Country Situation Analysis

Northern Uganda

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Contents

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ReBUILD Uganda Research team

Abbreviations

AIDS	Acquired Immune –Deficiency Syndrome
ARC	American Refugee Committee
CAP	Consolidated Appeal Process
CBHI	Community Based Health Insurance
COHRED	Council on Health Research for Development
CSA	Country Situation Analysis
CSO	Civil Society Organisation
CSOPNU	Civil Societies for Peace in Northern Uganda
FB-PNFP	Facility based private not-for-profit
GDP	Gross Domestic Product
GHI	Global Health Initiatives
HC	Health Centre
HIV	Human Immunodeficiency Virus
HMIS	Management of Health Information Systems
HRH	Human Resources for Health
HSD	Health Sub-districts
IDPs	Internally Displaced Persons
IMR	Infant Mortality Rate
INGO	International Non Governmental Organisation
LRA	Lord's Resistance Army
MMR	Maternal Mortality Rate
MoFPED	Ministry of Foreign Affairs
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NCDs	Non Communicable Diseases
NGOs	Non-governmental organizations
NUMAT	Northern Uganda Malaria, AIDS and Tuberculosis program
NUREP	Northern Uganda Recovery Plan
NUSAF	Northern Uganda Social Action Fund
OPM	Office of the Prime Minister
PHPs	Private health providers
PLHIV	Persons living with Human Immune virus
PMTCT	Prevention of mother to child transmission
PNFP	Private, not-for-profit

PPPH	Public private partnership for Health
PRDP	Peace, Recovery and Development Plan
PTSD	Post traumatic stress disorder
SWAp	Sector-Wide Approach
TCMP	Traditional and Contemporary medical practitioners
U5MR	Under-five mortality rates
UBOS	Uganda Bureau of statistics
UCMB	Ugandan Catholic Medical Bureau
UDHS	Uganda Demographic health survey
UMMB	Ugandan Muslim Medical Bureau
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNOCHA	UN Office for Coordination of Humanitarian Assistance
UOMB	Uganda Orthodox Medical Bureau
UPDF	Uganda People's Defence Forces
UPMB	Ugandan Protestant Medical Bureau
USAID	United States Agency for International Development
USH	Uganda shillings
VHT	Village Health Team

1 Introduction

1.1 Background to ReBUILD project

15 of the world's 20 poorest countries have endured violent social and political conflicts since the 1980s (Bezar & Mohammed, 2009). Conflicts contribute to poor public health and hinder health system development. These countries include Uganda, Zimbabwe, Cambodia and Sierra Leone, which are at different levels of recovery. While Cambodia and Sierra Leone have been recovering from conflict since 1991 and 2002 respectively, northern Uganda and Zimbabwe are still in the early stages of recovery.

This presents an opportunity to study health systems at different phases of post conflict recovery. Although there is an overwhelming body of health systems research worldwide, there has been a tendency to neglect post conflict settings. If research on this topic were to be conducted, it could inform decision-making in the early post-conflict period and set the direction of development for the system.

The overall purpose of ReBUILD is *"to deliver new knowledge to inform the development and implementation of pro-poor health systems in countries recovering from political and social conflict"*. The main area of focus in this report is northern Uganda, specifically the Acholi sub-region.

1.2 Background to Northern Uganda

1.2.1 The fluidity of Northern Uganda

The ReBUILD project will focus on post conflict Northern Uganda, in particular the Acholi sub-region. We will compare the Acholi Sub-region with other neighbouring post conflict and non-post conflict areas. The Acholi sub-region now consists of seven districts, as shown in Table 1.

Table 1.2.1: Districts in Acholi sub-region

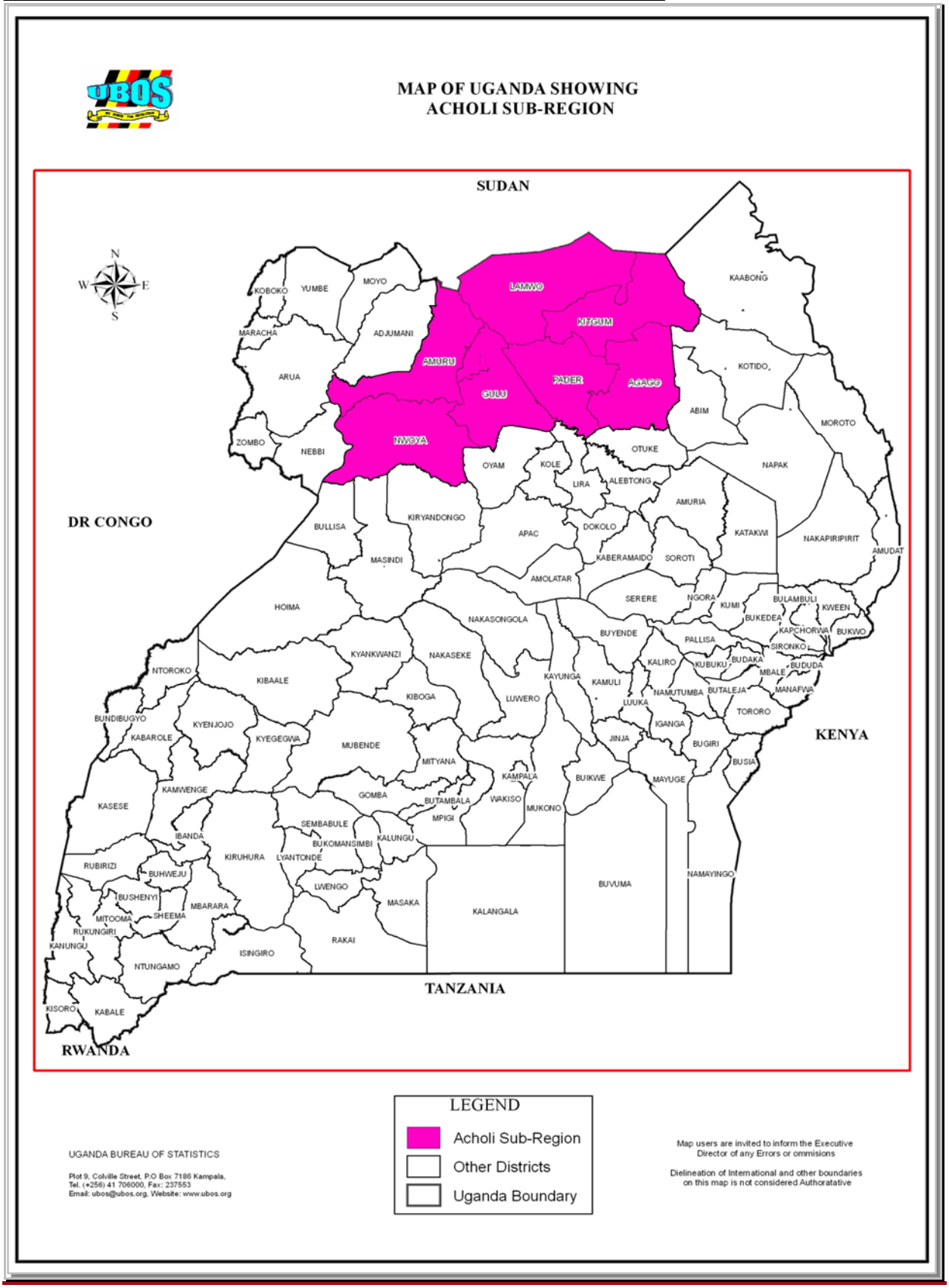
#	District	Year of formation
1	Kitgum	Mother district(before the conflict)
2	Gulu	Mother district (before the conflict)
3	Pader	December 2001 (from Kitgum)
4	Amuru	2006 (from Gulu)
5	Nwoya	July 2010 (from Gulu)
6	Agago	2010 (from Pader)
7	Lamwo	2009 (from Kitgum)

Source: Compiled by research team

Table 1.2.1 indicates that a number of districts have been created from 'mother' districts since 2001. According to Uganda Article 179 of the 1995 Constitution, the creation of new districts enables "effective administration and helps bring services closer to the people" (Parliament of Uganda, 1995). The research team obtained a map of Uganda from the Uganda Bureau of Statistics (UBOS) during the data collection period in June 2011. Figure 1.2.1 shows the total number of districts in Uganda (n = 112). The Acholi sub-region is shaded in pink[1]

[1] The reference for figure 1.2.1 does not appear in the reference list at the end because it was obtained by special request from the Uganda Bureau of Statistics.

Figure 1.2.1: Map of Uganda showing the Acholi Sub-region



1.2.2 Post conflict socio-economic profile of Northern Uganda

Available literature shows that Northern Uganda is lagging behind the rest of the country in terms of the Human Development Indices (HDIs) and Human Poverty Indices (HPIs) at regional and district level.

Figure 1.2.2: HDI by region (2003-2006)

Source: The Human development report 2007

Although the data in Figure 1.2.2 indicates that the national HDI had improved to 0.88 in 2003 from 0.581 in 2005, there were regional imbalances that were skewed against Northern Uganda. The Central region posted the highest HDI of 0.637, followed by the Eastern region (0.588) and the Western region (0.563). The Northern region tailed with an index of 0.499. Significant improvements were noted for the Central, Western and Eastern regions, however the low HDI in the Northern region was affected by the conflict, and contributed to a much lower national HDI overall.

Furthermore, whereas Uganda's national income per capita is estimated at Ushs. 570,000 (approximately US$ 320), the figure for the North stands at just Ushs 153,000 (almost one quarter of the national average). Although income poverty at national level fell from 56% in 1992 to 31.1% in 2006, 61% of the residents in the Northern Region have remained poor.

Similarly, although Uganda's national infant mortality rate stands at 76 per 1000 live births, the average rate for the North is 106 per 1000 live births (UBOS, 2003).

The North had the highest HPI of 30.7% compared with the Central region which stood at 20.19%; the Western region had a HPI of 20.56% and the Eastern region stood at 27.11%. Table 1.2.2 illustrates how the districts in the North are trailing behind the rest of Uganda in human development indicators. For example, it shows that the districts of Gulu, Amuru, Kitgum and Pader have an average life expectancy of 37 years, which is far below the current national average of 50 years.

Table 1.2.2: Selected HDI/HPI indicators for the North, by district, 2006

District	Life Expectancy	Adult Literacy Index (%)	GER	HDI
Adjumani	47.92	61.7	77.2	0.479
Amolatar	41.01	65.5	144.3	0.524
Amuru	30.86	54.0	145.4	0.430
Apac	41.04	63.6	134.2	0.508
Dokolo	41.01	65.5	144.3	0.524
Gulu	30.86	54.0	145.4	0.430
Kitgum	29.13	57.1	142.5	0.439
Lira	41.01	65.5	144.3	0.524
Oyam	41.04	63.6	134.2	0.508
Pader	36.58	52.9	159.4	0.469
NATIONAL	50.00		112	0.581

Source: The Human Development Report 2007

In addition, the same four disadvantaged districts have the lowest adult literacy rates as well as the lowest HDI values.

