DREF operation final report

International Federation of Red Cross and Red Crescent Societies

Uganda: Cholera

DREF operation n° MDRUG003
23 January, 2008

The International Federation's Disaster Relief Emergency Fund (DREF) is a source of un-earmarked money created by the Federation in 1985 to ensure that immediate financial support is available for Red Cross Red Crescent response to emergencies. The DREF is a vital part of the International Federation's disaster response system and increases the ability of national societies to respond to disasters.

Summary: CHF 150,000 was allocated from the Federation's Disaster Relief Emergency Fund (DREF) on 12 December, 2006 to support the national society in delivering assistance to some 300,000 beneficiaries.

600 Uganda Red Cross Society volunteers were equipped with knowledge about cholera transmission and prevention and deployed to the field to reach out to at least 300,000 people in the five divisions within Kampala City Council affected by the epidemic. The teams also facilitated active community-based case identification and referral of cholera cases to the health units for treatment and also undertook assessments to determine long-term solutions.

<click here for the final financial report, or here to view contact details>

URCS volunteers distributing bars of soap to an affected woman and child. Source: (URCS)

The situation

In December, 2006 Uganda's Ministry of Health (MOH) reported 305 cases of Cholera registered in a span of 3 weeks and 10 deaths confirmed in Kampala city. Starting with some 212 cases on 1 December, some additional 93 cases were reported in the next 3 days. This equaled a daily infection rate of 23 to 24 cases with a case-specific mortality rate of 3 percent. A cholera treatment centre established in Mulago Referral Hospital reported a caseload of 10 to 15 cholera patients per day, an indicator that if the epidemic was not addressed promptly, it could result in the doubling of caseload in less than two weeks. The Cholera treatment centre also reported that most patients suffered from acute diarrhea resulting from consumption of contaminated food and water. The most affected communities were those in low lying areas that are overcrowded.

A case fatality rate of one percent with an attack rate of 7 percent was reported marked by 11 deaths since the beginning of the outbreak. A total of 1,099 cases were recorded with 30 percent from Kawempe Division of Kampala city as shown in the table below. The proportion of males to females diagnosed was 95 to 100 and about 22 percent of the cases were from children under the age of five.

Table 1: Distribution of Cholera Cases in Kampala

Kampala city divisions	Number of cases
Kawempe	333
Makindye	249
Rubaga	212
Central	128
Nakawa	68
Others (especially Wakiso)	108
Total	**1,099**

According to MOH reports, the epidemic started to spread from internally displaced persons' (IDP) camps in Kitgum and Pader Districts as well as the south western parts of Uganda and increased over the next 2 months spreading to other districts. The first case was recorded on 31 October 2006 where a woman from Mengo-Kisenyi in central Division was admitted at Mulago Referral Hospital. The outbreak was contained after 4 months by 10 March, 2007 followed by closure of the Cholera treatment centre. According to the health authorities in Kampala, the cholera outbreak was the sixth to occur in Kampala City in a space of 10 years since 1997 giving an average of one cholera epidemic after every two years beside other disasters that affect Uganda.

Coordination

There was active inter-agency coordination among stakeholders including the MOH, Mulago Referral Hospital, Medicos Sin Fronteras (MSF-Spain), UN agencies such as World Health Organization (WHO) country office, United Nations Children's Fund (UNICEF) and World Food Programme (WFP), Uganda Red Cross Society (URCS), local humanitarian agencies, religious organizations and the International Federation. With support from the Kampala City Council Public Health department and URCS volunteers, various focus groups and individuals carried out social mobilization activities to encourage a wider participation from the affected communities.

The URCS worked closely with the Ugandan government through activities supported by the MOH, Mulago Referral Hospital and Kampala City Council. Collaboration with the MOH, affected communities and leaders in Kampala district played a significant role in facilitating community entry. The Ugandan government in collaboration with MSF-Spain set up the Cholera Treatment Centre at Mulago Referral Hospital which provided clinical case management to cholera patients. Previously, patients had been forced to seek further medical check-ups at Kawaala Health Centre thus complicating their already vulnerable conditions. Some public toilets were also emptied and prepared for community use by the MOH and each division was allocated a cesspool emptying equipment. As a result, there was improvement in solid waste management. As shown in the table below, response actions among various humanitarian and government agencies were conducted in relief items provision, health care and disease surveillance, training, policy administration and through coordination meetings.

