NATIONAL TUBERCULOSIS AND LEPROSY PROGRAM

ACTIVITY REPORT

TOUR OF THE DISTRICTS IN THE EASTERN ZONE OF UGANDA 12th to 23rd DECEMBER 2005

Compiled by:
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Dr. Kalyesubula-Kibuuka Simon,

3rd January 2006

Executive Summary

Uganda has a population of 27.6 million [1], which is distributed into 69 districts (since July 2005). Efforts to control Tuberculosis started way back in 1965 when a National Tuberculosis Control Program was established. A combined program for TB and Leprosy was conceived in 1988 and the National TB and Leprosy Program started in 1990. Regardless of these efforts, the disease continues to be a threat fuelled by the HIV/AIDS scourge yet TB and HIV collaborative interventions are still in their infancy.
Leprosy control has been domain of church based organizations for a long time, who took it as a humanitarian Christian mission [2]. In Uganda significant support has been received from the International Federation of Anti-Leprosy association (ILEP) partners, notably the German (GLRA) and Netherlands (NSL) Leprosy Relief Associations [3].
The NTLP is headed by a Program Manager assisted by nine Senior Medical Officers who are termed as Zonal TB Leprosy Supervisors (ZTLS).
Uganda is the 16th of the 22 high-burden countries of tuberculosis (TB) The TB burden in Uganda continues to increase, NTLP notification increased in 2003 3.4% and 6.0% in 2004 when 44,605 cases were detected. In 2004, 46 of the 56 districts continued to detect and report new leprosy case ranging from 1 in Iganga, Hoima, Kabarole, Kyenjonjo and Rukungiri to 82 in Lira district [4]. While the absolute number of new leprosy cases has shown a slight increase in the 2004/05, the case detection rate shows a very gradual downward trend

The Eastern Zone is made up of seven districts namely Kaberamaido, Katakwi, Kapchorwa, Kumi, Mbale, Sironko and Soroti. Kumi Hospital which is Church founded, serves as the regional Leprosy Referral Facility.
A Tour of the seven districts in the Eastern Zone was arranged, with the out-going ZTLS, Dr. Abel Nkolo, from 12th to 23rd December 2005. Ten districts in the Eastern Zone were visited. Five DDHSs, seven DTLSs, six HSDTBFPs, two ADTLSs, two DHVs and one HSD In-Charge were met during the ten days tour. Ms. Zeah Wephukhulu the DTLS overseeing the four districts in Karamoja region was met.
Three more districts have been created in the Eastern and one in the North-Eastern Zones, which is increasing the demand for DTLSs and replacement HSD TB FPs. The need for quality assurance, monitoring and evaluation of TB and Leprosy control activities continues to increase There is some infrastructure and capacity for implementing TB/HIV collaborative activities in the Zone. Sustaining Leprosy elimination is achievable and so is controlling and reversing the burden of TB in the Zone.
The following recommendations are therefore made; urgently formalise the position and status of the DTLS Moroto who is overseeing TB and Leprosy control activities in the Karamoja region, conduct a Clinical Audit of the Leprosy Cases on treatment in the Zone for purposes of reviewing quality of records and services for leprosy control, urgently arrange for the training of the DTLSs for Amuria, Bukwa and Manafa as well as refresher for Kapchorwa, Sironko and ADTLS for Soroti and finally consider enhanced Supportive supervision for the DTLSs of Kapchorwa and Kaberamaido.

Introduction

Uganda has a population of 27.6 million [1], which is distributed into 69 districts (since July 2005). Efforts to control Tuberculosis (TB) started way back in 1965 when a National Tuberculosis Control Program was established. A combined program for TB and Leprosy was conceived in 1988 and the National TB and Leprosy Program started in 1990. Regardless of these efforts, the TB continues to be a threat fuelled by the HIV/AIDS scourge yet the TB/HIV collaborative interventions are still in their infancy.

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A combined program for TB and Leprosy was conceived in 1988 and the National TB and Leprosy Program started in 1990[3].GLRA provides financial and Technical support for central, intermediate (zonal) and district level operations [4].

Leprosy is included in the UNMHCP under the element 4, other Public health interventions against diseases targeted for elimination and/or eradication [5]. NTLP has a system for monitoring of the control activities through support supervision and quarterly district reports in place, and a regular supply of free and good quality anti-leprosy drugs was maintained as donations from WHO[4].

