University of Khartoum

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The Role of NGOs in Health Service Provision for the Displaced around Khartoum

The case of the SCC's Primary Health Care Program in Jebel Aulia

(1995-2002)

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Dedication

To the soul of my father *Balla Yagoub*

My uncil ***Eltayieb Yousif Elkrial***

Acknowledgment

I owe very special thanks to Dr. Khalid Ali El Amin who has supervised this research .I thank him for his valuable comments, encouragement and the constructive criticism, which made this thesis see light. Also I wish to express gratitude to Combine Harvesters and Engineering Company Administration for their great support.

I would also like to thank all SCC staff at the Headquarter, the regional office and in the center for their cooperation. Finally I thank all those who backed me in doing this research.

My god bless them all

Abstract

Taking Sudanese Council of Churches Primary Health Care Program in Jebel Aulia as a case study, this thesis aims at investigating the role of NGOs in providing health services for the displaced around Khartoum, Displacement phenomenon grows and accelerated during the past two decades. Those increasing displaced made pressure on health services in Khartoum state .The government was unable to provide the necessary health care for those displaced and Non governmental Organizations started to play a vital role in improving health status of the displaced.

The research uses a case study methodology to investigate the problem. It depends on primary and secondary data. Primary data consists of direct observation and interviews while the secondary data cover data collected from books, journals, SCC annual reports and research papers on the subject.

The major findings of the study are that, SCC primary health care program has contributed effectively to the promotion of the health status of the displaced in the Jebel Aulia Camp. The program could be considered as a pioneer effort in improving health conditions in the area.

Despite this success the program had faced number of constraints that limited its effectiveness. Some constraints are related to SCC; SCC staff workload is so heavy that it hampers proper work performance. Additionally SCC lack of financial resources constitutes major problems. Constraints related to partner NGOs; some times the programs are terminated despite the need for them. Constraints related to government; government administering drug distribution increases drugs costs and sometimes contributes to drug scarcity and relocation of the displace disturbances the targeting.

To avoid these problems the program needed to be supported with the necessary needs such as drugs, staff training and transportation facilities to guarantee the smooth running of the work .SCC staff and community efforts need to be integrated for a deeper understanding of the concept of preventive health.

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Abbreviation

ANC	Anti-Natal Care	
CBOs	Community Based Organization	
EPI	Extended Program of Immunization	
GM	Growth Monitoring	
HE	Health Education	
HV	Home Visitors	
IDPs	Internal Displaced Persons	
MoH	Ministry of Health	
MSF	Mediocre Sans Frontiers	
NGOs	Non Governmental Organizations	
ORT	Oral Rehydration thereby	
PHCP	Primary Health Care Program	
SCC	Sudanese Council of Churches	
TFC	Therapeutic Feeding Center	
UNCIEF	United Nation Children Fund	
WF	Wet Feeding	

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Chapter One

Introduction

This thesis attempt to investigate the role of the Sudanese Conical of Churches (SCC) in health provision for the displaced around Khartoum state, taking Jebel Aulia displaced camp as the case study. Before entering on the details it is useful to give brief statement about the SCC structure, objectives, projects and to give brief description for the area of the study.

1-1 The SCC Historical Background: -

Sudanese council of churches the SCC is an indigenous ecumenical Christian organization operating nationwide. It operates in six regions namely: Northern Sudan, Western Sudan, Eastern Sudan, Blue Nile, Upper Nile, Bahr Elgazal and Equatorial region. The Council was formed in 1967 at the time when the church's was in dire need of strong unity within itself. All the leading churches in the country formed it: Catholic, Orthodox and Protestant churches. (SCC, 1995,15)

The SCC has become operational following the 1972 Addis Ababa Agreement, which ended the 17 years “Anyanya” rebellion war against Sudan Government. SCC first structure is built to enable agencies and partners to respond to the relief, reconstruction and resettlement (3-R3) needs of the several million Sudanese referring from exit through the years. And due to the continuation of war in the South Sudan the structures have to expand. Today the Council is mainly dealing with relief and to limited extent rehabilitation among the displaced across the country .SCC is involvement in the field of development which started in the late 1970s has been very

much reduced and overshadowed with relief and habilitation program (SCC; 1995.p87).

The SCC has several aims. Apart from is religious role in advice and support the churches. It helps in the formation, run of the development projects and programs, carrying out and supporting emergency, relief and rehabilitation, health care, education, community development and others services to improve spiritual social and maternal welfare of the Sudanese people. Also it supplements national socio-economic development, sustains and promotes partnership with Christian and humanitarian organizations Regionally and internationally, furthermore it upholds the principle of equality, justice and peace. The sources of the SCC finance include membership registration fees subscription, contribution from partners and other church agencies and aids from the intergovernmental agencies.
(SCC, 1955: 25).

1-2 Jebel Aulia Displaced Camp: -

During the past two decades and because of the war in the South of the Sudan and drought in the West there has been an enormous increase in numbers of the people living in slumps and shantytowns in Sudan. About one third of greater Khartoum dwellers live in the shelters out of the city. The proportion is increasing and exerts major influence on the Old City environment and infrastructure. Since 1990 it is clear that the population of all the displaced areas of Khartoum are in transition. So the government policy during that time is to consolidate the displaced population through forced relocation to large land reserves on the outskirts of Khartoum.

The forced removal of the (Hillat Shoog) settlement to Jebel Aulia in the late of 1990 was the first initiation of Jebel Aulia displaced camp. The general feature of the area is that good numbers of displaced persons have no mud houses they live in makeshifts shelters made of plastic sheets, cartons

or sacks. The area is composed of multi-ethnic and multi-religions people. The bulk come from Southern Sudan and Nuba Mountains. The majority are children and women. The location of the area is to the East of the old town of Jebel Aulia with a distance of 42-k/m south of Khartoum.

The socioeconomic status of the people is so mixed. Noteworthy that some residents of the community have been able to achieve a degree of economic stability. This is partly reflected in the increasing in number of mud and brick houses.

However a substantial number of the residents of the settlement continue to remain economically insecure and these are the neediest of the population in the area. The stagnant situation in the camp doesn't allow people to start a regular work to cope with their difficult living conditions. The government has established a total presence in the area in the form of peoples committees to handle public services, but in practice these committees play a security role.

The number of the population in the area is 23166(central bureau of statistics), where keeping in mind the in and out movement and natural population growth. The general population activities are marginal jobs, i.e. day laborers, wage workers, small-scale trade (petty traders) and fishing in Jebel Aulia Dam. Very few educated individuals are employed in both private and public sectors, the police and the military. With the exception of this group the conditions of the camp residents have not improved. The soaring prices of all essential food items is beyond the means of working Sudanese people, let a lone the displaced who have no regular income.

