REDUCING AVOIDABLE LOSS OF LIFE AND THE DISEASE BURDEN DUE TO EMERGENCIES IN UGANDA

2008 ANNUAL REPORT

Health Action in Crises in Uganda (HAC) Programme

World Health Organization

WHO's Goal in Emergencies

Before, during and after emergencies, WHO is committed to:

- Saving lives and reducing suffering in times of crises
- Building efficient partnerships for emergency management and ensuring these are properly coordinated
- Advocating for political support and consistent resources for disaster preparedness, response and recovery
- Developing evidence based guidance for all phases of emergency work in the health sector
- Strengthening capacity and resilience of health systems and countries to mitigate and manage disasters
- Ensuring that international capacity is available to support countries for emergency response through training and establishment of surge capacity

Message by the WHO Representative

The year 2008 has been very conducive for WHO's work in emergency in Uganda. This conducive environment contributed to our achievements of major successes during the year key among which are the finalization of the health recovery strategy and plans, roll-out of the VHT concept and a nutrition surveillance system in Karamoja region and successful response to the refugee situation in Western Uganda. Despite these modest achievements there are still many obstacles to effective health recovery and service delivery in all the conflict affected districts of Uganda. For instance, the changing humanitarian context from security and population displacement to relative security and population movement from IDPs to original homeland where access to social services are poor. Humanitarian partners must therefore see this as a challenge which must be promptly addressed not only to improve living conditions in the return areas but also to contribute to sustenance of the peace and stability being currently experienced in the area. The changing context in northern Uganda and Karamoja must also influence and guide the work of all the partners providing assistance in the area.

In view of this, WHO's work in emergency in 2009 and the coming years will focus on providing technical support to the Government of Uganda (GoU) and all relevant partners to recover the health systems of northern Uganda and Karamoja. To effectively do this, we shall review our current strategies and concentrate more efforts on WHO core functions and our primary areas of comparative advantage such as monitoring of the health situation, articulation of evidence-based policy options, setting of norms and standards, providing leadership within the health sector building of effective partnerships for health, nutrition and HIV/AIDS recovery. Of course we shall continue to provide downstream hands-on support to the GoU and partners as the need arises.

In line with the transition from relief to recovery and development, the health, nutrition and HIV/AIDS cluster in Uganda which has been the major platform for coordination of the emergency health response will also need to be reviewed and gradually phased out while phasing in a more GoU led coordination mechanism for the health recovery in the north. To do this, the coordination and management capacities of our government counterparts at the national and district levels must be built to ensure that they can effectively assume the coordination responsibilities for northern Uganda and Karamoja.

Specifically for Karamoja, we hope to increase our presence in order to effectively fulfil our leadership role in health in the region. We also hope to sustain our current activities within the region.

I seize this opportunity to thank the GoU, all our partners, the WHO Regional Office for Africa (AFRO) and WHO Headquarters for their support and cooperation which has made our achievements in 2008 possible. I also appeal for your continued collaboration and partnership as we strive to address the myriads of health, nutrition and HIV/AIDS challenges in northern Uganda and Karamoja in the coming months.

Thank you

Dr. Joaquim Saweka
WHO Representative, Uganda

Pictutre 1:

The WHO/HAC staff in Uganda during a staff retreat held at Lillian Towers in Lira district

ACKNOWLEDGEMENTS

The achievements and contribution that WHO/HAC team made towards the delivery of and improvement in health services in northern Uganda and Karamoja region would not have been possible without the generous financial support from our donors. Special thanks go to our development partners; SIDA, DFID, CERF, ECHO, USAID, the Governments of Italy and Norway. We are also indebted for the support and cooperation from humanitarian partners in the field; NGOs, the Red Cross family and sister UN agencies. We thank the Government of Uganda especially the Ministry of Health and the District Health Teams for the enabling environment. We are also thankful to the beneficiaries of our programs those in the IDP camps and return areas especially the VHT members who have been working relentlessly for the sake of those we serve.

We would further like to thank Dr. Luis Samb, WHO Regional Director for Africa, Dr. Omar Khatib, Regional Advisor EHA AFRO, The EHA team in Afro, and the IST focal person Dr. Michel Yao, for their unreserved support and guidance. Special thanks to the HAC team in the Headquarter for providing all the support we have requested for in the provision of capacity building, and technical guidance.

The HAC team in Uganda specially thank Dr. Joaquim SAWEKA, the WHO Representative to Uganda for his leadership in steering the team towards achieving our objectives. We appreciate the administration and professional staff of WHO country office for their immense contribution and positive attitude.

Finally we thank all those whose names have not been mentioned here but have greatly contributed to our sucess in 2008.

We Look forward to working together with you all in 2009 for a better future!

HAC team Uganda

List of Acronyms

AIDs	Acquired Immune Deficiency Syndrome	**LC**	Local Council
AFRO	African Regional Office	**LRA**	Lord's Resistance Army
ART	Antiretroviral Treatment	**MDG**	Millennium Development Goal
CAP	Consolidated Appeal Process	**MDR**	Maternal Death Reviews
CESVI	Cooperazione-e-sviluppo	**MoH**	Ministry of Health
CDDs	Community Drug Distributors	**MTI**	Medical Teams International
CERF	Central Emergency Relief Fund	**NGO**	Non Governmental Organization
DC	Disease Control	**NPO**	National Professional Officer
DHT	District Health Team	**NTDS**	Neglected Tropical Diseases
DHO	District Health Office	**PHAST**	Participatory Hygiene and Sanitation Transformation
DRC	Democratic Republic of Congo	**PMTCT**	Prevention of Mother to Child Transmission
DSFP	District Surveillance Focal Person	**PRDP**	Peace Recovery and Development Plan
ECHO	European Commission for Humanitarian Aid	**RD**	Regional Director
EHA	Emergency Health Action	**SAM**	Severe Acute Malnutrition
EMOC	Emergency Medical Obstetric Care	**SAM**	Services Availability Mapping
EPR	Epidemic Preparedness and Response	**SIDA**	Swedish International Development Agency
FPA	Final Peace Agreement	**LRA**	Lord's Resistance Army
GAM	Global Acute Malnutrition	**MDG**	Millennium Development Goal
GBV	Gender Based Violence	**TBAs**	Traditional Birth Attendants
GoU	Government of Uganda	**TOT**	Training of Trainers
HAC	Health Action in Crisis	**TPO**	Tran cultural Psychosocial Organization
HAT	Human African Trypanosomiasis	**RDTs**	Rapid Diagnostic Tests
HBMF	Home Based Management of Fever	**UN**	United Nations
HC	Health Center	**UNFPA**	United Nations Population Fund
HDI	Human Development Index	**UNICEF**	United Nations Children's Fund
HIV	Human Immuno-deficiency Virus	**UNHCR**	United Nations High Commission for Refugees
HMIS	Health Management and Information System	**USAID**	United States Agency for International
HPI	Human Poverty Index		Development
IEC	Information, Education and Communication	**USD**	United States Dollars
IDP	Internally Displaced People	**VHF**	Village Health Teams
IDSR	Integrated Disease Surveillance and Response	**WASH**	Water, Sanitation and Hygiene
IRC	International Rescue Committee	**WCO**	WHO Country Office
IRS	Indoor Residual Spraying	**WHO**	World Health Organization
JMS	Joint Medical Store	**WR**	World Health Organization Representative
KIDDP	Karamoja Intergrated Disarmament & Development	**UBOS**	Uganda Bureau Of Statistics

