

Promoting Effective Coordination of Emergency Health, Nutrition and HIV/AIDS Response and Recovery in Uganda

*Annual Report of the Health, Nutrition and
HIV/AIDS Cluster*

2007

Foreword

The health, nutrition and HIV/AIDS cluster in Uganda has matured over time. Through improved information sharing, intra and inter cluster consultations and collaboration and creation of an enabling environment and space for members to express themselves and actualize their mandates and comparative advantages, the cluster has been able to improve coordination of emergency health, nutrition and HIV/AIDS response in the country.

In the field, the cluster demonstrated that it can deliver if members and other health partners are well coordinated as demonstrated during the emergency flood response in Teso and Bugisu sub-regions during the year. Added value of the cluster was also demonstrated during the recent outbreaks Marburg and Ebola outbreaks in country where the cluster was used as a platform for organizing the national and district level coordination taskforces. I believe that the lessons learned by the cluster during the year have laid a solid foundation for improvement of its activities in 2008.

Despite its achievements so far, the cluster still has many challenges ahead key amongst which are Karamoja and implementation of the Peace Recovery and Development Plan (PRDP). In Karamoja, a region in chronic conflict, health, nutrition and HIV/AIDS indicators are very poor and the humanitarian situation is precarious. The cluster will need to improve upon its presence in the region by encouraging more members to establish presence there and to advocate for more funding to implement key life saving health, nutrition and HIV/AIDS interventions in the region. The uniqueness of the Karamoja situation and problems calls for unique solutions therefore proven health interventions which has worked well in other parts of the country will need to be adapted to suit the Karamoja context in order to improve health and nutrition indicators in the region.

In 2008, the cluster must align its strategies and activities with the changing scenario in the conflict affected districts of Uganda. As the situation evolves from emergency response towards transition, return and early recovery; the cluster must put in place mechanisms to ensure a smooth transition from cluster to sector coordination. To achieve this, the cluster must proactively engage the health sector budget working group and develop effective exit strategies that will focus on building the capacity of sector coordination apparatus to effectively take over coordination of the reconstruction efforts in all conflict affected districts of the country.

Addressing these challenges requires concerted efforts from all cluster members, government counterparts and donors. I therefore seize this opportunity to solicit for your support, collaboration and cooperation to move the cluster forward in 2008.

I thank you very much

Dr. Melville George
WHO Representative (WR) Uganda

Acknowledgements

Our sincere appreciation goes to all those who contributed in one way or the other to the success of the health, nutrition and HIV/AIDS cluster in Uganda in 2007. We wish to acknowledge the immense contributions and support of the donor partners in Uganda who provided the much needed funds and moral support to the operations of the cluster in Uganda. We also acknowledge the support and participation of our government counterparts at the national and district levels, without whom we could not have rolled out the cluster and implement cluster activities during the year. We recognize the support of UNOCHA and the coordinators of all the other clusters who guided and provided us with opportunities for inter-cluster linkages and coordination.

Our gratitude also goes to the heads of all cluster member agencies and the global health and nutrition clusters for providing us with technical guidance and administrative support to handle key cluster tasks and responsibilities.

Last but not the least, the cluster successes achieved in 2007 belongs to those who made it all happen: the cluster members and coordinators at national and district levels! Congratulations to all of you for a job well done!

Health, Nutrition and HIV/AIDS Cluster Members

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAP	Consolidated Appeal Process
CBDS	Community Based Disease Surveillance
CBOs	Community Based Organisations
CERF	Central Emergency Response Plan
CFR	Case Fatality Rate
CHAP	Common Human Action Plan
CHD	Child Health Days
CMDs	Community Medicine Distributors
CTC	Community based Therapeutic Centre
DFID	Department For International Development
DHTs	District Health Teams
EMoC	Emergency Obstetrics Care
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
HC	Humanitarian Coordinator
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
IDSR	Integrated Disease Surveillance and Response
ITN	Insecticide Treated Nets
IRS	Indoor Residual Spraying
LLIN	Long Lasting Insecticide Nets
MoH	Ministry of Health
NGO	Non Government Organisation
OPD	Out Patients Department
OPM	Office of the Prime Minister
PRDP	Plan for Recovery and Development Plan
SAM	Service Availability Mapping
SIDA	Swedish International Development Agency
TFC	Therapeutic Feeding Center
UAC	Uganda Aids Commission
UN	United Nations
UNOCHA	United Nations Office for Coordination of Humanitarian Affairs
USD	United States Dollars
VHT	Village Health Teams
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
3Ws	Who Does What where