Table 2: Response from Humanitarian Agencies and Ugandan Government

Active Partners	Health Interventions
World Health Organization (WHO)	• A total of 230 health workers from all divisions were trained to improve capacity in the referral system.
Medicos Sin Frontieras (MSF)	• Conducted treatments at the cholera centre.
United Nations Children's Fund	• Provided medicine, sundries and tents for the Cholera centre.
Kampala City Council (KCC)	• Conducted weekly coordination meetings where stakeholders discussed reports and shared work plans. • Provided video equipment for sensitization.
World Food Pogramme (WFP)	• Provided food to patients in the Cholera treatment centre
Plan International	• Provided gumboots and disinfectants to the Kampala city council.
Ministry of Health (MOH)	• Active disease monitoring by the district surveillance team. • Trained health workers in case management. • Outlawed vending of food in open places within Kampala.
Makerere University Institute of Public Health	• Conducted key informant interviews and focus group discussions as a mobilization tool. • Recruitment of change agents within the communities.
International Committee of the Red Cross (ICRC)	• Provided 100 boxes each containing 15 litres of intravenous fluids to assist patients at the Cholera treatment centre.

Red Cross and Red Crescent action

The Uganda Red Cross Society equipped volunteers with knowledge about cholera transmission and prevention and deployed them to the field to reach out to at least 300,000 people in the five divisions within Kampala city Council affected by the epidemic. The teams also facilitated active community-based case identification and referral of cholera cases to the health units for treatment and also undertook assessments to determine long-term solutions.

Progress towards objectives

Goal: To prevent and mitigate the spread of Cholera in Uganda.

Water, sanitation, and hygiene promotion

Objective 1: To equip 500 volunteers of the URCS with the basic knowledge about the causes, signs and symptoms, prevention methods and effects of cholera.

Achievements

600 volunteers were trained on health education focusing on cholera prevention and control, sanitation and cleanliness in affected communities. The training was able to attract an additional 100 volunteers and was seen as an effective means to reach out to a wider community with useful information. The content of the two-day training focused on the history, structure and fundamental principles of the Red Cross and Red Crescent Movement and information on cholera including causes, signs and symptoms, disease management, referral to health facilities, prevention, personal and community hygiene as well as environmental sanitation. Participants learnt about the basic techniques for self protection and prevention. The exercise combined both refresher training and new concepts aimed at the branches and volunteers. As a result, the trainees gained improved capacity to manage Cholera outbreaks.

Objective 2: To reach 300,000 people in the five divisions of Kampala City Council with information on preventive measures against cholera.

Achievements

URCS equipped and deployed 500 volunteers to carry out community awareness through door-to-door sensitization. They were provided with volunteer tool kits, Red Cross Aprons, a pair of boots and heavy-duty gloves, a printed overall, an umbrella, bags to keep their tools and protective face masks. They were grouped according to gender as a strategy to enhance effective communication and minimize cross-gender sensitivities. During sensitization, they used chalk to make mark against the houses visited to monitor their movements, enhance orderliness and avoid unnecessary re-visits. Some 1,200 boxes of soap were distributed to more than 10,000 affected families by the URCS followed by demonstrations on proper hygiene measures. This significantly improved personal and utensil hygiene.

Other sensitization activities were conducted through public meetings in market places, worship centres, entertainment areas and through electronic and print media. Information, Education and communication (IEC) materials were developed and printed in both local Ugandan and English languages. 500 posters and 10,000 brochures were produced and distributed to individuals in markets, places for worship, schools and health centres by the volunteers. The brochures were distributed to the communities and used as health education/sensitization aid by the volunteers. 1,000 T-shirts and 500 volunteer tool-kits were produced and distributed to the volunteers. Audio-visual equipment was also used for effective dissemination of information. Kampala City council teams also benefited from more than 15 sensitization meetings discussing how to address the epidemic effectively.

Challenges

Some areas were hard to reach because they had been cut off by recent floods. In addition, upon arrival to some affected communities, URCS volunteers had to tread carefully not to get embroiled into differences existing between the communities and local authorities.

Objective 3: To facilitate early and active community-based case identification and referral of cholera cases to the nearest health facilities in Kampala.

Achievements

By maximizing the use of existing community-based networks and close collaboration with the local authorities, community early case identification and referral systems were put in place guided by the

community volunteers through the volunteer networks strengthened by the coaching system. The community disease surveillance team was also mobilized for active disease monitoring and reporting.

Photo, above: The URCS supports activities at the cholera isolation centre

An ambulance provided by the URCS was used to transfer an average of 15 patients per day from the most affected areas to hospital. About 600 people from communities in Bokasa, Erisa, Kakajjo, Katwe, Kanyogoga, Kibe, Masanafu, Mengo Kisenyi, Muyenga, Nabisaalu, Nakulabye, Namungoona, Natete, Namuwongo Market, Ndeeba and Rubaga Road benefited from these services. Volunteers were on standby on a daily basis for any casualties and others were present at the cholera isolation center to assist hospital staff in receiving patients from the ambulance, bathing patients with chlorine solution, serving porridge and oral re-hydration salts (ORS), introducing cholera patients with other medical complication like HIV/AIDS to the main hospital, and assisting nurses with first Aid and helping to handle complicated cases like people with mental illnesses. As a result, the Cholera isolation centre effectively contributed to mitigation of the spread of cholera as more affected community members chose to seek early treatment upon seeing that help was available.

