the Great Lakes Countries. This is in comparison with the past 5 years experience of the Great Lakes Epidemiological Bloc. It has been observed that commendable improvement has been made in disease surveillance in timeliness and completeness of reporting. As a result, epidemic disease trends and their magnitude can be monitored in order to provide response and appropriate actions.

In October of each year, WHO and Ministry of Health officials from Great Lakes region working in disease surveillance, preparedness and response meet to review the progress made in this area. Although remarkable progress has been made in disease surveillance and information sharing, there are some weaknesses in preventive activities and lack of resources to control the epidemic-potential diseases. Different actions undertaken in the last five years have led to the control of epidemics in many regions of different countries (e.g. cholera), but they are still confined in few pockets called epidemic-prone zones. These zones are generally located along border districts or provinces .

In the last meeting held in Bujumbura in October 2001, participants identified six epidemic-prone zones in the Great Lakes region. The aim was to focus on these zones to initiate preventive measures and improve continuous disease surveillance in order to effectively control the epidemic-potential diseases in the region.

The implementation of preventive and control activities in these zones has been hindered by lack of resources. Although disease surveillance is still going on, very little has been done in the prevention and control of epidemics.There is need to mobilise more financial support from partners in order to initiate projects focussed at those zones.

Zone A: Around Kigoma on Lake Tanganyika
Zone B: Borders DR Congo, Rwanda and Uganda
Zone C: Around Kagera River
Zone D: Around Lake Ki vu
Zone E: Around Lake Albert
Zone F: Borders Rwanda and Burundi