

Reducing Avoidable Loss of Life and Burden of Disease due to Crises in Uganda

Health Action in Crisis (HAC) Programme

Annual Report
2006



Foreword by the WHO Representative, Uganda

Dr. Melville George, WHO Representative, Uganda & other WCO staff during a WHO/HAC retreat in Gulu



The year 2006 was full of challenges for WCO in terms of it's work in Health Action in Crisis.

First, there was an intensification of WHO activities in the North with the opening of three sub offices in Pader, Kitgum and Lira in addition to strengthening the coordinating sub office in Gulu. This involved the recruitment of a number of staff and the acquisition of logistics and communication equipment to facilitate our work.

Secondly, WHO took on the mantle of cluster lead for Health, Nutrition and HIV/AIDS. Collaborating with other partners and stakeholders to strengthen the systems for coordination has continued and I want to take this opportunity to thank UNICEF (the previous lead) for the work done.

Thirdly, lots of efforts have been put in the technical areas of Service Availability Mapping for some Northern districts and capacity building for response to the key health problems of HIV/AIDS, Malaria, TB and Reproductive Health. We have started to see some improvement; TB indicators in the Northern districts of Pader, Kitgum and Gulu are now second only to those of Kampala whilst ART sites in the same districts have doubled in 2006.

All of this would not have been possible without the enabling environment and collaboration made by Government and the contributions and financial support of our donor partners (DFID, SIDA, FINLAND, NORWAY) and other implementing partners (UN system and NGOs).

We are now experiencing a rapidly emerging process of population resettlement and return by IDPs in the North. The challenge for health systems strengthening in terms of rehabilitation, reconstruction, re-equipping and staffing of health facilities is critical and urgent. The PRDP provides an opportunity for this. We all need to appreciate the magnitude of the efforts needed to ensure that the health system is in a healthy state to respond to the legitimate health needs of the returning population.

We look forward to working with you all in this direction.

Dr. Melville George
WHO Representative Uganda

Acknowledgements

The year 2006 was very eventful for WHO/HAC Uganda; during this year good progress towards reducing avoidable loss of life, burden of disease and disability due to crises in Uganda was achieved. These progress and achievements were made possible by the immeasurable contributions of many key players within and outside the healthcare sector of the country. Of special note are the immense contributions and support of the development partners (DFID, Sida, ECHO, Governments of Finland and Norway) who provided the much needed funds and moral support to our operations in Uganda. We also acknowledge the immense support of the WHO/HAC teams in AFRO and headquarters.

We are grateful to Dr. Luis Sambo, Regional Director AFRO, Dr. Chris Mwikisa, Director, Division of Healthy Environments and Sustainable Development, Dr. Omar Khatib, regional adviser EHA/AFRO and Dr. Michel Yao, inter-country EHA focal point, Nairobi for their very sound professional support and advice which greatly facilitated WHO/HAC work in Uganda. We also express our gratitude to Drs Khalid Shibib and Simao Luzitu of WHO/HAC Geneva for providing us with technical and professional guidance to handle key tasks and responsibilities related to WHO core functions in emergencies.

Of special note are Dr. Melville George, the WHO Representative Uganda, Mr Kamau Thuo the administrative officer and all WCO Uganda professional and support staff whose sound technical, administrative and logistic advice and support were very useful in enhancing our capacity for timely response to the northern Uganda humanitarian crises.

Finally, we thank our counterparts in the MOH and conflict affected districts for their cooperation and giving us unrestricted access to the IDP camps.

To everybody, we say THANK YOU!

