

The experience of Catholic Health Care facilities in providing services to refugees and other victims of war – The experience in Uganda.

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Abstract

The paper looks at the fact that it is not only refugees who are victims of war and conflict, but also internally displaced people (IDPs) who quite often suffer the consequence of the displacement more than refugees. In fact sometimes even more affected are people who stay on in their homes in the middle of the conflict. While recognizing the total trend and current number of refugees in Uganda, the example of South Sudanese refugees from recent influxes into Uganda is a case whose effect is examined, while for the internal displacement, a retrospective experience of St Mary's Lacor hospital in northern Uganda during the past long war in the country is used.

It is observed that Refugees may be war victims or not war victims but due to other reasons for persecution or due to natural disasters. But there are also other "War victims" who are not refugees. The two have a lot of similarities. Unfortunately quite often international attention is faster and more on refugees than on IDPs. The paper attempts therefore to first define these two major categories of displaced persons, refugees and internally displaced people. It then looks at the similarities between.

Like IDPs, refugees who are not in camps are not provided for and share resources with the local community, including health facilities. Health facilities serving internally displaced people (IDP) are themselves in direct danger from the conflict and violence. Uganda currently reportedly has 1,355,764 refugees, 75.4% of whom are South Sudanese. Though not in war now, Uganda has had a long and big experience with internal displacement in the past, putting huge stress on health facilities, especially in the northern region.

It is important to understand what effects these displacement of people have on health care institutions during such conflicts. This paper shares the experiences of the catholic health facilities in the regions affected by refugee influx as well as during the massive internal displacement during the past war. Internal displacement does have much more stress on the local catholic health facilities in terms of utilization because refugees often have many health facilities constructed by refugee agencies. Instead health worker attrition to refugee health facilities affects provision to the host community. Good quality in these local catholic health facilities attracts more users of some important services like maternal health.

The role of health facilities in war situation goes beyond medical care. They are a center of security for both resident and commuting displaced people, providing social rehabilitation, spiritual care etc. Catholic health facilities have been able to remain open through the conflict. Post conflict demand for resources is as big as during the conflict. It is important to support health facilities in poor countries or fragile situations through such moments as well as to strengthen their systems for longer term resilience. Developing internal sustainability strategies are important. Partnerships and collaboration with other stakeholders and within the church are important.

Introduction

Refugees and War victims

Refugees may be war victims or not war victims but have had other reasons for persecution. There are also other “War victims” who are not refugees. They leave their homes but do not cross the borders. They are internally displaced people (IDPs). IDPs often suffer the same or even worse than refugees.

The UNHCR defines refugee as someone who has been forced to flee his or her country because of persecution, war, or violence. He or she has a well-founded fear of persecution due to race, religion, nationality, political opinion or membership in a particular social group.

On the other hand internally displaced persons are also forced to flee their homes for the same reason as refugees, but remain in their own country and have not crossed an international border. For that reason they are not protected by international laws and usually not eligible for many types of aid that are accessible to refugees.

According to the Internal Displacement Monitoring Center, data collected in the period 2009 to 2015 showed not only increase in number of both refugees and people displaced by conflict and violence but that the number of internally displaced people has been much higher than that of refugees.

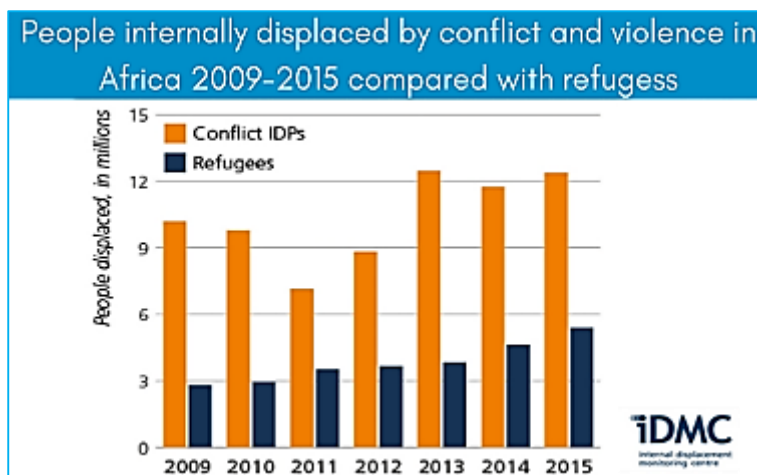


Figure 1: Showing the increasing in number of refugees as compared to internally displaced people in Africa from 2009 through 2015

