

HEALTH REPORT ON OMEE I CAMP

Omee I IDP camp is found in Kilak HSD and has a population of 7730 people living in 1720 households, according to a household census conducted in December 2004. The population is not aggregated according to gender and age. The people have migrated from Pabbo, Amuru, Karuma and other areas in search of fertile soils for farming (Mr. Johnson Obale, Camp leader)

1. Health care delivery

The nearest health facility is Amuru HC III situated about 18 km away and connected by a motorable road. Accessibility of the health centre is difficult in emergency situations as there is a segment frequently used by rebels.

The camp was last visited by health workers from the health centre on 16th February 2005 during the Child health Days campaign and vaccination and drugs were given out. The camp has only one resident CORP who distributes Homapak for the Home-Based Management of Fever. There was enough supply of Homapak during the visit though the community complains that the CORP is not always available. There are some 7 traditional birth attendants who assist with all deliveries in the camp. The camp was also visited in February 2005 by a health worker from World Vision who offered a sensitization talk on HIV/AIDS. The population expressed the wish to extend VCT services to the camp as they believe many people may be harbouring the deadly virus without their knowledge.

2. Environmental health and sanitation

The people live in unventilated huts which also in most cases serve as a family kitchen. The huts, though haphazardly sited, are better spaced. Disposal of refuse, animal's and children's faeces are poor though there are some latrines concentrated at the periphery of the camps

3. Common ailments identified by the community

The commonest health problems of children, according to the community, are malaria, cough, candidiasis of the gut in children under 5 years, malnutrition and diarrhea. The candidiasis affects mainly malnourished children who also have diarrhea and presents as ulceration with white patches affecting the mouth up to the anal region. This was a very big worry to the community. In adults, the commonest problems, in their order of priority are fever, cough, intestinal worms, scabies and sexually transmitted infections.

4. Mortality.

In the last three months, there were 8 deaths in the community involving 4 children and 4 adults. The children all died from malaria and in the adults the causes of deaths were assault, suicide, fever and death of a mother due to delivery complications.

5. Priority health needs as identified by the community

- Train more TBAs and CORPs but the selection for the CORPs be done by the community and not from Amuru as has been the case previously.
- Regular outreach services be extended from Amuru HC III to include immunizations, antenatal services, VCT, etc
- Another borehole be drilled to supplement the existing water sources in the camp. The borehole near the army detach is out of bounds for most civilian population.
- A functional health facility must be built

6. Priority health needs identified by assessors

- A regular cleaning of the camp surroundings must be organized by the camp authorities. Disposal of refuse in garbage pits and children's faeces in latrines encouraged.
- Integrated and regular outreaches organized from Amuru HC III to provide services contained in the Uganda National Minimal health Care package.
- Train more CORPs and provide delivery kits to TBAs
- The HSD team should make effort to ensure that hard to reach areas receive The National health care package.
- The camp leaders should regulate time for drinking alcoholic drinks preferably to evenings only.

- Have regular health assessments in hard to reached areas
- Conduct another assessment after 3 months period
- To assess the entire population living in the camp and new registration of those in need for food distribution
- Increase the number of community drug distributors in the camp

7. Nutritional assessment:

Due the fact the nutrition advisor went to Omee 1, most of the collected data concerned that camp and the results found are as follows:

Estimate population figure: 7730 people. There has been reported increase in the population figure, mainly from Pabbo, Karuma, Amuru and Olwal coming to this camp for agriculture reason due to the fertile land surrounding the camp.

Household number: 1720

Areas of origin: Pabbo, Olwal, Amuru, Karuma

The mid upper arm circumference (MUAC) does not indicate the level of malnutrition within the community but can be used to estimate the risk of children to malnutrition and death; it was therefore used as to have indication on the malnutrition, taking into account the fact that MUAC measurement express the risk of malnutrition for children with height 75 – 110 cm (or age from approximately from 1 – 5 year), the results found are as follows:

- MUAC < 11 mm: 1 children (possible in criteria for the TFC)
- 11 =< MUAC < 12.5 mm: 2 children (Probably in criteria for the SFC)
- >=12.5 mm: 97 children (considered as normal)

There was no case of oedema found during this visit.

This prevalence indicates 1 % of children were at very risk of death for malnutrition while 2 % of children had been at risk for malnutrition which gives a total of 3% of the entire selected children.

This result could be considered as acceptable in specific zone and doesn't require emergency nutrition intervention at this period.

It was however reported deterioration in security situation around and within the camp caused by the LRA and unfortunately affecting the access to the land. Very few family (approximately 200 households) are benefiting from family food ration given by WFP in Amuru, the camp has only 2 boreholes.

This camp doesn't have health facility but has community resource person distributing homapak in the camp, responsible for drug distribution in the camp. The IDPs do receive outreaches from qualified health worker (from Amuru health centre) the visits are not regular, the last visit was on 16th March 2005. The leadership of the camp is very weak and can't organize general cleaning of the camp and no regular health education has been conducted in the camp.

There is no need for emergency nutrition intervention at this current period