NTLP

At the Ministry of Health (MOH), the National Tuberculosis and Leprosy Program (NTLP) is under the department of National Disease Control. It has three operational levels, reflecting the organization of the National Health Service:

Central Unit (National Level), the NTLP is headed by a Program Manager assisted by nine Senior Medical Officers who are termed as Zonal TB Leprosy Supervisors (ZTLS). NTLP sets policies, technical and operational guidelines, plans, trains, ensures procurement and regular supply of drugs and supplies as well as supervision and overall coordination of TB control activities countrywide.

District Level, TB and Leprosy control activities are by the District TB Leprosy Supervisors (DTLS) under their respective District Directors of Health services (DDHS) and supervised by the ZTLSs. The DTLS supervises the Health Sub-district TB Focal Persons (HSDTBFPs) who is expected to coordinate and supervise TB control activities in their catchments.

Health Unit is the level of primary care and includes health facilities of different grade, ranging from Health Centre II (H.C II) at the parish thru H.C III at sub-county, H.C IV at HSD, District General Hospital at District, Regional Referral Hospital at regional Level and National Referral Hospital.

Eastern Zone

The Eastern Zone is made up of seven districts namely Kaberamaido, Katakwi, Kapchorwa, Kumi, Mbale, Sironko and Soroti. Kumi Hospital which is Church founded, serves as the regional Leprosy Referral Facility.

Burden of Tuberculosis

Uganda is the 16th of the 22 high-burden countries (HBC) of tuberculosis. TB morbidity in the country is estimated at an Annual Rate of Infection (ARI) of 3% equivalent to 150 smear positive pulmonary TB cases per 100,000 populations per year and a Case Finding Rate of 85 per 100,000 populations [3]. Between 2003 and 2004, all cases notification rose by 2.5% to 44,505 and new PTB cases by 6% to 20,984. 80% of all TB cases notified fall under treatment Category 1 (New Cases), 12% under Category 3 (Children) and 8% under Category 2

(Retreatment). The TB burden in Uganda continues to increase, NTLP notification increased in 2003 3.4% and 6.0% in 2004 when 44,605 cases were detected. The HIV prevalence amongst TB patients is estimated to be 60%.TB is one of the most common AIDS defining diagnoses [14,16], and TB remains one of the leading infectious killers of adults in the world today [15] .

Table 2.0 **Eastern Zone -TB cases notification for the 2004 cohort**

Catchments	**New NSD**	**Retreat NSD**	**New SS(+)**	**New SS(-)**	**Retreat SS(+)**	**Retreat SS(-)**	**EP TB Cases**	**Totals Notification**
Eastern Zone (% of total)	127 **(2.85)**	10 **(0.51)**	1,844 **(8.7)**	822 **(6.2)**	142 **(8.9)**	25 **(3.6)**	285 **(8.2)**	3,266 **(7.32)**
Kampala (% of total)	2,760 **(62)**	142 **(73.2)**	3,515 **(16.74)**	2,275 **(17.2)**	385 **(24.2)**	189 **(27.1)**	1,242 **(35.8)**	10,508 **(23.6)**
National	**4,449**	**194**	**20,986**	**13,225**	**1,592**	**697**	**3,469**	**44,612**

Tuberculosis Control Strategy

The priority of an effective NTLP is to achieve cure rate among sputum smear positive cases. The NTLP in Uganda adopted the WHO objectives of

- **70% case detection rate and**
- **85% treatment success rate**

Uganda being a member state of the World Health Organization (WHO), NTLP has adopted the Directly Observed Therapy, Short-course (DOTS) strategy, recommended by the International Union Against Tuberculosis and Lung Disease (IUATLD) and the WHO.
Community Based DOTS (CB-DOTS) was adopted by the MOH in Uganda as the best strategy for controlling TB since1997. To date, this strategy has been expanded to all districts in the country although the sub-county and patient coverage is still wanting. Under the CB-DOTS model, a public health worker (referred to as a Sub-County Health Worker (SCHW) links the formal health system to communities in their respective sub-counties.
These SCHWs; conduct community mobilization, facilitate communities through their leaders to select community volunteers (CVs), train the selected CVs, supervise them and replenish their TB drugs fortnightly.
The CVs are responsible for administering, directly observing therapy and referring the TB patients to health centre for follow-up sputum testing and clinical reviews.