Source: IDMC (<http://internal-displacement.org/library/publications/2016/africa-report-2016/>)

The Africa Report on Internal Displacement (iDMC, December 2016¹) indicates that in 2015 alone conflicts and disaster forced 9,500 people each day to leave their homes in Africa. In that year (2015) a total of 3.5 million new displacements occurred on the continent out of whom 2.4 million were due to conflict and violence “making Africa only second to the Middle East for conflict and violence as a cause for displacement”. It reports that as of December 31st 2015 there were cumulatively nearly 12.4 million people living in ongoing internal displacement in Africa as a result of conflict and violence as of the end of 2015 and that being more than the entire population of Kinshasa, and 30 per cent of the world’s total number of IDPs at the time. East Africa reportedly accounted for over half of this total head count.

However, even this is thought to be an underestimate because, “Governments and their international partners provide monitoring data for Africa’s major displacement crises caused by conflict, but

geographical coverage is often incomplete because access is limited by insecurity” (iDMC, Norwegian Refugee Council; December 2016). Therefore, besides IDPs who are not in camps, this difficulty in getting complete data increases the number of “invisible IDPs).

Similarities between refugees and Internally Displaced Persons (IDPs)

The two have a lot of similarities. Unfortunately quite often international attention is faster and more on refugees than on IDPs. For example, not much is heard about IDPs in South Sudan but a lot about the South Sudan refugees in Uganda. Like IDPs, refugees who are not in camps are not provided for and share resources with the local community, including health facilities.

Health facilities for refugees are not directly hit by the conflict or war process. Therefore while IDPs are caught up in the middle of the conflict, refugees are in a peaceful zone or out of the conflict zone.

Refugees and IDPs therefore have similar plights but slightly different risks. Nonetheless both create burden on the local health system. In addition, both IDPs and refugees who are not in camps are relatively invisible.

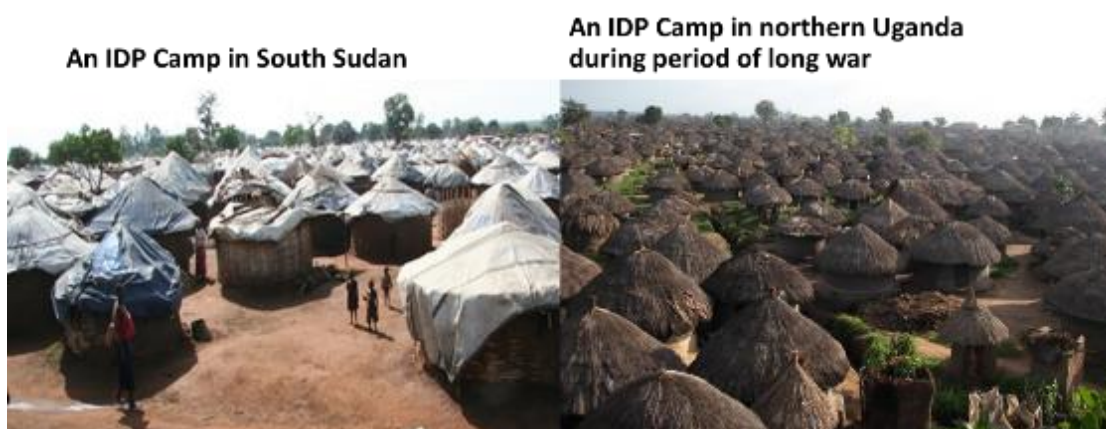
Two wars / conflicts and two types of displacement

This paper is now based on two wars or conflicts and two types of displacement as described above and reflects on experience of Catholic health institutions in Uganda with both refugees (from other countries) and Internally Displaced people in northern Uganda during the past war.

For Uganda it is now not an active war, but the past long war / conflict. It is reflected on to describe what happens in a situation of internally displaced people, whom would rather be called “internal refugees” because they also take refuge outside their homes, except not beyond the national boundary, as compared to the real refugee situation.

