SYMPOSIUM ON MANAGING THE TRANSITION FROM HUMANITARIAN TO DEVELOPMENT AID: EAST AFRICAN SYMPOSIUM ON AID EFFECTIVENESS AND HEALTH SYSTEMS DEVELOPMENT

PROGRAMME BOOK

THEME

Aid and Aid Effectiveness in Post Conflict settings: Transitioning from Humanitarian assistance to developing capacity for health systems.

15th – 16th AUGUST 2018
SERENA HOTEL
KAMPALA UGANDA

MAKERERE UNIVERSITY

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Contents

Responding to humanitarian crises in ways that strengthen longer-term health systems: What do we know?

Brief prepared by **Kim Ozano** and **Tim Martineau**

July 2018

Increasing global conflict and fragility means the health of the world's poorest and most vulnerable populations are at risk. To address this, it is crucial that the international community can respond to humanitarian crises in a way that also leads to sustainable long-term development.[1,2] This is not a new problem, but one with challenges of differing principles and ways of working between relief, rehabilitation and development agencies. Within the health sector, the humanitarian provision of short-term health needs can have an immediate or longer-term impact on the development of sustainable health systems and longer-term health goals.[3,4] Most actors see the value in achieving Sustainable Development Goals (SDGs) in conflict and crisis-affected settings, however, there are tensions between delivering emergency services in a timely and flexible manner and achieving longer-term, country-led, health goals.[5] Whilst there are efforts to improve connectivity between humanitarian and development actors through better coordination, shared outcomes, financing streams and engaging in longer-term planning,[6] differences in working principles, mandates and cultures present challenges to achieving this.[2,7] In addition, protracted crisis situations, such as South Sudan and Syria, require humanitarian and development sectors to act simultaneously.[2,5,7,8] This brief outlines what is known about how to respond to humanitarian crises in ways that also contribute to subsequent stronger health systems.

The humanitarian-development nexus for aid delivery

Historically, the separation between relief, rehabilitation and development assistance has often resulted in a vacuum of service delivery between emergency services and longer-term health reforms.[6,7] To address this, partners at the 2016 World Humanitarian Summit agreed a 'New Way of Working' (NWoW) based on a shared understanding of sustainability, vulnerability and resilience.[9] The 'NWOW' supports having pooled data, analysis and information frameworks with better joined up planning and programming processes,[9] that aspire to support national and local ownership with capacity development spanning multiple years. The G7+ have published examples of health projects inspired by the New Deal.[10]

Key messages

There is a new global momentum to address the transition gap from emergency aid to development. The existing literature and experiences outlined in this brief suggest some overarching areas for consideration if interventions are to contribute to (or at least not undermine) long-term health systems for vulnerable populations while meeting immediate health needs.

- **Identify commonalities in the principles behind humanitarian and development efforts**
- **Identify how donors can support implementing partner organisations and their workforce to better link relief, rehabilitation and development**
- **Consider how resource distribution may support or hinder linkages between governments, humanitarian and development actors**
- **Apply health development principles early on in emergency settings, with longer-term perspectives and planning**
- **Where there is no legitimate government in place, consider decentralised planning, analysis and funding**
- **Involve local partners in needs assessments and decision making to strengthen capacity at national and sub-national levels**
- **Track the intentions of international actors at the local level to predict gaps in service delivery and minimise potential threats to longer term health outcomes**
- **Be aware of the impact that power relations and vertical programming may have on longer-term health systems strengthening**
- **Evaluate and share practical examples of how programmes have achieved better connectivity between aid sectors without compromising quality of service delivery**

All the briefing papers in this series can be accessed at http://bit.ly/2rUPRH9

This briefing paper series has been developed by the **ReBUILD Research Programme Consortium** to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a **research agenda-setting study** carried out by the **Health Systems in Fragile and Conflict-Affected States Thematic Working Group** of Health Systems Global.

www.rebuildconsortium.com

Whilst this focus on the 'humanitarian-development nexus' is welcomed by many, it is not without contention.[5,11] Some international non-government organisations (NGOs) argue strongly that efforts to converge humanitarian and development goals present risk to delivering timely and responsive emergency services.[12] There are also concerns regarding the disconnect between humanitarian principles of neutrality and independence, and development goals that require a partnership approach with potential political and governmental allegiances.[5,13] Caution is needed when advocating for principles such as government ownership, when humanitarian partners are often required to work with illegitimate agencies to ensure vulnerable people receive services. Engaging humanitarian actors in discussions early on may help alleviate concerns and encourage productive communication.[2,13] Furthermore, the 'NWoW' has been criticised for having no clear implementation process, milestones or benchmarks to monitor the process.[11] However, projects aligned with the NWoW and the New Deal principles are already being developed and implemented.[10,14,15] **(See Box 1)**

Box 1 – NWoW and New Deal principles in practice

Designing collective outcomes to address the ongoing protracted crisis while contributing to longer term SDGs

The financing strategy mission in **Sudan** brings together multiple donors from humanitarian, development and peace agencies to set collective goals with clear financing streams for immediate needs such as nutrition, building health facilities and infrastructure, as well as longer-term goals associated with strengthening the ministries and laying the groundwork for delivering against the SDGs.[14]

