PRIMARY HEALTH CARE
HOLY TRINITY PEACE VILLAGE

IMPACTS – CHALLENGES

"Those who are well do not need a physician, but the sick do" (Mt 9:12)

Figure 1 Primary Health Centre Main Building

Beginning in early 2006, a Primary Health Care Centre, PHCC, was established in Holy Trinity Peace Village – Kuron to serve the people of the area. There were two staff and they met under a tree outside the Village compound. Every morning they carried their boxes of medicines out to the tree, set up chairs and a small table and treated whoever would come. Humble beginnings indeed. The nearest centre would be found in Namurapus some two and a half hour drive.

Within two years, the PHCC was moved to Matara and established itself as the only institution for health for over 100 kilometers. The Fr. Matthew Haumman Matara Primary Health Centre Centre in Matara was officially inaugurated in early 2009. Over the past decade, this Centre has served thousands of local Toposa, HTPVK staff, and visitors with out-patient consults, lab tests, pharmacy, nutrition, maternal and child health, outreach, vaccinations and in-patient services. Most in patients are children.

Vaccination programs are facilitated and managed by the Ministry of Health MOH who hire their own staff to come to Matara and go out to the villages for vaccinations. The records are kept at the Health Centre.

In 2014, UNICEF assisted in the construction of a Maternity Ward. Join Good Forces funded the Gender Based Violence Building, Kitchen, and Bathrooms. Mercy Beyond Borders put in the Water Pump system and hookups to the PHCC. At this time, solar power, Internet and Dish TV service were also added. Also, in 2015 a borehole was drilled by Jamus Construction for the Matara Nursery, VTC, and Health Center. The first Medical Doctor arrived in October.2016. The doctor started a Water and Sanitation for Health program (WASH) in January 2017 but due to accountability issues it was closed within one year.

Also, in 2017, there was a security problem when youth armed with knives entered the compound around 8:00pm and looted the food stores. The Elders of the surrounding communities were ashamed of this. They castigated the youth that this is "our centre" and they shouldn't be doing this. Hon. Titus Lokwachuma got involved as he is on the Board. He came all the way from Narus and forced the youth to pay a fine of around seven bulls. With this, the centre was able to purchase maize for those patients who came to the PHCC. The people then took full responsibility to guard that maize until it was distributed. This event had the positive effect of increasing a sense of ownership amongst the local people. Many people commented: *"This centre belongs to us."*

Figure 2 Outreach to villages

In that same year, a 2-room staff house was built on the Health Centre premises to replace the existing mud hut housing. Unfortunately, in 2017 the ambulance supplied from the Nederlands was broken and to date has not been repaired. The Carter Centre next to the PHCC evacuated their site in October of 2019 and signed the structures over to HTPVK who uses those structures for staff housing.

Figure 3 Dispensary and recording of medicines

At one point in the past, there were only three staff. At another point, there was a husband/wife couple who stayed about one year. Another Norwegian lady also came for some time. A Catholic Sister was with the Centre for some 5 years and she was very active in funding and organizing the centre. In 2021, the PHCC is currently staffed by: 1 Clinical Physician (staff paid by MOH but supplemented by HTPVK), 3 Nurses, 2 Midwives, 1 Lab Technician, supported by several staff. There is no assigned transport to the PHCC which makes referrals to Kapoeta difficult.

Initially, drugs and supplies would come through UNICEF and small NGO partners would supply various other drugs to compliment the orders. In the early days, an American NGO called American Refugee Committee supplied drugs to the centre. After that a national NGO called CMD was doing this. Then Comitato Collaborazione Medica, CCM, was assisting with drug supply. Presently, all drugs and supplies are to be provided by the MOH through County Health Department but at times the chain is broken due to logistical difficulties. The order goes through the MOH in Juba who ships to Kapoeta CHD, and they are delivered from there to Matara Health Centre by CCM. This system is less than ideal as it allows a lot of hands to touch the most desired drugs for black market as well as this delivery system takes time. Recently, in 2021 there are delays, lack of communication, and even no drug shipments at all. This curtails the programs in Matara.