WHO/HAC Team Uganda

Abbreviations

ART	Anti-retroviral Therapy
CAP	Consolidated Appeal Process
CBDS	Community Based Disease Surveillance
CCS	Country Cooperation Strategy
CDR	Case Detection Rate
CMDs	Community Medicine Distributors
CMR	Crude Mortality Rate
CORPs	Community Owned Resource Persons
DDHS	District Director of Health Services
DFID	Department for International Development
DHTs	District Health Teams
ECHO	European Commission Health Office
HAC	Health Action in Crisis
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IDPs	Internally Displaced Persons
IDSR	Integrated Diseases Surveillance and Response
MOH	Ministry of Health
NGOs	Non-Governmental Organisations
NU	Northern Uganda
RD	Regional Director
SGBV	Sexual and Gender Based Violence
Sida	Swedish International Development Cooperation Agency
TB	Tuberculosis
TYP	Three Year Programme
VHTs	Village Health Teams
WCO	WHO Country Office
WR	WHO Representative

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Executive Summary

As a result of broad consultations within and outside WHO, a Three Year Performance Improvement Program (TYP) aimed at strengthening WHO's capacity to support member States and others to prepare for and respond to emergency was commissioned in 2004. Within the framework of the TYP, CCS and the Ugandan HSSP II WHO has been providing support to the MOH, DHT) and other local and international partners to mitigate the health impact of the conflict in northern Uganda for at least 3 years.

Summary achievements of WHO/HAC in Uganda in the year 2006 include expansion of operations into 8 additional conflict affected districts of northern Uganda, implementation of health services availability mapping surveys in Gulu, Kitgum and Pader districts which provided vital baseline information for identifying keys health priorities in the districts and local mobilisation of over five million USD from various donors such as DFID, Sida, Norwegian and Finnish governments to address critical gaps in health, nutrition and HIV/AIDS response in northern Uganda. Other key achievements include timely, effective and successful response to meningitis, cholera and measles outbreaks all over the country, successful roll out of the new malaria treatment policy in all districts of northern Uganda, strengthening of IDSR, increasing the number of ART sites from 5 in 2004 to 35 in 2006 and construction of two maternity units in underserved areas of Oyam and Lira districts.

Despite many constraints, WHO/HAC Uganda made tremendous progress in establishing its presence and visibility in northern Uganda in 2006. The programme is now present and providing technical, financial and logistic support in the delivery of health care services in all districts of northern Uganda. The proximity to the DHTs in these districts has also enhanced the co-ordination role of the organization. These achievements will contribute to reduction of morbidity and mortality in northern Uganda in the coming months and years. Looking back, the excellent leadership and support from the WHO Regional Director and WHO Representative, collaboration and support from programme officers and the administrative unit in the WCO, presence of very committed, dedicated and hard working teams in the field and excellent support from the donors (DFID, Sida, Norway, Finland, ECHO) were some of the strengths that contributed to the successful work of WHO HAC Uganda in 2006. However, insecurity, lack of human resources for health especially at the health facility level, low fund absorption capacity by the district and ineffective co-ordination of health response in the district were some of the key challenges faced by the programme.

To consolidate the achievements made so far by WHO/HAC Uganda and ensure that these achievements translate into substantial reduction in morbidity and mortality, in northern Uganda, the strategic focus of the programme in the year 2007 is to proactively improve health coordination through the cluster approach, build effective partnerships especially with NGOs, strengthen the MOH and district capacity for emergency preparedness and response and health service delivery at the health facility and community levels in the IDP camps and return areas and strengthen HMIS/IDSR to ensure timely and good quality disease and health data for programme monitoring, evaluation, planning and priority setting.

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1. Background

1.1 WHO/HAC in Uganda

As a result of broad consultations within and outside WHO, a Three Year Performance Improvement Program (TYP) aimed at strengthening WHO's capacity to support member States and others to prepare for and respond to emergency was commissioned in 2004. This programme which is implemented through the Health Action in Crisis (HAC) programme is centred around WHO's core functions in emergencies namely:

- Supporting member states to co-ordinate health response to emergencies
- Measurement of ill health, and assessing priority health needs of populations affected by emergencies
- Identification and filling of gaps in health response to emergencies and;
- Strengthening capacity of health systems for preparedness and response

Within the framework of the TYP, WHO has been supporting the MOH, DHTs and other local and international partners to mitigate the health impact of the conflict in northern Uganda for an extended period. As part of the TYP and in order to provide better support to the population in need and strengthen emergency preparedness and response capacity in the country in general and northern Uganda in particular, WHO established the WHO/HAC office in Kampala and opened a sub-office based in Gulu in late 2004. The programme has further expanded its operations into other districts of Acholi and Lango sub-regions.