Burden of Leprosy

Prevalence of leprosy currently is 2.8 cases per 100,000 population, and case detection rate of 2.5 per 100,000[4]. In 2004, 46 of the 56 districts continued to detect and report new leprosy case ranging from 1 in Iganga, Hoima, Kabarole, Kyenjonjo and Rukungiri to 82 in Lira district [4]. While the absolute number of new leprosy cases has shown a slight increase in the 2004/05, the case detection rate shows a gradual downward trend. Analysis of the infectious cases (MB) separately does not show the downward trend. Going by the overall trend, it is therefore too early to talk about eradication of leprosy.

Table 1.0 **Trends of specific targets for Leprosy elimination in Uganda**

N	**Indicator**	**Baseline 1999/00**	**Achieved 2000/01**	**Achieved 2001/02**	**Achieved 2002/03**	**Achieved 2003/04**	**Achieved 2004/05**	**Target s 2005**
	New Cases Abs. Nos.	869	818	688	668	525	663	400
	New PB cases	483	373	282	233	168	208	150
	New MB cases	386	445	406	435	357	455	250
	Case Detection Rate /10,000	0.40	0.37	0.31	0.27	0.21	0.17	0.25
	Prevalence Rate/10,000	0.55	0.46	0.42	0.29	0.26	0.28	0.25
	Elimination at District level	41	47	50	50	50	50	69
	Child Proportion of new cases	11.1%	9.3%	10%	11.4%	11.3%	14.5%	5%
	New cases with no visible deformities	90.6%	90.2%	88%	89.1%	86.4%	90%	95%

Leprosy Control Strategy

Uganda achieved elimination of Leprosy in 1994; however some districts have continued to report more cases than the set targets for elimination. In 2004 Leprosy remains endemic in Kumi and Soroti districts in Eastern Zone.

The strategy NTLP adopted for Leprosy control include:

- Passive Case finding
- Multi-Drug Therapy(MDT)
- Sustaining Leprosy elimination in all districts in the country.

Description of activity

Pursuant to the my posting order from the Program Manager NTLP dated 02nd December 2005, l was redeployed in the acting capacity as the TB and Leprosy Supervisor for the Eastern Zone. It was therefore necessary for me to tour the districts in the Eastern Zone for purposes of analysing the situation in my newly assigned catchments.

Objectives of activity

The general objective was; to analyse the situation of TB and leprosy control in the districts making up the eastern zone.

The specific objectives are;

1. To tour the districts in Eastern Zone.
2. To conduct a situation analysis of the TB and Leprosy control situation.
3. To meet as many DDHSs, DTLSs and DHMTs in Eastern Zone as the tour allows.
4. To meet the stakeholders in TB and Leprosy Control in the Eastern Zone
5. Takeover the ZTLS office in Kumi.

Methodology

A tour of the seven districts in the Eastern Zone was arranged, with the out-going ZTLS, Dr. Abel Nkolo. Resources were secured and a ten days tour of zone was conducted from 12th to 23rd December 2005. The ten districts in the Eastern Zone were visited. Five DDHSs, seven

DTLSs, two ADTLSs, two DHV s and one HSD In-Charge were met during the seven days tour. Ms. Zeah Wephukhulu the DTLS overseeing the four districts in Karamoja region was met.

Findings

Table 3.0 **Inventory of services Delivery Facilities in Eastern Zone**

Catchments	**Population**	**Names & contacts**	**No. of HSDs**	**No. of Sub-County**	**DTLS cadre (since)**
Amuria	**221,173**	Eperu Gervas 078.862.634	**2**	**4**	**N.A**
Bukwa	**57,891**	DDHS, Dr. Engwau	**2**	**4**	**N:A**
Manafa	**N.A**	Wamakale Fred	**2**	**14**	**Clinical Officer(2006)**
Mbale	N.A	Mubuya Constant 078.616.549 P.O.Box 904, Mbale	6	17(100% vs 60%)	**Clinical Officer(1993)**
Soroti	389,696	Akopan Francis 077.864.486 Okello John 077.874.675	4	17(52%)	**Leprosy Assistant**
Katakwi	85,859*	Okirror John Bernard 077.472.311 P.O.Box.	1	9	**Leprosy Assistant(2001)**
Kumi	404,467	Okolimong Martin 077.535.733 Box9, Kumi	3	16	**Clinical Officer(1993)**
Kapchorwa	161,000	Bossey Aggrey 0.45.51049 P.O.Box 02, Kapchorwa	2	12	**Clinical Officer(1994)**
Sironko	3315,506	Namakola Charles 077.864.733	3	19	**Leprosy Assistant(2001)**
Kaberamaido	475,970	Obore Mike 078.327.104 P.O Box. 94, Kaberamaido	2 Kalaki, Kaberamaido	8(1 T.C)	**Leprosy Assistant (1994)**
Totals	2,824,141	Kalyesubula-Kibuuka, 078.550.362 Box 39, Kumi	**24**	**125**	**Senior Medical Officer(2005)**
National totals less K'la	26,800,375	Adatu-Engwau Box 16069, Wandegeya	**214**	**934**	**Principal medical Officer**

