



Health, Nutrition and HIV/AIDS Newsletter

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Editorial

By Dr. Olushayo Olu,
Health, Nutrition & HIV/AIDS Cluster
Coordinator

The year 2008 has been very eventful; in January we were faced with an outbreak of meningitis in the midst of an ongoing Ebola outbreak in Bundibugyo and Hepatitis E in Kitgum. In February we were able to control the Ebola outbreak and declared the country Ebola free. In March we re-opened discussions and commenced development of a health recovery strategy and district specific PRDP health plans for all 40 PRDP districts. Amidst all of these competing needs and issues, we were unable to produce the first quarter edition of the cluster newsletter. To this end, we have combined the first and second quarter editions of the newsletter and we are happy to present to you some very exciting and interesting articles on topical issues within the health care system of the country.

In this issue of the newsletter we bring you a very interesting article on Medical Male Circumcision (MMC), a new but contentious HIV/AIDS prevention strategy. We also bring you among others, articles on new innovations in PMTCT in Gulu, HIV/AIDS prevention in Karamoja, Hepatitis E outbreak in Kitgum and integration of refugee health services to district health system in northern Uganda. We have also introduced a new section called district highlights which will give a quick glance at district health performance in addition to the regular sections on news and events.

Many thanks for your cooperation and support to the health, nutrition and HIV/AIDS cluster in Uganda and please relax and enjoy this edition of the cluster news letter

Inside this issue

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Male Medical Circumcision for HIV prevention: Which way Uganda?

By: Dr. Innocent Nuwagira, HIV Unit, WHO Uganda



National dissemination of the randomized controlled trial study results.

What is MMC?

Medical Male Circumcision (MMC) has two definitional dimensions: first, as a surgical procedure, it is the removal of the foreskin of the male reproductive organ, the penis. This practice has been on for a long time, usually for medical, religious or cultural indications. However, the use of the term “medical circumcision” is deliberate as it refers to the procedure being done under medical surgical conditions. On the other hand, and most recently, MMC can be seen from the point of a new technology for HIV prevention. Seen this way, it is part of a set of interventions and measures that form a comprehensive package for HIV prevention. It is important to understand that MMC does not provide complete protection against HIV infection, hence not a stand-alone intervention but is part of a package.

The evidence – role of MMC in HIV prevention

Some stakeholders have questioned the nature and level of evidence regarding MMC for HIV prevention. There is ample and compelling evidence supporting MMC for HIV and this evidence has accumulated over a period of time.

Four ecological studies, 35 cross-sectional studies, 14 prospective studies and 3 randomized control trials have been conducted across Africa and other parts of the world.¹ Several studies among populations with different levels of male circumcision prevalence have indicated that circumcised males are less likely to be infected by sexually transmitted infections, including HIV.^{3,4} All the three studies established that MMC was partially protective (up to 60%) against HIV transmission from women to men. In medical research terms, RCTs

provide the strongest possible evidence obtainable by research. It is, therefore, plausible to argue that evidence supporting MMC for HIV prevention is beyond reasonable doubt and compelling. Venturing into the biology of the male reproductive organ provides some plausible explanations regarding the protective effect of MMC against HIV infection.

The foreskin has a very high concentration of HIV target cells, thus making this part of the body a very weak point for HIV entry. Besides, the thin layer of the inner foreskin is susceptible to minor tears and abrasions, and can facilitate entry of infectious organisms, including HIV pathogens. Additionally, the area under the foreskin remains a warm, moist and comfortable environment for rapid replication of many pathogens, some of which cause ulcers that further facilitate HIV entry. Therefore, removal of the foreskin denies HIV this weak.

It is important to note that the benefits of MMC do not stop at reducing the likelihood of HIV infection. In fact, available evidence suggests that several other benefits accrue from MMC. It has been established that male circumcision reduces the risk of genital ulcers, syphilis, chancroid, human papilloma virus, invasive penile cancer, and cervical cancer in the female partners. Of course, all the above are in addition to improved personal and spousal hygiene. Mathematical and statistical models have also added more flavour to the MMC debate. For example, the emerging consensus is that 100% coverage by MMC could avert about 6 million new infections and 3 million deaths in sub-Saharan Africa alone in the next two decades.⁵ In Uganda, the recently concluded National Strategic Plan puts the impact of complete coverage with MMC at a reduction of incidence by 15% in the next 5 years. In terms of HIV epidemicity, the above modeled impact would be a phenomenal contribution to the epidemic decline.

Global consensus on MMC Informed by research, consultations, and expert opinions,

WHO and UNAIDS consultations, and expert opinions, WHO and UNAIDS drew a list of global recommendations regarding MMC for HIV prevention. It has, for example, been recommended that MMC be recognised as an additional important intervention to reduce the risk of heterosexually acquired HIV infection in men; and that MMC be considered as part of a comprehensive HIV prevention package and not a substitute of any effective prevention method. This point emphasizes that MMC should be considered together with ABC+ strategy. It was further recommended that countries with high HIV prevalence, generalized heterosexual HIV epidemics and low rates of MMC consider to urgently scale up access to male medical circumcision services; and that MMC be provided with full adherence coverage with adherence to medical ethics and human rights principles, including informed consent, confidentiality, and absence of coercion. Policy and programme implications of MMC scale up.

