

SUDAN: MEDICAL CARE FOR THE INTERNALLY DISPLACED PEOPLE IN WEST DARFUR STATE

Introduction:

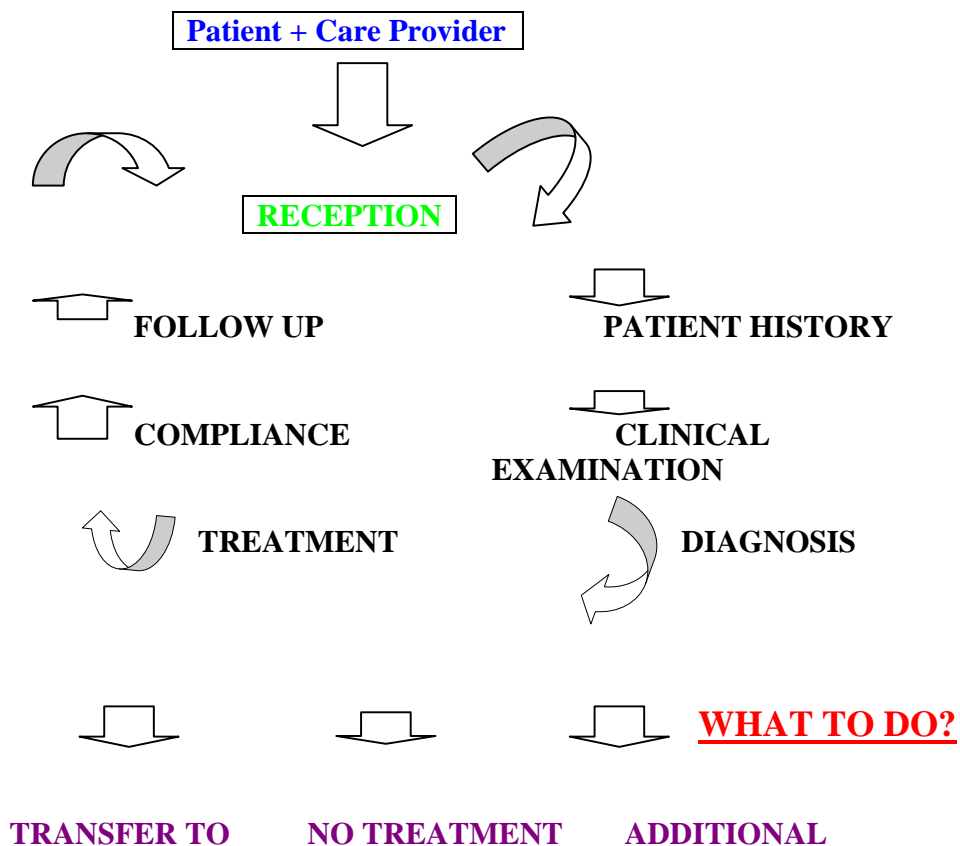
Medical Care for the displaced populations in Darfur can be defined as the interaction between a patient with a health problem and a caregiver who must find the solution to the problem, or at least determine what should be done.

REFERRAL FOR WEST DARFUR:

In order for medical services to be distributed with regard to an appropriate health care level in West Darfur State, a clear provision must be made for mechanisms of transfer between the different levels. Thus, health care personnel must be clearly informed about the services offered at each level of the health system, so that they can refer patients either to better- equipped medical facility or to a lower level of care, confident that the medical attention they receive will be satisfactory.

In almost every situation, the care giving personnel find themselves confronting the problem of particular medical cases requiring transfer to specialized units in the same region or country. Care providers in West Darfur State must absolutely realize that they cannot deal with all the medical problems that arise, and that they must give priority to those for which an immediate solution can be found.

STEPS IN THE MEDICAL CONSULTATION FOR WEST DARFUR:



A HIGHER LEVEL

TESTS

We must realize that individual care depends on the interpretation of the each care provider. This leaves the way open to numerous irregularities, unless certain measures are established to rationalize the approach—a rationalization, which must still, of course, take account of the individual characteristics of the patients and those who treat. The primary tool in this domain is standardization of the health care delivery chain.