Table of Contents

pages

Table of Contents

pages

Background

1.1 The General Context in Uganda

Uganda is making good progress in its drive towards achievement of the Millennium Development Goals (MDGs) targets; HIV sero prevalence rates have stabilized at 6.4% (although the rate of new infections are said to be on the increase), there is better awareness about HIV and improved access to ART in the country and modest improvements have been made in Infant, under 5 and maternal Mortality rates. However, the country is ranked 154 out of 177 on the Human Development Index (HDI) Scale (2007/08 Human Development Report) with life expectancy at birth being 49.7 years and a Human Poverty Index (HPI) of 34.7.

Natural and man-made disasters such as the over 20 years of civil conflict in the north; cattle rustling, insecurity and recurrent drought in the north-east; floods in the east and recurrent epidemic outbreaks in all parts of the country (especially in the north) contribute significantly to the poor HDI and HPI. The effects of these disasters are often severe due to lack of early warning system for disasters especially at the community level, lack of preparedness, risk and vulnerability reduction mechanisms and inadequate human, financial and material resources needed to effectively prepare for and timely respond to these emergencies. The health consequences of these disasters often overwhelm and destroy the fragile health systems and infrastructures in the country, which in turn results in high morbidity and mortality rates.

1.2 The Humanitarian Situation in Uganda in 2008

Despite the stalemate in the signing of the Final Peace Agreement (FPA) and subsequent collapse of the peace talks between the rebel Lord's Resistance Army (LRA) and Government of Uganda (GoU), the relative peace and stability being witnessed in conflict affected northern Uganda was sustained throughout 2008. This relative peace and stability triggered further population movement from IDP camps back to villages of origin. In 2008, all the remaining IDPs in Lango returned to their original villages and there is currently no IDP camp in the sub-region. In Acholi, although the percentage of IDPs that have returned to their original homelands increased from 2% in 2007 to 12% in 2008, this figure is far below what is expected mainly due to uncertainty of the final outcome of the peace negotiations and lack of social services (water, sanitation, health, education etc) which should serve as "pull factor" to the return areas.

Renewed attacks on LRA positions in DRC by combined DRC, Ugandan and South Sudanese armed forces in December 2008 resulted in fresh LRA attacks on civilians in the DRC with possibility of spill over into northern Uganda, which may trigger population return back to camps for safety.

Despite the launching of the Karamoja Integrated Disarmament and Development Plan (KIDDP) which is aimed at addressing the root causes of insecurity and under development and improve livelihoods in the region during the year, the situation still remains precarious. Although slight improvements were achieved in the security situation in the region, the combined effects of the 2007 flooding, failure of rains in the early part of 2008 (which resulted in crop failure and food insecurity) and several outbreaks of livestock diseases resulted in another nutrition crisis in the region during the year. As early as February 2008, nutrition indicators in the region had deteriorated with some districts having Global

Acute Malnutrition (GAM) rate as high as 15.6% and Severe Acute Malnutrition (SAM) rate of 2.6%. Health indicators in the region also remain below national averages.

The food crisis and insecurity in the region resulted into migration of many peasants to more favourable parts of the region and urban centres in other regions in search of better living and economic conditions. To curtail this migration, the government of Uganda started a resettlement programme through which migrant Karamajongs are returned from urban centres to resettlement camps within the Karamoja region. Currently there are 5 of such camps which accommodates approximately 20,000 returnees (from urban centres) and internally displaced agricultural migrants. Access to social services such as health, education, water and sanitation in these camps are very limited resulting in to very poor living conditions.

Elsewhere in the country, escalation of the crises between the government of DRC and the rebels in the eastern DRC resulted into a refugee influx into western Uganda. As at November 2008, over 10,000 refugees have been registered in the border district of Kisoro, Kanungu and Insingiro with local health care structures being overwhelmed. Early in the year, several hundreds of Kenyan refugees also crossed into eastern Uganda to avoid the post-election violence in western Kenya. In eastern Uganda, the effects of the 2007 floods lingered on till mid 2008 when heavy rains started again in the area. In addition several epidemic outbreaks of Hepatitis E, Cholera, Meningitis, Plague, Ebola and Marburg Viral Hemorrhagic Fevers (VHF) were also reported in various parts of the country.

To respond to the myriads of emergency situations highlighted above, WHO continued to support and complement GoU's efforts in peace building and ensuring population return and recovery in the north and north-east while ensuring that the emergency health concerns of the remaining IDPs, refugees and general population were timely and effectively addressed. In Karamoja, technical and financial support was provided to the districts of the region to implement key focused life saving health and nutrition interventions while advocating for more attention and funding for the region.

Picture 2: WHO staff pack drugs that were delivered to health centres in Kitgum district to support managmnet of Hepatitis E patients