This report briefly describes some of the major achievements of WHO/HAC Uganda in 2006 and highlights the important conclusions, key lessons learned and visions for 2007.

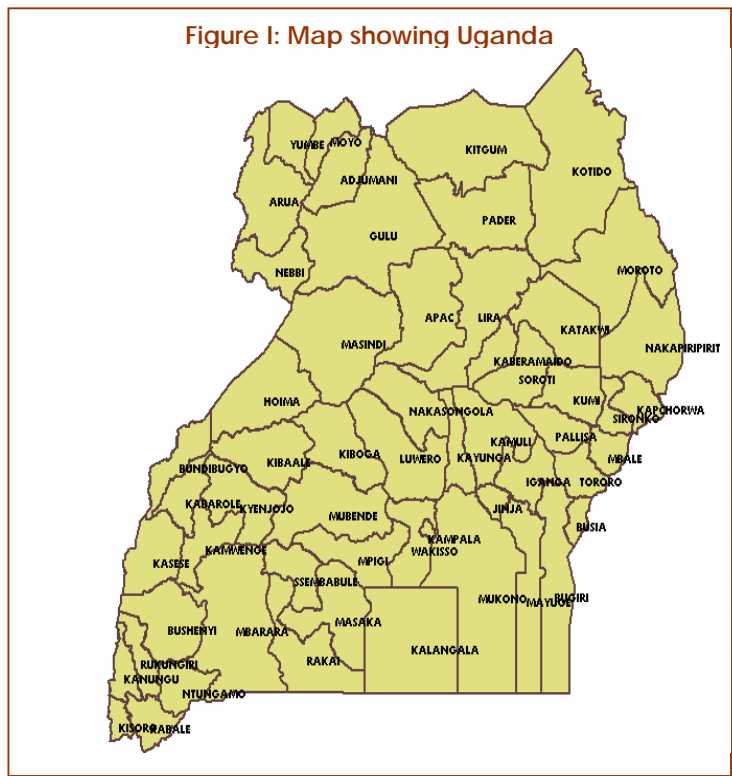
1.2 Uganda: Brief Background and General Context

Uganda is located in the Great Lakes Region of Africa. It is bordered in the north by south Sudan, in the east by Kenya, south by Rwanda, Tanzania and Lake Victoria and in the west by the Democratic Republic of Congo (DRC). The country is affected by different kinds of conflicts in north, northeast and western parts.

Of its 28 million population, over 1.7 million live in IDP camps in over 10 districts as a result of 20 years of armed conflict in the northern part of the country. Acholi, the worst affected sub-region, accounts for majority of the IDPs; other sub-regions such as Lango, Teso and west Nile have also been affected.

Overcrowding, inadequate healthcare services, poor water and sanitation facilities, violence and insecurity in the camps predispose the IDP population to high morbidity and mortality rates. A UN mortality survey carried out in the Acholi sub-region of northern Uganda in July 2005 showed alarming CMR of 1.54 and under five mortality rate of 3.18/10,000/day.

The figures from the districts of Kitgum and Pader were double the emergency threshold for both CMR and U5 MR. According to the report, the top leading reported causes of morbidity in the region are malaria, respiratory tract infection, intestinal worm and skin infection, and the leading causes of mortality are malaria, AIDS, violence and respiratory tract infection. A HIV sero-prevalence survey carried out in 2005 revealed that the northern region has a prevalence of 8.2%; higher than the national average of 6.4 %.



In Lango sub-region (which comprises Lira, Apac, Dokolo, Amolatar and Oyam districts) where the LRA insurgency has reduced and security situation improved, over 60% of the IDP populations have returned to their original homes. Given the improved security situation in northern Uganda, the government of Uganda developed a Peace, Recovery and Development Plan

(PRDP) to support return of IDPs to their original homes. In Acholi sub-region, many of the IDPs are moving into satellite camps, settlement sites and some villages close to their original homes to improve their sources of livelihood through access to land and to reduce the population pressure in the big camps. Success of the ongoing peace talks in Juba is expected to trigger more voluntary return of IDPs to their original homes.