Objective 4: To undertake a detailed assessment in the affected areas with the view of establishing long-term prevention measures against potential future outbreaks.

Achievements
Detailed field assessments were conducted in the most affected branches of Kampala City and 6 regions of Uganda including Arua, Bundibugyo, Gulu, Hoima, Kaseese and Lira. The assessment teams observed a case fatality rate of 1 percent which meant that caseload management had improved over the response period. Useful information was obtained that could assist in planning for a long-term programme to build capacity of the affected communities in managing or preventing the re-occurrence of the epidemic. The URCS monitored the situation in Kampala, shared its observations as well as assessment findings during meetings held by branch teams every weekend and reported to the headquarters. Advocacy for provision of curative services by the Ministry of health to the areas that were missing the component was also carried out. The assessments provided the URCS with additional knowledge and built on its response capacity in dealing with the epidemic.

Communications
The print and electronic media was kept informed on the spread of the epidemic for information dissemination to the public for a period of 3 months. A total of 10 interactive radio talk shows were held to sensitize the members of the public on cholera prevention, control and other health issues with support from the Uganda government. In addition, some 30 film shows on proper preventive measures were conducted to the communities in affected divisions supported by the WHO.

Conclusion

Lessons learned:
By involving neighbouring districts such as Wakisio during efforts to control the spread of cholera in Kampala, there was better containment and prevention of further spread of the epidemic to the neighbouring district as well as overall management of resources and information since the epidemic was a common disaster. During the interventions, other affected branches outside Kampala also mobilize volunteers and resources to control and minimize deaths and some received information, education and communication materials and bars of soap from the URCS headquarters.

How we work

All International Federation assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and is committed to the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The International Federation's activities are aligned with its Global Agenda, which sets out four broad goals to meet the Federation's mission to "improve the lives of vulnerable people by mobilizing the power of humanity".	**Global Agenda Goals:** • Reduce the numbers of deaths, injuries and impact from disasters. • Reduce the number of deaths, illnesses and impact from diseases and public health emergencies. • Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability. • Reduce intolerance, discrimination and social exclusion and promote respect for diversity and human dignity.

Contact information

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<final financial report below; click here to return to the title page>

International Federation of Red Cross and Red Crescent Societies

MDRUG003 - Uganda - Cholera Outbreak

Final Financial Report

Selected Parameters	
Reporting Timeframe	2006/12-2007/12
Budget Timeframe	2006/12-2007/12
Appeal	Mdrug003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

I. Consolidated Response to Appeal

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
A. Budget		150,000				150,000
B. Opening Balance		0				0
Income						
Cash contributions (received)						
DREF		*-1,674*				*-1,674*
C1. Cash contributions		*-1,674*				*-1,674*
Reallocations (within appeal or from/to another appeal)						
DREF		*150,000*				*150,000*
C3. Reallocations (within appeal or from/t		*150,000*				*150,000*
C. Total Income = SUM(C1..C6)		148,326				148,326
D. Total Funding = B +C		148,326				148,326

II. Balance of Funds

	Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL
B. Opening Balance		0				0
C. Income		148,326				148,326
E. Expenditure		-148,326				-148,326
F. Closing Balance = (B + C + E)		0				0

III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure						Variance
		Health & Care	Disaster Management	Humanitarian Values	Organisational Development	Coordination & Implementation	TOTAL	
	A						B	A - B
BUDGET (C)			150,000				150,000	
Supplies								
Other Supplies & Services	21,140							21,140
Total Supplies	21,140							21,140
Personnel								
National Society Staff	12,715							12,715
Total Personnel	12,715							12,715
Workshops & Training								
Workshops & Training	13,141							13,141
Total Workshops & Training	13,141							13,141
General Expenditure								
Information & Public Relation	91,689							91,689
Office Costs	1,565							1,565
Total General Expenditure	93,254							93,254
Contributions & Transfers								
Cash Transfers National Societies			138,685				138,685	-138,685
Total Contributions & Transfers			138,685				138,685	-138,685
Programme Support								
Program Support	9,750		9,641				9,641	109
Total Programme Support	9,750		9,641				9,641	109
TOTAL EXPENDITURE (D)	150,000		148,326				148,326	1,674
VARIANCE (C - D)			1,674				1,674	