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COMMENTARY

Running an ETU in a newly established IDP camp in Sri Lanka

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Large numbers of internally displaced people (IDPs) have been a problem in northern and eastern provinces of Sri Lanka for several years as a result of the long-running conflict between government forces and the Liberation Tigers of the Tamil Élan (LTTE). The authors worked in a field health centre set up inside a camp where IDPs who had fled intense conflict between government forces and the LTTE in May 2009, which resulted in the defeat of the LTTE, had settled. There, the patients, resources and organizing structure were quite different than what we have seen in a typical Emergency Treatment Unit (ETU). While working at the ETU of this health centre, we encountered several common health conditions. Some of them were typical and related to the displaced and disorganized lifestyles in the camp and previous places where people had lived during the war. These conditions included diarrhoeal diseases, acute asthma, acute gastritis, septicaemia, hypoglycaemia, hyperglycaemia, hypertension and seizures. The physical and human resources were not optimal in the field health centre where we worked, which provided services for about 52,000 IDPs. We faced a number of challenges in running this ETU due to the disorganized conditions, and lack of staff and equipment. The ETU did not have proper monitoring and investigation facilities for the patients, and we relied on translators which led to misunderstanding, misdiagnosing and privacy issues. This experience leads us to review the duties of a doctor in this type of critical situation with limited physical resources, lack of other health care workers, overcrowding and different administrative restrictions. While working for the maximum benefit and comfort of our patients, we had to adhere to some nonstandard medical practices, as well as respecting the security of the country. We propose that these health and administrative problems identified were unique to this structure, and that our experiences will be beneficial for health administrators as well as health professionals in planning and implementing the health services in a similar environment in the future.

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Introduction

Internally Displaced People (IDPs) are defined as people or groups of people who have been forced or obliged to flee or to leave their homes or places of habitual residence and who have not crossed an internationally recognized state border[1]. Large numbers of IDPs have been living in the northern and eastern provinces of Sri Lanka for several years due to the long-running civil war. At the beginning of 2006, nearly 325,000 people were displaced within Sri Lanka[2], and about 171,000 IDPs fled the conflict zone during April 2009 as a result of the escalated conflict[3].

Most of the problems related to IDPs in Sri Lanka have been discussed from a mainly political perspective. However, health problems related to IDP have not been discussed sufficiently by health professionals and academics in Sri Lanka or internationally. Identification of those problems, planning and early remedies are important to relieve them medically.

The authors, both medical doctors, worked as members of a voluntary health team inside an IDP camp in the early part of May 2009. The camp was located in Zone 2 of the Manik Farm area in Vavuniya district in the northern part of Sri Lanka. By the time we arrived to work there, IDPs had been settled at the camp for about 7 to 12 days. Most of them had crossed to 'cleared' areas (areas declared free of Liberation Tigers of the Tamil Élan (LTTE) fighters by the Sri Lankan Army) a few days previously, and had been transported by buses to this camp. The field health centre we worked consisted of an Out Patient Department (OPD), Emergency Treatment Unit (ETU), room for minor surgical procedures, and maternal and childcare units. At the beginning, the field health centre was highly disorganized, but conditions did gradually improve and the number of patients slowly reduced. During our time working in the ETU, we encountered many common health problems, which can be related to the conditions of displacement and chaotic life due to war. We will discuss these in greater details below, as well as identify some of the challenges we faced working in the ETU.

Health problems

Diarrhoeal diseases

Diarrhoeal diseases were common among IDPs due to overcrowding, poor sanitation, and unhygienic food. The source of water for IDPs were tanks which were filled with water transported by browsers from different places. The IDPs used common toilets without running water in the camps. Scarcity and the poor quality of water provided may have contributed to the extent of the rapid spread of diarrhoeal diseases. Patients presented with dehydration due to diarrhoea and vomiting for several days. Children were often in much poorer condition and many presented with

hypovolaemic shock. Management was entirely based on clinical features, and patients were treated with intravenous (IV) fluids, antiemitics and antibiotics – however, the availability of antiemitics and antibiotics were limited.

Acute asthma

Acute asthma was another common presentation. The dry and dusty environment in the camp induced respiratory tract infections and asthma. Some of the patients before displacement had been able to access medications and regular hospital follow up, but these had been lost due to displacement and war. Although some had inhaled drug delivery devices, many drugs were not available for months. Initially, a nebulizer was not available in the ETU, therefore acute asthma was managed with prednisolone and oral antibiotics and the patient then transferred to the nearby Chettikulam District Hospital (CDH). A nebulizer was received a short while after our arrival, along with other necessary IV drugs. Following this, management was much easier and we transferred only a few asthmatic patients to the CDH.

Acute attack of gastritis

This was a common presentation of IDP possibly due to prolonged periods of lack of food and under-nutrition and malnutrition. Patients presented with epigastric pain which was initially difficult to differentiate from myocardial infarction (MI) as ECG facilities were not available. When an MI was suspected IDPs were transferred to CDH. The necessary IV drugs and tablets such as omeprazole were not available for the acute management of gastritis most of the time, therefore the patients were treated only with medications such as famotidine and aluminium hydroxide.