STANDARDIZATION OF PROCEDURES:

Diagnostic Standardization

Many diagnostic procedures have already been laid down in the form of flowcharts. They can easily be adapted to the situation and to the type of personnel who will need to use them.

One good system involves using standardized cards for different symptoms: fever, diarrhea, abdominal pains, conjunctivitis, cough, lower limb edema, dyspnea, hepatomegaly, crackles heard during auscultation of the lungs, etc. This is more useful than cards for etiologically defined problems such as pneumococcal pneumonia, amebic diarrhea, and left ventricular heart failure. This standardization can take the form of flow charts. Diagnostic standardization should reflect age (infants, children, adults) and sex.

THERAPEUTIC STANDARDIZATION

The word therapeutic procedure means not only surgical action or the prescription of medicines, but also the decision to transfer the patient to another, more suitable health center, or else abstain from intervention because it is useless or impossible. The standardization process is carried out in several levels, as follows:

Standardization of Treatment:

In emergency situations, the use of biological tests and x-rays remains the exception. This restriction must be kept in mind when a course of treatment is planned. Standardized treatment should be the rule at all levels of the medical hierarchy (CHWs, Nursing personnel, doctors). A vertical coordination must be achieved between the different standardization plans, to make sure they complement each other. Standardization is particularly important in emergency situations. First, it should be remembered that countries requiring relief assistance standard procedures usually already exist for treating the main pathologies, such as tuberculosis, malaria, and diarrheal diseases. Humanitarian agencies should try at the outset to standardize procedures, in order to harmonize their own emergency procedures with those employed by the health ministry. Occasionally, relief agencies may institute specific procedures, which do not correspond to those advocated by the ministry of health. This problem must be negotiated with the local health authorities.

Standardization of Drugs

Logically, the standardization of treatment regimens implies standardization of the drugs used. For many years now, efforts have been going on to rationalize drug use, and the principle Humanitarian agencies accept WHO's recommendations. Lists of essential

drugs, reflecting both the medical problems themselves and the different treatment levels, already exist:

- The WHO/UNHCR list of essential drugs
- The ICRC list of essential drugs
- The MSF list of essential drugs.

This rationalization must take into account four factors:

1. The population's health problems rather than the wishes of the medical teams
2. The fact that the essential basic drugs will be used by personnel with varying levels of ability (the drug list should therefore be adapted to the level of use).

UNHCR, for example, suggests three lists:

- The basic list for the CHWs who use the drugs at the most peripheral level;
- A supplementary list for doctors and nursing personnel who use these drugs in dispensaries and general hospitals;
- A specialized list for doctors and nursing personnel working in units where they encounter particular problems

3. Cost (generic drugs)
4. The policy of the local ministry of health on essential drugs.

This approach of using standard drugs, will also oblige the relief team, depending on the needs of the population, to:

- i. Coordinate action with the health ministry and other agencies involved in a given emergency situation;
- ii. Rationalize drug donations and prevent the dispatch of unsolicited drugs;
- iii. Manage stocks more efficiently.

Standardization of patient transfer procedures:

The transfer of patients from one care level to another must obey precise rules so that the care given at one level of health-care system will correspond to the skills of the health-care personnel associated with that level. Standardizing transfer procedures makes it possible to define what kinds of patient must be evacuated. This prevents complex cases from being treated at low-level facilities that do not have the capabilities for it, and, conversely, prevents simple cases from being too easily passed on to higher levels, where they would encumber operations.

The following are the advantages of standardization in terms of the stages of the care giving process:

- Facilitates the management of drugs and equipment
- Facilitates the integration of new personnel
- Regulates transfer to higher care levels
- Prevents competition between facilities on the same level.

Training Health-Care Personnel

The health professionals (nursing staff, doctors) working in emergency situations should already be trained. At most, additional instructions regarding specific problems may be given.

Non-professional personnel can perform a certain number of medical tasks, as long as they have been trained to do them so. Training programs have been instituted in most situations involving displaced or refugee populations. This type of training provides the

basis for an effective teaching program for CHW. In these situations, training of CHWs to perform a certain number of curative tasks will be the focus for training programs for different health staff categories in this State. WHO, SMOH, UNICEF, and all International NGOs, local NGOs involved in the health services of West Darfur State should in a coordinated manner work hard in training the health staff in various levels and facilities on the main prevailing diseases in this state as well as the referral process, including the referral form, in order to improve and streamline the health services for the IDPs in this State. Health care staff at different levels should be clearly informed the health services available at each level of health facilities, particularly those services at rural hospitals (5) and the State Hospital at El Geneina. The current health services in West Darfur State are poor and continued medical education will in the long run strengthen this important and indispensable service to the people of this state.

