Using livelihoods to support primary health care for South Sudanese refugees in Kiryandongo, Uganda

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Introduction: Conflict in South Sudan has displaced 2.3 million people, of whom 789,098 (35%) have taken refuge in Uganda – a country that allows refugees to work, own property, start their own businesses and access public health services. In this context, refugees have identified livelihoods and primary health care as key priorities for their wellbeing.

Objective: Building on previous research in South Sudan and Uganda, the objective of our current work is exploring how income-generating livelihood activities and other interventions can be used to support primary health care for South Sudanese refugees in Kiryandongo District, Uganda.

Methods: We drew on existing secondary data and five scoping visits to the refugee settlements in Kiryandongo and northern Uganda to formulate our approach.

Results: In Kiryandongo District, primary health care and livelihoods can best be supported by an integrated combination of 1) providing standardised training to local Village Health Teams (VHTs); 2) helping organise VHTs into village savings and loan association groups; and 3) supporting VHTs with training to establish sustainable income-generating activities.

Conclusions: Integrated interventions that address income-generating activities for community health workers can meet the basic needs of front-line volunteer primary health care staff and better enable them to improve the health of their communities.

Keywords: primary health care, refugees, livelihoods, South Sudan, Uganda, Kiryandongo

INTRODUCTION

Renewed conflict in South Sudan has displaced 2.3 million people outside the country, of whom 789,098 (35%) have taken refuge in neighbouring Uganda (see Figure 1).[1] Eighty-two percent of South Sudanese refugees are women and children.[2] With increasing barriers to operating within the country due to ongoing instability, some organisations supporting primary health care in South Sudan have also turned to exploring how South Sudanese refugees in neighbouring countries can be assisted.

As action researchers with personal interests in South Sudan, we have worked to generate practical knowledge that can best contribute to both scholarly understanding and actionable implementation. Prior to our current work with South Sudanese refugees, we had collaborated with BRAC South Sudan (a non-governmental organisation) and the South Sudan Physicians Organization to explore how social enterprise income-generating activities can support primary health care via community health workers.[3] These experiments, funded by Grand Challenges Canada and in partnership with the South Sudanese Ministry of Health, included micro-franchising models, fixed and mobile clinics, and mobile health (mHealth) applications designed to improve maternal and child health.[4, 5] This exploratory work was leveraged and extended with additional funding from the International Development Research Centre, the Canadian Institutes of Health Research and Global Affairs Canada under their Innovating for Maternal and Child Health in Africa initiative.[6] This follow-on work is utilising a randomised controlled trial (RCT) methodology to understand the

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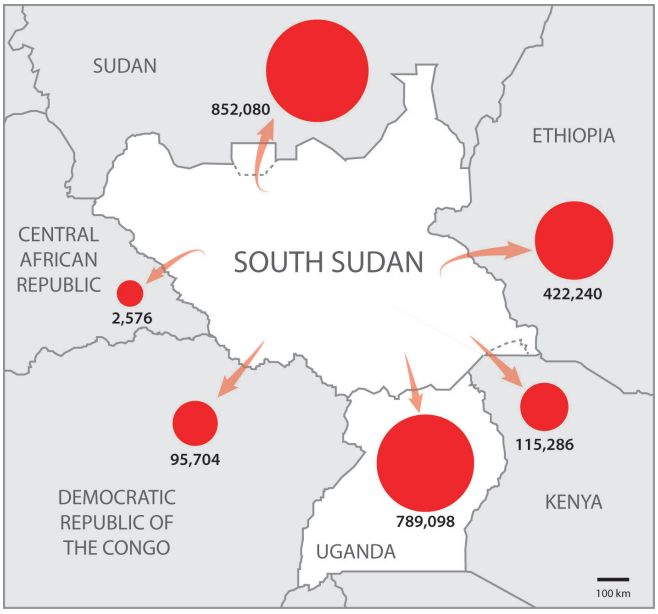

Figure 1. Numbers of South Sudanese refugees in neighbouring countries

most cost-effective ways to motivate and incentivise community health workers to improve primary maternal and child health care in both South Sudan and Uganda.

While undertaking this research it became increasingly challenging to implement a large-scale RCT in South Sudan due to the high levels of population displacement. Whereas the Ugandan portion of the RCT is ongoing, we began to explore ways to support South Sudanese refugees outside the country. The purpose of this most recent work, which was funded with an additional grant from Grand Challenges Canada, was to assess the health and livelihoods needs of South Sudanese refugees in the Kiryandongo settlement camp in Uganda and develop a plan for further implementation and learning.