1.3 Purpose of the Country Situation Analysis (CSA)

Despite efforts to improve the health system in post conflict Northern Uganda, policy makers, donors and programme managers lack comprehensive and up-to-date information. This includes information on the health of the population, major stakeholders, as well as current research gaps and agendas that could inform policy over time.

The need to address this is particularly important as policy decisions taken in the early stages of recovery should be carefully balanced between immediate humanitarian needs and longer-term development. Although several studies have been carried out, the majority have focused on conflict resolution, management and resettlement rather than the health system (NRC & IDMC, 2010; Kindi, 2010; USAID, 2010; Berg, 2011). It was therefore imperative for the ReBUILD project to conduct an analysis of the current situation.

The specific objectives of the Country Situation Analysis (CSA) were:

- To assist with the prioritisation of research questions in each context, by establishing current actors, agendas and gaps
- To provide information to help position research in the most effective way possible
- To allow for tracking of research impact overtime.

Methods

This situation analysis used the following methods:

- Literature review of secondary sources
- Stakeholder consultation
- Key informant interviews

1.4 Literature review of secondary data sources

The research team conducted a desk review of resources addressing health systems development and research in the areas of human resources for health (HRH) and health financing. Some of the resources reviewed explored a more general context whereas others were specific to pre and post-conflict.

These included but were not limited to:

- Demographic surveys by the Uganda Bureau of Statistics
- Ministry of Health (MOH) documents covering policy, strategic plans, service data, quality performance assessment reports and standards for health
- Discussion papers on Northern Uganda by the Ministry of Finance
- Journal articles on healthcare financing, human resources and post conflict Northern Uganda
- Progress reviews and reports by the UN OCHA, USAID, UNICEF, and the World Bank
- Health Sector Assessment Report
- Evaluation, baseline survey and annual reports of several NGOs that have worked in Northern Uganda, in particular the American Refugee Committee (ARC) and World Vision
- Newsletters and published books from organisations such as the Norwegian Refugee Council (NRC) and the Association of Volunteers in Internal Service (AVSI)

- Planning documents specific to Northern Uganda: PRDP and NUSAF
- Evaluations of some programmes specific to Northern Uganda: NUSAF, NUMAT and NUREP.

The literature review provided an overview of Uganda's health system in general and in the post conflict setting. The MoH documents were vital in understanding government structures and the evolution of public service delivery. The USAID reports gave information about the current situation of health services in post conflict areas. Evaluation reports for World Vision, ARC, UNICEF provided further information about the effects of conflict.

1.5 Stakeholder consultation

A breakfast meeting was held on 28 July, 2011 at the Serena Hotel in Kampala. The meeting brought together stakeholders including representatives from the Ministry of Health (MOH), Parliament, Prime Minister's office, Makerere University School of Public Health (MUSPH), University of Liverpool, DFID, USAID, WHO, AVSI, Lacor Hospital and the media.

The purpose of the meeting was to increase the relevance of the ReBUILD programme to stakeholders involved in health programs in post conflict Northern Uganda. Specifically, the meeting aimed to share ReBUILD objectives among key agencies working in post conflict Northern Uganda and to receive stakeholders' feedback on ReBUILD's research questions and its overall purpose.

1.6 Key informant interviews

15 interviews were conducted with Northern Uganda-based officials from development partners. Key informants were selected to include a cross-section of participants from government, private not-for-profit hospital facilities, donors and major NGOs providing health support in post conflict Northern Uganda.

Interviews addressed issues outlined in the topic guide (see Annex 1), with a specific focus on: identifying key players in health sector development in post conflict Northern Uganda; recent research outputs; demand expressed for health systems research; articulated priorities; challenges faced and gaps that needed to be filled.

The following sections discuss findings obtained from the synthesis of the literature review, stakeholder consultation and key informant interviews. Sections 2 and 3 describe the conflict and post-conflict periods respectively. Section 4 describes recent research outputs on health financing and human resources for health, while Section 5 outlines the research opportunities identified. Conclusions are presented in Section 6.

2 Conflict in Northern Uganda

2.1 Causes of the war in Northern Uganda

Since the mid-1980s, Northern Uganda has experienced violent conflicts and insurgency that have occurred as a result of rebel activity, particularly in the Acholi and West regions, and cattle rustling in the Karamoja region.

A combination of factors fuelled the conflict; resistance to the current government, support from external forces, the proliferation of guns in the region, poverty, imbalanced access to economic opportunities and in Karamoja, the need to accumulate wealth (MoFPED, 2002). The rebel insurgency can be divided into five principle phases as shown in the timeline in Table 2.1. This does not include cattle rustling in Karamoja.

Table 2.1: Timeline for rebel insurgency in Northern Uganda

Phase	Main fighting body	Period
Phase I	Uganda People's Democratic Army (UPDA)	March 1986/July 1988
Phase II	Holy Spirit Movement (HSM)	Late 1986/End 1987
Phase III	UPDA and Severino Likoya	Jan1988-Aug 1989
Phase IV	Uganda People's Democratic Christians Army(Joseph Kony)	Late1988-Feb 1994
Phase V	Lord's resistance Army (LRA)	March 1994-present

Source: MoFPED 2002

Although the fighting by the various groups mentioned in Table 2.1 contributed to insecurity in Northern Uganda, this report will focus on the LRA (Phase IV and Phase V) and the emerging effects. Examples of which include displacement of people and government decisions to put people into camps.

2.2 Origin and growth of the LRA

By the time UPDA had signed the peace accord in 1988, Joseph Kony, an Acholi, had already broken away from the group in 1985 and formed the *Lord's Salvation Army*, then the *United People's Democratic Christians Army* (UPDCA). It was renamed the *Lord's Resistance Army* (LRA) in 1992. The LRA is reported to be guided by spirits such as the Holy Spirit Movement (HSM) of Alice Lakwena (see Table 2.1 phase II).

Between late 1987 and February 1994, the LRA pursued war. The government undertook a number of steps to end this initial phase of insurgency, including mobilising the civilian population to form defence units (MoFPED, 2002). A lack of technical competence in the armed forces is said to have prevented complete victory against the LRA. In 1994, government talks with the LRA fell through and marked the beginning of mass abduction of children, which intensified during the following year.

Following 1994, the war intensified because the LRA received military assistance from the Sudanese Government. They changed tactics and focused on abduction, especially since military hardware was no longer a constraint (Gersony, 1997). During the 1996 election, the LRA announced that they would lay down their weapons and give up the rebellion if the Democratic Party (DP) opposition leader were to become Uganda's President. The DP lost and so the LRA resumed their acts of insurgency. In January 1997, Uganda's Parliament voted to allow the government to pursue military means to end the conflict. In retaliation, the LRA committed the worst atrocities on the population amongst the Acholi as well as neighbouring areas (MoFPED, 2002).

2.3 Transitional period to end conflict

In June 2006, the Ugandan government and the LRA entered peace negotiations which signified a chance to resolve the conflict. Although the Juba Peace Talks failed to produce a final signed agreement (except for the cessation of hostilities agreement), the talks created relative peace in Northern Uganda (ARC, 2007; Kindi, 2010). This gave prospects for recovery and regional development.

In 2008, the relative peace coupled with the government declaration of voluntary return or other 'durable' solution (such as settlement in the camp or relocation to another part of the country), helped accelerate the movement of IDPs from the 'protected' camps to unplanned satellite and official transit camps (Berg, 2011). The UN Consolidated Appeal for 2010 noted that "returning populations face significant challenges in transit locations and villages of origin, including the absence, or inadequacy, of basic services such as water, sanitation, health and education" (United Nations, 2010).

There are some emerging threats to peace, which include: land disputes, disguised armed robbers, HIV/AIDs, sexual and gender based violence, marital strife and witch craft (ARC, 2007). Nevertheless, a report by the United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA) indicates that the region has remained safe and secure with no sightings of the LRA in the region since June 2006. However, the LRA remains active in neighbouring Sudan and the Democratic Republic of Congo (DRC), as well as in the Central African Republic (CAR) (United Nations, 2011).

3 Post conflict period

3.1 General effects of the conflict

Loss of lives

The conflict claimed many lives and displaced many people from their homes. It also devastated social services, local livelihoods and the physical infrastructure of the region. The worst affected districts included Pader, Gulu, Kitgum and other districts throughout the north where much of the fighting took place (Rowley et al., 2006; World Vision, 2009; Kindi, 2010).

Displacement

Evidence shows that massive displacement occurred in virtually all of the districts which form the northern region and some parts of the eastern region that were affected by the insurgency. In some of the districts such as Kitgum, over 90% of the population was displaced (Kindi, 2010). Although in 2003 Pader district was reported to have 78% of IDPs (see Table 3.1), a report showed that in 2009, 95% of the district population was forced to seek refuge in IDP camps (World Vision, 2009). The IDP camps were a 1996 government initiative to create protective villages for the people who had been displaced.

Table 3.1: Total number of IDPs by district[2] by 10 October 2003[3]

No	District	District population	IDP population	Percentage
1	Kitgum	286,122	281,372	98.3%
2	Gulu	468,407	414,258	89.5%
3	Kaberamaido	122,924	97,561	79.4%
4	Pader	293,679	229,115	78%
5	Soroti	371,986	136,112	36.6%
6	Katakwi	307,032	104,254	34.0%
7	Kumi	388,015	59,207	15.3%
8	Lira	757,763	79,097	10.4%
9	Apac	IDPs with host families estimated at about 50,000 people		
	Total	2,995,928	1,405,976	46.9%

Source: Department of Disaster Preparedness and Refugees, 2003

Table 3.1 indicates that the districts of interest to ReBUILD – Gulu, Kitgum, and Pader – were more affected by displacement. Over 88% of the 2003 population was displaced. By 2007, 121 IDP camps had been created in the Acholi region alone (NRC & IDMC, 2010). The populations that were not absorbed into camps migrated to urban areas, causing the overcrowding of towns and social facilities such as hospitals and churches.

[2] There are no details for Amuru because the district was not yet formed by 2003. Amuru district was created in 2006 after these statistics were compiled.

[3] These numbers were liable to change with the extension of the conflict over time. This is clear for Kitgum and Pader districts in Table 3.1.

3.2 Resettlement of the population from IDP camps to their original residential areas

It is estimated that more than 85% of internally displaced people (IDP) living in camps have returned to their original villages or to transit/satellite camps closer to their homes (USAID, 2010). An annual report for World Vision Pader in 2009 revealed that out of a total population of 269,957 that had settled in the IDP camps in Pader district, 181,901 have moved to transit camps and 68,982 have moved back to their original villages (World Vision, 2009).

The people remaining in camps are mainly vulnerable people such as the elderly, widows, orphans and those living with HIV/AIDS and other chronic illnesses. Individuals who prospered in small scale businesses have also remained in camps to continue with their businesses (USAID, 2010).

Estimates from a camp population mapping exercise by UNCHR in December 2010[4] indicated that 125,598 internally displaced people requiring "durable solutions" were living in the following locations:

6,390 in **14** active camps (Acholi and Teso sub regions)
20,000 in settlements in Kiryandongo District (formerly Masindi)
46,849 in former camps (Acholi, Teso and Madi sub regions)
52,359 in **282** transit sites (Acholi sub region).

