

**EVALUATION OF JOINT UN EMERGENCY HEALTH, NUTRITION
AND HIV/AIDS PROGRAMME IN NORTH AND NORTH EASTERN
UGANDA**

26 July-10 August 2007

DRAFT REPORT

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11 September 2007**

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Acknowledgements

The team would like to thank the many organisations and individuals who contributed to this review. Their willingness to make time available for meetings and to share their views is greatly appreciated. Thanks are due to staff at DFID, UNICEF, WHO, WFP and UNFPA for their insights and excellent support for team logistics and arrangements. We would especially like to thank UN staff who accompanied us during field visits. We are also grateful to representatives of the MOH and national NGOs for their contributions and to the government officials, health personnel, NGOs and communities we met in Amuru, Gulu, Kitgum, Lira and Pader districts.

Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral
CAP	Consolidated Appeals Process
CBDS	Community Based Disease Surveillance
CFR	Case Fatality Rate
CHAP	Common Humanitarian Action Plan
CMR	Crude Mortality Rate
CORPS	Community Owned Resource Persons
DDMC	District Disaster Management Committee
DHO	District Health Officer
DHT	District Health Team
EPR	Epidemic Preparedness and Response
GAM	Global Acute Malnutrition
GOU	Government of Uganda
HC	Health Centre
HMIS	Health Management Information System
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
IASC	Inter-Agency Steering Committee
IDP	Internally Displaced People
IDSR	Integrated Disease Surveillance and Response
IMR	Infant Mortality Rate
JMC	Joint Monitoring Committee
JPSC	Joint Programme Steering Committee
M&E	Monitoring and Evaluation
MMR	Maternity Mortality Ratio
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
NGO	Non Government Organisation
NUMAT	US Northern Uganda Malaria, AIDS and TB Programme
OCHA	UN Office for Coordinating Humanitarian Assistance
OVC	Orphans and Vulnerable Children
OPM	Office of the Prime Minister
PEAP	Poverty Eradication Action Plan
PEPFAR	US President's Emergency Plan for AIDS Relief
PHLA	People Living with HIV and AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private not-for profit provider
PRDP	National Peace, Recovery and Development Plan for Northern Uganda
SGBV	Sexual and Gender Based Violence
TASO	The AIDS Support Organisation
U5MR	Under-Five Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMHCP	Uganda National Minimum Health Care Package
VHT	Village Health Team/member of VHT
WHO	World Health Organisation
WFP	World Food Programme

1. SUMMARY

Background

1.1 The joint UN emergency health, nutrition and HIV/AIDS programme in North and North Eastern Uganda commenced January 2006. DFID's total commitment for 2006 and 2007 is £11,305,676 (£6,837,699 (\$11,829,220) in 2006 and £4,467,976 (\$8,489,156) in 2007 (see Annex 1).

1.2 The programme Goal is: Reduced morbidity and mortality among internally displaced persons, returning and returned populations and those affected by cattle rustling in the Acholi, Lango and Karamoja sub-regions and in the two districts of Amuria and Katakwi in the Teso sub-region. The programme Purpose is: Sustained delivery of an integrated health services system including strengthening the health management information system (HMIS), epidemic preparedness and response in internally displaced people (IDP) camps, transitional camps and return populations. Programme Outputs focus on strengthening human resources for health, health infrastructure, HMIS and epidemic preparedness and response (EPR), and coordination of the health sector response; and on delivery of child health, malaria control, reproductive health, and HIV/AIDS interventions.

1.3 In July-August 2007, DFID commissioned two consultants to evaluate the programme. The objectives of the evaluation, set out in the Terms of Reference in Annex 2, were to 1) identify impact, outcomes and outputs resulting from the programme; 2) clarify short-term humanitarian and health, nutrition and HIV/AIDS needs in Northern Uganda and recommend areas for joint UN programme support; and 3) identify key challenges for the health sector during the transition from the current humanitarian situation to recovery and development.

1.4 Findings and recommendations in this report, which focus mainly on programme progress and issues relating to joint programming, are based on meetings with key stakeholders and field visits (see Annex 3) and review of background documents (see Annex 4). A brief overview of issues identified under objectives 2) and 3) is included in Section 5. These issues are discussed in more detail in a separate report, which sets out options for future DFID support for health, nutrition and HIV/AIDS in North and North Eastern Uganda.

1.5 The following summarises evaluation findings and recommendations. Section 2 of this report provides a more detailed review of programme progress and Section 3 highlights general observations concerning the programme. Section 4 discusses programme management issues. Recommendations are highlighted in bold italics. Section 5 summarises health sector challenges in Northern and North Eastern Uganda.

Findings

1.6 The joint programme is the main source of external support to the health sector in Northern Uganda and has played an important role in ensuring that the population receives basic health care. However, the programme is ambitious in scope and coverage relative to its timeframe and resources, and there is a risk that some interventions will achieve limited impact. In practice, activities have largely been

concentrated in districts in Acholi and Lango. Teso and Karamoja have received limited attention.

1.7 A mortality survey conducted in 2005 showed that crude mortality rates (CMR) in Northern Uganda were significantly above emergency thresholds. A follow-up mortality survey, planned for 2007, has not yet been conducted, so it is not possible to comment on the impact of the programme at Goal level. Achievement of the programme Purpose is likely to be difficult in view of the health sector challenges in Northern and North Eastern Uganda. At Output level, the joint programme has performed better in some areas than others.

1.8 The programme has provided funds to the Ministry of Health (MOH) to finance payment of a one-time allowance to health workers to address recruitment and retention problems in Northern Uganda. It is too early to judge whether or not this will be sufficient to attract health workers to the region or to reach the target of 55% of posts filled. Feedback from district health teams (DHTs) indicates that recruitment of doctors will continue to be a challenge and that task shifting may be required to address this. Human resource shortages are exacerbated by weaknesses in human resource management.

1.9 Progress with improvements in health infrastructure has been relatively slow. Construction and renovation of health facilities seen by the evaluation team was incomplete. None had water supply, power and sanitation in place or adequate housing relative to staffing norms. More consideration could have been given to phasing of activities, specifically completion of housing before advertising staff posts, given the impact of lack of accommodation on staff recruitment and retention.

1.10 Provision of training and equipment has increased the timeliness and completion of HMIS reporting. Further improvements in HMIS are constrained by the limitations of the system itself. The programme has piloted community-based disease surveillance (CBDS) and completeness of reporting is over 95%. Sustainability is a concern, since the system requires multiple forms to be completed by community volunteers and the MOH has no budget for CBDS. The joint programme has also strengthened district EPR capacity and outbreaks have been well investigated, managed and contained.

1.11 The programme has increased childhood immunisation, vitamin A supplementation and de-worming coverage. Maintaining high coverage will be a challenge when populations move from IDP camps and without external funding. Progress in improving TT coverage has been more limited. The programme has trained health workers and Community-Owned Resource Persons (CORPS) to improve management of common childhood illness at facility and community levels. The extent to which health facilities manage sick children according to IMCI standards is difficult to assess.

1.12 There is a lack of clarity concerning the roles and responsibilities of CORPS and community volunteers who comprise the village health team (VHT). There is no consistent training for VHT to enable them to provide a basic standard set of prevention and care interventions. Training for VHT and CORPS appears to vary in quality and has not been planned or delivered in a coherent or efficient way. Supervision and monitoring of VHT and CORPS by health facilities is also a concern.

1.13 Programme nutrition activities have concentrated on surveys and management of malnutrition in young children. Survey findings indicate that global acute malnutrition

rates have fallen below the 10% emergency threshold but have increased in return areas in some districts. Community feeding centres are being phased out but support is continuing for NGOs to provide treatment for children with severe malnutrition at health facilities. Underlying illness, responsible for most severe malnutrition, does not always appear to be well addressed. The programme provided additional rations to women attending maternal and child health (MCH) services. Districts will not be able to sustain this approach and there could be an adverse effect on uptake of services when food incentives are withdrawn.

1.14 The introduction of community coartem has been spearheaded by the programme. VHT have been trained to manage fever and available data indicates improvement in community malaria management. One round of indoor residual spraying (IRS) has been completed in Kitgum and Pader and is planned in Gulu. IRS has taken place without an adequate budget for a second round of spraying or for appraisal of effect. Available funds are insufficient to conduct the planned vector control feasibility study in Karamoja. The evaluation also highlighted some concerns about retention and use of ITNs.

1.15 There has been significant improvement in access to prevention of mother to child transmission (PMTCT) services. However, the evaluation found limited evidence of scale up of adolescent health, emergency obstetric care (EmOC) or sexual and gender based violence (SGBV) services. No data are available on the proportion of HC III currently providing basic EmOC. No HC IV is providing comprehensive EmOC. Adolescent friendly health services (AFHS) training commenced recently, so provision of AFHS through the programme has not yet begun. It is too early to judge the impact of family planning training. Community networks for management and referral of survivors of SGBV have been established in some IDP camps and the programme reports an increase in referrals to health facilities.

1.16 The HIV/AIDS component of the joint programme focuses on HIV counselling and testing (CT), quality of care, and increasing awareness among youth. Comprehensive data are not available on the proportion of the population with access to HIV counselling and testing (CT), outcomes for patients on ART or the extent of comprehensive knowledge among young people.

1.17 Health services availability mapping (SAM) has been conducted in Acholi, Lango and Karamoja regions. The programme has provided support for cluster functioning, and feedback indicates that the cluster approach has significantly improved coordination and information sharing at national and district levels. In some districts, the cluster has helped to reduce duplication of effort, identify gaps, improve coverage, increase joint planning and monitoring of activities, and promote harmonised reporting formats and adherence to national standards. In principle, MOH participates in the national cluster and district clusters are co-chaired by WHO and the District Health Officer (DHO). In practice, MOH and DHO involvement is limited, due partly to a perception that the cluster approach is a UN initiative and partly to limited capacity.

1.18 The evaluation highlighted a range of benefits and challenges associated with joint UN programming. The joint programme has helped to clarify UN agency mandates, determine roles based on comparative advantage, improve communication and strengthen joint planning. Good working relations have been established between technical staff at central and district levels. Joint programming has also helped take forward the cluster approach and reduced transaction costs for the MOH and DFID.

However, joint programming increases transaction costs for the UN agencies, since considerable time is required for joint planning and proposal development. Differences in planning cycles, operational procedures and reporting systems are also challenges to joint programming.

1.19 In practice, individual agencies implement programme activities separately and the joint programme appears to have contributed to an expansion of UN staffing at district level. The evaluation also raised wider questions about joint programming, including the need for criteria to determine when joint programming is the most appropriate approach and indicators for measuring the efficiency and effectiveness of joint programme processes and outcomes.

1.20 Districts and NGO partners are positive about their engagement with joint programme UN agencies and the technical support they receive. Challenges cited relate to delays in disbursements and differences in UN agency reporting requirements. The evaluation also identified the need for a common UN agency approach to selection of implementing partners, monitoring performance or providing feedback on performance.

Recommendations

1.21 Recommendations for the remainder of 2007 and for future programming, which assumes continuation of a joint health, nutrition and HIV/AIDS programme implemented by the UN, are based on the evaluation findings in Sections 2, 3 and 4 and challenges for the health sector identified in Section 5.