The Karamoja region (now Moroto, Kotido, Kaabong and Nakapiripirit districts), located in north-eastern Uganda, has been rendered insecure, inaccessible and is underdeveloped due to cattle rustling and inter-ethnic clashes among the Karamajong warriors while inter-regional conflicts around the Ugandan-DRC-Rwandese borders have also led to humanitarian problems in that area.

These long standing conflicts have eroded the coping capacities of the affected communities resulting in insecurity, destruction of most health care infrastructures, migration of trained health workers to safer urban areas, very low literacy levels, lack of local economies (resulting in high rates of poverty) and lack of basic infrastructures such as roads, electricity and means of transportation in these areas.

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2. Progress and Achievements in 2006 – WHO/HAC Kampala

2.1 Ensuring Coordinated Emergency Response through Effective Health Coordination

In 2006 there was a remarkable increase in WHO/HAC presence in northern Uganda which greatly facilitated WHO's co-ordination and technical roles and responsibilities in the country as a whole and northern Uganda in particular. In general the percentage of WHO emergency positions filled increased from 30% in late 2005 to 97% by the end of 2006. Three new offices were opened in Kitgum, Pader and Lira districts during the year bringing the total number of field offices to four, and five additional National Professional Officers (NPOs) were recruited bringing the total number

Figure II: Ensuring Effective Health Coordination: A WHO Staff in a Malaria Coordination Meeting in NU



to eight. In addition Gulu has an international focal point and team leader who co-ordinates the three offices in Acholi sub-region. The NPO/HAC provide technical support in co-ordination of health in emergencies to the DHTs while the NPO Disease Control work closely with the DDHS to support the implementation of key activities aimed at reducing morbidity and mortality in northern Uganda. This increased presence and technical capacity of the programme greatly enhanced WHO's health co-ordination role and strengthened its technical capacity to effectively support

the Ugandan government and other partners in effective coordination of health response in northern Uganda and other parts of the country. This expansion was critical to WHO regaining the health, nutrition and HIV/AIDS cluster leadership in November 2006. WHO/HAC also continued to provide regular and up-to-date health information to the DHTs and partners present on the field through production and distribution of the Health Action in Northern Uganda newsletter, emergency health CD-ROMS and the establishment of an emergency health library in the Gulu sub-office to enhance information dissemination and exchange and to further strengthen the cluster approach.

2.2 Providing Reliable Information for Planning: Assessing Priority Health Needs

During the year, WHO/HAC technically supported and participated in several rapid health assessments of return and resettlement areas in northern Uganda; humanitarian situation in Karamoja region and epidemic outbreak investigations in West Nile, Karamoja, Northern and Western regions of the country which facilitated timely response to these outbreaks. In Lira district, WHO/HAC supported the development of the health questionnaire for the joint UN assessments of the return areas and participated in the assessment of all health facilities (functional and non-

functional) in the district. The outcomes of these assessments and investigations enabled informed decision making, resource mobilization and planning for future interventions.

As part of the efforts to improve health planning and co-ordination in northern Uganda, WHO/HAC supported health services availability mapping surveys in Gulu, Kitgum and Pader districts between March and May 2006. These surveys provided vital baseline information for identifying keys health priorities in the districts especially in the return and resettlement areas and planning the CAP 2007 and DFID II joint project proposals.

In an effort to support a human rights-based approach to humanitarian interventions and actions, WHO/HAC commissioned a health and human rights study in Kitgum and Pader districts in northern Uganda in late 2006. The study is aimed at understanding the views of communities and health providers/partners in relation to awareness about health related rights; the key element of 'the right to health' (availability, accessibility, acceptability and quality of services) and human rights principles (participation, empowerment, non-discrimination, accountability and local ownership). The initial findings of the report which will help guide improvements in health services provision will be disseminated very soon.

