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INTEGRATING SERVICE DELIVERY IN IDP CAMPS: THE CASE OF NORTHERN UGANDA

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Abstract

The mid-north and parts of eastern Uganda are under siege from the LRA and poor health. There are about 1.6 million people displaced by the LRA living in squalid camps. In these camps, the IDPs are cramped in huts built barely a metre away from each other and are solely dependant on food handouts. The staggering burden of disease and poor indicators in the country is contributed to greatly by these conflict areas especially the northern. The severe poverty being experienced in these regions worsens this. General population accessibility to health facilities is not good, being hampered by the general insecurity in the area. Further, because of the rather difficult working environment in the affected districts, the general staffing levels and distribution are poor and insecurity has made the exercise of distributing drugs to lower level units difficult. in order to better the delivery of health services amongst the IDPs, four areas have to be addressed; these are increasing services to the IDPs and encouraging the utilisation of these services; deploying appropriate health workers; education and reiterating the SWAp working arrangement. However the missing link between these interventions and achieving good performance and health indicators in the IDP camps has been verticalism and an uncoordinated delivery of health services by the various stakeholders and partners working amongst the IDPs. This paper advocates for an integrated delivery of health services amongst IDPs in order to achieve the best possible outcomes from priority interventions.

Introduction

The mid-north and parts of eastern Uganda (Acholi, Lango and Teso regions) are under siege from the LRA. There are about 1.6 million people displaced by the LRA living in squalid camps and in Pader and Kitgum districts, more than 90% of their populations are in camps. In these camps, the IDPs are cramped in huts built barely a metre away from each other and are dependant on food handouts.

The staggering burden of disease in the country is contributed to greatly by these conflict areas especially the northern. The severe poverty being experienced in these regions worsens this. Despite significant gains in reducing poverty recorded in most of Uganda, the north has continued not only to lag behind but the poverty level has continued to increase. This has obvious implications for the health outcomes too. For every 10 persons in the north, between 6 to 7 persons live below the poverty line, i.e. cannot generate Ug. Shs. 2000 per day compared to 3-4 persons for the rest of the country. This means that they cannot meet daily basic needs (The Monitor 2004).

There are many reasons for the increased burden of disease on the poor. First, the poor are much more susceptible to disease, because of lack of access to clean water and sanitation, safe housing, medical care, preventative behaviours, and adequate nutrition, just to name some key factors. Second, the poor are much less likely to seek medical care even when it is urgently needed, because of greater distance from health providers, the lack of out-of-pocket resources needed to cover health outlays, and lack of knowledge of how best to respond to an episode of illness. Third, the out-of-pocket outlays that poor people make when serious illness strikes can push them into a poverty trap from which they do not recover, by forcing them into debt or into the sale or mortgaging of productive assets (like land). A serious illness may plunge a household into prolonged impoverishment, extending even to the next generation as children are forced from school and into the work force (WHO 2001).

The current health situation

The conflict in the north has had a severe impact on the health of the population in the region. Malaria has been identified as the most important killer disease of children and adults and explains the increased morbidity that has a major impact on productivity. When people return to their areas to farm, they often sleep in the bush to hide from rebel attacks, thus exposing themselves to mosquito attacks. It is reported that during periods of high intensity of combat and threats of rebel attack, up to 40,000 people often sleep on verandas of major towns and at Lacor hospital, with absolutely no protection against mosquitoes (CSOPNU 2002). As mentioned earlier, malaria is a major public health concern in the IDP camps since it particularly affects under-fives and pregnant women.

Other prevalent diseases which are largely preventable, are HIV/AIDS and STDs, Tuberculosis and acute respiratory infections (ARIs), diarrhoea, trauma, skin infections, maternal problems and many of the immunisable diseases.

Although the HIV infection rates from the major sentinel surveillance sites in the country continue to show declining trends (MoH 2002), some places particularly Lacor hospital in Gulu continue to record relatively higher rates. A further desegregation of data by district shows a remarkably large number of adults living with AIDS in the districts of Gulu, Kitgum, Lira, Apac, Arua, Moroto and Nebbi among the northern districts. No prior analysis has been made to explain these trends but there are indications that the high incidence of HIV/AIDS in some parts of northern Uganda is linked to internal displacement and migration, moral decadence, low awareness about methods of control and poverty. In Pader district, the district average HIV seroprevalence rate as captured from ANC surveillance is about 8.2%.

Infant and under-five mortality have stagnated over the last decade and remain at very high levels. Major determinants include high fertility, low birth spacing, teenage pregnancies, unsupervised deliveries, falling immunisation coverage, increased malaria prevalence and malnutrition. Taking an example of Pader district, the IMR is 165 and Under 5 MR is 279 compared to national figures of 88 and 146 respectively, and the DPT3/HepB+Hib coverage is 39.8% (Pader 2004).

Maternal mortality is extremely high. For Pader district, the MMR is 700-1000 compared to the national figure of 505. Pregnant mothers are often unable to access antenatal care due to conflict and this partly explains why complications such as ruptured uterus or vesico-vaginal fistula (VVF) urinary problems are recurrent due to not having the necessary caesarean section. Many of these mothers are married early when too young which adds to the complications during birth. There are also few deliveries taking place in health units, which for Pader district constitute 16.7%.

Mental health is amongst the most pressing non-fatal health problems facing the regions today. One in every 4 persons is reported to be having some form of mental illness. These mainly include schizophrenia, psychosocial disorders, neurological disorders, psychosocial consequences of years of war/conflict and civil strife.

Health services in the north

Access to health facilities by the population is greatly hampered by the insecurity in the area and a big proportion of the population is in IDP camps. In Pader district, only 20% of the population lives within 5 km from a health facility (Pader 2004).

Because of the rather difficult working environment in the affected districts, the staffing levels and distribution are poor. Doctors have been attracted to work in the districts, with only the private providers being able to attract this cadre because of the special remuneration package that they offer. This has meant that for the public units, lower level cadres have had to end up performing doctor's duties, for example manning and managing HC IVs.

Furthermore, drugs in the districts have, to a large extent, been available, but problems have been with their distribution and utilisation. Insecurity has made the exercise of distributing drugs to lower level units difficult, and also since most of these lower level units are not manned by very qualified personnel, they either don't bother ordering for certain kinds of drugs, or if they do, they tend not to use such drugs. In the case of Lira, over the past many months, the district has been struggling with a large population of displaced people, and also frequent attacks on people resulting in increased drug utilisation. The pattern of drug availability and utilisation in the district has therefore been largely fluctuating and unpredictable. Some donors have aided the district under a humanitarian assistance programme.

General utilisation of health services/facilities has also been problematic. For example, Dokolo HC IV in Lira district has a total of 80 beds in 4 wards (male, female, children and antenatal) but because of the insecurity, no admissions are taking place. Most patients prefer getting treatment and going to their homes or elsewhere other than getting admitted at the health unit.

Current interventions

The determinants of health can be identified as peace income, education, food and nutrition, shelter, stable ecosystem, social justice, equity, safe water and environmental sanitation. Other determinants of health include participatory governance, gender equality, healthy lifestyles and universal health services. The prime movers of health transformation are therefore economic growth, education, nutrition, sanitation and safe water, the decline in family size and out-reach maternity services (Okuonzi 2001). So in order to better the delivery of health services amongst the IDPs, four areas have to be addressed; these are increasing services to the IDPs and encouraging the utilisation of these services; deploying appropriate health workers; education and reiterating the SWAp working arrangement.

The Government of Uganda is currently stressing the prevention and control of malaria during pregnancy, promotion of the use of insecticide-treated nets, and effective manage of emergency and epidemic situations. Malaria, which is the lading cause of morbidity and mortality in the regions is being targeted for reduction by encouraging the use of bed nets, implementing a new drug policy presumptively treating pregnant women and ensuring a constant supply of drugs.