South Sudanese Refugees

Between March and October 2018, the Office of the Prime Minister (OPM) of Uganda, in collaboration with UNCHR and the World Food Programme (WFP), undertook a biometric verification process of all refugees in the country.[7] Uganda is hosting a total of over 1.1 million refugees, with 66% originating from South Sudan, 26% originating from the Democratic Republic of the Congo, and the remaining refugees originating from Burundi, Somalia, Rwanda and other countries in the region.[8] Notwithstanding the South Sudanese peace and power-sharing agreements signed in 2018, UNHCR estimates that Uganda is likely to be hosting over 1 million South Sudanese refugees by the end of 2020 as the refugee influx is expected to continue due to the economic collapse and war in many parts of the country.[9]

The conflicts in South Sudan have also internally displaced an estimated 1.5 million people, meaning that one in three South Sudanese have been forced to migrate either inside or outside the country because of the conflict.[10, 11] South Sudan is generating Africa's largest refugee crisis, which has surpassed that associated with the Rwandan genocide.[11]

Refugees in Uganda

Uganda is the third largest refugee-hosting country in the world after Turkey, which is hosting an estimated 3.5 million refugees from Syria, and Pakistan, hosting 1.4 million refugees from Afghanistan.[12]

Unlike many other refugee-hosting nations, Uganda's policies toward refugees are relatively progressive. As embodied in the 2006 Refugees Act, the 2010 Refugees Regulations and the 2017 Comprehensive Refugee Response Framework, Uganda accepts all refugees regardless of country of origin or ethnic affiliation and allows them the right to work, establish a business, hold private property and move freely around the country, as well as the right to access basic public services, including education and health care.[13] South Sudanese (and Congolese) asylum seekers are granted refugee status on a prima facie basis, with refugees from other countries being required to undergo an interview and refugee determination process.[9] Uganda pursues a non-encampment policy so that refugees are provided with a plot of land for housing and cultivation and can settle alongside and integrate into existing Ugandan host communities.

In 2018, the government began including refugee issues into national and local development plans for the first time.[9] In 2019, the Ugandan government launched the Health Sector Integrated Refugee Response Plan (HSIRRP) to create equitable and well-coordinated opportunities for health services for both refugees and their host communities.[14] The HSIRRP confirms Uganda's commitment to the 2016 New York Declaration on Refugees and Migrants, the Global Compact on Refugees, and the Comprehensive Refugee Response Framework, which urge countries to stand in solidarity with refugees and share the burden of mass forced human displacement.[15]

Uganda currently hosts refugees in 11 settlements. South Sudanese refugees are primarily located in Adjumani, Yumbe, Arua, Moyo and Kiryandongo Districts (see Figure 2). Our work is based primarily in the Kiryandongo refugee settlement, which we chose because of its long history in accommodating South Sudanese refugees and its accessibility from Kampala, the capital of Uganda, and Gulu, the largest city in northern Uganda.

METHODOLOGY

Still in the early stages of our project activities, our results are based on existing secondary data sources, and informal interactions and consultations with a wide variety of stakeholders including health workers, refugees,

non-governmental organisations, church groups, and representatives from UNCHR and the OPM. During the consultations we focused on gathering background information on how best to implement health and livelihood activities among refugees and their host communities. As such, no primary research data about health and livelihoods has yet been formally gathered. One or both authors visited the Numanzi and Agojo refugee settlements in Adjumani District in April 2017 (3 days) and the Kiryandongo refugee settlement in April 2018 (10 days), July 2018 (10 days), October 2018 (3 days) and December 2018 (12 days).

RESULTS

Kiryandongo Refugee Settlement

The Kiryandongo refugee settlement comprises 54,977 refugees (approximately 10,000 households). The settlement is located on 27 square miles of land adjacent to the town of Bweyale in Kiryandongo District near the major highway that runs from Kampala to Gulu (see Figure 3).[8] The Kiryandongo area had previously been a resettlement area for refugees fleeing the Mau Mau conflict in Kenya in 1950s.[16] Subsequently the region became part of a cattle ranching area created by the Idi Amin government. This legacy lives on in the names of the three sections of the camp (Figure 3). The area was then re-assigned by the current government in the 1990s to settle members of the Sudanese People's Liberation Army (SPLA) who had fled across the Ugandan border from Parajok in Torit. By 1992, the allocation of plots of land was initiated and families began to build homes and plant crops.[16] The camp was then closed to new refugees in 1995. The settlement was reopened in 2014 to accommodate the huge influx of refugees fleeing the 2013 conflict in South Sudan. Like all refugee settlements in Uganda, Kiryandongo is governed by the OPM and UNHCR. Twenty-two additional multilateral and non-governmental organisations also support refugees in the settlement.

