

# Protracted Refugee Situations: Parallel Health Systems and Planning for the Integration of Services

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The international community typically responds to refugee situations by establishing 'care and maintenance' programmes specifically for refugees. Limited resources may also be directed to hosting communities, but donors often channel the bulk of funding through UNHCR and its implementing partner NGOs, who in turn create service delivery structures that are operated in parallel to local structures. Although there may be cause for this approach in a short-term emergency phase, particularly if the host country systems are very weak, this eventually becomes financially problematic if refugees continue to live in exile for years at a time. In the short term, it can also engender an inequitable and inefficient use of scarce resources. This paper traces the evolution and impact of implementing refugee health services in parallel to local systems using observations from Uganda, and offers Quality Design as a model for planning the local integration of services.

Keywords: protracted refugee situations, integration of services, health service delivery, northern Uganda, southern Sudan

## Introduction

The United Nations High Commission for Refugees (UNHCR) was established in 1950 with the short-term mission of assisting European refugees from the Second World War. However, conflicts in post-colonial Africa in the 1960s quickly occupied the organization and UNHCR has been fully engaged ever since with a mandate of providing refugee protection and assistance the world over. Early on, UNHCR recognized that many refugee situations in Africa and other places would not be quickly resolved and that there was need for refugees to become 'self-reliant' in order to avoid long-term dependence on the international community. Initial attempts to promote refugee self-reliance developed in central Africa in the early 1960s with the settlement of Rwandan refugees in the

Kivu province of the Democratic Republic of Congo, and northeastern Burundi. Efforts at this time focused mainly on agriculture-based zonal development activities, which met with limited success (Betts 1993; Weighill 1997).

The 1980s saw the international community formally debate the question of how to organize refugee assistance in Africa at the International Conference on Assistance to Refugees in Africa (ICARA I and ICARA II) meetings held in 1981 and 1984. While ICARA I may have been successful in drawing attention to the growing challenges of refugee assistance on the continent in general, ICARA II sought to link refugee aid and development—implicitly recognizing the fact that refugee populations extending over a period of years can have development consequences both for the host country and refugees themselves. Various principles arising from the ICARA II Final Declaration and Programme of Action identified conceptual responses to protracted refugee situations, including the need for the international community to plan assistance responses that recognize longer-term development needs even at the early stages of an emergency (Gorman 1993). For a variety of reasons, however, neither the conference principles, nor the funding appeals for projects in refugee-affected areas proposed at the meeting, met with more than a lukewarm post-conference response. In the end, early attempts at refugee self-reliance, local integration, and linking refugee aid to development, have largely been abandoned in favour of the current ‘care and maintenance’ approach. Indeed, Betts (2004) notes that current stakeholders in discussions about targeting development assistance for refugees seem largely unaware of the history of the ICARA initiatives.

Twenty years later, UNHCR continues to wrestle with the programmatic issues of long-term refugee populations. Many refugee situations today are of a protracted nature. A working definition of a protracted refugee situation is offered by UNHCR as one where,

over time, there have been considerable changes in refugees’ needs, which neither UNHCR nor the host country has been able to address in a meaningful manner, thus leaving refugees in a state of material dependency and often without adequate access to basic rights (e.g. employment, freedom of movement and education) even after many years spent in the host country (UNHCR April 2002).

Of Africa’s more than three million refugees, the vast majority live in long-term circumstances (Jamal 2003; UNHCR 2003) and many UNHCR agency operations are of protracted nature (UNHCR October 2002). According to UNHCR, it is estimated that by the end of 2003 approximately 6.2 million persons were living in 38 protracted refugee situations worldwide, with the majority of such situations located on the African continent. Trends from the period 1993–2003 indicate increases in both the number of protracted refugee situations as a proportion of refugee situations in general, and the length of time that refugees are living in such circumstances, which has risen on average from nine to thirteen years during the ten-year period (UNHCR 2004).