For HIV/AIDS, substantial progress has been made in reducing the prevalence of HIV/AIDS. Due to early intervention, committed and sustained political leadership, a strong focus on prevention and a multisectoral approach. However the past progress in reducing HIV/AIDS prevalence is to some extent reversible, as the recent increase in prevalence from 6.1 to 6.5 percent suggests, and it is therefore important that efforts continue in this direction. The spread of the virus depends almost exclusively on sexual and reproductive behaviour, which in turn is affected by awareness about the disease. While the knowledge about AIDS in the country is universal, the level of awareness is not matched by the knowledge of ways to avoid contracting the virus, as the most recent UDHS reveals (UBOS 2002). Apparently HIV/AIDS spreads fastest where poverty and instability prevail indicating that control may require slightly a different approach from that used in non-conflict areas. Special attention should be directed to Northern Uganda to increase awareness about HIV/AIDS particularly among the women and youth. The PEAP target of 5% by 2005 can only be attained if the IEC campaign focuses on increasing awareness of prevention, condoms are adequately distributed and used, mother-to-child transmission reduced, and the north is given special attention.

Staff recruitment, by District Service Commissions, is taking place in earnest, but the challenge is how to get appropriately qualified staff. A central role in delivery of most cost-effective health interventions belongs to primary care providers, a category that can include physicians, nurses, nurse practitioners, or midwives, depending upon how the jobs are defined. Nonphysician primary care providers have many advantages. They cost less to train and they receive lower salaries. They are easier to attract to rural areas and usually communicate more effectively with their patients (World Bank 1993). These are the kinds of health workers that will be most useful for the delivery of health services amongst the IDPs. They should be appropriately trained in PHC and the primary care training should include, at a minimum, the skills necessary to provide the essential clinical services such as family planning services and the proper diagnosis and treatment of sexually transmitted diseases (STDs).

The IDP camps have been provided with health facilities as a means of improving accessibility, although the level of specialised care that can be offered at these health units is questionable. The IDP camps that have been created in the districts in response to the insecurity in some parts of the districts have necessitated the deployment of health workers from the various HSDs in the camps. So this has resulted in artificial staff shortages in some HSDs. The cadres in greatest demand are doctors and nursing staff.

The district health services in the region have been provided with vehicles to improve on their delivery of health services and to also enable them to conduct outreach programmes, however, transport is still a big problem for district health service delivery and this has been compounded by the rebel attacks on the already few existing vehicles.

The Government is enhancing basic education, both primary education and adult literacy, aimed at equipping the population with skills to survive and improve the quality of life. The education level of a mother is inversely associated with infant mortality. Further, mother's education is also strongly correlated with the chances of children receiving immunisation (UBOS 2002). Uganda's current illiteracy rate is 37%, the highest illiteracy rate in East Africa. Almost 5.5 million women and 1.4 million men in Uganda are non-literate, i.e. a total of 6.9 million adult Ugandans. There is a higher illiteracy status in rural (40%) than in urban areas (13%). There are other significant disparities, including between regions and districts. Northern Uganda at 53% lags behind the central region at 23% (MoFPED 2001). Deliberate and elaborate efforts need to be taken to encourage education amongst the IDPs and to ensure that the children and adults remain enrolled and acquire the basic cognitive skills they need.

PHC programmes are however not reaching the entire population. According to the 2000/01 UDHS, the Total Fertility Rate (TFR) in the northern region is 7.9; perinatal mortality rate is 46.8; only 27 percent of deliveries are attended to by trained health workers; DPT3 immunisation coverage is 44.9 percent; and the infant mortality rate is 105.9 deaths per 1000 live births. The under five-mortality rate is 178 deaths per 1000 live births. These rates are worse than the national averages, mainly due to the conflict.

In addition to other factors leading to poor health performance, achieving good performance and health indicators in the IDP camps have been verticalism and uncoordinated delivery of health services by the various stakeholders working in IDPs.