The recommendations by WHO and UNAIDS have significant and far reaching effects depending on how countries respond. Should countries consider scaling up availability and access to MMC services, there are issues that need to be addressed before full scale up. If countries decide not to scale up, this could be a missed opportunity. Because, at 60% efficacy, MMC is as good as any other available vaccines. For those countries with generalised heterosexual AIDS epidemics scale up MMC is most advisable. Indeed Uganda like many a developing country, fits in the recommended category for rapid scale up of MMC for HIV prevention. In case of Uganda, there are conceptual, cultural, political and health systems issues to handle in order to

realise and maximise the public health benefit of MMC:

- Socio-cultural issues in the context of introducing or expanding the availability of MMC services including socio-cultural adaptation, promotion and delivery of MMC in a culturally appropriate manner that minimizes stigma associated with circumcision status
- Wide consultations to ensure meaningful engagement of all key stakeholders.
- Ensure that human rights, legal and ethical professional codes of conduct and principles guide policy and programming to ensure safe, accessible and equitable service delivery.
- Monitor and reduce potential harmful outcomes of promoting MMC, including minimizing potential negative gender-related impacts.

What has Uganda done regarding MMC so far?

Uganda has moved in the right direction albeit cautiously. Although available statistics indicate that there has been increased demand for services in most surgical sites in the country, government is taking time to consult stakeholders and move rather slowly. WHO has been supporting government in all the activities this far. Some of the activities have included:

- National dissemination of the randomized controlled trial study results.
- A national dialogue meeting on MMC, and a number of other on-going public debates and discussion fora both in the capital city and some districts, especially those in Eastern and Northern Uganda.
- Completed the desk-review part of the national MMC Situational Analysis that is scheduled to be completed by July this year.
- Participated in several meetings and expert consultations at various levels, including hosting an international meeting on *meeting the demand for male circumcision* held in Kampala, mid March 2008, co-sponsored by WHO, UNAIDS, and The Bill and Melinda Gate Foundation.

Ministry of Health scales up Antiretroviral treatment in northern Uganda

By Dr. Engwau Francis NPO HIV/AIDS WHO Lira

In 2003, World Health Organization (WHO) and United Nations AIDS (UNAIDS) launched the Three by Five in order to increase the number of people accessing antiretroviral therapy. To address the challenges of the Three by Five and of Universal Access, In 2004

WHO developed a public health approach for scaling up treatment and care in resource limited countries. The Integrated Management of Adult and Adolescent Illness (IMAI) ensures a systematic and comprehensive approach to care, treatment and prevention in the management of HIV/AIDS at hospitals, health centers and communities. The IMAI approach uses simplified, standardized guidelines to support delivery of ARVs in resource limited settings.

Since 2004 the Ministry of Health (MoH) with the support of various stake holders embarked on scaling up of this public health approach country wide. Currently over 120,000 patients out of the estimated 300,000 who are in dire need of ARVs are accessing comprehensive chronic HIV care including ARVs.

Northern Uganda has been affected by over 2 decades of conflict and as a result, many health services and service delivery points have been adversely affected. HIV/AIDS services like counselling and Testing (HCT), Anti-Retroviral Therapy (ART) service delivery have not been spared of the problem either.

By the end of 2007, the northern region had 44 ART sites for a population of over 2.5 million people with an HIV prevalence of 8.3% from the 2005 National behavioural and sero survey. Of the estimated 224,000

people who are infected with HIV, 30,000 are in need of ARVs. However only 12,000 people are able to access these medicines in this region representing approximately 35% of the estimated patients eligible for

ARVs.

In a bid to provide ART service delivery in health facilities in northern Uganda, WHO supported the Ministry of Health in 2006 to train 98 health workers from various health facilities in comprehensive HIV/AIDS management. However the ART sites still faced a number of challenges such as high attrition of health workers, very high workload and often working for long periods with limited motivation hence many of the trained service providers tend to avoid working in the ART clinics.

With the enormous challenges ART clinics face, Ministry of Health with the technical and financial support of WHO

and Northern Uganda Malaria, Aids and Tuberculosis (NUMAT) recently conducted an IMAI training of 56 health workers drawn from 21 health facilities in Lira district to scale up ART

services in northern Uganda. In the process of organising for the training, WHO and NUMAT had a number of discussions. WHO supported MoH in identifying and facilitating central trainers while NUMAT identified and facilitated the regional trainers and the Expert patient trainers (EPTs). Participants were identified by both WHO and NUMAT.

The training was composed of clinicians, nurses, midwives and counsellors who were equipped with knowledge and skills to carry out basic antiretroviral therapy including initiation of ARVs, support, monitoring and management of opportunistic infections. Another group of Expert patient Trainers (EPTs) who are Persons living with Aids (PLAs) were trained to give expert guidance to trainees on specific clinical needs of AIDS patients. The trainings for each category consisted of active participation by all, the use of visual aids and role plays. There were also outdoor practical sessions at the skills stations in which the participants interacted with the Expert patient Trainers and engaged in card sorts. A general patient management and logistics management session was also held. Finally, actual practical clinical sessions where participants had real

patients took history, made diagnoses and provided management of the patients was done with feedback from the facilitators. Of the 21 health facilities from which the health workers were trained, 15 already existing ART sites were

strengthened and 6 new health facilities, health centre IIIs from high risk communities such as fishing communities, will be able to provide ART.



IRC targets at having an HIV-free generation in Karamoja

By Thomas Bohnett, Communication intern - IRC Uganda

Karamoja region is set apart from the rest of Uganda both by geography and by the traditions of its inhabitants, most of whom are semi-nomadic livestock herders.