However, in 2011 a key informant interview with an official from UNCHR Gulu revealed that a number of camps were still operating in Acholi sub region in June 2011 and gave the reasons for non-closure (see Table 3.2).

Table 3. 2: Updated data on open camps and reasons for non-closure

[4] United National High Commissioner for Refugees, December 2010 Update on IDPs movement

District	# of Active camps	Problematic/active camps	Reason for non-closure
Gulu	1	Corner Agula	Inter-clan land conflict resolution process on-going (ICLA).
Agago	4	Lira Kato Omiya Pacwa Paimol	DDMC held in Agago district headquarters on 2 March, 2011 resolved to close all three active camps. CAO to inform the District Executive Committee. Security to be increased on the Karamoja border.
		Arum	IDPs are unable to return to an area occupied by UPDF barracks.
Kitgum	3	Akilok Orom	Fear of armed raids by Karamojong and Southern Sudanese warriors is limiting the return of some IDPs still based in both camps.
		Mucwini	UNHCR & UHRC to meet with Kitgum RDC on issues of between the Pajong and Pubec clans with regard to compensation.
Lamwo	3	Ngomoromo Aweno Olwiyo Potika A & B	The Lamwo RDC is working to expedite the relocation of a Local Defence Unit occupying land belonging to IDPs in Potika A/B Camp. De-mining continues to clear land belonging to IDPs still displaced in Ngomoromo and Aweno Olwiyo camps.
Amuria	1	Amootom Original	Assessed for closure in August 2010. Awaiting DDMC Amuria to set date and arrange for official closure.
Total	12		

The number of camps still in operation indicates that the return process is still slow. Aside from the reasons shown in Table 3.2, interviews with other key informants revealed that the slow

return process is related to land disputes and a lack of social amenities in the return areas. Another reason is the feeling of "camp nostalgia", in that some people are reluctant to return given that they have known no other *better life* than that in the camps.

"The few camps that have not closed still have people who have not gone back to their previous homes because of: land wrangles, the good life near camps (such as video shows, pool) and the investments some of them have made (shops, rental structures)". ***Key informant 7, Gulu***

"[...]Children would remain in camps and parents would go to villages. A father relocated and the child said "Daddy, we need to relocate back home to the camp" ***Key informant 1, Kitgum***

With factors such as land disputes, there are debates about whether returning home to the original villages is a durable solution. An interview with an NRC official revealed that:

"Under the camp management project of Norwegian Refugee Council (NRC) it recommended that for successful return, people can't just return to their original communities. They can also be resettled elsewhere or reintegrated in the existing camps". ***Key informant 7, Gulu***

For many, worries about the presence of landmines and unexploded ordnance, bandits, the lack of services and limited access to their former villages has cemented their decisions to return. A study by the Norwegian Refugee Council (NRC) and the International Displacement Monitoring Centre (IDMC) found that;

"Many of the sites from which the IDPs fled are very far removed from populated areas that are supported by security services, water, sanitation, schools, commercial centres and roads. In many instances, potential return sites are not accessible by footpath due to over a decade of long grass growth. For IDPs that fled from remote areas, return to those largely un-serviced sites is not practical" (NRC & IDMC 2010, p135).

The land wrangles in the return areas also created a dilemma for displaced persons who could have been perceived as foreigners/intruders at home (where they are returning or being resettled) versus being citizens of the same country. Whereas much has been documented about resettlement and land wrangles, little is known about what returning home means to different groups such as youths and adults, health workers and teachers.

3.3 Effects of war on the health status

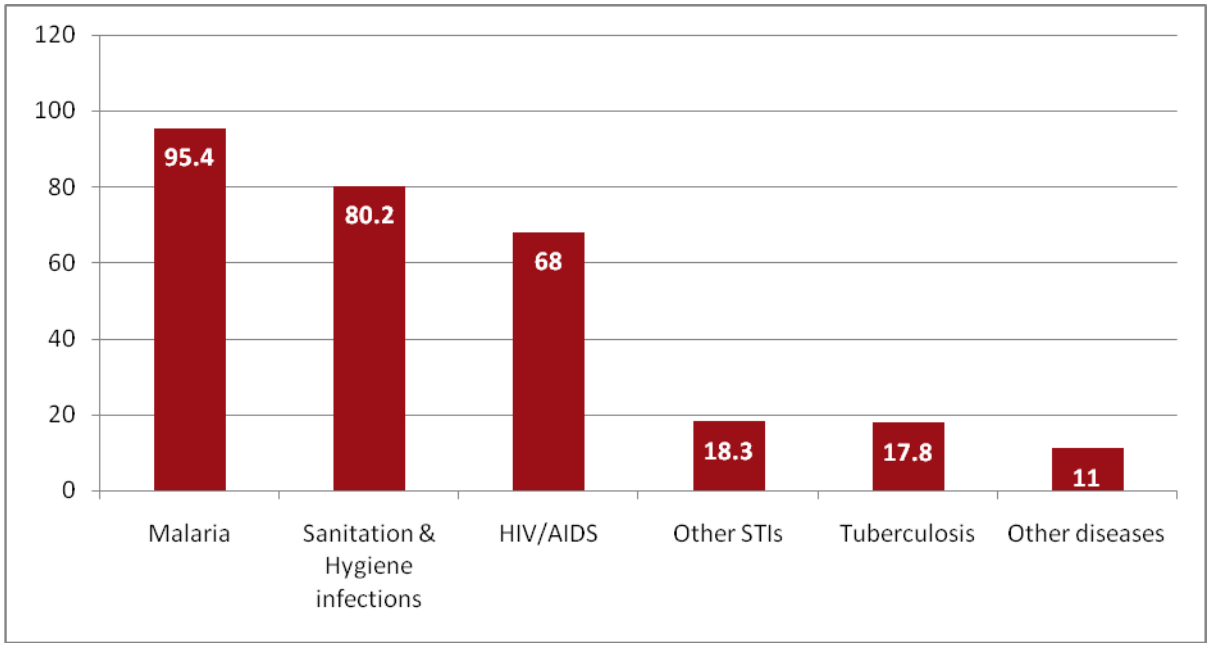
War related ill health and death

Conflict gives rise to death, injuries and ill health to both combatants and the civilian population (WHO, 2002). Deaths and injuries include those caused by landmines and other ordnance which characteristically continue to kill and maim long after the end of the conflict.

Displaced populations in low income countries are particularly susceptible to malnutrition and communicable diseases such as malaria, acute respiratory infections, diarrhoeal diseases and measles (Waters et al., 2007). Indirect impacts occur from "the disruption of livelihoods, inadequate food and water supplies, and the destruction of health systems, as well as to continued insecurity" (Kruk et al., 2010).

In 2007, a survey by the American Refugee Committee on health conditions in the IDP camps found that the common health threats IDPs experienced were malaria (95.4%), sanitary & hygiene related infections (80.2%) and HIV/AIDS (see Figure 3.3) (ARC, 2007). In the rainy season, infections from malaria and sanitation/hygiene related diseases are likely to become more severe.

Figure 3.3 Health challenges in major and transit IDP camps



Source: ARC, 2007

High fertility rates & incidence of HIV

Available literature shows high rates of sexual violence have been documented in many conflict and post conflict situations where the rule of law had not been re-established (Mukwenge & Nangini, 2009; Bartels et al., 2010). In most cases, rebels use rape as a weapon of war, not only to humiliate women, girls and their spouses, but also to "terrorise, displace, and demoralise" whole communities with concomitant health impacts (Mukwege & Nangini, 2009).

Women are put at risk and the reasons for such violence vary across settings; for example sexual violence in the 'protected' camps in Northern Uganda might be related to survival strategies (e.g. women having sex for food); alcohol abuse can lead to domestic violence; soldiers can abuse their power (Okello & Hovil, 2007). In 2005, The National Sero-Prevalence and Behavioural Survey revealed a higher level of HIV/AIDS prevalence in the conflict affected areas of Northern Uganda (9.1%) compared to the national average (7%), requiring an urgent multi-sector response (MOH, 2005).

The key informant interviews also revealed other indirect effects of war on fertility due to beliefs about replacing dead family members and securing enough children beyond those expected to die from certain common illnesses like malaria, cough and diarrhoea. It was reported that giving birth to many children in the long run results in uterine prolapse:

> *"There is a high fertility rate, for example, I operated on two women who had each given birth to their 13th child. They were suffering from uterine prolapse […] Some people want many children because they feel that they lost so many people during the war and they need to "refill the region". There is also a belief that a woman should have more than three children because cough will kill one, diarrhoea will kill one and malaria will kill one. This means that women always want to give birth to more than three children."* ***Key informant 5, Gulu***

Childhood malnutrition and mortality rates

Conflict situations show significant increases in cases of child mortality due to malnutrition. An analysis of the nutrition situation in Uganda revealed that between 2001 and 2006, the northern region was characterised by a high prevalence of stunting, underweight children and wasting. Other regions experienced a decline in prevalence of the above indicators overtime, but the decline in the northern region was especially slow.

This slow decline has been attributed to the region's security situation, seasonality and prolonged drought (USAID, 2010). Food insecurity, which arose from the disruption of livelihoods, limited availability of agricultural land and weakness of manpower, is also a contributing factor to acute childhood malnutrition in post conflict areas. Other causes of child mortality include malaria, diarrhoea and pneumonia.

Although most causes of child mortality are preventable (i.e. many child health problems can be effectively handled at community level), the children at highest risk of death require accurate

diagnosis, rapid referral, appropriate hospital interventions and follow up visits (Kruk et al., 2010). All these linkages in healthcare management are severed due to a dysfunctional health systems. Congestion in camps causes poor sanitation and war related illnesses such as malaria.

Mental illness from the effects of camps and war

The Lord's Resistance Army (LRA) abducted many young men and girls and conscripted them as rebels. This led to widespread mental illness, although this is often not recognised (Kruk et al., 2010).

"To prevent escape and instil the feeling of rage, some of these children were forced to commit atrocities against their own communities and families. The girls were subjected to sexual abuse and some became mothers at a tender age. Although many of these children have escaped or been rescued from rebel captivity by the Uganda People's Defence Force (UPDF), their experience, particularly of the atrocities committed on their own communities, and the horrible harm they committed at a tender age necessitated rehabilitation before reintegration" (ARC 2007).