Applying heath development principles early on in emergency settings to set the ground for development

The DARES collaboration, operating in **Yemen**, **Central African Republic**, **Somalia** and **Libya**, defines short, medium and longer-term targets and results, with specific activities to identify national and sub-national capacity requirements including strengthening health systems and the health workforce.[15]

Limited practical examples of bridging humanitarian and development principles

Literature highlights the need for new ways of working but there is limited guidance about how to do this in practice.[16] Practical examples of how donors, NGOs and governments have implemented change, no matter how small, are needed to help implementers understand ways of better connecting without risking quality of service delivery.[16] Aspirational programmes in health which are trying to align humanitarian, recovery and development goals will need evaluation and dissemination to share lessons learned and highlight best practices.[5,16]

Limited crosscutting experience within implementing organisations

With few professionals having experience across relief, rehabilitation and development assistance, there is a deficiency of expertise and capacity to work across different forms of aid and coordinate activities.[16] Encouraging organisations to develop their workforce to gain experience of delivering health services in all stages of fragility would benefit joint programme planning. Shared offices and programmes of implementation could facilitate this process.[1] Donors could also help transition by funding the same organisation to deliver humanitarian and development programmes, incentivising them to link strategies, and supporting them to develop opportunities for follow-up funding.[2]

With the above limitations in mind, it is also important to recognise the challenges already raised by the development sector around building sustainable health systems after conflict or crisis. The examples discussed below draw both on literature and lessons from protracted crisis and post-conflict/crisis development sectors, and wider lessons on challenges for sustainable health systems in low and middle-income countries. **See also accompanying brief on sustainability of health systems**.

Risks associated with vertical programming led by international agencies

The distribution of finances and resources from donors to local providers is a key issue for sustainable health systems with ongoing humanitarian work **(see accompanying brief on types of healthcare provider)**. Often, donors fund local NGOs to provide pre-determined services with vertical systems for monitoring, reporting and budgeting with minimal state involvement.[1] Interventions are delivered as isolated programmes (e.g. maternal and child health, HIV/AIDS) focused

on short-term results.[17] As governments become more functional and legitimate, they inherit a verticalised, fragmented health system with minimal skill development of the health workforce.[18] A social network analysis assessing organisational infrastructure for service delivery in post-conflict northern Uganda found much less support for workforce strengthening compared with programme-specific agendas for HIV and maternal health services.[18] Wider literature highlights a lack of appropriate policies in conflict and crisis-affected settings related to governance and administration systems including organisational planning, financial and human resource management for deployment, incentives and gender equity – all needed to ensure a fair balance across sectors and geographical distribution.[4,8,19]

See also accompanying briefs on inclusive health systems and sustainability of health systems; also the **'Building Back Better' e-resource on gender and post-conflict health systems.**

A long-term approach to health system reconstruction and strengthening, aimed at consolidating the state, supporting government legitimacy and ensuring effective, equitable service delivery, is required in conflict/crisis-affected settings.[20] Health service visibility can enhance credibility and legitimacy, whereas bypassing government health systems for long periods of time can mean communities develop negative perceptions of government services, as found in Nigeria and Sierra Leone.[20] Legitimacy of governments is further exacerbated when NGOs recruit health workers on terms that are not sustainable by the host government.[21] A better understanding is needed of how international resource flows affect long-term health goals at the national and sub-national level. Identifying effective ways to track the intentions and potential disengagement of international actors (e.g. using social network analysis) would enable local governments to predict gaps in service delivery and make adaptations to protect longer-term outcomes.[18]

Managing the power of international aid and supporting country ownership

Whilst the abundance of international aid actors in emergency settings can help deliver much-needed services, actors need to be aware of the power they hold and the risk of creating dependency. Lessons should be heeded from countries such as Cambodia, where the vast amounts of aid resulted in a dependence on international donors at both national and district level.[21,23,24] This fostered a belief that outsiders have 'better' knowledge, resources and power, creating an internalised inferior position within the health workforce.[25,26] Power imbalances have also been reported in Sierra Leone over access to financial resources and information between NGOs and district level managers.[21,27]

To counter such power disparities, actors could better support country ownership of activities by working with governments, where legitimate. Particularly in protracted crises, there is a need to identify concepts and methods for working with pluralistic, under-governed, trans-national health systems.[6] Early development of policies for delivering a set of core health services with performance indicators and a foundation for a sustainable health system can facilitate the process.[28] In Afghanistan, USAID engaged in health diplomacy with both the Ministry of Public Health and Ministry of Finance to promote global health and forward national interests. By supporting such interactions they strengthened the health sector and potentially helped wider state-building.[28]

Decentralised planning and funding in areas with no legitimate government

In conflict-affected settings, there may not be a clear, legitimate government to develop accountable health systems, especially where there are violations of human rights or incapacities.[6,19] Steets et al.[2] suggest decentralised planning, analysis and funding to address issues of national governance. In some cases, bypassing national ministries to work directly with regional level staff and partners has been effective.[17] In South Sudan, larger donors have split their efforts into states to avoid duplication, reporting positive experiences working at this level to analyse data and plan services.[3] Benefits include proximity to the local population, increased motivation to help and a tendency for partners to outlive political change at a personal level.[6] A review of reports from programmes working in conflict/crisis-affected settings found a need for more focus on accountability and participation from affected communities, concluding that the 'NWoW' cannot succeed without accountability to and by those most affected by protracted crises.[6] Global health programmes in Afghanistan that delivered at the local level found improvements in quality and service delivery.[29] **(See Box 2.)**