The nutritional status of the people has not improved as shown by the increasing attendance to the supplementary feeding and the increasing number of severely malnourished children attending the wet feeding

program. So far the program extended to cover numbers of poor families by distributing some food items.

The area suffers from widespread diseases among people especially poverty related diseases i.e. tuperclouses, malaria and diarrheas. The absence of health awareness is clear in the use of contaminated latrines and poor environmental sanitation and these result in the increase number of morbidity and mortality among the infant and under five age children. In the settlement there are four clinics used to deliver health services. One of them is the SCC primary heath care center. Two out of these four clinics were closed down for project termination and now there are only two clinics at work.

NGOs are the only bodies working with people in solving their problems by providing public services. They deeply involved in relief, rehabilitation and development programs. Some international NGOs used to supply clean water, latrines, and disposal of the solid wastes and education of health practionors. These NGOs include are UNICEF, CARE International, ADRA and MSF. They initiate about 96 hand pumps and healthy latrines. But dues to there need people always have to sail latrines and hand pumps equipment.

Under these conditions building up stable and effective local government in the community in order to meet the urgent needs takes much time. Therefore, NGOs often form important links between the population and the national and international agencies in transmitting aid, relief and technical assistance. Health provision for the displaced around Khartoum has become an important issue for non-governmental organizations the concerns about it grew during the past two decades. There was a number of national and international NGOs involved in this field. They attempted to designate suitable forms of medical intervention to promote the general heath

conditions of the displaced. These interventions took deferent points of view. Some NGOs preferred partial intervention by forming either curative or preventive heath care.

The SCC is one of these NGOs which has been involved in relief and development programs since 1990. It has implemented a comprehensive primary health care program with a target of 150.000 patients annually. The objective of this study is to investigate the role of the SCC primary health care program in the area.

1-3 Statement of the Problem: -

The problem of the study is focussed on the efficiency and performance of the program in providing heath care. Accordingly the research attempts to discuss the following questions.

1- What form of interventions the SCC has adopted to improve the health conditions of the people?
2- How for the intervention has improved the health conditions of the people?
3- What are the constraints, obstacles and limitations hindering the program?

1-4 Justifications of the Study:

The form health service covers wide spectrum of personal and community services, treatment of diseases, prevention of illness, sanitation of environment and promotion of health. The most important way to achieve health services is the primary health care; it's the key to an attainment of health. The primary health care concerning prevailing health problems, methods of supply of safe water and basic sanitation. Health cares include maternal health and the appropriate treatment of common diseases.

Health makes a fundamental contribution to the country's economy and the better health conditions among the population in the societies mean additional power to the work force. As health improves productivity increases and the country can maintain high rates of economic growth. For this reasons the study of health now a day's is an integral part of development studies. Khartoum State during the past two decades attracted more than one million of the displaced people and those are ranging in long

relocating areas. This massive immigration exceeded the local government capabilities. Therefore the government called upon the national and international volunteer organizations to provide humanitarian and development assistance i.e. education, nutrition, social and health care programs. These complex situations need continuous analysis, evaluation and criticism. More than ten years from the starting date of the SCC primary heath care program there was no one other than the SCC staffs themselves who have written about the program.

1-5 Assumptions

1- Sudanese council of churches "primary heath care program" succeeded in providing heath services for the displaced in Jabel Aulia.

2- The program contributed effectively in promoting heath conditions of the displaced in the camp..

3- Although of the successful there are some institutional, technical and governmental constrains hindering the program.

1-6 Research Methodology:

The time period covered by this study started in 1995 and phased out in October 2002. The study will cover the health activities of the SCC primary health care program PHCP in Jabel Aulia using distributive analytical framework.

In data collection, two source are used, the first source is secondary data; these were the SCC annual reports, thesis, books, journals and ministry of health DOVA reports. The second source is the primary data from interviews conducted with the SCC medical directors, staff in the field and regional office.

1-7 Research Organization: -

The research is consisting of five chapters. Chapter One includes historical background about the SCC and description of the area of study in addition to the structure of the research. Chapter Two is a literature review. Chapter Three discusses the SCC primary heath care program with emphasis on nutrition program, maternal health, extended program of immunization EPI, health education and curative clinic, Chapters Four discuss the obstacles, limitations and constraints hindering the program. Chapter five includes the conclusion and the recommendations.

Chapter two

Literature Review

The Involvement of NGOs in Displaced Area

This chapter discusses the contribution of non-governmental organizations in relief, rehabilitation and reconstruction for the displaced. NGOs were deeply involved in the heath field. They attempt to compensate apathy of the government officials through allocation and mobilization of funds and implementation of development programs aiming at raises the living standard of the displaced .The discussion in this chapter emphasized on their

role in reducing displaced suffering, the provision of health care and humanitarian assistance's.

2-1 The Humanitarian Assistance's: -

Non-governmental Organizations NGOs are voluntary agencies set up to serve those who are in dire need. They usually pool efforts and finance through donations. These voluntary organizations first emerged after the Second World War and continue as humanitarian assistance bodies to give relief, rehabilitation and develop. The recent definition of NGOs creates the important characteristics of NGOs. NGOs refers to the grassroots movements as well as could refers to organizations used to transfer or links 'donors' or assistance providing institutions to there so called target population. On the other hand organizations specialized in mobilizing resources for relief, rehabilitation and development purposes, and provide Aids to wider need communities. Rahnema (1985. 9-10)

Introducing of NGOs in humanitarian assistance providing and delivering emergency relief and development services at low cost to those who are dire need is honestly indisputable. This could be extracted from the definition of term NGOs. The term NGOs is used as a common denominator, for all organizations within the aid channels that may institutionally separated from state apparatus, and are not primary commercial or profit making purposes, have their own procedures for self-governance, and serve public purposes. Terje (1994. p. 12). From the above arguments it come that, NGOs is a voluntary organizations that depend on its own energy and resources given freely by their members and supporters, to provide humanitarian assistance for their target population regardless of their political and economic incentives. Furthermore the organizations allocate and mobilize assistance from the North rich countries, to halt the decline in human life in poor countries caused by natural and man-made disasters.

The nature of NGOs work can be specialized to vary from purely humanitarian and development projects to consciousness raising and organized efforts for improving living condition of the isolated communities. Development Aid Commission (DAC) report (1985) Indicates that, over the past two decades NGOs as a whole have played a vital role in the transfer of finance and humanitarian assistance to developing countries, as well as technical and development assistance. The deep involvement of NGOs in humanitarian aid channels gives them comparative advantage to act, serve and understand isolated communities. The function of NGOs reflected their deeper understanding the people behavior and attitudes.

NGOs conceptions and means of intervention develop through time. From purely humanitarian assistance provision, to massive development programs covers wide spectrum of goals and diminitions. Now the aim of NGOs is to work out new horizontal form of partnership, and active interaction with isolated people concerned in order to help them develop their own alternative approaches of their development problems. Thus conventional understanding of NGOs nature of work come to a halt according to formulating of new conceptions focuses on sustainable development and community participation.