2.3 Ensuring Timely Identification and Effective Filling of Gaps

In collaboration with other members of the health, nutrition and HIV/AIDS cluster, WHO/HAC led the organization's participation in the development and mid-year review of the 2006 and the 2007 Common Humanitarian Action Plan (CHAP) and Consolidated Appeal (CAP) in Uganda. Based on the 2006 CAP, the programme raised over five million USD from various donors such as DFID, Sida, Norwegian and Finnish governments to address critical gaps in health, nutrition and HIV/AIDS response in northern Uganda.

2.4 Capacity Building as a tool for Enhancing Emergency Preparedness and Response

2.4.1 Timely Epidemic Preparedness and Response

Figure III: Capacity Building: A WHO Staff Supporting a DHT Staff in NU



The year 2006 witnessed many epidemic outbreaks in Uganda; cholera in Kitgum, Pader, Gulu, Kampala and west Nile region, meningitis in Gulu and Karamoja, measles in Pader and Kitgum and many other outbreaks. Through the provision of technical support to the DHTs, procurement of health and water testing and reagents, laboratory supplies, vaccines, drugs and other medical supplies, printing and distribution of IEC materials, case management and infection control guidelines, WHO/HAC was able to strengthen the districts capacities to timely and effectively

respond to these epidemics. This is evident in the very low attack and case fatality rates recorded

in these epidemic outbreaks. Given the overcrowding, poor living condition of the IDP camps in Gulu, the technical support and materials provided through WHO/HAC contributed to the districts ability to maintain the attack and case fatality rates of the meningitis outbreak within acceptable limits. Prompt response to the measles outbreak in Pader district was also largely catalysed by the technical support and medical materials provided by the WHO/HAC programme.

2.4.2 HMIS and IDSR

The timeliness and completeness of HMIS reporting has improved tremendously through technical support to district surveillance focal persons, procurement and distribution of village telephones to priority health facilities, provision of computers and internet access to the districts, training and provision of HMIS manuals and reporting forms to health facilities in northern Uganda. In Amuru district for instance the timeliness and completeness of reporting improved from 53% in January 2006 to 100% in December 2006.

To further strengthen disease surveillance in northern Uganda, WHO/HAC in collaboration with the MOH re-activated Community-Based Disease Surveillance (CBDS) systems using the CORPS and VHT structures in Kitgum and Pader districts. This system will further complement the health facility based surveillance system and facilitate early detection and timely response to epidemic outbreaks.

2.4.3 Malaria

WHO/HAC in collaboration with the malaria programme of WHO, MOH and the DHTs technically,



financially and logistically supported the roll-out of the new malaria drug policy in northern Uganda through: training of health workers on the new policy, development, printing and dissemination of new guidelines on the policy and procurement of over 400,000 doses of the Co-Artem for use at the community level. As part of the roll out of the drug at the community level, WHO/HAC provided support in the training of over 2000 VHTs and CMD in home-based management of fever, community surveillance and mobilization for immunization and general health promotion activities

in Gulu, Kitgum and Pader districts. It is believed that these activities will contribute to the reduction in mortality and morbidity due to malaria which is the highest cause of mortality in northern Uganda.

2.4.4 HIV/AIDS/TB

Consequences of conflict such as breakdown of family and community structures, forced displacement, joblessness, poverty and alcohol abuse and increased incidence of SGBV in northern Uganda has resulted in a high HIV prevalence rate in the region. This coupled with other important risk factors such as malnutrition, and other underlying diseases, has fuelled increased incidence of TB in the camps.

While MOH estimates the annual risk of TB infection in Uganda to be 3% this is likely to be higher in IDP camps due to overcrowding, poor nutrition, high HIV sero prevalence rate and poverty prevalent in the IDP camps. To address these problems, WHO/HAC in collaboration with the WHO HIV/AIDS programme supported the training of over 90 health workers (clinical teams comprising of doctors, nurses, counsellors, midwives and nursing assistants) on comprehensive HIV/AIDS treatment and care and supported the establishment of ART treatment in more than five health centres in northern Uganda in 2006 bringing the total number of ART sites in northern Uganda to 35. As demonstrated in figure VI below this also resulted in over 100% increase in the number of patients receiving ART in northern Uganda from 2005 to 2006.