WHO (2008) estimates indicate that 10% of people who experience traumatic events will have serious health problems and a further 10% will develop behaviours that will constrain their ability to function. Some common psychological disorders are: depression, anxiety, post-traumatic stress disorder (PTSD) and psychosomatic disorders such as insomnia and bodily aches. Mental illnesses require specialist counselling skills and medicines (WHO, 2008). The stakeholder interviews highlighted a slight improvement in the psychological health of the people given reduction in fear of abduction. However, the interviews highlighted the absence of specialised skills in trauma management in the communities and districts at large, except for the few humanitarian organisations (e.g. AVSI and TPO) that provide psychosocial services. These findings are echoed in selected key informant quotes:

"[…] Psychologically, people are happier, free not fearful and more relaxed than when they were still living in the camps" ***Key informant 8, Gulu***

"Gulu has one psychiatrist yet the problems are many […]" ***Key informant 5, Gulu***

"TPO and AVSI provide psychosocial services. TPO uses community based approaches to deal with mental health cases and to empower lower HCII in mental health case support" ***Key informant 3, Gulu***

3.4 Impact of conflict on the health system in Northern Uganda

The health system in Northern Uganda underwent various changes throughout the phases of the conflict. Before the conflict, the health system was functioning but not optimal and constraints were invariably shared across regions in the country. During the conflict, the health system in Northern Uganda was divided into two. First, there was a functional camp-based health system run by international agencies and NGOs, staffed mainly by expatriate health workers. The health system was dominated by vertical programmes such as immunisation, malaria treatment and treatment of HIV AIDS among others. There was a parallel procurement process for the camps which was less bureaucratic, thereby increasing efficiency and delivery of drugs. Other social services such as water sources and schools were concentrated in the camps as opposed to the villages. Second, in the villages where health services had formerly been provided by the state (pre-conflict), most health facilities had been destroyed and remained dysfunctional without supplies. Health workers had fled to neighbouring towns and countries.

Government health service delivery was confined mainly to towns where referral hospitals were located (WHO, 2006). In 2006, Gulu district (one of the districts in Acholi sub-region) was ranked number one in the top 15 performing districts in the country based on league table scores (MOH, 2006). Private not-for-profit hospitals like Lacor Hospital benefited from

increased donor funding, improved service provision and capacity building (St Mary's Hospital Lacor, 2010).

In the post conflict period, the health system experienced various changes as well as challenges. Some were perpetrated by the organisation of the health system during the conflict and lags in the policy making process. People were (and still are) required to return to their home areas as a way of decongesting the camps. This reduced the risk of camp-related illnesses such as diarrhoeal disease. However, it also meant that people moving away from the camps had to start a new life. Movement from camps to original villages raises issues of access and equity as well as healthcare systems not functioning properly. Decentralisation and the creation of new districts has not solved the problems.

There are now efforts to improve the integration of the numerous actors who operated in camps during the war. The new system will bring together all actors including government, PNFPs and INGOs. Health facilities are being rehabilitated and in some places new ones have been built but are still not functional. There has also been a decline in expatriate health workers, with a few working in advisory roles or remaining to build the capacity of those in existing systems through training.

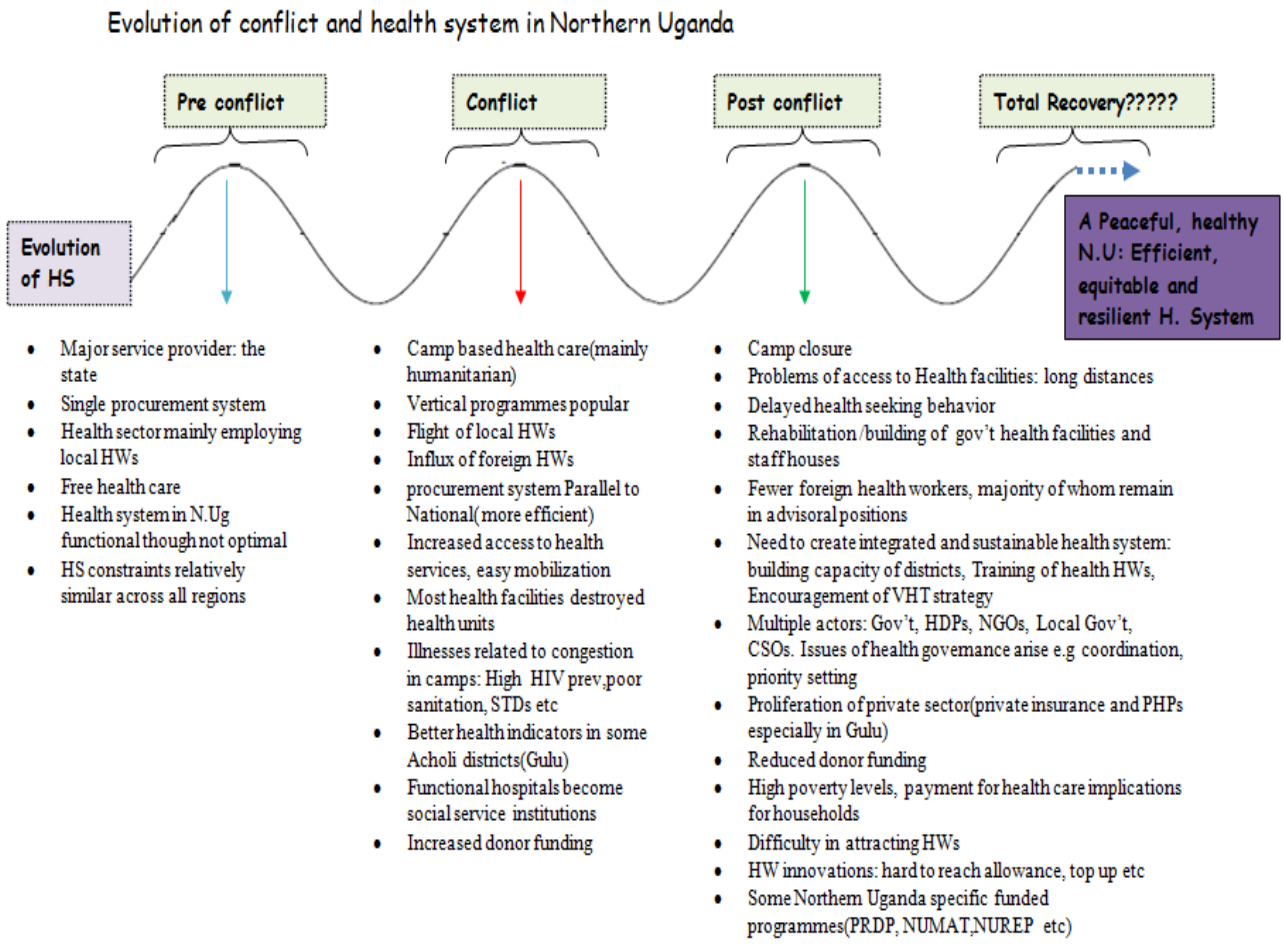
However, some facilities still have expatriates as it remains difficult to attract health workers to public health facilities in rural areas of the region. The global health workforce has led to a high turnover of health workers who seek better salaries in neighbouring Sudan. A Village Health Team (VHT) strategy has been suggested by donors and other health development partners to re-establish a community health programme (see section 6.4).

Diminishing donor funds has created fear over the sustainability of projects that have largely relied on these funding sources. There is growing participation from the private sector to support the booming NGO sector, although this appears biased towards urban areas. This has

the potential to build a private sector network that could provide sustainable private health delivery in the post conflict and recovery phases.

Although private health delivery in post conflict settings is not always positive, the health system in Northern Uganda is still undergoing changes that need to be monitored closely. See figure 3.4.

Figure 3.4: Evolution of the conflict and the health system in Northern Uganda



Source: Formulated by Research Team

3.4.1 The public/private mix

The National Health System (NHS) of Uganda is made up of the public and private sectors. The public sector has a tiered structure. The national level bodies at the highest level are: Parliament, Ministry of Health (MOH)[5], National Medical Stores (NMS), Uganda Virus Research Institute (UVRI), Professional Councils and the Cancer Institute among others. The next levels in

[5] The Ministry of Health (MOH) is the dominating national body mandated to make policies and regulate health service delivery.

descending order consist of national referral hospitals followed by regional referral hospitals. (MOH, 2010d)

Uganda's public health system has become decentralised over the years with the intention of improving the quality of health services and pharmaceutical supplies in hospitals. This has resulted in an increase in health facility utilisation (Annokbonggo et al., 2004).

The regional referral hospitals follow a decentralised system of health service delivery that is based on district local government and health sub-districts. At the district level, the district general hospital is the highest structure for healthcare. Following a recommendation from the National Health Policy I and II, the district health system has been further divided into health sub-districts (HSDs), which are functional zones aimed at implementing provision of integrated health services (MOH, 2010d). The highest level of the health sub-district is the health centre IV at county level. This is followed by HC III at sub-county level, HC II[6] at parish level and the HC 1 (also known as Village Health Team (VHT)) located at the village level (Jeppson, 2004; MOH, 2009). Table 3.4.1 shows the number of health facilities in Acholi sub-region by ownership.

Although all levels of the health sub-districts – from HCIV level down to the VHT – are contributing to the minimum healthcare package (MHCP), the range of health services delivered varies with the level of care. Higher level facilities provide more comprehensive set of services relative to lower level units see Table 3.4.1). Under the decentralised system, the role of the MOH changed from service provision to policy making and regulation. As a result, each district became responsible for planning, management and delivery of its own health services (World Bank, 1994).

However, district management capacity is still very limited in many districts. Leadership, management and specialist skills are in short supply at all levels of healthcare and high levels of attrition tend to curtail capacity building initiatives (MOH, 2009).

[6] According to the Uganda 2nd National Health Accounts Report by the Ministry of Health (MOH,2004), The HCII is the lowest physical structure and point of entry into the physical Health system.

Table 3.4.1: Health facilities per district in Acholi sub-region[7]

District	Facilities GoU	Facilities PNFP
Amuru and Nwoya	1 General Hospital (Anaka) 1 HC IV 7 HC III 28 HC II	 2 HC III 9 HC II
Gulu	1 Regional/ General Hospital 2 HC IV 13 HC III 29 HC II	St Marys Lacor Regional Hospital Gulu Independent Hospital (not included) 1 HC III 11 HC II
Kitgum and Lamwo	 3 HC IV 15 HC III 20 HC II	St Joseph Kitgum 1 HC III 1 HC II
Pader and Agago	 1 HC IV 19 HC III 40 HC II	Kalongo Hospital 1 HC III 2 HC II

3.4.2 Access to services under decentralisation

It has been argued that there is little evidence of equity in terms of access to healthcare and the distribution of decentralisation benefits between central and peripheral districts (Witter et al., 2000; Jeppson, 2004).

The HSSP II objective for infrastructure development was to ensure that 85% of the population is situated within 5km walking distance of a well-equipped health facility. However, nationally access is at 72% (MOH, 2010d). Although there are no available statistics to show coverage in

[7] The private for profit facilities are not included in the table. However, there is evidence that PFP sector is expanding in post conflict Northern Uganda.

post conflict Northern Uganda, the situation could be worse compared to the rest of the country.

The key informant interviews highlighted that access to social services was poor. It was noted that formerly displaced people were faced with a challenge of starting a *"new life"* as they moved from places of plenty (the camps) to their villages where social services are less accessible.

Factors contributing to poor access include poor road networks, which can also hinder immunisation and sanitation campaigns. Key informants suggested that equity issues in relation to access were mostly felt by single women, heads of child-headed households, the elderly and the physically disabled.