2-2 The Contribution of NGOs in Solving Displaced Problems.

Voluntary organizations initiated in the north rich countries based in the donor's countries and work broad mainly in the third world. Conducting emergency relief to those who are in dire need (UNDP 1994) estimated that there were about 4000 development NGOs in the North rich countries with about 1000 to 2000 southern NGOs and assisted between 100 to 250 million isolated peoples. The report stated a great efforts and assistance released to displaced and disaster affected persons in the third world. Particularly in Sudan, there were some 400 to 500 NGOs are currently active in

humanitarian aids and development activities. Collectively spending $9-10 million dollar annually in relief, reconstruction and resettlements programs directed to about one million displaced comes from southern and western of Sudan. Salwa (1992, 13)

As part of their works, NGOs have to provide assistance to the displaced wherever they founded. NGOs are working for relief eviction of natural disasters, like drought and flood, and its followed starvation and famines. Likewise the NGOs now come to rescue in man-made disasters such as war and environmental degradation. Some NGOs are involved in sustainable development projects, and in some cases they may be involved in both. Salwa (1987. 23).

She farther mentioned that, due to their solid links with displaced, sometimes NGOs posed high neutrality in adopting an alternative approach and has gain the respect and trust of the displaced. Its there for important that NGOs working in area of displaced be assessed and evaluated on a case by case basis tacking in to account each case. Salwa (1987. 24).

Due to long period of working with displaced, NGOs now have a holistic view of human and cultural groups. They reject the top-down and technocratic approach to solution of displaced problems. They are conscious of the dangers and in adequacy of the delivery systems which only bread alienating dependency. They also recognize that the displaced people do not have to provide suitable answers to their problems. These intensify the responsibilities of NGOs to back displaced in such ways enable them to gain at least minimum levels of living standard. NGOs interaction with displaced communities goes beyond current political trends, and has provided aid to needy communities it had to allocate resources and directed assistance to their neediest communities. Hence NGOs ability to deliver emergency relief

and rehabilitation, and their effective contribution to displaced communities is indisputable. Jina (2001. 16)

2-3 Heath Care Provision: -

The most serious health problems of displaced people are the high rates of morbidity and mortality. This results from various interrelated conditions; malnutrition, infections and the consequences of ill timed, closely spaced, lack health care, and other social services and economic conditions. The remedies for many of these shortcomings of health services are known and available. But some cannot be usually applied unless the overall concept of health care is appropriately modified. The main needed concerned by NGOs is to develop a system through which effective health care can be made both accessible and available to displaced. Promotion of the health status for the displaced areas is a sustainable process of fundamental change in policy, and instructional arrangements guides by NGOs, designed to improve the functions and performance of health system and ultimately the health status of the displaced. Tvedt (1994. 35).

In conference in Khartoum 1996 about reforming health status of displaced. It comes that all over Khartoum State there is typical patterns of health hazards. Within these patterns certain population groups and sections of society are exposed to the highest health hazards and have the lowest chances for survivals and share poorest quality of life. These are people in the rural areas and displaced comps. The identification of these groups has enable NGOs and health researchers to place health status in total development. And conceptualize health as a multi-sectoral product. NGOs strategies and the national humanitarian assistance system must have all contributes to the growth and preparation of health conditions of displaced. The report further mentioned that health care provision in displaced camps now extends beyond local boundaries to the notional, regional and global

NGOs. The task of health care provision must undertake from global, national to local grass roots movement. The first step is identifying the main group disparities. By using the aggregate data. This can be applied through the selection of one displaced camp characterized by particularly low health and socio-economic indicators and generalizing the remedies a product in other camps.

Anther report from Humanitarian Aid Commission (HAC) 1997 stated that; bulks of the health budgets come from NGOs are tided to curative services. The people in the camps suffer from the impact of diseases more than diseases itself. Diseases controllable by preventive measures, (e.g. malaria, TB and diarrhea's) receive little attention. Although it more effective to spend on preventive rather than curative health. The number is too large for the later to provide with adequate health and better services. In some cases political and financial constraints defeat the desire of NGOs in providing health assistance, which maybe the only driving force able to introduced change to provide public services, particularly health services from their collective finance.

Chapter Three

The SCC's Primary Health Cares Program

This chapter attempts to investigate the effectiveness of the SCC primary health care program in Jebel Aulia and tries to explain, to what extent the program succeeded in promoting the general health conditions of the displaced in the camp. For this purpose data was collected from the SCC annual reports. It covered the works of five clinics and these are the extended program of immunization, the nutrition program, the maternal care, the health education and the curative clinics.

3-1 The SCC Primary Health Care Program: -

In the past two decades the SCC established a comprehensive primary health care program (PHCP) aiming at promoting the health situation of the displaced around Khartoum. The program is composed of two part preventive and curative health care. SCC primary health care program for the displaced started to working in the early months of 1978 as an emergency program. So as to meet the health need have displaced. The SCC primary health care program in Khartoum state operate in eight health centers scattered a round the countryside of the state. The program runs clinics amongst the displaced in: Elsalama I, ElNewela, and Zagallona in Omdurman, Jebel Aulia and Mayo Farm in Khartoum and Gadida (Karton Kassala) in Khartoum North. The main activities carried out by the program include Extended Program of Immunization (EPI), Control of Diarrhea Diseases (CDD), TB program, Curative Care and Maternal Care, Nutrition and Health Education.

The target population of the program is estimated to be 100.000 to 150.000. However the government policy of commercializing medical treatments push many nearby residents to seek free medical services

available in the displaced areas. This has therefor increased the target population (SCC, 1998:125).

3-2 The Primary Health Care Program in Jebel Aulia: -

The primary health care program includes, nutrition center, extended program of immunization, maternal care, health education and curative clinic

3-2-1The Extended Program of Immunization EPI: -

The extended program of immunization is one of the SCC primary health care programs. EPI carry's out immunization services for the children and women against preventable diseases like the six immunizable diseases and, tetanus. The program has been held for the first time on daily basis in the clinic center. There has sustainable vaccinator in the health center he had been trained in immunization to assist in both vaccination and mobilization whenever possible. The extended program of immunization aimed at reducing mortality caused by the six immunize able diseases and immunizes pregnant women and non-married girls against tetanus (SCC, 1997:35). Table (3-2) presents the number of children and women attending extended program of immunization during the period (1995- 2002).

