HEALTH, NUTRITION AND HIV/AIDS CLUSTER PERFORMANCE REPORT UGANDA

2006

1. BACKGROUND

The Inter-Agency Standing Committee (IASC) was established in June 1992 in response to United Nations General Assembly Resolution 46/182 on the strengthening of humanitarian assistance. The General Assembly Resolution 48/57 affirmed its role as the primary mechanism for inter-agency coordination of humanitarian assistance. According to the General Assembly resolution 46/182, the IASC should be composed of all "operational organizations" and with standing invitation to the Red Cross and Red Crescent Society. IOM and relevant non-governmental organizations can be invited to participate on an ad-hoc basis. In 2005, the *Humanitarian Response Review (HRR),* an independent assessment of the humanitarian agencies' capacity to respond to complex emergencies and natural disasters, was commissioned by the Inter-Agency Standing Committee (IASC) and the UN Emergency Relief Coordinator (ERC). The review underscored the need to urgently address gaps in humanitarian response as main rationale of the approach outlined below.

1.1 Rationale for the Cluster Leadership Approach:

In response to several recommendations from the HRR, the IASC globally adopted a '***cluster leadership***' approach to fill gaps in the humanitarian response. In September and December 2005, IASC Principals endorsed the designated lead agencies in nine critical programme and operational areas.[1] (*see Box 1*). Where it was felt that there are gaps in capacity and delivery, the overall aim of the '***cluster leadership'*** approach served to strengthen the ability of agencies to respond effectively in emergencies through strengthened **coordination, timeliness, accountability and predictabilit**y in the response.

[1] These nine sectors were selected to address critical gaps identified by the HRR. Other sectors, such as food aid and education, have not yet been designated as clusters primarily because the IASC Principals felt these sectors were relatively better coordinated and assistance was being provided effectively. The coordination of these sectors is still vital in crises for example, and organizations such as UNICEF or WFP should continue to lead coordination in areas where they possess the capacity and the mandate to respond effectively, i.e. emergency education and food aid.

Box 1: Cluster lead designation by agency	
Nutrition	UNICEF
Water and Sanitation:	UNICEF
Health:	WHO
Camp Coordination and Management	UNHCR (conflict affected IDPs)
Emergency Shelter:	UNHCR (conflict affected IDPs), IFRC (natural disasters)
Protection:	UNHCR, UNICEF, OHCHR (depending on context)
Logistics:	WFP
Telecoms:	OCHA (overall process), UNICEF (data services) and WFP (security telecommunications service)
Early Recovery:	UNDP

1.2 Cluster leadership development in Uganda

Northern Uganda has experienced a 20 year old conflict between the Uganda People's Defense Force (UPDF) and the Lord's Resistance Army (LRA) that has resulted in displacement of over 1.3 million people (90% of total population) living in Internally Displaced People's (IDP) Camps out of a total population of 1.7 million. Despite improvements in the security situation in the last year the situation continues to remain uncertain with the population still living in camps alongside plans for gradual resettlement of the population. Nonetheless, the prolonged nature of the conflict and encampment has denied the rights of the population particularly children and women to access basic health care, safe water, primary education, protection and shelter making this a severe humanitarian crisis.

Humanitarian indicators in the eastern Karamoja sub-region, characterised by cultural factors and endemic conflict involving the agro-pastoralist Karamojong population, remain consistently lower than national averages. Instability and an intense dry season in the sub-region, comprising Moroto, Nakapiripirit, Kotido, Abim and Kaabong districts, continue to place a burden on the Karamojong, many of whom have moved to neighbouring districts in search of pasture and water, resulting in occasional clashes with the indigenous population. Drought conditions in neighbouring Kenya have also increased instability and cattle raiding between communities on both sides of the border. In the Teso sub-region, an additional 165,000 people remain internally displaced in Katakwi District as a result of the ongoing Karamojong-induced insecurity.