2.0 WHO/HAC's Major Achievements in 2008

2.0 Key Projects

2.1.1 Emergency Health and Nutrition Response in Karamoja

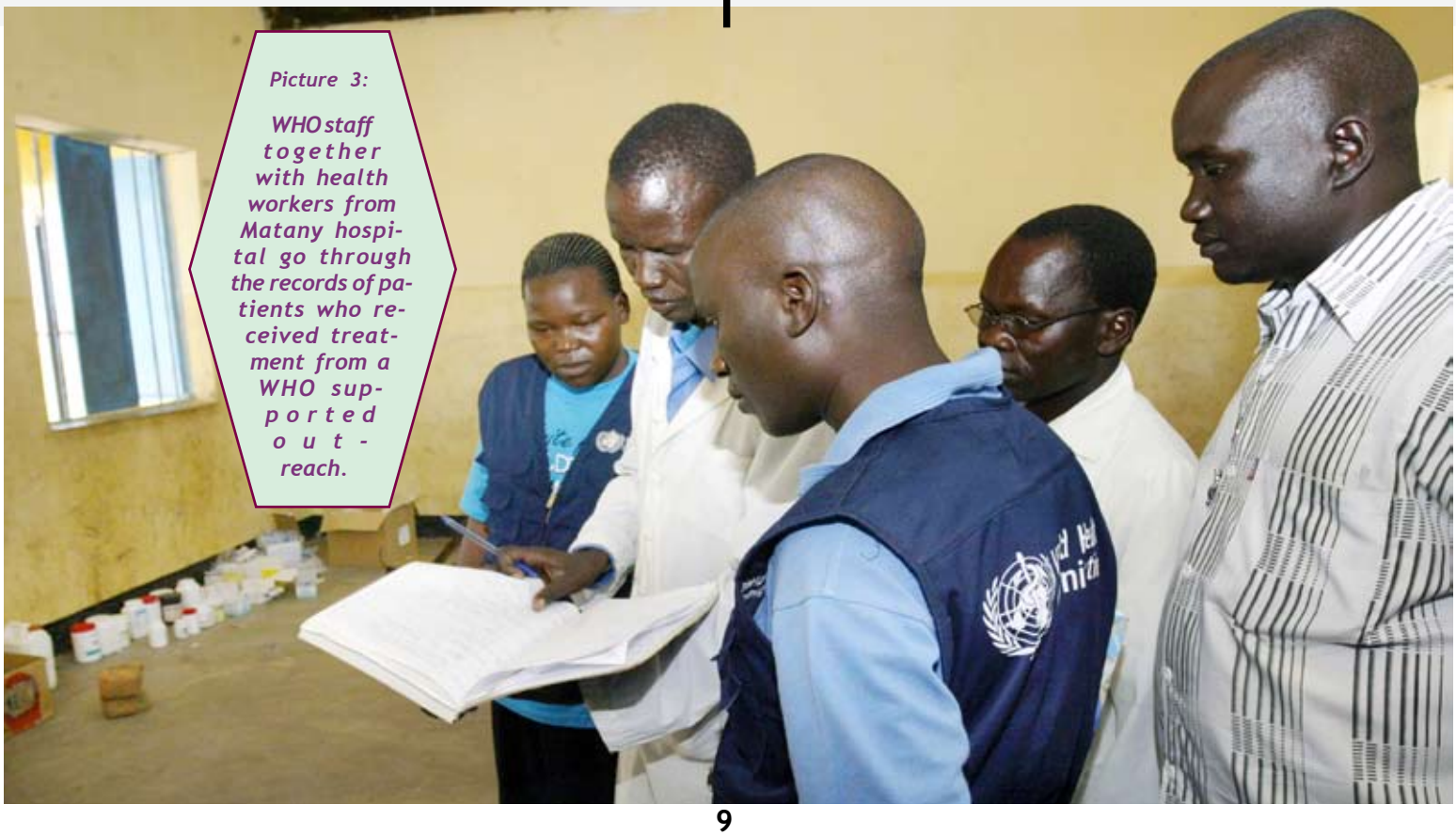
To respond to the worsening health and nutrition situation in Karamoja, WHO with funding from CERF supported the operationalization of the VHT concept in region. Support was provided to adapt the Village Health Team (VHT) manual to the unique context of Karamoja region. Subsequently, 74 trainers, 2300 district and sub county authorities drawn from all the districts of the region were trained and sensitized on the VHT concept and their roles in the programme which strengthened ownership of the VHT concept by the districts.

Through the trained leaders, selection of 3,343 VHTs was conducted from the five districts and so far over 1000 have been trained, provided with incentives and materials such as T-shirts, caps, gumboots, drug cupboards and registers and are currently operational. Being crucial in the implementation of the VHT concept, health workers from all the 91 health units in the region also received an on the job orientation which has enabled the smooth running of the monthly VHT review meetings with support supervision from health unit in-charges.

The trained VHTs were very instrumental in mobilizing communities for the Child Days campaign in the region which resulted into improved vaccination coverage. Furthermore, the VHTs have enhanced information and education at the community level.

In addition, support was provided to strengthen the HMIS/IDSR system through training of district surveillance focal points from the region on basic use of computers, e-HMIS and Nutri Survey software and computers, printers and village phones were provided to aid data collection, storage, analysis and dissemination.

Also under this project, essential drugs, laboratory reagents, medical supplies and kits including 6 cholera and 10 meningitis kits were procured and prepositioned in all 5 districts of karamoja to enhance epidemic preparedness and response. Rehabilitation and equipping of 5 key health facilities was supported to improve access to good quality health services in the hard-to-reach areas of the region. With Community health outreaches to provide basic health services , drought displaced populations were also supported with over 1500 people benefiting from the services.



Picture 3:

WHO staff together with health workers from Matany hospital go through the records of patients who received treatment from a WHO supported outreach.

Picture

WHO staff delivers Health Management Information System reporting forms to one of the Teso districts.

2.1.2 DRC Refugee Response in Western Uganda

Following intensified fighting in the Democratic Republic of Congo between the rebels loyal to Laurent Nkunda and the Government in Goma in September 2008, Western Uganda experienced a big influx of over 30,000 refugees crossing in to the western part of the country. This influx resulted in overstretching of local health services. In collaboration with health cluster partners, WHO provided technical and financial support to UNHCR and the affected districts to conduct rapid health assessments, provide drugs and medical supplies to the local clinic, strengthen disease surveillance and ensure effective coordination of the emergency response to the refugee situation.

Following detection of a cholera outbreak in two reception camps in the area, WHO supported the affected districts by providing 1 cholera kit capable for treating 100 patients for 3 months, training of health workers on stool sample collection and transportation. Cholera treatment guidelines and Information, Education and Communication (IEC) materials were also provided.

2.1.3 Floods Preparedness and Vulnerability Reduction in Teso Region

To ensure adequate preparedness for floods in the flood prone regions of the country, WHO/HAC with funding from the Italian Government supported the re-training of VHTs in the districts of Teso and Bugisu sub-regions. New VHTs were also trained and operationalized in districts that previously did not have VHTs. In addition, 4 malaria sentinel sites were created to monitor the malaria trend in the Teso sub-region, newly recruited health staffs were trained on EPR and IDSR and 54 other health workers trained on drug supply chain management.

Furthermore, the IDSR system in the region was strengthened through provision of IDSR reporting tools and computers.

Picture 5:

A Clinical Officer recruited by WHO attends to an Hepatitis E patient at Mucwini Health Centre III.

2.1.4 Hepatitis E Outbreak Response

In 2008 WHO intensified its technical, financial and logistical support towards the ongoing Hepatitis E response in the districts of Kitgum, Gulu, Amuru and Pader. Through her coordination role, the programme supported the reactivation of the district epidemic management taskforce which comprised of the Medical, Water Sanitation and Hygiene and Education cluster representatives, District Political and Administrative leaders. Support was also provided to reactivate various sub-committees of this taskforce which includes clinical management, surveillance, social mobilization as well as logistics.

To support timely and effective case management of hepatitis E patients, WHO through its HAC programmes provided additional 14 clinical staff to support clinical and nursing care in priority health facilities and Hepatitis E treatment centres in Kitgum district which was the epicenter of the outbreak. Assorted drugs and medical supplies were also procured and distributed to all treatment centers in the district. In addition, the orientation of 300 health workers on HEV in order to enhance early case detection and management, development and printing of standard case definitions, treatment protocols and data collections forms (line lists) were also supported.

Furthermore, sensitization of change agents i.e. the district and community leaders, religious leaders, VHTS and radio and news paper journalists were conducted.

In collaboration with the district health teams, sensitization of communities was also supported through radio spot messages, talk shows, posters and brochures. To respond to the most critical gap of community mobilization and hygiene education/ promotion, WHO recruited 3 temporary Water and Sanitation/ Communication specialists to support Kitgum district hygiene education and promotion. Training of environmental health staff and VHTs in Participatory Hygiene and Sanitation Transformation (PHAST) and communication skills was also conducted This resulted into improved health promotion and education at the community thus a reduction in the number of Hepatitis E cases reported.