Box 2 – Involving local partners in needs assessments and decision-making

Global health programmes in **Afghanistan** that delivered at the local level improved both quality assurance and service delivery. This included amendment of educational materials for rural populations, religious awareness in gender groupings for health educational interventions and recruitment of local staff, educated in languages and customs.[29]

Support capacity building of mid-level management

Capacity building processes are often not targeted at mid-level managers by either humanitarian or development sectors, but research suggests strengthening of district health-management teams can quickly improve performance of front-line health workers.[30] Yet in Uganda, district level managers reported a lack of authority to make decisions about their workforce, with minimal control over resources, restricting their capacity to implement decisions.[31] Working at local level can better connect humanitarian aims to longer term development and promote ownership. However, international organisations should ensure they are not simply sub-contracting local partners to carry out pre-designed plans with little input and ownership from partners on the ground, as has been found in Uganda, South Sudan and Burundi.[32] Building capacity of the health system at the district level, together with tracking of resources to ensure ownership of longer term performance, should be considered when delivering aid across humanitarian and development sectors.[17,33]

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ReBUILD Consortium

The ReBUILD Consortium is an international research partnership working on health systems strengthening in settings affected by conflict or crisis.

For more on ReBUILD's research and outputs, visit the website at **www.rebuildconsortium.com** and follow us at **@ReBUILDRPC.**

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MANAGING THE TRANSITION FROM HUMANITARIAN TO DEVELOPMENT AID

East African Symposium on aid effectiveness and Health Systems Development

DATES: 15th –16th August 2018

LOCATION: Kampala - Uganda

VENUE: Serena Hotel, Kampala

THEME

Aid and Aid Effectiveness in Post Conflict settings: Transitioning from Humanitarian assistance to developing capacity for health systems.

ReBUILD Consortium

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ABOUT THE SYMPOSIUM

Background

The aid effectiveness discourse advances the importance of more effective partnership between donors/ aid agencies, recipient governments and implementing partners. In post conflict settings, aid effectiveness aim to align the development assistance to country's priorities, building state capacity and systems beyond the relief phase.

Post-conflict settings present unique opportunities to build health systems despite complex transitions from short-term humanitarian assistance ("emergency relief") programming to longer-term "development assistance". Coordination of the multitude actors during the transition may pose challenges and missed opportunities to health systems development. For instance, The Washington Report on Humanitarian Affairs, John Prendergast observed that, "A new approach to humanitarian assistance is needed. Major progress has been made over the past year in moving away from food aid [….] to a more rehabilitative approach. Further shifts need to be made to reinforce civil structures and build up local capacity". David Milliband a former

minister in UK Government also noted that humanitarian situations (in Kenya) where poverty levels among people outside refugee camps are much higher than those inside the camps – a situation that was not aligned with the medium and long term needs for the local and national economy.

In the recent past, several conferences, symposia and meetings have been held to focus on health in fragile states including conflict settings in Africa. What seems to be missing in all these is a firm focus on rebuilding health systems. Health systems contribute to the social security and safety net that are key to peace and development programming.

Generating evidence to guide post-conflict health programming and aid effectiveness in these setting is sparse. The ReBUILD Consortium, with assistance from DFID has undertaken a programme of research in several countries including Northern Uganda to generate evidence to guide aid programmes in health systems reconstruction. Riding on SDG concerns - Leaving No One Behind, the ReBUILD Consortium with seed support from DFID is organising a symposium on aid effectiveness in post conflict settings in the East African region with the objectives to:

1. Advance the dialogue on aid transitions from relief to development with particular focus on aid flows, programme designs and building capacity for health systems.
2. Create regional visibility and engagements aimed at improving longer-term programming for health system improvements in post conflict settings.
3. Build linkages within regional and global development agencies to improve collaboration, learning and programme designs and adaptions to enhance results and accelerate progress for health and well-being post conflict communities.
4. For those interested, the symposium will also offer skills building session on Apply Social Network Analysis (SNA) in the assessment of aid flows and effectiveness drawing from the work of the ReBUILD Consortium.

Symposium theme

Aid and Aid Effectiveness in Post Conflict settings: Transitioning from Humanitarian assistance to developing capacity for health systems.

Symposium deliberations will mainly focus on the key areas of concern including, general financing for health, human resources for health, community livelihoods and how to manage the transition.