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1. Background: History, Rationale and Goals of the Health, Nutrition and HIV/AIDS Cluster in Uganda

In late 2004, the UN through its Emergency Relief Co-ordinator, initiated a process to reform the humanitarian response to emergencies globally. Part of this reform process included the introduction of a cluster approach system whose aim is to improve the predictability, timeliness, and effectiveness of humanitarian response and pave the way for recovery. The approach focuses on strengthening collaborative response with the additional benefits of predictable and accountable leads which will in turn facilitate partnerships among the UN, Red Cross Movement, and Non Governmental Organisations (NGOs) at the global and field levels. At the global level, the approach was expected to build capacity in the key gap areas through consistent access to appropriately trained technical expertise and enhanced material stockpiles and securing the increased engagement of all relevant humanitarian partners while at the field level, the cluster approach is expected to strengthen coordination and response capacity by mobilising clusters of humanitarian agencies (UN, Red Cross-Red Crescent, international organisations, NGOs) to respond in particular sectors or areas of activity with each cluster having a clearly designated and accountable lead as agreed upon by the Humanitarian Coordinator (HC) and the Country Team.

In Uganda, 20 years of conflict in the northern part of the country resulted into a major humanitarian crisis with displacement of over 90% of the population in the Acholi sub-region (and an additional 700,000 persons in Lango and Teso sub-regions) into internal displaced peoples (IDP) camps at the height of the crisis. The humanitarian crisis attracted a large number of humanitarian agencies (local and international) to the north with northern Uganda having 10 to 100s of health partners including NGOs and UN agencies. Due to the large number of IDPs, IDP camps, implementing partners present and insecurity in the Acholi and Lango sub-regions, co-ordination of the health services delivery and emergency response to the health consequences of the conflict was a major challenge.

As part of the UN humanitarian reforms, Uganda was selected as one of the first few countries to pilot the cluster approach. In November 2005, the IASC Principals and Uganda IASC Country Team members designated seven clusters in Uganda including the health, nutrition and HIV/AIDS cluster. The cluster became operational in April 2006 and replaced the health and nutrition working group coordination meetings which previously coordinated emergency health and nutrition response in northern Uganda. The goals of the cluster are to provide leadership in emergency preparedness, response and health recovery to prevent and reduce emergency-related morbidity and mortality; ensure evidence-based actions, gap filling and sound coordination; and enhance accountability, predictability and effectiveness of good quality humanitarian health, nutrition and HIV/AIDS response in Uganda.

This document is the second annual report of the Health, Nutrition and HIV/AIDS cluster activities in Uganda. It summarises the achievements of the cluster, conclusions, lessons learned in 2007 and proffers the way forward and recommendations for 2008.

2 Progress and Achievements of the Cluster in 2007

2.1 Ensuring Effective Coordination of Humanitarian Response

To fulfill its main task of coordinating emergency health, nutrition and HIV/AIDS response in Uganda, the cluster expanded its coordination hubs to six in Kampala, Gulu, Kitgum, Pader, Lira and Moroto districts during the year. Through these hubs, the cluster covers all 14 districts of Acholi, Lango and Karamoja sub-regions. The Moroto district hub was established in 2007 to provide better health coordination in Karamoja, a region where the security situation is unstable. As the need arose during the year, temporary cluster hubs were opened to coordinate emergency health, nutrition and HIV/AIDS response to emergency situations within the country. The cluster was activated in Soroti in September 2007 to coordinate emergency humanitarian response to the flood situation in Teso and Busoga region. The cluster also acted as a platform for the coordination of the Ebola epidemic response in Bundibugyo district and meningitis response in West Nile region during the year.

The cluster currently has over forty members drawn from NGOs, CBOs, government and UN agencies and meets once every month at the national level and district levels. Each cluster hub is divided into technical working groups which are forums for in-depth discussion of topical technical issues. The working groups make recommendations to the cluster for decision making. At the national level, two working groups namely health and nutrition and HIV/AIDS are operational while cluster architecture at the district level varies from district to district. In 2007, 11 cluster coordination and several working group meetings were held at the national level. These meetings provided opportunities for cluster members to share ideas, information and educate each other on key health, nutrition and HIV/AIDS issues through technical presentations. At the district level, Who is doing What and Where (3W) matrices were developed and regularly updated to identify critical gaps in emergency response.