Response to the crises and need for more effective coordination

The Government of Uganda and its partners have been addressing the needs of the IDP's through provision of humanitarian assistance and overseeing their return, resettlement and re-integration through normal sectoral planning of IDPs in such areas as the provision of basic preventive and curative services, water and sanitation, protection, and disease specific interventions. However, it became apparent that there is greater need for coordinated multi-sectoral, multi-disciplinary procedures for government institutions, development and humanitarian agencies, in order to effectively plan and provide humanitarian assistance in the conflict affected districts in northern and north eastern Uganda. The government developed an IDP policy paper and mandated the office of the

Prime Minister, Department of Disaster Preparedness and Refugees (OPM/DDPR) as the overall coordinator for the protection of, and humanitarian assistance for, the internally displaced population. The OPM plays a lead role in ensuring the appropriate response of ministries, other government institutions and humanitarian development agencies to emergency situation of internal displaced people and that the response is well coordinated right from the national level by the Inter Agency Technical Committee (IATC) down through the District Disaster Management Committee (DDMC) to the Sub-County Development Management Committee (SCDMC).

However, within the humanitarian community in Uganda there was general acknowledgement and acceptance that sector management and accountability in Uganda needed to be strengthened. The UN Country Team (UNCT) felt that this could be achieved by making existing and nascent sector coordination groups more robust and accountable, and therefore endorsed "**the cluster approach**" as a unique inter-agency forum for coordination and decision-making involving the key UN and non-UN humanitarian partners.

In Uganda the creation of the IASC-Kampala was one of the recommendations made at the 55th meeting of the IASC/WG in Geneva on 13th November 2003. The members of the IASC in Uganda are government, designated representatives of the UN-Operational agencies (UNDP, UNICEF, UNHCR, WFP, FAO, WHO). In addition, there is a standing invitation to IOM, ICRC, IFRC and Uganda Red Cross, the NGOs Consortia CSNOPNU and representatives of the NGOs. The secretariat of the donor groups on good governance and the donor groups on Northern Uganda Amnesty and recovery from conflict (DGNUARC) are also invited to the meeting. IASC also nominates on an ad-hoc basis representatives of specialized organizations. The United Nations Office of the Coordination of Humanitarian Affairs (OCHA) provides IASC-Uganda with secretarial support.

In November 2005, given UNICEF's capacity and presence in northern Uganda, the United Nations Country Team (UNCT) assigned UNICEF the role of cluster lead for the **Health, Nutrition and HIV/AIDS cluster.** However, this role was to be reviewed in October 2006 when it was expected that WHO would have built capacity to assume his role as cluster lead.

The Health, Nutrition and HIV/AIDS Cluster under the leadership of UNICEF reviewed the IASC generic terms of reference and developed its own strategy and work plan for 2006 (see Annex) to guide the implementation of cluster activities in Uganda. Below outlines the performance and progress of the Health, Nutrition and HIV/AIDS Cluster in 2006.

2. ACHIEVEMENTS

The Health, Nutrition and HIV/AIDS Cluster became operational around March 2006 and replaced the Health and Nutrition Sector Coordination meetings jointly chaired by Ministry of Health (MOH) and UNICEF. Below outlines the achievements of the cluster in 2006 according to 1) Participation, 2) Highlights of achievements according to Cluster work plan developed at beginning of 2006, 3) Interventions carried out and performance indicators.

2.1 Participation

Participation from all sectors of the humanitarian community has been particularly high in 2006 both at national and district levels. This has also been as a result of the addition of the HIV/AIDS sector to the Health and Nutrition cluster. The Ministry of Health and UNICEF co-Chaired and hosted monthly cluster coordination meetings at national level. Participation and attendance varied for individual meetings however, overall the following were involved: Ministry of Health including programme managers from Reproductive Health, Child Health, Aids Control Programme, Malaria Control, UN agencies; UNICEF, WHO, UNAIDS, UNHCR (occasionally), UNDP, WFP, UN OCHA, UNFPA, FAO (occasionally), ICRC, international and local NGOs; AVSI, IMC, ACF, MSF-Suisse, MSF-Holland, Save the Children in Uganda, World Vision, GOAL, CARITAS, NWMT,CPAR,CCF,IRC, Malaria Consortium, UPHOLD, Local NGO's/CBO's: AIC, Health Alert, ACWD, LUNASO. Various representatives of local Governments of Lira, Oyam, Amolatar, Dokolo, Apac, Kitgum, Pader, Gulu and Amuru Districts. Office of the Prime Minister were particularly involved in the meeting to discuss the return and resettlement of IDP's.

2.2 Work plan progress

2.2.1 Coordination, mapping and planning

Activity mapping

Under cluster coordination, activity maps were developed and approved by all partners. Activity maps clearly indicate partner activities and location of implementation. The aim of the exercise is to identify gaps and overlaps and deal with them accordingly. Activity mapping is updated every trimester taking into consideration new and phased out activities as well as new partners and gaps. Minimum package of services for IDP camps based on Sphere project and the Uganda national minimum health care package were developed under cluster leadership.