Specifically, the symposium will examine what we are learning in the following areas;

- Transitions in the area of human resources; 1) from expert-hires to a stable and local workforce; from non-state provisions to government-led provisions; and 3) from targeted and well financed essential benefits to fairly diffuse entitlements – among others.
- Transitions in the area of community livelihoods; 1) how communities survive during conflict and immediate post conflict, 2) how the transition from humanitarian support to post conflict reality is managed, 3) voices and experiences of affected communities
- Transition and the burgeoning private sector; 1) the mechanisms to harmonise services provided across and private sectors, 2) integration of the new growth of private providers into the national service delivery system

ReBUILD BRIEF
JULY 2011

ReBUILD Consortium Briefing

A research programme to support health system development in post conflict Northern Uganda

PETER BUSOMOKE

Above
Mother and baby at the mass immunisation campaign in Corner Kilak camp in Pader District, Northern uganda

In countries affected by conflict, health systems break down, and emergency assistance provided by humanitarian organisations is often the main source of care. As recovery begins, so should the process of rebuilding health systems but we do not know enough about how effective different approaches are. Health systems research has tended to neglect post conflict contexts, because it may be more diffi cult to carry out studies in unstable environments and capacity is often weak. The ReBUILD Consortium has been created to address this challenge.

About us

The ReBUILD Consortium is a 6 year research partnership funded by the UK Department for International Development which began in February 2011. We are working in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore how we can strengthen policy and practice during the rebuilding of health systems in post confl ict situations. This document provides an introduction to the Uganda programme.

In Uganda, the research is being led by Makerere University School of Public Health and the School of Women and Gender Studies. Collaborative links with Gulu University will be established so that they can participate in the research activities. The purpose of this partnership is to generate research evidence that responds to the challenges that policy makers are facing. We plan to engage with stakeholders from Government, development partners, academia and civil society throughout the research process to ensure that REBUILD activities are relevant and support processes to develop the health system in post conflict Northern Uganda.

Our partners

Biomedical Research and Training Institute, Zimbabwe
http://www.brti.co.zw

Cambodia Development Resource Institute, Cambodia
http://www.cdri.org.kh

College of Medicine and Allied Health Sciences, Sierra Leone

Institute for International Health and Development, Queen Margaret University, Edinburgh
http://www.qmu.ac.uk/iihd

International Health Group, Liverpool School of Tropical Medicine
http://www.lstmliverpool.ac.uk/research/academic-groups/international-health/health-systems-development

ReBUILD Consortium

Our focus

The Uganda programme will focus on the North of the country which is facing particular health system challenges as a result of emerging from conflict. We will focus on the Districts of Acholi Sub region and others in close proximity. Other districts may participate in order to provide comparative perspectives as needed.

Health financing and the workforce for health programme will form the main themes of the ReBUILD work. For instance, difficulties in recruiting and retaining the health workforce mean that there is a lack of qualified personnel in post conflict health facilities. The ratios of health worker to population are extremely low. Many public rural facilities are non-functional in the Acholi sub-region. Despite intensive efforts to re-equip facilities over the past couple of years, most communities are too far away from a functional facility. In some areas the practice of a health worker working in more than one facility is an issue and informal charging for health services may create a barrier to access. Nonetheless, the reconstruction activities in post conflict Northern Uganda represent opportuniti-esto rebuild the health system. The Government and international community have provided additional financial resources to address different constraints in the health and related systems. The ReBUILD Consortium will contribute research evidence to help optimize these opportunities for health system development. We hope that the ReBUILD Consortium can provide a platform to strengthen existing research-to-policy links and broker new opportunities for exchange.

Research themes

Understanding changes in health financing and poor households' expenditure on health

User fees in Uganda were abolished in 2001 and so health services are theoretically free. In practice there is a complex, plural system. Our research will look at changes in health financing policies and their relationship to the post conflict trajectory. We will explore how policy changes influence the behaviour of households and their spending. Attention will be paid to the gendered implications of policy and expenditure.

Exploring the development of the health workforce in post conflict areas

As health systems are reconstituted after conflict, there are opportunities to modify health workforce policies and practices, including health worker incentives. In Uganda many internally displaced people are returning to their homes in the North but it is unclear whether health workers will follow suit. In the light of the need to attract health workers from the urban to the rural areas the Government is providing a 30% pay rise to those who work in hard- to- reach areas. Our research will enable us to better understand the post-conflict dynamics for health workers and what form of incentive environments best supports rational and equitable health services. We will explore how incentive environments have evolved in the shift away from conflict, what has influenced their trajectory and what the effects of this are.

The project will research the scope for reconciling health worker survival strategies with incentive structures that promote pro-poor health care.

Above
A nurse helps patients at Lira main hospital

Key policies

Our work is aligned with:

The *Peace, Recovery and Development Plan (PRDP)* which focuses national and international attention on enabling the North to catch up with the rest of the country developmentally, including on its health indicators.

The *Health Sector Strategic and Investment Plan (HSSIP)*, 2009/10 – 2014/15, which guides policy at the national level with the aim of increasing access to, and the quality of basic primary health care. HSSIP recognises the need to tailor interventions in the North to fit the post-conflict situation.

The *Human Resources for Health Strategic Plan and Policy*, 2005 – 2020, which seeks to guide the development, distribution, retention and motivation of the health workforce to improve productivity and performance of the health system.

Our research will also support Uganda's efforts toward the *Millennium Development Goals (MDGs)*, particularly MDG 4 on child health, MDG 5 on maternal and reproductive health and MDG 6 on communicable disease.