The second is the current or active South Sudan conflict from which there are several refugees in Uganda

Figure 2: Internally Displaced People (IDP) camps in South Sudan (left) and in Uganda during the war time (right)

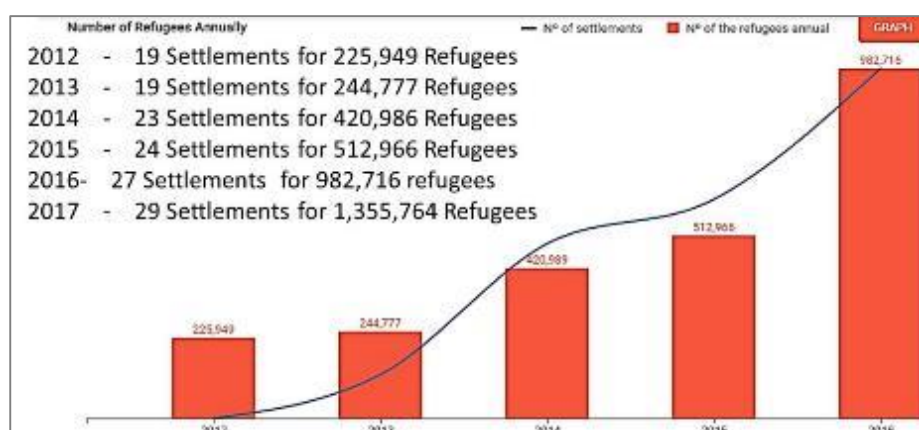


Source: IDMC (<http://internal-displacement.org/library/publications/2016/africa-report-2016/>)

Trend in number of refugees and refugee camps in Uganda

Uganda has left open door to refugees running from conflicts situations. From 19 refugee settlements covering 225,949 refugees in Uganda in 2012, the numbers have steadily grown to 29 settlements covering 1,355,764 refugees by end of August 2017 (UNHCR).

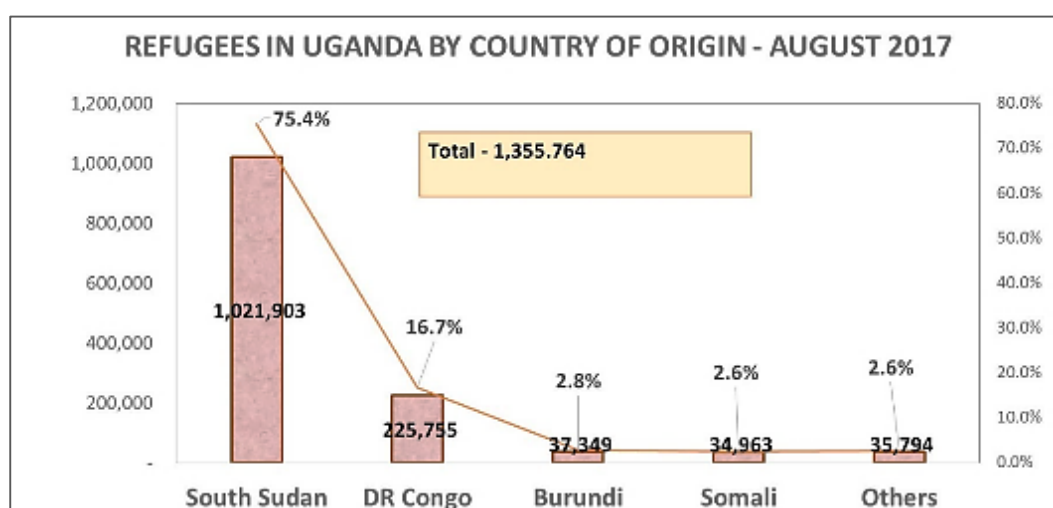
Figure 3: Trend in number of refugees and refugee camps in Uganda



Source: UNHCR <https://ugandarefugees.org/analysis/settlements>

Seventy five percent (75.4%) of these are from South Sudan as seen in figure 4.

Figure 4: Refugees in Uganda by country of origin as August 2017



Source: IDMC (<http://internal-displacement.org/library/publications/2016/africa-report-2016/>)

The biggest burden of the refugees is on the northwestern (West Nile) region of the country. There are smaller numbers in the north, western and southwestern regions.