WHO also supported the district surveillance teams with daily compilation of Hepatitis E patient's reports from the health facilities, contact tracing of all suspect cases and sensitization of communities in the surrounding homes of the suspects leading to early detection and referral of Hepatitis E cases to health facilities thus reducing community deaths.

Picture 6:

A Clinical Officer of Mucwini Health Centre III recieves drugs from a WHO staff meant to support the managment of Hepatitis E patients

Picture 7: WHO staff together with staff from Dokolo district lay a trap for tsetese flies.

Picture 8: WHO staff meets with health workers in Dokolo Health Center IV to review the progress of the program.

Picture 9: World Health Organization staff examines a suspected case of Sleeping sickness in Dokolo Health centre.

2.1.5 Response to Human African Trypanosomiasis (HAT) in Lango

Lango sub-region of northern Uganda which lies within the tsetse fly belt started experiencing cases of acute sleeping sickness in 2004 caused by restocking of HAT infected cattle and the subsequent cattle trade at the local cattle markets in the districts. As a result Ministry of Health with support from WHO carried out a mapping exercise of the cases and scaled up its support to Dokolo district, the HAT epicenter. Technical and financial support was provided to the district to implement key evidence-based multi-sectoral interventions aimed at preventing further spread of the disease and strengthening capacity of the district to control sleeping sickness. With funding from the Swedish Government, a HAT treatment centre was established in Dokolo district to serve the Lango sub-region, 12 core clinical team members were trained in clinical management of HAT, 30 health workers from all the health facilities of the districts were trained and drugs, medical supplies and reagents for HAT diagnosis provided to the treatment centre. WHO supported procurement and deployment of 1,300 insecticides impregnated pyramidal tsetse fly traps, trained 3 tsetse fly trap keepers from each of the 32 parishes , Sprayed 25,000 cattle with effective vectocide, established 4 animal check points for certification and spraying of cattle on transit within and without the district, provided Information, Education and Communication (IEC) materials to 710 oriented community leaders and conduction of radio talk shows and radio spots on local radio stations. Support was also provided in the orientation of 355 VHTs, 355 village local council chairpersons and 30 district leaders including technocrats on HAT prevention and control.

This was meant to create awareness, facilitate early identification, referral and follow up. Monthly progress review meetings with all the stakeholders, monitoring, technical support and supervision of the implementation process was also supported.

All of the above interventions have resulted in remarkable improvements in HAT case detection and referral at the community level.

2.1.6 Mental Health Response in Acholi

As a consequence of the longstanding civil war in northern Uganda, the prevalence of mental health disorders has increased and is expected to rise further as people return to their original homes. To respond to this problem, WHO (with funding from the Swedish Government) provided technical and financial support to the mental health department of the MOH to districts of Acholi sub-region to plan, implement, monitor and evaluate a mental health programme. This project had 4 components namely strengthening of community mental health support structures, extension of services to the communities through outreaches, building mental health capacity (through training of health workers, provision of essential drugs and distribution of IEC materials on mental health) and operations research to better understand the mental health situation in the area.

To improve the recognition, assessment and management of mental health disorders by health workers, 53 health workers were trained, 4 mental health clinics run by psychiatric clinical officers were established, over 100 community leaders sensitized and over 400 posters and leaflets distributed hence increasing the number of patients visits in the region.

At the community level, 24 VHTs were trained and subsequently supported to organize community awareness meetings on mental health. Three parent support groups with each comprising 20 parents and health worker peer support groups were also formed to support families of mental health patients. Under this project, data was collected on suicide in Gulu and Kitgum districts.

2.1.7 Health Recovery

During the year, WHO continued to support MOH and all 40 PRDP designated districts of the country to plan for health, nutrition and HIV/AIDS recovery. Technical, financial and logistic support was provided to finalize the health recovery strategy and all 40 district specific health recovery plans. The strategy and plans aims to strengthen health systems and revamping health services that collapsed during the conflict and gradually expand coverage in areas where access is limited. Key among the issues that the recovery strategy and plans seeks to address are lack of dedicated structure for health sector recovery activities, difficulties in attracting, motivating and retaining qualified health workers in remote areas and lack of clarity on the precise resource envelope for health recovery of the north.

Picture 10. A dilapidated health centre: WHO is supporting health recovery in the war revenged Acholi sub region.

2.0 Other WHO/HAC Achievements

2.2.1 Coordination

During the year, WHO maintained its presence and continued to support the health, nutrition and HIV/AIDS cluster coordination in all the 14 districts of Karamoja, Lango, Acholi and at the national level. In Karamoja, the establishment of a regional health, nutrition and HIV/AIDS regional coordination mechanisms which brings together all 5 District Health Teams (DHTs) and health stakeholders in the region on a quarterly basis was technically and financially supported by WHO. The inaugural meeting of this body was held in June 2008 while a follow-up meeting was held in September 2008.

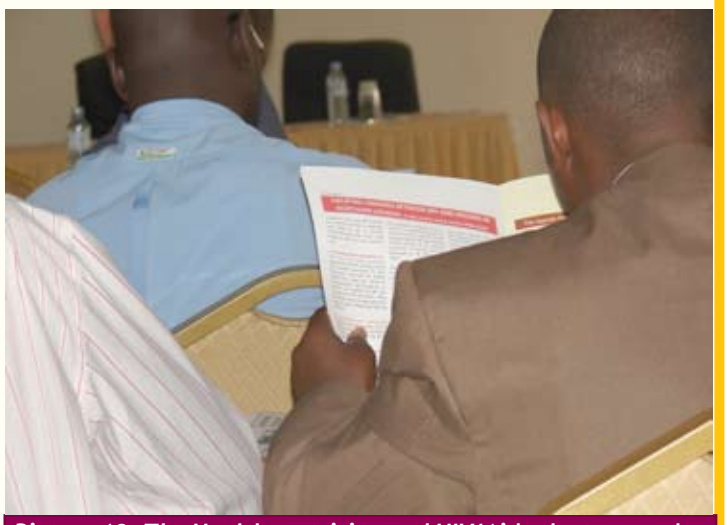
In response to the changing scenario in the north, WHO supported the development of a phased exit strategy for the health cluster coordination mechanism to ensure that the capacity of existing government coordination structures at the national and district levels are strengthened to take over the coordination of the emergency health response and health recovery in the region. The strategy has been finalized and will be negotiated with MOH and district local governments in the first quarter of 2009.

In Lango sub-region, support was given to activate health coordination meetings in districts which hitherto did not have health clusters. In response to the DRC refugee in western Uganda, WHO collaborated with UNHCR to establish a health, nutrition and coordination mechanism for the emergency response at the national and district levels. Regular situation reports, Who is doing What, Where and When (4) matrices and assessment reports were being prepared and disseminated on a weekly basis to inform partners about the situation in the area.

