Perceptions about human rights, and sexually reproductive health services by internally displaced persons, northern Uganda

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Background

Since the late 1980 to 2010, an estimated 1.6 million persons from northern and eastern Uganda were displaced due to a protracted civil war between the Lord's Resistance Army (LRA) rebels and the government armed forces. Most of the displaced originate from the Acholi sub-region, which includes the districts of Gulu, Lamwo, Amuru, Kitgum, Nwoya and Pader that have borne the brunt of the war. During 2005 most of the populations of Pader and Kitgum districts were displaced (95% or 279,000 and 93% or 267,000 respectively). Today most of the population in the districts of the Acholi sub-region have returned home.

Table 1: IDP population in north and eastern regions of Uganda, 2005-2007

Region	Original	Estimated	% of	Pop	% of		Pop in	%
original								
	Camp	camp pop	original	in	original		Villages	camp
	Pop end 2005	May 2007	camp pop	transit	camp pop	of origin	pop	
Acholi*	1,111, 987	659,459	59		407,155	37	44,749	4
Lango**	466,000	2,159	0.4		-	-	463,944	99.6
Teso***	142, 951	110,000	77		22,000	15	5,300	4
Total	1,721,041	771,618	48		429,155	24	513,993	28

Source: IASC Working Group, November 2007

Keys *Acholi districts include Gulu, Kitgum, Pader and Amuru; **Lango districts include Lira, Apac, Amolatar and Dokolo; *** Teso districts include Soroti, Kumi, Amuria, Kaberamido and Katakwi

During 2007, the phenomenon of displacement has been gradually evolving into return home and some of the camp population is shifting into decongestion camps.

During emergency situations, displaced populations especially women and children are extremely vulnerable owing to a variety of socio-cultural, economic and physiologic reasons (MSF1997; Tambiah 2004). Excess mortality in displaced population settings is often caused by the same disease that affect displaced populations including acute lower respiratory tract infection (ARI), malaria, measles, diarrhoeal diseases and malnutrition (MSF 1997; Toole et al. 1999). Several factors including poverty, poor nutrition, inadequate water and sanitation, lack of adequate health services, insecurity displacement predispose displaced population to high levels of morbidity and mortality (MSF 1997).

The health indices in the Acholi sub-region remains poor with high crude and under five mortality rates, estimated at 1.54 and 3.18 per 10,000/day respectively.[2] The crude mortality rate (CMR) and the under five mortality rate (U5MR) in Gulu district IDP camps are high estimated at 1.22 and 2.31 per 10,000/day respectively. These mortality rates are both above the emergency thresholds of 1/10,000/day and 2/10,000/day respectively and the national estimates of 0.46/10,000/day and 0.98/10,000/day respectively.[2]

Those delivering health care in crisis must take account of the different needs, recognise potential barriers and ensure that women and men can access health services equally. Women and men must participate equally in the planning, management and delivery of health services in humanitarian action, and women must be part of the decision-making and implementation processes at all levels.

Uganda is a state party to various international and regional human rights instruments providing for the right to the highest attainable standard of health – the right to health. The right to health is one of the fundamental human rights and there are many important linkages between the right to health and other human rights such as the right to food and the right to education. The aim of this paper was to explore the accessibility and availability of health care services in the IDP affected districts of northern Uganda.

Methods

Study sites

The study was carried out in Kitgum and Pader districts in northern Uganda. In 2007, there were an estimated 629, 617 internally displaced persons i.e. 310,111 IDPs in Kitgum and 319,506 in Pader districts respectively.[9] The districts had a total of 67 IDP camps i.e. 24 camps in Kitgum and 43 in Pader respectively.

Figure 1: Map showing study districts, Kitgum and Pader in northern Uganda

Study design

This was a cross-sectional study comprised both of rights holders (i.e. internally displaced community members including adults and adolescents) and duty bearers responsible for services provision at the central and local district levels (including individuals and institutions such as ministry of health and local district health services providers and humanitarian relief i.e. UN agencies, international NGOs and community based organisations (CBOs)).

