

**CASE STUDY 6: REVIEW OF HEALTH SERVICE DELIVERY IN UGANDA -  
GENERAL COUNTRY EXPERIENCE AND NORTHERN UGANDA**

This paper forms part of the 2004 DFID report on Service Delivery in Difficult Environments, undertaken by the Health Systems Resource Centre

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## 17 INTRODUCTION

The inclusion of Uganda as one of the case studies for 'difficult environments' may not be immediately obvious. Uganda is considered one of Africa's economic success stories with an average 7% annual economic growth<sup>113</sup>, political stability for almost 20 years and robust macro-economic and pro-poor policies. As a result donors have moved towards putting their financial development aid into direct budget support and sector budget support, rather than working through projects. However, Uganda persists as a difficult environment or country under stress due to ongoing conflict in the North and East of the country where large areas of the regions remain outside government control. Uganda is not on track to meet MDG health targets, with the government citing insecurity in northern districts as being the primary reason. For example, the rise in infant mortality rates (from 81/1000 in 1995 to 88/1000 in 2000) and in under-5 mortality rates (from 147/1000 to 152/1000) has been blamed on the conflict.<sup>114</sup> The situation in Northern Uganda is summed up by authors of a World Bank case study when they write: "The poor outlying rural districts have shown little improvement in basic social and economic conditions. In many areas, particularly the north where conflict continues, pre-war conditions and levels of livelihoods have still not been restored. Investments in social sectors, such as education and health have failed to improve the overall levels of service delivery."<sup>115</sup>

Conflict and violence are not new phenomenon to Ugandans, nor to Uganda's development partners as the country has undergone a number of phases of political violence since independence. It therefore provides a useful case for analysing donor health service delivery assistance.

### Political-Social Context: 1960 – 2004

Uganda provides an interesting case for exploring how health services have evolved from the heady days of independence through a highly turbulent period in the 1970s and early 80s, to the current phase of relative stability in southern and central regions and on-going instability in northern and eastern regions. For the purposes of this analysis the last 40 years of history will be divided into four phases: (1962 – 1971) post-colonial stability and growth, (1971 – 1986) political turbulence and violence, (1986 – 1993) post-conflict rehabilitation and stabilisation and (1993 – 2004) long term stable government with parts of the country suffering continuing insecurity, with a focus on the latter two phases.

1962 – 1971: The new government inherited a colonial structure of district hospitals, mainly run by the Ministry of Health, health centres that were a mix of government and NGO (mainly religious charities) and private hospitals run primarily by NGOs either in the capital or in very remote and underserved parts of Uganda (e.g. northern districts). The colonial infrastructure was heavily based on hospitals. Makerere University was considered to be one of the best in Africa, with a particularly good reputation for training in medicine, nursing and public health. Communicable disease control programmes and research programmes were active, funded by bilateral donors and research organisations in more developed countries.

There was great disparity in the distribution of physical health infrastructure left from the colonial period. Colonial administrative centres were very well served by infrastructure, especially in the central, southern and eastern parts of the country. Other areas, especially

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<sup>113</sup> [www.aegis.com/news/afp/2002/AFO20694.html](http://www.aegis.com/news/afp/2002/AFO20694.html)

<sup>114</sup> *ibid*

<sup>115</sup> Kreimer et al (2000) Uganda Post-Conflict Reconstruction – Country Case Study. Washington: World Bank

the north, were underserved, with much of the population having to travel long distances to seek care from a 'western' medical centre.<sup>116</sup>

1971 – 1986: Increasing political violence within Uganda under Idi Amin led to the departure of most of the country's development partners from the mid 1970s. A return to security in 1980 saw a return of some of the larger international NGOs in 1980 (e.g. CARE and SCF UK)<sup>117</sup>. Lack of investment in public services and no support from NGOs (except for some religious organisations, which remained throughout this period) meant a collapse of most of the health system. Numerous health providers supplemented their shrinking/non-existent government income by providing private health care in their own clinics. Health service provision was highly fragmented and opportunistic.<sup>118</sup>

During civil war lasting from 1981 to 1986 a number of international NGOs in Uganda provided emergency medical care to both internally displaced and refugee populations, as well as to the general population in the most affected districts. Health interventions in the Luwero Triangle, notorious for the particularly brutal fighting and attacks on civilians, are indicative of support in health at the time. NGOs worked opportunistically depending on the security situation, with expatriate staff providing much of the assistance working through mobile units<sup>119</sup>. Aid was generally fragmented and responsive to specific needs arising from the humanitarian crisis generated by the conflict in the country. The northwest of the country, Amin's homeland, was completely decimated with massive population movement out of the country to Sudan and Eastern Zaire, as well as destruction of physical infrastructure and means of economic production.

1986 – 1993: The National Resistance Army took control of most of the country, defeating the government and many of the other rebel movements operating at the time. The new government, the National Resistance Movement, lead by Yoweri Museveni, began a period of stabilisation of the territory of Uganda and most parts of the country began a period of reconstruction and rehabilitation. Multi-lateral and bi-lateral donors began to put increasing levels of resources in to support the rehabilitation effort. Health care service delivery was a key element of many aid programmes, though this was not mirrored by development of national health policy, which remained ad hoc and focused on hospital rehabilitation.<sup>120</sup> Numerous vertical programmes were created by various donors to fill the policy vacuum (UNICEF – EPI, other child survival programmes; USAID – family planning; Danish aid – essential drugs; World Bank – physical rehabilitation etc.). On-going rebel activity and instability in the north and north east of the country meant fewer resources were put into this area, as donors preferred providing support to the more stable central and southern areas of the country. As various rebel movements were 'put down' further areas of the country were opened up and accessible for government and non-government activity.

1993 – present: The government produced it's first three year national health plan in 1993 along with the 1993 Local Government Statute, and subsequently the Health Sector Strategic Plan in 2000.<sup>121</sup> All documents outlined plans for decentralising government services to district level, including health services. Cost sharing of health services was introduced, first at district hospitals and then at health centres, accompanied by the setting up of health management committees that were to include participation from local communities, though user fees were subsequently abolished by the government in 2001<sup>122</sup>. The government has

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<sup>116</sup> Macrae 2000

<sup>117</sup> SCF UK 2004

<sup>118</sup> Macrae 2000

<sup>119</sup> op cit

<sup>120</sup> Macrae 2000

<sup>121</sup> MOFPED 2002

<sup>122</sup> MOFPED 2002

had a health SWAP from 2000, though not all donors are signed up to supporting health services through the SWAP. Donors continue to use a range of aid instruments to support the health sector, from projects to direct budget support.

Uganda's general reputation as having a 'willing' government arises from its pro-poor policy environment, having established its own poverty reduction policy, and its robust macro-economic policies. The Ugandan Government's Ministry of Finance and Economic Planning has put a ceiling on all sectoral budgets in an effort to maintain control on line ministry related spending, and therefore sustain a strong macro-economic environment<sup>123</sup>. The Ministry of Health ceiling has led to a number of anomalies as some donors who wish to put more into health services turn to project aid to circumvent MOFPED limits.<sup>124</sup>

### Current Situation in Northern Uganda

Northern Uganda continues to pose challenges, both in terms of security and health service delivery. The security situation has deteriorated in the Northern districts since 1994, in contrast with marked improvements made elsewhere in the country. Government troops and rebels are equally accused of committing human rights abuses, leading to deep suspicion of both sides on the part of the local population.<sup>125</sup> Government health services are concentrated in district centres, in hospitals, while international NGOs and churches are providing very limited health care outside district centres, as well as to displaced populations. The 2004 Consolidated Appeal Process found that while prior to 2002 only 50% of health units in northern districts were operating, since then even more have closed down<sup>126</sup>. Health service delivery remains fragmented and opportunistic in many parts of northern Uganda, mirroring health service delivery in the early 1980s in central Uganda. The main difference between the early 2000's in northern Uganda and the early 1980s in central Uganda is the fact that government health services are operating within a national framework and there are functional district health management teams in the northern districts, even though outlying health centres may have little or no staff working in them. Further stress is placed on the system by the large numbers of permanent and temporary internally displaced persons (IDPs) in Northern Uganda, whose numbers have grown in the last year (see Table 1).

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<sup>123</sup> 2004 Health sector review

<sup>124</sup> De loor and Sancho (2004) Uganda Country study

<sup>125</sup> Dolan (2000)

<sup>126</sup> UNOCHA (2004) Consolidation Appeal Programme

**Table 1: Internally Displaced Persons by district**

District	Total Population	Displacement October	April 2004 WFP	April 2004 – Office of the Prime Minister
Kaberamaido	122,924	97,561	107,560	32,520
Soroti	371,898	136,112	88,000	34,000
Katakwi	307,032	104,254	144,945	117,008
Apac	676,244			29,725
Lira	757,763	79,097	289,988	287,996
Gulu	468,407	419,2588	438,678	438,639
Kitgum	286,122	281,372	273,078	279,589
Pader	293,679	229,115	279,526	273,968
Kumi	338,015	59,207		6,000
<b>TOTAL</b>	<b>7,135,797</b>	<b>1,407,976</b>		<b>1,639,017</b>

### Humanitarian Situation 2004 – Parliamentary report

#### Service Delivery Responses

The periods of interest for this study are the post-conflict period and most recent period of partial stability in Uganda. The first two phases outlined above are important to bear in mind as they remain etched in people's memories; the first as a level of service they aspire to (and on which the health infrastructure continues to be based) and the second as a period they hope never to relive again in Uganda.

A number of interesting dynamics were created in the post-conflict/reconstruction phase from 1986 to 1993. There was tremendous political will to create the conditions for full reconstruction in the country, which included efforts at national reconciliation of the various warring factions within the country. The new government formed was inclusive of former political parties, regional and religious factions. This in turn meant that ministers were keen to be seen to bring resources into their particular region or community. The key dynamics of this period included:

- The national government's attention was primarily focused on re-establishing a political and economic environment conducive to growth. The social sector ministries were less of a priority, with almost no attention given to developing comprehensive health policy for the country.<sup>127</sup> For most of the late 1980s and early 1990s UNICEF was seen as the 'alternative' Ministry of Health, due to the amount of national health policy driven by the UNICEF director<sup>128</sup>. It would be worth exploring further to what degree this helped or harmed the progressive rehabilitation of the Ministry of Health itself. At the time UNICEF's contribution was seen as very positive as it was supportive of staff development in the MOH while also contributing to much needed public health policy development and implementation;
- A 'divvying' up of the country between bi-lateral donors, with different donors wooed to support different districts or regions. In 1993 bilateral donors were still having discussions about avoiding geographical overlap of health project work, for example the British ODA agreed to support health programmes in eastern Uganda as long as USAID contained their own programme area to the south and west of the country<sup>129</sup>. Lack of an overarching government plan and donor pursuit of their own interests created major

<sup>127</sup> Macrae J. (2000)

<sup>128</sup> Personal communication

<sup>129</sup> *ibid*

problems for coordinating health services and a highly inequitable situation between districts and between specific services (those of high interest to donors, such as HIV prevention and AIDS care – and those of low interest, such as malaria prevention and treatment).

- In a well-intentioned effort to ensure that key civil servants, including health providers, spent more time on their jobs rather than seeking means of supplementing their very meagre incomes, a system of 'sitting allowances' was created. Sitting allowances created numerous distortions throughout Ugandan government systems, with some refusing to meet with donor or NGO staff unless they were paid. By the mid-1990s donors began to phase out sitting allowances, recognising the distortions they were causing within the civil service. Again, this would be a useful area for further exploration to consider to what degree sitting allowances helped or hindered progress towards normalcy.
- During the rehabilitation period little attention was paid to what was happening in the private sector, which flourished as health providers sought ways to support themselves outside the public sector. In a 2000 study carried out by Makerere University of private health service provision in Kampala a picture emerges of very unregulated and unsafe practice amongst private providers<sup>130</sup>. Progress towards greater regulation was being hindered by corruption and poor government capacity to enforce regulations that did exist.

A separate picture emerges from the above analysis as to progress on rehabilitation and reconstruction in Northern Uganda. There were deep suspicions about the loyalty of the population of northern districts amongst the current government and non-northerners as the worst of Uganda's rulers came from these areas (especially Arua and Gulu districts). This suspicion remains. The dynamic has not been aided by various regional politics that has seen the government in Sudan supporting rebel movements in northern Uganda, provoked by Ugandan government support for the SPLA and its factions, nor the ongoing instability in the area due to rebel activity. Looking at this situation in terms of the willingness/capacity framework – the government would appear to have ambivalent will and uncertain capacity to resolve the conflict in the north and to devote national resources to services in northern districts. Research into the conflict in the area has shown that government soldiers contribute to the insecurity by attacking civilians as well as rebel combatants<sup>131</sup>. Only one minister in government comes from the north, all 14 others come from central and southern parts of the country. The deputy Prime Minister, attending an NGO workshop in 2000 in the north of the country commented that it was his first time ever to visit a northern district. Questionable political willingness is compounded by poor human capacity in these same districts, where most trained professionals have left, either to other parts of Uganda or to other countries.

A number of interventions have been designed to try to both address the short term humanitarian needs of Northern Uganda, as well as reduce the unequal distribution of wealth and services between Northern districts and the rest of the country. These interventions are now explored by which actor is providing assistance.

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<sup>130</sup> Asiimwe D. (2000) Transformations and Progress in Uganda: The Trend Towards the Privatisation of Health Care. Kampala: Makerere Institute of Social Research, Makerere University.

<sup>131</sup> Dolan C (2000) Conference on Conflict Resolution in N. Uganda. London: ACORD

## 18 ANALYSIS OF INTERVENTIONS IN NORTHERN UGANDA

### Government interventions

The government has committed up to 22% of the national budget for local government services to northern districts. A 2004 parliamentary report found that large amounts of these allocations go unspent due to the districts' inability to carry out most routine work in the north. In the health sector for example, on average only 60% of posts are filled, though this masks much higher levels of unfilled posts in some areas of the northern region. Each district has a functioning District Health Management Team, as well as a District Disasters Management Committee. The capacity of members of these teams is viewed to be relatively weak, and various donors have started initiatives to try and strengthen these groups.

The government only recently (2003) created a policy for the health care of internally displaced persons, with the help of WHO and UNICEF. Much of the gap in health care provision is provided by non-state actors (especially NGOs), though this also remains limited due to insecurity in the region. Whilst parliament has voted to declare the Northern and Eastern regions disaster areas, this has not been ratified by the executive branch of government. Also, while parliamentarians have acknowledged that the Ministry of Health in particular needs to be able to disburse emergency funds to northern districts to respond in a timely and flexible manner to the changing situation there, this has not been followed by any action from government. This 'business as usual' theme is reflected in the first draft of the Second Health Sector Strategic Plan, where almost no acknowledgement is made of the specific needs of northern and eastern districts, except for a brief reference to elevated rates of diarrhoeal disease amongst IDPs<sup>132</sup>.

Health care provision to more remote parts of the Northern region, and particularly to certain IDP camps, continues to be severely inhibited by the security situation, which is seen as the domain of the government to work on improving. While the national Participatory Poverty Assessment exercise (which included some northern districts) found that government health services in general were of poor quality, respondents in northern districts had even greater problems with accessing health services and treatment from government health centres.<sup>133</sup>

In summary, the government policy stance on northern Uganda remains ambivalent and inflexible. By not declaring the Northern areas as a disaster area, and therefore opening up the possibility of increased government resources, the central level is perpetuating a policy void in the North. District level government appears to be more willing to work on coordinating humanitarian efforts alongside the day to day running of district level services.

### Multi-laterals

The UN Office of Humanitarian Assistance (UN OCHA) has begun to take a more active role in coordinating the humanitarian response to the crisis in Northern Uganda. Having declared the crisis as being at least as bad as the one in Darfur, UNOCHA and other UN agencies have, in the last year, deployed more staff to be based in the northern districts, to both help with assessing the evolving situation in the districts as well as to work on strengthening district level responses to the crisis. The latest Consolidated Appeal (CAP) has asked for US\$112 million in support of the UN's programme with IDPs and the general population of the affected districts. The largest proportion of the CAP was for food aid to IDP camps.

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<sup>132</sup> MOH 2004

<sup>133</sup> MOFPED 2002 Deepening the Understanding of Poverty. 2<sup>nd</sup> participatory poverty assessment report

At the same time the World Bank has put in place the second phase of its Northern Uganda Reconstruction Programme (NURP), a social fund programme that warrants closer scrutiny. The World Bank funded the Northern Uganda Rehabilitation Programme (NURP I) from 1992 to 2000. The purpose of NURP was to provide an extra boost to both economic and social infrastructure in northern districts, which were recognised as lagging behind the rest of the country. With a target budget of US\$ 600 million, in the end the programme only realised and used US\$ 93 million. Evaluations of NURP have shown that it was singularly ineffective in achieving its goals, for a number of reasons<sup>134</sup>:

- The first two years of the programme were 'lost' in detailed preparation. These two years coincided with the most stable period in the northern districts
- The programme was too 'top down', which encouraged a high degree of corruption throughout the fund distribution chain;
- Centralised procurement procedures that have been widely acknowledged as both inefficient and wasteful;
- Poor absorptive capacity of the northern districts, both in terms of human and infrastructure capacity;
- Re-emergence of active conflict and influx of humanitarian assistance – the first reducing further the government's capacity to respond and the second creating significant coordination problems.

One study of the experience of NURP I found that "Various sources discussed the possibility that through its failings NURP may have contributed to the escalation of the conflict"<sup>135</sup>. NURP II has now been created, responding to lessons learned in the first phase of the programme. It includes the Northern Uganda Social Action Fund, which aims to empower communities in Northern Uganda's 18 districts through capacity building, and intends to channel much more funding directly through NGOs and CBOs with an active presence in the northern districts.

An evaluation of the World Bank's post-conflict response in Uganda in general found that the Bank's strengths in reconstruction include its support for macro-economic stabilisation and rebuilding physical infrastructure. However, World Bank programmes that target rebuilding of human, social and cultural capital were unsatisfactory.<sup>136</sup> The same authors went on to conclude that post-conflict/ rehabilitation interventions need to be much more flexible, focusing more on process than on 'blueprints', while much more attention also needs to be given to 'enhancing human capital and organisational efficiency in the public sector.'

### **Non-Government Organisations**

Most donors have funded humanitarian NGOs to undertake service provision, or support to services in northern districts. Many of the international humanitarian organisations (ACORD, MSF, CARE, ACF, IRC etc.) are active in northern Uganda, implementing a variety of health related programmes, including running health centres, supporting hospitals and feeding centres. Two programmes amongst these are worth mentioning.

**CARE's Gulu Emergency Response project** works with Gulu District Health Management Team, providing institutional support to the district team and to health facilities. CARE has been active in Uganda since the early 1980s (and also before 1974), and has considerable experience in working with district health teams in other parts of the country. Its experience and long term presence in the country has allowed the organisation to take a more

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<sup>134</sup> Kreimer et al (2000) and MOPPED (2003)

<sup>135</sup> Kreimer et al (2000) p 57

<sup>136</sup> *ibid*

developmental approach to its humanitarian activities, learning from transitional work undertaken in the late 1980s and early 1990s when its work in various districts shifted from emergency relief to long term development assistance<sup>137</sup>.

**Lacor Hospital** in Gulu District offers another story of how health services have responded to the crisis in the north, as well as illustrating the differences between responses now and twenty years ago<sup>138</sup>. The hospital was founded by Italian missionaries in the mid-20<sup>th</sup> century and maintained services throughout the worst periods of conflict in the late 1970s and early 1980s. Under the guidance of its medical director in the 1980s, the hospital transformed itself from a purely independent health service provider in an isolated part of Uganda to a private, not-for-profit (PNFP) provider integrated into the wider health system and part of the national health strategy. In 1999, under the new health SWAp Lacor Hospital went from having 0% of its budget covered by government to 16% of its budget paid from government sources.

In the last 20 years the hospital has become a centre of medical excellence in the country and is the second largest hospital in the country, despite its remote location, renewed conflict and finding itself in the centre of Uganda's latest Ebola epidemic. In a review of the reasons behind its success, the author found that the hospital has also had a large influence on the national health system as well, as an important training ground for medical and nursing staff who go on to work in the public system throughout the country. A number of factors have been attributed to its success, including the emphasis put on building human resources, maintaining productive links with national health authorities, networking and sharing professional development, 'Ugandanisation' of hospital leadership and its external fundraising capacity.

The author of the Lacor case study finds that "While some might argue that (Lacor's) structure is too heavy or too costly for the Ugandan health system, the author believes that this case highlights the strategic importance of a niche activity like Lacor"<sup>139</sup>.

### Lessons

The situation in Northern Uganda is unique, as it represents a 'micro-difficult environment' within a more stable, macro non-difficult context. This is not to say that the macro, national context has not had a role in the continuing problems of northern Uganda. However, the fact that there are strong national pro-poor policies and delivery mechanisms in place for the rest of the country does create a different dynamic than ones found in other 'non-willing' countries. Various analysts of the problems with improving health in northern Uganda suggest that there are a number of lessons to learn from the experience so far:

#### Strengthening state accountability

- **Government policy frameworks and coordination are important for guiding assistance through both public and private sectors.** MOFPED's analysis of reconstruction efforts in Northern Uganda concludes that "while special programmes have played a significant role in rehabilitating the north in the past such interventions should be treated with caution in future as they may isolate the region from mainstream economies and politics"<sup>140</sup>. The government clearly sees its role in ensuring national policies remain the guiding force in the country. However,

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<sup>137</sup> CARE (2004) Gulu Emergency Response.

<sup>138</sup> Hauck V (2004) Resilience and High Performance amidst conflict, epidemics and extreme poverty. ECDPM Discussion Paper No. 57A

<sup>139</sup> *ibid* p.19

<sup>140</sup> MOFPED (2003)

- **Ugandan government needs more encouragement to treat the north and east as a special case:** One analyst suggests that the government hasn't taken on board the depth of the problems faced by people living in the north and therefore that special measures are required. Instead civil servants at national level prefer to believe that they can treat the northern districts in the same way as the rest of the country.<sup>141</sup> As a result, even though 22% of local government grants are allocated to northern districts there has been no improvement in health and education services because national funds are not effectively utilised.<sup>142</sup> An example of this sense of 'business as usual' approach by government is seen in the recent budget, where health civil servant salaries have been raised by 25% in the new budget, but there has been no increase in the budget allocation to PNFP health units, including Lacor to support this rise in salary costs. There is a danger that these health units will lose staff, and therefore the capacity to provide services, in the northern districts where they are most needed<sup>143</sup>;
- **Long time frames are vital in supporting conflict resolution and post-conflict reconstruction efforts.** Kreimer *et al* found in their study of Uganda's post conflict efforts that a country needs at least two decades of sustained effort to recover and surpass pre-conflict economic and service delivery status. Most donors tend to work in much shorter time frames and move too rapidly to adapt appropriate aid instruments, rather than taking the longer term view.<sup>144</sup>

#### Impact on pro-poor service delivery

- **Project aid can complement and support government systems and give space for innovation.** Without NGO project assistance in Northern Uganda little health or food assistance would be reaching IDPs and areas affected by the conflict. Limited government capacity in the northern districts and limited willingness to invest more human and financial resources towards improving service delivery capacity necessitates the intervention of non-state actors.

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<sup>141</sup> WHO (2004) Uganda update

<sup>142</sup> MOFPED (2003)

<sup>143</sup> Hauck 2004

<sup>144</sup> Kreimer 2000

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