To discuss important emerging issues, strategize and plan for cluster activities in 2008, a cluster retreat was organized in March 2008. During this retreat, key issues such the cluster support to the PRDP and progress, lessons learned and recommendations for VHT implementation were discussed and 2008 cluster strategy and plan were developed.In addition to the above, WHO continued to produce the quarterly health, nutrition and HIV/AIDS newsletter and disseminate information through the cluster website.

Picture 11: Health, nutrition and HIV/Aids working group meet during the health cluster retreat held at Ridar Hotel in Mukono.

Picture 12: The Health, Nutrition and HIV/Aids cluster meeting being conducted at Anaka hospital in Amuru district.



Picture 13: The Health, nutrition and HIV/Aids cluster member reading the health, nutrition and HIV/Aids cluster newsletter during a retreat.

2.2.2 Measurement of ill health and assessments

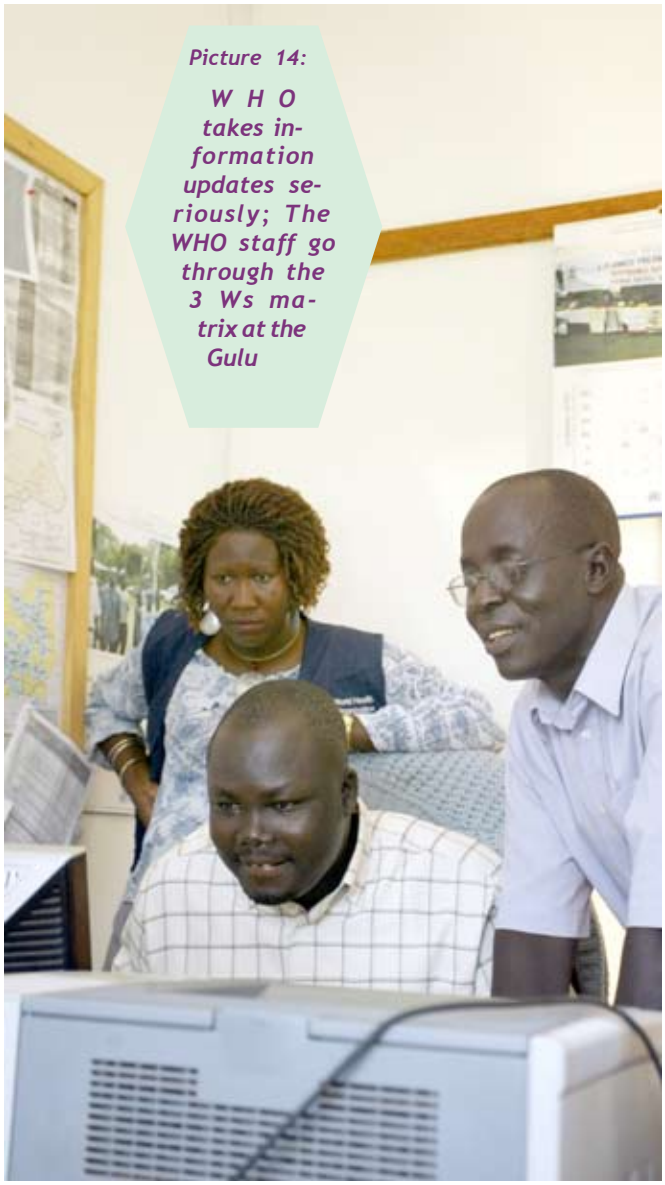
During the year, WHO sustained its technical, financial and logistic support to Integrated Diseases Surveillance and Response (IDSR) in all the 14 districts of the north and Karamoja with completeness reporting maintained at over 80% in all districts ensuring early detection and timely response to all epidemic outbreaks in the area.

In collaboration with the DHTs in Karamoja and relevant partner agencies, a nutritional surveillance system was designed to provide regular nutrition information in between nutrition surveys. This system which will use indicators such as weight for height, weight for age and height for age to monitor the nutrition situation in the region will be rolled out in the last quarter of 2008 using funds obtained from the Central Emergency Response Fund (CERF)

Several assessments including updating of the health Services Availability Mapping (SAM) data in Gulu and Amuru, assessment of returns sites in Acholi, rapid health, nutrition and HIV/AIDS assessment of the DRC refugee situation in western Uganda, epidemic outbreak investigation of hepatitis E in Kitgum, meningitis in west Nile were also supported by WHO during the year.

In collaboration with MOH and Ugandan Bureau of Statistics (UBoS) WHO, technically supported the development of a concept note for a mini Demographic Health and Household Survey (DHS) in Acholi and Karamoja regions. The goal of this survey which will measure key health, nutrition and HIV/AIDS indicators including mortality.

The district level (as opposed to the regional level) is to provide comprehensive district specific health, nutrition and HIV/AIDS data to establish the current



Picture 14: W H O takes information updates seriously; The WHO staff go through the 3 Ws matrix at the Gulu

situation and provide information for priority setting, planning, implementation, monitoring, supervision, evaluation and coordination of recovery and development efforts in northern Uganda. The survey will be carried out by UBoS in the first quarter of 2009 and will be financially supported by WHO.

Following reports of rampant cases of onchoncerciasis in the Acholi sub-region, WHO supported the MoH to conduct rapid epidemiological mapping and investigations of all the reported rumors of the disease in the districts of Kitgum and Pader. The information gathered is being used to guide interventions measures.

2.2.3 Gap identification and filling

Many epidemics outbreaks occurred in Uganda in 2008; key among these were the meningitis outbreak in West Nile and the protracted outbreak of hepatitis E outbreak in Acholi sub-region. In collaboration with other health cluster partners, WHO provided technical guidance, financial and logistic support to the MOH and the affected districts to establish and strengthen active surveillance systems, ensure implementation of activities aimed at preventing further spread of the outbreaks and ensuring effective management of cases. Coordination of the emergency response to these outbreaks was also supported.

In Karamoja, WHO collaborated with the DHTs and health partners to strengthen the health system and address the main drought/nutrition/health related causes of death while in Western Uganda support was provided to respond to DRC refugee influx into the area. In addition, WHO led other cluster members to review the 2008 CAP/CHAP and develop the 2009 CAP documents.

2.2.4 Health system strengthening

In addition to supporting planning for health recovery, WHO provided support to the MOH and districts of northern Uganda and Karamoja to strengthen the health system and implement key health programmes such as reproductive health, HIV/AIDS and Home Based Management of Fever (HBMF) among other interventions. In Lira district, the training of over 500 Community Drug Distributors (CDDs) on Home Based Management of Fever (HBMF) was supported while Maternal Death Reviews (MDR) were supported in 2 health facilities in Apac and Lira districts. Support supervision and on-job mentoring of the ART/PMTCT centers across Acholi, Lango, Teso and Karamoja sub regions was also supported to improve quality of care in these centres.