Monthly cluster coordination meetings

National

A total of ten national level cluster coordination meetings were held in 2006 up to November out of which 2 meetings were held in the districts of Lira and Gulu. Key successes include; a widely attended meeting held in Lira in May 2006 aimed at

sensitizing partners on the cluster approach and involved a field visit to some of the IDP camps. In addition, it was the first forum for partners to provide inputs into Cluster Strategy and work plan developed. A planning meeting for the return and resettlement was held in Lira (6th – 7th Sep 06) attended by the Minister of State for Health in charge of Primary Health Care, Hon. Otim Otala and the Acting Resident Humanitarian Coordinator, Martin Mogwanja. Other successes include Meeting held in Gulu (19th – 21st Sep 2006) to Review Cluster progress and to develop CAP 2007 strategy (could add some details on the outcome of these meetings)

District

Monthly Inter-Agency Cluster meetings were regularly held to follow-up progress in programme implementation at both national and district levels. The meetings have largely been accepted as the forum for key decisions on H&N in the districts. To ensure local government ownership, the cluster coordination meetings at district level are chaired by the respective district health officers. UNICEF as lead agency in 2006 co-chaired the meetings; this has now passed on to WHO. The meetings provided an excellent opportunity for the district and partners to know what progress had been made in responding to the humanitarian situation. It was noted that while the monthly cluster meeting provided an excellent forum for all partners to have a general view of the humanitarian effort, it was too large to be able to focus on the finer programmatic issues faced by implementing partners and the district, as a result sub working groups were proposed and developed with agreed terms of reference. In 2006, Lira and Gulu districts started using the working groups which include among others Malaria, HIV/AIDS, child health and reproductive health, infrastructure rehabilitation and development.(should we attach an annex here??)

2.2.2 Assessments, planning and strategy development

Joint Assessments

In recognition of the continuous changes in camp populations and levels of service delivery to the populations as a result of these movements, joint assessments were conducted from June 2006. The purpose of these assessments was to determine existing services, identify gaps and aid planning for the sector. Health facility assessments were conducted in all districts to determine requirements to functionalize health facilities especially in return areas. As a result, minimum packages for rehabilitation and health care delivery in emergency setting were jointly defined under cluster coordination and a CAP developed and launched by the cluster that will see at least 13(37%) health facilities in Pader, and xx in Kitgum and Lira rehabilitated in 2007. Assessments on population movements and decongestion were also performed with other clusters.

2.2.3 Monitoring, evaluation and reporting

2.2.4 Harmonisation and application of standards

2.2.5 Capacity building

2.2.6 Advocacy and resource mobilisation

2.2.7 Summary of partner submissions (interventions and performance)

The majority of partners within the cluster focused their interventions in the Acholi and Lango regions where activities are coordinated at district level. Primary focus over the last five years has been in Gulu and Lira districts with Apac, Kitgum and Pader receiving less partners. Of more concern is the serious lack of attention to Karamoja region mainly due to its volatile and unpredictable security situation.

Submissions from partners on their 2006 performance were received from the following; AVSI, GOAL, IMC, ICRC, TPO, CESVI, IRC, Malaria Consortium, World Food Programme, IRC, WHO & UNICEF. Annex xx summarizes the key findings.

2.3 Interventions and performance of key indicators

Overview

Humanitarian activities to address vulnerabilities among internally displaced persons (IDPs) in 2006 registered some progress and sustained the lives of approximately 1.5 million IDPs. The improved response was made possible by the implementation of the cluster approach and the increased capacity of both UN agencies and NGOs. These two factors led to a more coordinated humanitarian response and increased the delivery of services in collaboration with the local governments.

A mortality survey carried out in the Acholi sub-region in July 2005 showed crude mortality rate (CMR) of 1.54/10,000/day and under five mortality rate of 3.18/10,000/day. Although no mortality survey was conducted in 2006, progress has been made in the areas outlined below. It is expected that when the mortality survey planned for 2007 is carried out, there will be marked reduction in mortality and morbidity rates in this region.