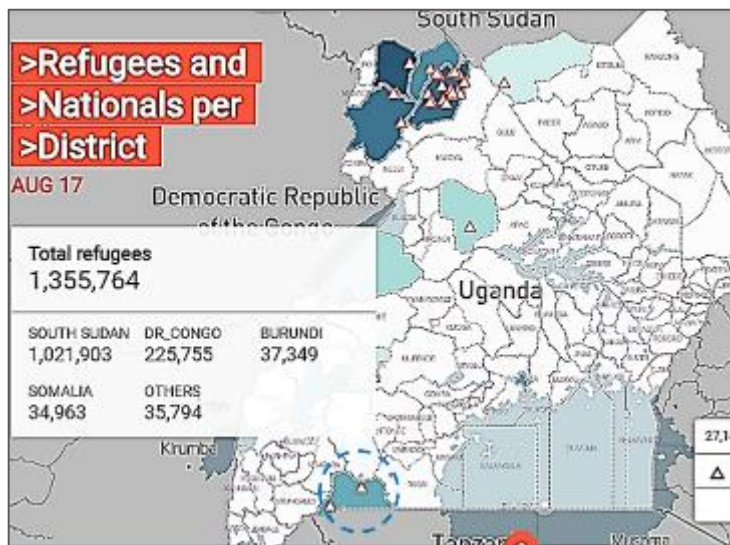


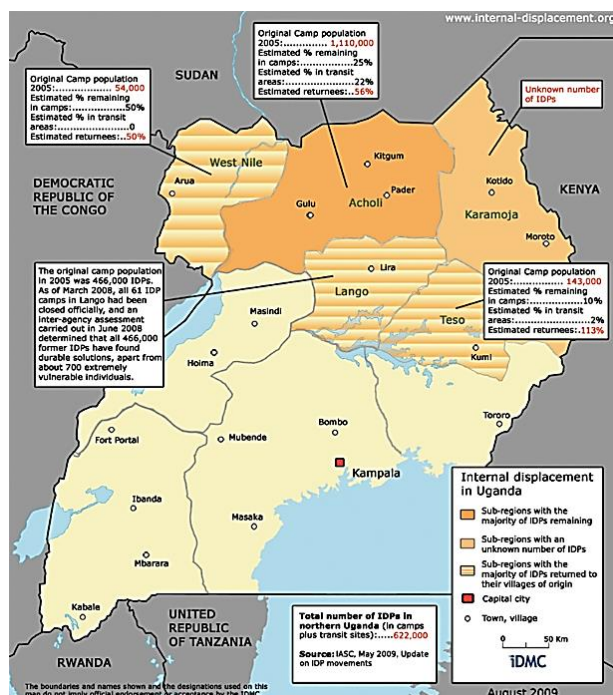
Figure 5: Showing that biggest burden of refugees is on the northwest of the country

Source: UNHCR <https://ugandarefugees.org/analysis/settlements/>

An IDP Situation

Unlike refugees, in an IDP situation both the health facilities and the people they serve are distressed and are insecure. Many government health facilities easily close while faith-based facilities are more likely to remain open.

Figure 6: Areas that had IDPs in Uganda



In the case of Uganda most IDPs were mainly from Northern Uganda. They were largely displaced within the war area while a few went to other regions. The peak was reported to have been by 2005 and by 2009 most had been reintegrated into their original communities or outside the region. But the effect on health facilities remained for long, also dealing with post-conflict traumatic syndrome and the need to rehabilitate the facilities.

Source: IDMC (<http://internal-displacement.org/library/publications/2016/africa-report-2016/>)