At the same time, UNHCR has faced severe funding deficits in recent years. In 2000, the agency was forced to borrow \$40 million of its \$50 million working capital funds in order to meet financial obligations through the end of the year. The situation was attributed to late donor pledge announcements, as well as general under-funding (UNHCR 2000). In 2001, the agency announced a review of its programmes worldwide with the aim of identifying non-essential programmes that could be cut in expectation of further budget deficits (AP World News 2001). By late 2002, the agency reported that it had been forced to halt some of its programmes, noting that of the \$80 million needed to maintain minimum standards, it still required \$54 million (UNHCR November 2002). Towards the end of 2003, the agency faced an expected shortfall of \$80 million in its total annual budget. While efforts were made to reduce headquarters and administrative costs, protection and assistance programmes were also negatively affected (UNHCR September 2003). By mid-year 2005, the agency's anticipated annual programme budget shortfall for the year was \$136 million and further reductions in programme activities were likely (UNHCR June 2005). Among other things, this financial picture has forced the agency once again to consider seriously how to meet the needs of refugees in protracted situations.

In October 2001, UNHCR coordinated a panel discussion on protracted refugee situations in Africa based on a discussion paper which noted the need to develop better strategies for managing long-term refugee needs. Recognizing that neither voluntary repatriation nor third country resettlement are viable options for many refugees, the paper pointed to more closely examining local integration, while warning of the different interpretations of this approach. It further suggested that *refugee self-reliance* be pursued while refugees remain in exile. At the same time, UNHCR has organized other meetings on the topic as well, such as informal consultations on addressing protracted refugee situations in Africa, and a global consultation on international protection that focused on local integration specifically. UNHCR's Evaluation and Policy Analysis Unit has undertaken a series of studies called the UNHCR Protracted Refugee Situations Initiative, looking at lessons learned from on-going examples, and a number of other writings and presentations have also highlighted the experience of protracted refugee situations from a variety of perspectives (see for example Crisp 2003; Jamal 2003; Morjane 2002; Jacobsen 2001).

One of the examples frequently cited in discussions about local integration and self-reliance comes from the on-going experience in Uganda. In 1999, UNHCR and the Government of Uganda (Office of the Prime Minister) introduced the Self-Reliance Strategy (Government of Uganda and UNHCR Uganda, 1999). As a strategy document, it offered two main objectives:

- To empower refugees and nationals in the area to the extent that they will be able to support themselves.
- To establish mechanisms which will ensure integration of services for the refugees with those for the nationals.

While much of what has been written and discussed about self-reliance and local integration emphasizes the need for refugees to be able to cope outside the UNHCR care and maintenance system, many of the challenges in the Uganda experience actually stem from the second objective: *service integration*. As a conceptual paper, the Self-Reliance Strategy (SRS) did not offer concrete guidelines for managing the integration of refugee services into local systems. This ultimately proved to be one of many factors to undermine its potential success. A mid-term review of the SRS cited several reasons to explain how progress on implementation between 1999 and 2003, ‘slowed down and virtually ground to a halt shortly after’ initial start-up activities (SRS Mid-term Review Team 2004). In part, the downfall of the SRS lay in faulty assumptions at the policy level and the failure to recognize the complexities of the local political environment. At the same time, a vision of service integration as an administrative task oversimplified realities on the ground, and overshadowed the need for a systems-based approach.

In 2004, the Office of the Prime Minister (OPM) and UNHCR established a secretariat to manage the process of creating a new policy framework to guide integration: the Self-Reliance Strategy–Development Assistance for Refugee Hosting Areas in Uganda (SRS–DAR). The SRS–DAR overarching goal is, ‘to improve the overall standard of living of the people of refugee hosting districts’ (Government of Uganda and UNHCR Uganda 2004). Although the document contains no indicators by which to monitor or evaluate progress on its goal and objectives, the question of whether the SRS–DAR proves able to overcome the challenges facing the SRS can be measured in part by service delivery outcomes, including those within the health sector.