SELECTED HEALTH INDICATORS ACROSS ACHOLI AND LANGO SUB-REGIONS

Indicator (%)	Kitgum			Pader			Gulu			Lira			Apac		
	04	05	06	04	05	06	04	05	06	04	05	06	04	05	06
DPT3	50	70	82	86	108		114	107		65	82		80	76	
Measles	49	79	85	76	88		111	121		81	83		86	81	
TT2 pregnant	27	25	31	25	41		91	72		49	61		36	40	
IPT2	19	33	49	32	41		52	49		27	37		44	46	
Health unit births	19	19	31	17	35		33	42		17	21		18	27	
OPD attendance															
Nutrition(TFC RR)															
Nutrition(TFC MR)															
Nutrition(TFC DR)															

EPR

During 2006, northern and eastern Uganda witnessed outbreaks of measles, cholera and meningitis. The measles outbreak was contained by a mass vaccination campaign (over 860,000 children were vaccinated) in all the five districts. Coverage was 98% -120% in all districts and a case fatality rate (CFR) of 1.7% was registered. Over 2,000 cases of cholera were reported with a case fatality rate of 1.8% and an attack rate of 0.5% in northern Uganda.

More specifically the **measles outbreak** occurred in the districts of Kitgum and Pader in June of 2006, and affected approx 500 children. The DHT took the lead in coordination and using comparative advantage, different agencies took on different assignments that contributed to the overall response. UNICEF supported the response with logistical support, funds for training and support to district health personnel and procured the measles vaccines used for the mass measles campaigns. WHO took the lead in technical support and surveillance and confirmation of cases. Agencies such as MSF, IMC and AMREF were involved in management of cases in the health facilities while others still such as COOPI, AVSI, AMREF, ICRC, and others took on the role of social mobilization for vaccination providing personnel, and other resources such as transport etc for the campaign.

Cholera epidemic response: The response to cholera in the districts of Gulu, Kitgum and Pader clearly demonstrated the advantage of coordination through the cluster approach. In all districts, a cholera task force was set up including DHT members and agencies from both the H&N and WES clusters. The task force was assigned the duty of managing the epidemic and working groups consisting of case management, surveillance, water and sanitation and social mobilization were constituted by the task force to coordinate efforts in the said areas. WHO coordinated surveillance and case management (NWMTs, MSF, IRC, ICRC, IMC, were involved) while UNICEF coordinated social mobilization (COOPI, AVSI, ASB, MSF, IMC, NWMTs, AMREF) and WES (AVSI, COOPI, AMREF, IMC, URC,). Resources available for the response were pooled/put on the table so that it was easy to respond and avoid duplication of efforts. Gaps were quickly identified and through mapping and having up to date information of partner strengths and activity areas, it was easy to identify who could best fill the gaps.

The Meningitis out break in Gulu and Kitgum affected 78 people leading to mass meningitis immunization campaign in Gulu. All districts developed EPR plans under the cluster approach. The response to the epidemic as well coordinated with participation of all key partners.

Five Emergency Health Kits (EHK) (one to each conflict district) were provided to allow the districts to respond to emergency health situations in a timely and efficient manner. Each kit contains the basic medicines and medical equipment to serve 10,000 persons for 3 months. 487,000 people were vaccinated against meningitis in the affected districts of Nakapiripirit, Moroto and Gulu which registered a case fatality of ….. A national Avian Influenza preparedness and action plan was also jointly developed to respond to the threat of avian influenza which was reported in neighboring Sudan.

Malaria and HBC

The percentage of children with fever who received treatment within 24 hours improved from 71.6% to 79%. This is higher than the 2006 target of 60%. This was achieved through 1) The introduction of the more effective ACTs in all health facilities and at community level as the first line drug for malaria. 600 health providers were trained on the new drug policy. The training of COPRS is on-going 2) The provision of drug kits for the treatment of malaria, diarrhoea and pneumonia to 2,500 Community-Owned Resource People (CORPS) in the five conflict affected districts 3) The training of 12,000 CORPS and VHT members on Home Based Care, including the new module on nutrition, thus improving the scope and quality of treatment to the most vulnerable. ITN coverage reached an average of 28% of pregnant women compared to the national average of 14%. This was achieved through the distribution of 237,000 LLTN.