Table (3-1) Numbers of Children and Women Attending the Extended Program of Immunization

YEAR	EPI	% of the Total
1995	3257	19%
1996	2794	16%
1997	2332	13%
1998	1158	7%
1999	1297	8%
2000	3714	21%
2001	1585	9%
2002	1013	7%
Total	17150	100%

Legend:

EPI Extended Program of Immunization

Source calculation from different SCC annual reports; 1995, 1996, . . . 2002

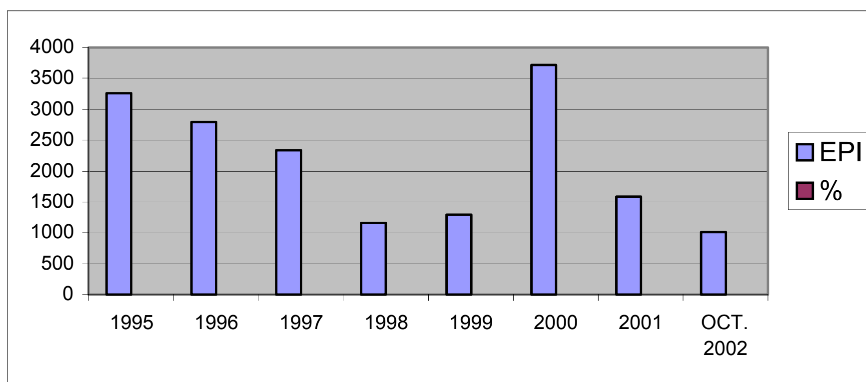
The Extended program of immunization is apart of the primary health care program. EPI receives support from UN agencies like UNICEF and international NGOs like MSF and Save Children as well as the Federal Ministry of Health.

Extended program of Immunization EPI has a significant contribution in providing Immunization dosages against tetanus and six immunizable diseases in the camp. The program succeeded in providing 90% of the total number of children and women in the camp (those are the target group) with adequate immunization dosages during the period of 1995 – 2002.

The estimate percentage of children and women in the camp is about 70% of the total number of population approximately (central bureau of statistic). This percentage represented 19012 child and women. Comparing this Figure with the total number of cases that received Immunization doses in the program during the period of the study that is 17150; see table (3-1). The figures explain that the program succeeded in provides 90%of the target group with immunization services and this show the great effectiveness of the extended program of Immunization.

Despite the significant contribution of the program it had faced seasonally fluctuations in numbers of cases attended the center as a result of various interrelated conditions that will be mentioned in chapter four .

Fig (3-1) Annual Percentage Share of Cases Received Immunization during the Period (1995- 2002)



Legend:

EPI extended program of immunization

3-2-2 The Nutrition Program: -

The nutrition program is the second component of the primary health care program. The program has been operating in the area since the early of 1990 and succeeded in attracting numbers of NGOs i.e. MSF and ADRA. (SCC, 1997:125) The program aims at improving the nutritional status of the malnourished children, providing nutritional health education for mothers and health visitors in the activity. As well as follow up growth monitoring of children came to under five-age clinic, distributing foodstuffs for TB patient and therapeutic feeding for severely malnourished children. Now the program conducts nutritional surveys among the population in the area, manages and supervises the program and services training for the staff and field visitors. Nutrition program includes wet feeding center, oral rehydration therapy, therapeutic feeding center TFC and growth monitoring GM. Table (3-2) Total Numbers of Cases Received Treatments in Oral Rehydration Therapy, Wet Feeding, Therapeutic Feeding and Growth Monitoring During (1995- 2002).

Year	Total number	ORT	%	WF	%	TF C	%	Gm	%	Total %
1995		950	11%	2530	29%	436	5%	4708	55%	100 %
1996		937	16%	1231	21%	521	8%	3256	55%	100 %
1997		746	19%	771	20%	843	21%	1566	40%	100 %
1998		1662	26%	1412	22%	765	2%	2598	40%	100 %
1999		2499	41%	1174	19%	985	17%	1427	23%	100 %
2000		1878	27%	497	7%	479	7%	4046	59%	100 %
2001		1567	27%	320	5%	353	6%	3599	62%	100 %
OCT 2002		485	11%	949	22%	930	21%	2025	46%	100 %

Source: calculations from annual SCC reports

ORT Oral rehydration therapy

WT wet feeding

TFC therapeutic feeding center

GM growth monitoring

The first part of nutrition program is oral rehydration therapy. This part distributes foodstuffs and nutritional treatments for the severely malnourished under five age children. The unit receives assistance from UNCEF. The center

receives cases from both the camp and nearby residents. When the child join the center he receives super specialist nutrition care in term of (meal of High-energy milk) and oral re hydration until he gain the natural weight.[1] .

The program has provided nutritional treatment for about 1453 malnourished children on average during the period of (1995 – 2002). As a result of unavailable data on the targeted group of this program it is difficult to state the efficiency of the program in terms of percentage of the total number of cases attended the center. But the figures on table (3-2) reflect the contribution of the program in improving the nutritional statues of the infected children.

Wet feeding is the second component of the nutrition program. In this component foodstuffs are distributed to very poor families in term of (family ration) as well as foodstuffs to women who stay with their malnourished children in the center to grantee food supply for other family members at home.

Wet feeding program has a significant contribution in providing essential foodstuffs for the families in the camp. The program succeeded in provides 92% of total number of families in the camp with the essential foodstuffs during the period of 1995-2002.The total number of families in the camp is 1206 (central bureau of statistics). Comparing this figure with the total number of families that received foodstuffs in the center during the period of the study that is 1108 see table (3-2). It's clear that the center has provided 92% of total number of families in the camp with the essential foodstuffs. This percentage shows the great efforts of the wet feeding center in providing foodstuffs.

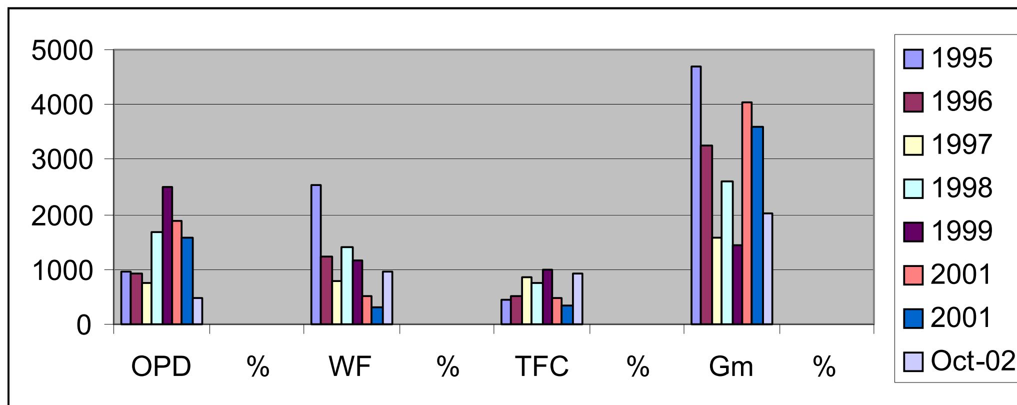
Therapeutic feeding is the third activity of the nutrition program. The program is considered an important part within the primary health care program because it is specialized to serve TB patients. The unit operates in association with the curative clinic because TB patients initially have their medical treatment in the curative clinic beside the therapeutic feeding center. Therefore, wet feeding used to secure foodstuffs for every patient as long as he could receive treatment.