Data collection procedures

We trained data collectors for three days. The study instruments (questionnaire, focus group, and key informant guides) were translated into the local language – Luo/Acholi and back into English. The data collection tools were pre-tested. The quantitative data were captured, cleaned, and edited. The completed questionnaires were checked by the principal investigator daily for accuracy, completeness and consistency before the data collectors left the IDP study sites/camps.
We sampled 15 of 24 IDP camps (62.5%) in Kitgum district using purposive and random sampling techniques. The camps were stratified by parishes, population size, and security considerations and randomly selected. In Pader we selected 20 of 43 (46.5%) camps into the study.

Administratively, a camp is sub-divided into blocks and zones. A block constituted a study cluster. We selected households based on the modified WHO Expanded Programme of Immunization cluster sampling technique.[10] The centre of the cluster was identified. A bottle was spun to determine the initial direction of movement. A random starting household was identified by listing all households from the centre to the end of the cluster and a random starting household was chosen, and the next selected for interview was the nearest to the one where the interviewed had been conducted.

In a household, either a male or female adult head of household was interviewed. We selected male or female respondents in the proportion of 40% to 60% respectively. However, after every third household, an adolescent aged

between 14 and 19 years was identified and interviewed. A total of 51 respondents (adult/adolescent) were interviewed per cluster in Kitgum and 40 in Pader district. In total 1,383 individuals comprising 720 (52%) of respondents in Pader and 663 (48%) in Kitgum district were interviewed.

We held 27 in-depth key informant interviews and conducted 52 focus group discussions. The key informants included camp commandants, and Local Council 1, 2 and 3 Chairpersons, in charge of health units including health centre II and III. In addition, leaders of community-based organisations (CBOs) were interviewed. At the district level, civic authorities including local council (LC V) chairpersons, resident district commissioners, chief administrative officers; and in the health sector, the district health team members such as the district health officer (DHO), medical superintendent, medical officers, the person in charge of the nurse training school (the matron), district health visitor, and personnel responsible for health centre IV were interviewed. Finally, we interviewed various humanitarian relief workers from agencies including United Nations High Commission for Human Rights (UNHCHR), United Nations Children's Fund (UNICEF), World Health Organization (WHO), and Non-Governmental Organisations as follows: 27 in-depth key informant interviews were conducted with 14 staff from international and local humanitarian agencies (UN/NGO/CBOs), 8 with district health staff, and 5 with community and district civic leaders.

Quantitative data were checked for completeness, sorted, coded and captured using EPI data version 3.02 packages. The data were analyzed using SPSS version 12.00 software package. Qualitative data were analyzed manually. Content analysis was based on condensation and abstraction of main themes.