Throughout the 1980s and 1990s, this isolation kept Karamoja safe from the HIV/AIDS epidemic infection rates of 75% lower than elsewhere in Uganda.

However a number of changing factors including high levels of rape and increasing migration to large urban areas such as Kampala the country's capital coupled by skyrocketing rates of infection of 3.5% of those aged 15-49 are fuelling infection rates in the region as compared to less than 2% just a few years ago.

The HIV prevalence rate is still lower than the national rate of 6.5%, but increasing at an alarming rate. "There is a real crisis here, and we don't have much time left before this goes out of control," said International Rescue Committee (IRC) Uganda HIV/AIDS program officer Drametu Jimmy.

In response to the situation, the IRC recently launched a new program in Karamoja focused on the prevention of transmission of HIV/AIDS from pregnant mothers to their unborn babies. The programme focuses its support on twenty health centers spread across the region. It supports HIV positive pregnant mothers with nevirapine just before going into labour; this treatment is up to 85% effective at preventing infection in children born to HIV/AIDS positive mothers. Since the launch of the program 3 month ago, 25 mothers have received the treatment.

According to Florence Okot 32, when she learned of her HIV status she thought that her life had come to an end and was sure that her unborn baby would also get infected with the HIV virus but after a few month of taking the anti-retroviral therapy and the administration of a drug designed to prevent HIV from being transferred to her unborn baby, Okot smiled on her way home after giving birth to a healthy baby. The rashes on her forehead and arms had cleared and her exhaustion lifted. She eventually gathered enough energy to run her small business of mending clothing in Kotido.

In a community where HIV/AIDS stigma is still high, Okot said *"I am now*



able to say, 'Look at my child. Look at my work. Am I not alive? I am as much a part of this community as you.'"

Reaching potentially infected mothers is a significant challenge in Karamoja, where the population moves widely across a rural area with poor or non-existent infrastructure. To respond to this, the IRC trains and sponsors mobile health teams to go where populations are to offer testing and treatment, and especially to encourage mothers to deliver their children at health centers where nevirapine can be administered. The HIV/AIDS Coordinator Alex Opio Chono says, *"If we are able to get the mothers to the health centers for delivery,*

we can achieve remarkable results."

Because HIV/AIDS is still relatively new to Karamoja, knowledge and attitudes about the disease lag behind the rest of the country. A recent study conducted in 2005 by the Government of Uganda revealed that only 15% of women of reproductive age knew that transmission of HIV/AIDS from an infected mother to her child was preventable, compared to the 35% elsewhere in Uganda. The spread of HIV/AIDS within Karamoja is closely related to the use of rape during violent cattle-raiding among the region's different clans and the still-common practices of rape during courtship and of bride inheritance, in which a widow is taken as a wife by a male member of her husband's family.

To counter these practices and their effects, the IRC also operates education efforts around gender-based violence in six sub-counties in Karamoja and offers clinical services in the three health centers in Kotido, Moroto, and Nakapiripirit that respond specifically to the needs of rape survivors. The IRC further sponsors regular community gatherings in the where drama groups perform plays and songs with HIV-related educational themes with a number of the performances introducing to male audiences the idea that practices of rape and abuse of women's rights are flatly unacceptable.

Although there are few partners dealing with HIV/AIDS programmes in the region, the IRC is committed to ensuring that the people of Karamoja receive similar services and knowledge on HIV like any other persons in Uganda ■

Improving follow up of babies born to HIV positive mothers at St Joseph's Hospital, Kitgum district. *By Angella St.Jules, Head of Health - AVSI Kitgum*

In Uganda, Mother to child

transmission of HIV is the second major mode of spread of the virus and virtually the only route of infection to young children (source: Policy Guidelines for Prevention of MTCT of HIV, revised edition Aug 06 MoH).

The provision of comprehensive Prevention of Mother to Child Transmission (PMTCT) services is an integral component in the efforts to reduce the transmission of

HIV. Moreover, in northern Uganda, where the health sector has suffered as a result of two decades of conflict, these services are proving to be an entry point to mothers understanding all services available through their local health centers.

St Joseph's Hospital, a private not for profit hospital (PNFP) under the Gulu Catholic Archdiocese located in Kitgum, is one of the leading health facilities in the region providing comprehensive PMTCT services. Since beginning to offer PMTCT services in May of 2002, St Joseph's hospital has assisted 12,663¹ women with ante-natal services, of which approximately 99% of the mothers have accepted to be tested for HIV. The HIV prevalence of the mothers tested in 2007 stood at 8.9%.

One of the primary challenges in the provision of PMTCT services is the follow up of mother and baby pairs after delivery, particularly in ensuring the testing of the baby to facilitate an adequate follow up. Not only is it important to have an early diagnosis of the baby so that treatment can begin at the earliest moment in order to enhance the chances of the baby living positively, it is also an important mechanism to evaluate the effectiveness of the PMTCT service toward the ultimate goal of



promoting an HIV free generation of children.

Up to September 2007, the only available means of testing babies of HIV positive

mothers at St Joseph's was to wait until the child reached 18 months of age at which time an antibody test was conducted. The introduction of the Dry Blood Spot (DBS) testing² in mid-September 2007 has allowed babies of as young as 6 weeks old to be tested, dramatically increasing the number of babies being tested for HIV.

A total of 122 babies have been tested with DBS during the seven-month period between mid-September and March 2007, as compared to a total of 157 babies tested using the antibody test since the hospital began testing babies in 2004 up to August 2007. The antibody test continues to be used to test children above the age of 18 months.