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Business Unusual: CARE International's experience on the path to transitioning from humanitarian response to long term development in West Nile

Uganda remains the biggest recipient of South Sudanese Refugees, Population of refugees and asylum seekers in Uganda is estimated to be 1,472,566 of which 72.5% (1,067,637) are from South Sudan. The humanitarian situation for South Sudanese refugees in Uganda and in particular those arriving in the West Nile Region has continued to deteriorate, the mass influx has put a lot of pressure on the country's resources, land and basic services.

Since 2014, CARE Uganda has been responding to the South Sudanese Refugee crisis with interventions in Sexual and Reproductive Health (SRH) and GBV prevention, care and support in Imvepi, Rhino and Bidibidi settlements in the West Nile Region with funding from ECHO, Norwegian Ministry of Foreign Affairs, Global Affairs Canada, UNFPA and Austrian Development Agency.

CARE has been able to put to provide services and support in areas of GBV/protection response and prevention; Sexual Reproductive and Maternal Health; Semi-permanent and temporary shelter provision to Persons with Special Needs; and Livelihoods support to the vulnerable groups especially women and girls as represented in the table below;

Cumulative Accomplishments to date by Sector from December 2014 to June 2018							
By Sector	Children < 5years		Children 6 to 18years		Women	Men	Total
	Female	Male	Female	Male			
GBV/SRMH	438	113	10,039	6,369	95,178	60,110	172,247
Shelter	1,676	1,619	2,769	2,660	9,299	6,146	24,169
Livelihood	0	0	0	0	4,859	659	5,518

Transition from temporary to integrated livelihood semi-permanent shelter programing: CARE has provided dignified, safe and sustainable shelter to the most vulnerable members of the refugee community. The design aligns with the Inter Agency GBV and shelter guidelines, and incorporates durable materials such as zinc-coated iron sheets to help the shelter stay cool during the day, as well as burnt brick and cement mortar lined pits for latrine and bathing facilities to avoid collapsing.

Survivor centred Gender Based Violence programming: CARE has increased its support through a survivor centred approach to protection from GBV and Sexual Exploitation and Abuse of refugees & host communities through information provision, making safety improvements, training community leaders, and case management services. Community based facilitators (CBFs) have been central to achievement these goals.

Sexual Reproductive Health and Rights: CARE has provided timely access to lifesaving SRHR services for crisis-affected populations through strengthened the referral system, increased community outreaches as well as institutional and human resource capacity building. CARE's work in SRHR has been undertaken within existing MOH/local district health structures using a rights based approach. Additional capacity building training for health staff and Community Based Facilitators has been organized from time to time.

Symposium program

DAY 1: WEDNESDAY, 15TH AUGUST 2018			
Session type	**Time**	**Description**	**Facilitators**
	08.00am-08:30am	Registration	Secretariat
PLENARY SESSION 1	8.30am-10.00am	**INTRODUCTORY SESSION**	**Chair: Dr. Sarah Ssali**
	8:30-8:45	Welcome remarks-ReBUILD Uganda	Dr. Aloysius Ssennyonjo / Ms. Milly Nattimba
	8:45-9:00	Remarks by ReBUILD UK	Mr. Nick Hooton
	9:00-9:45	Co-funder's message	CARE International in Uganda
	9:45-10:00	Aid architecture: setting the scene	Professor Freddie Ssengooba
	10:00-11:00	**OFFICIAL OPENING CEREMONY**	**Chair: Dr John Ssekamatte**
	10:00-10:10	Anthems (National & EAC)	
	10:10-10:15	Remarks by the Dean, Makerere University School of Public Health	Assoc Prof. Rhoda Wanyenze
	10:15-10:20	Remarks by the Principal, Makerere University College of Health Sciences	Prof. Charles Ibingira
	10:20-10:30	Speech by the Director General of Health Services, Ministry of Health	Dr. Henry Mwebesa
	10:30-10:40	Speech by Representative, DFID	
	10:40-11:00	Speech by Minster of State for Disaster Preparedness, Office of the Prime Minister	Hon. Musa Ecweru
	11.00am-11.30am	**BREAK**	
PARALLEL SESSION 2	11.30am-1.00pm	**Panel session 1:** Funding models and the impact on transitioning from humanitarian aid to long-term development planning.	**Session Chair: Prof Freddie Ssengooba** **Panellists:** 1. Dr. Ritah Nakigudde-DFID 2. Professor Suzanne Fustukian 3. Dr. Robert Limlim-Office of the Prime Minister 4. Dr. Peter Okwero-World Bank Uganda 5. EU 6. Mr. Samuel Okello - CARE International in Uganda 7. Dr. Martin Mayen, Health Pooled Fund, MoH S. Sudan