Integration of services amongst the IDPs

Integrated planning

The National Health Policy and Health Sector Strategic Plan reiterate the necessity of delivering health services in an integrated manner and in as much as possible using the cross cutting inputs. Cross cutting inputs are those that are required for the implementation of activities across the board, e.g. infrastructure, human resources, drugs, equipment and logistics. The requirement for supervision and monitoring is also cross-cutting.

This requires common provision of activities/ interventions with the different participants/partners in the process agreeing on work plans and work methods; resource mobilization and allocation; and a common management arrangement. Partners are more likely to attain more influence over the total pattern of expenditure through joint agreement on priorities.

However currently activities and interventions are being implemented/delivered in a vertical manner in the districts and IDP camps with independent management structures, documentation, work plans and expenditure procedures. This is causing a duplication and overlap of efforts; wastage of resources and time; and inefficiency of service delivery.

It is therefore vital that the workplans to improve the delivery of health services amongst IDPs be incorporated into the district annual workplans. A single annual plan can be prepared instead of separate plans for multiple different activities. This saves time and helps improve coordination. There will be minimal duplication of efforts and resources and management costs are less. Supervision and appraisal, and the cost of evaluation and audits will be shared between the partners. Due to a shift to a single strategic framework, efficiency and equity would improve.

Embracing SWAp

Given the limited capacity of Uganda to mobilize government revenues, and the considerable demands on those revenues for public administration, infrastructure, agriculture, police, defence, education, and debt servicing in addition to health, domestic resource mobilization will not begin to close the financing gap between current spending and totals needed to coverage essential health services.

The Sector Wide Approach to health development (the SWAp) was developed during the mid- 1990s as a means for addressing many of the delivery programs of donor-supported programs. The basic idea of the SWAp is that the donors work together with national authorities, agreeing strategies for support, and seeking ways to pool their assistance for, a country-designed and country-led strategy. The success of the SWAp, at country level, depends on the extent to which national governments and donors are able to subscribe to, support and then sustain a collaborative mechanism for assistance to the health sector.

For Uganda, the policy objective of the SWAp is to provide an enabling environment that would allow for effective co-ordination of efforts among all partners in Uganda's national health development, increase efficiency in resource application, achieve equity in the distribution of available resources for health and effective access by all Ugandans to essential health care.

A Sector-Wide Approach (SWAp) is being used as the framework for implementing the Health Sector Strategic Plan (HSSP). Under this framework, the Government of Uganda takes on the ownership and leadership role with all the other partners and stakeholders participating in joint prioritisation, planning, monitoring and evaluation, pooled funding, capacity building, amongst others.

However not all donor aid is captured by this working arrangement. Some of it, and a great deal of it, is still being channelled into the health sector through vertical programmes. Some Development Partners are still outside SWAP and continue to fund vertical programmes and in effect disrupting Government overall programmes and priorities. All partners working amongst the IDPs should be identified and encouraged to work either directly with the central government or with the local governments but under the mutually beneficial SWAps working arrangement.

Intersectoral collaboration

A wide range of multisectoral interventions is needed to reduce infant and maternal mortality. The single most important activity - improving the access to obstetric emergency health care - is likely to be very costly but is what is urgently required. Other sector outputs, such as education and water/sanitation are also critical if the alarmingly high infant and maternal mortality rates are to be reversed amongst the IDPs.

Food shortages or inadequate food needs to be addressed. A child who is malnourished is much more likely to contract respiratory infections, diarrhoea, measles and other preventable diseases , and less likely to receive needed health care (UNICEF 2001). The children in the camps will need better nutrition other than the daily rations of corn and beans.

Conclusion

The issue of appropriate and adequate shelter for the IDPs needs to be addressed in an intersectoral manner. The huts in the camps are made from poor materials like earth and grass and these sometimes serve as breeding grounds for pests like fleas, rats, ticks and jiggers. Such pests transmit diseases to the inhabitants of such dwellings. The materials used to construct these huts therefore needs to be improved and if this is not possible steps should be taken to regularly fumigate such poor dwellings. The situation whereby there are many people living under one roof can be a breeding ground for diseases, more especially if the huts are not well aerated. This will also need attention.

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