A total of 26 babies have tested positive for HIV, thus presenting a prevalence of 9.3%.

³ PMTCT mothers are being encouraged from the point of their first ante-natal

visit on the importance of bringing their babies for testing of HIV. The health workers at St Joseph's are utilizing their strengths in inter-departmental coordination to ensure that babies are captured at the point of immunization, at which point they are referred to the PMTCT unit. At this moment, mothers are given the opportunity to bring their babies to the laboratory to have their blood taken (heel or fingers pricks) and the fresh blood deposited on the filter cards, while the mother is advised to return in two weeks to receive the result. The Laboratory Technician from the hospital travels on a weekly basis to JCRC in Gulu to submit new samples and receive results.

The Family Support Group (FSG) meetings conducted by the health workers with participation of the mothers, partners and other family members, provide a forum from which to both distribute information and promote discussion. Health workers are certain to educate the parents during each meeting about the availability and benefits of testing their babies for HIV. Home visits are yet another outlet for follow up available to the health workers at St Joseph's.

The mechanisms of follow up indicated



above are further utilized in order to encourage the mothers to come for results. Mothers are often willing to test their babies but still fear to receive the results, not knowing what the

future holds for an HIV positive baby. The health workers continue to encourage all persons to know their status, regardless of age, and therefore assist the mothers to understand the benefits of receiving the

The IRC kick starts the Integration of Refugee health services in to district development plans. *By Dr.Lilian Kiapi-Iwa - IRC Uganda*

As a result of the internecine conflict which affected southern Sudan from the 1980s until 2005, an estimated 223,000 Sudanese sought refuge in Uganda. Of these, 175,079 are formally 'assisted' and live in refugee settlements in central (Masindi) and northwestern Uganda (Yumbe) where they are supported by UNHCR, WFP and other implementing partners of the two agencies. In addition, the two-decade long civil war in northern Uganda, besides devastating the health care delivery infrastructure, set the stage for a massive public health crisis. Over 1.9 million people were displaced and have been living in degrading and uninhabitable conditions in IDP camps. While increased movement of the overcrowded mother camps has been a welcomed trend, essential services are lacking in most of the return areas. In Karamoja region, ongoing violent conflict and social instability have contributed to a dramatic increase in HIV/AIDS infection rates over the past decade.

In 2006, the International Rescue Committee (IRC) in Uganda made a strategic decision based on the onset of peace in south Sudan and the subsequent voluntary repatriation of refugees, to gradually phase out activities in the refugee areas and scale up efforts in Kitgum and Karamoja. In line with this, the IRC began taking steps that set the stage for an eventual phase out of its activities. These were geared towards ensuring that service provision to the refugees and the Ugandan nationals living in refugee hosting areas would after its departure; continue uninterrupted because of the full involvement of the respective district health authorities.

Throughout 2007, IRC held meetings with the District Health Office, Office of the Prime Minister (OPM) and UNHCR as well as WFP at the district levels to discuss the integration process. Also in attendance were Local community leaders and representatives of service beneficiaries. During the meetings, plans were drafted and adopted for implementation by all concerned parties to ensure a successful integration process. Among the plans that the IRC and her partners started implementing are: Staffing plans, in which all staff paid by the IRC to work at health facilities in the refugee sites were advised to apply to join the



respective district service commissions. During the recruitment process facilitated by the IRC, fourteen staff were recruited for a health centre III in Masindi and eight for a health centre III in Yumbe, a second round of interviews were conducted to be able to meet the minimum requirement of nineteen staff per health centre. To complement its capacity building plan, IRC in collaboration with the respective district authorities arranged trainings on various topics including, logistics and financial management, health

information systems, refugee health service management and computer operations for senior staff at the district and sub-district levels.

A joint assessment of physical infrastructure utilisation and repair needs was also undertaken as an effort to implement the Physical infrastructure plans. Based on this, a budget for necessary and anticipated rehabilitation and construction during the integration process was developed.

IRC further together with the district health office each documented the amount of money spent on drugs, medical supplies, vaccines and other inputs for the health facilities managed by the IRC in each district. This covered the drug and supplies management plans. This process helped

the district health office and health centres to prepare their work plans for the 2008/2009 financial year. To implement its equipment plans an inventory of equipment that the IRC was using for the health program (ranging from ambulances to examination beds and radios) was undertaken jointly by the IRC and the district. Non-functional equipments were

assessed for repair needs and funds for this were made available. IRC also did implement the Coordination plan by holding regular coordination meetings at each of the districts to discuss the integration process. The meetings were attended to by the IRC, UNHCR, WFP, district leaders from different sectors, refugee representatives as well as political leaders.