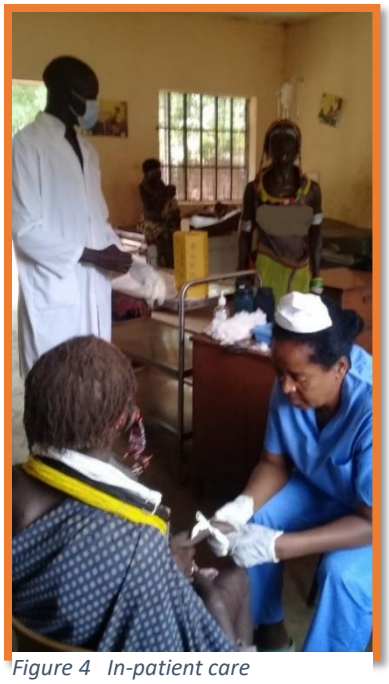

Figure 4 In-patient care

CCM is also providing salary incentives to the staff working in the PHCC through the Health Pooled Fund. They sometimes also recruit staff to work in Matara. Andrea Foods of South Sudan, AFSS, operates a Nutritional Assessment and Supplement program throughout the year out of the centre.

Today, the centre is one of the busiest and active programs in the entire Holy Trinity Peace Village area. It is open 24 hours, seven days a week. Staff are on call day and night. The farthest that a person ever came was from Kapoeta (8 hours drive away). This would have been a nomadic animal herder.

Figure 5 Checking during Out-patient care

HPTVK has sent one Toposa male on scholarship to Community Health Training Institute in Wau for a 3 year Nurse course. Amvelio Latabo is a home grown nursery and primary student from Kuron area. He will graduate and return in April.2022. Another male is also studying in Torit._Daniel Lokwar has also attended nursery, and primary school here in Kuron and after graduating from Secondary School in Narus he is now on scholarship in Torit for Clinical Officer training. He should rejoin the Health Centre sometime in 2023

For the first time the lab is able to do Tuberculosis testing. CORDAID has sponsored the program through the MOH. In October.2021, 4 positive cases were registered. The frustration is that there is no isolation building and the facility cannot keep patients with TB long enough to treat the disease.

Figure 6 Patients attending at the PHCC

IMPACTS OF THE PHCC

In the past four years the Centre has not registered many child deaths at the Health Centre itself. It is not known how many are dying in the villages. People do bring their children late to the Centre and then it is difficult to treat them. However, staff have seen fewer children have died in the vulnerable years of 0 to 5. More children are covered with vaccinations then ten years ago.

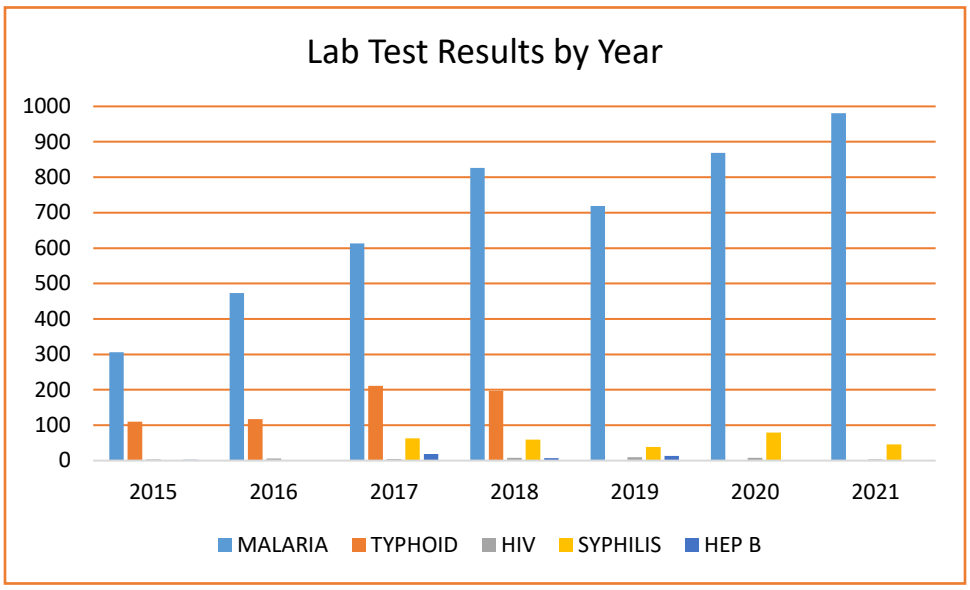

Figure 7 Lab Technicians testing samples

As one sees from the above chart, MALARIA is by far the most seen and treated disease. TYPHOID comes second and the rest drop off considerably. Disease such as HIV and TB are most difficult to treat as there are no proper medicines and the patients are nomadic and won't stay to complete the course.