Table I: Cluster Architecture at the national and district levels

Cluster Hub	Working Groups	Chair of Working Groups
Kampala	Health and nutrition	WHO
	HIV/AIDS	Uganda AIDS Commission
Gulu	Nutrition	Gulu Regional Hospital
	Mental health	Gulu Regional Hospital
Kitgum	Malaria	District Health Officer (DHO)
	HIV/AIDS	DHO
Pader	HIV/AIDS and Tuberculosis	District HIV/AIDS Focal Person; co-chair is WHO
	Malaria/Epidemic Preparedness and Response (EPR)/Community Health Services (CHS)/Infrastructure	District Health Inspector (DHI) (District Surveillance Focal Person as alternate); co-chair is WHO
	Reproductive/Child Health and Nutrition	District Health Visitor; co-chair is UNICEF
Lira	Health and Nutrition	DHO; WHO is co-chair
	HIV / AIDS	District HIV Focal Person; WHO as co-chair
Moroto	HIV/AIDS	District HIV/AIDS Focal Person; IRC as co-chair
	Health and Nutrition	Doctors With Africa (CUAMM); co-chaired by Matany Hospital

2.2 Providing Reliable Information for Health Planning and Priority Setting

In recognition of the rapidly changing humanitarian scenario in northern Uganda and to regularly identify gaps in health service provision, cluster members conducted various assessments either jointly as a cluster or inter cluster activity or by individual agencies in 2007. These assessments include among others health facility assessments in IDPs camps and return areas in Acholi and Lango sub-region, assessments of health facilities in the flood affected districts of Teso and Bugisu regions, assessment of areas of return to identify basic needs of the affected population, assessments of health and nutrition status of the population (e.g. health and nutrition survey, maternal death audits etc) in Acholi, Lango and Karamoja sub-regions and health Services Availability Mapping (SAM) survey in Lango sub-region. Other assessments conducted during the year include health and human rights study in Kitgum and Pader, Gender Based Violence (GBV) risk assessment in Padibe east and Padibe west camps in Kitgum district and several nutritional surveys which were jointly conducted by cluster members.

The results of these surveys were used to inform priority setting, health programme planning and to revise the cluster strategy for 2007 and 2008. The report of the SAM survey in Lango was used as a basis for developing project sheets for Consolidated Appeal Process (CAP) 2008, and are currently being used to develop a health recovery strategy and plan for northern Uganda.