"It is difficult to access health facilities because of the long distance between people and the health centres. When people were still living in camps, it was easy for them to access the health facilities because it was near to them. Nowadays, most people have to use bicycles or walk on foot to go to health centres to get these services". ***Key informants 5 and 8, Gulu***

"I think the situation is complex. People have gone back. Sanitation has improved but mobilisation for activities like vaccination is difficult. Initially, while they were still in the camps, it was easily done by use of loud speakers. Now people come for treatment when they are very sick because of walking long distances". ***Key informant 6, Gulu***

Table 3.4.2 The Public health system structure, levels and roles

Administrative level	Corresponding health structure	Roles	National health facility standard	Current situation
National	National referral hospital(NRH)	All services by RHH and general hospitals plus comprehensive specialist services, research and teaching	1:10,000,000	1:30,0000
Region	Regional referral hospital (RRH)	All services of general hospitals plus teaching and research	1:3,000,000	1:2,307,692
District	District/general hospital	All HCIV services plus in-service training, consultation and research to community based healthcare programmes	1: 500,000	1:263,157
County as sub-district or constituency	HC IV	All HCIII services plus preventive, promotive, outpatient, curative and inpatient services, emergency surgery and blood transfusions	1: 100,000	1:187,500
Sub county	HC III	All HCII services plus preventive and promoting maternity and inpatient services. Delivery services may	1:20,000	1:84,507

		be available		
Parish	HC II	Provides preventive, promoting and curative services (mainly outpatient). Antenatal services may also be available	1:50,000	1:14,940
Village	HC I (village health team/VHT)	Community based healthcare services, health promotion and education (to service approximately 100 people using community)	1:1000,1per 25HHs	

***Source**: Uganda NHA Report 1998/99 – 2000/01; Health Sector Strategic Plan and Ministry of Health Inventory 2002, MOH HMIS 2009, MOH Statistical Abstract 2010.*

It was also emphasised that although people have access to health facilities, they are often ill-equipped.

"[…] in camps, they could access services easily but now there is a challenge of moving. In camps there was competition for service delivery among programmes but now there are inadequacies of the government's lack of drugs and equipment". ***Key informant 3, Gulu***

3.4.3 The private sector

The private health service delivery system consists of private not-for-profit providers (PNFPs), private health practitioners (PHPs) and the traditional and complementary medicine practitioners (TCMPs) (MOH, 2010d). Some 75% of the PNFPs are facility based (FB-PNFPs) and have their administration coordinated nationally by their respective bureaux and local diocesan boards (Okwero et al., 2010).

These bureaux include Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOCB) and Uganda Muslim Medical Bureau (UMMB). The majority of the FB-PNFPs operate with financial support from donors and the Government of Uganda. They account for 41% of the hospitals and 22% of the lower level facilities.

3.4.4 Non state sectors

It has been argued that when a crisis threatens lives, there is a humanitarian imperative to act to prevent needless suffering and death (Newbrander, 2006).

The conflict situation in Northern Uganda saw an influx of humanitarian assistance by UN agencies, INGOs and PNFP to provide support services. Healthcare services were predominantly camp-based and included vertical programmes such as immunisation, treatment of common diseases, reproductive health services, clean water, training in sanitation and hygiene, emergency health and nutrition, HIV prevention and treatment, child protection and shelter (UNICEF, 2007).

Multilateral and bilateral donors are key players in Northern Uganda; with offices both in Kampala and Northern Uganda to support the implementation of many programmes. Multilateral donors include the World Bank, World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), World Food Programme (WFP) and United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). Bilateral donors include, Italian Co-operation, United States Agency for International Development (USAID) Swedish Agency for International development (SIDA), Japanese International Cooperation Agency (JICA), Danish Agency for International Development (DANIDA), United Kingdom Agency for International development (UK AID/DFID), Irish Aid and the Government of Norway (SIDA, 2006; MOH, 2010d).

Civil society organisations (CSOs) are also among the key non-state actors in Uganda. The country's civil society sector is active in both advocacy and the delivery of services, and engages in a wide variety of issues. In 2002, a coalition of 50 CSOs formed the Civil Society Organisations for Peace in Northern Uganda (CSOPNU). It advocated for "just and lasting peace" in Northern Uganda based on an understanding and articulation of the root causes of the conflict. It recently authored the report, "Counting the Cost: Twenty Years of War in Northern Uganda", which includes recommendations to the government, the UN, and the international community about ways to protect civilian rights (Rowley et al., 2006).

A number of international NGOs operate throughout the country, many with a field presence in the conflict affected districts. During the key informant interviews, it was revealed that few INGOs were implementing programmes that directly target health, although several had income generation/livelihood programmes that could impact on health in the long run. A number of international organisations were mentioned as still operating in post conflict Northern Uganda. These include CARE, World Vision, ARC, NRC, AVSI, Medical Corps and CARITAS (see annex 2). Indeed, one of the challenges in the North revolves around efforts to coordinate the activities of a vibrant non-state sector.

3.4.5 Players in health systems research

Players in health systems research in Uganda can be grouped into: management, research institutions, academic institutions and those who finance research. There are two ministries involved in management of health research in Uganda: the Ministry of Health (MOH) and the Ministry of Finance and Development Planning (MoFPED). There are also two statutory bodies involved in the management structure: the Uganda National Council of Science and Technology (UNCST), which falls under MoFPED, and the Uganda National Health Research Organisation (UNHRO). The UNCST oversees all research in the country and acts as a clearing house for institutions and individuals conducting research.

Several government institutes that conduct research currently fall under the MOH: the Uganda Virus Research Institute (UVRI), Uganda Cancer Research Institute (UCRI), Uganda Natural Chemotherapeutics Research Laboratories (UNCRL), Uganda Trypanasomiasis Research Organisation (UTRO), and the Joint Clinical Research Centre (JCRC). Academic institutions commissioning research include: Makerere University Faculty of Medicine, Makerere University School of Public Health, Mbarara University of Science and Technology, and the Infectious Disease Institute.

Donors fund most of the research in Uganda. The main donors for health research include the US Government through National Health Institutions (NIH) and the Centre for Disease Prevention and Control (CDC); US foundations such as the Gates Foundation and the Rockefeller Foundation; Sweden (SIDA/SAREC); the UK (DFID); Canada - International Development Research Centre (IDRC); Denmark - Danish Agency for International Development (Danida); the Netherlands (DGIS); Norway (NORAD); World Health Organisation (WHO); the World Bank and United Nations International Children's Fund (UNICEF) (COHRED, 2008). The main problem with donor-funded research is that it concentrates on the research interests and priorities of the donors themselves. Additionally, current funding for research has been perceived to be "*low; fragmented, disjointed without linkage to HSSP II or research priorities"* (Okware, 2009).

There is limited or no evidence of health research being conducted by NGOs. NGOs focus on implementing programmes, with most of their research activities consisting of baseline surveys and follow up monitoring and evaluation surveys (COHRED, 2008).

According to the Uganda National Research Organisation, health policy and systems research was one of the national health system's research priorities between 2005 and 2010. The specific research priorities under health systems research are summarised below:

Table 3.4.5: Uganda's Priotities under Health systems research and Health policy research for the period 2005-2010

Priorities under health systems research(2005-2010)	Priorities under health policy research (2005-2010)
• Community health information systems • Improving access and quality of healthcare • Effective use of health resources • Development of interventions to improve referral systems • Decentralisation of health services • The cost of using inefficacious treatment • Gaps in equity • Cost effectiveness of syndromic approaches to case management versus strengthening diagnostic capacity	• Inter-sectoral collaboration and coordination mechanisms • Development of health policy/review and analysis • Health sector reforms • Alternatives for healthcare financing • Donor impact on health • Comparative studies on the burden of disease • The role and extent of private sector component in service delivery

Source: UNHRO 2005

Several studies have been conducted in relation to health systems research. Most of them have been summarised in the recent Uganda Health Systems Assessment Report of 2011 (MOH et al., 2012). It should be noted that although many studies have been done in this area, few of these have a post conflict focus. Instead, most focus on conflict resolution and management. This presents an opportunity for ReBUILD to carry out research in this area.

4 Recent research outputs

4.1 Health financing in Northern Uganda

This section reviews literature on health financing in Northern Uganda. Key themes include resource generation/pooling, resource allocation and purchasing/provider payments.

4.1.1 Sources of health financing

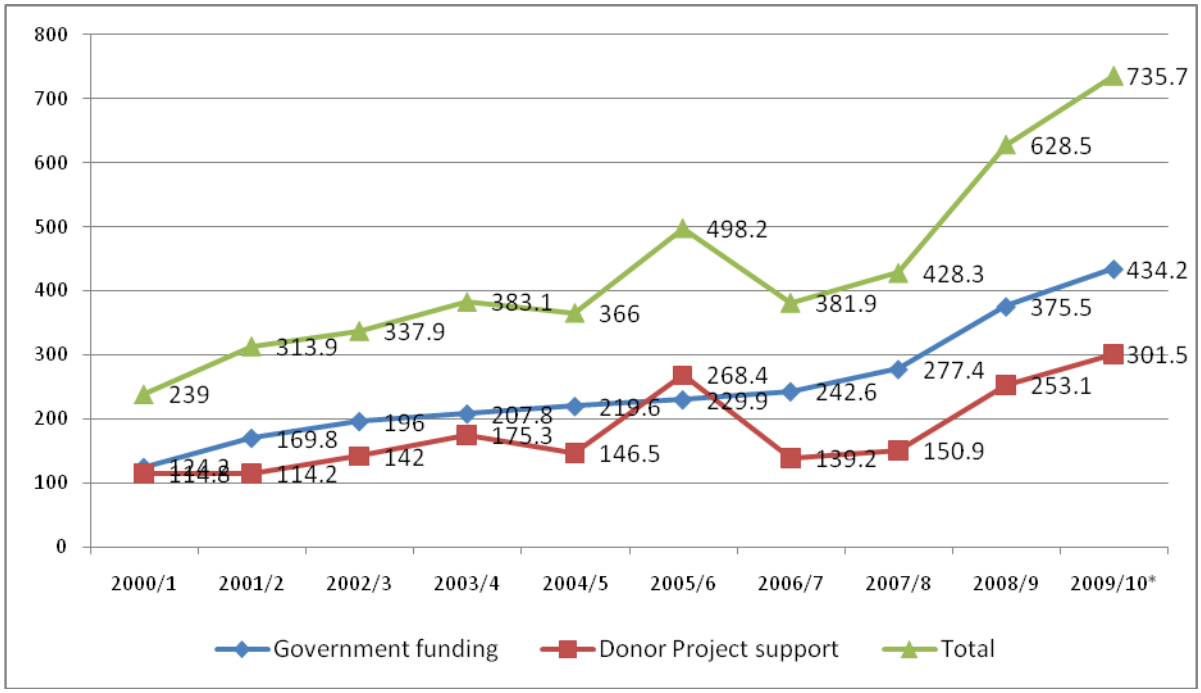
The sources of health financing in Uganda include the government, donors and private out of pocket (household) expenditure. However, in Northern Uganda differences exist in the proportion of revenues from the three sources compared to the rest of the country.