This paper reviews the process of streamlining refugee health services into district systems such that parallel service delivery mechanisms for refugees and nationals are converted into one functional system. The experience documented in this paper is based on field work carried out in Arua, Moyo, and Adjumani districts between 1999 and 2001 at a time when district-level stakeholders were asked by centrally-based counterparts to find ways of putting the concepts of the Self-Reliance Strategy into action. A return visit to Adjumani District was undertaken in early 2005 in order to document further changes in terms of health service integration. The paper points to the fact that regardless of factors in the policy environment that may better support attempts at service integration under the current SRS–DAR, efforts that do not appreciate a systems-based approach will likely falter and may not lead to the envisioned improvements in the standard of living for refugee hosting populations, or the refugees themselves.

In order to place the Ugandan experience within a broader framework of refugee aid and local integration, the next section of the paper starts with a brief overview of refugee assistance mechanisms and the concept of parallel service systems. Following that, a background to the current refugee situation in the West Nile districts is presented, including a description of post-conflict health services in Uganda, and the establishment and impact of parallel refugee health

systems. The introduction of the SRS, implementation challenges, and the development of the SRS–DAR are further described, and the experience of two models of local systems integration is explored. Although this paper focuses on health systems in particular, many of the lessons learned are applicable to other sectors in the integration process in Uganda, and may also be valuable in considering the concepts of local integration and self-reliance in other country contexts.

### **Refugee Assistance Mechanisms**

The manner in which service integration occurs in a protracted refugee situation will depend in part on the way that refugee services were established. The most difficult refugee service structures to integrate are those that have been managed in parallel to local services. Before looking at the details of the Ugandan case, it is useful to consider some of the typical health service delivery models in refugee settings, which include the following:

- *Host Country Government.* In some cases, albeit few, the national and/or local health systems within the host country may be able to devote a sufficient amount of their own health budget, and a sufficient number of their own personnel, to cater for the additional refugee population. Refugee health is addressed within the already existing health systems available to the local population and/or services are extended as necessary to reach the refugees. In this situation, refugee health needs are integrated into an existing system and a parallel service delivery structure does not exist.
- *Donor support to local health systems at the national level.* In some cases, UNHCR and/or individual donor organizations provide funding and technical support to the host country Ministry of Health for either national level management support in refugee health programming or for direct implementation of on-site refugee health service delivery. Documented examples of this approach in Africa are found in what was the Refugee Health Unit of the Government of Somalia during the influx of Ethiopian refugees in the late 1970s (Godfrey and Mursal 1990), as well as Malawi's Ministry of Health management of health services for Mozambican refugees in the late 1980s (Kunz 1990), and Guinea's PARLS (Programme of Assistance for Liberian and Sierra Leonean Refugees) in the 1990s (Van Damme 1998).
- *Donor-funded Non-Governmental Organizations.* In many cases, UNHCR and/or individual donor organizations provide funding to NGOs to implement a part, or the entirety of, a health service delivery programme focusing specifically on the refugee population. In such a situation, the NGO establishes a health programme that runs parallel to local service delivery. While basic national host country service delivery protocol may be observed, there are often differences between the refugee and local health systems in, for example, resource endowment, logistics, and staffing. The differences may also appear in additional services offered to refugee populations such as

referral services, in-patient feeding, and payment of hospital fees, which may not be available within the local health services.

Each of the above options carries with it long-term implications in terms of ownership, planning and decision-making procedures, staffing, funding, and other management sustainability issues. In situations where the refugee population stay is extended over a period of years, the impact of these consequences cannot be overstated.

Whereas the first option, in which the host country government assumes immediate responsibility for service delivery to the refugee population, may be the most predisposed to long-term viability, it is also the least likely to evolve. This scenario requires a host country national health system that is relatively well-developed, and determined to play an active part in the management of refugee health. In Africa, where scarce resources are thinly stretched to meet minimal standards of care, this is often not possible.