2.3 Strategy Development and Planning for Success

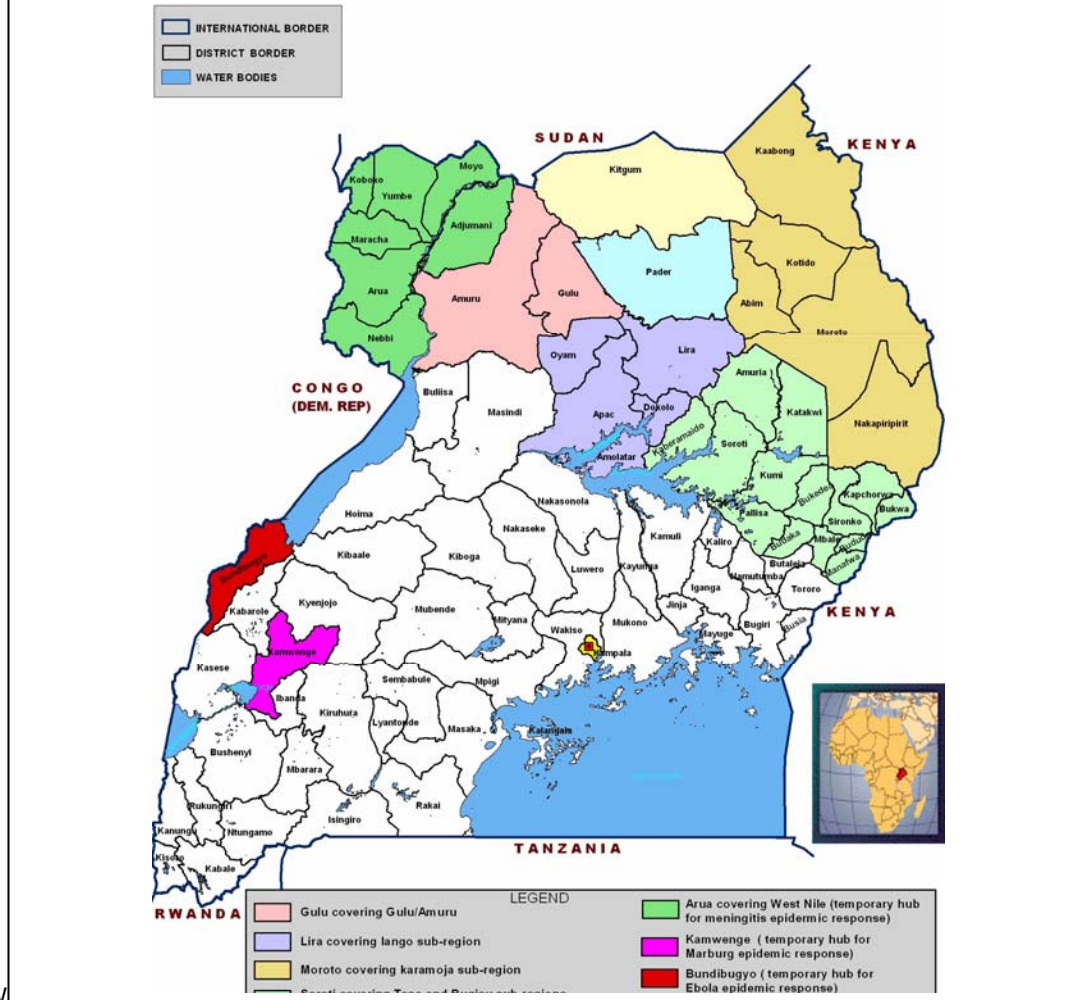
In 2007, the 2006 cluster strategy document was revised to reflect the changing scenario in northern Uganda based on lessons learned from 2006 and a 2007 cluster work plan was developed. The 2007 cluster work plan was over 90% implemented as can be seen in annex I. During the year, the cluster members also developed a cluster contingency plan for 2007, emergency response plan to the flood affected districts of Teso and Bugisu sub-regions, epidemic response plans for meningitis, Ebola, Cholera, Hepatitis E and Marburg epidemics outbreaks which occurred in the country. The cluster also supported Ministry of Health (MOH) to develop a comprehensive health recovery strategy to operationalize the health component of the Peace, Recovery and Development Plan (PRDP) in northern Uganda.

In the flood affected districts, the cluster supported the District Health Teams (DHTs) to develop and implement risk and vulnerability reduction activities as an exit strategy from the emergency flood response. In collaboration with the global health cluster, generic gap identification guidelines were also developed during the year.

2.4 Reducing Duplication of Efforts through Effective Information Sharing

To improve information sharing among cluster members, a quarterly cluster newsletter and a nutrition bulletin were launched during the year. So far 3 editions of the newsletter and 1 of the of the nutrition bulletin have been produced. The newsletter provides technical and general information on health, nutrition and HIV/AIDS issues

Figure I: Health, Nutrition and HIV/AIDS Cluster Hubs and Activities in Uganda in 2007



While the nutrition bulletin mainly presents nutritional data and trends in the country. In addition to these, monthly cluster reports are produced and daily or weekly situation reports are disseminated especially during emergencies. These documents are disseminated through cluster information sharing channels which were established during the year and include the cluster mailing list, cluster website and Google share group which are managed by the cluster secretariat. These resulted in to better information sharing, dissemination and coordination among cluster members.

2.5 Building Capacity of Cluster Partners for Effective Emergency Response

As part of the activities to strengthen the cluster approach in Uganda, a 3-day health, nutrition and HIV/AIDS cluster capacity building workshop took place in Kampala in May 2007. The goal of the workshop was to further strengthen the capacities of health, nutrition and HIV/AIDS cluster members in Uganda to contribute to improved emergency health action. Forty three participants drawn from the United Nations (UN) agencies, NGOs, district local governments, Ugandan AIDS Commission (UAC) and Office of the Prime Minister (OPM) attended the workshop. Topics covered during the course include the international humanitarian system, humanitarian response review, humanitarian reforms and cluster approach, management of health information during crisis, coordinating health in complex emergencies, communicating effectively during crisis, joint health strategy development, transforming health priorities into action and epidemic preparedness, investigation and response among other topics. The training provided a good opportunity for joint planning by cluster members which resulted into a joint health, nutrition and HIV/AIDS plan for

Karamoja which has demonstrated that despite different mandates and ways of working, it is possible for cluster members to jointly plan emergency response. During this training, participants gave very useful feedbacks about the cluster approach which was used to further improve cluster activities and coordination during the year.