In Pader and Lira districts, support was given to the district health teams to train all the in- charges of health facilities in the two district on drug supply management. Support was also given to Ministry of health to train 25 District leaders on Indoor Residual Spraying (IRS) monitoring exercises. Lira was provided with logistic support to transport essential medicines and supplies from Joint Medical Stores (JMS) in Kampala and to the district.

Pictutre 15:

Pictutre 16

above & below:

WHO staff carry out support supervision of some health facilities in Gulu district

Pictutre 17

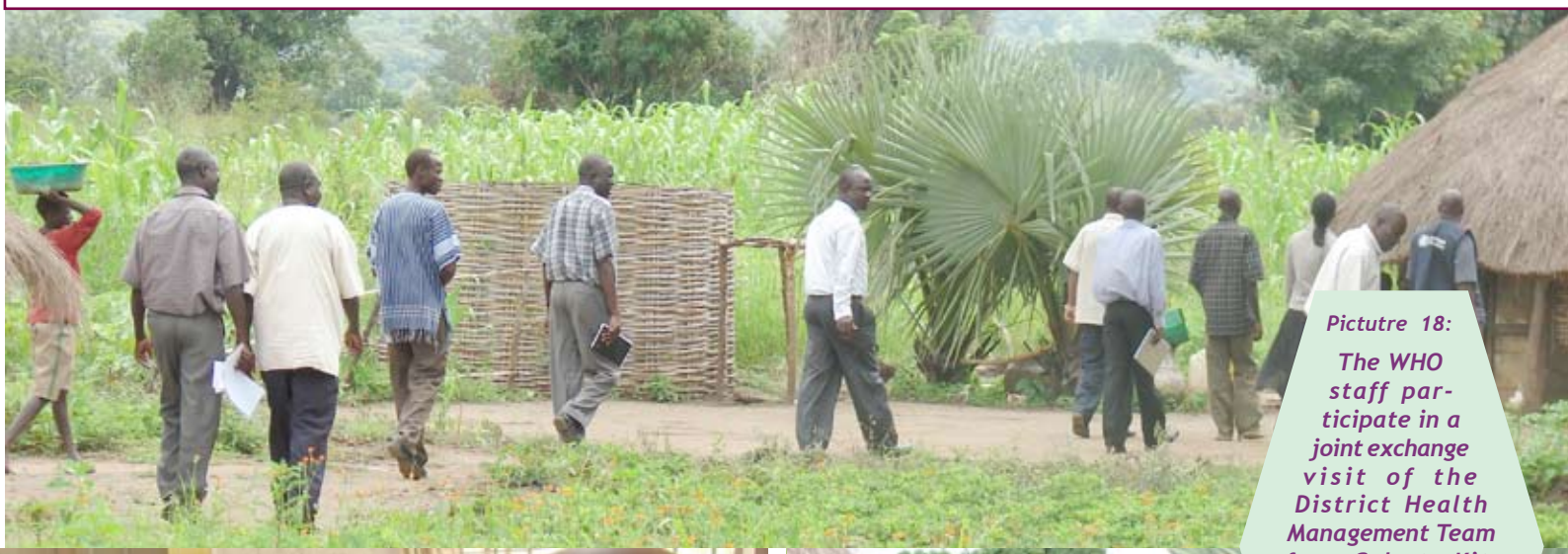
2.2.5 Health Information, Education and Communication

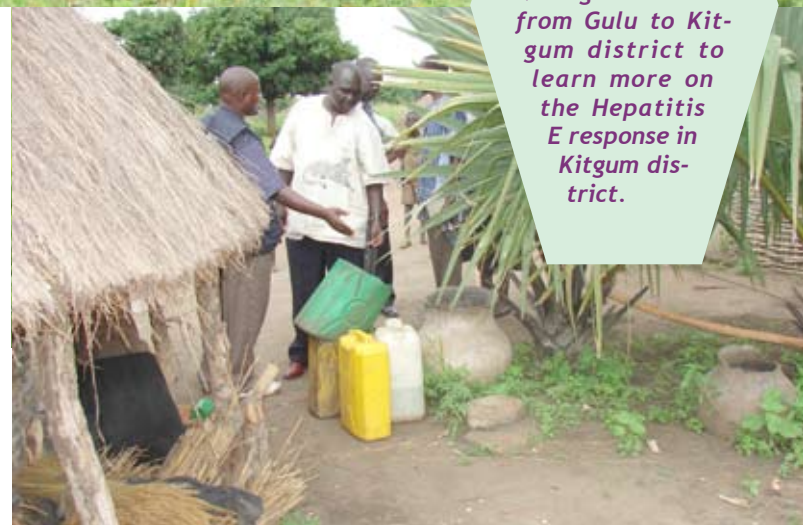
During the year, WHO/HAC provided support in the development, translation, printing and dissemination of several IEC materials for disease prevention and control during emergencies. Radio programs/talk shows, spot messages, films, brochures/leaflets, posters, VHTs Job aids, guidelines for different health programmes in northern Uganda and sensitization of radio and newspaper journalists were also supported to improve health promotion and disease prevention. Public information and advocacy activities were also undertaken by producing an educational film on Hepatitis E and WHO/HAC in action film.

2.2.6 Key partnerships with other agencies and government

As part of its objectives of building partnerships for effective emergency response, WHO continued to strengthen existing partnerships and build new ones during the year. In collaboration with MSF-F, CESVI, Merlin Uganda and UNHCR, WHO participated in a joint assessment of the refugees in Western Uganda. In addition partnerships was built with Institute for Cooperation and Development to rehabilitate 5 health facilities in Karamoja region and the organization also worked with Transcultural Psychosocial Organization (TPO) to implement community-based mental health activities in the Acholi sub-region. In Teso sub-region, WHO partnered with CESVI, an Italian NGO and Pilgrim to support outreaches to communities affected by floods.

These partnerships further strengthened collaboration and information sharing within the health cluster in Uganda and reduced our operational cost as we shared logistics.





Pictutre 18:

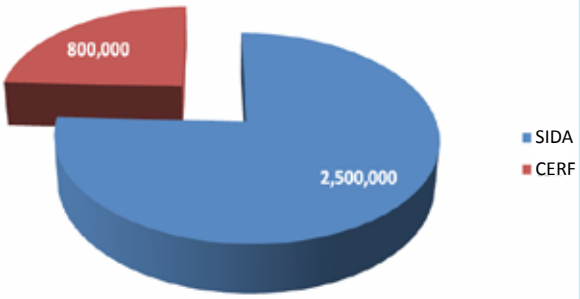
The WHO staff participate in a joint exchange visit of the District Health Management Team from Gulu to Kitgum district to learn more on the Hepatitis E response in Kitgum district.

2.9 Resource Mobilization and Technical Capacity

2.91 Funds

In 2008, WHO mobilized a total of 800,000 USD from CERF and 2,500,000 USD from SIDA to support the implementation of emergency activities at the district and national levels.