Host Communities

The Kiryandongo District of Uganda has a population of approximately 317,500. The area is poorer than the national average, with the majority of households (80%) earning their livelihood from subsistence farming (although 91% have other non-agricultural household-based enterprises).[17] Forty-two percent of adults over 18 years are illiterate and only 12.5% have access to electricity; 23% of households are more than 5 km from a public or private health facility.[17]

In Kiryandongo, as in other refugee settlements in Uganda, the OPM, UNHCR, the Food and Agriculture Organization (FAO) and non-governmental organisations provide basic services such as security, clean water and food

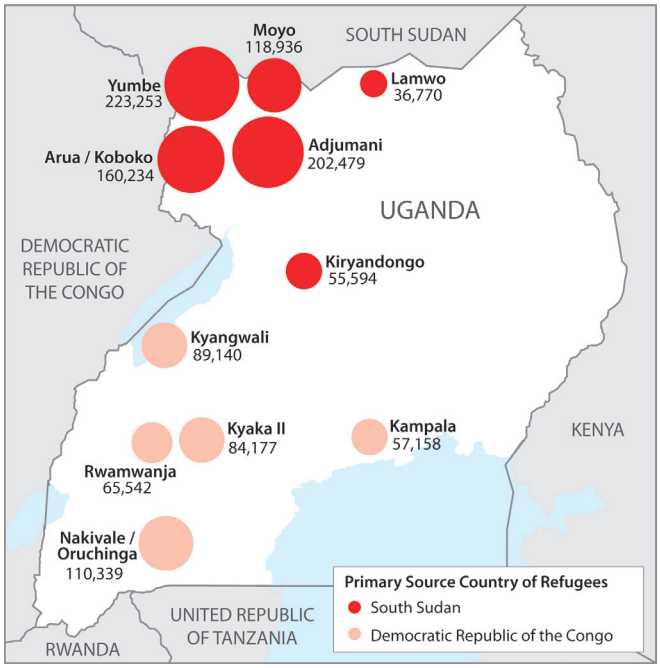

Figure 2. Refugee Settlements in Uganda with population sizes

to newly arrived refugees. Health facilities and schools are also located in the settlements. In poor districts this can result in refugees receiving better health, education, and security services than residents of local Ugandan host communities. As a result of this potential for inequities, the Ugandan government requires any refugee support programmes and activities by non-governmental organisations to allocate a minimum of 30% of support for local host communities. All health facilities and schools established in the refugee settlement must also be accessible to host community members.

Primary Health Care

Uganda has a decentralised health care system consisting of both public and private sectors. Refugees fall under public government health services, which is organised according to six different levels: national, district, county, sub-county, parish and village. In Kiryandongo District there is a General Hospital which is classified as a Health Centre 4. The refugee settlement has one Health Centre 3 facility, called the Panyadoli Health Centre, and two Health Centre 2 facilities, called Nyakadoti and Panyadoli Hills. The three health centres in the settlement serve both refugees and host community members. However, government funding is limited with medications regularly out of stock and the Ministry of Health often relying on NGOs and donors for support. In the Kiryandongo settlement, the Real Medicine Foundation (an NGO), with the assistance of UNHCR, has been actively supporting health care among refugees and their host communities. Serious health cases are referred to Kiryandongo or Gulu General Hospitals, which are outside the settlement.