In order to strengthen Integration of Refugee health services into district

Partners respond to Hepatitis E in Kitgum district

By Dr. Charles Okot, NPO/HAC WHO Kitgum

In November 2007 Kitgum district first reported suspected cases of Hepatitis E when a cluster of 6 cases were notified in Madi Opei HC IV Sub-county (Lamwo HSD); situated 45 km North East of Kitgum Town and 18 km from Tsero Tenya in Southern Sudan. An outbreak investigation was conducted by the District

Rapid Response Team (RRT) which revealed that the index case was a 40 year old pregnant woman who presented to the health facility in October 2008 with symptoms fitting the case definition of Hepatitis E. Hepatitis is a general term meaning inflammation of the liver and can be caused by a variety of different viruses such as hepatitis A, B, C, D and E. It is a water borne disease transmitted via

the faecal route. Contaminated water or food supplies have been implicated in the major outbreaks. Hepatitis E (HEV) virus has worldwide distribution, but predominate factors include tropical climates, inadequate sanitation, and poor or personal hygiene. Outbreaks are

associated with overcrowding, rainy seasons and floods. The incubation period following exposure to HEV ranges from 3 to 8 weeks, with a mean of 40 days. Typical signs and symptoms of hepatitis include jaundice, anorexia, hepatomegaly, abdominal pain and tenderness, nausea and vomiting and fever. signs and symptoms of hepatitis include jaundice, anorexia, hepatomegaly, abdominal pain and tenderness, nausea and vomiting, and fever.

to CDC Atlanta.

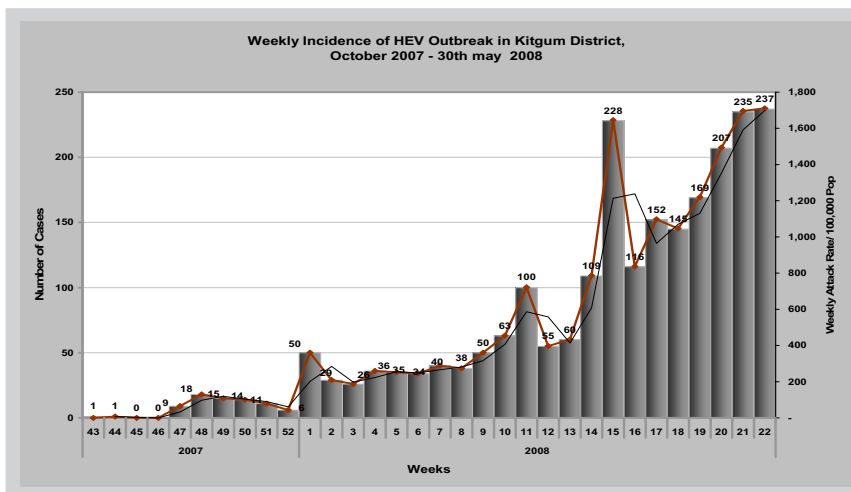
By 30 May 2008 cumulative total of 2,228 cases of Hepatitis E had been notified with 42 deaths giving a case fatality rate (CFR) of 1.9%

Underlying risk factors for the epidemic

The epidemic curve in IDPs, characterized by extreme poverty, illiteracy, overcrowding

and break down in sanitation condition coupled with poor hygiene behaviors/practices;

2. Poor attitude from the community to adapt to healthy hygiene practices and behaviors despite intense Health education and promotions provided a sense of low self-esteem and dependence among the IDPs which means communities are waiting for humanitarian agencies



Improving follow up.....from page 5

results of the test. Babies who receive positive results are immediately referred to the hospitals AIDS clinic for treatment and are continuously followed up by the dedicated staff. These children who receive treatment early are examples of how HIV positive children can live positively.

To date, St Joseph's hospital is the only health facility in the district offering DBS testing of babies. The office of the District Health Officer of Kitgum, in collaboration with AVSI and other partners, has a plan to scale-up the service at a number of health facilities in the district by the end of 2008.

(Footnotes)

¹ Includes data up to March 2008.

² DNA PCR testing using DBS.

³ In absence of prevention up to 25% of newborn are infected by HIV. This means that ART halved the transmission of HIV from mother to child.

associated with overcrowding, rainy seasons and floods.

The incubation period following exposure to HEV ranges from 3 to 8 weeks, with a mean of 40 days. Typical signs and symptoms of hepatitis include jaundice, anorexia, hepatomegaly, abdominal pain and tenderness, nausea and vomiting and fever. signs and symptoms of hepatitis include jaundice, anorexia, hepatomegaly, abdominal pain and tenderness, nausea and vomiting, and fever. *above is the epi curve characterised by multiple peaks of increasing number of cases since the epidemic started* an indication of the vast transmission potential of HEV that exist in the community. The disease eventually spread from Madi Opei sub-county, the epicenter of the epidemic, to 10 other sub-counties. Laboratory confirmation of Hepatitis E was made in made in December 2007 when samples were sent to UVRI -Entebbe then subsequently were sent

MoH scales up Antiretroviral ...from page 3

Despite all the efforts in improving service delivery at the ART sites, several challenges still need to be overcome in order to improve services. They include poor retention of staff in the districts, limited number of staff at health facility level which negatively affects the quality of services offered at the ART sites and limited motivation to the staff working at the ART sites. Linkages of other HIV services such as HCT, PMTCT, TB/HIV collaboration with the ART clinics is a challenge as well as continued support supervision and mentoring at all the health units.

Having put in to consideration all the above challenges and lessons learned, the PRDP plan will consider supporting staff at the ART sites in order to improve on the motivation issues such as providing facilitation to the ART clinic staff to carry out home based care, HCT outreaches and minimal support to the clinic staff. Further still district authorities need to ensure that a minimum number of staff at the ART sites is provided to improve on the quality of care and strengthening capacity at the Sites. For all the above programmes to succeed the Ministry of Health needs continued support from Partners working in area of HIV/AIDS.

Male Medical Circumcision for HIV Prevention: which way Uganda?