In continuation of its capacity building efforts, the cluster also supported some of its members to attend various international courses organized by the global health cluster, WHO and MERLIN during the year. Two cluster members were sponsored to attend the "Public Health Pre-deployment Course" which was held in Moscow in mid-2007 while 3 cluster members attended the "Analyzing the disrupted Health Systems in Countries in Crisis" which was held in Tunisia in December 2007.

2.6 Ensuring Timely Detection and Effective Response to Emergencies

2.6.1 Effective Emergency Preparedness

Based on the lessons learned from the emergencies and epidemic outbreaks experienced in 2006, the cluster developed a health, nutrition and HIV/AIDS contingency plan (see annex II) using different scenarios. Based on this contingency plan, cluster members developed individual emergency preparedness plans and systems in readiness for any eventual emergency. This greatly facilitated timely and effective response to all the major health related emergencies witnessed during the year.

2.6.2 Timely Emergency Response

During the year, cluster members jointly responded to several emergencies all over the country. In Kitgum, Kampala, Pader and Koboko, timely and effective joint cluster response to cholera outbreaks resulted into containment of these outbreaks and Case Fatality Rates (CFR) of 1.9%, 1%, 9.6% and 1% respectively most of which are within acceptable limits. In West Nile region, response was mounted to an epidemic outbreak of meningitis through support to the affected districts in epidemic response coordination both at the national and district levels, provision of drugs and medical supplies for effective case management, training of health workers on epidemic management, social mobilization and strengthening of the disease surveillance system. As a result of the cluster response activities, the epidemic was timely and effectively contained and the CFR recorded was 4.1%, which is within the accepted level of 10% for such epidemics. In Bundibugyo district, which experienced an outbreak of Ebola, cluster members supported the response through provision of technical support for coordination, early case detection, infection control, social mobilization, surveillance and laboratory strengthening.

In Teso and Bugisu sub-regions where heavy rains resulted into massive flooding and landslides which affected several districts, the cluster was activated to support the coordination of the emergency health, nutrition and HIV/AIDS response in the affected districts. Four medical officers/epidemiologist and 2 logisticians were recruited and deployed to the affected districts to provide technical and logistic support to the DHTs. To improve coordination of the emergency response, cluster coordination meetings were held on a weekly basis and in total 14 weekly health cluster meetings were held during the response. Regular cluster meetings were also held at the national level to coordinate national response to the floods while regular meetings were held in Mbale for partners and districts in the Bugisu sub-region. These meetings were very provided a forum for joint planning of weekly activities, information sharing and joint evaluation by cluster partners. Other areas of cluster support to the flood response include rapid health assessments, development of emergency response plan and flash appeal, resource mobilization, organization of outreaches and mobile clinic to the areas that were cut-off, provision of essential drugs, medical kits and laboratory supplies to the affected health facilities, distribution of Long Lasting Insecticide Treated Nets (LLINs) and social mobilization which contributed to reduced morbidity and mortality during the emergency.

2.7 Promoting Good Quality Service Health Service Delivery through Sound Monitoring, Reporting and Application of Standards

To monitor the health nutrition and HIV/AIDS trends in northern Uganda and Karamoja, the cluster identified a set of key indicators in 2007. To some extent some of these indicators were monitored and regularly presented in cluster monthly reports. For instance the completeness of weekly IDSR reports was monitored and reported on a weekly basis throughout the year. To improve the poor percentage of completeness of reporting from health facilities cluster members provided technical, logistic and financial support to all the districts of northern Uganda and Karamoja which resulted in to completeness rate of reporting of over 80% in all districts. Once the completeness rate of reporting reached 80% the data collected from the system was regularly used to monitor weekly disease trends which facilitated timely detection of epidemic outbreaks in the area (see figures I and II). Nutrition indicators such as Severe Acute Malnutrition (SAM) and Global Acute Malnutrition (GAM) rates were also regularly monitored through nutrition surveys and summaries presented in the Uganda Nutrition Bulletin.