There is now regular registration for the total number of TB patients in the camp. The center computing only those who are undergoing treatment in the center. The total number of TB patients in the

camp is not far from that number registered in the center. And the program serves successfully about 95% of the TB patients in the camp[2].

The growth monitoring is the forth component of the nutrition program. The component is supervising under five age children who joins the center, from the first time they intend the center until they reach five years. When a child joins the center, he receives medical and nutritional treatments to gain the standard weight /height. The number of the children registered in this unit is very high (see Table 3-2). Despite the duplication which may occur in registering children in more than one part in the nutrition program at same time and its implications on over estimations the actual numbers of children, its clear that the unit serves large number of sever malnourished children. Fig (3.2) shows the annual percentage share of therapeutic feeding, wet feeding, oral rehydration thereby and growth monitoring in the nutrition program.

Fig (3.2) The Annual Percentage Share of Therapeutic Feeding, Wet Feeding, oral rehydration, Thereby and Growth Monitoring in the Nutrition Program.



Legend:

ORT Oral Rehydration Thereby: WF Wet Feeding

TFC Therapeutic Feeding Center: GM Growth Monitoring

3-2-3 The maternal Health:

The maternal health is a part of the SCC primary health care program. The maternal clinic aims at providing maternal care for pregnant and lactating women, reducing anemia, providing antenatal and postnatal care. The program operates in two dimensions of antenatal care, first seen and vaccination. (SCC, 1997:130) Table (3-3) shows the numbers of cases attended the maternal care clinic during (1995- 2002).

Table (3-4) Numbers of Cases Attends Maternal Care Clinic During (1995-Oct 2002).

Year	**TOTAL NUMBER**	**First seen**	**%**	**Vaccinator**	**%**	***Total %***
1995		612	75%	206	25%	100%
1996		537	81%	127	19%	100%
1997		441	85%	80	15%	100%
1998		520	85%	91	15%	100%
1999		445	81%	102	19%	100%
2000		474	68%	226	32%	100%
2001		501	75%	169	25%	100%
Oct 2002		313	79%	83	21%	100%

Source: calculation form SCC annual reports

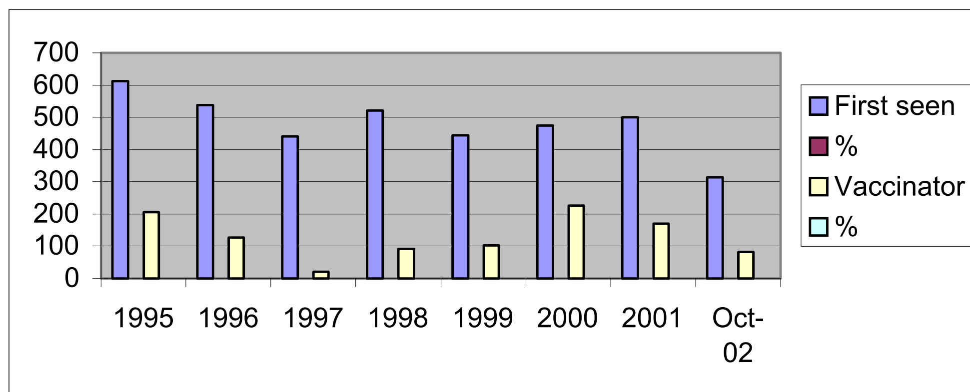
The maternal care is the super specialist clinic in primary health care program. The clinic used to provide medical services for pregnant and lactating women .The program activities have been extended recently to cover non-married girls and develop the local awareness about reproductive health. The maternal care clinic operates on two domains; first seen and vaccination. In the first seen pregnant and lactating women register for the first time to receive medical treatments and foodstuffs[3].

It's clear that the numbers of women joining the first seen are more than those whom come to receive vaccination. About 79% of the total number of women joining the maternal care clinic come to register in the first seen on average; see table (3-3). The justification of this substantial diversity between women join first seen and those who come to receive vaccination is that, women when join the clinic for the fist seen would have to receive foodstuffs in addition to the daily follow up. This was very attractive for the women in the past. But in the current time when food stocks come to finish the numbers of women coming to the center decrease dramatically from more than 600 women per month to less than 300women[4].

Vaccination is the second part of the maternal care program. There was permanent vaccinator in the center. He used to provide daily services and training volunteer midwives. The average percentage of women

received vaccination is 21%of the total number of women joining the maternal care clinic on average, see table (3-3). Fig (3-3) shows the annual percentages of women receiving the maternal services during the period of (1995- 2002).

Fig (3.3) **The Annual Percentages of Women Receives Maternal Care Services During the Period of (1995- 2002).**



3-2-4 The Health Education and the Health Visitors: -

The health center is visited regularly by a unit supervisor for the purpose of supervising the ongoing training of community health workers. The unit attempts to address the field workers problems, which vary considerably on a day-to-day basis. At years health education unit is regarded as one of the few official areas of operation of this national program. The SCC currently is the only NGO working directly with the Ministry of Health in this program, and the only body addressing the issues of TB amongst the displaced in the context of the national policy. (SCC, 1995:85).

The program objectives are to coordinate health education activities of the primary health care program in the area, to train personnel on the health education, to produce health education materials and to manage the medical library. Also the health education aims at improving the coverage of the nutrition program, raising the attendance

rate and reducing the number of defaulters through the tracing of absentees and improving community involvement through acting as link between the health centers and the community by providing basic education[5].

Home visits are the second part of the health education program. The objectives of this program is to deliver vaccination services, provide short training in reproductive health, immunizes children and pregnant women in their homes as long as educate people how to use latrines and raise the family awareness about sanitation and educate methods of family planning.