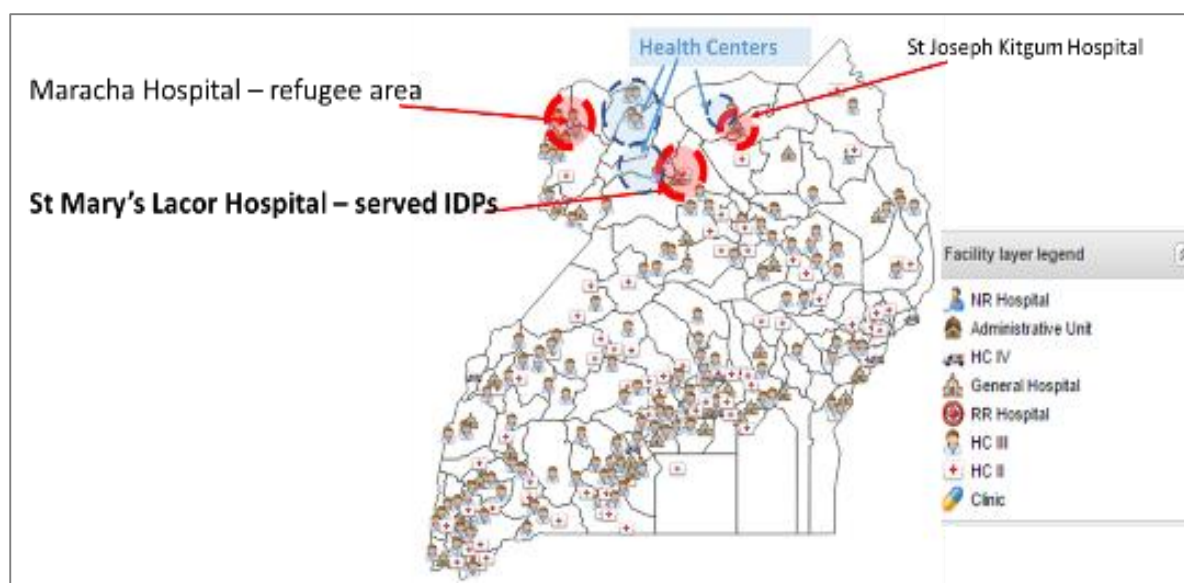
Effects of refugees and IDPs on health facilities

To understand this one needs to look beyond service related indicated to also include effects on the health systems that sustain those services.

The Catholic Church in Uganda has 294 health facilities accredited to the Uganda Catholic Medical Bureau, which is the health department of the Uganda Episcopal Conference. Out of these:

- 32 are hospitals,
- 6 are mini-hospitals (Health Center level IV),
- 178 health center level III and
- 68 health center level II

Figure 7: Map of Uganda showing distribution of Catholic founded health facilities as of September 2017¹ and indicating facilities in areas affected most by refugees and in the past by IDPs.



The health facilities are distributed all over the country. St Mary's Lacor hospital and St Joseph Kitgum hospital were among health facilities in the middle of war and affected by internal displacement. Maracha hospital and five health centers are in the area currently affected by refugees from South Sudan.

Refugee effects on northwestern Uganda (West Nile Region)

The positive effect is the support by refugee agencies to two of the five Catholic health centers near the camps to improve their water supply and sanitation.

The main negative effect has been the attrition of some health workers from the Catholic hospital and the health centers to the facilities constructed in the refugee camps. These were nurses / midwives and clinical officers / Medical Assistants. They transferred due to better salaries paid by refugee agencies.

¹ Ministry of Health; DHIS2

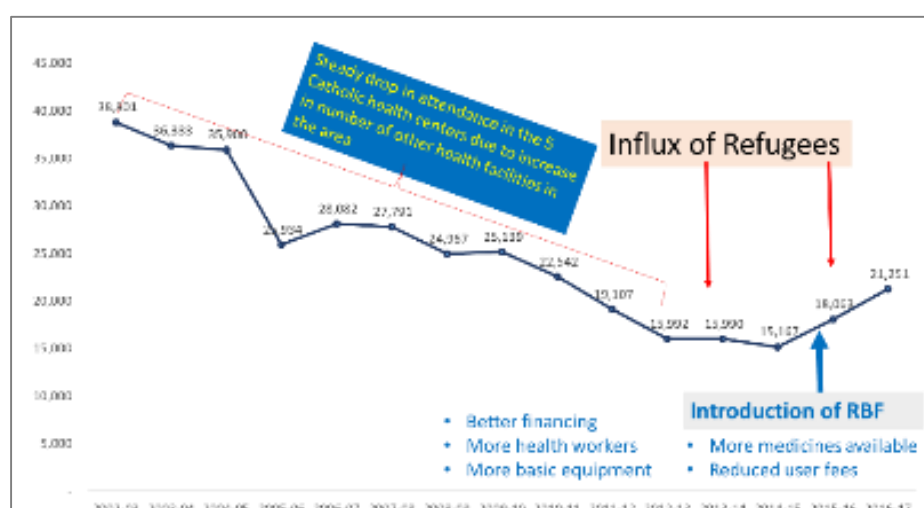
Otherwise no increase has been observed in number of outpatients (ambulatory) attendance that could be attributed to the refugee influx.