	1.00pm – 2.00pm	**LUNCH BREAK**	
PARALLEL SESSION 1	**2.00pm-3.30pm**	**Parallel sessions 1A: Aid, aid effectiveness and macroeconomic considerations**	**Session Chair: Dr. Ibrahim Kasirye**
	2:00-2:15	Development aid flows: macroeconomic challenges and possible remedies.	Mr. Marios Obwona, National Planning Authority
	2:15-2:30	The impact of aid on health outcomes in Uganda	Tonny Odokonyero, EPRC
	2:30-2:45	"You win some, you lose some" An analysis of PEPFAR's HIV-specific donor funding model after a decade of support in Uganda (2004-2014)	Mr. Henry Zakumumpa, Makerere University
	2:45-3:30	**Discussion**	
	2.00pm-3.30pm	**Parallel sessions 1B: Human resources for health in conflict and post conflict settings**	**Session Chair: Dr. Richard Mangwi**
	2:00-2:15	Baylor Uganda's Experiences in contracting health workers	Mr. Paul Akuguzibwe
	2:15-2:30	Managing transitioning of contract health workers into formal district employment systems	Ms Vento Ogora Auma
	2:30-2:45	District health system manager's perspectives on managing contract donor-supported health workers in post conflict settings	Dr. Janet Olaa DHO - Nwoya
	2:45-3:00	Living through conflict and post-conflict: experiences of health workers in northern Uganda and lessons for people-centred health systems	Ms. Justine Namakula
	3:00-3:30	**Discussion**	
	3.30pm-3.45pm	**BREAK**	
PLENARY SESSION 3	3.45pm-5.00pm	**Panel session 2: T**he role of non-state providers in building and strengthening health systems during and post conflict.	**Session Chair: Dr Sam Orach** **Panellists** 1. Ms Justine Namakula – ReBUILD 2. Dr Timothy Musila-MOH 3. Dr. Paul Onek – DHO Gulu district 4. Dr. Ian Clarke – Clarke Group 5. Dr. Abdullahi Rashid Ibrahim- UNICEF Somalia 6. Mr. Kenneth Massa – CARE International 7. Mr. Emmanuel Ngabirano 8. Dr. Christine Namayanja
	5.00pm-7.00pm	Social event and departure	

DAY 2: THURSDAY, 16TH AUGUST 2018			
Session type	**Time**	**Description**	**Facilitators**
	08.00am-08:30am	Registration	Secretariat
PLENARY SESSION 4	8:30-11:00	**Health systems in conflict and post conflict settings**	**Session Chair: Prof Christopher Garamoi Orach**
	8:30-9:15	**Special presentation 1:** Health systems consideration and development aid. What are we learning from ReBUILD project?	Prof Freddie Ssengooba, Team Leader, ReBUILD Uganda
	9:15-9:45	**Special Presentation 2:** Managing epidemics in conflict settings: Implications for rebuilding systems	Dr. Haja Wurie, Sierra Leone
	9:45-11:00	**Panel session 3: Health service delivery models and how they affect the transition through and post conflict**	**Panellists:** 1. Dr. Julius Kasozi 2. Dr. Charles Olara, Director MOH 3. Dr. Nathan Onyachi , Former Director -Gulu Regional Referral Hospital 4. Dr. Cyprian Opira-Lacor Hospital 5. Brigadier Dr. Ambrose Musinguzi-UPDF 6. Dr Peter Lochoro- Country Director CUAAM 7. Bishop John Baptist Odama
	11.00am 11.30am	**BREAK**	
PARALLEL SESSIONS 2	**11:30-1:00**	**Parallel session 2A: Skills Building Session on how to use aid management tools to track aid flow**	**Facilitators:** **1. Prof. Freddie Ssengooba** **2. Dr. Christine Kirunga**
	11:30-1:00	**Parallel session 2B:Strengthening support systems in conflict and post conflict settings**	**Session Chair: Dr. Kasozi Julius**
	11:30-11:45	Leveraging aid to strengthen the laboratory sector in Uganda	Dr. Suzanne Kiwanuka - MakSPH
	11:45-12:00	Building and strengthening leadership capacity for aid effectiveness	Mr. Conrad Musinguzi, Baylor Uganda
	12:00-12:15	Providing legal aid in refugee and post conflict settings	Refugee Law Project, Uganda
	12:15- 12:30	Experiences from South Sudan Health Pooled Fund	Dr. Martin Mayen
	12:30-1:00	Discussion	

	1.00pm-2.00pm	**LUNCH BREAK**	
PLENARY SESSION 5	**2.00pm-3.30pm**	**Panel session 4: Bottom up responses: Community resilience and resources, gender and related issues in post conflict settings**	**Session Chair: Dr. Alfred Driwale** **Panellists:** 1. Dr. Sarah Ssali, ReBUILD Uganda 2. Mr. Egan Tabaro 3. Dr Andrew Ocero-URC 4. Hon. Fungaroo Kaps Hassan, Arua 5. Ms. Delphine Mugisha – CARE International 6. Mr. Mathew Nviiri, RI 7. Salome Awidi, UNISA PhD student
PLENARY 6	**3:30-4:15**	**Closing ceremony**	**Session chair: Dr. Sarah Ssali**
	3:30-3:40	Symposium highlights	Dr. Aloysius Ssennyonjo & Ms. Milly Nattimba
	3:40-3:45	Remarks by ReBUILD Consortium, UK	Mr Nick Hooton
	3:45-3:55	Closing remarks, DFID	TBC
	3:55-4:15	Speech by PS, Office of the Prime Minister	Mrs. Christine Guwadde Kintu
	4.00pm-4.30pm	REFRESHMENTS AND DEPARTURE	Secretariat

MAKERERE UNIVERSITY

ReBUILD Consortium

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SKILLS BUILDING SESSION

How to use aid management tools to track aid flows: Practical Introduction to Social Network Analysis (SNA) for Systems Development

Date: Thursday 16th August 2018 Time: 11.30am – 1.00pm

Main Facilitator: Assoc. Prof Freddie Ssengooba, PhD Co-facilitator: Dr. Christine Kirunga-Tashobya, PhD

Overview of the Skills Building Session

Unlike the dominant health systems analytical methods that collect information about the agent or actor characteristics and behaviour, applied SNA is a useful tool to explore the interaction and links between agents. This training session will introduce and create confidence in the applications of applied SNA techniques in health systems research.