Table (3-4) Health Education Sessions and Home Visitors during (1995-2002)

Year	total number	HE	% of total	HV	% of total	Total %
1995	9240	4509	49%	4731	51%	100%
1996	5799	3754	65 %	2045	35%	100%
1997	5889	3219	55%	2679	45%	100%
1998	1296	164	13%	1132	87%	100%
1999	11039	4920	45%	6119	55%	100%
2000	9651	4642	48%	5009	52%	100%
2001	8023	4846	60%	3177	40%	100%
2002	4641	2633	57%	1985	43%	100%
TOTAL	55564	28687	51%	26877	49%	100%
Av.	6940	3798	49%	3359	51%	100%

Legend:

HE health education - HV Home visits

Av Average

Source:calculationsfromSCCannualreports;

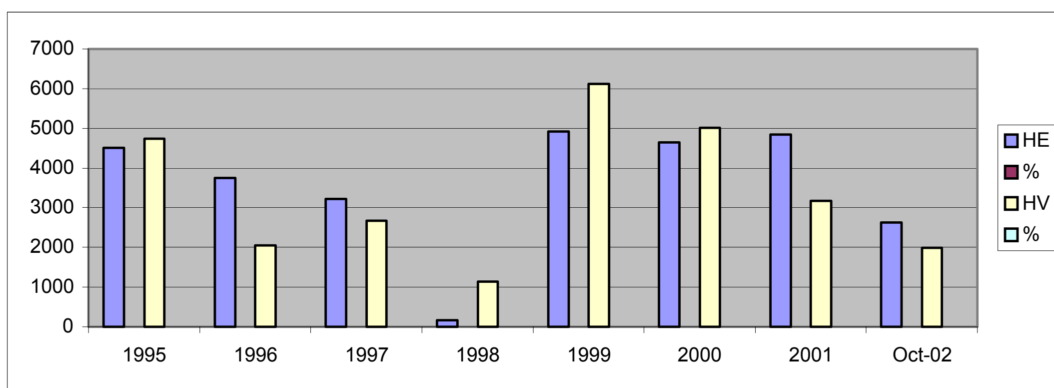
1995,1996,1997,1998,1999,2000,2001 and 2002

The health education is the corner stone in every effective primary health care program. It's one of the successful preventable interventions introduced initially to help isolated peoples to act with their urgent health problems. There is about 3798 health education sessions took place in the camp on average annually during the period of (1995-2002) see table (3-4). This figure reflects the deeper involvement of the SCC staff in the community health issues[6].

Home visits are another part of the health education program. It concerns pregnant and lactating women in addition to anther reproductive health issues. Home visitors are playing a vital role in promoting maternal health in the camp.

Volunteer midwives visited every house in the camp twice a year during the period of (1995-2002). The program conducted 3359 home visit annually see table (3-3). If we know that the total number of families in the camp is 1206 it's obvious that every house has more than double chance to be visited by volunteer midwives. The considerable thing is that this sort of health services held for the first time in the camp by the SCC primary health care program.

Fig (3-4) Percentage Share of Health Sessions and Home Visits in the Health Education Program during the Period of (1995-2002).



Legend:

HE: Health education

HV: Home Visits

3-2-5The Curative Health Care: -

The curative health care clinic includes the outpatient clinic, laboratory and the pharmaceutical services. The objective of this program is to help the displaced to raise their health conditions and to distribute the essential drugs. Recently the clinic has continued to see increasing numbers of patient as a result of the rush of people joining the settlement and the attraction of people from nearby areas due to the general shortage of drugs in the whole country. The average attendance in the clinic per day is 120 patient (SCC, 1995:17). The common cases attending the clinic had been the same over the past decade and these were malaria, diarrheas and other poverty, and malnutrition related diseases. Table (3-5) presents the numbers and the percentages of the total attendance to the clinic during the period (1995 2002).

Table (3-1) Numbers and Percentages of Cases Attends the Curative Clinic during the Period (1995-oct2002)

Year	Total numbers	OPD	%	LAB	%	Pharmacy	%	
1995		17964	47	6238	17	13575	36	
1996		17307	50	5231	15	12313	35	

1997		16548	47	4174	12	14012	41	
1998		13369	49	4079	15	9732	36	
1999		12770	42	3887	13	13873	45	
2000		25428	42	7147	12	27644	46	
2001		14737	42	5577	16	14409	42	
2002		12166	44	3787	13	11916	43	

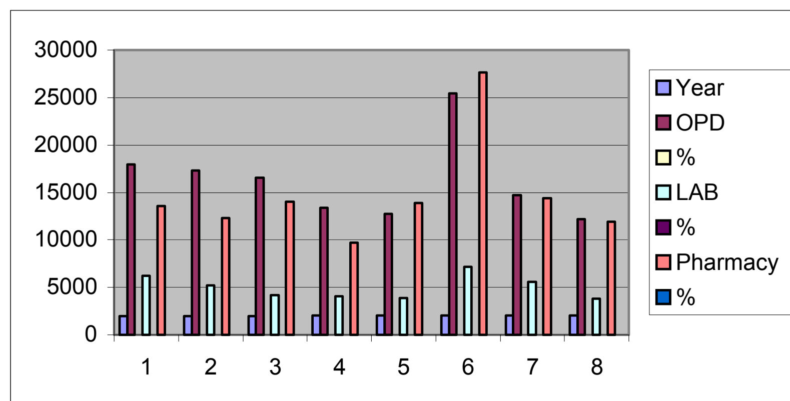
Source calculations from SCC annual reports - OPD Out patient clinic - LAB Laboratory

Curative clinic is important component in the primary health care program in Jebel Aulia. This component has provided the residents in the camp with the necessary health needs such as out patient clinic, pharmacy and laboratory. The clinic provided every one in the camp with more than one chance to receive medical treatments[7].

There is about 40585 patients attending the clinic on average annually during the period of 1995-2002 see table (3-5). Comparing this figure with the total number of resident in the camp that is 27166 (central

bureau of statistics) .We find that the total number of cases attended the clinic are double the total number of residents in the camp. If we consider that this services did not exist in the camp before the SCC primary health care program, we can see the significant contribution of the curative clinic in the illness alleviation in the camp. To show the relative contribution of the outpatient, pharmacy and the laboratory; these are the curative clinic components see table (3-5). Fig. (3-5) shows the percentage share of cases received treatments in the outpatient clinic, the laboratory and the pharmacy during the period (1995-2002).

The % share of Out Patient Clinic, Laboratory and Pharmacy in Total Attendance during the Period (1995-2002) Fig (3-5):



Legend: OPD Out patient clinic: LAB Laboratory

Chapter Four

Limitations, Obstacles and Constraints

This chapter will focus on obstacles, limitations and constraints hindering Sudanese Conical of Churches in its attempts to improve health services in Jebel Aulia displaced camp. These constraints can be divided into three categories constraints related to SCC, constraints related to government and constraints related to NGOs like ADRA and CARE international.

4-1 Constraints Related to SCC:

Given the vast size of people covered in the primary health care program in Jebel Aulia transportation of the staff, drugs and other supplies to the health center and lack of proper maintenance of the existing vehicles has been a major obstacle. Assessing the regular operation of the primary health care program. Its clear that while the program is autonomous increases in some regards the program depends to greater extent on efficient support services from the SCC structures. This includes the work of the SCC mechanics and of the logistic office in licensing of vehicles. Other essential support includes the work of the personnel office. Finally the finance office plays a key role in their ability to provide information or funds as the case may be. Because the SCC structure is one of interdependent relationships, the operation of programs needs collective efforts from the SCC departments, therefore any weakness in relationships made communication excessive demands on any unite, or program unite and lead to disturbances in the program operation. This is especially true for constraints to be considered as speed of access to cash flow for operational needs, and speed of the hiring process for new and replacement personnel.