Child Days

Through the cluster approach, districts were able to involve their partners and UN agencies in planning for and implementing various activities including the mass measles campaigns in Kitgum and Pader as well as mobilize resources for child days implementation that all saw significant numbers of children reached with services. During this period, Vitamin A supplements for children aged 6-59 months and postnatal mothers were administered. Children between the ages of 1-14years were de-wormed using albendazole. Routine & catch up immunization including tetanus toxoid immunization was conducted. There was promotion of family care practices namely: ORT; sleeping under nets for pregnant women and children < 5; hand washing, breast feeding. There have been positive trends in many service coverage areas since implementation of Child days. Vitamin A coverage increased from 51% in May 2003 to 78% in November 2005, with 61% of the districts meeting the national targets. There was no mass de-worming national program before the Child days, but de-worming against soil-transmitted worms nationally increased from 30% (May 2004) to 83% (November 2005), with two thirds of the districts meeting national targets for albendazole. What coverage is reported for the northern districts? Immunization coverage trends have also been positively affected by the child days initiative although the routine immunization programme has been negatively affected. The DPT3 coverage was raised from 83% in 2004 to 89% in 2005. This is above the HSSP I target of 85%. Are all these details necessary??????

Reproductive health

The EmOC strategy was rolled out in 30 including all district hospitals in the north district hospitals. 26 (87%) of these have showed a significant improvement in the progress on the signal functions for EmOC using the Performance Improvement (PI) tool. 682 health workers and 46 managers/administrators were trained on the job for EmOC improvement. Through increased advocacy on the failure to address the key contributing factors to maternal deaths, there has been increased SWAP donor support and a credit line for procuring EMoC equipment has been established in the MoH. Between 2005, the proportion of pregnant women receiving TT2 increased from 40% to 56% in and IPT2 increased from 30% to 37% (2005 to 2006). 4,000 mama kits were distributed to pregnant women at the 4th ANC attendance clinic to ensure clean delivery and also to encourage

women to deliver in health facilities. There was a slight increase in health facility deliveries from 25%in 2005 to 29% in 2006. A total of 25 maternity units (HCIII and HCIV) in both northern and eastern regions were equipped with MCH kits and surgical kits respectively improving access to reproductive health to over 35,000 pregnant women.

Given that neonatal mortality contributes up to 40% of the infant mortality seen in Uganda, a plan of action for new born care was developed and aspects of this have been incorporated in the Home Based Care Manual. 60 health workers were trained as TOTs in EmOC. These will train 200 health workers in HCIVs and, HCIIIs. SGBV action committees have been established at district and camp levels to try and address the rampant cases of SGBV.

Nutrition

Nutrition and health assessments in the conflict affected districts of Gulu, Kitgum, Pader and Lira indicate a decline in malnutrition rates from above 15% Global Acute Malnutrition (GAM) in 2003 to <10% in 2006, achieving the target. Whilst malnutrition rates in Lira and Apac are <10% GAM (emergency cut off), rates have almost doubled in Lira from 2.5% in 2005 to 5.9% in 2006 and stagnated in Apac from 4.4% in 2005 to 4.7% in 2006. Rates in Teso have also increased from 3.1% in 2005 to 5.4% in 2006. Malnutrition in Karamoja remains a problem with malnutrition rates above 10% despite a general improvement from 19% in 2004 to 12% in 2005.

ADD GRAPHS

TFC spread across the northern and eastern regions supported the treatment of over 5,000 acutely malnourished children. The current performance of therapeutic feeding programmes is within recommended targets except for mortality data (target <10%); 81% cured rate, 11% death rate and 7% default rate. This is a slight improvement from 2005 performance data; 79% cured; 13% death and 8% default rate. However, mortality within TFC's remains a challenge and should be addressed by supporting more regular training and strengthening linkages with HCT/ART due to close relationship between HIV/AIDS and severe malnutrition (e.g. about 30% of severely malnourished children are HIV/AIDS positive).

ADD GRAPHS

Expansion of community based management of severe malnutrition has been undertaken in the conflict affected districts by NGOs with support of UNICEF. A total of 1,176 severely malnourished children were treated as part of community therapeutic care (CTC) out of an estimated 3,000 targeted severely malnourished children, achieving 39% coverage via the CTC. Valuable experience and lessons learnt were taken into account in the development of a national guideline on Community Therapeutic Care by MOH with technical support from Valid International, an institution contracted by UNICEF. In 2006,

approximately 6,200 acutely malnourished children were identified and received timely appropriate treatment.