Purpose and Objectives

a) To challenge participants to appreciate the research questions and methods for studying relationships between agents in addition to the study of agents in isolation of these relationships

b) To demonstrate the steps in research design for applied social network analysis based on the 2017 published study; *"Application of social network analysis in the assessment of organization infrastructure for service delivery: a three district case study from post-conflict northern Uganda"*

c) To demonstrate -using UCINET software- how to handle ego-centric and social-metric data from applied social network analysis for basic analysis and interpretation.

d) To demonstrate how to generate visual analytical outputs such as social graphs (social network diagraphs) and tips for making impactful presentation of social network findings to aid decision making.

Technical content

Presentations and demonstrations of step-by-step application of social network analysis in addressing a health systems research question. Session will use UCINET software and data from the ReBUILD-Consortium study in northern Uganda.

Session Approach

a) Introductory session:

- What is SNA and the relevant research questions that it addresses?
- Introduction to conceptual frameworks that drive network-based analysis;
- Two main approaches to SNA – social-metric and Ego-centric.

b) Practical session on Using SNA

- Interactive presentations using the 5 main steps of SNA study design, sample tools, tips on survey and data handling, basic manipulations, analysis and products.
- Facilitator-led demonstrations; participants will be walked through the essential steps applying SNA from research question through to database, analysis and interpretation.
- Participants will ask questions and interact with the facilitators for each step.

c) Concluding session

- How participants intend to use SNA and where they would need assistance.
- Participants will get a list of training opportunities for SNA across the globe and on-line courses, software, and slides used for the sessions.

Target audience

Young researchers, students in doctoral and masters programs, research practitioners and academics/faculty.

Significance of the skills building session

It brings a realistic example from a completed study to demonstrate the applicability of social network analysis to the community systems research and practioners within Uganda's health sector. Research scholarship in health systems has had limited adoption and use of social network analysis despite its main advantage – empirical approach to constructing the networks and the interdependencies that exist among organizations that form a functional system for the provision of a particular health service (or outcome) in a given zone/ district.

If well-targeted to the users, the findings from such studies have instrumental benefit for decision makers. In the Uganda case, the findings have been used by MOH to establish ways to allocate fund-holding agencies in a manner that corrects the inter-district inequalities that were demonstrated in the comparative findings (social network diagraphs) between three districts. Managers of the health systems programs for TB or HIV can identify the actors and their centrality and try to steer the health system from empirical evidence of network function and or centrality of the member agencies.

Registration: If you would like to attend the session, please register with;

Ms. Angela Nanyanzi on nanyanzi.angela@gmail.com and copy **Ms. Jackie Norah Nanteza** on Jackie.nanteza@musph.ac.ug. **Registration closes** at 3.00pm on ***Tuesday 14th August 2018***. *A limited number of positions is available.*

ASSESSING THE IMPACT OF "CARING TOGETHER LEADERSHIP APPROACH" ON FRONTLINE HEALTH WORKERS IN UGANDA: A QUASI-EXPERIMENTAL STUDY

Conrad Musinguzi, Leticia Namale, Elizeus Rutebemberwa, Aruna Dahal, Patricia Nahirya-Ntege, Ispas Gabriela, Adeodata Kekitiinwa

Abstract

Leadership plays a key in strengthening human resources for health but very few health workers have been supported in their role as leaders. We sought to measure the impact of the Caring Together leadership intervention on the changes in leadership styles, motivation, job satisfaction and teamwork among health workers.

Using a prospective quasi-experimental design we conducted pre-post facility surveys in the intervention ie Eastern and Rwenzori and the control ie West-Nile regions of Uganda. Data captured health workers' perception of leadership styles displayed by their facility leaders, their level of motivation, job satisfaction, and team work. Paired t-test and Matched propensity score difference-in-difference method were used to measure Pre-post differences and attribute the change to the intervention.

Because of the intervention, transformational leadership increased by 5.3%, p=0.05 and while teamwork due participative decision making and information sharing increased by 5.8%, p=0.04 and 11.1%, p=0.003 respectively. This improvement was pronounced in the Rwenzori region and among lower health centres. There wasn't any significant effect on staff's motivation and job satisfaction.

This leadership training approach encouraged superior leadership styles and fostered cohesion among health workers. Health systems should embrace the Caring Together facility-based leadership model as a successful approach for leadership development.