During the year, monthly cluster reports were also written starting from February 2007 and disseminated to the Humanitarian Coordinator and cluster members; in all 10 monthly cluster reports were produced during the year.

2.8 Ensuring Timely Identification and Filling of Critical Gaps

The cluster was able to support the district to fill some of the critical gaps identified through the numerous health assessments and surveys conducted during the year. For instance with funding from DFID and Sida, cluster members were able to support the districts in Acholi, Lango, Teso and Karamoja sub-regions to recruit health staff, repair/renovate and construct health units, procure and distribute medical equipments and supplies including Emergency Obstetrics Care (EMoC) equipments. As a result of the payment of incentives to health workers and recruitment of new staff, the proportion of approved positions filled by health professionals increased from 33% to 59.8% in northern Uganda and Karamoja during the year. The most notable increases were in the districts of Lira, Oyam and Dokolo which attained over 90% of the recommended staffing level. Cluster members also supported the rehabilitation and construction of several health facilities (including staff houses). These activities greatly improved access to health care especially in the return areas of northern Uganda. For instance per capita OPD utilization in Lira district increased to 0.95 which is close to the national average of 1. ANC attendance in Lira district also increased from 16% in 2005/6 to 23% in 2006/7.

2.9 Ensuring Good Community Participation using Community-based Health Initiatives and Approaches

In pursuance of one of its key roles of ensuring community participation in health response, the cluster supported many community-based health initiative activities during the year. Cluster members jointly or individually trained several thousands of Village Health Teams (VHTs) in Lango and Acholi sub-regions. In Kitgum, Pader, Gulu/Amuru districts and Lango sub-region, cluster members trained and operationalized 3541, 2493, 1315 and 4000 VHTs respectively during the year. These VHTs are currently providing basic health services such as health education, distribution of condoms, treatment of dehydration and malaria in children under five years of age. In Kitgum district, a Community-based Disease Surveillance (CBDS) system using VHTs was rolled out and is being used to monitor disease trends at the community level. Several Community Medicine Distributors (CMDs) were also trained.

2.10 Building Strong Partnerships and Enhancing Advocacy for Resource Mobilization

Under the guidance of the humanitarian coordinator, UNOCHA and together with the other clusters, the health, nutrition and HIV/AIDS cluster participated in the development and mid-year review of the 2007 Common Humanitarian Action Plan (CHAP) and Consolidated Appeal (CAP) in Uganda. Based on the 2007 CAP, cluster members raised 21, 331, 771 USD out of the 47, 508, 348 USD which was required in the 2007 CAP which represents 45% funding level. An additional 880,000 USD (750,000 from CERF and 130,000 from Italian Government) were also raised through a flood flash appeal to respond to the health consequences of the floods in Teso and Bugisu sub-regions while 1, 000, 000 USD was raised for the Ebola epidemic outbreak response in Western Uganda.

During the year, the cluster was able to foster partnerships between members in order to improve our response capacity to mental health problems in the north, flood response in Teso and various epidemics. The cluster also succeeded in building inter-cluster partnerships with the WASH cluster to jointly respond to the outbreaks of cholera and Hepatitis E in Kitgum district