The second option, involving donor support to national and/or district level health systems of the host country, may be the more desirable option but is also relatively uncommon for a variety of reasons. In the cases referenced above, it is an approach that the refugee-hosting government itself actively seeks. For many countries, especially those in a weakened post-conflict, or ongoing conflict situation, it may be difficult to absorb additional funding for refugee services even if it is made available directly to the government.

This in turn facilitates a tendency to elect the third option, that is, to support international, regional, or sometimes local NGOs to undertake the refugee health services delivery function. Unencumbered by other responsibilities, and using a typically less bureaucratic organization, NGOs are often perceived to be more effective in directly accountable, quick response, quality service delivery. Whether or not this is always true, it is the most common choice. Unfortunately, when short-term emergencies develop into long-term refugee situations, it is also the most problematic strategy. As the following section describes, Uganda's civil war and ensuing political crises in the years preceding the initial influx of Sudanese refugees in the late 1980s precipitated the establishment of parallel refugee services through donor-funded non-governmental agencies. While necessary at the time, this has proven an unsustainable approach.

## **Parallel Refugee Health Systems in Uganda**

### *Conflict and Forced Migration: Southern Sudan and Northern Uganda*

Sudan's modern history is characterized by internal upheaval beginning even before independence in 1956. In 1963 the Anya Nya, an anti-government guerilla group, staged a rebellion in the Equatoria and Upper Nile regions of southern Sudan to protest Khartoum's Islamization policies. Throughout the 1960s, as many as 86,000 southern Sudanese sought security in northern

Figure 1

Map of Uganda Highlighting Arua, Moyo, and Adjumani Districts



Uganda (Akol 1994, cited Merx 2000). A coup led by General Idi Amin in 1971 created deteriorating security conditions in many parts of Uganda, while at the same time a peace accord between the Anya Nya and the Khartoum government in 1972 opened the possibility of repatriation for Sudanese. Between 1972 and 1974 an estimated 75,000 Sudanese crossed back into Sudan (Merx 2000). In 1979 Idi Amin was overthrown, and his home district of Arua, along with the rest of West Nile and much of northern Uganda, became increasingly insecure. During the early 1980s, approximately 93,000 Ugandans fled to southern Sudan (Allen 1996, cited Hovil 2002), which quickly built up to at least 300,000 Ugandans registered as refugees in Sudan by 1984 (Harrell-Bond 1986). The National Resistance Army (NRA), under the leadership of current President Yoweri Museveni, took power in 1986 and restored a relative peace to the area. In 1987, thousands of Ugandan refugees spontaneously returned to West Nile from Sudan after violent attacks by the Sudanese People's Liberation Army (SPLA), and between 1986 and 1989 up to 250,000

Ugandans repatriated (Merkx 2000). The Ugandan returnees were joined by the first, relatively small groups of what was to become a substantial southern Sudanese refugee population, beginning in 1986.

Heightened insecurity in southern Sudan brought the first major wave of 100,000 Sudanese into West Nile in 1993–1994. Most were initially received in the Koboko area of Arua District and later moved to refugee settlements elsewhere in the district for security reasons (Payne 1998), while others crossed into Moyo, and what was later to become, Adjumani districts. Between 170,000 and 210,000 Sudanese sought refuge in Uganda in the 1986–1994 period (Merkx 2000). In 1997, the combination of Ugandan rebel attacks in West Nile, and the opening of key towns in southern Sudan prompted the return of several thousand Sudanese; it is estimated that 40,000–50,000 refugees repatriated (Merkx 2000). However, the vast majority stayed, and many Sudanese have lived in West Nile for ten years or more.