'You win some, you lose some': an analysis of PEPFAR's HIV-specific donor funding model after a decade of support in Uganda (2004-2014)

Henry Zakumumpa, Makerere University, School of Public Health

There is an unresolved debate in global health circles as to whether PEPFAR's vertical donor support for national HIV responses in low and middle income countries strengthens health systems or undermines them. Drawing upon primary data collected between 2014 and 2016 in Uganda as part of a doctoral study, as well as an extensive desk review, we examine the merits and demerits of vertical donor HIV programming in Uganda since the pilot phase of HIV services scale-up in June 2004. We apply the five principles of the Paris declaration on aid effectiveness to interrogate PEPFAR's HIV-specific donor funding model in Uganda. Whereas PEPFAR's vertical donor funding model, implemented within parallel structures to the mainstream Ugandan health system, was effective in the context of a national HIV emergency in Uganda and achieved dramatic results in HIV epidemic control over the past decade, a paradigm shift is imperative given the backdrop of declining global health aid and the mounting calls for health services integration as well as the emerging discourse challenging the false dichotomy between infectious and non-infectious diseases.

Development aid flows: macroeconomic challenges and policy choices

Marios Obwona National Planning Authority

Most donors aim at promoting poverty reduction, strengthening education, health and agricultural sectors, good governance and ensuring self-sustaining economic growth in the recipient economies. In spite of these broad objectives of foreign aid, economic growth has always been the key benchmark used to evaluate the effectiveness of aid, especially as greater aid inflows are expected to lead to faster growth. However, for most Sub-Saharan African countries, it has emerged that the more foreign aid they receive, the more aid dependent they become.

Two contradictory theoretical conclusions used to explain foreign aid effectiveness. The public interest perspective (PIP) argues that foreign aid does work and that it should be continued to reduce poverty in developing countries.

The public choice perspective (PCP), however, argues that foreign aid does not work, and that it instead harms developing countries and, therefore, should be stopped to avoid further damage. The third explanation of foreign aid ineffectiveness that goes beyond the scope of the PCP is that aid policies are often formulated without synthesis, research and institutional analysis, and thus misinterpret the poor policy environments in developing countries.

Whether effective or ineffective, aid flows bring macroeconomic challenges and this presentation highlights some of those challenges that fiscal and monetary authorities face in managing aid inflows.

The impact of aid on health outcomes in Uganda

Tonny Odokonyero[1], Robert Marty, Tony Muhumuza, Alex T Ijjo, Godfrey O Moses

Abstract

The health sector has attracted significant foreign aid; however, evidence on the effectiveness of this support is mixed. This paper combines household panel data with geographically referenced subnational foreign aid data to investigate the contribution of health aid to health outcomes in Uganda. Using a difference- in- differences approach, we find that aid had a strong effect on reducing the productivity burden of disease but was less effective in reducing disease prevalence. Consequently, health aid appears to primarily quicken recovery times rather than prevent disease. In addition, we find that proximity to health aid is highly influential on the health gains to individuals. Apart from the impact of aid, we find that aid tended to not be targeted to localities with the worse socio-economic conditions. Overall, the results highlight the importance of allocating aid close to subnational areas with greater need to enhance aid effectiveness.

1 Economic Policy Research Centre – SPEED for Universal Health Coverage.

"Engaging private providers to implement output based mechanisms and *strengthening their capacity to report into the national health information system"*

Uganda Voucher Plus Activity is designed to increase health services for pregnant women by promoting safe, facility-based deliveries to reduce maternal and neonatal morbidity and mortality. The Activity improves access to quality maternal and neonatal health services by recruiting private sector providers and building their technical capacity to deliver quality services to pregnant women and processes payments for services rendered.

The Activity is implemented across 33 districts in Northern and Eastern Uganda, with the service package covering four ANC visits, eMTCT, safe deliveries, complications and illnesses in pregnancy, emergency transportation services for delivery, PNC and postpartum family planning services.

Key Results

- Since inception, 195,857 vouchers to have been sold and distributed to poor pregnant women, of which 71% have been redeemed for at least one service to improve safe motherhood practices.
- 71, 386 safe deliveries have been registered since active service delivery in October 2016 to reduce maternal and infant mortality.
- 156 private providers delivering OBA voucher services of which 4 are private wings of public hospitals
- By end of June 2018, a total of $2,836,867 paid to private providers in reimbursements for services rendered to voucher clients.
- Supporting the private sector to use national M&E tools i.e. HMIS and DHIS2 for collecting, using and reporting facility data. Of the 156 providers, 86% are actively reporting into DHIS2.
- DHIS2 statistics for all the 33 supported districts show that the Voucher Plus Activity accounted for an impressive 13% of all ANC1 client visits, 16% for all ANC4 visits, and 22.5% for all institutional deliveries.
- Over 100,000 of private sector fiscal value investments to improve quality of care and support community engagement activities in 2 years.
- 3 BEMONOC private facilities upgraded to CEMONC facilities as a result of OBA

Strategies used to build local capacity for OBA schemes

- Fee for service reimbursements with strong M&E systems
- Collaborative engagement of district DHTs in QI and HMIS
- Fostered private sector investments for HSS.
- Business training for private providers to enhance skills in effective management of health as a business, 'Money make money attitude".
- Community empowerment to demand for quality services- Ugandan-led development approach
- Enhanced public-private partnerships for health (PPPH) through improved referrals and effective service linkages

New theater and equipment at Divine Medical Centre in Sironko

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