Figure 1: Sources and status of WHO/HAC funding in USD: 2008



2.9.2 Staffing

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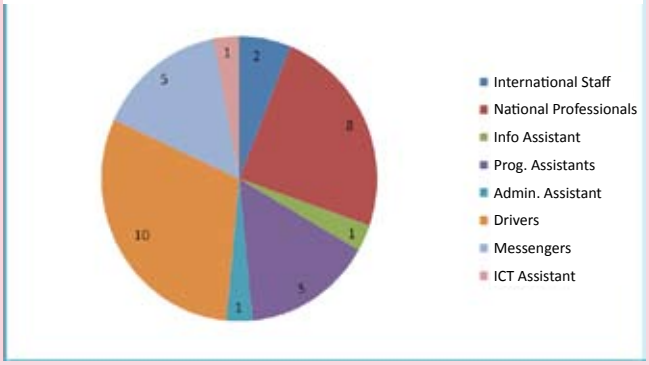
Currently WHO employs 33 staff members who are 100% dedicated to emergencies out of which10 are professional staff (2 international and 8 nationals) while the rest are support staff comprising information Assistant, logisticians, administrators, drivers and cleaners. With the exception of Karamoja and Pader districts that each has one professional staff, the rest of the HAC offices have 2 professionals. At the national level there are2 professional staffs (1 national and international) and an administrative assistant who provide support to MoH to plan, implement, monitor, supervise and coordinate emergency health response all over the country.

Figure 11: Status of WHO/HAC Uganda Human Resource as at December 2008



3.0 Lessons Learned

3.1 Key Conditions

As a result of effective partnerships (within the health cluster), availability of funds, technically sound staff and good logistics, WHO has been able to sustain its presence in northern Uganda and Karamoja in 2008 and consolidate on the achievements made in 2007. Our strategic focus on health recovery and development in 2008 has yielded modest dividends in the sense that a health recovery strategy and plans are now available to guide the MOH and all the 40 conflict affected districts of northern Uganda and Karamoja in rebuilding their health systems. However, there are still major gaps and critical challenges in the health recovery efforts in the north. Filling these gaps remains the most critical problem that needs to be addressed in northern Uganda to ensure that the area catches up with the rest of the country in the coming months and years. WHO therefore needs to strategically position itself and re-profile its emergency operations to effectively provide the appropriate technical support to the MOH and districts in this direction.

In Karamoja region, the roll-out of the VHT concept has been well accepted by the communities, district political and health leaders and has translated into improved health outcomes as can been seen in the markedly increase in the coverage rate of the Child Days Campaign following the roll-out. This demonstrates that if well planned and implemented, community-based health initiatives can be successfully implemented in difficult settings such as Karamoja. The current humanitarian efforts in the region (Karamoja) is not commensurate to the needs hence there is need for all partners to scale up their activities in the area.

3.2 Strengths

The recent activation of the Standard Operating Procedures (SOPs) for emergencies and the delegation of authority from the Regional Director (RD) to the WHO Country Representatives (WRs) have resulted in a more efficient system for emergency response which has greatly strengthened the emergency response capacity and field operations of WHO. Under the new system, decentralization of staff recruitment and procurement to the lowest level possible have resulted in very uimely and more effective emergency response

The field presence of WHO at the district has strengthened our capacity to timely respond to health emergencies. The field presence also means closer proximity to the DHT which has resulted into more effective and timely technical assistance to them (DHTs) thus building their confidence and trust in the organization.

Picture 19: The acting WHO Representative and other staff assessing one of the Hepatitis E centres being supported by WHO in Kitgum district.

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3.3 Weaknesses

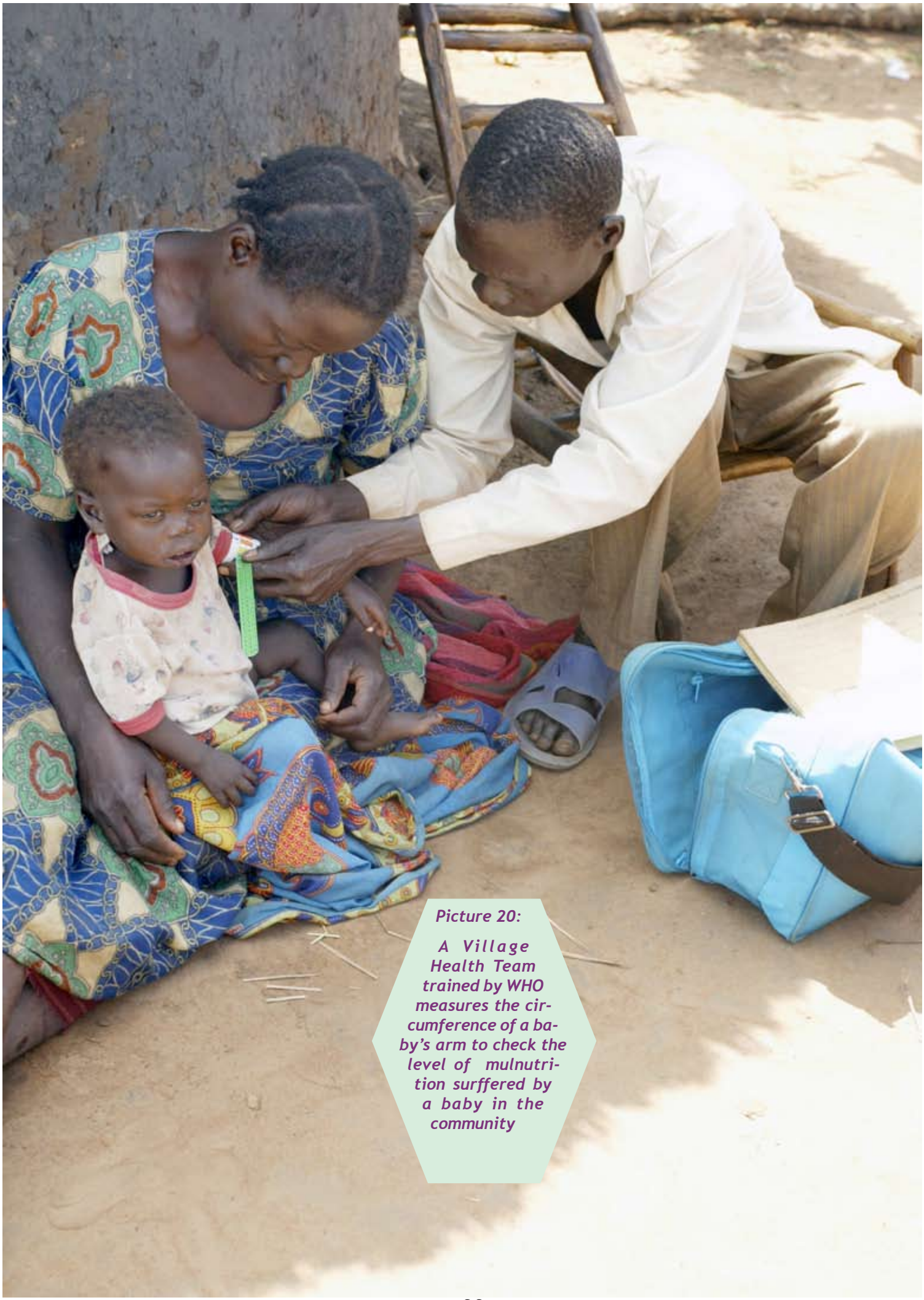
Inadequate funding and slow pace of implementation of the PRDP continue to challenge provision of adequate and good quality health, nutrition and HIV/AIDS service promotion in the return areas of northern Uganda. Staff absenteeism, weak fund absorption capacity, fragmented drug and commodity supply chain management and poor supervision of health activities further compound the problem. Poor community ownership and participation in health services delivery, inadequate emergency preparedness at the district level, fragmented implementation of important health activities such as VHTs, low literacy levels and gender inequality also constraint delivery of good quality health services in northern Uganda and Karamoja.