Figure V: Tuberculosis Case Detection Rate in Northern Uganda - 2003 to 2006

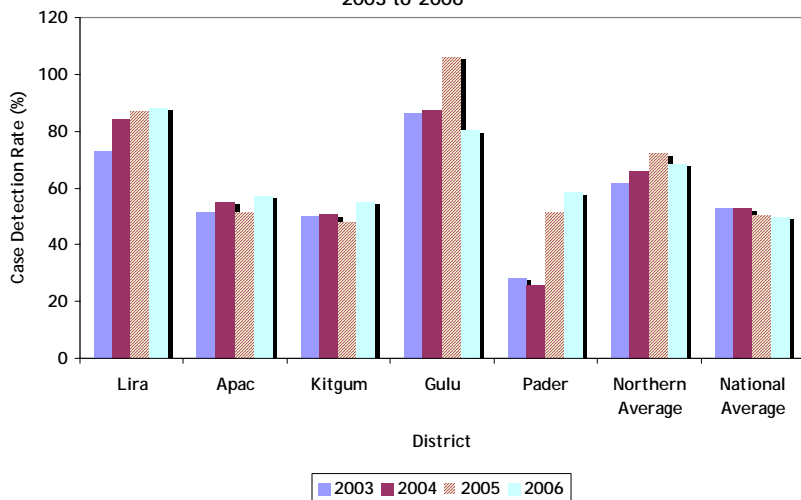
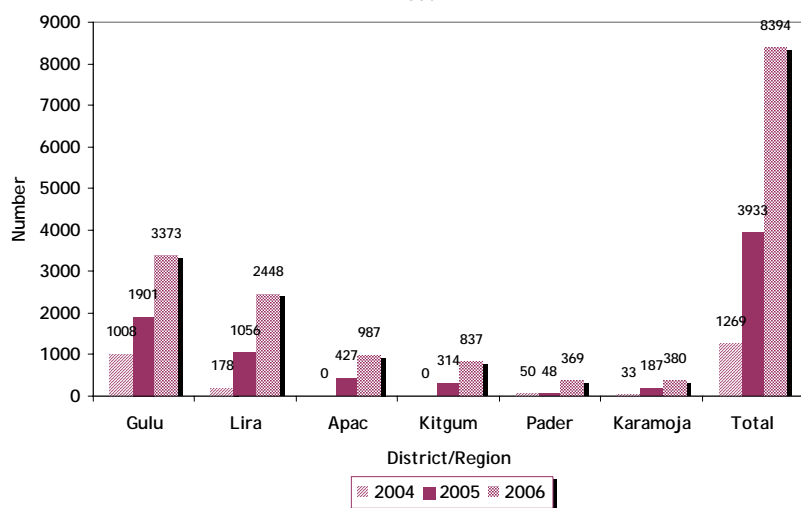


Figure VI: Number of Patients on ART in Northern Uganda & Karamoja: 2004 - 2006



Also supported was community-based TB DOTS in all districts of northern Uganda through provision of technical support to the district tuberculosis focal persons, donation of microscopes to improve diagnosis and case detection, anti TB drugs to address drug shortage, training, supervision, monitoring and evaluation all of which resulted in improved case detection and cure rates of the disease. These interventions contributed to an increase in TB CDR in all districts of northern Uganda (except Gulu) in 2006 and higher CDR average for northern Uganda as compared to the national average (figure V above).

2.4.5 Reproductive Health

Recognizing the importance of safeguarding women’s health in reducing overall morbidity and mortality in northern Uganda, WHO/HAC supported the training of health workers in emergency obstetric care procedures, post abortion care and maternal audit reviews, supported the

construction and equipping of two maternity units in Lira and Oyam districts, provided equipment to ensure safe delivery for pregnant mothers and provision of post abortion care. In addition, 50,000 essential medical forms for ante-natal and post natal care of mother and new borns and over 20,000 mama kits for clean delivery were provided to all districts of northern Uganda.

2.4.6 Information Education and Communication (IEC)

WHO/HAC also provided support in the production of IECs for disease prevention and control, including sponsoring radio programs/talk shows, spots, production and the dissemination of brochures/leaflets, posters, health promotion handbook for VHTs and guidelines for the different health programmes in northern Uganda.

Figure VII: A WHO supported Maternity Ward under construction in Adwari sub-county, Lira District



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3. Looking Back: Conclusions and Major Lessons Learned

3.1 Key Conclusions

Despite many constraints, WHO/HAC Uganda made modest but remarkable progress in establishing its presence and visibility in northern Uganda in 2006. The programme is now present and providing technical, financial and logistic support in the delivery of health care services in all districts of northern Uganda. The proximity to the DHTs in these districts has also enhanced the coordination role of the organization. These achievements will contribute to reduction of morbidity and mortality in northern Uganda in the coming months and years. To ensure this, there is a need for a continuous WHO/HAC presence in this area for the next few years to support a smooth transition from humanitarian response to return and early recovery of the affected populations and communities.

Through support from the Regional Director, WHO Representative Uganda, HAC team in headquarters, WHO Regional Office for Africa and inter country programme, the programme was able to shorten the staff recruitment process and procurement lead time which greatly enhanced the capacity to timely respond to health emergencies. Despite these achievements, there are still many challenges especially in the Karamoja region, areas where the organization is yet to fully establish its presence. Insecurity and lack of human and logistical resources remain key challenges to the operations of the organization in northern Uganda.

3.2 Major Lessons Learned

3.2.1 Enabling Factors

- **The excellent leadership and support from the WHO headquarters**, the African Regional Office (AFRO) through the Regional Director and Adviser, and WHO Country Office (WCO) headed by the WHO Representative, Uganda enabled WHO/HAC Uganda to rapidly establish itself and regain credibility in the country in 2006. Delegation of authority from the RD to the WR to recruit professional staff and procure essential supplies and equipment locally was the key factor responsible for the rapid deployment of staff to respond to the changing circumstance.
- **Collaboration and support from programme officers** and the administrative unit in WCO greatly enhanced WHO/HAC's capacity to deliver
- **Presence of very committed, dedicated and hard working field teams** in Gulu, Kitgum, Pader and Lira ensured that we were present in the field and providing support to the DHTs and IDPs
- **Excellent support from the donors** (DFID, Sida, Norway, Finland, ECHO) who provided the much needed funds to facilitate our activities
- **Good partnerships with the district health teams and the Ministry Of Health (MoH)**

- **Use of innovations** such as Agreement for Performance of Work (APWs) to support specific field tasks and loaning of logistics such as vehicles, essential drugs and medical supplies, computers etc from other programmes greatly facilitated timely delivery of services to the IDPs

3.2.2 Challenges

- **Insecurity** is a major challenge to our operations in the north. Insecurity makes access to many camps which are often underserved very difficult, limits time spent on the field and increases operational costs.
- **Insecurity has limited access of IDPs to sources of livelihood and/or employment** resulting in high poverty levels which make it difficult to retain health intervention such as bed nets. It has also caused a breakdown of social and community structures leading to increased SGBV and HIV transmission rates, overcrowding and poor sanitation all of which facilitate easy outbreaks of fires and transmission of diseases thereby increasing mortality and morbidity.
- **Lack of skilled human resources for health** coupled with poor retention of available workforce at the district, health sub-district and health facility level is a major constraint to delivery of good health care services.
- **Low absorption capacity of the districts for funds** and activities often slows down the pace of our work
- **Ineffective co-ordination** of health response to the humanitarian crisis in northern Uganda which often results in duplication of efforts and inappropriate allocation and use of resources. Factors responsible for this poor co-ordination include:
 - i. Proliferation of aid agencies with poor supervision, monitoring, regulation and control of the agencies
 - ii. Ineffective communication, poor information dissemination and sharing among aid agencies
 - iii. Differences in agency mandate leading to competition (especially in attracting funds)
 - iv. Complex and often parallel co-ordination structures at the national level
 - v. Lack of capacity, knowledge and skills for health co-ordination especially at the district level
- **Disconnect between administrative and logistic procedures meant for normal circumstances and humanitarian crisis:** although there has been an improvement in delivery time for international procurement between last year and now, there is still more room for decreasing the delivery time for international orders especially essential drugs, diagnostic tests and other medical supplies needed for timely response to health emergencies.
- **The rapidly evolving humanitarian context** also continue to challenge priority setting, planning and coordination of health response

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4. The Way Forward: Strategic Vision and Key Recommendations for 2007

The strategic focus of WHO/HAC for the year 2007 is to proactively improve health coordination through the cluster approach and building effective partnerships especially with NGOs, strengthen the MOH and district capacity for emergency preparedness and response and health service delivery at the health facility and community levels in the IDP camps and return areas and strengthen HMIS/IDSR to ensure timely and good quality disease and health data for programme monitoring, evaluation, planning and priority setting. In addition emphasis will be placed on more effective advocacy, communication and resource mobilization to address funding gaps and increased presence in Karamoja, a region where the humanitarian situation remains precarious and the populations underserved.

To achieve these, there is need to implement the following key recommendations:

4.1 General

- **Increased Government ownership and Participation in Coordination of Emergency Response:** The role of government in ensuring effective coordination of health response in northern Uganda cannot be overemphasized hence the need for the development partners especially WHO to proactively engage government especially at the district and health sub-district levels and encourage ownership, more participation and leadership in emergency response coordination in northern Uganda.
- **Availability of adequate, well trained and skilled human resources for health** is important in providing good health care services to IDPs of the north hence the need to urgently address the human resource shortage in the north. In the short-term, this can be achieved through support of outreach/mobile services to hard-to-reach and underserved camps, strengthening of community-based health initiatives such as the CORPs and VHTs through regular refresher trainings, provision of support supervision and adequate quantities of drugs and medical supplies and the deployment of volunteers such as the Technical Aid Corps (TAC) to the hard-to-reach areas. In the long-term, GoU needs to establish clear guidelines and strategies for attracting and retaining trained and skilled health workers to northern Uganda.
- **Improve Fund Absorptive Capacity of DHTs:** through streamlining and integrating activities such as training, monitoring and supervision to reduce the current parallel systems which results in waste of man-hours and financial resources. Development partners especially WHO should also explore the possibilities of providing short-term consultants to directly support the DHTs in the implementation of specific and critical tasks based on clearly identified needs.
- **Restoration of Peace:** ultimately, peace is critical to mitigating the effect of the humanitarian crisis in northern Uganda and needs to be pursued with all vigor by GoU and the LRA.

4.2 WHO/HAC

- **Additional Human Resources and Funding for WHO/HAC Uganda:** WHO at the HQ, regional, country and district level should nurture its growth and visibility in northern Uganda and harness the full complement of WHO comparative advantage and strength to fruition and use these as tools to strengthen the health, nutrition and HIV/AIDS cluster management. Specifically, additional human resources especially for nutrition and logistic are needed and sustained funding for 2007 and beyond to support co-ordination and operations at national and district levels should be raised.
- **Improved Logistic and Administrative System:** a good logistic, finance and administrative system which ensures the availability of required essential drugs, medical supplies and equipment in the right quantities, at the right time and place is critical for timely and effective response to health emergencies hence the need to fast-track WHO/HAC logistic and administrative systems in order to reduce our response time.
- **Sustained Presence of WHO/HAC in Northern Uganda:** the technical and logistic support of WHO to the MOH and DHTs in emergency preparedness and response to the humanitarian crisis in Uganda is very relevant, essential and has contributed to reduced morbidity and mortality levels especially during epidemic outbreaks hence there is need to sustain our presence in the country for now.
- **Expansion of WHO/HAC Operations to Karamoja Region:** given that the humanitarian conditions in Karamoja region is as bad as in northern Uganda if not worse, there is a need for WHO/HAC to look at the possibility of establishing its presence there in the coming months.