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Letter to the Editors

Sirs, Having worked as a medical officer in a hospital in Karamoja, home of the seminomadic Karimojong of north-east Uganda, I would like to add a few critical notes to the interesting article of Sheik-Mohamed and Velema (1999) on the supply of health care for nomads.

In the district where I worked, a network of 13 dispensaries, three centres and two hospitals provide health services for a population of around 200 000 with a density of roughly 14 inhabitants per km^2. Health needs among the Karimojong are striking, but at least according to our hospital figures (St. Kizito Hospital 1996), the existing services are increasingly being used, with a remarkably high rate of children admitted (at district level, 56/1000 p.a. on average during the period 1987–94). Regardless of whether the appropriate level was used, it shows that one of the weakest groups in the population, and most in need of health care, seems to find its way to medical services.

Among the Karimojong, women, children, and the elderly live in semisedentary settlements; young men are scattered during the dry season in small groups over the vast plains. Because of this dual social structure, the services reach mainly the sedentary part of the population, and this applies by definition to all geographically immobile services and projects, community-based or not. The young men, mostly the healthiest segment of society, are thus the main group having difficulties in accessing health care, mainly during the dry season. Employing nomadic community health workers, however, may not solve this problem. As the groups are often small and many in number, a great many health workers would need to be trained. More importantly, once trained they might prefer to stay in the larger settlements or move to market centres, as they often do not wish to fully continue their traditional nomadic lifestyle. In my opinion this points to an intrinsic vulnerability in the organization of any type of mobile services for nomadic people. Whenever members of the nomadic community are contracted to act as field workers, the risk is that it will alienate them from their original community and that they eventually leave the remote settlements, hoping to improve their situation in towns and market places. Obviously this should not mean that none of them must receive basic health training – on the contrary – but in my opinion it will not suffice as a cornerstone in meeting the health needs of their people.

On the other hand, the settlements have a tendency to migrate as well, albeit at a much slower pace – years *vs.* months. Settlements can emerge at very remote places. However, the problem of access in these situations is not unique to nomadic people but to all small communities scattered over vast areas.

Finally, there are other important factors influencing the Karimojong's access to health services. Episodic violent clashes between clans render travel to and from the medical services life-threatening. Above all, the most important cause of low accessibility worldwide, poverty, also applies to the Karimojomg. Therefore it seems to me that the geographical and socio-economic environment, rather than cultural inaccessibility or distrust of the government, are the main causes of little access to health services in the Karamoja, and that strengthening the existing network of services is the best option, provided safety and development in the area are also on the agenda.

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