Septicaemia

Respiratory tract infections, diarrhoeal diseases and skin infections were common among IDPs. Some of them had travelled for long distances in tough weather conditions. Some people had walked through deep water for a considerable distance before being transported in crowded vehicles to the relative safety of the camp. All these factors contributed to the transmission of infections. The unhealthy environment and lack of medical facilities for a long period may also have contributed to the outbreak of infections. Some patients had been living with infections for days when they presented to field clinics. Since we did not have facilities to culture blood samples, and had very few IV antibiotics, most patients

suspected of having septicaemia were transferred to CDH or Vavuniya General Hospital (VGH). One elderly patient who was suspected of having septicaemia unfortunately died while being treated in the ETU.

Hypo/hyperglycaemia

Patients diagnosed with diabetes mellitus presented with both hypo- and hyperglycaemia. Considerable numbers of people living in the camp were without their family members – many were in other camps, still in 'un-cleared' areas or may even have died. Most elderly patients who lived alone were unable to queue to receive food rations. The food was prepared commonly for all IDPs, and there were no special diabetes diets available. Poor diabetes control was exacerbated by the lack of availability of anti-diabetic drugs for the IDPs even prior to their arrival in the camps. The ETU received a glucometer to test blood sugar levels a few days after our arrival. However, initially it remained very difficult to manage patients suspected of having hypoglycaemia or hyperglycaemia. Insulin was not available and patients had to be given oral fluids and medications and transferred to CDH for further treatment.

Hypertension

Several patients were found to have elevated blood pressure as their regular anti-hypertensive drugs were not available for many weeks. Regular close monitoring was difficult as the field clinic was closed at night. However, patients were treated with available oral treatment and assessed on the following day.

Seizures

A number of patients presented with acute attacks of seizures. Infants often presented with febrile seizures. One adult patient developed a seizure while waiting in the queue in the OPD and was admitted and treated at the ETU. Most epileptic patients who previously had good control of their illness had lost their drugs and medical records due to their displacement. Some patients had even taken different drugs from those normally prescribed to them as they had been living in many different places and received treatment where the availability of drugs was different. This may have resulted in a setback in the management of their seizures.

Challenges

We were working in a newly established IDP camp. Physical and human resources were initially not the optimum required to cater to the needs of the

approximately 52,000 IDPs living in that camp. We had a number of difficulties running this ETU, as the types of patient, resources and organizing structure were quite different than that we had seen in a typical ETU. Conditions did gradually improve, largely thanks to the immense efforts of the administrators and health care workers of different levels.

Disorganization

The field health centre was located in a large tent and its sides were half-covered with plastic sheets. It did not have a door which could be closed, therefore many 'unwanted' persons could easily enter the unit. The ETU consisted of eight beds, a few tables and chairs, and several saline drip stands. There was no proper examination bed covered from all sides. Drugs were stored in such a way that finding a particular drug was very difficult. The admissions book and proper recording systems were not well maintained and the whole centre was crowded with patients. There was no clearly defined way to get admitted to the ETU, and usually patients were referred from the OPD, though some patients came directly to the ETU.

Lack of staff

The lack of trained staff was also a huge problem. There were about 15 doctors working in the whole field clinic during the time we were in the ETU. We had two paediatricians and one senior medical registrar in the field health centre. There were no nurses during this time, and running an ETU without trained nurses was very difficult. We had a few attendants and health care assistants who had previously worked in local hospitals in the surrounding area of Vanni. Skilled tasks such as inserting a cannula and giving injections were performed by the doctors, though inserting a cannula in an infant was a challenge to most doctors who worked there as most infants were dehydrated.

The location of the IDP camps was away from the major heath resources in the country and in a very resource-deprived area. There was already a considerable shortage of medical staff in these areas of the country, largely as a result of the war and displacement. In addition, the location of the IDP camp was considered to be a high-risk area due to the recent war and risk of insecurity, as well as land mines, etc. Therefore mobilizing healthcare staff was a difficult task under the existing regulations of the health administrative service and the strong trade unions of the health employees. Although administrators were able to provide most physical resources, providing human resources at the necessary large scale within a short time was not easy. However, we did see some gradual improvements in human resource with participation of voluntary health workers in some other categories.

Lack of instruments, monitoring and investigation facilities

When a patient presented with chest pain the only option we had was to transfer those suspected of having ischemic heart disease to VGH which was located about 30 km away – about a 50 minute journey. We did not have an ECG machine to monitor heart output in the field health centre. Indeed, as noted above, the only instrument we had to carry out any investigations was a glucometer; we had only one sphygmomanometer for the field clinic for some of the time, and had to use our own personal auroscopes, aphthalmoscopes and stethoscopes. In addition to the lack of resources, it was very common to have two patients or even three patients to a bed. Since there were no nurses, all monitoring was done by doctors.