Since July 2005, the number of districts in Eastern Zone increased from seven to ten. The new districts are; Amuria created from Katakwi, Bukwa from Kapchorwa and Manafa from Mbale.
Two of the new districts (Amuria and Manafa) have identified HSD TB Focal Person and assigned them as the acting DTLSs, but Bukwa is yet to identify a DTLS.
In the Karamoja region, the DTLS overseeing the TB and Leprosy Control activities was met in Kumi. She had just returned from a six weeks training in TB and Leprosy control at ALERT in Ethiopia. She was very ready to take on the new assignment as soon as her posting order is prepared. She reported that the region has Kabong as a new district making them four in North Eastern Zone. Kabong district is yet to have an acting DTLS identified and assigned. There is an urgent need to formalise the position and status of the DTLS Moroto who is overseeing TB and Leprosy control activities in the Karamoja region, since she is already experiencing challenges from her immediate supervisor regarding her status in the district.

Table 4.0 **Inventory of services Delivery Facilities in Eastern Zone**

Catchments	**No. of SCHWs**	**No. of DTUs**	**No. of TUs**	**No. of ARTs sites**	**No. of VCT sites**
Amuria	9	6	9	1	**1**
Bukwa	4	1	4	1	**1**
Manafwa	14	6	18	2	**3**
Mbale	17	16	18	4	**4**
Soroti	17	5	18	N.A	**N.A**
Katakwi	9	6	18	1	**1**
Kumi	16	4	18	3	**4**
Kapchorwa	12	3	6	1	**1**
Sironko	19	3	13	2	**2**
Kaberamaido	8 (T.C N.A)	3	11	1	1(Lwala Hospital)
Eastern Zone	**125**	**53**	**133**		**18****

N.B: In Kaberamaido the Town Council (TC) does not have a SCHW as yet and Lwala hospital is the only site accredited to provide Anti-Retro-Viral medicines (ARVs) in Kaberamaido district.

Table 5.0 **Leprosy Cases notification in the seven districts of Eastern Uganda Cumulative till 3rd Quarter 2005**

N	**Catchments**	New Cases Abs. Nos	New PB cases	New MB cases	Case Detection Rate /10,000	Child Proportion of new cases	New cases with visible deformities
	Mbale.	01	00	01	0.013	00	01
	Katakwi	04	00	04	0.11	00	00
	Kaberamaido	03	01	02	0.23	33%	00
	Kapchorwa	00	00	00	0.00	00	00
	Kumi	26	05	21	0.64	00	10
	Sironko	01	00	01	0.032	00	00
	Soroti	15	05	10	0.39	06.7%	03
	Totals	**50**	**11**	**39**	**0.19**	**04%**	**28%**

Table 6.0 **TB Cases cumulative notification in the seven districts of Eastern Uganda till 3rd quarter**

N	**Catchments**	All cases 0 – 14 Yrs	New SS+	New SS-	New EP Cases	All Relapse Cases	All NSD cases	All TB cases notified
	Mbale.	28	593	137	53	32	104	919
	Katakwi	03	143	06	28	13	00	190
	Kaberamaido	02	58	17	08	07	04	94
	Kapchorwa	01	51	29	02	01	00	83
	Kumi	05	164	86	86	26	07	369
	Sironko	03	169	06	06	15	03	201
	Soroti	06	217	159	50	22	24	472
	Totals	**48**	**1,395**	**440**	**233**	**116**	**142**	**2,328**

Discussion of Findings

Since July 2005, the number of districts in Eastern Zone increased from seven to ten, the three new districts created are; Amuria from Katakwi, Bukwa from Kapchorwa and Manafa from Mbale. Amuria and Manafa districts have identified HSD TB Focal Persons (HSDTBFPs) and assigned them as acting DTLSs, Bukwa is yet to identify one. In the Karamoja region, the DTLS of Moroto is overseeing the TB and Leprosy Control activities there.
All districts have at least one VCT, ART site and which are providing comprehensive TB care for PLWHA in their catchments.
Soroti reports the highest number of Leprosy cases followed by Kumi, though Kumi reports the highest proportion of cases with disabilities. Mbale reports the highest number of TB cases followed by Soroti and Kumi districts. Kumi reports the highest proportion of EP cases followed by Katakwi and Soroti.