The low staff morale exists due to difficult economic conditions, the below average salaries and additional stress from the transport difficulties of field work.

Center emergency operations grow in size and as a result some difficulties a raised in the working conditions experienced by primary health care program staff. The large volume of people seeking assistance from program creates conditions not conducive to the carrying out of office work drugs storage, meetings and carry out other normal activities as Primary Health Care Program staff member.

Also the SCC registration was not able to continue buying drugs from the central medical supplies as the registration of the SCC was made a condition. The only option now is to purchase drugs from the market, which is very expensive.[8]

During the same years there was a spread of some epidemic diseases such as malaria, meningitis and TB. Keeping in mind a limited technical and financial resource, These diseases are contributed to the obstacles that faced the program. This shown in the substantial increased in numbers of patients attended the center in the year 2000;
see table (3-5).

4.1.1 The Maternal and Children Health Constraints:

Food items supplied by SCC were inadequate for pregnant and lactating women. In the past the program was supported by ADRA. They used to supply food items and folic acid tabs to reduce anemia among pregnant women. Currently ADRA does not provide assistance as result of program termination. ADRA handed over the responsibility to the SCC, which is unable to operate the program as it was in the past, due to financial constraints. This reduced the number of women attending the clinic from about 600 women per month to less than 300. The majority of women lacked interest in following up and started to seek better treatment in another camps such as Maio Farm and Alsalama.[9] See table (3-3)

In addition to the fundamental role of following up pregnant and lactating women, the clinic services extend to form program of home

visits, through numbers of volunteer midwives, to deliver nutrition education. Home visitors in the past currying foodstuff and cleaning facilities as an incentive. Due to shortage of food supply home visitors now have been distributing nothing and they only give advice which is not accepted without facilities.

The slow flow of funds from the regional office to the health center has greatly hindered the smooth running of the program and irregular release of allocated funds caused serious delay in implementation of planned activities.[10]That is clear in the few numbers of patients who received nutritional treatments in the TFC program see table (3-2).

4.1.2 The Nutrition Center Constraints

Oral Rehydration therapy program faced financial problem, because the center buys ingredients directly from market. Moreover, the fund offered by the headquarters is not up to needs. Therefore the center turn two cheaper types of diets. And some times the center have to discharge the malnourished children before the stated period as a result of the shortage in the supply. This affects the nutrition process and added to the problem.

The staff of the center works for along time as temporary workers till they were appointed two years age. Such situation affects the sprits of the SCC officials as they feel worry about their future, which provides no adequate guarantees this, affects the performance of the workers at the center.[11]

In the past the center used to provide food in the form of "family ration". So mothers were able to look after their children who suffer from malnutrition in the nutrition center. When ADRA stopped providing food mothers started to leave children alone or with another child to search food for those who are at home. When the infected children were treated

from malnutrition they came again to the center because of the absence of suitable nutrition at home.[12]

In the year 2000 ADRA took over the support due to the expiry of the program in north regions, supply of food come to a halt and the number of families received foodstuffs decreased dramatically see table (3-2).

4.1.3 The Health Education Constraints:

Concerning health education, health awareness issues result from the ignorance or the citizens they are unaware of the instructions given. Moreover, some citizens refuse to comply with the health promoters. This, in many cases, leads the health promoter to give up his role, also the absence of the incentives. "Food for work", ADRA ceased aid to promoter this makes the health promoter abandon his/her work in search of better opportunities.

A group of workers at the center are volunteers who earn incentives in the form of material goods (food for work) are now earning nothing, as there are no foodstuffs in the center, for the expiry of ADRA program. As far permanent officials they are doing their work in low sprits as a result of feeling of insecurity.

4-2 Constraints Related to Government:

Current government policy towards the displaced continues to create a climate of vulnerability fear and uncertainty within the target group, it is difficult to formulate sustainable new program activities for those who come daily when their status existence is unclear. This obvious in the increasing numbers of patients attended the center in the year 2000; see table (3-1), (3-5)

Lack of information about the real number of the displaced in Jebel Aulia including census details and other demographic data is a constraint for planning and program assessment. [13]

At first ADRA, MSF as and the SCC used to bring free medicines, however for financial reasons the center has not been able to go on. Moreover, ADRA stopped working in Khartoum. An agreement was signed between the Ministry of Health and all NGOs to be represented in the agreement by one organization. This organization would undertake the purchase of medicine from medical supplies and distribute them to other NGOs. The NGOs, interns, sell these medicines at low prices to help the displaced. It was a greed upon that the project would continue for six months. After that NGO would abandon the project and each organization should receive its purchases directly from the medical supplies. In spite of the fact that the prices are low the patients are decreasing, as they have no enough money.

4-3 Constraints Related to NGOs:

Concerning the issue of medical drugs ADRA used to supply the center with the necessary medical drugs according to an agreement with the Ministry of Health. Due to this agreement ADRA would distribute the medicines to all the organizations. However, that agreement has now come to a halt for the expiration of the contract duration. When CARE international took over form ADRA, a problem come up, the medical supply is now about to stop.

ADRA used to offer incentives to the workers in the center under the formation of "food for work program" especially the community health promoters and midwives since the SCC deal with them as volunteers. These incentives are no longer available on for the departure of ADRA. This situation created a problem as workers in the center began to feel that there was no adequate motive for work.

When CARE international took over from ADRA, the therapeutic feeding for T.B. patients was stopped. This pushed patients who were undergoing treatment in the center out to look for work before completing

their treatment. Thus as the treatment process was stopped such patients became a threat to the whole community. When they came back to the center SCC health staff have to multiply the dosage for them. Therefore, the treatment expenses increase, and the numbers of TB patients attended the center declined gradually see table (3-2).

To conclude, despite it is success SCC program faced many limitations, obstacles and constrains hindered the work. These constrains arise from different sources and affected in different magnitudes the smooth running of SCC program activities. First there are internal constrains and these are related to the SCC, and second there are external constrains which intern could be divided into two sources the first source is related to the partner NGOs and the second is related to the government.

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1- *Chapter Five*

Conclusions and Recommendations

5-1 Conclusions

From the study conducted the health services provision for the IDPs in Khartoum State is become most important issue this due to the growing numbers of displaced who are in dire need. An increase number of IDPs and refugees who are in dire need for relief assistance results in increased number of NGOs established relief, feeding centers, food distribution centers, health clinics, built and support an educational institutions, this along wise with instituted development programs.

Health provision is part of NGOs activities. It covers immunization of children against polio, vaccination against meningitis, treatment of diseases like malaria and diarrhea. Supply of specific drugs for specific diseases like tuberculoses, and meningitis, Which are continue to contributes to the highest rates of mortality and morbidity especially among young children, health education, hygiene and Aids campaign, provision of supplementary and theoretic feeding for children weight to height is below 80%.