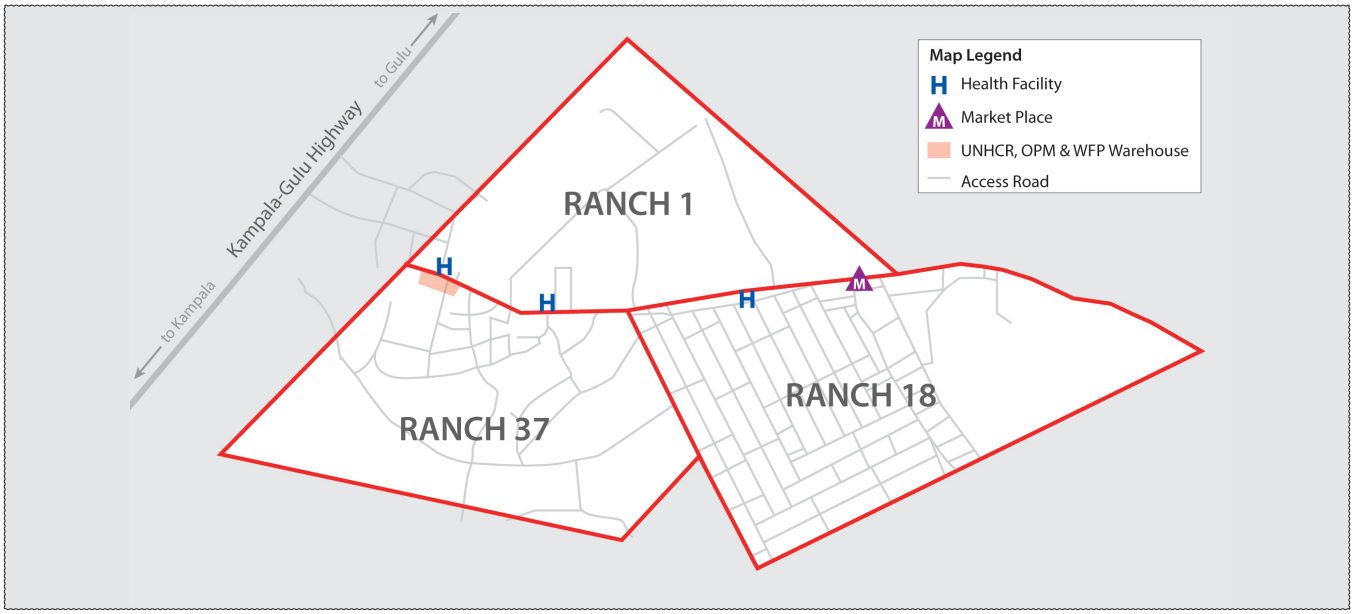

Figure 3. Kiryandongo Refugee Settlement

Currently, the provision of primary health care in the refugee settlement and surrounding host community is aided by government community health workers called Village Health Teams (VHTs). The VHTs are managed by the District Health Office (DHO), which is under the Ministry of Health. VHTs are volunteers who have received some very basic health training to promote primary health care in their communities. VHTs visit households and act as resource persons for disease surveillance, identification and education on hygiene, sanitation and other health issues. Existing evidence on community health workers like VHTs shows that, if properly trained, coordinated and incentivised, they can reduce neonatal and childhood mortality, maternal and child undernutrition, maternal mortality, the spread of HIV/AIDS, and mortality and illness due to malaria and TB. [18] There are approximately 138 VHTs within the Kiryandongo settlement and 62 in the surrounding host communities. On average, each VHT serves about 60 households (approximately 300 people) although some VHTs can serve up to 200 households (even though the government guideline is 25 households). The training of VHTs is not standardised as different VHTs may have received different trainings at different times from different NGOs. For example, only 60 of the 200 local VHTs have received the two-week generic training in primary health care (the World Health Organization's Integrated Community Case Management (ICCM) training), which is the basic standard. In addition to insufficient and inconsistent training, VHTs face the challenges of the health system not having access to drugs to treat community members and limited opportunities to generate income. VHTs also highlighted the need for additional training to identify and refer mental health cases.

Livelihoods

In the annual survey conducted by UNHCR in Kiryandongo, refugees identified opportunities for livelihoods and income-generating activities as their most important priority. Despite Uganda's progressive policies towards allowing refugees to start a business, own property and seek employment, at least 80% of Uganda's refugees live below the international poverty line of US$1.90 per day.[18] A 2018 survey found that refugee households tended to be less resilient than local host community households due to limited diversification of income sources, limited productive assets and the limited variety of crops cultivated.[18] Agriculture is the most common livelihood activity for refugees (38%). Although 97% of host community households and 95% of refugee households in northern Uganda were engaged in agriculture, only 45% of host community households and 22% of refugee households sold part of their production.[18] Other challenges to agricultural production among both refugees and host community members are low levels of productivity and access to animal health services, and high levels of post-harvest losses and crop diseases.[18] For non-agricultural livelihoods activities, barriers included the lack of training, credit and business support services. Refugees also reported the lack of social networks as an impediment to their livelihood and income-generating activities.

STRATEGIC INTERVENTIONS

Given our knowledge of the primary health care situation in the Kiryandongo settlement and the priority that South Sudanese refugees placed on income-generating activities and livelihoods, we have put forward a plan to address these priority needs. This approach has three pillars: 1)

training VHTs; 2) engaging VHTs and other refugees in savings and loans groups; and 3) providing training and support to allow refugees with existing skills to establish sustainable income-generating activities. Each pillar is described in turn.