The increases in number of districts is welcome for purposes of taking TB and Leprosy control services closer to the communities, as has been observed elsewhere in the country under decentralisation. While this intervention increases the community access to TB and Leprosy control services, it poses a challenge of increasing demand for the already constrained skilled human resources capacity under the NTLP. This requires more DTLSs, Clinicians and Laboratory scientists at the referral facilities created, assigning ill-prepared officers is associated with deterioration in quality of care provided.
Like elsewhere in Uganda, all districts in the Eastern Zone now have at least one accredited ART site, one facility offering HIV Counselling and Testing (HCT) for HIV/AIDS
Despite Uganda achieving Leprosy elimination in 1994, some districts like Kumi, Soroti, Katakwi and Kaberamaido still detect and report more than 1Leprosy case per 100,000 of population [4]. Kumi reported the highest proportion of Leprosy cases with disabilities probably because it is regional Leprosy referral facility for the Eastern Zone. These cases could be referrals to Kumi because she has facilities and capacity to manage disabilities, or it could be that the clinicians at Kumi have retained their capacity to diagnose disabilities and therefore report them.
Mbale reports the highest number of TB cases because of its population size, but also as observed elsewhere in the country and in Soroti are Regional Referral Hospital (RRH) [8, 9, 10].
The creation of new districts calls for training of more DTLSs for the new ones and enhanced supportive supervision of the ones performing poorly.

The availability of HCT services closer to the communities as well as ARVs augurs well with the government policy under the PEAP [11, 12] of improving access to health services as well as achieving the MDGs in Uganda [13].
In spite of decentralisation and creation of districts which takes services closer to the communities, Regional Referral Hospitals continue to detect, treat and report high numbers of diseases episodes and cases in Uganda [8, 10].
It is necessary to ascertain the physical addresses of the Leprosy cases with grade 2 disability reported from Kumi Hospitals for purposes of improving quality care for Leprosy cases in the Zone.
Another issue worth following up is the proportion of TB cases defaulting on treatment at the Regional Referral Hospitals in the Zone, in view of its effect on the treatment outcome for the districts specifically and the zone in general.

Conclusions

Three more districts have been created in the Eastern and one in the North-Eastern Zones, which is increasing the demand for DTLSs and replacement HSD TB FPs. The need for quality assurance, monitoring and evaluation of TB and Leprosy control activities continues to increase
There is some infrastructure and capacity for implementing TB/HIV collaborative activities in the Zone. Sustaining Leprosy elimination is achievable and so is controlling and reversing the burden of TB in the Zone.

Recommendations

1. Urgently formalise the position and status of the DTLS Moroto who is overseeing TB and Leprosy control activities in the Karamoja region.
2. Conduct a Clinical Audit of the Leprosy Cases on treatment in the Zone for purposes of quality of records and services for leprosy control.
3. Urgently arrange for the training of the DTLSs for Amuria, Bukwa and Manafa as well as refresher for Kapchorwa, Sironko and ADTLS for Soroti.
4. Enhanced Supportive supervision for the DTLSs of Kapchorwa and Kaberamaido.

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National TB & Leprosy Program
Eastern Zone,
P.O.Box 39, Kumi
3rd January 2006.

The Program Manager,
National TB & Leprosy Program,
P.O .Box 16069, Wandegeya

Dear Sir,

ACTIVITY REPORT – TOUR OF THE EASTERN ZONE 12TH -23RD DECEMBER 2005

I was able to tour the districts in the Eastern Zone catchments under the NTLP on the dates stated above.

Find attached a copy of the activity for your perusal and comments.

Yours truly,

KALYESUBULA-KIBUUKA SIMON,
AG. ZONAL TB & LEPROSY SUPERVISOR

c.c. GLRA Representative, Kampala, Uganda.
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c.c. Medical Officer Tuberculosis, WHO Country Office.