The argument could be made that the PHCC program is the most attended and beneficial in the entire Kuron Peace Village Program. Health has improved for those who avail themselves of the services. Even though the local people continue to rely upon traditional methods of treatment and superstitions abound, more and more people are coming to the centre.

CHALLENGES

The compound does not have a vehicle. It was broken in 2017 and it was unable to be repaired. In extreme cases, the clinical staff are unable to mobilize a vehicle to take someone to Kapoeta. Take the case of a man whose leg was shot and needed to be amputated as infection was setting in. The staff were helpless in trying to treat him in Matara. In the case of a woman who had a complicated birth, she and her baby died because the type of care she needed was not available and there was no transport to Kapoeta. This is frustrating to those who know with better care these lives could have been saved.

Challenges from APRIL 2017 HTPVK Board minutes

PHCC has the following challenges and needs:

o Funding of "top up" of salaries.

o 4 new batteries for the solar system.

o A reliable water supply.

o When sufficient water supply is established, a shower for patients should be constructed and installed.

o There is a need for additional rooms for staff accommodation.

o A new maternity ward was constructed a couple of year back. Due to lack of funding it is still not taken into use. The building is located across the road, outside the fence of FHC. The fenced area should be extended to include the maternity ward, and also the building made for outreach programs.

o In addition to this, the staffs' accommodation area should be separated from the area for patients and treatment.

O PHCC has its own internet connection via satellite. There is a need to find funding for continuous Internet connection.

The funding for maintenance and up keep of the PHCC is very limited. A multi-year funding cycle would be much more conducive to working on a planned and strategic basis. Staff are living on the compound and as such do not have any privacy. This has been noted in several minutes but the problems still exist.

Figure 8 Out Patient registration

All data and statistics are recorded on paper. There is very little in the way of putting statistics on computer. All the records from 2012 to 2016 were destroyed by a doctor working at the Centre at that time. Other records were subsequently destroyed by a Clinical Officer who remarked that they were not needed any more. This makes it difficult in finding patterns of disease over time. Many of those records are lost forever.

There was never any extensive base line data survey done before the PHCC was opened. In June.2014, UNICEF funded a survey of seven villages and then an outreach program was formed for those seven villages. This lasted only one year as there were serious accountability issues which led to the closing of the program.

Figure 9 Maternal and Child Health Class

Currently, there is not very much base line data. Health Centre records are incomplete. Follow-up on cases in the villages is difficult as Toposa are constantly moving. It is not known how many of the patients seen in the centre might die in the village at a later time. Migration, lack of communication, and difficulty with cultural norms preclude collecting accurate and timely data. (Once a person dies, Toposa typically will not refer to that person anymore in conversation. Any enquiries about what might have happened to that person would receive vague, round-about and misleading answers.)

Presently, there is no charge for health services. As the local people become more used to the service and see the benefits, perhaps in the future a small fee could be charged to recuperate some of the costs.
Traditional ways of thinking take time to change. In the short few years of the existence of the PHCC some of the people have changed some of their perceptions in a positive way. Many Toposa still continue with the old ways but the youth are more and more convinced to change and accept new practises.

The Toposa are a semi-nomadic people. This means they move according to the season. So in the case of treatment for diseases that require a long period, it is very difficult to capture the patient and ensure they not only follow the proper guidelines for treatment, but also take the treatment to the end. This is one reason In-patient numbers are high for malaria. Patients are kept in the Centre until the treatments are finished to reduce the risk of them stopping the treatment when they feel better.

There are problems with people bringing the sick too late and therefore making treatment more difficult. The Toposa must be convinced to bring in the sick earlier for better care. What is worrying is that malaria cases

have actually risen over the past several years. There are mosquito nets being used in the villages but mostly this is for men. They make the wives and children sleep outside.

Figure 10 Out patient Equipment

Traditional medicine healers in this area have had strong influence on the historical treatment of illness. These so called "Namuron" (the closest translation to English is witch doctor) had sway over the people and were quite powerful. The presence of a modern medicine centre threatens them and their income. However, the people themselves, are becoming frustrated that they spend so much money and time and yet nothing changes in their sickness. Many times the first thing PHCC staff have to do is wash the animal feces off the person who has come from the Namuron who did this to them.