But the health worker attrition affects quality of service provided to the local / host population.

There was no visible rise in number of outpatient attendants in the local health facilities mainly due to a number of permanent as well as temporary health facilities constructed for refugees in their camps by the refugee agencies and the Office of the Prime Minister. These were reportedly constructed with no or little involvement of the Ministry of Health and the local faith-based health system.

Data on new out-patients (ambulatory) attendants in five catholic health centers (not hospitals) near the refugee camps show that there has been a steady drop in total number of patients over a period of 10 years. This steady drop was due to continuous increase in number of other health facilities (mainly of government) in the area. The leveling in 2014-2015 was due to extra effort in preparation for a results-based financing program in the region and finally its introduction in 2015-2016. This upward trend in the last two years has been seen in all health facilities participating in the RBF program in the region. It is a result of better financing, more health workers, more basic equipment, and more medicines available and reduced user fees. It is therefore not attributed to the refugee influx.

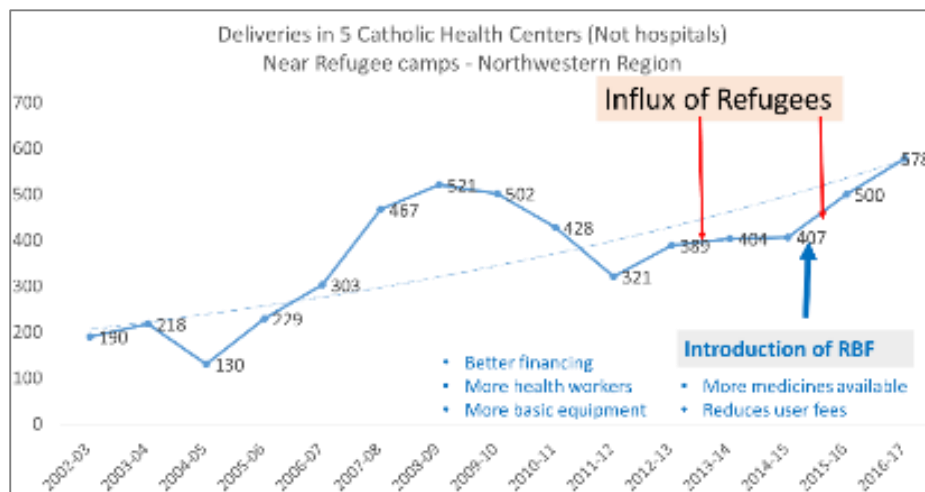
Figure 8: Outpatient New Attendants in 5 Catholic Health Centers (Not hospitals) near refugee camps in the Northwestern region (West Nile)



Source; Analyzed from Ministry of Health (Uganda) data on DHIS 2

However, maternal deliveries have over the years continued to grow in the catholic facilities in the area due to better quality of service. Nonetheless, some indigenous mothers go for antenatal care and delivery in the refugee camps due to provision of food and some household equipment to the mothers.

Figure 9: Trend of maternal deliveries from five Catholic health centers (not hospitals) in the refugee affected areas of north western Uganda (West Nile Region)⁴



⁴ Source; Analyzed from Ministry of Health (Uganda) data on DHIS 2

Similarly the sharper rise in deliveries in these five health centers is attributable to the RBF program rather than to the refugee influx.

Current initiative by Uganda Catholic Medical Bureau

Having noted that impact that stress, malnutrition and hunger contribute to spread of infectious diseases e.g. tuberculosis, and the poor surveillance and treatment of tuberculosis within South Sudan in the last decade, Uganda Catholic Medical Bureau would like to contain tuberculosis and other infectious diseases in the host community. This is by supporting an already overstretched health system and strengthening faith-based services in the proximity of the settlements. UCMB is working with German Leprosy & TB Relief Association (GLRA) to strengthen diagnosis of TB and other infections in the facilities neighboring the refugee camps. For example, we plan to place a GeneXpert machine in the Catholic hospital there (Maracha hospital).