Contemporary and anticipated challenges

Despite compelling evidence, anticipated benefits and positive strides being taken by government regarding expanding and scaling up MMC services in Uganda, several existing and anticipated challenges abound:

- The question of voluntary HIV counseling and testing remains largely unanswered. While counseling would not be that contentious, testing would. Available evidence does not recommend circumcision for HIV positive men, in any case they are already infected and no demonstrated benefit to their female spouses. In fact, evidence suggests that there is increased risk of spreading HIV infection if a circumcised HIV positive man resumes sex before certified wound healing. But should service providers deny MMC services to such a person? How about ethical, legal and human rights implications? The other side of this discussion is whether HCT should be compulsory or optional for persons seeking MMC services for HIV prevention. Which ever way one chooses to go, there are issues to contend with, and the current and future discourse on this subject should highlight and try to address this challenge.
- Relatedly, the quality, depth and frequency of HCT will truly remain challenging, especially with frequent stock-outs of essential supplies such as HIV test kits. Currently, only about 15% of Ugandans have accessed HCT despite indicative demand being more than 80% adult population. This will further be complicated by the scarcity of human resources for health care delivery, especially regarding their numbers, skills and commitment; not mentioning the special circumstances of the hard-to-reach and hard-to-stay areas especially Northern Uganda and Karamoja regions.
- Follow up will certainly be an additional challenge especially the need to ensure certified wound healing before resumption of sex; as well as monitoring of the likely tendencies for reduced personal risk perception and protection such as reduced condom use and increased number and concurrence of sexual partners.

tion and protection such as reduced condom use and increased number and concurrence of sexual partners.

- Whereas the argument for task shifting to sort out numbers of health workers has merit in this discourse, capacity and skills enhancement needs and means should be anticipated and planned for.

Suggested way forward

The evidence is compelling, benefits and anticipated impact on HIV infection decline are persuasive, discussions have been held, stakeholders are enthusiastic, and demand is increasing. So, what should the country do?

- Conduct further public debate and consultations in a bid to develop national consensus to inform policy and programming.
- Develop an elaborate policy, standard operating procedures, guidelines and a communication strategy informed by research and the ongoing discourse.
- Prioritize expansion of MMC services for younger males say between ages of 12-30 years among whom HIV prevalence may still be low but incidence potentially likely to be high now or in the near future.
- Prioritize HIV negative men of any age, especially those with sexually transmitted infections, long-distance truck drivers, men in discordant relationships, customers of commercial sexual workers or those in and around fishing communities.

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The IRC kick starts thefrom page 6

development plans, each district health office selected a focal person for refugee health services who would be one of the senior staff based at the District Health Officer's office. This person will be a link between beneficiaries and UNHCR upon the phase out of the IRC's support activities.

The responsibility for the provision of health services has therefore been gradually handed over to the respective District Health Officers with identified specific activity responsibilities. The process that ends on 30th June 2008 will be documented by the IRC so that lessons learned during the process can be shared with partners and the model can be adapted by other NGOs working in similar settings in Northern Uganda or elsewhere ■

Partners respond to Hepatitis E in Kitgum district

to provide everything e.g. building latrines.

3. Long incubation period of Hepatitis E (up to 8 weeks) and the ability for interruption of infections to take effect. This also calls for near permanent in hygiene behaviour and practices

4. Many Humanitarian Agencies continued implementing their intervention in the routine manner not the accelerated, sustained interventions that are required to interrupt the transmission of infections like hepatitis.

A multi-disciplinary District Epidemic Task Force which is chaired by the Resident District Commissioner (RDC) and coordinated by World Health Organization (WHO) has been established. It comprises of 3 main sub-committees, namely Surveillance/ Case Management; WASH; and Social Mobilization. The sub-committees comprising largely of technical experts, hold their meetings prior and feed into the District Task Force.

The specific intervention measures instituted by the various sub-committees include:

1. Surveillance and Case management activities being undertaken include investigation and confirmation of Hepatitis E epidemic; Detection, Treatment and Notification of HEV Cases at all levels; and eventually data analysis and reporting. To increase the sensitivity of the surveillance system, active case search is being conducted in the community by VHTs for suspected cases to health facilities for diagnosis.

2. Water and sanitation interventions which have been put in place included;



community latrines in the main IDP camps;

Provision of hand washing facilities in all community latrines; public Health Education promotion using various channels but largely reliant on the VHTs using the PHAST approach. School Health Programmes has been embedded in the WASH interventions. The latrine component of WASH interventions involves Enforcement of Public Health Act, regulations and by laws

3. Social mobilization strategies being employed include mobilization of community for action e.g. sinking pits for latrine and construction, camp clean up exercise; community dialogues/ interpersonal communications e.g. public meetings/ rallies, focus group discussions, Drama; and Media and Print communications e.g. Radio Programmes Talk shows, Radio spots, Jingles; IEC Materials –posters; FilmVan.

4. The last intervention measure involves providing oversight role all the above interventions through supervision, Monitoring and evaluation of intervention strategies;

provision of sanitation facilities through construction of comm

Technical guidance and oversight role by Technical teams; Joint Inter-Agency supervision & monitoring of HEV intervention strategies on a weekly basis and regular reviews of intervention strategies by the district Task force

Key Challenges affecting HEV Interventions

- Acute shortage of Human Resource for health. The district is operating with a staffing norm of less than 40%
- Inadequate funding to address the emergency interventions, especially with the increasing number of sub-counties being affected by the epidemic and return process.
- Provision of safe water and sanitation facilities requires a lot of resources and time, which can be easily addressed within a short period of time if resources are readily available
- Low participation by the community and local leaders to participate actively in HEV control interventions.
- The level of social mobilization and implementation of Public Health Acts has not deepened enough to cause any significant change in the community behaviour
- Overcoming behavioral change and dependency of a traumatized community cannot be attained within a short time ■



“Malaria – A disease without borders” Gulu district Marks First World Malaria Day.