The SCC is one of national NGOs involved in health provision for IDPs since 1972. The SCC is Christian organization operating nation wide across the Sudan. The real operating of the SCC after Addis Ababa agreement. The SCC structures were built to enable agencies and partners to relies reconstruction, and resettlement needs of the several million Sudanese referring from exit through the years .The role of the council knows is mainly dealing with relief and to limited extended rehabilitation among IDPs across the Sudan. The universal objectives of the conical is to formation and running of the development projects, plan, carrying out and supporting emergency so as to improve spiritual soul and maternal well-being of the Sudanese people.

The SCC initiates primary health care programs across the displaced areas around Khartoum State The program aims at serving the displaced and includes both preventive health care which is consist of extended pogrom of immunization, nutrition program, material care and health education and curative care. The SCC primary health care program in Jebel Aulia is one of these programs operate since 1990. As a result of this efforts the SCC now is a drive force in providing health services for the IDPs in Khartoum, this efforts need presentation assessment and criticism, and these are the reasons for doing the study. s

Extended program of immunization is anther activity in the program .The program used to reduce mortality caused by the

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hydration for severely malnourished children.

The maternal care is the fourth part of program activities, this part deal with mother and child health. The programs used to reduce anemia in pregnant women and distribute food items to pregnant and lactating women. Health education is the last activity in the program. The unit is account as first defense line against diseases. The main purposes of health education are supervising on going training of local health workers and address the field worker problems. Home visits are a part of health education and maternal care activities. Home visitors delivers vaccination services and provides short training in reproductive health. Curative health care includes out patient clinic, laboratory and pharmaceutical services. From the analysis of the SCC primary health dare program performance in the camp .it is obvious that the program was greatly supported the displaced and contributed effectively in irradiating the diseases and raising the standard of living in the camp .the program made the medical services accessible and available for all displaced in the camp regardless his religion or financial position .

Despite these facts the program had faced number constraints had often hindered smoothly running of services. These constraints are of three types; i) constraints related to the SCC these are, program operating needs high technical and financial capabilities that are not be found sometimes, the program faces problem of lack of coordination of drugs supplies and nutrition program creates difficulties as a result of food shortage constraints related to the SCC could be summarized into major two reasons financial difficulties and workload. ii) Constraints related to Government, these are government policies toward displaced characterized by the instability and this affected

planning and supervision iii) constrains related to the partner NGOs the program supported by operate under international and institutional conditions. In such cases these international NGOs i.e. MSF, ADRA in some aspects. These NGOs are compelled to ceased their subsidize and this creates addition constraints to the program.

5-2 Recommendations: -

Work in the camp become too big for the SCC a lone. There is a need for admission of more NGOs.

The program needs to be supported with food for work to be more effective and attractive for both patients and volunteers.

3- The staff of the center needs refresher courses to improve skills and the need also to determined their job position to avoid the worry about their future.

4- Its useful to keep full registrations for all people in the camp, to avoid disturbances creates from lack of information.

5- relocation policies adopted by the Government must tack in to consideration the bad condition of the displaced. Accordingly displaced should be supported in such a way that could enable them to cope with their new situations.

6- Joint activities between the SCC and other NGOs need more co ordinations to a halt the expected declines come from termination date of any organization program.

7- The staff need to offer transportation facilities, to grantees there arrival on time specifically during autumn, whereas, they had to cut about two kilometers from the station to the center on foots.

8- Agreement of medical supply, which consolidate drugs purchases from the central medicine supplies, and for one organization is greatly hindered work in the center. There is need for new flexible agreement which make each organization free in search of its needed medicines.

9. SCC staff and the community efforts needed to be integrated for a deeper understanding of the concept of preventive health.

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Table (3-5) Numbers and Percentages of Cases Attends the Curative Clinic during the Period (1995-2002)

Break down the total numbers of patients

ar	Total numbers	OPD	%	LAB	%	Pharmacy	%	Total %
95	37777	17964	47	6238	17	13575	36	100%
96	33751	17307	50	5231	15	12313	35	100%
97	43734	16548	47	4174	12	14012	41	100%
98	27180	13369	49	4079	15	9732	36	100%
99	30430	12770	42	3887	13	13873	45	100%
00	80219	25428	42	7147	12	27644	46	100%
01	43723	14737	42	5577	16	14409	42	100%
02	27869	12166	44	3787	13	11916	43	100%
tal	287893	130289	45	40130	14	117474	41	100%
Av.	40585	16737	44	5013	15	14685	41	100%

Legend:

OPD: Out patient clinic

LAB: Laboratory. Av.: Average

Source calculations from deferent SCC annual reports; 1995,1996,1997,1998,1999,2000,2001and 2002

Table (3-2) Total Numbers of Cases Received Treatments in Oral Rehydration Therapy, Wet Feeding, Therapeutic Feeding and Growth Monitoring During (1995- 2002)

Break down the total numbers of patients

Year	Total number	ORT	%	WF	%	TFC	%	Gm	%	Total %
1995	8624	950	11%	2530	29%	436	5%	4708	55%	100%
1996	5945	937	16%	1231	21%	521	8%	3256	55%	100%
1997	3926	746	19%	771	20%	843	21%	1566	40%	100%
1998	6437	1662	26%	1412	22%	765	2%	2598	40%	100%
1999	7085	2499	41%	1174	19%	985	17%	1427	23%	100%
2000	6900	1878	27%	497	7%	479	7%	4046	59%	100%
2001	5839	1567	27%	320	5%	353	6%	3599	62%	100%
2002	4389	485	11%	949	22%	930	21%	2025	46%	100%
Total	48120	10719	22%	8864	18%	5312	11%	23225	49%S	100%
Av.	6143	1453	22%	1108	19%	644	11%	2916	48%	100%

Legend: ORT Oral rehydration therapy

WT wet feeding, TFC Therapeutic Feeding Center, GM growth monitoring, Av: Average

Source: calculations from deferent annual SCC reports; 1995,1996,1997,1998,1999,2000,2001and 2002

Table (3-3) Numbers of Cases Attended Maternal Care Clinic during (1995- 2002).

Break down the total numbers of patients

Year	Total Number	First seen	% of Total	Vaccinator	% of Total	Total %
1995	818	612	75%	206	25%	100%
1996	664	537	81%	127	19%	100%
1997	520	441	85%	80	15%	100%
1998	611	520	85%	91	15%	100%
1999	547	445	81%	102	19%	100%
2000	700	474	68%	226	32%	100%
2001	670	501	75%	169	25%	100%
2002	396	313	79%	83	21%	100%
Total	4927	3843	77%	1084	33%	100%
Av.	616	480	79%	136	21%	100%

Legend: Av.: Average

Source: calculation form SCC annual reports; 1995,1996,1997,199,1999,2000,2001and 2002