Results

Respondents' socio-demographic characteristics and duration of encampment

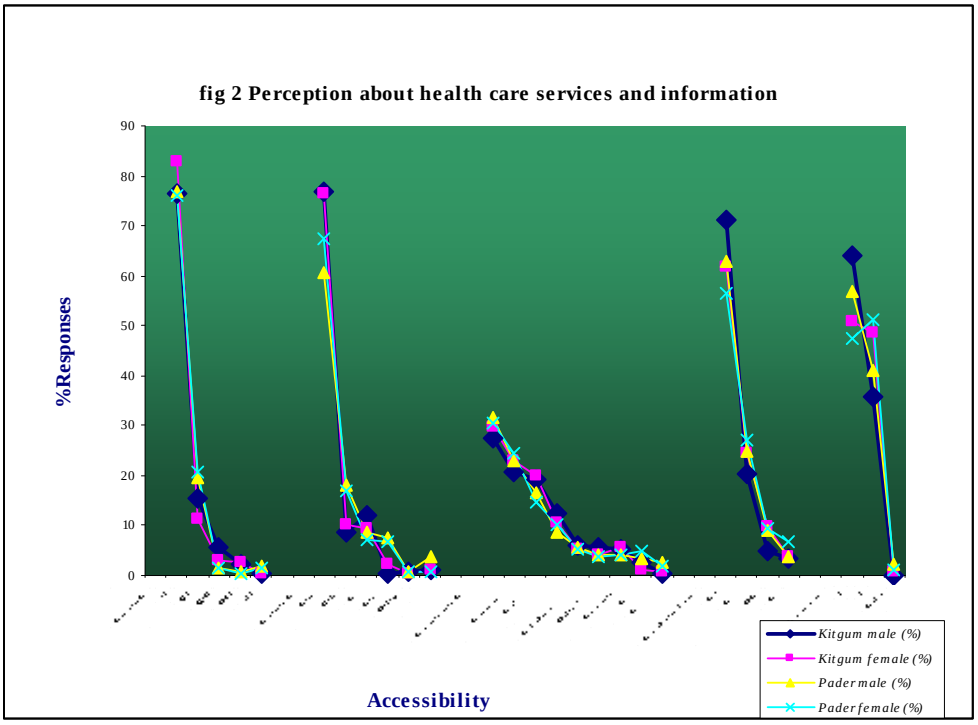
More than a quarter of the respondents 26.1% (25.7% males and 26.4% females) were below 19 years of age. Most adult respondents 61.4% (57.3% males and 64.2% females) were in the age group 20-49 years. 24.2% of respondents (9.1% males and a significantly higher proportion of females, 37.4%) had no formal education while 56.8% of respondents had attained at least primary level education. Most respondents 75.2% (73.9% males and 76.4% females) had lived in encampments for a period ranging between one and ten years.

Perception about availability of drugs, supplies and personnel in health facility

Most respondents 87.3% (85.6% females and 88.9% males) mentioned a health facility as the choice for delivery, either for themselves or their wives (see Table 6). The main barriers women face in accessing health care services include lack of money 36.4% (34.9% male and reported by a higher proportion 37.9% female); lack of information 24.3% (25.3% males and 23.2% females) and lack of decision power mentioned by 17.5% (17.7% males and 17.3% females).

Perception about access to health care services and information

Most (78%) respondents (79.5% in Kitgum and 76.5% in Pader) live within 5 km of a health facility. The main reasons for choice of a health facility are proximity to health facility 29.6% (males 29.1% and females 30.1%), availability of free treatment 22.7% (males 21.5% and females 23.9%); availability of drugs 17.2% (17.4%
males and females 17.0%) and good quality services 11.4% (12.3% males and females 10.4%).



Barriers to accessing health care services

Several barriers to health care access were identified. These included high costs of health care services; distance to health facility, health personnel attitude, being rude and being few staff and lack of drugs and supplies in the health facilities in the settings. The costs associated with health care were mentioned as high. This relates to high transport costs in case of referrals of patients. *"… some of the expectant mothers are referred to Kalongo hospital which is very far and expensive to reach in terms of transport costs…" Adult Women, Lukole*

The study shows that overall, the majority 79% (77.7% of males and 80.3% females), consider the consultation room private in the settings. However, right holders remain concerned about lack of visual and audio privacy in the facilities as highlighted in the excerpts below;

Conclusion and recommendations

Our study suggests that most displaced populations lived in close proximity to health facility.

Although geographic access to health services is high (due to facilities in the camps), this is expected to drastically reduce when the population is resettled in their homes in due course. Therefore there is need to establish mechanisms for effective health services delivery in the post emergency period (resettlement phase) including outreach services, strengthening referral system and establishing new first line health facilities. Capacities of first line health facilities including health centre level (II, IIIs and HCIV) ought to be strengthened. Referrals for medical, surgical and emergency obstetric care (EmOC) in the settings should be improved through availability of ambulance vehicles and other bicycle ambulances and radio or telecommunication networks.

Subtitle

Perceptions about human rights, and health services by internally displaced persons, northern Uganda

Figure or Table Title

Figure 1: Map showing study districts, Kitgum and Pader in northern Uganda

Figure 2: Perceptions about health care services

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ABSTRACT

PERCEPTIONS TOWARDS HUMAN RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY INTERNALLY DISPLACED PERSONS, NORTHERN UGANDA (submitted already)