By Pauline Ajello, Public Information Assistant WHO/HAC -Gulu

April 25th was World Malaria Day and also Malaria Awareness Day. It was a day of unified commemoration of the global efforts to provide effective control of malaria around the world. In observance of this day and in recognition of the tremendous opportunities to reduce the burden that malaria imposes on the health of people worldwide, Uganda and particularly Gulu district joined the rest of the world in commemorating this very special day on the 9th of May 2008.



Gulu district celebrations were held at Kali Ali health center 11 in Paicho sub county. While speaking at the celebrations the RDC Odong Milton also chief guest appealed to partners to help strengthen the district health system in order to reduce the burden of Malaria. The Vice Chairperson of Gulu district Hon. Kitara Makmot observed the need for more health center 11s at all parish levels in the district. He thanked all those who initiated the concept of Village Health Teams saying this has been very helpful in managing malaria and giving treatment to malaria patients at the village levels.

The World Malaria day in Gulu was supported by health partners focusing on prevention and treatment of malaria. Key among them are; Malaria Consortium, NUMAT, Accord, WHO, UNICEF, ICRC and Gulu district health office. Gulu Hospital and Gulu independent hospital provided on sight treatment to children with malaria/fever.

Distribution of Long Lasting Insecticidal nets, Indoor residual spraying, Intermittent presumptive treatment of malaria (IPT) in

units and two at the community level using Village Health Teams (VHTs) to administer community co-term are some of the strategies in place partners are trying to use to manage malaria in the district. To monitor trends of the disease and inform partners of the malaria control progress in the district, weekly surveillance updates are also provided by health facilities. However little has been done at the environment level through destruction of mosquito breeding areas to prevent malaria.

It is important to remind ourselves that Malaria is Africa’s leading cause of death for children under the age of five years. In Uganda malaria is endemic with 63% of Ugandans exposed to high transmission levels and 25% exposed to moderate transmission that

are epidemic prone according to 2005 M o H report. The report also states that in Uganda, malaria is more prevalent during the rainy season of March to June and August to November, with the exception of northern Uganda where the malaria season is more prevalent between May



pregnant women and prompt treatment at two levels, one at the health

and November. The Uganda National Household survey (UBOS, 2006c) revealed that half of the population that fell sick during the years before the survey, reported malaria or fever as their major sickness. Nearly half of hospital in-patient deaths among children under five are attributed to severe malaria. Malaria accounts for 40% of Ugandan public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits in areas with high malaria transmission. With acute disease, a child may die within 24 hours. In industry and agriculture, malaria accounts for more than 50% of all man hours lost. This affects production and revenue for the industry, families and the nation. Malaria is therefore a leading cause not only of ill health and death in Uganda but also of poverty. The good news however is that Malaria is eminently treatable. Children can be saved if immediate hospitalization and treatment is available.

In 1998 World Health Organisation undertook the Roll Back malaria initiative as an international effort to control Malaria. This initiative aims at halving the 2000 levels of malaria morbidity and mortality by 2010 and reducing the burden further by 50% by 2015. The Roll Back Malaria initiative is the frame work within which

Uganda implements malaria control activities. The objectives of the initiative are to ensure that pregnant women and children under five years of age have access to the most suitable and affordable

combination of personal and community protective measures such as insecticidal mosquito nets and prompt, effective treatment for malaria, within 24 hours of

In and Out



*DR. George Mellivile
Out going WR*

Dr. Melville George the WHO Representative for Uganda since November 2005 retired from services of the organisation at the end of April 2008. He was very instrumental in rolling out the Health, Nutrition and HIV cluster in the country and actively participated in the coordination and supervision of emergency response in Northern Uganda and Karamoja. He also played a critical role in ensuring that WHO regained her leadership in Health, Nutrition and HIV Cluster. He is replaced by Dr. Jean Baptiste Tapko as the acting WR until a substantive WR is appointed for Uganda



*Rachael Goldstein
Outgoing HoSo*

Rachael Goldstein the Head of UNFPA Gulu Office left the country for Zimbabwe. She joined the Gulu sub office in April 2007 until May 2008



*Anna Mutavati
District GBV Coordinator*

Anna Mutavati recently assumed office from Rachael Goldstein as the new UNFPA District GBV Coordinator and Head of Gulu Sub office. Anna holds a degree in law and a Masters degree in Women's Law. Before she joined UNFPA Uganda Anna worked in UNFPA Zimbabwe as Programme officer for gender and advocacy where the primary focus was Gender based violence prevention



*Dr. Okello Quinto
DHO Amolatar*

Dr. Okello Quinto has been appointed the DHO of Amolatar district. Before his appointment Dr. Okello Quinto worked at Lira district Health Office as the principle Medical Officer for 18 years. He holds a Master of Public Health. Dr. Quinto is very supportive of the Health, Nutrition and HIV Cluster activities in Amolatar



*Florencia Gonzalez
Head Health Department*

Florencia Gonzalez recently assumed office as the head of health Department with AVSI-Gulu Florencia has an undergraduate degree in Sociology and a master's in Public Health from The George Washington University. Prior to joining AVSI, Florencia was working in Washington DC in epidemiology and clinical research. She also has a background in managing community health outreach programs for underserved populations