4.1.2 Government health financing

The government raises funds to finance the health sector from two main sources: (i) taxation and (ii) contributions from development partners towards the national budget. Uganda has a small tax base so raising funds via taxation has many drawbacks.

The major development partners that contribute to healthcare financing in Uganda are PEPFAR, Global Fund, Africa Development Bank, DANIDA, USAID, GAVI, WHO and the World Bank (MOH, 2010). Figure 4.1.2 shows per capita the government and development aid expenditure for health between 2000 and 2009.

Fig 4.1.2: Public health financing trends for the health sector, 2000/1-2009/10(in billion shillings)



Source: MOH,Health SectorStrategic and Investment Plan 2010/11-2014/15

Figure 4.1.2 shows that there has been a gradual increase in both government and donor health financing over the period of 10 years (2000/01-2009/10). However, this graph is not disaggregated by region.

4.1.3 Donor funding for Northern Uganda

Although Northern Uganda is receiving funding for health from the general expenditure budget, there are projects that have been primarily funded by the government and donors. Donor support remains the principal funding source for health service delivery in the northern districts of Uganda where government support has proved inadequate for responding to the complex humanitarian situation. Most funds are channelled through INGOs and UN agencies (Rowley et al., 2006; MOH et al., 2012).

Table 4.1.3 shows some of the projects being funded in Northern Uganda. Specific reference is made to the financial worth, activities and funding sources.

Table 4.1.3: Funding opportunities in Northern Uganda: financial worth and sources

Project Name	Dates	Financial Worth	Activities	Funding source
Northern Uganda Social Action Fund(NUSAF I)[8]	2003-2009	$133.5m	Education; health; water supply and sanitation; economic infrastructure; agriculture and environment	World Bank
Northern Uganda Social Action Fund (NUSAF II)	2009-2013	$100m	Elimination of terrorist threats to stability; building security; provision of water; health immunisation and educational outreach	World Bank and Government of Uganda
Northern Uganda Rehabilitation Programme (NUREP)	2007-2009	$98.2m	Promotion of human rights and the rule of law; agricultural support; promoting peace through music, drama, and sports; de-silting micro dams; opening up access roads; constructing social infrastructure; water works;	EU

[8] This project has ended and been replaced by NUSAF II.

			psychosocial support and vocational training; water and sanitation	
Peace Recovery and Development Plan (PRDP)	2007-to date	$606.5m	Consolidation of state authority; rebuilding and empowering communities; revitalisation of the economy; peace building and reconciliation	EU Government of Uganda and
Northern Uganda Malaria, AIDS and TB programme (NUMAT)[9]	2006-2011	$30m	Active malaria prevention strategies. Immunisation programmes, and HIV and TB programmes.	USAID/PEPFAR, Government of Uganda
UK PCDP UK post conflict development programme for Northern Uganda	2010-2015	£100m	Strengthening Local government capacity for equitable service delivery and management ; Rebuild and empower most vulnerable conflict-affected communities; Revitalising the private sector and creation of accessible employment opportunities ; Active engagement of Government, civil society and communities in peace building and reconciliation	DFID

[9] Retrieved from http://www.jsi.com/JSIInternetProjects/InternetProjectFactSheet.cfm?dblProjDescID=318

As shown in Table 4.1.3, there are several funded programmes targeting post conflict Northern Uganda aimed at directly or indirectly improving the health situation. The main weakness of having a dependence on donor funds is that most funding is earmarked for specific projects or interventions. For example, PEPFAR funding was specifically for HIV/AIDS, malaria and tuberculosis related activities under the NUMAT project. A lack of information on donor's funding contributes to inefficient and inequitable resource allocation and utilisation for health service delivery (Nabyonga et al., 2009).The interviews revealed that although donor funding should be credited for bridging the funding gap by government, it raises issues of sustainability as expressed by a key informant from a PNFP facility:

"[…] this [referring to the issue of sustainability] is a good subject for the stakeholders meeting. Lacor Hospital being at 70% donor support, it is risky in case donors stop funding, we are not sustainable at all. What is it that the community can do to help? Is it going to increase user fees? I do not think so […]" ***Key informant 6, Gulu.***

The issue of earmarked donor funds is a weakness that cuts across all themes of healthcare financing in Uganda including revenue collection, pooling and allocation of resources and purchasing of services.

4.1.4 User fees and exemptions

User fees were abolished in 2001 to ensure equity and increase access to public health services. This implied that all services in public hospitals were free to all. However, the continued dependency on user fees in private wings of public hospitals, PNFPs and private for profit health facilities still raises debates about equity (MOH, 2005). This particularly affects access to health services for vulnerable families and groups. Although the removal of user fees was perceived as a positive step, the poor quality of services in public health facilities has created a two-tier system. The poor are left to access the free, but poorer quality services whereas richer patients

can pay to access better quality services in private health facilities of better quality (Zikusooka et al., 2009).

As in the rest of the country, households in post conflict Northern Uganda still pay for healthcare particularly in PNFP facilities. However, innovations exist to enable access to healthcare through the reduction or waiving of fees for vulnerable groups. This has been in spite of incremental costs, e.g. personnel and supplies, in certain facilities. Lacor Hospital's 2009/2010 annual report revealed that fees for its antenatal clinic for the admission of children and pregnant women were waived and this has since continued (St Mary's Hospital Lacor, 2010).

4.2 Other sources of health financing

4.2.1 Private health insurance

Private health insurance in Northern Uganda is still in its infancy. The presence of numerous NGOs may contribute to the attractiveness of the region to private health insurance providers. During the key informant interviews in Gulu, it was noted that insurance companies such as African Air Rescue (AAR) have opened up services to cater for the overwhelming demand of clients that work for the NGOs.

The NGO employees are free to access healthcare services from the AAR clinic and the bill is sent to the organisation for clearance. This may improve the quality of available services through attracting health workers and better diagnostic capacity, as illustrated in the quote below:

"We have a clinic here in Gulu. We opened it up based on the number of clients that were here. Most of our clients work in NGOs based here so we thought since they were many, we could open up a clinic for them […] so that they do not always have to come to Kampala. But we also offer services for those who are not insured. We offer quality services […] Our staff are very

qualified, as you can see, that is our laboratory […] those are beds where our clients rest […] Feel free to come and visit our clinic any time." ***Key informant 11, Gulu***

However, issues of sustainability and equity have been raised over the provision of services by African Air Rescue (ARR) because it is mainly for NGO staff and others who can afford it.

4.2.2 Community based insurance

It is not known whether community based insurance operates in Northern Uganda. Available literature only points to the existence of community based insurance operating in some communities throughout the country. There are currently more than 15 community based health insurance (CBH) schemes in Uganda coordinated by an umbrella organisation known as Uganda Health Financing Association, which is overseen by the MOH.

4.3 Resource allocation

At national level, resources are generally allocated through the medium-term expenditure framework (MTEF). It was introduced by the MoFPED to streamline and guide the budget process, and to set out planned outputs and associated expenditures in the medium term (MOH, 2010). In the MTEF, resources are allocated to all sectors based on the National Development Plan (NDP), policy priorities and macroeconomic frameworks. The resources are then sent to district local governments. In the case of Northern Uganda, most government funding given to district local government is for primary healthcare (PHC).

As indicated in Table 4.3, PHC covers both traditional primary healthcare and PRDP primary healthcare. Under the traditional PHC, the activities to be undertaken include the consolidation and renovation of existing health facilities. For the next three years, special priority will be given towards the provision of staff accommodation. The PRDP (PHC) priorities are at the discretion of local governments following MOH policy guidelines on health infrastructure (MOH, 2010).

It has been noted that in addition to having limited resources, local governments are given conditional grants with little discretionary powers to adjust resource allocations (MOH et al., 2012). Districts also have a limited capacity to utilise all the allocated resources. The marked delays in disbursement of available funds by both government and donor agencies limit effectiveness and create room for corruption.

Table 4.3: Direct government transfers for selected districts for FY 2010/11

District	Normal allocation	PRDP	Total PHC Development
Gulu	98,937	1,850,496	1,949,433
Kitgum	132,576	408,982	541,558
Pader	63,122	722,967	786,089
Amuru	70,849	966,834	1,037,683
Lamwo	85,086	282,359	367,445
Nwoya	21,163	291,820	312,983
Agago	80,337	934,492	1,014,829

Extracted from: MOH 2010c: PHC guidelines and transfers for district health services FY: 2010/11

4.4 Human resources for health

The staffing levels in post conflict districts of Northern Uganda are very low compared to the district norms. The planned numbers for recruitment are also low compared to the gap between the district staffing norm and the current staffing.

Table 4.4 shows staffing levels for selected districts of Acholi sub-region against district staffing norms.

Table 4.4 Summary of current staffing levels for selected districts and recruitment plan for FY 2011/12

District	District staffing norm	Current Staffing	Planned number for recruitment
Kitgum	468	312	43
Gulu	657	479	44
Pader	331	239	45
Amuru	306	235	30
Agago	379	225	55
Nwoya	233	83	45
Lamwo	343	111	111
Kampala	268	330	0

Source: Extracted from Human Resources for Health Bi-annual Report (MOH, 2011)

There is little data on the type of health workers working in public health facilities and PNFPs. Available literature focuses on the skills mix of health cadres country wide, without disaggregating by region. According to the HRH strategic plan of 2007, the training pipeline should have a ratio of 2:5:1 for senior, mid-level and support cadres for the future workforce (MOH, 2007).

Although it is widely acknowledged that there are few health workers in the country compared to WHO recommendations, the situation is worse for Northern Uganda. It is clear that enticing staff to centres in post conflict Northern Uganda is difficult. The majority of health facilities are inadequately staffed despite efforts of district administration.

"People are going back to their land and the DHO has squeezed a few staff to different areas, which compromises quality due to inadequacy of staffing. For example: HC IV 11-15 staff

instead of 38, HC III 7-9 staff Instead of 17 or 18, and HC II 3-5 staff instead of 9". ***Key informant 1, Kitgum***

4.4.1 Global labour market

The global labour market has been cited as a threat to numbers of health workers in Northern Uganda. For instance, the increasing numbers of INGOs in South Sudan saw many health workers moving there because of better remuneration than that in Northern Uganda. This has caused substantial problems in deploying and retaining health workers in the region. One of the key informants explained:

"Some of the medical applicants are interviewed but they don't pick their appointments". ***Key informant 12, Kitgum***

"Peace in South Sudan has led to people moving there because the remuneration is three times more for an enrolled nurse. For example, an enrolled nurse is paid 400,000 yet in South Sudan, they are given two million shillings. This has led to brain and skills drain in the district". ***Key informant 1, Kitgum***

Some interviewees noted that in many health centres, staff motivation is low, which leads to reduced opening hours and absence from work. However, important motivational factors identified in the situation analysis included good pay; availability of other social amenities such as electricity, good schools for the children, and opportunities for dual practice. Some of the interviewees elaborated on the motivational/demotivating factors for deployment in rural areas, particularly in post conflict Northern Uganda:

"Some doctors don't want to come here [rural areas] because they there are no other sources of income. For example, there are few chances of dual practice. The other reason is that rural areas lack good facilities such as good schools for children of health staff who have been posted. If you have children of school going age, you want them to go to good schools that are not available in rural areas. So you choose not to come but you stay, for instance in Kampala where there are good schools. The third reason is […] you know people just feel this is too rural for a

doctor and there is nothing attractive. There is no power in some rural areas where you can even use your laptop or computer. Lastly, people [health workers] say the pay is too small to attract them to rural places. The few who come only stay for 1 or 2 months. In fact, I would say that the government just wasted money to construct a theatre that is very expensive yet the health workforce keep on moving away from those places that are fully equipped. The government should set up a system that ensures that all who finish medical school should go and serve for 2 years in a rural area". ***Key informant 5, Gulu****.*

"In terms of retention of health workers here in the region, it is a challenge. There is need to do more in the area of providing decent accommodation with solar power, internet connections, offering good salaries and access to good schools for children of health workers". ***Key informant 4, Gulu***

Some of these issues may also apply to rural areas elsewhere in Uganda.