In 2001, close to 120,000 southern Sudanese refugees were living in the West Nile districts of Arua, Moyo, and Adjumani. Elsewhere in Uganda, another 58,000 refugees were settled, originating from Rwanda, Sudan and the Democratic Republic of Congo. These figures reflect only those refugees registered with UNHCR and do not include the several thousand Sudanese who are self-settled in West Nile and other districts. In addition there were over 500,000 internally displaced Ugandans. As Table 1 indicates, the estimated proportion of the population consisting of refugees in West Nile districts varied, with estimates of 5 per cent, 19 per cent, and 32 per cent in Arua, Moyo, and Adjumani, respectively, at that time.

*Health Services in Post-conflict Uganda*

When the first of the current Sudanese refugees arrived in West Nile in 1986/1987, Uganda’s National Resistance Army had only recently secured control of

*Table 1*

**National and Refugee Populations in Uganda, 2000–2001**

District	Nationals	Refugees	Total population, including refugees	Refugees as percentage of total
Arua	704,937	38,007	742,944	5.1
Moyo	100,195	23,944	124,139	19.3
Adjumani	121,505	57,567	179,072	32
Total	926,637	119,518	1,046,155	11.4

Sources: Refugee population figures are taken from official UNHCR/Uganda Programme estimates as of October 2001 and do not include ‘self-settled’ refugees not registered with UNHCR; National population figures were provided by the Government of Uganda, Ministry of Health as estimates of year 2000 populations.

the country. As with most government services, 15 years of civil conflict had severely damaged the country's health infrastructure. The quantity and capacity of both clinical and management staff had been reduced to below functional levels in many areas. At the national level, policy-making and management capacities were heavily damaged (Macrae *et al.* 1996). Although much stronger now, the local health system on the ground was in no way able to serve needs of incoming refugees at that time. Even if district health systems in West Nile had been robust in 1986/1987 some external assistance through either funding, or relief agency implementation, would have been needed.

By 2000/2001, more than 15 years into Uganda's rehabilitation process, health services for the West Nile districts continued to fare worse than the rest of the country in many key indicators, as shown in Tables 2 and 3 below.

Table 2

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**Health Resource Indicators (Financial and Human Resources, 2000/2001)**


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Indicator	National	Arua	Moyo	Adjumani
Per capita budget (US\$)	11	9.03	5.79	3.24
People served by each doctor	28,492	35,639	113,054	176,850
People served by each clinical officer	32,945	63,055	37,685	88,425
Women of reproductive age served by each nurse/midwife	4,761	1,558	3,230	8,843
People served by each health unit	10,374	16,670	8,075	25,264

Source: Moyo and Adjumani District information collected as part of health resource assessment exercises for the Quality Design project activities.

Table 3

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**Health Status Indicators (2000/2001)**


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Indicator	National	Arua	Moyo	Adjumani
Infant mortality rate (per 1,000 live births)	97	137	143	143
Under-five mortality rate (per 1,000 live births)	147	245	241	242
Maternal mortality ratio (per 100,000 live births)	506	612	600	>600
BCG vaccination coverage	79 %	64 %	112.7 % <sup>1</sup>	60 %
DPT3 vaccination coverage	43 %	54.1 %	71.2 %	37 %
Measles vaccination coverage	57 %	52 %	65.8 %	38 %

Source: District health sector planning documents for 2001/2002, Moyo, Arua, and Adjumani Districts.

<sup>1</sup>The figure of 112.7 per cent BCG vaccination coverage (Moyo District) is the official district figure; as normally the figure would not exceed 100 per cent, the calculation is likely the result of using census projections for the relevant age group rather than actual figures which would only be available through an updated census.

The first of the current Sudanese refugees in West Nile arrived early in Uganda's post-war recovery process. Within this context, UNHCR encountered weakened local partners, at both the Ministry of Health and at the district level, if indeed it sought them. While an opportunity existed for UNHCR to strengthen struggling local health systems in the refugee-affected districts, this was likely viewed as an effort outside their traditional refugee protection mandate, as well as being beyond available resources. Arguably, the easier and more expedient approach for UNHCR in such circumstances is the establishment of service delivery systems for refugees, parallel to local structures, through contracts with NGO implementing partners. At the same time, Ugandan health managers were consumed with the on-going challenges and changes to their own systems, and were not actively seeking any larger role.