Today, some of the Namuron are coming to the centre for treatment and this is a great positive testimony to the efficacy of the centre. Not all traditional medicine is bad and the PHCC staff are frequently in communication with and working with the Namuron. This greatly increases respect of all parties and cooperation improves.

Many mothers continue to bring their children after waiting too long. A good number of mothers are severely anemic and this affects the placenta which leads to still births and even the mother dies.

Women prefer to birth in the communities and are hesitant to come to the centre. However, after the birth, the Mother and Child Health, MCH, programs are well attended. The women appreciate the information and suggestions of the Health Centre staff.

Witch medicine is still sometimes preferred over the centre treatment

Figure 11 Clinical Officer consults with Mother

Funding of the program has always been a concern. There was a certain Sr. Angela who was the driving force behind fund raising in the past. When she left the funding was reduced a great deal. Several entities will fund parts and pieces but no one donor has recently funded all aspects, including the salaries, which are so vital to maintaining the qualified staff. Without on-going and reliable funding the structures cannot be maintained nor can new structures be constructed as needed.

No sooner was the Maternal Child Health Care building finished when a freak wind tore off the roof and it now sits abandoned, never used. This was a blow to the MCH program which was scheduled to become an integral part of the over-all services. Most of the patients are women with children and they needed a place where treatment, deliveries, education, and special care could be given.

If the mothers come from far, they have to stay in the Health Centre according to the treatment requirements. They cannot bring enough food with them. If there is no food they will leave and the treatment is not completed. If there would be a supply of food which the Health Centre could provide it would help these women. However, the program would have to be careful as if word got out there was "free" food at the Health Centre then every woman around would come and stay.

LESSONS LEARNED

(What worked well and what didn't work well)

A constant and consistent dialogue needs to be kept going at all times with the community. To this end, the outreach programs are not just about recruiting patients to the PHCC but also to help them understand the positive approaches to modern medicine. There are also presentations given at the centre from time to time on personal health. Each staff member is a tutor and is constantly telling people how to properly take care of their children and themselves. The main diseases like malaria and diarrhea are the focus because if you give too much information on too many topics people tend to forget.

Figure 12 Nurse checks baby eyes

The lifestyle of the Toposa (pastoralist/semi-nomadic) means outreach programs are the most advisable and effective. However, these are also expensive, require solid planning and cooperation, and would entail a larger staff to handle such a program.

Figure 13 Food Supplement Program

Food supplements in this area of nutritional deficits are an important addition to the caloric intact but also to capture people for education and awareness raising. They come for the food and then are given some lessons on health. There was an NGO that gave out a lot of supplies in order to make the mothers come to the centre to give birth. Currently, PHCC does not do this preferring them to come out of their own will.

Outreach programs are essential to take health care to the communities who have difficulty traveling to the centre. This also allows staff to find cases needing attention, which no one knows about: disabilities, elderly, abandoned people.

Respect is gained by proving the value and effectiveness of the treatment protocols. Most patients are under educated and don't realize the advantages of modern medicine. Each person has to be treated with respect and honor in accordance with the cultural norms. Women especially, need to be motivated to gain health for their children through constant and regular health check ups.

Any funding which comes should be monitored at the Health Centre instead of the management office. There are too many experiences of the funds being lost or used somewhere else in the past. If a person at the Health Centre could be responsible for these funds, it would be better.

Figure 14 Cleaning the facilities

High tech equipment required advanced knowledge, heavy and constant power and regular maintenance should not be sent to this Centre. Perhaps in the future but for now simply to serve the public with basic necessary and in demand services is enough. Of course, the road is an obstacle to getting rapid first-rate service but as it is this is the best health care for hundreds of kilometers. If a Doctor could be assigned to this Centre to raise the status to Clinic, that would help tremendously.

COMMENTS:

Several patient's comments condensed together: "*Before our children were dying like nothing. Now when we bring them here most of the time they live. This is a good place. Our children live here not die. The food [extra] is what we need."*

From woman patient: *"Why does the Namuron (witch doctor) come to the Health Centre for treatment? He is just eating my money with no result. Even HE believes this place [the PHCC] is better!"*

(Sources: staff interviews, documents, meetings, reports, field research and other sources, then edited by Gabe Hurrish: 25.Oct. to 05.Nov..2021)