Follow up of referred cases:

Once treatment is over, the attitude may be out of sight, out of mind! It is difficult to put together, at the very beginning of an action, a file system permitting proper patient follow up. This is an administrative task, which is often unpopular with the care giving personnel, whose priorities lie elsewhere. Nonetheless, keeping files allows changing medical teams to follow up patients. It is moreover, an essential element in the epidemiological monitoring of curative activities. Follow up is also important when a patient moves from one level of care to another (for example, a patient referred from a dispensary to hospital, or vice versa), and therefore should be an integral part of the referral system in West Darfur State health care services. Both the SMOH health staff, NGOs, and others involved in providing health services to the IDPs must follow up closely those IDPs patients that they referring to other health facilities. These referred patients must be provided with transport to and from the health facility to which they have been referred, because on several occasions, some patients who were referred to El Geneina hospital remained in the hospital for quite while after they were treated and discharged for lack of transportation to go back to their IDPs camps.

Health Facilities and staff in West Darfur as of July 30, 2004

• **Hospitals:**

3 operational: El Geneina (state), Zalingi (district), and Garcilla (rural)
3 not open yet: Kulbus (district), Forabaranga (rural), and Gulu (Jebel Mara-rural)
Kulbus hospital was attacked and all equipment and drugs were looted.

- **Health Centers:** covers a population of 15,000, located in a town and run by a Medical doctor or medical assistance and performs minor surgeries. 6 operational:
El Geneina- 3 (including the health Insurance Clinic)
Zalingi,
Garcilla,
Morni

- 2 not yet opened (constructed by Saudi donation, furniture and equipment available) at Habilla and Besida.
- **Dispensary:** 33. It covers population of 10,000, located in rural area and is run by a medical assistant.
 - **Dressing Station:** 90. It covers 4-5 PHC units (a population of 6,000-10,000) and is run by a nurse.
 - **Primary Health Care Unit:** 172
It covers a population of 1,500 to 2,000 and is run by a Community Health worker.

Health Personnel:

- Medical Doctors: 27
 - El Geneina: 15
 - Zalingi: 3
 - Garcilla: 2
 - Health Insurance: 5
 - Medair: 1
 - Habila: 1
 - Morni (Run by MSF-F): 6
- General Medical Assistant: 44 (hospital, health Center, and dispensary)
- Theatre attendant: 9
- Medical Assistants for Anesthetists: 3
- Laboratory Technicians: 3
- Nurses: 118 and 87 are currently under training
- Community Health workers: 166
- Health visitors: 11
- Assistant Health visitors: 4
- Midwives: 255
- Nutrition Officer: 1
- Nutrition Educator: 7
- Vaccination Technicians: 39
- Public Health Officer: 8
- Sanitary overseers: 21
- Assistant Sanitary overseers: 37

SECONDARY HEALTH CARE FACILITIES IN WEST DARFUR

August 3, 2004.

HOSPITAL	CURRENT SITUATION	GAP	IDPs	WHO PLAN
1. EL GENEINA State Hospital (Referral Hospital)	<ul style="list-style-type: none"> ▪ WHO rehabilitating and re-equipping the laboratory and blood bank. WHO is also rehabilitating the Gynecology, Medical and Women's surgical wards of the hospital. ▪ MSF-F: Rehabilitating Operation Theater, medical team, Pediatric ward –17 beds, therapeutic feeding center, and supplementary feeding center. Also has built the Incinerator, and provided a Generator. ▪ One surgeon (APW WHO contract), 3 Obstetric doctors and 15 Sudanese medical doctors ▪ MSF-Ch is rehabilitating men's Medical ward. 	More Medical Specialists are needed.	63,066	<ul style="list-style-type: none"> -WHO lab. And blood Bank to start within August -WHO is also Rehabilitating the Gynecology, Medical and Surgical wards for Women - Consumables to be delivered by WHO starting October. -Expanding the access to referral health care in West Darfur through budget and in kind support study, including user fees waiver study is ongoing -Collecting weekly both OPD and IPD data epidemiological reporting <ul style="list-style-type: none"> -1 Italian Trauma Kit -1 NEHK