*Jocelyne Takatsuno
Program Coordinator*

Jocelyne Takatsuno assumed her new office at the International Rescue Committee in April 2008, as the Program Coordinator in Kitgum. Prior to joining IRC, she has worked with New Field Foundation as the operations manager and a program officer for Relief International in Darfur, Sudan, the Federal Aviation Administration as the Africa desk officer and acted as a consultant to a number of international organizations

**We wish you all the best in your retirement
and new appointments**

Ministry of Health launches Mental Health Program in N.Uganda

By Pauline Ajello Information Assistant WHO Gulu

In an bid to help the community cope with mental health challenges as a consequence of civil strife and massive displacement, loss of property and life and other associated suffering, the Ministry of Health (MoH) with support from Transcultural psych-social Organization (TPO on 27th May 2008 launched a mental health programme in northern Uganda.

While presiding over the ceremony at Gulu referral hospital, the Minister of state for health in charge of general duties Hon. Dr. Richard Ndahura said that the government of Uganda has invested considerably in the infrastructure development and building human resource capacity for mental health services and has included it in the minimum health care package of Uganda

In 2005, a WHO consultant was deployed to conduct a mental health needs assessment. The finding of the that, there were limited staff with little or no mental health professionals in the districts, limited outreaches in community based activities for mental health and that there were low levels of skills in mental health among primary health care workers, all in a vulnerable security situation.

The project therefore aims to build capacity of health workers in selected health centers to deliver and integrate mental health services into their primary health care services in Gulu, Kitgum and Pader district and will work closely with Gulu regional referral hospital mental health unit to give support supervision to the lower health units and will as much as possible work through community based structures through which mental health services delivered on clinic days will be identified

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onset of illness and to ensure that at least 60% of all pregnant mothers have access to intermittent preventive treatment using SP. In Uganda, the President's Malaria Initiative coordinates with the Ministry of Health, the National Malaria Control Program and several local and global partners including the Roll Back Malaria Partnership (RBM), the Global Fund to Fight AIDS, TB and Malaria (GFATM), the UK International Development Agency (DFID) and the World Bank to ensure that Malaria is brought under control ■

District highlights

A glance at Pader and Lira districts in northern Uganda

District	Demographic characterizes	Achievements	Major health indicators: Immunization			constraints
Pader	Total population (UBOS, 2007): 411,800 with 40.4% still in camps Estimated <5 years: 84,419 People	<ul style="list-style-type: none"> VHT program coverage of 100% with a total number of 2,609 members in 13 sub counties implementing the community coartem program. 53 functional health units; 1 PNFP hospital, 1 HC IV, 17 HC III and 34 HC II. The Human Resources of Health situation improved from 23% in 2006 to 33% supported by Health, Nutrition and HIV partners A very active health, nutrition and HIV/AIDS cluster and cluster partners. 	Indicator	Achievements (2006)	Achievements (2007)	<ul style="list-style-type: none"> Limited control on private drug vendors River blindness remains uncontained in Atanga, Awere, Lapul and Laguti sub counties Human Resources for Health (HRH) situation still poor Has 36 parishes without any health facility in the district
			DPT3	91%	77.5%	
			Measles	84.3%	87.4%	
			Deliveries in H.U	24%	24%	
			OPD utilization per capita	0.93	0.99	
Lira	Total population (UBOS, 2007): 601,300	<ul style="list-style-type: none"> Improvement in Human Resources of Health from 82% to 93% of staffing norms as above the recommended by HSSP II Dysentery controlled by the Health Cluster in Lira at Got Ojwang Settlement Camp; Olilim Sub-County in March 2008 	Indicator	Achievements (2006)	Achievements (2007)	<ul style="list-style-type: none"> Human resources for health remain in skills mix, human resource management and retention. There are still significant gaps in specific categories of qualified staff especially medical officers and anesthetic staff
			DPT3	91%		
			Measles	84.3%	95%	
			Deliveries in H.U	24%	26%	
			OPD utilization per capita	0.93	0.7	
			Human Resources for health		93%	

Call for Applications

What: Public Health Predeployment Course

When: 16th - 29th November 2008

Where: Ottawa Ontario Canada

The main objective of the course is to prepare professionals with experience in public health and other related fields to design, implement, manage and coordinate health sector emergency response and early recovery programmes in crises situations effectively, efficiently and safely

Deadline for application: 31st August 2008

For Details: <http://www.who.int/hac/techguidancetraining/predeployment/phpd4/en/index.html>

Editorial Board members

Dr. Olushayo Olu,
Health, Nutrition and HIV/
AIDS Cluster Coordinator

Dr. Godfrey Bwire
Ministry of Health

Dr. Filippo Ciantia,
Country Director
AVSI Uganda

Pauline L Ajello,
Information Assistant,
WHO Gulu Sub Office

Dr. Eric Alain Ategbo,
Nutritionist UNICEF
Uganda

For more information regarding the Health, Nutrition and HIV/AIDS newsletter, please contact

Dr. Olushayo Olu, WHO Country Office,
P.O.Box 24578 Kampala, Email: Oluo@ug.afro.who.int
Mobile: +256 752 721962

OR

Pauline L Ajello, Information Assistant WHO Gulu Sub Office
Mobile: +256 772721963, Email; ajello@ug.afro.who.int

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