1. Training Health Workers: Strengthening Primary Care

Interactions with existing VHTs and representatives from the DHO showed that providing standardised ICCM training to all VHTs who served the settlement and surrounding communities would make the greatest contribution toward primary health care. [19] This is based on the evidence that access to health care services can contribute to generally better population health outcomes. [19]

Delivering standardized ICCM training in the settlement would require coordination with the DHO as well as collaboration with the Real Medicine Foundation. Training would typically be accompanied by the provision of kits of medicines which would be approved by the DHO. UNHCR and the government do not allow the sale of medical items to refugees within the boundaries of the settlement, so if refugees have money to purchase medicines that are not available in the settlement, they currently go to private pharmacies just outside, in Bweyale.

2. Savings and Loans Groups: Building Financial and Social Capital

Livelihoods and income-generating activities were identified as a high priority activity by refugees and VHTs. The second pillar of support would be to mobilise VHTs and other refugee and host community members into village savings and loan association (VSLA) groups. VSLA groups comprise a group of 15–20 people who come together on their own or are mobilised by a support organization such as an NGO. To be included in a group, individuals need to demonstrate an intention and ability to work for themselves and their group. They receive training on group dynamics and financial literacy, how to organise, register and run the group, and a lockable metal savings box and a ledger for keeping track of savings deposited and loans taken by group members. The group may also receive some additional start-up capital or in-kind donations (goats, pigs, animal sheds, sewing machines, etc.). The group elects officers and meets regularly to collect savings and disburse loans as well as receiving additional refresher training from time to time. This approach is based on the principles of asset-based community development, which starts by considering resources available (rather than starting from considering unmet needs) and recognises the importance of social capital as an asset that can be leveraged and further developed.[20] Within the Kiryandongo settlement, the NGO BRAC was beginning a pilot project to organise VSLA groups.

After training in running a VSLA group, each group identifies a particular livelihood activity that they would like to pursue. For example options possible in the Kiryandongo settlement are:

- Agriculture (crops): Maize, tomatoes, cassava, mushrooms, aubergines, okra, chia, cabbage, watermelon, sukumawiki (collard greens), kale, spinach
- Agriculture (livestock): Pigs, chickens, goats
- Agriculture processing: Milling
- Leatherwork: Shoes, sandals, belts, bags
- Paper products: Bags, cards, baskets, mats, trays
- Baked goods: Breads, cakes
- Fibre products: Banana fibre baskets, bark cloth mats
- Cosmetics and detergents: Creams, liquid and solid soaps, shampoo
- Clothing and accessories: Sewn cloths, knitted products, beading, table cloths, bed sheets, reusable sanitary pads
- Retail: Shops, kiosks and stands
- Services: Hairdressing, restaurants, construction, tailoring

After selecting an activity, each group would receive specialised training in that area (e.g. tailoring, pig rearing, etc.) as well as ongoing supervision, technical assistance and market linkages where available. Groups can graduate to financial self-sustainability with ongoing supervision and oversight. The VSLA groups can use their savings to purchase needed supplies for their activities (e.g. animal feed, cloth, etc.), with profits from sales returning to the savings pool.

3. Training: Supporting Existing Skills

Some South Sudanese refugees entering the Ugandan settlements come with a variety of existing skills and previous experience in agriculture, trading or production. These refugees may benefit most from some additional supplemental training (in tailoring or agricultural production for example) and from opportunities to join existing VSLA groups that are also interested in such kinds of livelihood activities. Existing skilled refugees may also benefit from access to capital and establishing linkages for them to sell their products in local marketplaces.

CONCLUSION

Recent conflict has displaced one in three people in South Sudan, with Uganda expected to host over one million South Sudanese refugees by 2020. With

Uganda's progressive refugee policies, we can look beyond humanitarian aid to view refugees as economic actors who can contribute to their own livelihoods and wellbeing. Refugees have identified livelihoods and income-generating activities as their most important priority along with an ongoing need for primary health care.

We explored opportunities for how health and livelihoods could be mutually supported using existing data and five scoping visits to refugee settlements in Uganda. We found that three strategic and mutually supporting interventions that could make the greatest difference were training of health workers, supporting existing skills and building social capital through savings and loans.

These interventions are currently being explored to further test these assumptions and learn more about how primary health care, livelihoods and peaceful co-existence between refugee and host communities can best be supported.

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