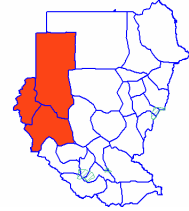
2. ZALLINGI Rural Hospital	<ul style="list-style-type: none"> ▪ ICRC has finished the physical rehabilitation ▪ ICRC has provided a surgical team, including the surgeon and the hospital is functioning ▪ There are 2 Sudanese Physicians and 3 midwives ▪ MSF-F is running a feeding center in the hospital. 	More Medical Specialist are needed	57,000	Assessment and follow up and provide: -1 Italian Trauma Kit -1 NEHK
3. GARSILLA Rural Hospital	<ul style="list-style-type: none"> ▪ MSF-H: Rehabilitated the hospital and signed MOU this week with SMOH to run the hospital. 1 international surgeon and 2 Sudanese Medical doctors. 22 nurses, 3 midwives, 1 lab technician, 1 sister. 	More Medical Specialist are needed	City: 120,000 IDPs camps 31,788	WHO will facilitate the signature of MOU -1 Italian Trauma Kit -1 NEHK
4. KULBUS Rural Hospital	<ul style="list-style-type: none"> ▪ Merlin agreed to be responsible for the overall running of Kulbus hospital ▪ Merlin is to bring medical team, a surgeon, medical equipments and supplies as needed. 	All services are currently not functional	8,524	WHO to facilitate signature of MOU, and supply with Cholera kit and other supplies as needed. -1 Italian Trauma Kit -1 NEHK
5. FUR BARANGA Rural Hospital	-MSF-CH has started working as of July in Habila awaiting the opening of Fur Baranga rural hospital	Currently non functional. IDPs are settled in the whole hospital premises	26, 124	-WHO to follow up and send a cholera kit (Habila), and for Fur Baranga rural hospital: -30 beds and their mattresses -1 Italian Trauma Kit -1 NEHK -2 tents for TFC in Habilla
6. GULU Rural	-SMOH to sign MOU with MSF-Spain	-1 Sudanese	32, 544	WHO has actively facilitated the signing

Hospital	on August 2, 2004. MSF- Spain will be fully responsible for the Gulu Hospital. Will be fully functional immediately. -Goal NGO is taking care of the Primary Health services in Gulu locality	medical doctor, 4 international medical doctors (gynecologist, Pediatrician, and Internal Medicine), and a Medical Coordinator		of the MOU between the Parties on August 2, 2004, and is closely following up the implementation phase. -WHO ready to provide -1 NEHK -1 Cholera
7. Morni Rural Hospital	-Built and run by MSF-F. The hospital is functioning.	-3 Sudanese medical doctor, 3 international Medical doctors	73,876	WHO has provided - 1 NEHK - 1 Cholera Kit (D and F) - 1 Trauma Kit B - 2 tones of 32 sq. meters of tents.

**WEST DARFUR STATE, MINISTRY OF HEALTH
TRANSFER/REFERRAL OF MEDICAL CASES**



To be completed in duplicate with reference hospital keeping the copy



Reference Number: _____

Clinic Camp: _____ Date of Transfer: _____

NGO/ Agency: _____ Time of Transfer: _____

Patients Name: _____ Age: _____ Sex: _____

Patients Address: _____

Name of Accompanying Person: _____

Reason for Transfer/Referral: _____

Treatment Already Received: _____

Name and Title of Person Referring: _____

PHC/ Hospital Name: _____ Date _____

Time of Arrival: _____

Initial Examination at Entry: _____

Initial Diagnosis: _____

Actions to be Taken: _____

Name and Title of Examiner: _____

Evaluation of the Referral (circle): Useful Not useful On time Late

Feedback:

Date of Report: _____ Date of Discharge: _____

Final Diagnosis: _____

Treatment Received: _____

Instructions and Follow-up: _____

Name of Doctor and Signature: _____ Stamp of the Hospital or Facility: _____

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