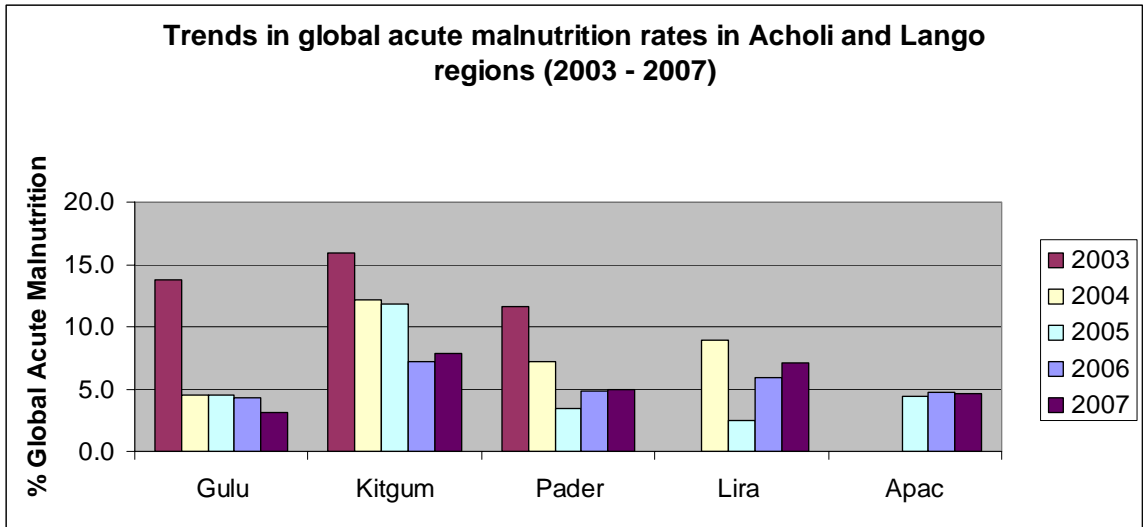
2.11 Putting all Hands on Deck for Effective Health, Nutrition and HIV/AIDS Service Delivery

2.11.1 Malaria

Malaria is the main cause of morbidity and mortality in Northern Uganda and contributes to between 40-50% of disease burden and death in Under-5 Years. In 2007, the cluster promoted and supported Indoor Residual Spraying (IRS) as a malaria vector control strategy. Cluster partners supported MOH to conduct baseline epidemiological, entomological and environmental surveys in selected areas of Gulu, Amuru, Kitgum and Pader districts to collect baseline data for monitoring IRS. Spraying was supported in Gulu, Amuru, Kitgum and Pader districts with coverage rates of 98%, 99%, 91.1% and 94.3% achieved respectively. Distribution of Insecticide Treated Nets (ITNs) was also widely supported by cluster members in all the districts resulting into an ITN coverage rate of 41.8% among the IDPs of the north.

2.11.2 Nutrition

Nutrition surveys in 2007 indicated that the nutrition situation in conflict affected districts of northern Uganda continues to improve, with the exception of deterioration in Lira district, where there has been a slight upward trend since 2005. This is attributed to inadequate access to basic services in areas of return. Prevalence of severe malnutrition reduced from 2-7% in 2003 to 1-4% in 2007. However, the nutrition situation in Karamoja show levels above the emergency threshold (>10% Global Acute malnutrition) underscoring the need to scale up nutrition interventions in the region. On a positive note, cluster members' support for therapeutic feeding of severely malnourished centres in Karamoja was initiated for the first time in the region both in Matany Hospital and Kaabong Hospital.



A total of 5,740 severely and 46,372 moderately malnourished children were treated through feeding programmes (therapeutic and supplementary respectively) in 2007. The overall death rate of 9% is within the acceptable 10% level according to SPHERE (Humanitarian Charter and Minimum Standards in Disaster Response).

2.11.3 HIV/AIDS

The combined efforts of cluster partners largely contributed to an increase in the number of eligible HIV/AIDS patients who are accessing Anti-Retroviral (ARVs) Drugs from 8394 in 2006 to 10,467 in 2007 representing an increase of 20% in northern Uganda and Karamoja regions.

3 Looking Backwards: Conclusions and Lessons Learned in 2007

3.1 Important Conclusions

Despite the challenges initially faced, the health, nutrition and HIV/AIDS cluster has succeeded in clearly establishing itself as a coordination body within the health sector of Uganda in general and northern Uganda in particular. The cluster has been able to improve coordination, gap identification and filling, joint planning and implementation of emergency response and information sharing all of which contributed to improved health outcomes within the health sector of the country. The development of yearly cluster strategic document and plan, wide dissemination of cluster guidance notes among members and the cluster capacity building workshop facilitated better understanding of cluster roles, responsibilities and benefits by the cluster members and contributed to improved response of the cluster to the humanitarian crisis in the Uganda. The use of thematic working groups within the cluster shortened duration of meetings while improving their quality hence making the meetings more productive. It is hoped that these modest achievements will contribute to reduction in morbidity and mortality in northern Uganda over time.