Effects of internal displacement on hospitals – the example of St Mary's Lacor hospital

This hospital that belongs to Gulu Archdiocese in northern Uganda was started in 1959 by the Comboni Missionaries. In the power point picture one can see the picture in 1959 (left) and the current picture in 2017 (right).

Figure 10: Aerial views of St Mary's Lacor hospital in 1959 and 2017²



Figure 11: Founding doctors Pietro Corti and wife Lucille Corti (left) and current CEO, Dr Cyprian Opira (right)



The hospital treats on average 280,000 patients annually, has 600 permanent Ugandan staff and has 58,000 sq m of buildings. It provides clinical / medical services, technical support services, training schools, staff housing and guest houses. All these have been done in-house with technical competencies built over the decades of conflict.

² Source: Lacor hospital file photos (courtesy of the hospital management)

Figure 12: Some of the staff of St Mary's Lacor hospital in a picture with Archbishop John Baptist Odama (center front)



Providing more than just medical treatment

During the conflict the hospital provided more than just medical treatment.

It provided long-term residence as well as night cover to “Night commuters”. In addition, one of the largest IDP camps in northern Uganda was built around the Lacor satellite health center of Amuru. Lacor hospital and its health centers provided cover for disease control and clinical treatment by remaining open even at the peak of the crisis and by providing extreme subsidy in user fees to the community.

From 1995 through 2006 Lacor hospital is reported to have received up to 10,000 night commuters, mostly women and children who entered the hospital each night. Congested hospital compound and veranda could be seen most of the time.

Figure 13: Night commuters arriving with mats to sleep in St Mary's Lacor hospital (left) and others sleeping on the hospital veranda during the war period (right)



Figure 14: Lacor's Health Centre in Amuru, surrounded by one of the largest IDP camps in northern Uganda (over 50,000 people) during the war period



The hospital also provided post-clinical livelihood to many war victims. Figure 15 shows a young boy whose both lower limbs were destroyed by explosion, had bilateral amputation, healed, was rehabilitated, and trained and now (2017) works in the hospital pharmacy.

Figure 15: A young boy treated for severe bomb blast injury to both lower limbs in 1886, rehabilitated and trained to work in the pharmacy department of the hospital



Besides serving the victims of war, Lacor hospital was also the main center for the control of an outbreak of ebola that occurred during the war period (October 2000 – Feb 2001). Dr Mathew Lukwiya (the team leader in the hospital), together with 12 other health workers died in this outbreak.

Figure 16: Dr Mathew Lukwiya and twelve other health workers of St Mary's Lacor hospital died of ebola during an outbreak in the period of war in northern Uganda



Pastoral / Spiritual care was also provided to patients as well as the displaced people residing or sleeping in the hospital. Archbishop John Baptist Odama and all the priests participated in this.

Figure 17: Archbishop John Baptist Odama personally giving pastoral care to patients in St Mary's Lacor hospital



Challenges faced by the hospital

There were many challenges and I will not mention all. But they included the bombing and shooting, looting of medicines, kidnapping of staff in the hospital by rebels, difficulty in recruiting staff to provide competencies not available in the area etc.

Communication was difficult. There was high increase in number of patients as most government hospitals and health centers in the region were not functioning. Total hospital bed occupancy was above 130% and reached 300% in the pediatric ward. There was a high number of war injuries with over 1000 surgical operations done on war victims each year.

It was difficult to maintain hygiene and security in the hospital with the thousands of night commuters and resident IDPs.

For many years the hospital worked beyond its capacity.

There was the challenge of finding financial support to keep fees very low or no fees for some basic services.

Responding to health systems challenges

First the hospital had to construct a perimeter was to protect itself at least from stray bullets and direct assaults. It had to construct staff houses within the hospital fence and distribute food to them to reduce exposure to bullets and abduction. The hospital bed capacity had to be increased from 360 to 478. In addition three satellite health centers were kept open with additional 48 beds.

The hospital constructed a sewage system and waste water treatment plant (finance by CEI) and constructed 60 pit latrines for night commuters.

The water and power distribution systems were overhauled

There was construction of a police station and police quarters in the hospital and a fire brigade for the hospital was established with a water tank lorry.

The Health systems coping mechanism / resilience system

There was a formal decision of NEVER CLOSE THE GATE to patients and displaced persons. There was also flexibility to answer actual health needs of the population and a focus health services while leaving other type of assistance (like food distribution) to other organizations outside the hospital.