1.22 During the remainder of 2007 the programme should:

- Together with MOH and local government, develop a system whereby the one-time allowance is paid on the basis of performance and after staff have been in post for a specified length of time; and monitor the impact of the one-time allowance on recruitment and retention of different cadres of health workers as well as progress towards the overall target of 55% of posts filled. UN agencies and DFID should continue dialogue with the MOH on task shifting as an option for addressing critical human resource shortages.
- Take immediate steps to complete planned renovation and construction of health facilities and staff accommodation, and provision of equipment and furniture, and ensure that work is well planned and carried out to a sufficiently high standard. Completion of staff housing should take priority, to promote retention of existing and newly recruited staff.
- Start to plan for handover of responsibility for HMIS and EPR to the districts in Northern Uganda, and explore with MOH options for simplifying the HMIS. The programme should also start planning for reduction of support for interventions that districts are responsible for delivering as part of the UMHCP. Dialogue with central MOH and districts will be critical to ensure adequate resources are allocated for these interventions. Future support should give greater emphasis to community mobilisation, to create and sustain demand for these services

- Evaluate the accuracy and effectiveness of the CBDS pilots before further roll out. If CBDS proves worthwhile, the programme needs to consider ways in which it can be sustained by the districts and, more specifically, how reporting requirements for VHT can be streamlined and VHT can receive feedback.
- Take steps to follow up training, to assess the extent to which new knowledge and skills are being put into practice and the impact on quality of care provided.
- Together with MOH, conduct a review of VHT selection criteria, roles, training, supervision, monitoring and incentives, and agree common standards and approaches to ensure that VHT can provide a consistent set of community prevention and care interventions. The programme should also assess coverage with trained VHT as the population moves out of camps to transitional settlements or return areas, to determine future selection and training of VHT. The future role of CORPS as the population moves out of camps should also be clarified.
- Ensure that children treated for severe malnutrition are also assessed for other illnesses and receive appropriate treatment and care, in particular strengthening links with paediatric HIV/AIDS diagnosis, treatment and care.
- Monitor the impact of provision of additional food rations to HIV and TB patients and phase out provision of extra rations through MCH services, focusing instead on raising community awareness of the importance of these services.
- Collaborate with other actors, e.g. PMI and the Malaria Consortium, to provide evidence of effectiveness and specific impact of IRS on malaria mortality and morbidity in the endemic context of Northern Uganda.
- Take steps to strengthen and monitor provision of EmOC.
- Continue support for the health, nutrition and HIV/AIDS cluster approach, and explore ways in which dependence on external support could be reduced. The programme should also take action to increase MOH, DHT and HSD ownership and to support their active participation in the clusters; convening meetings at the MOH and at DHT offices and encouraging DHOs to chair meetings should be a first step.
- Consider how district clusters can ensure that comprehensive data on provision of CT is captured. Quarterly QoC supervisory site visits should include meetings with HIV/AIDS patients and review of factors that influence treatment adherence.
- Develop a common set of criteria for selection of NGO partners, a common approach to monitoring their performance and feedback systems. The UN agencies should also streamline and harmonise financial and narrative reporting requirements and take steps to improve the efficiency of disbursements to implementing partners.
- Develop a joint programme plan that sets out what data needs to be collected to measure impact and a coherent approach to data collection and analysis, which uses existing systems as far as possible.

- Together with DFID establish an efficient mechanism to provide oversight to, and monitor the performance of, the joint programme.

1.22 DFID should fund a further phase of health, nutrition and HIV/AIDS programming in Northern Uganda during the period January 2008-March 2009, focusing on phase out and transitional support in line with the JMC transition approach; and a separate programme of support tailored to the specific needs and context in Karamoja.

1.23 The next phase of programming should:

- Reflect the 2008 CAP and be developed in consultation with the districts. Updated SAM, information on support provided by other development partners and data on population movement should be used to inform ongoing planning of future programming and prioritisation of interventions. Flexibility should be built in to programme design and contractual arrangements to enable the programme to respond to an evolving context and changing needs.
- Hand over responsibilities for delivering UMHCP minimum standards and for HMIS and EPR to districts; provide strategic support for strengthening health infrastructure in return areas and district management and supervisory capacity; identify and implement innovative approaches to address shortages of human resources for health; strengthen EmOC and FP services; and strengthen community level preventive and basic health care, including greater emphasis on hygiene, nutrition, FP and HIV education.
- If managed by the UN, identify one programme manager; deliver the UN contribution in line with 'One UN', with joint UN offices and teams at district level; and determine which UN agencies are involved on basis of district priorities and agency comparative advantage.
- Fund NGO implementing partners that have demonstrated good performance and focus on fewer stronger partners.
- Ensure baseline information is collected and an effective log frame and M&E framework, including SMART OVI, are in place.

1.24 More specifically, depending on the priorities identified in the CAP and during district consultations, a future programme should:

- Develop and implement additional innovative approaches to address shortages of specific cadres of personnel, for example, Medical Officers and laboratory technicians, in the worst affected districts, drawing on experience in other countries in the region and including performance-related incentives.
- Provide strategic support to strengthen district and sub-county human resource management and supervisory systems and capacity.
- Provide strategic support to strengthen health infrastructure in return areas in districts with the greatest need. This support should include 1) ongoing rehabilitation and construction of facilities (based on district priorities, an updated SAM and the

parish approach) and of accommodation (for cadres of staff that are most difficult to attract and retain) and 2) building the capacity of districts to manage and supervise contractors.

- Continue to monitor nutrition status in return areas, including exploring ways in which nutrition indicators can be captured by existing systems. There should be increased emphasis on community nutrition education to address the potential risk of worsening nutritional status in these areas, and specific interventions to address high rates of malnutrition in Karamoja.
- Give greater emphasis to community education on net use.
- Develop a strategy to support districts to strengthen EmOC. This should include, at a minimum, ensuring that all HC III can provide basic EmOC and at least two HC IV in each district have functional theatres, ensuring that a referral system is in place and that ambulances are functional, and that data on provision of EmOC is collected.
- Consolidate efforts to improve FP provision and give higher priority to raising community awareness and creating demand for FP services.
- Work with district clusters to identify gaps in HIV/AIDS prevention, treatment and care and support efforts to achieve comprehensive coverage and service provision. The potential of district clusters to strengthen coordinated planning and implementation and, specifically, to improve coordination of HIV/AIDS activities, including those funded through the US Government, should be exploited fully.
- Increase support for HIV prevention and awareness, including community education and availability of condoms. Condoms should be made available through VHT and included in family kits given to households when they return to their original homes.

2. PROGRAMME PROGRESS

Programme impact and interventions

2.1 The mortality survey conducted in 2005 showed that crude mortality rates (CMR) in Northern Uganda were significantly above emergency thresholds. The follow-up mortality survey, planned for 2007, has not yet been conducted, so it is not possible to comment on the impact of the programme at Goal level. The joint programme is discussing the scope of this survey with the Ministry of Health (MOH). Discussions have been temporarily halted due to the recent Marburg virus outbreak. The MOH would like the survey to include three comparison districts outside northern Uganda, but this would increase the budget to around \$450,000.

2.2 Some data are available from other sources (see Annex 5), which show improvements in basic health indicators. Specific data is also collected separately by the UN agencies, for example, on childhood immunisation coverage, nutritional status and malaria case management by village health teams (VHT), and by some NGOs. For example, a USAID-funded GOAL survey in four sub-counties of Pader district in April 2007 found CMR of 0.9/10,000/day. However, none of these multiple data sources provide a comprehensive picture of mortality and morbidity in Northern Uganda or of

trends over time. ***With regard to assessing impact, a future programme should set out what data needs to be collected and a coherent approach to data collection and analysis.***

2.3 The team used the revised log frame (December 2006) to review progress towards programme Outputs (described as Sub-Project Goals in the joint programme log frame) during the period January 2006 to June 2007, drawing on information provided and programme progress reports. Assessment of progress in some areas was difficult, either because of a lack of baseline data or of targets or SMART indicators. ***The log frame for a future programme should include OVI at Goal and Purpose level, more clearly defined Outputs and SMART indicators, to allow progress to be measured.***

2.4 The joint programme has performed better in some areas than others. This is partly reflected in the extent to which funds allocated to different intervention areas have been spent (see Annex 1). Support to strengthen HMIS and EPR and improve coordination of the health sector has resulted in demonstrable improvements. Good coverage with child health interventions has been achieved. Support for districts to address shortages of human resources for health has been provided, but it is too early to determine the outcome. Progress with implementing planned malaria, reproductive health and HIV/AIDS interventions and activities to improve health infrastructure is mixed.

Human resources for health

Sub-Project Goal: Support human resources for health in North and North Eastern Uganda including Karamoja and Teso

Indicators

Proportion of approved posts in health units (GOU and PNFP) filled by health professionals increased from current average of 33% to 55%

- One time settling in allowance equivalent to 30% of 6 months basic salary provided to all health workers in the target regions
- Support recruitment of health workers in the target districts
- Update payroll registers including supply of computers

2.5 Activities have been implemented as planned. The programme has disbursed funds to central MOH to finance payment of a one-time allowance to health workers already in post and newly recruited health workers (1,559 public sector and 2,124 private not for profit (PNFP) sector including 1,104 newly recruited health workers), in line with the Government of Uganda (GOU) hard-to-reach areas health workers incentives scheme. The process of payroll verification by central MOH is complete. Vacancies have been advertised and applications received. Districts report that short-listing and interviews will be conducted in the near future.

2.6 The one-time allowance aims to address recruitment and retention problems in Northern Uganda. It is unclear when the allowance will be paid to existing and newly recruited health workers or how this incentive will be linked to performance or length of service. ***The joint programme, together with MOH and local government, should develop a system whereby the one-time allowance is paid on the basis of performance and after staff have been in post for a specified length of time.***

2.7 It is too early to judge whether or not the one-time allowance will be sufficient to attract health workers to the region or to reach the target of 55% of posts filled. The programme has met with MOH, Ministry of Finance, Planning and Economic Development (MOFPED), local government and PNFP representatives to identify ways to monitor its impact. Feedback from district health teams (DHTs) indicates that recruitment of doctors will remain a problem in Northern Uganda. While the response from nurses and midwives has been good, some districts have received few applications from Medical Officers. Recruitment of specific cadres of health personnel may require a further round of advertising, more targeted approaches, greater efforts to address the poor image of Northern Uganda, and additional incentives. Specific approaches are likely to be required for Karamoja and Teso. Lessons could be learned from measures taken in other countries, for example, Ethiopia and Malawi, to address shortages of human resources for health. Further financial incentives will depend on external support, since the MOH does not have the resources within the current health sector budget to fund one-time or additional allowances. ***The joint programme, together with MOH and the districts, should develop and implement a plan to monitor the impact of the one-time allowance on recruitment and retention of different cadres of health workers and progress towards the overall target of 55% of posts filled. A future programme should include additional innovative approaches to address recruitment and retention of specific cadres of personnel in the worst affected districts, drawing on experience in other countries in the region and including performance-related incentives.***

2.8 The evaluation highlighted related issues of task shifting and human resource management. Under current regulations, only doctors are allowed to carry out certain tasks, e.g. prescribing antiretroviral drugs and performing emergency caesarian section. The acute shortage of doctors in some districts of Northern Uganda means, in practice, that the population does not have access to antiretroviral therapy or comprehensive emergency obstetric care. ***The UN agencies and DFID should continue dialogue with the MOH on task shifting as an option for addressing critical human resource shortages.*** Responsibility for management of health workers at health centre (HC) IV and below resides with sub-county government. There is limited evidence of action to address absenteeism or poor performance of staff. Staff who work hard and stay in post receive little recognition or reward. Supportive supervision is weak. The Inter-Agency Steering Committee (IASC) cluster report 2006 also highlights poor management of staff and significant absenteeism and underperformance. Retention and motivation of existing and newly recruited staff is unlikely to improve unless these issues are addressed. ***A future programme should include strategic support to strengthen district and sub-county human resource management and supervisory systems and capacity.***

Health facilities

Sub-Project Goal: Strengthen functionality of health facilities in districts of Gulu, Kitgum, Apac, Pader, Amuru, Lira, Kotido, Kabong, Nakapiripirit

Indicators

Percentage of planned HC III and HC IV functional

- 17 health facilities renovated and equipped (water supply, power, sanitation, functional theatres at HC IV)
- 17 laboratories functional (laboratory technicians trained)
- 27 new staff houses constructed and furnished and 40 staff houses renovated

2.9 The June 2007 programme progress report states that rehabilitation of nine health facilities in four districts by the NGO CPAR has begun. Progress reports provided to the evaluation team on the number of health facilities rehabilitated and equipped and the number of staff houses constructed or renovated show that implementation of planned activities is complete at two of five HC in Gulu, at two of four in Amuru, 13 of 15 in Lira, one of two in Apac, and one of three in Oyam. Planned construction and rehabilitation work commenced in June 2007 in Kitgum and in July 2007 in Pader.

2.10 However, construction and renovation of HC II, HC III and HC IV seen by the evaluation team was incomplete. None of the health facilities visited had water supply, power and sanitation in place, including some reported as having work completed. No HC IV had a functional theatre. Limited attention appears to have been paid to planning effective use of existing space, including issues such as patient flow and the most appropriate location for drug stores or laboratories, in rehabilitation of health facilities. No health facility visited had adequate housing relative to the staffing norms for HC III and HC IV, or completed staff accommodation. At one HC III, staff were living in the OPD and maternity unit. At a HC IV, the Medical Officer had been staying in a hotel but noted that this was not sustainable. More consideration could have been given to phasing of activities, specifically completion of housing before recruitment of staff. ***The joint programme should take immediate steps to complete planned renovation and construction of health facilities and staff accommodation, and provision of equipment and furniture, and ensure that work is well planned and carried out to a sufficiently high standard. Completion of staff housing should take priority, to promote retention of existing and newly recruited staff.***

2.11 Orders have been placed for equipment to strengthen blood transfusion and laboratory services and theatres, and the programme supported an equipment inventory conducted by the MOH infrastructure department in early June to inform procurement of essential equipment for rehabilitated facilities. The programme has provided 20 microscopes and training for microscopists. Where laboratory services are provided these appear to be done well. WHO has conducted assessments of the functionality of laboratories in Gulu, Amuru, Kitgum and Pader but the team was not given up to date information about progress towards the target of 17 functional laboratories. The 2007 Project Document mentioned strengthening the supply chain to reduce stock outs, but the programme does not include specific activities to address this.

2.12 Programme impact will be limited relative to need. The joint programme aims to improve on average two facilities and associated staff housing in each district. The MOH estimated in August 2006 that 138 of 243 HC and 2 of 11 hospitals in 9 districts of Northern Uganda required rehabilitation. DHTs identified rehabilitation of health facilities in return areas as a priority for any future DFID-funded programme. District budgets for infrastructure improvements are very limited – the cost of renovating one health facility under the programme was double the annual district development budget. District contracting procedures are reported to be slow, bureaucratic and subject to political influence. Funds have been provided to the MOH infrastructure department to conduct supervision during construction, but the team did not see any evidence of this. Districts appear to lack capacity for effective management and supervision of contractors, as evidenced by incomplete rehabilitation and construction of health facilities and staff accommodation seen during field visits. ***Future DFID funding should include strategic support to strengthen health infrastructure in return areas in districts with the***

greatest need. This support should include 1) ongoing rehabilitation and construction of facilities (based on district priorities, an updated services availability mapping and the parish approach proposed in the OCHA transition plan) and of accommodation (for cadres of staff that are most difficult to attract and retain) and 2) building the capacity of districts to manage and supervise contractors.

Health Management Information System

Sub-Project Goal: Strengthen district HMIS/IDSR capacity epidemics/outbreaks and monitor disease trends, outcomes and impact of emergency response interventions

<u>Indicators</u>
Timeliness and completeness of HMIS increased from 75% to 95%
<ul style="list-style-type: none"> • HSD surveillance strengthened (in-patient data reporting CFR malaria, pneumonia, diarrhoea, HIV) • 50 village telephones procured and distributed (to improve communication at community level) • Community-based disease surveillance initiated (VHT/CORPS trained; village phones; 4 computers new districts)
CFR of epidemics during programme timeframe reduced to below 2% for cholera and below 10% for meningococcal meningitis
<ul style="list-style-type: none"> • Emergency kits procured (including rapid response kits) • Support emergency response to epidemics • Ongoing water quality surveillance established in cholera and diarrhoeal disease prone districts of Gulu, Amuru, Kitgum, Pader and Kotido

2.13 The joint programme has provided valuable support to districts to improve the HMIS. An HMIS and integrated disease surveillance and response (IDSR) reporting assessment was conducted, to provide a basis for planning support to strengthen surveillance. Provision of training and equipment, including computers and village phones, has contributed to an increase in the timeliness and completion of HMIS reporting, to over 90% in Acholi region and over 80% in Lango region. WHO is following up on completeness of HMIS reporting. Further improvements in HMIS are constrained by the limitations of the system itself, which requires health facilities to complete and submit multiple forms. ***The joint programme should start to plan for handover of responsibility for HMIS to the districts, and explore with MOH options for simplifying the HMIS.***

2.14 The joint programme has piloted community-based disease surveillance (CBDS) in Kitgum (in 9 of 18 sub-counties) and Pader (in 16 of 19 sub-counties), and plans to expand to further areas in Kitgum, Pader, Amuru and Gulu. Training has been conducted for 300 VHT in Kitgum and 120 in Pader, and reporting tools have been distributed. CBDS collects data on CMR, under-five mortality rate (U5MR), infant mortality rate (IMR) and maternal mortality ratio (MMR) and is intended to complement facility-based data. Data has been collected since February 2007. The system is being well implemented and completeness of CBDS reporting is over 95%. These VHTs now complete separate CBDS reporting forms, birth and death registers, and treatment and drug distribution records, for the programme and MOH. This multiple form filling may be an unrealistic expectation of community volunteers.

2.15 Preliminary analysis has been carried out for data from two sub-countries. It will be important to ensure that VHT receive feedback following analysis, so that CBDS data is used to inform their work. During the remainder of this year, the programme plans to provide support for the national and district HMIS to capture CBDS data. However, it is unclear how CBDS will be sustained without external funding, since the MOH does not have the resources to finance the system. ***The joint programme should evaluate the accuracy and effectiveness of the CBDS pilots before further roll out. If CBDS proves worthwhile, the programme needs to consider ways in which it can be sustained by the districts and, more specifically, how to streamline reporting requirements for VHTs and ensure they receive feedback.***

2.16 The joint programme has also strengthened district capacity to monitor and respond to disease outbreaks, including training district EPR teams and community mobilisation efforts. Outbreaks have been well investigated, managed and contained, including in Kotido, Kaabong and Nakapiripirit districts in Karamajong region. The MOH reported a case fatality rate (CFR) of <2% (1.8%) during cholera outbreaks in Northern Uganda, where over 2,000 cases were reported, with the most recent case reported in April 2007. Cholera task forces in affected districts (Kitgum, Pader and Gulu) included the DHT, health, nutrition and HIV/AIDS and water and sanitation clusters, as well as WHO and UNICEF. The programme has procured water testing kits for Lira and Apac districts and provided funding to Gulu district to establish water quality surveillance as part of cholera preparedness measures. A meningitis outbreak during December 2006-March 2007 was contained by April 2007, with 3,642 cases and 150 deaths reported (CFR <10%); a mass meningitis immunisation campaign was conducted in Gulu, Moroto and Nakapiripirit. Mass vaccination was implemented successfully in response to a measles outbreak in June-July 2006 in Kitgum and Pader, and a CFR of 1.7% was registered. UNICEF provided logistical support and procured vaccines, WHO provided technical support for surveillance and case confirmation, NGOs played an important role in social mobilisation for vaccination and case management in facilities. ***The joint programme should start to plan for handover of responsibility for EPR to the districts.***

Child health and nutrition

Sub-Project Goal: Improved capacity for effective management of common childhood illnesses including malaria, diarrhoea and pneumonia at health facility and community levels (contributing to reduction in mortality and morbidity)

Indicators

At least 60% of health facilities managing sick children according to IMCI standards

- Facilities supervised and improvement in quality of care for children including paediatric HIV/AIDS care and care for the newborn

At least 80% under-fives in conflict affected districts and Karamoja districts fully immunised (DPT3, measles) and at least 80% girls and women of childbearing age (13-49 years) receive 3 doses TT immunisation

- Coverage vitamin A supplementation, de-worming

At least 60% of LC I/camps have functional support structures (VHT, CORPS, parish mobilisers) to manage common childhood illness and promote family care practices

- Percentage CORPS trained and equipped
- Number VHT, CORPS equipped with HBC drug kits
- Nutrition assessment conducted

2.17 There has been good progress in increasing childhood immunisation, vitamin A supplementation and de-worming coverage. UNICEF figures for six districts (Lira, Apac, Pader, Kitgum, Gulu, Amolatar) as of July 2007 show coverage at 121% for measles immunisation, 74% for DPT3, 85% for vitamin A supplementation and 90% for de-worming. The joint programme has provided measles vaccine for mass immunisation and effective support to districts for child health days. UNICEF is using the Reach Every District (RED) approach in Karamoja to target populations with large cohorts of unimmunised children. Progress in improving TT coverage has been more limited. UNICEF figures show TT2 coverage at 31%. Maintaining high levels of coverage will be a challenge when populations move from IDP camps to return areas, and households are more scattered. There are also concerns about sustaining these achievements without external funding. The MOH reports that it has no resources available for EPI. ***The joint programme should start planning for reduction of support for interventions that districts are responsible for delivering as part of the Uganda Minimum Health Care Package (UMHCP). Dialogue with central MOH and districts will be critical to ensure adequate resources are allocated for child health interventions. Future support should give greater emphasis to community mobilisation, to create and sustain demand for these services.***

2.18 The programme has taken steps to improve the capacity for management of common childhood illness at facility and community levels. Integrated Management of Childhood Illness (IMCI) training was conducted for 250 health workers in 2006 and IMCI guidelines made available. Separate training has been provided for 660 health workers on malaria management using coartem. A concept paper for improving quality of care of sick children has been developed. The extent to which health facilities manage sick children according to IMCI standards is difficult to assess. No information was available to enable the team to draw conclusions about quality of care or paediatric HIV/AIDS and newborn care. ***The joint programme should take steps to follow up training, to assess whether IMCI guidelines are being followed, and the quality of care provided.***

2.19 MOH standards suggest that there should be one VHT member for every 25-30 households. Data are not available to assess the percentage of LC I or IDP camps that have achieved this ratio or have functional structures to manage common childhood illness and promote family care practices. ***VHT coverage will need to be assessed carefully, especially as the population moves out of camps to interim sites or return areas, in order to determine future selection and training of VHT.***

2.20 At community level, VHT have been trained to diagnose and manage fever. The introduction of community coartem has been spearheaded in Northern Uganda. VHT have been trained in use of coartem in Amuru, Gulu, Kitgum and Pader. Provision of coartem to trained VHT and training for others in use of coartem is ongoing. Over 400,000 doses have been procured and distributed to health facilities and VHT. VHT who have yet to be trained are still using Homapak. Available data indicate improvements in cases of fever treated in the community within 24 hours to around 80%, although this is difficult to verify. An assessment of VHT performance in Gulu between October 2006 and March 2007 found an increase in cases of fever treated in the community and a reduction in cases treated at health facilities.

2.21 The evaluation raised some concerns about the accuracy of diagnosis of malaria in children. At one health facility visited, children who had not responded to first-line treatment were automatically given intravenous (IV) quinine, even though at least one child had obvious signs of pneumonia. WHO and MOH are evaluating the use of rapid diagnostic tests (RDTs) in Northern Uganda. The President's Malaria Initiative (PMI) is also reported to be conducting research on RDTs.

2.22 The programme has also trained a specific cadre of community health worker, Community-Owned Resource Persons (CORPS), as an interim measure for community management of common childhood illnesses in IDP camps. CORPS were given home-based care kits, which include basic drugs, in 2006, and are expected to replenish supplies at the nearest health facility. ***The future role of CORPS as the population moves out of camps needs to be clarified.***

2.23 There is a lack of clarity about roles and responsibilities of VHT and CORPS. In principle, CORPS focus on child health and are the only cadre of VHT to have a home-based care kit. In some sites visited, CORPS were responsible for children under the age of five and in others for children up to 14. Some CORPS also address other issues. For example, the Malaria Consortium has produced a leaflet setting out the role of CORPS in managing adult TB. Some VHT have home-based care kits. The quality of training of CORPS varies. Some CORPS were knowledgeable and very active, for example, conducting community health education and going house to house to identify sick children and check children's nutritional status. Others were less so. For example, some had home-based care kits that were obviously never used. Training for VHT and CORPS has not been planned or delivered in a coherent or efficient way. Some VHT and CORPS reported that they had attended three separate training courses in 2007.

2.24 VHT are selected using a range of criteria (see Box). Although VHT are supposed to consist of equal numbers of women and men, most VHT in sites visited were men. Better use could be made of these VHT to promote positive male involvement in issues such as family planning (FP) and use of condoms. VHT include, variously, CORPS, VHT trained only in malaria management, traditional birth attendants (TBAs), community-based distributors and community vaccination mobilisers. Some VHT have also been trained to conduct CBDS. There is no consistent training for VHT to ensure they can provide a standard set of basic prevention and care interventions. In one return village visited, the one VHT was only trained in malaria management and raised concerns about not being able to advise the community about diarrhoea management or to provide oral rehydration salts (ORS).

Summary of MOH VHT guidelines, 2001

VHT should be selected by popular vote and at least 50% should be women. Selection criteria include: resident, available, interested in health, able to read and write at least local language, good mobiliser and communicator, exemplary character, willing to work on a voluntary basis. VHT roles include: community mobilisation for health, community diagnosis and needs, implementation of health programmes, educating the community on health issues, conducting home visits to assess household health situation, maintaining birth and death registers, disease surveillance, monitoring health programmes, management of supplies, follow up of patients discharged from health facilities, assisting in referral and follow up of patients to the health facility. The guidelines also identify possible areas of VHT training including: communication skills, community mobilisation, guidelines on delivery of health services in the community, information collection, storage and use, report writing, and participatory planning.

2.25 Incentives, if carefully managed, can motivate community volunteers and reward good performance. VHT and CORPS made modest requests for incentives, including gumboots, umbrellas, basic rations such as sugar or salt, and T-shirts that identify them as community health workers. The programme does not seem to have taken a strategic approach to use of incentives, and there are inconsistencies in incentives provided for VHT and CORPS. UNICEF aimed to provide CORPS with bicycles but, in some cases, CORPS have not received bicycles while VHT members have. VHT members trained by WHO have received gumboots, while CORPS and other VHT have not. Supervision and monitoring of VHT and CORPS is also a concern. Support supervision is supposed to be provided by the nearest health facility. In practice, health workers at these facilities do not have time to supervise or monitor community health volunteers. ***The joint programme should map training provided by different UN agencies and implementing partners to VHT and, together with the MOH, conduct a review of VHT selection criteria, roles, training, supervision, monitoring and incentives, and agree common standards and approaches to ensure that VHT can provide a consistent set of community prevention and care interventions.***

2.26 Programme nutrition activities have concentrated on assessments and management of malnutrition in young children. Nutrition surveys have been conducted by programme-funded NGOs, e.g. in Lira and Apac by ACF, and in Pader and Kitgum by IMC. Findings indicate that global acute malnutrition rates fell from >15% in 2003 to below the 10% emergency threshold in 2006 in Gulu and Apac districts, rates have remained relatively unchanged in Apac district at around 4.4%, but that rates have almost doubled in return areas in Lira district from 2.5% in 2005 to 5.9% in 2006. A survey conducted by GOAL in four sub-countries of Pader found prevalence of malnutrition of around 5%, but prevalence was significantly higher in children under the age of three, due to poor weaning and feeding practices. Rates of malnutrition in Teso increased from 3.1% in 2005 to 5.4% in 2006, and remain above 10% in Karamoja despite an improvement from 19% in 2004 to 12% in 2005. Further nutrition assessment conducted by WFP is underway. Nutrition education has received limited attention. Nutrition is not a priority for districts, and reporting on nutrition indicators in the HMIS, with the exception of vitamin A supplementation, is inadequate. ***A future programme should continue to monitor nutrition status in return areas, including exploring ways in which nutrition indicators can be captured by existing systems in preference to conducting repeated surveys.*** WHO is working with the Global Health Cluster to pilot a Health and Nutrition Tracking Service (HNNTS) in Uganda, which will enable country clusters to monitor mortality and nutrition trends using existing data. ***There should also be an increased emphasis on community nutrition education to address the potential risk of worsening nutritional status in these areas. Specific interventions may be required to address high rates of malnutrition in Karamoja.***

2.27 Community feeding centres are being phased out as nutritional status improves and the 'emergency' phase ends. Support is continuing for NGOs to provide treatment for children with severe malnutrition at health facilities. UNICEF figures show that the number of children treated for severe malnutrition was 6,176 in 2006 and 2,818 as of July 2007. Visits to these treatment centres indicate that underlying illness, including HIV infection, responsible for most cases of severe malnutrition, is not always addressed. In one centre, staff reported that the underlying cause of severe malnutrition was oral candidiasis but that antifungal treatment was not available. The 2006 IASC cluster report notes that around 30% of severely malnourished children are HIV positive. An IMC

nutrition survey also highlighted the role of malaria in malnutrition. ***The joint programme should ensure that children treated for severe malnutrition are also assessed for other illnesses and receive appropriate treatment and care; strengthening links with paediatric HIV/AIDS diagnosis, treatment and care is especially critical.***

2.28 The programme is providing additional food rations to HIV and TB patients at household level and to women attending maternal and child health (MCH) services at facility level. While the former seems reasonable, meetings with PLHA did not identify food as not a major concern. The team has concerns about linking provision of extra food rations to attendance for MCH services. Districts will not be able to sustain this approach and there could be an adverse effect on uptake of services when food incentives are withdrawn. The GOAL 2006 partner submission to the national health, nutrition and HIV/AIDS cluster highlighted the reluctance of the community to attend health facilities for screening and education when food is no longer being supplied as a key challenge. ***The joint programme should monitor the impact of provision of additional food rations to HIV and TB patients and phase out provision of food rations through MCH services, focusing instead on raising community awareness of the importance of, for example, childhood immunisation and ANC.***

Malaria control

Sub-Project Goal: Reduced mortality and morbidity due to malaria by initiating indoor residual spraying (IRS) in Gulu, Kitgum, Pader and Amuru; and exploration of feasible vector control interventions in Karamoja

Indicators

At least 85% of targeted areas sprayed with pyrethroids

- District and sub-county leaders trained
- Baseline and post-IRS studies conducted
- Number of households sprayed and people protected

Feasible vector control interventions explored in Karamoja

- Study of feasibility, acceptability and effectiveness of vector control options conducted

2.29 A pre-IRS baseline study was conducted in Gulu, Pader, Amuru and Kitgum. A post-IRS study is planned. The programme has used the assumption that 100% coverage in IDP camps equates to 85% district coverage. One round of IRS has been completed in Kitgum and Pader and IRS is planned in Gulu, focusing on IDP camps, transitional settlements, schools and health facilities. The programme budget only covers one round of IRS. Impact will depend on further rounds. The programme anticipates that subsequent rounds of IRS will be funded through the PMI. Available funds are insufficient to conduct the vector control feasibility study in Karamoja. The programme plans to reallocate these funds. The team was concerned that IRS has taken place without an adequate budget for a second round of spraying, or for appraisal of effect. Whilst regular IRS is known to be effective in places subject to seasonal malaria, there is insufficient data on effectiveness from endemic areas such as Northern Uganda. ***The joint programme should collaborate with other actors, e.g. PMI and the Malaria Consortium, to provide evidence of effectiveness and specific impact of IRS on malaria mortality and morbidity in the endemic context of Northern Uganda, to determine whether or not IRS is an appropriate use of resources.***

2.30 The joint programme provided 70,000 insecticide treated nets (ITNs) in 2006, but has not distributed nets in 2007. ITN coverage is higher in IDP camps (28.8%) than the national average (15.9%), according to the UDHS 2006, but still inadequate to ensure all households and vulnerable sub-populations are protected. Net distribution funded through the PMI and Global Fund is reported as likely to be sufficient to increase coverage in Northern Uganda. Coverage with ITNs in Karamoja is low (5.9%), the worst for any region, and it is unclear to what extent this will be addressed by other initiatives. There are some concerns about net retention and use. In some camps where 100% coverage had been achieved in 2006, CORPS reported that only 50% of households are still using nets. Living conditions in the camps often result in nets being torn or damaged. The GOAL 2006 partner submission included findings of an ITN usage survey in Pader, which indicate that use of nets is around 50% and that many people have sold previously distributed nets or put them away for use when they resettle. The Malaria Consortium also highlights the need to strengthen community education on net retention and use. ***A future programme should give greater emphasis to community education on net use, and consider the specific needs of the population in Karamoja.***

Reproductive health

Sub-Project Goal: Scale up provision of adolescent health, PMTCT, EmOC, SGBV services

Indicators

At least 50% health facilities providing comprehensive EmOC

- Percentage HC III providing basic EmOC and percentage HC IV providing comprehensive EmOC
- Health facilities, camps, schools providing AFHS; number health workers, peer providers oriented and trained in AFHS
- Number health workers trained in clinical management SGBV
- Percentage service providers trained in FP services
- Percentage CBD trained and equipped

At least 50% pregnant women receive PMTCT services

2.31 There is good evidence of improvements in access to prevention of mother to child transmission (PMTCT) services. However, the evaluation found limited evidence of scale up of adolescent health, EmOC or sexual and gender based violence (SGBV) services. The programme has implemented a range of activities to improve the capacity of health facilities to provide emergency obstetric care (EmOC). In 2006 the programme procured 30 ambulances as well as equipment, instruments and supplies for 85 health facilities at HC III level and above in nine districts. Some districts have distributed equipment and supplies, while others have not, due to transport and staffing challenges. The programme also conducted training for existing health workers and TBA, encouraging the latter to refer women for delivery in health facilities as well as to monitor their health during pregnancy. Mama kits are provided to pregnant women by antenatal care (ANC) services. TBA reported that some women are reluctant to move to a health facility to deliver at night, because of security concerns, and so are delivered at home by a TBA. In some cases they do not have their Mama kit.

2.32 Despite these efforts, there appears to have been limited improvement in access to basic and comprehensive EmOC. The service availability mapping in Acholi region in 2006 showed that 0% of HC III provided basic EmOC. No data are available on the proportion of HC III currently providing basic EmOC. Since no HC IV has a functional theatre, and many lack staff able to perform emergency caesarean section, it is reasonable to conclude that none are providing comprehensive EmOC. Ambulances procured by the programme are reported to be used in districts such as Amolotar, Dokolo and Apac, but are unused in other districts that are unable to provide fuel or drivers. ***A future programme should develop a strategy to support districts to strengthen EmOC. This should include, at a minimum, ensuring that all HC III can provide basic EmOC and at least two HC IV in each district have functional theatres, ensuring that a referral system is in place and that ambulances are functional, and that data on provision of EmOC is collected.***

2.33 Adolescent friendly health service (AFHS) training commenced recently, so provision of AFHS through the programme has not yet begun. FP training for health workers is complete in Lira and Pader, in progress in Kitgum, and planned for Gulu and Amuru districts. To date, 234 health workers have been trained, 30 are currently being trained, and training for a further 125 will be conducted in September 2007. Training for community-based distributors (CBD) has commenced. To date, 90 CBD have been trained, 210 are currently being trained and a further 190 will be trained in September 2007. It is too early to judge the impact of training. However, available data indicate that both unmet need for, and low uptake of, family planning remain a challenge in Northern Uganda, partly due to the long-term conflict and partly to socio-cultural factors such as male opposition. UDHS 2006 figures show that CPR among currently married women is 24%, with 18% using a modern method, for Uganda overall, but that only 8% of currently married women are using a modern method in Northern Uganda. Unmet need for family planning is 58% in IDP camps, compared with 40% for Uganda overall. ***A future programme should consolidate efforts to improve FP provision and give higher priority to raising community awareness and creating demand for FP services.***

2.34 On SGBV, the programme has conducted a survey, provided funds for the MOH to adapt and print the WHO training manual on SGBV management, and developed plans for training service providers on clinical management and post-abortion care (PAC). Rape and PEP kits were procured in 2006. District GBV working groups, established as a sub-sector working group of the protection cluster, have developed referral systems for SGBV survivors and report on the number of rape survivors. Community networks for management and referral of survivors of SGBV have been established in some IDP camps and the programme reports an increase in referrals to health facilities. Such initiatives need to be scaled up as current coverage is estimated at around 25%.

2.35 Data provided for Gulu, Kitgum, Pader and Lira districts show an increase in the number of health facilities providing PMTCT services from 20 in 2005 to 40 in 2006, resulting in an increase in access to PMTCT services from 29% to 53% of pregnant women (national figures for the same period showed an increase from 31.1% to 34.7%). The same data show that the number of new ANC attendees at health facilities providing PMTCT increased from 27,038 (of 94,244 estimated pregnancies) to 51,172 (of estimated 97,438 pregnancies). The proportion of women attending ANC services receiving counselling increased from 65% to 74%; uptake of testing among women counselled increased from 77% to 90%; and provision of ARV prophylaxis to positive pregnant women increased from 63% to 73%. However, only 50% of infants of positive

mothers received NVP. Meetings with PLHA also raised some concerns about the quality of infant feeding advice and support provided to positive pregnant women. ***A future programme should concentrate on increasing uptake of ANC and delivery in health facilities, ensuring all infants of positive mothers receive ARV prophylaxis and appropriate infant feeding advice and support, and follow-up of positive mothers and infants.***

HIV/AIDS

Sub-Project Goal: Increase coverage HIV counselling and testing (CT) services and support existing mechanisms to improve the quality of care and treatment services in 29 facilities currently providing ART in IDP camps and Karamoja

Indicators

At least 50% of sexually active population access HIV counselling and testing

- All HC III and HC IV have capacity to provide CT services (HC III and IV health workers trained)
- Population reached by outreach services (provision logistical support to HSDs to conduct CT outreach services and PMTCT)

At least 95% of patients on ART are alive after 6/12 months of treatment

- Clinical teams at 29 ART sites in North Central region and 7 clinical teams in Karamoja trained on QoC and provided with QoC tools and guidelines; number of site visits to monitor quality improvement
- Comprehensive knowledge of HIV/AIDS among young people

2.36 The HIV/AIDS component of the joint programme comprises a few specific activities. HIV prevention has received limited attention. Feedback from DHT and cluster meetings, and findings from IOM mapping, indicate that service coverage is patchy. Districts lack CD4 machines, stock outs of ARVs are common, and there are concerns about the impact of population movement on continuation of ART, especially when PLHA return to villages that are further away from treatment sites. Lack of clarity about future activities and coverage funded through the US Government, in particular PEPFAR and NUMAT, makes it difficult to assess where the gaps will be. ***The next phase of the programme should work with the district clusters to identify gaps in HIV/AIDS prevention, treatment and care and support efforts to achieve comprehensive coverage and service provision.***

2.37 Another concern is the risk of increased HIV transmission as people return to their original homes. Recent research has cast doubt on the assumption that IDP are more likely to be infected than populations in more stable settings. A study among pregnant women in Gulu, Pader and Kitgum districts found that women living outside camps had a higher risk of being HIV infected than those living in camps. A recent review of the literature on displaced persons in eight countries, including Uganda, cited in UNAIDS AIDS Epidemic Update 2006, failed to find evidence that conflict increases transmission. However, there is growing evidence that the risk of HIV transmission increases in post-conflict settings.

2.38 Comprehensive data are not available on the proportion of the population with access to CT, so it difficult to determine whether or not coverage has increased. District HMIS collects data on CT provided by health facilities but does not capture data on CT

provided by NGOs or outreach services. The programme reports that training for HC III and IV health workers is planned. Funding was provided to TASO in 2006 for training 300 community counsellors. The programme provided over 200,000 test kits in 2006 to 4 hospitals, 13 HC IV and 37 HC III. Districts have experienced difficulties in sustaining supplies of test kits; stock outs were reported to be a common problem. **The joint programme should consider how district clusters can ensure that comprehensive data on provision of CT is captured, and work with the MOH and DHTs to address supply issues.**

2.39 The number of patients on ART in Northern Uganda and Karamoja increased from 3,933 in 2005 to 8,394 in 2006. Comprehensive data are not available on outcome for patients on ART. Clinical teams in Northern Uganda have been trained by WHO and MOH, and provided with MOH tools and guidelines. The programme reports that these clinical teams are conducting quarterly supervisory site visits. Training for clinical teams has not yet been conducted in Karamoja. Meetings with PLHA highlighted two areas of concern: lack of support for treatment adherence and difficulties in paying for transport to go and collect their medicines, which results in treatment interruption. **Quarterly supervisory site visits should include meetings with HIV/AIDS patients and review of factors that influence treatment adherence.**

2.40 Coverage with interventions to improve young people's knowledge appears to be limited. NGO partners funded through UNICEF and WHO are conducting life skills training for peer educators in some IDP camps and behaviour change communication activities targeting youth. While data are not available to determine the extent of comprehensive knowledge among young people, NGO 2006 reports to the national health, nutrition and HIV/AIDS cluster indicate that levels of awareness are low. Meetings with PLHA during the evaluation also indicate that HIV/AIDS-related stigma in the community is a significant problem. The programme procured 27.2 million condoms in 2006. Condoms are available at health facilities and from NGOs, but not easily accessible in communities. **A future programme should increase support for HIV prevention and awareness, including community education and availability of condoms. Condoms should be made available through VHT and included in family kits given to households when they return to their original homes.**

Health response coordination

Sub-Project Goal: Improve coordination of health, nutrition and HIV/AIDS activities at national, district and camp levels

Indicators

Comprehensive data for effective health services planning, prioritisation of interventions and emergency response coordination

- Health services availability mapping conducted in Lira, Apac, Dokolo, Oyam, Amolatar districts
- Support national and district health coordination and MOH regional planning; number of support supervision and planning meetings conducted
- Number of joint MOH-UN bi-monthly supervision visits; M&E and reporting including technical assistance to cluster members

2.41 The programme has supported improvements in information about government and NGO services and in coordination of activities. Health services availability mapping

(SAM) was conducted in Acholi region (Kitgum, Gulu, Pader, Amuru districts) in 2006 and the preliminary report of the SAM for Lango region (Lira, Dokolo, Apac, Oyam, Amulatar districts) is available. A WHO-led team conducted an assessment of human resources for health, health infrastructure and service provision for UMHCP in Karamoja in November-December 2006. A separate mapping of HIV/AIDS service provision to IDP communities in Gulu, Amuru, Kitgum, Pader, Lira, Oyam and Apac districts was conducted by IOM together with GOU and UN agencies, as part of the joint programme, in September-December 2006. **Regularly updated SAM and data on population movement should be used to inform planning of future programming and prioritisation of interventions.**

2.42 Institutional arrangements at national level are complex, with a large number of government, donor and UN coordinating structures and committees, and it is unclear how these all relate to each other. The health, nutrition and HIV/AIDS cluster has been functioning at national level since early 2006. District equivalents have been established in all districts in Acholi and Lango regions and in Moroto district in Karamoja region. There was some initial confusion about the cluster approach, and how this fitted with the existing coordination structures such as sector working groups and the Office of the Prime Minister (OPM) Joint Monitoring Committee (JMC) and District Disaster Management Committees (DDMCs). The programme held a cluster capacity building workshop, which helped to clarify these issues.

Cluster approach in Uganda

Strengthening the humanitarian response capacity through the cluster approach is one of four pillars of the UN humanitarian reform programme embarked on by IASC in 2005. The cluster approach also aims to build more effective partnerships between UN and non-UN humanitarian actors. Uganda is one of four countries experiencing chronic emergencies selected to pilot the cluster approach. Uganda has seven clusters: health, nutrition and HIV/AIDS; protection; water and sanitation; camp coordination and management; education; security; and early recovery. The health, nutrition and HIV/AIDS cluster became operational in April 2006, replacing health and nutrition sector coordination meetings jointly chaired by MOH and UNICEF. The most recent cluster performance report notes that a set of indicators to monitor cluster performance has been identified, that data is being collected through the HMIS/IDSR system and that 3W matrices (who is doing what where) have been developed with UNOCHA to facilitate gap identification and filling. Other achievements highlighted include the SAM and the successful response to cholera, meningitis and measles outbreaks in Northern Uganda and Karamoja. Challenges identified include initial misunderstanding of the concept, as a result of top-down planning and implementation; limited district capacity for meaningful participation; and the need to establish the cluster approach more firmly in Karamoja.

2.43 Feedback from government, UN agency and NGO representatives at national and district levels indicates that the cluster approach has significantly improved coordination and information sharing. The joint programme has provided support for cluster functioning, including funding for WHO leadership and facilitation of national and district clusters. National and district clusters meet regularly and include most of the key actors. At both levels, clusters have established sub-sector working groups, which report to the cluster, to allow more focused discussion. **Support for the health, nutrition and HIV/AIDS cluster approach should continue, but the programme should explore ways in which their dependence on external support could be reduced, including considering the potential for NGOs to share the leadership and facilitation role.**

2.44 The district clusters have played an important role in responding to disease outbreaks. In some districts, the cluster has also helped to reduce duplication of effort, identify gaps, improve coverage, increase joint planning and monitoring of activities, and promote harmonised reporting formats and adherence to national standards. For example, clusters reported that they had jointly planned and implemented child health days and worked together to ensure there was no overlap in net distribution. Other clusters reported action to address wider problems. In Lira, the cluster has reported absent staff at a HC IV to the DDMC, which suspended payment of salaries, and highlighted the variable quality of ANC services provided at different facilities; while in Gulu, the cluster has raised the issue of non-functional ambulances and the failure of health centres to include the status of stocks of HIV test kits and ARVs in monthly reports, which results in stock outs, with the District Health Officer (DHO). In other districts, the cluster has been less active and has largely functioned as an information sharing forum, with limited benefits for NGO participants. Meetings with district clusters highlighted concerns about non-participation of some NGOs, poor coordination of HIV/AIDS activities and weak links between HIV/AIDS service providers, and poor coordination of health, nutrition and HIV/AIDS activities at the health sub-district (HSD) level. ***The potential of district clusters to strengthen coordinated planning and implementation and, specifically, to improve coordination of HIV/AIDS activities, including those funded through the US Government, should be exploited fully.***

2.45 In principle, MOH participates in the national cluster and district clusters are co-chaired by WHO and the DHO. In practice, MOH and DHT involvement is limited, due partly to a perception that the cluster approach is a UN initiative and partly to limited capacity. District clusters mostly engage with the DHT through reporting to the DDMC. Lack of DHT participation in district clusters makes it more difficult to ensure that decisions are taken forward and issues are followed up. Some clusters are proposing to bring in HSD representatives to increase local government involvement and strengthen coordination at the HSD level. ***The joint programme should take action to increase MOH and DHT ownership and support their active participation in the clusters; convening meetings at the MOH and at DHT offices and encouraging DHOs to chair meetings should be a first step.***

2.46 Other issues highlighted by the evaluation include: lack of clarity about when coordination during the transition phase shifts to the early recovery cluster led by UNDP and how the health, nutrition and HIV/AIDS cluster relates to this; and lack of links between sectors, for example health, nutrition and HIV/AIDS and water and sanitation.

3. GENERAL OBSERVATIONS

Important support for delivery of essential health interventions

3.1 The joint programme is the main source of external support to the health sector in Northern Uganda and has played an important role in ensuring that the population receives basic health care. UN agency national and district technical staff are of a high calibre, demonstrate impressive levels of knowledge and skills, and have provided valuable technical support to the districts.

3.2 While most DHTs cited strengthening coordination, human resources for health and health infrastructure as the most useful areas of support, it is unclear whether districts would be able to deliver essential health interventions without the additional resources

provided through the joint programme. Achieving the programme Purpose is likely to be difficult in view of the health sector challenges in Northern and North Eastern Uganda (see Section 5).

Ambitious scope of activities and geographical coverage

3.3 The joint programme is ambitious in scope relative to its timeframe and resources. It encompasses a wide range of interventions, which expanded between 2006 and 2007. Geographical coverage has also expanded, from five districts in 2006 to 16 districts in 2007 (4 districts in Acholi region: Gulu, Kitgum, Pader, Amuru; 5 districts in Lango region: Apac, Lira, Oyam, Amolatar and Dokolo; 5 districts in Karamoja region: Kabong, Kotido, Moroto, Nakapiripirit and Abim; and 2 of the 5 districts in Teso region: Katakwi and Amuria).

3.4 Consequently, the programme is spread rather thin and there is a risk that some interventions will achieve limited coverage and impact. In practice, activities have largely been concentrated in districts in Acholi and Lango. Teso and Karamoja have received limited attention, in part due to continuing insecurity.

Lack of strategic, integrated and phased approach

3.5 The joint programme consists of a set of disparate activities rather than a coherent approach to addressing key issues. This is partly due to the challenges of working in regions affected by insecurity and partly to the way in which the programme has been funded. DFID funding for 2006 was made available at short notice, which did not allow much time for planning. Funding for both 2006 and 2007 has been for one year. This relatively short timeframe predisposes to short-term, one-off activities, such as provision of training and supplies.

3.6 However, a more strategic approach could have been taken in 2007. In health system strengthening for example, support to address wider issues of weak management and capacity would have enhanced specific interventions in human resources for health, health service infrastructure, HMIS and EPR, and health sector coordination. The same applies to addressing specific causes of mortality and morbidity. For example, tackling maternal mortality requires a strategic approach that includes constructing and equipping theatres, targeting recruitment of Medical Officers to HC IV, supporting DHTs to manage referral and transport systems efficiently, training and community education.

3.7 Phasing and synchronicity of activities is also an issue. For example, health workers are currently being recruited, but staff accommodation is not completed. Integrated planning and delivery of training for health workers and VHT, rather than a series of separate, uncoordinated trainings conducted by different UN agencies or implementing partners, might have been more efficient.

3.8 The programme has not yet taken steps to adjust its approach to the changing situation in Northern Uganda or to develop a targeted approach appropriate to the specific context and needs in Karamoja. Efforts to date in Karamoja have largely been undertaken by WHO and have focused on assessment of health needs and services, EPR, strengthening HMIS and IDSR, and establishing a WHO office in Moroto district to enhance coordination and provision of technical support.

Need for greater emphasis on follow up and sustainability

3.9 More attention could be paid to follow up, to ensure that, for example, health centre rehabilitation and construction of staff accommodation has been carried out as planned and to a high standard, ambulances are being used, and health workers and VHT trained are putting into practice new knowledge and skills. The joint programme also needs to take steps to ensure that components supported in 2006, for example, provision of measles vaccine, coartem, HIV test kits, NVP, cotrimoxazole and condoms, support for OVC, and hygiene education, are being sustained by district health authorities or other external agencies.

Limited attention to community health promotion

3.10 Programme efforts have largely focused on the 'supply side' of health, nutrition and HIV/AIDS, with less focus on increasing community awareness of, and demand for, services such as immunisation, ANC or CT. Training for VHT has concentrated on management of illness, with less attention given to developing their skills to conduct effective community education on hygiene and sanitation, nutrition, FP and maternal health or HIV prevention and care.

4. PROGRAMME MANAGEMENT

Joint programming benefits

4.1 At central level, participating UN agencies report that the joint programme has helped to clarify mandates and determine roles based on their respective comparative advantage, has improved communication between agencies and strengthened joint planning. It is evident that good working relations have been established between technical staff. The joint programme has also improved communication and helped to establish good working relations between agency staff at district level. Reported benefits include speaking with one voice, for example, WHO and UNICEF field staff agreeing joint positions before meetings with district government or representing other agencies in meetings, and enabling agencies without a field presence to operate through their UN partners. The participating agencies also view the joint programme as an opportunity to work together more closely at district level.

4.2 Joint programming has reduced transaction costs for the MOH, which now receives one proposal and one report instead of four, and has presumably also reduced transaction costs for DFID. The joint programme has helped to take forward the cluster approach and contributed to its effectiveness, and the findings of this evaluation suggest that the joint programme has played an important role in improving coordination of the health, nutrition and HIV/AIDS response.

4.3 There is limited evidence to substantiate some of the other reported benefits of the joint programme, such as enabling government to play a leading role in coordination of the emergency response with NGOs, enabling individual agencies to view their work as a joint effort at both national and district levels, and reducing district transaction costs through approaching the districts as a joint UN team. No data is available as yet to support the claims that the joint programme has enabled government to attract health workers to hard-to-reach areas and reduced morbidity and mortality of IDP.

Joint programming challenges

4.4 UN agencies also reported challenges associated with joint programming. Considerable time is required for joint planning and proposal development, which increases transaction costs for the UN agencies. The Joint Programme Steering Committee (JPSC) meeting minutes of March 2007 note that preparing for the programme in 2007 was a lengthy process. UN staff acknowledge that reaching consensus is not easy, given the different mandates and priorities of each agency. Differences in planning cycles, operational procedures and reporting systems also create difficulties for joint programming.

4.5 The perception of some MOH, donor and NGO stakeholders is that joint programming has not yet made a significant difference to the way agencies work together. Individual agency reports do not reflect commitment to joint programming – for example, the WHO Uganda HAC and UNICEF Uganda 2006 annual reports make no mention of the joint programme and report programme activities and achievements as though they alone are responsible – perhaps reflecting the continuing need for individual agencies to be able to demonstrate attribution to headquarters and donors.

4.6 The participating UN agencies report that the 2007 phase of the joint programme was based on the CAP, which itself is based inputs from districts via the clusters. However, the March 2007 Joint Programme Steering Committee meeting minutes highlight the need for clearer linkages between the CAP and the joint programme, and districts were not directly involved in programme planning and design. The perception of some stakeholders outside the UN is that the selection of areas of programme intervention reflected the need to identify specific roles for the four UN agencies that were consistent with their mandates, rather than district priorities. ***A future programme should reflect the 2008 CAP and should be developed in consultation with districts.***

4.7 The division of programme responsibilities between the participating UN agencies is also not entirely clear. The team was told, for example, that WHO was responsible for upgrading facilities in 2006 and UNICEF in 2007, but the June 2007 WHO HAC bi-monthly update describes renovation of staff quarters at Amugo HC II in Lira, with WHO support, as ongoing. UNICEF has trained CORPS, but WHO has also conducted training for CORPS on IMCI. UNFPA is reported to be responsible for provision of EmOC equipment and supplies and for training health workers on EmOC, but the WHO HAC annual report states that WHO has provided training for health workers in EmOC procedures and post-abortion care and has provided equipment to support safe delivery, including provision of over 20,000 Mama kits to all districts to in Northern Uganda. The WHO HAC report also states that additional WHO staff are required to support nutrition activities, even though WFP and UNICEF already have nutrition staff working on the joint programme.

4.8 It is difficult to describe the programme as a joint effort or as approaching the districts as a joint team. Individual agencies implement activities separately and districts describe activities as being implemented by UNICEF or WHO rather than by the UN. The Project Document states that existing UN offices – WHO in Gulu, UNICEF in Kitgum and UNOCHA in Gulu – will facilitate coordination and implementation of the joint programme at district level. In practice, it is difficult for agencies to deliver their

mandates without a presence on the ground, and the joint programme appears to have contributed to an expansion of UN staffing at district level. WHO, for example, has established new offices in Pader, Kitgum, Lira and Moroto. UNICEF, WHO, UNFPA and WFP together have 20 staff covering Gulu and Amuru. ***This highlights the need for UN agencies to find more efficient ways of working together at district level. Ideally, the joint programme, and any future UN programming, should work through a joint UN team based in a joint UN office or with the DHT. This requires progress on wider UN reform at global and national levels, for example, to harmonise administrative and other procedures.***

4.9 The evaluation findings raise wider questions about joint programming. Joint programming should not be an end in itself, and it would be useful to develop criteria to determine when joint programming is the most appropriate approach. Clear expectations of joint programming and indicators for measuring its efficiency and effectiveness in terms of process and outcomes are needed. Adherence to mandates, while a good idea in principle, creates challenges for joint programming and can potentially reduce efficiency. In this joint programme, for example, in line with their mandates, different agencies are involved in procurement of specific supplies and are funding NGO implementing partners to conduct different trainings for the same health workers or VHT. Some NGO partners are being funded by more than one UN agency. For example, IMC receives support both from WFP and from UNICEF to implement specific nutrition interventions. Procurement of all programme supplies and sub-contracting of all partners by one agency might be more efficient.

Engagement with implementing partners

4.10 Districts and NGO partners report that they have good relationships and communication with joint programme UN agencies, and value the technical support provided. Joint programme NGO partners are diverse in size, capability and geographical coverage. The evaluation saw evidence of differences in the calibre of implementing partners, for example, in the quality of training provided to CORPS by different NGOs. The UN agencies do not use a common set of criteria for selection of NGO partners or a common approach to monitoring their performance. More attention needs to be paid to monitoring the performance of implementing partners, to ensure that they deliver and to an adequate standard, and to providing feedback to these partners. ***The joint programme should develop a common set of criteria for selection of NGO partners, a common approach to monitoring their performance and feedback systems. Future funding of NGO partners should be based on their performance during 2006 and 2007.***

4.11 Implementation was held up at the start of the programme because of delays in initial disbursement of funds from DFID to UNICEF. This had a knock on effect. It was difficult for NGOs, and for UN agencies in turn, to report on activities during the past three months when funds for that quarter had only just been received. UNICEF is funding the largest number of programme NGO implementing partners. UNICEF rules require funds previously provided to be accounted for before the next instalment of funding can be released. This has caused difficulties for some NGO partners. Failure by districts and NGOs to provide timely reports has also resulted in delays in disbursements and in implementation of activities.

4.12 Lack of flexibility was cited as a problem by some NGOs. For example, if district priorities change, it can take considerable time for NGOs to renegotiate planned activities with the UN agencies. NGOs receiving funding from more than one UN agency highlighted the additional workload created by differences in agency reporting requirements, in terms of formats and timeframes. NGOs also noted that reporting demands have increased, with district UN agency offices now also requiring reports, sometimes on a weekly or monthly basis, in addition to central UN agency offices. ***The UN agencies should streamline and harmonise financial and narrative reporting requirements and take steps to improve the efficiency of disbursements to implementing partners.***

Programme monitoring and reporting

4.13 The Joint Programme Steering Committee (JPSC), which includes the heads of agencies and DFID, MOH and UAC representatives, was established to provide oversight of the joint programme. The JPSC met three times in 2006, but there was no meeting between 19th July 2006 and 29th March 2007, despite the fact that the UN agencies planned and submitted the proposal for the 2007 joint programme during this period. The UN agencies plan to replace the JPSC with six-monthly heads of agency meetings and to engage with the MOH through the national health, nutrition and HIV/AIDS cluster.

4.14 However, the MOH does not participate actively in cluster meetings and the cluster mandate does not include oversight of specific programmes. There is a potential conflict of interest in WHO's role as cluster lead and as a joint programme implementing agency. The MOU between the UN agencies states that the JPSC is responsible for decisions about joint programme direction, modification of activities, disbursements of funds to participating UN agencies and budget amendments. The cluster does not have the authority to take such decisions. Finally, it is unclear how DFID would maintain programme oversight. Joint programme progress reports are not adequate to enable DFID to monitor the performance of the programme and the UN implementing agencies. ***DFID and the UN agencies need to establish an efficient mechanism to provide oversight to, and monitor the performance of, the joint programme.***

5. CHALLENGES FOR THE HEALTH SECTOR

5.1 The following is a brief summary of some of the key challenges for the health sector in Northern and North Eastern Uganda during any period of transition.

Uncertain political context

5.2 The outcome of current peace talks between the GOU and the Lord's Resistance Army remains uncertain. This makes it difficult to predict the timing of future population movement and length of stay in IDP camps and transitional settlements. At present the situation varies from district to district. For example, in Lira, the IDP population had fallen from 341,452 in October 2005 to 139,025 by December 2006, and it is now estimated that around 90% of IDP have returned home. In other districts, such as Oyam, the majority remain in camps.

5.3 Also difficult to predict is the proportion of the population that will remain in IDP camps and the proportion that will return to their place of origin, although it is anticipated

that the population remaining in camps will comprise the most vulnerable groups, including the elderly and child-headed households, in the short to medium term. This presents a challenge for planning service delivery, in particular determining priorities for infrastructure improvements and staff deployment and provision of services for the population remaining in camps. Careful monitoring of the situation will be required, as will a flexible approach that responds to the specific needs of different districts.

Lack of a clear policy framework

5.4 The current GOU Joint Monitoring Committee (JMC) transition plan for Northern Uganda ends September 2007. The assumption was that this would be followed by roll out of the Peace, Recovery and Development Plan for Northern Uganda (PRDP), but it is now thought unlikely that the PRDP will commence before 2008. UNOCHA has developed a transition approach, which has been endorsed by the JMC, whereby provision of basic services, including primary health care, will be based on the population of a parish. The parish approach is intended to serve as a transition strategy between humanitarian efforts and recovery efforts within the framework of the PRDP for maximum period of one year. The national cluster is currently reviewing the draft health, nutrition and HIV/AIDS component of the transitional approach.

Limited district capacity and resources

5.5 DHT capacity is weak in most districts of Northern and North Eastern Uganda and poor management skills are a significant problem. Capacity has been further weakened by the creation of new districts. Recently established DHTs lack a full complement of qualified staff and, in some cases, office space, transport and equipment.

5.6 Districts in Northern and North Eastern Uganda are under-resourced. This has been exacerbated by reduction in local revenue collection following the abolition of graduated tax and by the creation of new districts. The MOH has a limited budget and is unlikely to increase its commitment to these regions, which already receive higher per capita funding overall than other regions of the country. Sustaining and improving health services will continue to depend on external funding.

Severe shortages of human resources for health

5.7 Shortages of qualified health workers are more severe in Northern and North Eastern Uganda than in other parts of the country. The MOH Annual Health Sector Performance Review 2005/6 shows that Kitgum and Pader had 52% and 32% respectively of staffing norms. The Acholi region SAM showed a doctor to population ratio of 1:21,519 in Kitgum and 53,291 in Pader (the national ratio is 1:18,600). Only 50% of HC II in Gulu, 21% in Pader and 9% in Kitgum had the required HSSP I staffing norms. Staff shortages are exacerbated by weak human resources management.

5.8 Whether or not the one-time allowance will improve recruitment and retention of staff in these regions remains to be seen, but achievement of HSSP II staffing norms seems unlikely. Other measures to attract and retain certain cadres of staff, and task shifting, will be required in the short and medium term. Further training of VHT is likely to be required to ensure adequate coverage in transitional settlements and return areas, as some trained VHT may not move with the rest of the population.

Poor infrastructure and systems

5.9 Health facilities are in a very poor condition in Northern and North Eastern Uganda as a result of years of neglect. Access to health centres is limited in some return areas and transitional settlements. Existing facilities lack equipment and functioning laboratories, theatres and wards. District budgets for infrastructure are inadequate relative to the number of health centres that need to be constructed, rehabilitated or upgraded and the lack of staff accommodation.

5.10 Problems with stock outs and irregular supply of essential drugs and commodities are also worse in North and North Eastern Uganda. The supply chain uses a pull system, and shortages of staff increase challenges related to quantification and ordering of supplies.

Potential for worsening health and nutritional status

5.11 There is a risk that indicators may worsen in IDP camps if services are withdrawn by external agencies that consider the emergency phase to be over, or by district health authorities that prioritise return areas. Health and nutrition status may also worsen in transitional settlements and return areas where there are no services and as food rations are withdrawn. There are particular concerns about an increase in malnutrition and micronutrient deficiencies as a result of food shortages during the period between return and the next harvest, a focus on provision of seeds only for starch crops, and inadequate infant and child feeding practices.

Service provision and sustainability

5.12 DFID funding for the joint programme in some districts represents significantly more than the PHC grant. Establishing realistic standards of health care will be critical, to ensure that districts are able to sustain delivery of services in future. It may not be feasible to provide the same levels of access to services in return areas as in IDP camps, and it will not be feasible to establish health facilities in every transitional settlement, since there are many of these sites in addition to the original camps and most are likely to be temporary. Managing community expectations will be a related challenge.

5.13 Alternative approaches may be required to provide services to populations in transitional settlements that are located a significant distance from health facilities in IDP camps and return areas or in return areas without health facilities. During the transition phase, VHT could play an important role in provision of basic community preventive and care services. Likewise, alternative approaches to community mobilisation, for example, for immunisation, are likely to be required to reach and motivate populations that are no longer in camps and are living in more scattered settlements.

Specific needs of Karamoja

5.14 Mortality and morbidity rates, and basic health indicators, are consistently worse than in other regions of Uganda. Karamoja has a reported CMR of 3.9/10,000 persons/day and MMR of 750/100,000 live births. While there has been an improvement in the security situation in Acholi and Lango, Karamoja and Teso continue to be affected by insecurity.

ANNEX 1: PROGRAMME BUDGET

Programme budget by agency 2006 and 2007

Agency	Phase 1 (US\$)	Phase 2 (US\$)	Total
UNICEF	5,231,000	3,838,261	9,069,261
WHO	3,630,000	3,254,800	6,884,800
UNFPA	2,067,000	235,000	2,302,000
WFP		527,177	527,177
Administrative costs	902,220	633,917	1,536,117
Total (US\$)	11,829,220	8,489,156	20,319,355
Total (£)	6,837,699	4,467,976	11,305,676

Programme budget by intervention area 2007

Intervention area	Budget (\$)	Funds received to date	Percentage funds received used
Human resources for health	1,373,089	1,373,089 100%	93%
Health infrastructure	2,066,170	1,031,000 50%	12%
HMIS	838,024	380,000 45%	3%
Child health and nutrition	770,400	680,210 88%	57%
Malaria	1,096,857	628,251 57%	67%
Reproductive health	705,320	385,000 55%	70%
HIV/AIDS	923,945	570,090 62%	13%
Health sector coordination	631,300	408,850 65%	15%

ANNEX 2: TERMS OF REFERENCE

1. Background

1.1 Conflict due to the Lords Resistance Army (LRA) insurgency and cattle rustling in Northern Uganda have resulted in internal displacement of the population, insecurity and breakdown of socio-economic infrastructure. The consequences have been overcrowded internally displaced persons (IDP) camps and inadequate basic services leading to high morbidity and mortality in the region. In northern Uganda, 63% of the population lives below the poverty line and this is attributed mainly to the limited access to income generating activities, including agriculture as well as poor health¹. While civilians displaced in to IDP camps as a result of the insurgency are exposed to numerous risks, attempts by the GoU to protect the affected population have often been inadequate.

1.2 Insecurity in the Karamoja region is largely due to cattle rustling carried out by armed warriors and has resulted in displacement of about 10% of the population in 62 IDP camps. The remaining population outside the camps includes pastoralist cattle keepers who live in overcrowded settlements called manyatas with several households within the settlement.

1.3 It's estimated that over 1.4 million people are displaced in DP camps dotted across northern Uganda. However, the current picture in conflict-affected northern Uganda is changing with populations in some of the areas affected by LRA conflict beginning to return home or moving into smaller temporary settlements nearer their places of origin. However the situation remains fragile with no definitive outcome of peace talks currently taking place in Juba, southern Sudan. In Karamoja insecurity continues at a very high level with a Government forced disarmament process underway.

1.4 Given the scale of the problem and the inability of the districts to technically or financially manage the response required, Government of Uganda efforts have had to be supplemented by the UN and NGO implementing partners.

1.5 Since 2005, addressing the health situation in northern Uganda has received greater attention from GoU and humanitarian actors (UN and NGOs). Humanitarian expenditures over the last three years have been over US\$450 million. Government has recently drafted a three year National Peace, Recovery and Development Plan for Northern Uganda (PRDP) with a total budget representing US\$40 per person over three years. However the implementation and management arrangements for this plan remain unclear at this point. The overall goal of this plan is to consolidate peace and security in all regions and lay the foundations for recovery and development. Implementation is unlikely to begin before 2008.

1.6 In response to the 2006 Consolidated Appeal (CAP), support was provided through the US\$ 13 million DFID/SIDA Joint UN Programme, as well as through NUSAF, DANIDA, GHF-ATM, GAVI, UNFPA and ADB. The amount mobilized through DFID and SIDA (7% of the appeal for 2006) and was meant to contribute to health infrastructure through construction and renovation of maternity units, staff accommodation, and

¹ United Nations. Common Country Assessment: Uganda. UN office in Uganda 2004

provision of transport (bicycles, motorcycles and ambulances), medical equipment, ITNs and drugs for malaria.

1.7 In 2007 DFID provided another £ 8.4 million for emergency health nutrition and HIV/AIDS response in the regions of Acholi, Lango, Karamoja and the districts of Amuria and Katakwi in the Teso region. The purpose of this support is to reduce morbidity and mortality among the conflict affected populations through strengthening health systems, targeting interventions for child health, nutrition, reproductive health, malaria and HIV/AIDS and improving health sector coordination.

1.8 As part of its Evaluation and performance monitoring, DFID Uganda wishes to obtain the services of appropriately qualified consultant/s to complete an Evaluation of the Joint UN Emergency programme for northern Uganda 2006. This exercise is essentially a comprehensive evaluation of the emergency operations to draw out key issues and recommendations for further action.

2. Objectives

2.1 To evaluate DFID Uganda's support to Joint UN (UNFPA, UNICEF, WFP, WHO) emergency programme in North and North Eastern Uganda. To identify the impact, outcomes and outputs that resulted from the joint UN programme.

2.2 Taking into account assessments already undertaken at cluster level, clarify humanitarian and developmental health/HIV/AIDS and nutrition needs in northern Uganda in the short term and recommend areas for support from the joint UN programme.

2.3 To identify the key challenges for the health sector during any period of transition from the current humanitarian situation to recovery and development and recommend different options for the joint UN programme of support during this period/

3. Scope of work and outputs

3.1 The consultants will assess the effectiveness of the DFID funded joint UN programme for the emergency health response for northern Uganda. DFID has provided \$19.4 million USD during the period January 2006 to December 2007.

3.2 In carrying out the evaluation of the health nutrition and HIV/AIDS response in 2006 and 2007, the consultants will:

- Identify and assess any evidence at goal and purpose level of the overall effectiveness (including mortality rates), outputs and outcomes of the health, nutrition and HIV/AIDS response.
- Assess the coverage in terms of the scope and volume of joint UN programme in relation to the affected population.
- Assess the benefit (including efficiency and effectiveness) of joint programming by UN agencies, using the example of joint programming for health, AIDS and nutrition in northern Uganda.

- Identify lessons learnt for UN agencies and donors in joint programming and provide recommendations for improving this approach for the future.
- Assess the effectiveness of the cluster approach in health and nutrition and the extent to which this programme impacted on or affected coordination and implementation arrangements within the cluster
- Assess the quality of engagement of the UN with the MoH and local government and other actors in the health sector in strengthening health systems, building GoU stewardship, targeting interventions, determining priorities and improving health sector coordination.
- Assess and comment on the timeliness and effectiveness of the UN agencies release of resources under the programme to identified implementing partners and the efficiency of management arrangements then applied.
- Assess the capacity of the implementing partners and especially their ability to deliver set targets and goals and give recommendations for further improvement.
- Consultants should take into account the ALNAP guide for humanitarian agencies "Evaluating humanitarian action using the OECD-DAC criteria".

4. Methodology

4.1 Literature review of relevant documents including the performance reports, minutes of relevant meetings, survey reports etc (List of relevant documents attached in annex 1)

4.2 Key informant interviews with the UN agencies, GoU, other donors including DFID and SIDA at both country and head- quarters level, Local governments collaborating NGOs, and civil society. List of suggested initial key informants will be provided prior to the field work.

4.3 Field consultations with the district authorities, NGOs and community groups including focal group discussions with IDPs.

5. Outputs

5.1 The consultant will write a narrative report of not more than 20 pages outlining their key findings against the scope of work outlined above and in the joint UN programme log frame.

5.2 The consultant will produce a draft report, in DFID Annual Review format, for discussion with DFID Uganda and a final report incorporating any agreed changes.

5.3 The consultant will produce an options paper on the different scenarios for future UN input during the transition process and during the implementation of the Peace Reconciliation and Development Plan.

5.4 The consultant will prepare a power point presentation for dissemination of the findings and recommendations to key stakeholders.

6. Timeframe

6.1 It is anticipated that up to 23 days' work per consultant will be required for this consultancy and that the humanitarian consultant will spend more of their days in the field. The start date of the consultancy is 26 July 2007 with an end date of 31 August 2007.

6.2 A draft report should be submitted by 17 August 2007 and a final report not later than 31 August 2007.

6.3 Dissemination of findings to be done by power point presentation to all stakeholders at a date to be agreed.

7. Reporting

7.1 The consultant will report to the DFID Conflict and Humanitarian Adviser and the Deputy Programme Manager.

8. Required Qualifications and Experience

8.1 It is anticipated that there will be a two person team. One of the consultants should have experience of joint UN programming. The other consultant should have experience of evaluating health sectors and humanitarian assistance.

ANNEX 3: LIST OF PERSONS MET AND EVALUATION SCHEDULE

National

DFID

Richard Edwards, Deputy Head of Office
Mercy Mayebo, Deputy Programme Manager
Graham Carrington, Conflict and Humanitarian Advisor
Gerald Owachi, Assistant Conflict Advisor

Ministry of Health

Sam Zaramba, Director General of Health Services
Kenya-Mugisha Nathan, Director Clinical and Community Health Services
Sam Okware, Chair, National Health Task Force on Northern Uganda
Bwire Godfrey, Secretary, National Health Task Force on Northern Uganda

Uganda AIDS Commission

Joyce Kadowe, Coordinator, HIV/AIDS programmes, Northern Region

UNICEF

Keith McKenzie, Country Representative and Acting Humanitarian Coordinator
Gloria Kodzwa, Deputy Country Representative
Vincent Orinda, Senior Programme Officer, Child Survival and Development
Janex Kabarangira, Project Officer, Health
Shannon Strother, Senior Programme Officer, Northern Region
Flavia Mpanga, Project Officer, Health
Robbinah Ssempebwa, HIV prevention
Eric- Alain Ategbo, Nutrition
Eva Kabwongera, EPI

WHO

Melville George, Country Representative
Lukwiya Michael, Programme Officer
Joseph Mwanga, NPO/EDM
Andrew Ballamaga, Technical Officer
Fiona Braka, NPO/EPI
Juliet Bataringaya, NPO/HSD
Frank Lule, NPO/HIV
Geoffrey Bisoborwa, Child Health
Juliet Nabyonga, NPO
William Mbabazi, NPO
Joseph Imoko, NPO
Lukoda Ramathan, T/A RH/HIV

UNFPA

Hassan Mohtashami, Deputy Representative
Primo Madra, Programme Officer

WFP

Alix Loriston, Deputy Country Director

Martin Ahimbisibwe, Senior Programme Assistant, Nutrition
Judith Lumu, Programme Officer
Yvonne Diallo, Programme Officer
John Ssemakaly, NPO/HIV
Mawadri Michael, Nutrition

UNOCHA

Tim Pitt
Kirsten Knutsen

UNAIDS

James Okara Wanyama, NPO

Belgian Technical Cooperation

Luc Geysels, Health Sector Advisor and Chair, Health Development Partners Group

NGO cluster members

Jeremy Konyndyk, Country Director, American Refugee Committee
Yolanda Barbera, IRC
Femke Bannink Mbazzi, Project Officer, AVSI
Peter Lochoro, Technical Advisor, Doctors with Africa
Uma Palaniappan, Medical and Nutrition Coordinator, ACF
Muna Shalita, Director, Maternal and Child Health, PSI
Timothy Ahimbisibwe, Save the Children
Kellen Tumuhairwe-Baguma, Training Coordinator, AIDS Information Centre

Malaria Consortium

Kate Kolaczinski, Vector Control and Emergencies Specialist

Lira District

Meeting with DHT, NGO and UN field staff

Peter Kusulo, DHO
Ochlu Geoffrey, DHT
Opid Bonny, In Charge, Ogun HC IV
Oderuu Robert, In Charge, Nebtong HC IV
Okello Lawrence, Medical Officer, Ersila South HSD
AA Terence, Acting District Community Development Officer, Lira District Local Government (LDLG)
Okoi Leo, MRA, LDLG
Lajul Joyce, MRA, LDLG
Akaki Thomas Bell, AHO/HPE, LDLG
Onao JB, LDLG
Onao Ben Aber, HWFP, LDLG

Atine JP, Project Coordinator, Lightforce International
Achiro Beatrice Otto, Project Coordinator, Caritas
Eriya Murana, AIDS Information Centre
Ocer Geoffrey, RICH Consult
Lgang Sam, RICH Consult

Solomon Asea, Senior Programme Assistant, WFP
Biira Jackie, Field Monitor, WFP
George Bhoka, Project Officer, HIV/AIDS, UNICEF
Charles Ocan, Project Officer, Health and Nutrition, UNICEF
Okdory Peter, Admin Clerk, UNICEF
Yoti Zabulon, NPO/DC, WHO
Emmanuel Obura, NPO/HAC, WHO
Okello Joel, Information Assistant, UNFPA
Kai Matturi, Programme Officer, UNDP
Othieno Daniel, DDPC, UNDP
Akello Fatuma, Senior Protection Clerk, UNHCR