4.4.2 Conditions/terms of references

There is very little documentation on the terms of references for health workers in Northern Uganda. In general, the public service commission of Uganda provides similar terms and conditions for all civil servants. Conditions and terms of reference tend to vary for health workers across facilities under non-governmental ownership. However, conditions may relate to arrival time at work, payment, retirement benefits, and insurance, among other conditions.

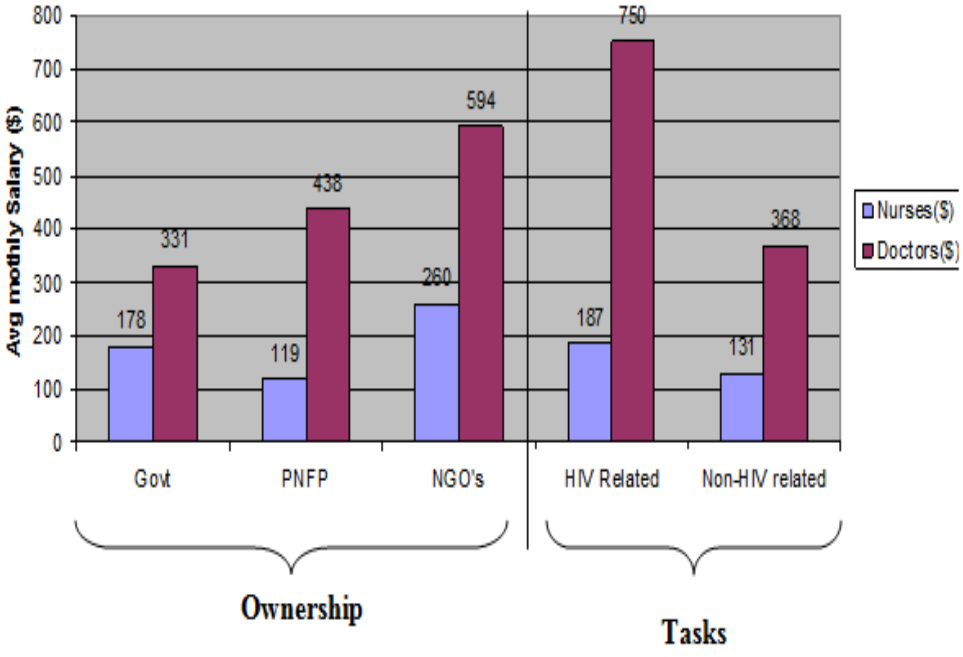
4.4.3 Contracts and payments

Contracts for health workers tend to vary depending on whether the facility is government, PNFP or NGO owned. Few studies have been conducted to track salaries of health workers' over time. Available evidence indicates that there have been few attempts to disaggregate health workers' salaries based on region of origin. However, some studies that attempted to report salaries of certain cadres (nurses, midwives and doctors) revealed marked variations in salaries

even within the same organisations for similar cadres. Further analysis revealed that doctors earn more than the nurses/midwives across facilities in relation to global health initiatives and HIV or non-HIV related tasks based on ownership of facility (Ssengooba et al., 2009).

Figure 4.4.3 shows that cadres in NGOs and HIV related activities generally have higher salaries than their counterparts in government owned facilities and PNFPs.

Figure 6.4.3: Average monthly salaries for selected cadres across analytical categories in 2009



Adopted from Ssengooba et al 2009

4.4.4 Innovations in HRH

Hard to reach allowance

A special and fixed wage allocation is made for hard-to-reach areas as an incentive to influence retention and deployment (MOH et al., 2012). It is expected that health workers in post conflict Northern Uganda will benefit from this. However, key informant interviews revealed that the definition of "hard to reach areas" is unclear. One of the key informants expressed concern that hard to reach allowances are given to those in rural areas. However, the definition of what is rural or urban is also not universal since former camps are regarded as urban.

A situation was cited where the government started to take back hard to reach allowance monies from health workers who worked in areas that had small trading centres and were therefore now categorised as 'urban'. It was recommended that the government consider redefining 'hard to reach' areas to cater for such circumstances.

Greater willingness to support salaries of health workers using donor funds

According to the revised Consolidated Appeals Process (CAP) document for Uganda, all donor agencies agreed to contribute resources into a pool (United Nations, 2006). Part of this money was to be used to pay a 30% salary increment for all health workers in hard to reach areas, including Northern Uganda therefore cancelling Uganda's 30% pay as you earn (PAYE)(MOH, 2007). Although this provides a good opportunity for rebuilding health systems through attracting staff to health units that are underserved, it has inherent sustainability challenges (Rowley et al., 2006). It is hard to retain once well paid health workers on low pay after humanitarian agencies end their operations and hand back to the district local government or other agencies.

Cash incentive schemes by districts to attract human resources

There is evidence that districts are taking initiatives to attract doctors; in a bid to tackle the 'missing doctor' problem, the Kitgum District Council decided to pay a top up allowance of Ushs.500,000. As a result, the district has been able to attract and retain two doctors (James Ekiru, 2011). A follow up call to the District Health Officer for Kitgum revealed that money for this allowance came from unconditional grants and locally generated revenue from the district. Within these sources of revenue, there are inherent sustainability issues that should be considered. In addition, top-up amounts vary considerably between districts. In a district meetings for District Health Officers it was revealed that Amolatar district (which is in the neighbouring Lango sub-region) pays 1 million shillings as a top-up to attract doctors.

Staff bonding scholarships

Key informant interviews revealed that certain PNFPs use staff bonding scholarships to retain staff. This is where hospitals send staff for further studies/training and upon returning the staff must commit to serving for an agreed period of time.

Boosting HRH through VHT strategy

As a way to boost HRH in post conflict Northern Uganda, the key informant interviews revealed that the government, donor agencies and INGOs are encouraging the use of village health teams (VHTs). The VHT strategy has also been encouraged elsewhere in the country. A VHT is the equivalent of health centre 1(HC I) and is responsible for the health of community members at household level (see Table 3.4.2).

A VHT comprises of 4 or 5 people voted for by the village. Each member is in charge of 25 to 30 households (MOH, 2001). The overall goal of a VHT is to strengthen health service delivery at household level for improved quality of life. They are also used to establish a household information system that helps planners introduce targeted health interventions under the Health sector strategic plan (HSSP) and the Millennium Development Goals (MOH, 2001).

In the context of Northern Uganda, VHTs are important in filling the gap left by the scarcity of health workers in the region. VHTs can assist with mobilising communities for utilisation of health services; health promotion, and carrying out home visits and follow ups. In this way, VHTs can help build numbers of human resources for health in the region.

5 Research opportunities

The ReBUILD project is based on the hypothesis that systematic research can help to identify opportunities to rebuild health systems. The following sections present a discussion of some of the contextual changes and processes in Northern Uganda, and the corresponding research opportunities they present.

5.1 Return/resettlement process and current incentives

In the post conflict period many internally displaced people are returning to their home areas or resettling elsewhere within the region. However, it is not clear whether health workers will follow suit despite there being incentives in place such as the hard to reach allowance and top up allowance. Although there is evidence that districts are taking it upon themselves to tackle the missing doctor problem, the sustainability of these initiatives is concerning.

There are also differences between districts regarding the amount of top up paid e.g. doctors in Kitgum receive Ushs 500, 000 compared to Ushs 1 million in Amulatar district. Differences in payment may also exist between the different INGOs in the region. This therefore presents an opportunity for studying and understanding the post conflict dynamics on human resources for health and the effects of these various incentives. Research could also be conducted on how the different types of pay and incentives introduced by INGOs contribute to unsustainable expectations.

5.2 Availability of different bundles of services

Efforts have been made to expand health and non-health service packages by government, international and national organisations. The non-health service package includes education support and poverty reduction support, particularly in the form of micro finance and village saving schemes. Some programmes have also targeted issues of land ownership and assistance

with agricultural inputs. Kruk et al. (2009) noted that other social programmes such as education or employment creation may share some of the state building features of health systems.

In addition to established PNFP actors, a large number of local and international humanitarian NGOs are providing basic healthcare in the absence of effective government service provision. The healthcare package by INGOs includes running health centres, nutrition and therapeutic feeding programmes, trauma care (AVSI and TPO) and hospital support. In the wake of HIV/AIDS, the healthcare package includes prevention of mother to child transmission (PMTCT) and HIV/TB programs (NUMAT) (Rowley et al.,2006).

Other health related programmes include active malaria prevention strategies, immunisation programmes, nutrition programmes (by UNICEF) as well as maternal and child health services. A critical look at both the health and non-health services offers us an opportunity to study the different "sets" of the determinants of health, their normalisation processes and the effectiveness of such programmes.

There is also an opportunity to conduct a benefit incidence analysis of selected programmes. This may link with the themes of financing and aid effectiveness, which are some of the core areas of the ReBUILD project. In relation to the healthcare packages by INGOs, it would also be worth investigating how different HRH training/management practices could affect integration within the health system in the region.

5.3 Funding opportunities and Research Opportunities

In Northern Uganda there are various funded programmes targeting poverty reduction, economic empowerment, social infrastructural rehabilitation, improvement of education, land resettlement, peace and reconciliation, and healthcare. Such programmes may have an influence on the health system in Northern Uganda.

Table 4.1.3 summarises some of the projects in northern Uganda, activities and source of funding. In addition, there are other mainstream programmes that are funded by the government of Uganda, namely the National Agricultural Advisory Services (NAADS), Universal Primary Education (UPE) and Universal Secondary Education (USE). Most of the development agencies work with international and local NGOs/CSOs to implement the programmes.

The availability of multiple funding sources creates a wider base for financing health services. Such an opportunistic financing environment many help us answer some of the questions in our research agenda.