3.4 Opportunities

Amidst all the weakness highlighted above, a few opportunities to improve health services delivery in the north were witnessed in 2008. For instance, the relative peace and stability in northern Uganda and Karamoja region coupled with reduce incidence of natural disasters and outbreaks witnessed during the year resulted in improved access and scale up of activity implementation in many return areas. The presence of many partners with varying competencies and comparative advantages ensured very smooth emergency response and functionality of more hitherto closed health facilities resulted in more outreaches to underserved areas.

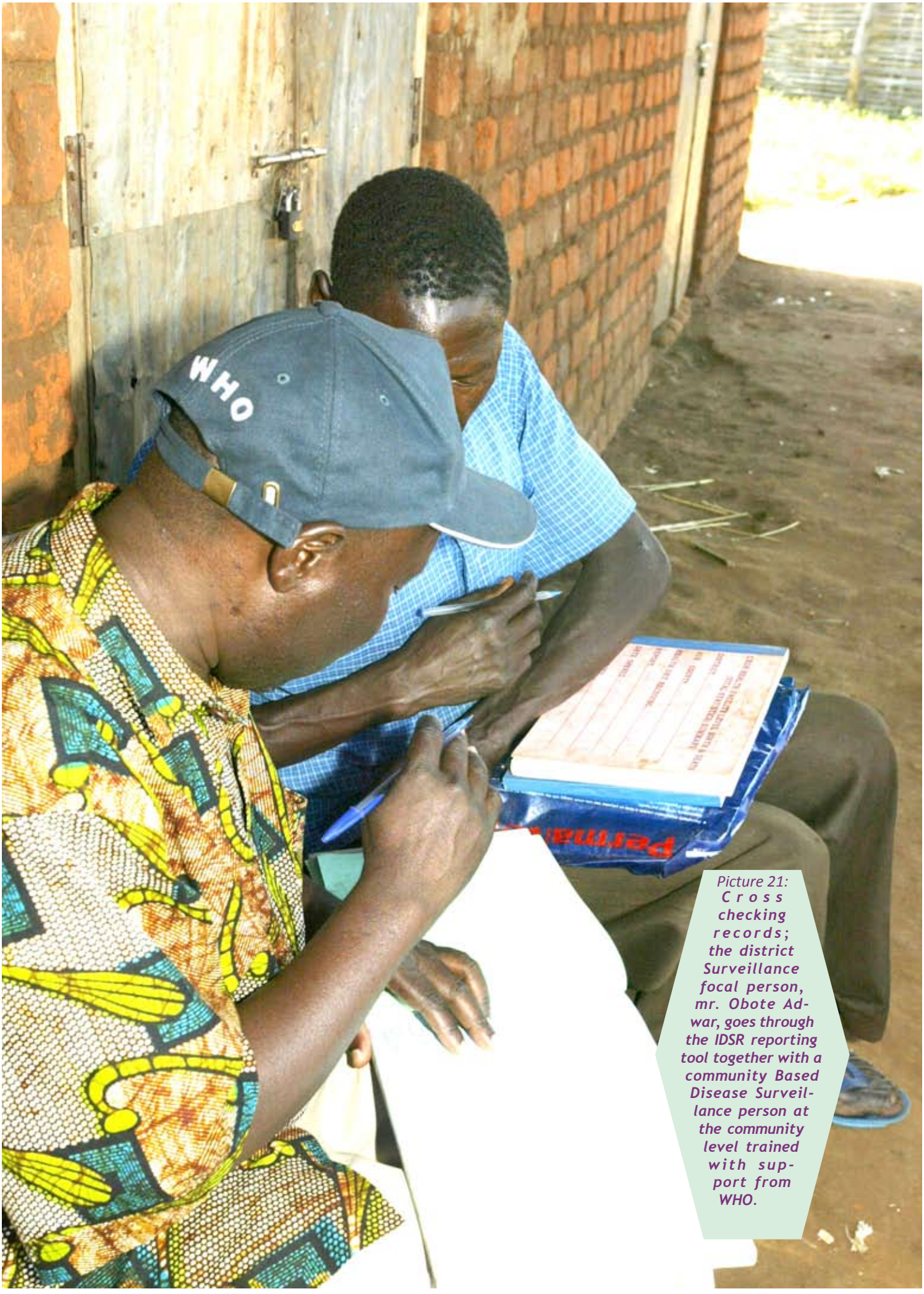
3.5 Threats

The collapse of the Juba Peace Talks between LRA and Government of Uganda has resulted in uncertainty about the future and the security situation in the north the return process. In Karamoja sub region, the inter-tribal conflicts in Karamoja poses a big threat to the delivery of health services to the districts in the region. Frequent and unsustainable demands for incentive by VHTs engaged in humanitarian activities is also a threat in the delivery of health services to the grass root communities.



Picture 20:

A Village Health Team trained by WHO measures the circumference of a baby's arm to check the level of mulnutrition surffered by a baby in the community



Picture 21: Cross checking records; the district Surveillance focal person, mr. Obote Adwar, goes through the IDSR reporting tool together with a community Based Disease Surveillance person at the community level trained with support from WHO.

4.0 Recommendations

In 2009, WHO will continue to work with MOH, the districts and partners to support health, nutrition and HIV/AIDS recovery in northern Uganda and Karamoja. In line with the ongoing transition, the organization will re-adapt its strategies and operations to focus more on the recovery efforts while also ensuring that the remaining humanitarian concerns are addressed. To this end, emphasis in 2009 will be focused more on implementing WHO's core functions including health system strengthening, monitoring and evaluation to provide evidence for decision making and action, disease control, emergency preparedness and response and coordination of the health recovery efforts and as well the leftover pockets of emergencies.

Specifically WHO plans to implement the following:

- Advocate to MOH, district local governments, donors and partners for more support and funding for health, nutrition and HIV/AIDS recovery in the north
- conduct a demographic and household survey which will provide baseline data for monitoring the implementation of the recovery efforts in the north
- Strengthen the HMIS system so that it can be used as an ongoing mechanism to monitor and evaluate the health recovery efforts in the north

Picture 22:

The Kitgum district Surveillance Focal person, Mr. Obote Adwar holds a meeting with Community Based Disease Surveillance members trained with assitstance from WHO

A WHO Publication:

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Production of this report and the work of WHO/HAC Uganda were made possible by generous contribution from the following partners: