Uganda Public Health strategic Plan 2013-2017

November 2013
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Operational context:

The National Health System (NHS) is made up of the public and the private sectors. The public sector includes all GoU health facilities under the MoH, health services of the Ministries of Defense (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Not for Profit (PNFPs) providers, Private Health Practitioners (PHPs), and the Traditional and Complementary Medicine Practitioners (TCMPs).

Public health service delivery in Uganda is in line with the national health policy and ministry of Health Strategic and Investment Plan that defines the National Minimum Health Care Package (UNMHCP). This has clusters that include;

1) Health Promotion, Disease Prevention and Community Health Initiatives;
2) Maternal and Child Health;
3) Prevention and Control of Communicable Diseases;
4) Prevention and Control of Non-Communicable Diseases (NCDs).

The country-wide water and Sanitation development programme is currently governed by a new 5-year Joint Water and Environment sector support Programme (JWESSP 2013-2018) which was jointly developed by the Government of Uganda and its Development Partners, under coordination by the Water and Environment Sector Working Group. This new Joint Water and Environment Sector Support Programme (JWESSP 2013-2018) document took effect in July 2013. The Programme document covers various sub-sectors and most of the refugee settlements, by virtue of their locations, find their closest linkage to the “Rural Water Supply and Sanitation sub-sector”.

Public Health set-up in Uganda:

Health care system

The provision of health services in Uganda is decentralised with districts and health sub-districts (HSDs) playing a key role in the delivery and management of health services at those levels. The health services are structured into National Referral Hospitals (NRHs) and Regional Referral Hospitals (RRHs), General Hospitals, Health Centre (HC) IVs, HC IIIIs, HC IIs and Village Health Teams (HC Is)

Headquarters and national level institutions - The core functions of the MoH headquarters are Policy analysis, formulation and dialogue, strategic planning, setting standards and quality assurance, resource mobilization, capacity development and technical support supervision. Additional roles include provision of nationally coordinated services including health emergency preparedness and response and epidemic prevention and control, monitoring and evaluation of the overall health sector performance.

Several functions have been delegated to national autonomous institutions including Uganda Cancer Institute, Uganda Heart Institute, Uganda Blood Transfusion Services, Uganda Virus Research Institute, National Medical Stores, Central Public Health Laboratories, Professional Councils, National Drug Authority (NDA) and research institutions. The Health Service Commission (HSC) is responsible for the recruitment, and deployment of HRH at Central and Regional Referral Hospital levels. In the districts, this function is carried out by the District Service Commissions. The Uganda AIDS Commission (UAC) coordinates the multisectoral response to the HIV/AIDS pandemic.
National, Regional and General Hospitals - The National Hospital Policy (2005) spells out the roles of hospitals and provide technical back up for referral and support functions to district health services. Hospital services are provided by the public, private health providers (PHPs) and private not for profit (PNFPs). The public hospitals are divided into three groups

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Facility Population Ratio Standard</th>
<th>Current situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National referral hospital</td>
<td>1:10000000</td>
<td>1:30000000</td>
</tr>
<tr>
<td>Regional referral hospital</td>
<td>1:3000000</td>
<td>1:2307692</td>
</tr>
<tr>
<td>General hospital</td>
<td>1:500000</td>
<td>1:263,157</td>
</tr>
<tr>
<td>Health centre IV</td>
<td>1:100000</td>
<td>1:187500</td>
</tr>
<tr>
<td>Health centre III</td>
<td>1:20000</td>
<td>1:84,507</td>
</tr>
<tr>
<td>Health centre II</td>
<td>1:5000</td>
<td>1:14940</td>
</tr>
<tr>
<td>Health centre I/VHT</td>
<td>1:1000</td>
<td></td>
</tr>
</tbody>
</table>

General Hospitals - provide preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care programmes.

Regional Referral Hospitals - offer specialist clinical services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, higher level surgical and medical services, and clinical support services (laboratory, medical imaging and pathology). They are also involved in teaching and research. This is in addition to services provided by general hospitals.

National Referral Hospitals - provide comprehensive specialist services and are involved in health research and teaching in addition to providing services offered by general hospitals and RRHs.

District health systems - The Constitution (1995) and the Local Government Act (1997) mandate the Local Governments (LGs) to plan, budget and implement health policies and health sector plans. The LGs have the responsibility recruitment, deployment, development and management of human resource (HR) for district health services, development and passing of health related by-laws and monitoring of overall health sector performance. Local governments manage public general hospitals and HCs and also supervise and monitor all health activities (including those in the private sector) in their respective areas of responsibility. The public private partnership at district level is however still weak.

Health Sub-District (HSD) system - The HSDs are mandated with planning, organization, budgeting and management of the health services at this and lower health centre levels. HSDs carry an oversight function of overseeing all curative, preventive, promotive and rehabilitative health activities including those carried out by the PNFPs and PFP service providers in the health sub district. The headquarters of a health sub-district are located at HC IV or a selected general hospital.

Health Centres III, II and Village Health Teams (HC I) - HC IIs provide basic preventive, promotive and curative care. They also provide support supervision of the community and HC IIs under their jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care, community outreach services and linkages with the Village Health Teams (VHTs). A network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services. The VHTs are responsible for:

- Identifying the community’s health needs and taking appropriate measures;
- Mobilizing community resources and monitoring utilization of all resources for their health;
• Mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health seeking behaviour;
• Maintaining a register of members of households and their health status;
• Maintaining birth and death registration; and
• Serving as the first link between the community and formal health providers.

Community based management of common childhood illnesses including malaria, diarrhoea and Pneumonia and management and distribution of any health commodities availed from time-to-time. While VHTs are playing an important role in health care promotion and provision, coverage of VHTs is however still limited: VHTs have been established in 75% of the districts in Uganda but only 31% of the districts have trained VHTs in all the villages. Attrition is quite high among VHTs mainly because of lack of emoluments.

Water Supply and Sanitation
In line with Uganda’s over-all decentralization and local financing framework, each local government is directly responsible for WASH service provision within their respective districts, under the District Water and Sanitation Conditional Grants (DWSCGs). The DWSCG emphasizes the technical standards that rural WASH infrastructure should adhere to and further promotes the strategy of community based operation and maintenance.

The Ministry of Water and Environment (MWE) has the responsibility for setting national policies and standards regarding water supply, sanitation and hygiene. The Ministry is also involved in planning and monitoring, and providing technical guidance and support to the Districts, through the Regional Technical Support Units (TSUs). The MWE fulfills this responsibility through the Directorate of Water Development.

Currently, District involvement in the WASH activities in the refugee settlement is limited to WASH data collection as part of the WASH data consolidation in the District as a whole; facilitation of WASH trainings – upon request; and participation in inter-agency WASH coordination meetings at the field level. UNHCR plans to strengthen field level collaboration with the respective District local governments to ensure implementation of coordinated WASH programmes, in compliance with the WASH plans for each respective District.
Refugee public health services

UNHCR in Uganda works through implementing partners and District local governments to deliver services in line with the national health policy and strategic plan. There are 9 refugee sites of which three (Arua, Adjumani and Kiryandongo) are run by health district local government while the six are run by international NGOs.

The refugees are settled in settlements as such health and water facilities are shared with the immediate host population. The proportional consultation is 42% (ranging 31% in SW to 78% WN).

Each of the health facilities is registered with the ministry of health therefore receives medical supplies from the national medical stores and very few health facilities receive staff secondment from government because of the district where the settlements are located are equally under staffed.

Health partners are part of the district health management team and facilities are supervised by the district. Refugees benefit from the referral facilities which are located with in or outside the district at no cost.

Water and Sanitation activities are implemented in all refugee settlements by NGOs and District Local government, in partnership with UNHCR, focusing on ensuring that in all settlements, refugees are provided water to a UNHCR minimum standard of 20litres/person/day (compared to the National standard of 25 l/c/d). Water is supplied to the refugees mostly through ground water sources (shallow wells and boreholes) and water treatment & distribution pipelines. Other supplementary water sources include rain water harvesting and water trucking - mostly at institutions.

By nature of the Uganda government land allocation policy to refugees, the refugee settlements bare a scattered settlement pattern which makes provision of water supply services within 200 metres walking distance (UNHCR WASH standard) an unachievable target for the Uganda refugee programme. As a result, and in consideration of the budgetary implication, the WASH sector agreed to target attaining the Uganda National standard of a minimum walking distance of 1km for rural communities within the settlements.

Vision:

The strategy derives its vision from the United Nations High Commissioner for Refugees (UNHCR) vision which aims at ensure that all refugees are able to fulfil their rights in accessing lifesaving and essential health care, HIV, reproductive health, food security and nutrition and water, sanitation and hygiene(WASH) services.
Guiding principles:

The guiding principles for the strategy are derived from the Public Health section strategy that focus on community-based approach to identify capacities, skills and resources of refugees and focus on building on them for better health care. Other guiding principles include access, equity, integration, prioritization and efficiency, evidence-based decision making.

Uganda programme priorities.

While all aspects of the Global strategic plan of Public Health Section 2014-2018 will be implemented in Uganda, the following areas will be given special attention during the period of this strategic plan;

- Improve access to quality comprehensive primary health care at both health facility and community with a vital roles of the village health teams as an entry point
- Strengthen preventive and promotive health care – for the most common cause of morbidity
- Strengthen the continuum of evidence-based HIV prevention, care, treatment and social support in order to contribute to reduction of new HIV infection, HIV-related deaths and stigma and discrimination among refugees.
- Improve access to comprehensive reproductive health, maternal and new-born health services including fistula care and cervical cancer screening in order to contribute to reduction of maternal and newborn morbidity and mortality.
- Effective prevention and management of malnutrition through reduction of micronutrient deficiencies and effective community management of acute malnutrition.

- Ensure safe water access within a 1 km walking distance of every household and reduce waiting time, number of persons per water point and improve the amount of water available per person per day to at least 15 l/c/d for Emergency locations & 20 l/c/d in stable phase locations
- Installation of sustainable water supply options in all institutions (schools, health centres, reception centres) so as to while reduce and eventually eliminate the daily need for water trucking.
- With regard to household sanitation, the WASH strategy is to provide material support alongside community mobilization. This will be done through providing families with communal sanitation digging kits for excavation of the pits, and Followed by distribution of latrine floor slabs and treated poles to only the families who have excavated a pit of 3-4 metre depth.

Goal of the strategy

The overall goal is to attain a good standard of health for all refugees in Uganda in order to live a healthy and productive life.

Objectives of the strategy

1. To strengthen coordination, monitoring and evaluation for better service delivery
2. To improve the health status of UNHCR PoCs to standards that are internationally acceptable.
3. To provide optimal access of reproductive health and HIV services to UNHCR PoCs and surrounding host population
4. To improve the nutritional well-being and food security of UNHCR PoCs and surrounding host population
5. To increase or maintain supply of potable water to UNHCR PoCs to acceptable standards
6. To provide satisfactory sanitation and hygiene conditions for UNHCR PoCs

Action 1: Reduce morbidity and mortality among refugees and immediate host population

Objective 1: Health status of the population improved

Objective 2: Population has optimal access to reproductive health and HIV services

Expected result:

1. Under-five and crude mortality rates kept below 0.75 and 1.5 per 1000 per month respectively in all refugee camps.
2. Maternal mortality rate reduced to 0 deaths/100000 live births/year
3. Measles vaccination coverage increased to 95%
4. Proportion of live births attended by skilled personnel increased to 100%
5. Percentage of HIV positive PoC eligible for ART who receive antiretroviral therapy increased to 100%
6. Percentage of qualifying rape survivors receiving PEP within 72 hours of an incident increased to 100%

Public health:

<table>
<thead>
<tr>
<th>S/No</th>
<th>Settlement</th>
<th>No. of H/Cs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjumani</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Arua</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Kiryandongo</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Kyangwali</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Kyaka II</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Rwamwanja</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Nakivale</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Oruchinga</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>29</td>
</tr>
</tbody>
</table>

There are 29 health facilities in 9 refugee settlements. These provide primary health care services to refugee and host population. Community health is provided by village health teams (West Nile) and community health workers (South West). Each of the health facility has access to an ambulance to refer patients and received medicines from ministry of health and UNHCR through AIRD who is a logistics partner. Current crude mortality is 0.1 deaths/1000/month; under-5 mortality rate is 0.3 deaths/1000/month. Health utilization is 2 consultations per year and each clinician does 56 consultations per day. Over a third (42%) of the consultation are made to the nationals. The bed occupancy rate is 69% and the hospitalization rate is 86.8/1000/month. Full coverage of expanded programme on immunization stands at 85.9% and growth monitoring stands at 42.7%.

Key strategies:

Institute rational drug use in health facilities

- Strengthen capacity for drug logistics and medicine supplies management
• Strengthen capacity for drug logistics and medicine supplies management
• Improve stock monitoring and response mechanism using m-track

**Access to primary health care services provided or supported**
• Provide support to government H/Cs; medicines, equipment, personnel
• Improve health infrastructure to meet national standards
• Ensure adequate and motivated health staff in all sites
• Support for specialized services/visits

**Referral mechanisms established**
• Operationalize Referral S.O.P
• Strengthen ambulance services
• Facilitate community transport to health facilities

**Preventative and community-based health care services provided**
• Scale up out-reach services to the community
• Ensure adequate, trained and motivated community based health workers
• Promote behaviour change through BCC/IEC campaigns

**Access to communicable disease programmes provided**
• Ensure a package of prevention services for communicable diseases in line with national guidelines and protocols
• Early detection and treatment for communicable diseases based on guidelines

**Access to non-communicable disease programs provided**
• Strengthen mental health services
• Early detection and management of NCDs in line with national guidelines
• Establish visiting specialist programs
• Provide basic rehabilitation services for the eligible

**Health services to children under 5 delivered**
• Strengthen immunization services in all sites
• Ensure IMCI is provided in all sites in line with national standards
• Ensure institutionalization of minimum package of quality new born care services
• Strengthen linkages between MCH and the other sectors

**Contingency plan for disease outbreaks maintained**
• Update epidemic preparedness and response plans annually
• Build capacity of partners to be able to operationalize the EPR
• Ensure active disease surveillance through established IDSR
• Establish strategic partnerships for a coordinated and effective response

**Health information system established**
• Ensure effective utilization of HIS at field level
• Ensure quality of HIS data
• Ensure continuous availability of HIS tools
• Ensure timeliness and completeness of HIS

**Laboratory services provided according to country-specific SOPs**
• Roll out UNHCR Lab guidelines (SOP)
• Ensure consistent supply of laboratory supplies and equipment
• Comply with standard quality assurance requirements

**Emergency response capacity improved**
• Ensure contingency plans include PH/RH and HIV
• Ensure minimum PH/RH-HIV standards in emergency response
• Convene HIV in emergencies efficiently and effectively

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**Objective 1: Health status of the population improved indicators**

<table>
<thead>
<tr>
<th>Key strategies</th>
<th>Indicators of achievement</th>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Institute rational drug use in all health facilities</td>
<td>Proportion of health facilities for which all prescriptions &amp; diagnosis march on BSC</td>
<td>0%</td>
<td>40%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>1.2 Access to primary health care services</td>
<td>Health facility utilization rates</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Referral mechanisms established</td>
<td>Proportion of health facilities using referral SOPs</td>
<td>0%</td>
<td>40%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>1.4 Preventive and community-based health care</td>
<td>Proportion of settlements with 1 community-based health workers serves 250 PoCs</td>
<td>0%</td>
<td>40%</td>
<td>80%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Reproductive health and HIV

UNHCR Uganda intends to improve access to reproductive health and HIV services in all the refugee sites. At the end of 2012, only 57% of pregnant women completed the 4 antenatal care visits, while 92% of the deliveries were assisted by the skilled health workers. Seven percent (7%) of the deliveries were done by caesarian section, 26.3% of the women of reproductive age were on some form of family planning and maternal mortality stood at 109 deaths/100000 live births/year. Majority (93%) of the rape survivors received PEP within 72 hours, 6 HIV comprehensive care clinics had 5841 (both refugees & nationals) and 91% of pregnant women accessed services for elimination of mother to child transmission of HIV.

The strategic plan seeks to reduce maternal morbidity and mortality and reduce HIV new infection, HIV stigma and discrimination and HIV-related deaths. The focus will be on improving staffing, improve the RH/HIV skills of the existing health workers, behavior change communication, improving of reproductive health and HIV commodities like mama kits, condoms, contraceptives and supplies for HIV testing.

Emphasis will be put on improving the family planning coverage, increasing antenatal coverage, delays at home and adolescent sexual and reproductive health. New areas like cervical cancer screening, fistula prevention and care and rolling out new scientifically-proven HIV prevention methods (sex work, safe male circumcision, elimination of mother-to-child transmission of HIV). HIV sentinel surveillance will be carried out to monitor the trends of HIV in the settlements.

Key strategies:

Comprehensive safe motherhood services provided

- Improve antenatal care coverage
- Ensure universal access to EMONC services
- Increase the post-natal coverage in all sites
- Ensure access to full spectrum of family planning services

Care and treatment of PoCs living with HIV and AIDS provided
- Ensure consistent availability of supplies
- Ensure adherence to ARVs
- Support PLWHA to benefit from social protection programmes
- Ensure better integration of HIV and TB services

**Clinical management of rape provided**
- Improve capacity to provide comprehensive rape management services

**Comprehensive reproductive health and HIV services provided**
- Provide youth friendly information and health services for in and out of school youth
- Initiate cancer of cervix screening and management with emphasis on high risk groups
- Strengthen fistula prevention and care services

**Comprehensive HIV prevention services provided**
- Strengthen RH/HIV services to MARPS
- Strengthen VMMC services

**Elimination of mother to child transmission of HIV services provided**
- Strengthen primary prevention among women and girls
- Strengthen FP among PLHIV

- Ensure ANC coverage & SBA for pregnant women with HIV (Option B+)
- Promote AFASS infant and child feeding practices

**Voluntary counseling and testing services provided**
- Ensure supply of testing kits
- Ensure PITC in all health facilities
- Improve linkages of HCT to care

**Safe and rational blood transfusion and standard precautions practiced**
- Ensure universal precaution supplies
- Build capacity of staff on infection prevention and universal precaution
- Standardize biomedical waste management
- Establish blood transfusion services

**Emergency response capacity improved**
- Ensure contingency plans include PH/RH and HIV
- Ensure minimum PH/RH-HIV standards in emergency response
- Convene HIV in emergencies efficiently and effectively

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### Objective 2: Population has optimal access to reproductive health and HIV services indicators

<table>
<thead>
<tr>
<th>Key strategies</th>
<th>Indicators of achievement</th>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Comprehensive safe motherhood services provided</td>
<td>• Proportion of skilled deliveries</td>
<td>93% 2 57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of maternal deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of complete ANC coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.2 Care and treatment of PoCs living with HIV and AIDS provided | • Proportion of ART clients who are eligible but are not on ART  
                                                               • Proportion of facilities with active post-test clubs | ?? 34%        | 5%    | 2%    | 0%    |
| 1.3 Clinical management of rape provided           | • Proportion of rape survivors who receive PEP within 72 hrs  
                                                               • Proportion of survivors who get STI treatment within 120 hours | 93% 86%       | 93%   | 93%   | 93%   |
| 1.4 Comprehensive reproductive health and HIV services provided | • Proportion of health facilities that provide youth friendly services  
                                                               • Proportion of health facilities doing cervical cancer screening | 17% 0%        | 30%   | 50%   | 75%   |
| 1.5 Elimination of mother to child transmission of HIV services provided | • Proportion of HIV+ women on option B+ at the time of delivery | 79%          | 85%   | 95%   | 100%  |
| 1.6 Voluntary counseling and testing services provided | Proportion of health facilities with weekly VCT outreaches   | 80% 90%       | 100%  | 100%  | 100%  |
| 1.7 Safe and rational blood transfusion and standard precautions practiced | • Proportion of settlements with blood transfusion services  
                                                               • Proportion of health facilities with | 62% 75%       | 90%   | 100%  | 100%  |
### Action 2: Reduce nutrition-related morbidity and mortality among children under 5 and women of reproductive age group.

**Objective 1:** Nutritional well-being improved

**Objective 2:** Food security improved

**Expected result:**

1. *Reduce prevalence of anaemia in children (6-59 months) and Women of reproductive age group by 50%*
2. *Reduce prevalence of global and severe acute malnutrition (6-59 months) by 50%*
3. *Improve the proportion of food distributions in which number of kals meets the recommendations of the JAM to 100%*

### Nutrition and food security:

The nutrition situation in Uganda is stable. The Global acute malnutrition ranges between 2.1%-4.6% and severe acute malnutrition ranges between 0.0% and 0.6% in the different settlements. The main challenge over the years has been high anaemia rates and stunting rates which exceed emergency thresholds of 40%.

Community management of acute malnutrition was rolled out three years ago in 4 out of the 8 refugee sites refugee settlement and supplies of Ready to use therapeutic feed are still a challenge. The remaining settlements still use the traditional therapeutic feed centre but still face challenges capacity of health workers to manage cases of acute malnutrition.

<table>
<thead>
<tr>
<th>Settlement</th>
<th>Year 0 – Year 3</th>
<th>Year 3 – Year 5</th>
<th>Beyond Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyaka II</td>
<td>100%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Kyangwali</td>
<td>100%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Nakivale</td>
<td>100%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Oruchinga</td>
<td>100%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Rhino Camp</td>
<td>100%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Adjumani</td>
<td>100%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Kiryandongo</td>
<td>100%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Kampala</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Nutrition surveys are done annually to inform nutrition programming and Joint assessment missions (JAM). The last JAM (2011) recommended a reduction in ration reduction depending on the period of stay (see table). The operation is in process of piloting the cash for food project in the West Nile refugee settlements.

Cash for food assessment and sensitization campaigns have been initiated in Kiryandongo and West Nile refugee settlement by UNHCR, WFP and OPM.
Key strategies:

**Appropriate IYCF Practices Promoted**
- Facility Based IYCF promotion
- Promote community participation and awareness in IYCF

**Community Management of Acute Malnutrition programs implemented and monitored**
- Procurement of essential nutrition supplies and products
- Ensure sufficient access to quality CMAM services
- Monitoring and Evaluation of CMAM program, its coverage and outcomes

**Measures to Control Anaemia and Other Micronutrient Deficiencies Undertaken**
- Procurement of Supplies and Equipment like haemocue and microcuvettes
- Procurement of special Products and Supplements
- Address non-food causes of anaemia
- Support anaemia surveillance
- Reducing anaemia burden in adolescent girls

**Supplemental Feeding Programmes implemented and monitored**
- Provision of supplemental food for pregnant and lactating women
- Provision of supplemental food for malnourished PLHIV
- Provision of supplemental food for people living with chronic illnesses or referrals of people with special needs

**Assessments and Analysis Undertaken**
- Standardized Expanded Nutrition Survey Undertaken
- Mobile Technology for Data Collection

**Capacity Development Supported**
- Training Nutrition Staff on new knowledge
- Training Non-Nutrition Staff on malnutrition management
- Ensure minimum staffing requirements for nutrition
- Training of village health teams on nutrition and support

**Nutritional Surveillance System implemented**
- Institution of community screening and ensuring information is reported in HIS
- Coordination of multi-sector approach to nutrition

**Adequate Quantity and Quality of Food Aid Provided**
- Ensuring an accurate and updated food log
- Ensuring a fair, efficient and effective food distribution system
- Ensuring adequate and acceptable food assistance

**Sectoral Cash Grants or Vouchers Provided**
- Undertaking key assessments for cash for food.
- Develop implementation plan for the use of cash and/or vouchers
- Support food security improvements through cash and/or vouchers

**JAM, Plans and Strategies Agreed with WFP**
- Strengthening the partnership with WFP
- Strengthening the project activities with WFP

**Adequacy of Food Assistance Monitored**
- Ensure monthly Food Basket Monitoring and Reporting
- Ensure monthly Post Distribution Monitoring and Reporting

**Objective 1 & 2: Nutritional well-being and food security improved indicators**

<table>
<thead>
<tr>
<th>Key strategies</th>
<th>Indicators of achievement</th>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Appropriate IYCF Practices Promoted</td>
<td>Proportion of facilities providing IYFC services</td>
<td>30%</td>
<td>50%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>2.2 Community Management of Acute Malnutrition programs implemented and monitored</td>
<td>Proportion of settlements implementing CMAM</td>
<td>50% (4/8)</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>2.3 Measures to Control Anaemia and Other Micronutrient Deficiencies Undertaken</td>
<td>- Proportion of facilities with Demo-gardens</td>
<td>30%</td>
<td>50%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>- Prevalence of anaemia in &lt;5 &amp; WRA</td>
<td>42.8%</td>
<td>30%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>2.4 Supplemental Feeding Programmes implemented and monitored</td>
<td>Proportion of settlements providing SFP</td>
<td>0-34.3%</td>
<td>50%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Key strategies</td>
<td>Indicators of achievement</td>
<td>2012 baseline</td>
<td>2014</td>
<td>2016</td>
<td>2017</td>
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<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 Assessments and Analysis Undertaken</td>
<td>Number of nutrition surveys carried out per year</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2.6 Capacity Development Supported</td>
<td>Proportion of health facilities with 50% of staff trained on nutrition</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>2.7 Nutritional Surveillance System implemented</td>
<td>Growth monitoring Rate Proportion of sites carrying out MUAC screening</td>
<td>42.7%</td>
<td>50%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>2.8 Adequate Quantity and Quality of Food Aid Provided</td>
<td>Proportion of refugees that receive at least 90% of recommended ration</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>2.8 Sectoral Cash Grants or Vouchers Provided</td>
<td>Proportion of settlements providing cash grants</td>
<td>0%</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.8 JAM, Plans and Strategies Agreed with WFP</td>
<td>Number of UNHCR-WFP action plans</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2.8 Adequacy of Food Assistance Monitored</td>
<td>Proportion of settlements that submit FBM reports for each of the cycle</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Action 3: Reduce WASH-related morbidity and mortality among refugees and immediate host population**

**Objective 1:** Supply of potable water increased or maintained

**Objective 2:** Population lives in satisfactory conditions of sanitation and hygiene

**Expected results:**

1. **Attain 100% coverage of improved/safe water facilities within 1km walking distance of each household**
2. **Reduction in average waiting time at water collection points to 15 minutes**
3. **Increase the average number of households with a drop-hole latrine constructed to UNHCR design standard to 85%**
4. **Elimination of dependency on daily water trucking operations, with the exception of emergencies**
5. **100% support to menstrual hygiene through provision of sanitary materials to all women in the reproductive age group (14-49yrs)**

**Water and sanitation**

Currently, the status of Water supply indicator falls below 20 l/c/d in at least 6 out of the 9 refugee hosting locations in Uganda. More than 50% of the refugee population walk more than 1km distance (Uganda National Standard) to the nearest improved water facility. The country has continued to face technical challenges with poor groundwater potential both with regard to unfavorable quality and inadequate quantity. Resultantly, success of borehole and shallow well installation projects currently stands at barely 60%. For the institutional locations which yet do not have a reliable water supply option, daily water trucking continues. This is clearly unsustainable due to the cost implication as well as the logistical unreliability with frequent mechanical breakdowns of the water trucks owing to the poor road conditions.
At the moment, at least 20 water facilities have been abandoned across the settlements by the communities, owing to unfavorable water quality. With support from UNHCR HQ, an operational research with the Southern Methodist University (SMU) is under-way to provide cost effective solutions for the groundwater quality problems.

In all settlements, the average institutional latrine coverage is below 1 stance:40 pupils (Uganda National Standard – Ministry of Health). We are currently facing challenges with some sections of the settlements which have very high groundwater table such that the traditional low cost household pit latrines are unsuitable. The recommended and suitable technology (Urine diverting Dry toilet) is not affordable for the average refugee family. Currently UNHCR is negotiating with its Government counterparts – the Office of the Prime Minister (OPM), to re-locate the affected families to areas with better soil conditions.

The Water supply strategy will be implemented in two major phases;

- Phase I: To ensure safe water access within a 1 km walking distance of every household
- Phase II: To reduce waiting time, number of persons per water point and improve the amount of water available per person per day

With regard to household sanitation, the strategic direction is to continue providing material support alongside community mobilization. The Implementation methodology will involve; providing families with communal sanitation digging kits for excavation of the pits, and followed by distribution of latrine floor slabs and treated poles to only the families who have excavated a pit of 3-4 metre depth.

At institutional locations, as well as the transit and reception centres, the WASH strategic direction is to strengthen community participation/involvement in hygiene promotion and appropriate management of WASH facilities.

There are currently 3 regular WASH staff in UNHCR, two of whom are NUNV. The Uganda WASH programme is occasionally supported by Emergency deployments of WASH specialists Secondees from UNHCR HQ, upon request.

In consideration of the protracted refugee situation in most of the refugee settlements in Uganda, and in close linkage with the global UNHCR WASH strategy, the country programme will pursue a shift in implementation from humanitarian approach (which often focuses on temporary infrastructure) to a development approach (which focuses on sustainable options with regard to durability and cost effectiveness). This will thus call for UNHCR’s participation in the Water and Environment Sector Working Group (WESWG) and the Water and Sanitation Working sub-group; to ensure a coordinated approach and better position UNHCR to advocate for support from other development partners in the inclusion of the refugee settlements as part of the overall District plan in the implementation of WASH activities in each respective district.

In linkage to the District Water and Sanitation Conditional Grants (DWSCG) Manual which is the National technical guidance document for the district Water and Sanitation activities, the UNHCR WASH strategy seeks promote community based operation and maintenance, as well as community contributions in form of labour (man power) in the implementation of projects with the aim of reducing the cost of WASH infrastructure development.
Key strategies:

**Capacity development supported**
- Provision of targeted trainings to staff and PoCs
- Recruitment of relevant staff
- Organization of learning events
- Promoting voluntary community participation in WASH activities

**Water management committees established and active**
- Strengthening of WUCs

**Water system constructed, expanded and/or upgraded**
- Increasing number of water points
- Timely repair of water facilities
- Major rehabilitation of Water facilities, as required
- Water quality surveillance & control
- Monitoring & Evaluation of water system constructions & operation

**Community sanitary facilities/ latrines constructed**
- Communal latrines of appropriate technology constructed in some villages with high groundwater table

**Environmental health and hygiene campaigns implemented**
- Conducting Home Improvement Campaigns
- Awareness raising - Mobilization & Sensitization on appropriate hygiene practices
- Institutional Hygiene promotion

- Monitoring & close follow-up of hygiene conditions

**Household sanitary facilities / latrines constructed**
- Increasing household latrine coverage
- Promotion of handwashing

**Hygienic supplies provided**
- Promotion of hand washing
- Household hygiene materials

**Medical waste management services for health centres / hospitals supported**
- Establishment of the required infrastructure
- Maintenance of the damaged infrastructure

**Sanitary facilities/ latrines in health centres / hospitals constructed**
- Increase number of sanitary facilities in HCs
- Maintenance of sanitary facilities

**Sanitary materials provided**
- Support to women in reproductive age group & elderly

**Vector/ pest control services provided**
- Malaria Control - reduction of mosquito breeding sites

**Sanitary facilities/ latrines at other institutions maintained/ constructed**
- Increase number of sanitary facilities at schools and FDPs
- Maintenance of sanitary facilities

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**Objective 1: Supply of potable water increased or maintained indicators**

<table>
<thead>
<tr>
<th>Key strategies</th>
<th>Indicators of achievement</th>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1.1 Capacity building undertaken for water management</strong></td>
<td>• Number of water management (water user committees, mechanics) trainings conducted for PoCs&lt;br&gt; • Proportions of WASH staff who have undergone at least one Water related training per year</td>
<td>4&lt;br&gt;100%</td>
<td>4&lt;br&gt;100%</td>
<td>4&lt;br&gt;100%</td>
<td>4&lt;br&gt;100%</td>
</tr>
<tr>
<td><strong>3.1.2 Water management committees established and active</strong></td>
<td>• Proportion of active water management committees</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>3.1.3 Water system constructed, expanded and/or upgraded</strong></td>
<td>• Average # of litres of potable water available per person per day&lt;br&gt; • Number of persons per water tap&lt;br&gt; • Number of persons per</td>
<td>14.99</td>
<td>17</td>
<td>19</td>
<td>20</td>
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</table>
## Key strategies

### Indicators of achievement

<table>
<thead>
<tr>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>borehole/shallow well</td>
<td>113</td>
<td>110</td>
<td>105</td>
</tr>
<tr>
<td>% of PoC living within 200 m from water point</td>
<td>454</td>
<td>400</td>
<td>350</td>
</tr>
<tr>
<td>% of PoC's with borehole/shallow well</td>
<td>24</td>
<td>30</td>
<td>40</td>
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</tbody>
</table>

### 3.1.4 Water system operations maintained

<table>
<thead>
<tr>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of chlorinated points compliant with standards</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% of non-chlorinated points compliant with standards</td>
<td>61.8%</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>% average functionality of water facilities</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
</tr>
</tbody>
</table>

### Objective 2: Population lives in satisfactory conditions of sanitation and hygiene indicators

<table>
<thead>
<tr>
<th>2012 baseline</th>
<th>2014</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1 Capacity Building undertaken for hygiene and sanitation</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Number of hygiene and sanitation promotion trainings conducted for the PoCs per year.</td>
<td>0%</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Proportion of settlements with volunteering community based hygiene promoters</td>
<td>92</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Number of persons per communal bath shelter</td>
<td>84</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Proportion of total population reached by environmental health and hygiene campaigns.</td>
<td>79.9%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Number of refugees per hygiene promoter</td>
<td>1,536</td>
<td>1,200</td>
<td>1,000</td>
</tr>
<tr>
<td>3.2.3 Environmental health and hygiene campaigns implemented</td>
<td>76.5%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Proportion of PoC's with household latrines.</td>
<td>46.3%</td>
<td>50%</td>
<td>65%</td>
</tr>
<tr>
<td>Proportion of PoC's with household latrines constructed to UNHCR standards.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3.2.5 Hygienic supplies provided</td>
<td>23.09%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Proportion of total population recieving 250g soap per person per month</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of health centres with functional incinerators</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of consultation/injection rooms/wards with appropriate waste disposal bins</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of health centres with adequate end-point waste collection systems</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3.2.6 Medical waste management services for health centres / hospitals supported</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3.2.7 Sanitary facilities/ latrines</td>
<td>80</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Key strategies</td>
<td>Indicators of achievement</td>
<td>2012 baseline</td>
<td>2014</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
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<td>------</td>
</tr>
<tr>
<td>in health centres / hospitals, schools and Food Distribution points constructed</td>
<td>• hole latrine or drop-hole toilet at schoolNumber of persons per latrines/toilet at HCs</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>• Proportion of FDPs with adequate sanitary facilities</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>3.2.8 Sanitary materials provided</td>
<td>• Proportion of women receiving adequate sanitary materials</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3.2.9 Vector/pest control services provided</td>
<td>• Proportion of communal/institutional structures fumigated periodically</td>
<td>60%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Strategic Approaches**

1. **Strengthen coordination, collaborations, monitoring and evaluation**
   In light of the minimal resources – both financial and human, the public health team in Uganda will harness the existing resources among refugees, within UNHCR, other sister UN agencies and partners. This will be done through:
   - Strengthening field level and national coordination to ensure quality service delivery.
   - Ensuring standardized monitoring and evaluation of the public health programme using the existing tools and methodologies.
   - Advocate for qualified refugees to be accredited by ministry of health so that they are able to provide public health services.

2. **Strengthen Capacity for better service delivery**
   Uganda refugee settlements are located in remote locations and the pay for IP is not competitive enough to attract and retain highly qualified staff. This leads to high staff turnover of partner staff. In order to strengthen the capacity for service delivery, the following will be carried out on annual basis:
   - Certified skills training for UNHCR and IP staff
   - Support implementing and operating partners to submit proposals to other donor so as to supplement the UNHCR resource contribution.
   - Coordination with other public health players in the country for better refugee service delivery.

3. **Emergency preparedness and response**
   Uganda’s location within the region makes it prone to refugee influxes. The public health team will be part of the country contingency planning and its members will constitute a team that will initially respond to health, nutrition and WASH need of new arrivals at any entry point in Uganda.
Regional strategic directions

Urban refugees in Kampala
The urban refugee population continues to grow and refugees who are residing in Kampala are supposed to be self-reliant. The strategy will be to advocate for refugee inclusion in health service delivery, provide support public health facilities, monitor and evaluate the health service delivery to refugees who are in Kampala.

West Nile Region
Following repatriation, the refugee population is reducing. It’s not cost effective to maintain an NGO to provide health services. The primary health care services will continue to be provided by the district local governments as an integrated health care system for both refugee and host population. The strategy will be to strengthen the capacity of the district local government to provide services at the same level as the immediate host population.

South Western Region
With the instability in the neighboring countries and continued new arrivals from DRC, the settlement in South Western Uganda will be run as a parallel health care system with services provided by NGOs. In order to maximize the refugees’ benefit from the minimum health care package provided by the ministry of health, NGO managers should be active members of the District Health Teams and will regularly attend the district local government meetings so that national services are extended to the refugee settlements.

Rolling out of the strategy

UNHCR senior management & UNHCR sub-offices
- The summary of the strategy will be shared with management and detailed list of thematic strategies shared with UNHCR field offices to ensure that all the partner submission are in line with the agreed strategic direction.

UN agencies & Donors
- The strategy will be widely shared with UNFPA, UNICEF, WHO for advocacy, resource mobilization and synergies. The donors will receive a copies of the strategy at any given opportunity.

Implementing and operating partners
- Orientation of partners on the new focus and priorities and ensuring that their subproject descriptions are in line with the strategy.
- Support mission to refugee settlements to provide technical support to implementing partners and districts.
- Improved monitoring of the strategy implementation using health information system and timely feedback to the implementing partners.
# List of Contributors:

<table>
<thead>
<tr>
<th>Names</th>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
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<td>UNHCR-Kampala</td>
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<tr>
<td>Sathya Doraiswamy</td>
<td>Snr Regional RH&amp;HIV Officer</td>
<td>UNHCR-RSH</td>
</tr>
<tr>
<td>Allison Oman</td>
<td>Snr Regional Nutrition and Food Security Officer</td>
<td>UNHCR-RSH</td>
</tr>
<tr>
<td>Murray Burt</td>
<td>Snr. Regional WASH Officer</td>
<td>UNHCR-RSH</td>
</tr>
<tr>
<td>John Tabayi</td>
<td>Snr Regional Public Health Officer</td>
<td>UNHCR-RSH</td>
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</tbody>
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