Pader District

Meeting with DHT and UN field staff

Ambrose Ochen, Acting CAO
Oyet Vincent, DHE, DHT
Bimeny Adongo, DHT
Okmi Dominic, DHI/MFP, DHT
Martin Oboke, DTLS, DHT
Jacinte Oboke, DAV, DHT
Angelo Menya, Drug Inspector, DHT

Alyek Ochero Juliet, Health and Nutrition Officer, UNICEF
Patrick Nape Otim, NPO/DC, WHO
Innocent Komakech, NPO/HAC, WHO

Meeting with cluster members

Angelo Menya, DHT

Alyek Ochero Juliet, UNICEF
Josephine Ojera, WFP
Bai Mankay Sankoh, WFP
Patrick Nape Otim, WHO
Innocent Komakech, WHO

Stephen Ochieng, PSI
Oceng Isaac Ofinus, NWMT
Amandine Desaunay, AVSI
Dan Mnyanja, IMC
Nyeko Phillips, Malaria Consortium
Adoch Stella, COOPI
Okeng Emmanuel, COOPI
Michelle Weson, Medair
Sally Williamson, Mercy Corps
Alobo Susan Toolit, CPAR

Kitgum District

Meeting with DDMC

K Oginde, District Chairperson LCV

Nyero Charles Okwera, Vice Chairperson, LCV
Langoya Abraham Nicholas, Secretary Finance
Olwedo Alex, DHO
Nahaman Ojone, RDC
Okaku Geoffrey, CAO
Rhoda Oromu, Assistant CAO
Obellim Christopher, representing DEO
Lumuru Peter Ali, Secretary Roads and Water
Abwono Filder Obote, Secretary Health Education
Longole John, CFO

Meeting with cluster members

Olwedo Alex, DHO
Abwono Filder Obote, Secretary Health Education
Obote M Odwar, Kitgum District Local Government (KDLG)
Tamali Lamunu, KDLG
Omoo John, DHI/DHT

Giovanna Romagna, AVSI
Angela St Jules, AVSI
James Okweny, AIDS Information Centre, Lira
Omach Jerolam, Straight Talk
Janet Akao, Straight Talk
Annie Turnbull, IMC

Rufina B Oloa, HIV/AIDS/OVC, UNICEF
Francis Oriokot, NPO, WHO

Gulu District

Meeting with DHT and UN field staff

Onok AP, DHO
Okot Lobach, DHE, DHT
Opwonya John Odong, DTLS/SMCO, DHT
Ojok Naptali, DA/HMIS
Opwenya Blu, DHI, DHT

Vincent Oryem-Yooman, NPO/HAC, WHO
R Solomon, Head of Sub-Office, WHO
Rachel Goldstein, Emergency Reproductive Health Officer, UNFPA
Grace Latigi, NPA, UNFPA
Dr Jackson Ojera, Programme Officer HIV/AIDS, UNICEF
Gloria Komakech, Field Manager, WFP

Ojok Robert, Programme Officer, AVSI
Bongomin Bodo, Medical Officer, AVSI

Meeting with cluster members

Luwo Godfrey, Project Officer, The Kids League
Samuele Otim Rizzo, Area Team Leader, AVSI
Bongomin Bodo, Medical Officer, AVSI

Benoit Ilungu, Nutritionist, ACF
Odong Patrick, Lecturer/Project Chairman, Gulu University
Oringa Patrick, Advocacy Manager, Marie Stopes
Robinah Babinge, Technical Adviser RH/HIV/AIDS, Pathfinder International
Anthony Onono, Project Assistant, RICH Consult
Keith M, Health Coordinator, CPAR
Evelyn Ogwal, Programme Director, CPAR
Mercie Onyut, Programme Manager, CPAR
Muchuro Simon, CPD Coordinator, Malaria Consortium
Kibwold Dennis, Centre Manager, Gulu Youth Centre
December Walter, Project Assistant, Health Alert

Vincent Oryem-Yooman, NPO/HAC, WHO
R Solomon, Head of Sub-Office, WHO
Gloria Komakech, Field Manager, WFP
Jackson Ojera, Project officer, HIV/AIDS/Health, UNICEF

Amuru District

Meeting with DHT

Mulwani C, Acting DHO
Okwonga John, Acting DHI, DHT
Olango Joseph, Acting DNO, DHT
Komakech Wilfred, HMIS, DHT
Oymalo Clovice, DHE, DHT
Olwedo Julius, Medical Superintendent, Anaka Hospital
Etwop Santa, Medical Officer

Date	Activity
Thursday 26 July	Briefing DFID Meeting OCHA Meeting MOH
Friday 27 July	Meeting UAC Meeting Heads of Agency WHO, UNICEF, UNFPA, WFP Meeting technical officers WHO, UNICEF, UNFPA, WFP
Saturday 28 July	Document review and preparation for field visits
Sunday 29 July	Travel to Lira
Monday 30 July	<u>Lira</u> Meeting DHT, UN field staff Visit Okwallo HC II and meeting with VHT/CORPS Visit Okwongo HC III Visit IDP camp
Tuesday 31 July	<u>Pader</u> Meeting DHT, UN field staff Meeting district cluster including NGOs Visit Lirapalwo HC III and Lirapalwo IDP camp Visit Pajule HV IV
Wednesday 1 August	<u>Kitgum</u> Meeting DDMC Meeting DHT, UN field staff, cluster NGOs Visit Kitgum district hospital, St Joseph's mission hospital Visit IDP camp Padibe including visit Padibe HC IV, meeting with VHT, meeting with PLHA
Thursday 2 August	<u>Gulu and Amuru</u> Meeting DHT Gulu, UN field staff Meeting DHT Amuru Visit Lacor hospital, Gulu Visit Kaladima HC III, Amuru district Visit Bobi HC III, Gulu district Meeting with PLHA group, Bobi HC Visit IDP camp
Friday 3 August	<u>Gulu</u> Meeting district cluster including NGOs Travel to Kampala
Saturday 4 August	Document review and synthesis key findings
Sunday 5 August	Document review, synthesis key findings, preparation presentation for UN debriefing
Monday 6 August	Meeting DFID Meeting national cluster NGOs Observe national cluster meeting
Tuesday 7 August	Meeting Malaria Consortium Document review Debriefing meeting UN agencies
Wednesday 8 August	Meeting DFID Meeting MOH Report drafting
Thursday 9 August	Joint debriefing MOH, UN agencies, DFID, NGOs Meeting health development partners
Friday 10 August	Meeting Humanitarian Coordinator, UNICEF Debriefing meeting DFID Report drafting

ANNEX 4: LIST OF DOCUMENTS CONSULTED

DFID, 2007. Uganda Country Profile.

DFID Uganda, 2007. Performance framework and delivery plan 2006/07-2008/09.

DFID, 2005. Joint inter-agency emergency health, nutrition and HIV/AIDS response in IDP camps in Northern Uganda. Project Memorandum. December 2005.

DFID, 2006. Joint inter-agency emergency health, nutrition and HIV/AIDS response in IDP camps in Northern Uganda. January 2006-December 2007. Project Memorandum. Revised December 2006.

Ginifer J, 2006. Internal review of DFID's engagement with the conflict in Northern Uganda. DFID, Evaluation Report EV663.

GOAL, 2007. Findings of a multi-indicator cluster survey. April 2007.

IASC. Health, nutrition and HIV/AIDS cluster performance report Uganda 2006.

IASC. Work plan for Uganda CAP 2008.

Joint Monitoring Committee, 2007. Proposed transition approach for LRA-affected Northern Uganda. 6th August 2007.

Joint Programme Steering Committee, 2007. Minutes of JPSC meeting 29th March 2007.

Ministry of Finance, Planning and Economic Development, 2005. Uganda Poverty Status Report.

Ministry of Finance, Planning and Economic Development, 2004. Poverty Eradication Action Plan 2004/5-2007/8.

Ministry of Health, 2007. Health, nutrition, HIV/AIDS emergency response in Northern Uganda: Update. 25th July 2007. National Health Task Force on Northern Uganda.

Ministry of Health, 2007. Health Policy Statement 2007-2008. Preliminary Draft, June 2007.

Ministry of Health, 2006. The hard-to-reach areas health workers incentive scheme. Draft concept paper. October 2006.

Ministry of Health, 2005. Annual Health Sector Performance Report Financial Year 2004/5.

Ministry of Health. Health Sector Strategic Plan II 2005/6-2009/10.

Ministry of Health, 2004. Emergency health response in northern Uganda. Action plan for the implementation of priority health interventions in 5 conflict affected districts.

Ministry of Health, 2004. Health services for the internally displaced persons in Uganda. Operational guidelines for health care workers.

Ministry of Health, 1999. National Health Policy.

ODI, 2006. Evaluating humanitarian action using the OECD-DAC criteria. An ALNAP guide for humanitarian agencies.

Sphere Project, 2004. Humanitarian Charter and Minimum Standards in Disaster Response. Oxfam.

Uganda GFATM Round 7 Country Proposal

Uganda Joint Assistance Strategy

Uganda AIDS Commission, 2005. Uganda AIDS Status Report 2004.

Uganda Bureau of Statistics, 2006. Uganda National Household Survey 2005-2006: Report on the Socio-Economic Module. December 2006.

Uganda Bureau of Statistics and ORC Macro, 2006. Uganda Demographic and Health Survey 2006. Preliminary Report. November 2006.

Uganda Bureau of Statistics and ORC Macro, 2001. Uganda Demographic and Health Survey (UDHS) 2000-2001.

UNAIDS, 2007. Uganda Country Profile.

UNAIDS, 2006. 2006 AIDS Epidemic Update.

UNDG, 2003. Guidance note on joint programming.

UNDP. Uganda Human Development Report 2005.

UNICEF, 2007 Situation update. Consultative meetings presentation guide.

UNICEF Uganda, 2007. Annual report 2006.

UNICEF, 2005. Country Programme Action Plan 2006-2010.

UNICEF, 2005. Report on the Situation of Women and Children in Uganda.

UNICEF, WHO, UNFPA, WFP, 2006. Emergency health, nutrition and HIV/AIDS response in the regions of Acholi, Lango, Karamoja and the districts of Amuria and Katakwi. 1st December 2006-30th June 2007. Project document. 30th November 2006.

UNICEF, WHO, UNFPA, 2005. Joint inter-agency emergency health, nutrition and HIV/AIDS response in IDP camps in Northern Uganda. 1st January-31st March 2006. Project document.

USAID et al, 2005. Malaria Rapid Assessment Report Uganda.

WHO Uganda. Country Cooperation Strategy.

WHO Uganda, 2007. Brief on activities carried out in Karamoja region. Karamoja Field Office, Moroto. 3rd August 2007.

WHO Uganda, 2007. Health, nutrition and HIV/AIDS newsletter. A publication of the Uganda health, nutrition and HIV/AIDS cluster. Volume 1, Issue 1, June 2007.

WHO Uganda. Health Action in Crisis Programme. Annual report 2006.

WHO Uganda. Health Action in Crisis Programme. Bi-monthly Updates 2006 and 2007.

WHO, 2006. World Health Report. Working Together for Health.

WHO et al, 2005. Health and Mortality Survey among Internally Displaced Persons in Gulu, Kitgum and Pader Districts, Northern Uganda.

WHO, UNICEF, UNFPA, WFP, 2006. MOU between WHO, UNICEF, UNFPA, WFP regarding the operational aspects of a joint programme in Uganda. 1st December 2006.

WHO, UNICEF, UNFPA, WFP, 2007. UN joint progress report for DFID 2. May 2007.

WHO, UNICEF, UNFPA, WFP, 2007. Joint UN emergency health, nutrition and HIV/AIDS programme in North and North Eastern Uganda: Activities and achievements. Presentation, 27th July 2007.

ANNEX 5: BACKGROUND DATA

Improvements in selected PEAP basic health indicators in Northern Uganda

Indicator	2001	2005	2006
OPD utilisation rate	0.61	0.95	1.0
DPT3/HepB+Hib	34%	95.3%	97.6%
% deliveries at health facilities	23%	42%	44.3%
% approved posts filled by trained HW	32%	57%	38%
% monthly HMIS reports received	68.3%	90%	96%

Source: HMIS

UDHS 2000/1 and 2006 preliminary data

	2000/1	2006
U5MR	152	138
IMR	88	76
MMR	505	435

UNICEF data vitamin A and deworming coverage

	2006	2007
Vitamin A supplementation		
Lira	54%	77%
Gulu	98.3%	115%
Pader	114%	89%
Kitgum	92.6%	82%
Deworming		
Lira	35%	97%
Gulu	95.7%	100%
Pader	80%	78%
Kitgum	87.7%	80%