The improvement in the data from CTC and TFC is due to the increased presence of humanitarian actors in the field as well as the on-going on-the-job training of health workers on the National Nutritional Protocol. In addition, due to improved security in northern Uganda, families and communities have had improved access to land to cultivate in some cases as well as the rapid identification of acutely malnourished children by the CORPS in 2006.

HIV/AIDS

At least ….% of young people aged 12-24 years in the 5 districts in Northern Uganda have access to HIV Counseling and Testing (HCT) services IEC for BCC materials and condoms. More than ….% of HIV positive persons especially women and children have access and use treatment services including home-based care. At least 34% of pregnant women now have access to PMTCT services. … % of the identified OVC's in five districts supported in programmes related to HIV prevention and care. All this was achieved through partnering with various NGOs and government counterparts to support activities for prevention treatment and OVC care.

Water and environmental sanitation (WES)

Northern Uganda witnessed a steady progress in the WES sector as there has been a change in investments from springs and hand pumps to motorised (diesel/solar) water supply systems. In IDP camps, safe water access increased from an average of 7 in 2005 to 9 litres/person/day. However, this is below the AWP target of 10 litres/ person/ day. The population to latrine stance ratio now ranges from 40:1 to 60:1. Water and Sanitation Committees (WSCs) and Community Health Clubs were established in all IDP camps. Sanitation Days and home improvement campaigns were implemented in 9 sub-counties. A total of 41 motorized and reticulated water systems benefiting over 200,000 people were constructed. Further, 241 boreholes with hand-pumps, 15 shallow wells with hand-pumps, and 20 protected springs were constructed benefiting over 80,000 people in the IDP camps. Additionally, 317 non-functional boreholes were rehabilitated to renew safe water access to over 95,000 people.

3. CHALLENGES

As in most conflict-affected settings, poor living conditions, insecurity and breakdown of health infrastructure contribute to the high morbidity and mortality. Violent incidents, including killings and abductions, have been documented.[2] However, data indicates that up to 90% of deaths in northern Uganda are a result of communicable diseases and

[2] UNDP and GOU. IDP profiling study. UNDP Uganda. Kampala 2005.

limited access to essential basic health care services[3]. The most important challenges are outlined below:

District capacity
While improvements have been noted in the district health team's capacity to be involved in coordination, implementation capacity is still lacking at lower levels. This is partly due to the critical shortage of health staff in the entire northern region but is also compounded by a lack of effective management of existing staff leading to massive absenteeism from the work place and underperformance of duties. The Joint Review Mission district visit conducted in Kitgum district in 2006 revealed that recruitment and retention of human resources for health is the most critical issue in northern Uganda. In Kitgum and Pader districts, health facilities had 52% and 32% respectively of standard staffing norms[4]. The Service Availability Mapping (SAM) survey showed that doctor to population ratio was 1:11,318, 21,519 and 53,291 in Gulu, Kitgum and Pader districts respectively compared to national ratio of 1:18,600. Only 50%, 9% and 21% of the HC IIs in Gulu, Kitgum and Pader districts respectively had the required HSSP I staffing norms[5]. Most of the trained staff are concentrated at district headquarters, leaving most health facilities with untrained or under-qualified staff.

Commitment and partner internal arrangements
Using the cluster approach initially involved significant amounts of human resource in terms of time for meetings and joint assessments etc. Partner commitment to the process was tested at times and often issues had to be discussed several times and for long periods before consensus could be reached. Partners had to learn to work more closely with each other than ever before and to accept collective responsibilities in some areas. At times partner internal arrangements conflicted when gap analysis required movement from one area of operation to another.

Infrastructure
With respect to the health services infrastructure, availability and functionality of health facilities is a major challenge. Data shows that only 67% and 0% of health centre IV in Gulu and Pader districts, respectively, were functional in 2006[6]. The lower health centers, many of which are located in camps, face severe challenges. Similarly, many larger camps still lack any functional health facilities.