Table 5.3 Summary of opportunities in post conflict Northern Uganda and corresponding research opportunities

	Existing opportunity	Corresponding Research opportunity for ReBUILD Project
1	Resettlement of the population from IDP camps to their original residential areas	• What is the skill mix of health workers in post conflict Northern Uganda? • What are the most effective ways to improve rural deployment as well as motivation of human resources for health in post conflict areas? • Beyond finance, what are the motivational factors for HRH? • What does "going back home" mean from the perspective of health workers and what are the implications?
2	Availability of different bundles of services	• Study the different "sets" of the determinants of health and their normalisation processes • Opportunity for evaluation studies about selected

		programmes and studies around benefit incidence analysis under the aid effectiveness protocol • Household expenditure patterns, particularly for healthcare. What are the opportunity costs?
3	Multiple funding opportunities	• Study aid effectiveness at community, facility and district levels • Evaluation of selected projects over time, e.g. PRDP in relation to staff housing • How can we get sustainable resources for funding healthcare in Northern Uganda? • Study the evolution of the private sector(both local and international)in relation to provision of health services
	Incentives to attract human resources	• How do the different pay/incentives introduced by INGOs contribute to unsustainable expectations? • What is the impact of incentives on HRH overtime?

What are the main issues relating to poverty and gender that should be taken into account in conducting health systems research?

Since conflict is viewed as a predominantly male domain, women and gender issues have generally been excluded from discussions and interventions for conflict and peace (Moser & Clark, 2001). It is acknowledged that men and women share a set of circumstances during armed conflict that exposes them to particularly adverse conditions and to the abuses of their human rights.

There are certain gender-based risks, dangers and disadvantages that disproportionately affect women (Moser &Clark, 2001). Those delivering health services (or conducting health systems research) in crisis and post-conflict must take into account these different needs and ensure equitable access to healthcare for both men and women (Orach et al., 2009). The number of female health workers recruited as well as their working conditions should also considered.

In post conflict Northern Uganda, efforts have been made to empower women economically. Key informant interviews in June 2011 revealed that AVSI had a project known as "Women's Income Generating Support" (WINGS), which supports women's groups in agricultural activities. Proposals are also underway to implement the "Vouchers for Safe Deliveries" project targeting women in the Acholi sub-region under Future Health Systems.

Although these women focused projects/activities may redress gender disparities in women's access to essential services, there is a fear that targeting women as a separate group in the reconstruction process risks fracturing the already stressed social relations. It could aggravate incidences of domestic violence, making it even harder for women to use land (Zuckerman & Greenberg, 2004; Kindi, 2010).

Zuckerman and Greenberg (2004) advised, *"It is also important to not only integrate women in development but to pay attention to gender – the gendered roles and responsibilities of women and men, and the ways in which they relate to one another. That is, work with men as well as women, and with them together; and also mainstream gender into programming or policy making".*

Another issue relating to poverty and gender are land conflicts. The majority of people returning from IDP camps are female. Evidence points to an increase in incidences of widowhood and female headed households, as well as an increase in households where men

failed in their roles while in the camps. This left some women to take over responsibility for their families' livelihoods (Kindi, 2010).

Given that Northern Uganda is primarily agricultural land conflicts coupled with customary practices make it difficult for people (particularly women) to access land for agriculture (Kandyomunda, 2004). A report on issues and recommendations in relation to the National Land Policy also recognises the obstacles that women face in accessing and owning land as well as the root causes of this situation

"The gendered structure of land rights is highly unequal, as women are economically constrained by their social roles and responsibilities, their low status, lack of ownership and access to productive assets, low participation in decision-making and high workload. This is because access to, and use of, land in Uganda is underpinned by the patriarchal nature of traditional communities, in which women and girls can only gain access to land through their male kin in their life cycle. Girls and unmarried women can claim land through their fathers. When they get married women claim land through their husbands." (Ministry of lands 2009, p.33)

In the presence of land conflicts, women are unable to practise agriculture and thus remain trapped in poverty. In these circumstances it is unclear how women, who are in turn tasked with the burden of caring for families, access healthcare in their areas of return. As one of the key informants revealed, women, particularly those in female headed households, are sometimes faced with a dilemma of either taking a sick child to the hospital and leaving other children unattended at home, or taking all of the children to the health centre where there is no provision of food.

Available literature shows that the majority of the population in Northern Uganda is living in dire poverty yet still pay for healthcare, despite the abolition of user fees in 2001 (MoFPED, 2002; UBOS, 2004). Research needs to be carried out to provide a clear picture of the gender

implications of payment for healthcare and what the opportunity costs are (this applies to both private, government and private not for profit facilities).

What are the main issues relating to governance to be taken into account in conducting health systems research?

Governance refers to the set of rules and institutions by which authority in a country is exercised (Kauffmann et al., 2007). Health governance is the process of competently directing health systems resources, performance and stakeholder participation towards the goal of saving lives and doing so in ways that are transparent, accountable, equitable and responsive to the needs of the people (USAID, 2006).

The main issues relating to governance that should be considered when conducting health systems research in post conflict Northern Uganda are those of having many actors engaged in health systems development in the region. These include the central government, local government, donors, NGOs and CSOs. In addition, community level structures and civic leaderships are being re-institutionalised in the post conflict period. The myriad of actors raises issues of coordination and harmonisation for the developing the region. However, it also brings new power relations and interdependencies for service provision that need to be considered. For instance we have donor-government relationships, donor-donor relationships and coordination as well as relationships between local governments and different partners.

In order to understand governance, we need to consider the rights and responsibilities of each actor, which in turn affect priority setting in the health system.

6 Conclusions

Study limitations

The research team sought to include more Northern Uganda specific information, however much of the relevant information is not collected systematically, hence the justification for this CSA report.

Summary of key actors, agendas and identified gaps that ReBUILD should attempt to fill in the local context

The key actors in health systems development include the government, donors, the private sector, NGOs and CSOs.

This review shows that there are several opportunities for the ReBUILD programme (Table 5.3). There are also some broader questions that fall outside the ReBUILD agenda but are pertinent to the broader reconstruction of the health system. Such questions relate to the evolution of the private sector as service provision in post conflict Northern Uganda, and issues of governance and evaluation of the effectiveness of current programmes. Therefore, there is a need to either create networks or to find some linkages within ReBUILD to improve these.

Although the private sector section may not be central to the ReBUILD agenda, it is important for this work to explore how the private sector (particularly indigenous NGOs) can grow not only to help systems strengthening but also to help sustain contributions of INGOs, for instance through contracting. Additionally, there are plenty of other health system constraints across the country – for example, shortages in finance, health workers and other supplies. Although ReBUILD will focus on the post conflict context, these will be beneficial for the whole health system.

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Annexes

ANNEX 1: Key informant guide

Bio data

Name of contact person:

Organisation:

Position in organisation:

Organisation's period of operation in the area:

Scope of operation (areas covered):

Services provided by organisation:

Other questions

1. How is the general health of the population now that people are resettling back in the communities?
2. What are the government programmes doing to improve health service delivery?
    a. Probe for innovations in financing
    b. Probe for innovations in human resources(attraction and motivation)
3. Which other organisations are providing health services in the region (in the last 2-3 years)?
    a. What are their areas of focus?
    b. What are the innovations in financing of healthcare services?
    c. What are the innovations in human resource (attraction and motivation)?
4. Replicability
    a. From your experience of working in post conflict Northern Uganda, what lessons can we learn in relation to rebuilding health systems in the area?
    b. What good practices in your operation/programme implementation can be replicated elsewhere?
5. What challenges are being faced (by government or other agencies) in the implementation of healthcare programmes?
    a. Issues of equity – (most vulnerable groups, women, children)

b. Issues of accountability and transparency
c. Participation
d. Sustainability issues

6. What kind of research would you like a programme like ours to address in relation to the questions discussed above?

Annex 2: Key players in Northern Uganda

LIST OF KEY INFORMANTS

No	Name	Organisation	Position in organisation
1	Dr. Engenyi Charles	Gulu referral hospital	Specialist OBGNY
2	Dr. Opira Cyprian	St Mary's hospital Lacor	Executive director/senior consultant radiologist
3	Mr. Tesfier	UNICEF (Gulu office)	Coordinator health programmes
4	Dr. Christopher Franz	AVSI (Gulu)	Senior Technical advisor/programme manager
5	Mr. Rocky Menya Oyoo	American Refugee Committee international(ARC)	Programme coordinator,Ber Bedo Project
6	Dr. Herbert Turyagenda	AAR Health services	Clinical Operations Manager
7	Ms. Judith Adokorach	Care International (Gulu office)	Gender advisor
8	Ms. Jennifer Taaka	Care International (Gulu office)	Psychosocial support advisor
9	Mr. James Otim	NUMAT programme	Deputy Chief of Party (Gulu)
10	Mr. John Opira	Norwegian Refugee Council(NRC)	Senior Project Officer (Camp management, Durable Solution
11	Ms. Stephanie Perham	UNHCR, Sub Office Gulu	Associate Reporting / Donor Relations Officer
12	Dr Alfred Olwedo	Kitgum District Local Government	District Health Officer
13	Mr. Oyugi Mathias	CARITAS	Social worker
14	Dr Onek A.P	Gulu district Local	District Health Officer

		Government	
15	Ms. Rhoda Oroma	Kitgum District Local Government	Assistant Chief Administrative Officer
16	**Ms**. Majorie	World Vision(SPEAR project)	Coordinator

Note: The numbering of the references to the quotations in this report is not in any way linked to the names as they appear in this table. Rather, it is linked to the order of transcripts as they were filed.

ANNEX 3: Framework for analysing existing literature on health financing

Illustrative grid for analysing dominant themes in health financing research outputs (to be elaborated as documents are reviewed)

Health financing function	Resource generation/pooling	Resource allocation	Purchasing/provider payments	Provision of services
Topics (most cut across the functions but can be seen as primarily linked to one)	Public expenditure patterns Global health initiatives; aid; aid coordination User fees & exemptions Insurance (social, community-based etc.)	Budgeting Resource allocation	Contracting Pay and incentives (individual and for facilities) Performance-based funding	Public/private mix Decentralisation Cost and efficiency of services
Linking topics	Links between these topics and overall health system performance Impact on equity and access (household payments; use of services; coping strategies; affordability, etc.) Demand-side finance approaches			

Annex 4: Framework for analysing literature on human resources for health

Illustrative grid for analysing dominant themes in human resources for health research outputs (to be elaborated as documents are reviewed)

Human resource function	Education and training	Staffing supply	Performance management	Personnel administration
Topics (most cut across the functions but can be seen as primarily linked to one)	Links to workforce planning Curriculum design Regulation & accreditation In-service training linked to performance management /continuing professional development	Workforce data analysis (numbers, types, density, geographic distribution, gender, by employer) and trends; unemployment Internal and external migration Skills mix/task shifting Workforce planning (including strategies for staffing underserved areas) HR financing dual working/ 'moonlighting'	Absenteeism Performance management systems (including supervision) Performance-based incentives/pay Quality improvement	Pay and Benefits (pension, housing, etc.) Career structures Workplace environment Labour relations (incl. unions/ professional associations)
Linking	Links between these topics and overall health system performance			

topics	HR information systems (covers all HR functions) Impact on equity and access (staff distribution, quality) Impact on quality (skills, incentives) Impact on global budget for health sector (HR is usually the biggest part)