Patient transport

The nearest hospital, CDH, was a small district hospital located about 5 km away from the health centre. The CDH was already crowded with thousands of patients, almost all of whom were IDPs. So our main concern was to manage patients in the ETU as much as possible even though we had few specialists (CDH did not have any at that time). Due to the strict security measures, IDPs were not able to be transferred or moved out of camp without permission from the administrators. These restrictions could adversely affect the provision of optimum health services. IDPs did have free access to the field clinic, but whenever they wanted to go to the CDH for special treatment, permission had to be obtained from the administrators. When we wanted to transfer a patient, arranging transport was not easy, due to the limited number of ambulances. We had to transport all patients in ETU to CDH in the early evening, as the field clinic was closed during the night. The evening transfers could be very heavy and time-consuming.

Language barrier

Most of us who came to work in the camp came on a voluntary basis from other parts of the country, and many of us could not communicate properly with the IDPs in their mother tongue (Tamil). We therefore relied on translators; some of whom were very good, while others were not. This led to misunderstanding, misdiagnosing and privacy issues.

Privacy of patients

Maintaining privacy was a real challenge in this crowded place. Many adults and children entered the ETU who were not patients. Undertaking a full

examination was not easy in these conditions, and some important health issues may not be divulged by patients in such a situation. It was very unlikely that a Sri Lankan woman would talk about very personal symptoms under these circumstances. In addition, almost all translators were male IDPs, therefore we may have missed some crucial information from patients due to this intermediate person. Patients may not have wished to divulge personal complaints to a third person who may even have been their neighbour.

Duty of the doctors

This experience leads us to review the duty of a doctor in this type of critical situation. We were unable to adhere to the standard medical practices which we had been practising in a regular hospital due to limited physical resources, lack of health care workers, overcrowding and various restrictions. As we understood, the local hospitals (CDH and VGH) were overcrowded, with thousands of acutely ill patients following the arrival of the IDPs. Human and other resources were too limited to handle the large number of patients. Knowing the conditions in these local hospitals, we were reluctant to transfer patients there. We felt that their management in the ETU, even with its limited resources, was still arguably better than transferring patients to already overcrowded places where they may only get to see a doctor days after they arrived. For each transfer, we had to balance the benefits of treating patients in the ETU with possible consequence of transferring, taking into consideration our lack of basic investigation tools like ECG. Therefore, the history and clinical examination were the only tools used in diagnosis; for example, some patients with chest pain had to be managed without diagnosis with an ECG, or we had to start oral hypoglycaemic drugs without knowing the patients blood sugar level.

We also had very few healthcare workers other than doctors. Doctors had to carry out the work of nurses, pharmacists, medical laboratory technicians and even health care labourers. Doctors undertook duties which are not usually done by them in regular hospitals in Sri Lanka, such as blood testing for glucose, going to the drug store to collect drugs, and escorting patients to a senior doctor or to the room of minor surgical procedures. We had to go beyond our usual duties as doctors and do everything we could to treat our patients. Nevertheless, doing duties of other health care workers can be associated with a risk of making mistakes and errors.

There were many concerns about privacy of the patients. Ideally, we should not examine patients in such open places and should not ask 'personal health questions' in the presence of others. But we had to balance privacy and health benefits to the patients.

Another consideration was that we were working in an IDP camp in a war-affected area. Many of the IDPs had come directly from the battlefield, and there was a high chance that there were combatants amongst the IDPs. The camp administrators had great security concerns, and IDPs were unable to move freely out of the camp. Probable medical need was the only instance where they were allowed to leave to attend CDH or VGH. We understood that there were some IDPs who came to us with medical complaints that may not have been genuine, with the expectation of being transferred to the CDH or VGH. We had to check each and every transfer carefully to make sure they were 'genuine' patients. This was the first time in our medical practice that we had to consider security issues while dealing with patients. We therefore had to balance our responsibility as doctors to treat and comfort our patients, whilst simultaneously being responsible for the security of the others in the camp, as well as our country.

As we understood, a considerable number of IDPs also had some military training – both willingly and unwillingly – when they were in 'un-cleared' areas. Most of them had just come out of the battlefield, and there was still intense fighting in some surrounding areas during the time we worked in the camp. Since we had never worked in the war-affected areas, and all of us in the team were from southern parts of Sri Lanka, and belonged to a different ethnic group to the IDPs, we also had our own insecurities. Even travelling from the south of the country to the north, where the IDP camp was located, was a challenge due to the security situation at that time. Even though we were working there on a voluntary basis, we often had this risk in our minds. Therefore, it was inevitable that we were sometimes suspicious of some IDPs, even though we provided our best care to them. Our sole aim was serving those people who needed desperate help.

Providing health services in a highly disorganized place, with limited resources, overcoming administrative and security barriers, was a really challenging experience. The health and administrative problems identified were in some ways unique to this system, but we hope that sharing these experiences will be helpful for health administrators, as well as other health professionals, when planning and implementing health services in a similar environment.

Notes on contributors

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