With all these factors, the availability and utilization of basic health care services is a challenge. Although most health facilities offer OPD services, utilization ranges from 0.6 to 1.3 visits per person per year in the Acholi region, less than the expected humanitarian standard minimum of 4 visits per person per year. Coverage of and access to other basic health services for water and sanitation, reproductive health, nutrition, HIV/AIDS, TB

[3] UN and IRC. Health and mortality survey among displaced persons in Gulu, Kitgum and Pader districts, northern Uganda. UN publication 2005
[4] Ministry of Health Uganda. Annual Health Sector Performance Report – FY 2005/6
[5] Uganda ministry of Health, WHO, UNICEF and UBOS .Mapping and Assessment of Health Services Availability in Northern Uganda-April 2006
[6] Uganda Ministry of Health, WHO, UNICEF and UBOS. Mapping and Assessment of Health Services Availability in Northern Uganda-April 2006

and SGBV is limited. Frequent stock-outs of tracer drugs are also common. Similarly, whereas health facility based integrated disease surveillance is well established, the ability to capture health events at the community level is rudimentary.

During the National Health Assembly and Joint Review Mission of October 2006, the issues of human resources for health and functionality of Health Centre IV were identified as national priorities for immediate attention.

Drug & supplies management
The availability and use of drugs and medical supplies in the districts varied greatly in 2006 with the systems in place by the ministry of health often ignored in favor of direct supply to health facilities by various agencies. This has distorted the management of drugs and while MoH has instituted a pull system for medicine supply this has not worked and it is difficult to determine demand and correct usage for drugs and supplies.

Inadequate water and sanitation services: Insufficient water supply remains a major problem in northern Uganda. In 2006, water quantity per person in Acholi sub-region was less than the standard recommended in emergency settings.[8] The same data further shows that only 5%, 0% and 15% of the camps in Gulu, Kitgum and Pader respectively had adequate sources of safe water. Sanitation services are also inadequate. Data from SAM indicated that only 45% of camps in Gulu and 35% in Pader had adequate latrine stances.

Inadequate coverage of prevention and control measures: In northern sub-regions, limited success has been achieved in scaling up malaria and HIV/AIDS prevention. Coverage of household insecticide-treated nets (ITN) and intermittent presumptive treatment (IPT) of pregnant women for malaria remain low. Similarly, comprehensive HIV/AIDS prevention, treatment and care is limited in most of the northern districts.

Coordination: The increasing number of humanitarian actors, the phase-in of the new cluster approach, inadequate government capacity and a rapidly evolving humanitarian context continue to challenge coordination. This can result in inefficient use of resources, uneven distribution of health services, limited coverage and inequitable access to services among the districts.

Low absorption capacity: Poor absorption of resources and accounting capacities of District Directorates of Health Services (DDHS) delay implementation and adversely affect the effectiveness of interventions.

4. LESSONS AND BEST PRACTICES

Child health days experience in Kitgum and Pader
In order to fully maximize the impact of child days for children, Kitgum and Pader districts agreed to work together to reach more children. A 2 day mop up exercise was therefore planned at the end of November to wind up the child days month. Through the cluster meeting, partners were identified in both districts that could help with resources

such as health workers, vehicles and funds to pay outreach workers during the 2 day accelerated program. It was agreed to carry out the mop up in parallel with Kitgum district starting followed by Pader. As a result resources that had been identified were first jointly used in Kitgum then transferred to Pader. A total of 68,847 children under 5 were reached with vitamin A in November compared to 50,174 children in may 2006 in Pader district. EXPLAIN THIS BETTER

Cholera control approach under inter agency approach
The cluster approach was found to be particularly useful during the cholera epidemics in Kitgum and Pader. All key partners came together to support the district in the response; partners formed part of the daily working groups and made resources available more quickly and easily due to this. The larger cluster was kept informed and all key decisions regarding response which sometimes required re allocation to areas not previously covered by a partner were taken to the cluster and decided there. Both the WES cluster and the H&N clusters came together strongly to respond to cholera.

ITN coordination working groups (sub cluster groups)
In lira district the malaria/ITN working group made it possible to streamline ITN distribution in the district. All partners now involved with ITNs distribute them through pre agreed mechanisms that must pass through the office of the DDHS. This has made it possible to better assess coverage and fill gaps. (figures please)

Local ownership
It has also been clearly shown that the cluster approach works best when it complements and supports district local structures. This has been noted in the use of VHTs and CORPs where community participation in the selection of their own members has seen a high acceptance level by them. As a result, corps and VHTs are now a resource that all partners working in an area or camp can easily tap into in order to reach their target groups. NOT CLEAR

5. RECOMMENDATIONS

The Cluster approach should ensure that the comparative advantage of actors is taken advantage of to achieve greater impact at district level.

Districts should be fully supported with the necessary resources to take full responsibility of cluster coordination.

6. WAY FORWARD