

## Gulu District Health and Nutrition Needs Analysis

The 19 year long insurgency in Northern Uganda has forced 90% of the population to live in IDP camps; the population projected at 491,000, consists of 4.3% infants, 20.5% children Under 5, 23% women of childbearing age and approximately 5% pregnant women<sup>i</sup>.

Health issues in camps include;

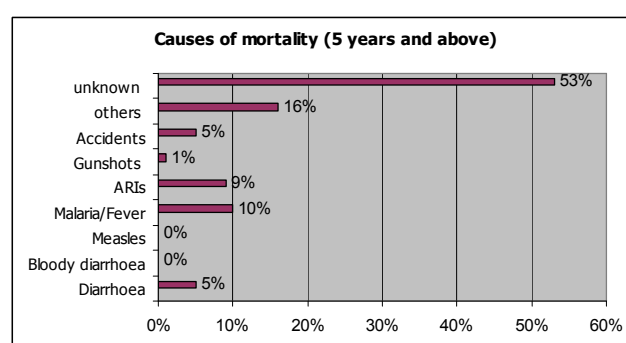
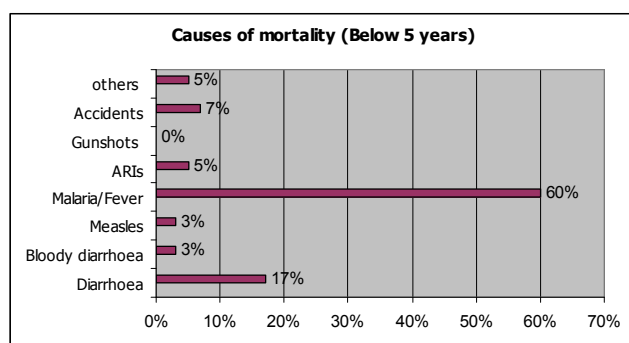
- Congestion which exacerbates spread of Acute Respiratory Infections (ARIs);
- Poor sanitation and water shortage which can be associated with the frequent outbreaks of cholera in the camps;
- Break down of traditional and cultural structures, which have contributed to the high prevalence of STI/AIDS and alcoholism.

### Health Care delivery

Most camps are situated where there are health facilities. Some of the newly gazetted IDP camps, however, have no access to health services because they are far from the health centres and often situated in insecure areas.

**Top diseases in OPD 2003/4:** Malaria 32.6%, ARIs (not pneumonia) 18.9%, intestinal worms 6.9%, skin diseases 5.1%, diarrhoea 5.0%, ARIs (Pneumonia) 4.5%, trauma (injuries, wounds, burns) 3.8%, eye infections 1.8%, others 16.9% (Office of the DDHS, Gulu).

### Top causes of mortality in 2003/4<sup>ii</sup>



## Health and Nutrition issues

1. **Malaria**, according to a recent survey<sup>iii</sup>, is responsible for a staggering 60% mortality among Under 5s and 16% above 5. Another survey<sup>iv</sup> places Malaria after diarrhoea, AIDS and ARIs in the under 5 category. There is adequate supply of first line treatment of malaria in health centres, but second line drugs (severe malaria) are available in very few health centres. Diagnosis of malaria in most camps is difficult as treatment is provided by unqualified CORPS; laboratory diagnostic units are few due to lack of qualified staff to use the microscopes. In the use of Home Based Management of Fever (HBMF), Community resource Persons (CORPS) have been trained to dispense Homapak, but in hard to reach areas supplies sometimes run out, yet the CORPS may not be fully resident in the camps to attend to patients. The coverage of intermittent treatment of malaria in pregnancy (IPT2) is high in Gulu district with 50% coverage as compared to the national average of 24%<sup>v</sup>. The policy on Insecticide Treated Nets (ITNs) and free provision has benefited pregnant mothers and under 5s. The ITNs were distributed in 33 of 51 IDP camps at ANC clinics where they proved instrumental in increasing the number of institutional deliveries.

<sup>i</sup> Office of the DDHS, Gulu

<sup>ii</sup> MoH/WFP & UNICEF, Sep/Oct 2004

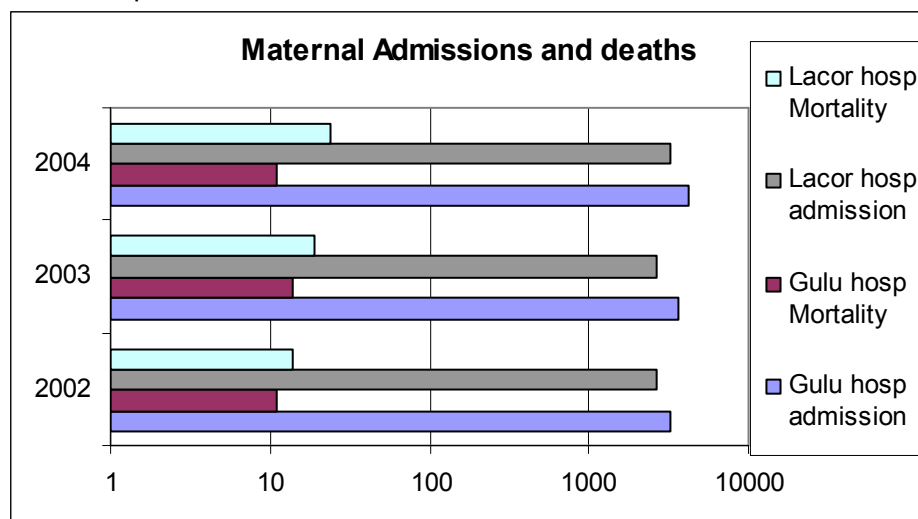
<sup>iii</sup> MoH, WFP & UNICEF, Sep/Oct 2004

<sup>iv</sup> Save the Children in Uganda (SCiU), Gulu Nov 2004

<sup>v</sup> Annual Health Sector Report October 2004

According to an ICRC assessment<sup>i</sup>, respondents in 8 IDP camps indicated that having a mosquito net would improve the health status of their households. In all but 1 camp, malaria was found to be the most common disease at household level.

2. **Acute Respiratory Tract Infections (ARIs)** is one of the commonest causes of morbidity among both children and adults. The congestion in the camp, cooking in poorly ventilated huts and underlying malnutrition are the reasons for the high prevalence of ARIs. Late referral has been a cause for the high morbidity due to ARIs. According to a recent survey, ARI/Cough is the second most common cause of morbidity among under 5s (28.6%)<sup>ii</sup>.
3. According to information from Lacor Hospital ANC clinic, a national sentinel site, **HIV/AIDS** seroprevalence is 11.8%, much higher than the national seroprevalence rate of 6.2%. A survey carried out by SCiU, Gulu in 13 IDP camps indicates that among the 6-59 months age group, AIDS was the second leading cause of mortality with 26%. VCT, PMCT and ART services are limited to the three hospitals in Gulu town. There is need to expand VCT, PMCT and ART services to cover more IDP camps. IEC/behaviour change communication for camp population is limited to few camps and there is need to expand it to cover other camps. There is also need to address the lack of ART services to Orphans and Vulnerable Children with HIV/AIDS.
4. Few health centres have functioning maternity wings that offer **antenatal care and deliveries**. Antenatal attendance is high in Gulu district, but there are few institutional deliveries due to lack of privacy in the health facilities. The low number of midwives and doctors in peripheral health facilities is another reason for low institutional deliveries. Emergency Obstetrical Care services are not available in most health facilities due to incomplete construction of Health Centre IVs theatres and absence of obstetric practitioners and lack of referrals.



On average maternal mortality in Gulu is high, and the number of institutional deliveries, although still low, is on the increase (see graph). That notwithstanding, there is a need to improve/build more maternal wings at health centres (Gulu district has 17 Health Centre IIs which by their design do not have maternity wings), to train TBAs to refer emergency cases to hospital early, train health workers in Emergency Obstetric services so that service delivery is improved. There is also need to improve/provide goal oriented ANC outreach in IDP camps that do not receive regular health services. Adolescent reproductive health is a largely forgotten area, yet it contributes to 50% of maternal mortalities. Only Pabbo IDP camp runs a Straight Talk adolescent clinic. There is need to extend their services to schools and other IDP camps.

5. **Malnutrition**, despite being below the emergency cut off of 10% Global Acute Malnutrition (GAM), remains a problem especially in the newly recognised camps. According to 2 independent assessments<sup>iii</sup>, GAM has been set at 7.7%, while Severe Acute Malnutrition Rate (SMR) is 1.1%. (MoH

<sup>i</sup> ICRC, Gulu April 2005

<sup>ii</sup> MoH/WFP/UNICEF: Assessment of 33 camps (Sep/Oct 2004) and MoH/SCiU (Nov 2004)

<sup>iii</sup> MoH/WFP/UNICEF: Assessment of 33 camps (Sep/Oct 2004) and MoH/SCiU (Nov 2004)

& SCiU), while MoH/WFP/UNICEF nutritional survey has GAM at 4.5% and SAM at 0.7%. The high rate in the newly recognised camps could be related to lack of access to proper health services and the fact that many of those camps have limited access to land and rely almost solely on food aid.

6. **Diarrhoeal diseases** may be attributed to the congestion in the IDP camps and the related generally poor sanitation. The diarrhoeal diseases account for 41% deaths among Under 5s and 30% among the above 5s<sup>i</sup>. The high mortality/morbidity is due to poor sanitation /personal hygiene and water shortage. Latrine coverage for Gulu district is 42%<sup>ii</sup>. The repeated cholera outbreaks experienced in the district could be attributed to the factors above.  
Overcrowding and poor sanitation conditions in IDP camps have increased the risk of epidemics in the district. Before the cholera outbreak in Pabbo in October 2004, the district had not experienced outbreaks since 2000. This new trend highlights the need to strengthen the district capacity in epidemic preparedness and response covering all components (surveillance, laboratory, preparedness and response plan including training of community based early warning network and rapid response teams, stockpile of emergency response supplies).
7. **Tuberculosis** being an opportunistic infection in HIV/AIDS and the congestion in the camps, poor ventilation, improper lighting (darkness) in huts and underlying malnutrition all contribute to its high incidence. Gulu has a detection rate of about 49%<sup>iii</sup>, but also no serious follow ups are being made, partially because of weak implementation and support supervision for DOTS and also in part due to inadequate laboratory services for proper diagnosis. There is need to train more laboratory staff, health workers and CORPs to follow up patients at camp/ community level through community-based dots. Another issue to consider is the restricted access to laboratory services by IDPs in camps. A solution such as transport of sputum specimen by a messenger or regular visits of a microscopist to camps should be considered.
8. **Mental health**, largely caused by war related trauma, rape, witnessing killings etc, is a major health problem to camp populations. There are few psychiatric staff, who are now involved in other medical work. There is need for capacity building in this area, to equip medical staff to handle the increasingly worrying problem of mental illness in Gulu district. Epilepsy in Gulu can be related to incidences of onchocerciasis in Koch Goma. There is need for intervention in this area as well.
9. Among the '**neglected diseases**', the major problem is with trypanosomiasis in Kilak Health Sub-district. Patients from that area have to go to Adjumani for treatment because Gulu has no treatment centre. A program targeting the eradication of lymphatic filariasis by 2020 is in place. A Schistosomiasis treatment program is in place, targeting 75% of school children in the area, due to their exposure to it.

*Note that the WFP assessment was done in '33 old' camps, while the SciU assessment was done in the 17 previously ungazetted camps.*

#### **Sources:**

1. Annual Health Sector Performance Report 2003/4
2. AVSI Gulu
3. HIV Seroprevalence in Northern Uganda: the complex relationship between AIDS and conflict, Filipo Ciantia, AVSI Uganda
4. Assessment of Health services in hard to reach camps ICRC/URC, Gulu
5. Norwegian Refugee Council (NRC)
6. Office of the DDHS, Gulu
7. Summary results of the Nutrition survey conducted by SCiU in partnership with the office of the DDHS Save the Children in Uganda, Gulu
8. UNICEF, Gulu
9. UPDF Gulu Military Hospital
10. Summary of the Nutrition and Health Assessment in the Internally Displaced Persons Camps in Gulu district (Sep/Oct 2004) World Food Programme/Ministry of Health/ UNICEF

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<sup>i</sup> Save the Children in Uganda (SCiU), Gulu Nov 2004

<sup>ii</sup> Office of the DDHS, Gulu

<sup>iii</sup> Office of the DDHS