Staff and their family were protected by providing accommodation for them inside the hospital. The hospital obtained seed money to start the credit cooperative of Lacor workers.

The emergency responses were integrated into a coherent development vision of the Hospital instead of relying on short term external technical assistance. New medical activities, like ARV treatment of HIV patients – quite demanding – were started.

There was reinforcement of governance and administration. With guidance of Uganda Catholic Medical Bureau, new governance and management charter and manuals were developed, adopted and implemented.

External assistance and projects were got only if accepted to be fully integrated in the hospital organization and were responding to the hospital management (not parallel in management)

Internal schools were started on national standards for filling vacancies e.g. Laboratory Technicians, Anesthetic Assistants. Doctors and nurses were sponsored for specialized training - also overseas with bonding.

There was a very active search of financial support abroad

Roles of different Stakeholders in supporting this coping mechanism

The military authorities did not interfere with the Hospital operation. The army and later police with a resident detachment protected the Hospital.

The Ministry of Health seconded some key medical staff and allowed them to be fully integrated in the Hospital chain of command.

The night commuters never caused significant problems in spite of their big numbers. This was also partly due to the good reception they got from the hospital management and staff. A positive relationship was built.

Financial support got from many foreign donors, among them a 10-year support project by Italian Episcopal Conference, was very helpful.

There was support (advocacy) by Uganda Catholic Medical Bureau within the new Public-Private Partnership started with the Government. Because of this government was able to second some of the key staff as mentioned above, and also to continue some little but very important budget support.

The owner of the hospital, (Gulu Archdiocese) exercised its authority only through the institutional channel of the Board of Governors. There was therefore a supportive and facilitative role of the Catholic Church and Missionary Congregations, while staying in the background.

Factors that enabled management to cope

The hospital changed its approach to management from a rather informal to more structured and institutionalized one. This built confidence in the stakeholders and enabled clear disaggregation of duties to handle the more complex situation. There was clear definition of roles in the statute with the board having an oversight and monitoring role, and management taking full operational responsibility. The ability to deliver on commitments with donors and spotless accountability assured good reputation. The set of implicit performance-focused strategies in the first formal strategic plan (2007) was helpful.

Lessons learnt

Much more from the experience of St Mary's Lacor hospital during the war and heavy internal displacement of people than from the experience with refugees, we learn first all that in a war or conflict situation the peak of patient attendance comes after the war. In this case the peak was in 2013, three years after the end of the war when people could move. But rehabilitation of other service providers e.g. government facilities, was still underway. We have also learnt that the reconstruction period is often as demanding as the war period itself. So, support should not end with the end of the war.

Strong governance and management is key to resilience of the institution. It is also very important for an organization, already pre-established in the area, to have established link with the local community and have knowledge of its culture, something that no external emergency aid organization can have, accept its help. Try to remain in charge of the operation.

Having proactive collaboration with or belonging to a Catholic network is important e.g. Uganda Catholic Medical Bureau (Uganda Episcopal Conference) in this case or collaborating with inter-faith health networks. The Uganda Catholic Medical Bureau (UCMB) is known and respected within Uganda's health sector. It is credible and collaborates with the Ministry of Health and Development Partners.

External support should not only be established for financial support but also for professional support, including external quality audits.

Finally, but not least, it is important not to work in isolation (even if you are the best hospital in the area), but create link, at least of mutual recognition and respect, with government hospitals.

Conclusion

Concern for refugees during a war can easily overshadow plight of internally displaced people. Providing health services to IDPs is more challenging because the health facilities are also in the middle

of the war. Catholic health facilities always remain open in the middle of such crisis because their neutrality in the conflict, commitment and faith.

The role of a health facility in war situation is more than providing medical care. Catholic health facilities are obliged by scripture to remain open to people running away from conflict or suffering the effects of the conflict. It may be due to injuries or simply unable to meet the cost of care. It is difficult for health facilities in poor or fragile countries to manage conflict situations without significant external support. Therefore it is necessary to support health facilities situated in areas prone to conflicts to become stronger

Strong leadership and management are key to the resilience needed by a health facility in such a crisis. Post conflict demands on the health facilities are as great as that during conflict.