However, there is still plenty of room for improvement in cluster coordination mechanisms and activities in Uganda. In 2007, joint supervision, monitoring and evaluation of the CAP 2007 and cluster activities was inadequate and there is need to pay more attention to this area in 2008. Geographic coverage of all IDPs camps and return sites with health, nutrition and HIV/AIDS services remains a challenge that the cluster need to address in the coming months. For instance, although the number currently on ART in northern Uganda and Karamoja is sizable and better than many other parts of the country, it represents only 39% of the projected 27,000 patients who should be on treatment in these regions. In addition, frequent stock-out of ARVs and HIV testing kits remains a major challenge to access to HIV/AIDS services in the ART sites. As evidenced from the Services Availability Mapping (SAM) survey done in Acholi in 2006 and Lango in 2007, availability of treatment is still skewed to the urban centres. Population returns to their original homes will further compound this skewing making access to ART services more difficult. The cluster will also need to focus on implementing key nutritional interventions to address the deteriorating nutritional situation in Karamoja and some parts of Lango in the coming months.

3.2 Major Lessons Learned

3.2.1 Strengths

- The presence of existing coordination structures and mechanisms at the national and district levels prior to the evolution of the cluster provided a foundation on which the cluster was built. The cluster was able to harness the achievements and resources of these pre-existing mechanisms to facilitate its roll-out. This underscores the importance of government participation in coordination in crises where government structures are still intact
- The very good participation in cluster activities by cluster members including district health teams, NGOs, UN agencies and donor partners contributed in a big way to the success of the cluster during the year.
- Excellent collaboration and technical support to the cluster by UNOCHA, the Global Health Cluster and other clusters such as WASH also contributed to the achievements of the cluster in 2007
- Good response from donors who provided the much needed funds for the cluster operations was also critical to the cluster success in 2007

3.2.2 Weaknesses

- The introduction of the cluster approach into the country was done using a top-down approach which resulted in initial misunderstanding of the concept. This coupled with lack of

information, reference materials and implementation guidelines about the approach caused initial resistance by some humanitarian actors to embrace the cluster.

- ☑ The complexity and multiplicity of humanitarian actors present in the country all with different mandates and ways of working often makes joint planning and consensus building difficult.
- ☑ At the district level, there is still very low capacity, knowledge and skills for health coordination especially within the district health structures.
- ☑ The rapidly evolving humanitarian context also continues to challenge priority setting, planning and effective coordination of health response in the conflict affected districts.
- ☑ Although the response from the donors to the cluster has been very commendable, lack of cohesion among some donors, communication and information sharing gaps between donors often results into duplication of funding and makes effective coordination difficult.
- ☑ Presence of many parallel co-ordination structures and mechanisms at the national level which often makes coordination difficult
- ☑ Competition and battle for turf among cluster members often makes working together and gap identification and filling difficult

4 The Way Forward in 2008: Strategies and Plans for 2008

In 2008, the cluster will strive to sustain its achievements in 2006 and 2007 and re-position itself and re-adapt its strategies to respond to the evolving humanitarian scenario in northern Uganda and Karamoja. In the coming months, the cluster will continue to advocate for more funding to address the myriad of gaps in the return areas, scale up capacity building activities for more effective response, strengthen information sharing and dissemination and encourage more joint planning, implementation, supervision, monitoring and evaluation. In Karamoja where longstanding conflict has resulted in deterioration in health service delivery and indicators, the cluster will scale up its presence by using a regional coordination mechanism to support health, nutrition and HIV/AIDS programme planning, implementation, coordination, supervision, monitoring and evaluation in the region.

Specifically the following activities will be implemented by the cluster in 2008:

- Provide technical support and guidance to MoH and DHTs to develop comprehensive and costed health recovery plans for all PRDP districts in northern Uganda and to finalize the health recovery strategy
- Pilot test a Health and Nutrition Tracking Service (HNTPS) which will aim at using existing health information collection channels and data to provide data for monitoring and evaluation of the health recovery process in northern Uganda and Karamoja
- Develop and implement an exit strategy and plan for smooth transition and handover of emergency health, nutrition and HIV/AIDS coordination from the cluster to the sector
- Pro-actively engage the health sector working group at the national level to ensure a smooth transfer of coordination from cluster to MOH
- Continue to respond to any health, nutrition and HIV/AIDS related emergencies in the country
- Build the capacity of cluster members on health in transition and health recovery and continue to advocate for and provide support to MOH and districts to strengthen the health systems in the conflict affected districts of the country