From the beginning, outside organizations, including international, regional, and local non-governmental organizations have implemented projects to meet the health needs of refugees in the West Nile districts through grants from UNHCR and other direct international donor funding mechanisms. Although there has always been some level of coordination between the implementing organizations and district health managers on specific issues, funding was separate, and many key aspects of refugee health services management evolved in isolation from the local systems.

Underlying the differences between district and refugee health systems are clear distinctions between primary health care (PHC) and emergency medical assistance (EMA) approaches to health service delivery as described by Van Damme *et al.* A PHC system approach views health service delivery as an important component in the overall development of a population. Planning and implementation of PHC programmes considers the long term needs of a population, requires harmonization with other sectors, and emphasizes that health services accommodate the needs and views of the community served through 'a partnership between health professionals and the population, based on a continuous dialogue' (Van Damme *et al.* 2002: 50). This is in contrast to EMA, which focuses on the physical survival of individuals, and service delivery from a short-term perspective within a set of relief activities designed to address the immediate needs of a population. Saving lives, and harnessing all available resources to get the job done, overshadow any consideration of the population's participation in deciding how the services should be administered (Van Damme *et al.* 2002).

While there is no published documentation as to the exact nature of the refugee health services in the West Nile districts when first established in the early 1990s, further description of the differences between EMA and PHC places the refugee health services at the time more to the side of EMA. Many of the characteristics of emergency medical assistance as described by Van Damme *et al.* were notable during the time of field work 10 years later. These include more curative health posts in the refugee camps for smaller sized populations than used in the districts' PHC system. As well, the EMA structure

often involves home visitors, which in this case were catered for in the refugee health system as community health workers. Under the PHC approach community health workers are 'seldom adequate' and in this context the districts had none at the time. Emergency medical assistance is typically a parallel health system, 'marginally linked to pre-existing health system'. Later sections of this paper describe such a situation in further detail.

Although the refugee health services established in the West Nile context were clearly more oriented to emergency medical assistance than primary health care, Van Damme *et al.* point out that many refugee situations lie somewhere in the range of non-development and non-emergency circumstances. This was and continues to be the case in the West Nile setting where a 'blocked situation' context, many split families, little autonomy, poor prospects for return, chronic overcrowding (in this case relative to cultivable land), and no excess mortality or micronutrient deficiencies place the situation squarely in the middle of the development/emergency framework presented by the authors. In such cases, they point out, there is need for a 'creative compromise' between EMA and PHC approaches, as no standard design for health service delivery may be feasible.

Conceptually, the integration of refugee health services into the district system called for by the Self-Reliance Strategy required a shift in the thinking of UNHCR and the refugee NGOs from emergency medical assistance to harmonization with the district's primary health care structures. A creative compromise was indeed at the centre of the process. Before further describing the difficulties in designing such a compromise, the next section of the paper outlines the challenges imposed by the original establishment of the refugee health services under an emergency medical assistance model.

## **The Impact of Parallel Health Systems**

### *The Evolution of Separate Health Management Practices*

The existence of parallel systems over a period of many years can cause management anomalies that eventually become very difficult to address, particularly in the areas of funding mechanisms, planning and budgeting, administration, implementation of service delivery, health service delivery policy, reporting, and monitoring and evaluation. The differences in management between district and refugee health systems in the West Nile context are shown in Table 4.

### *Resource Discrepancies between Systems*

The establishment of parallel health systems has the potential to undermine equity, quality, and sustainability. Using its own funding and management structures, UNHCR's support to refugee health services created certain inequities between the level of resources available to refugees and to nationals. Although full information about UNHCR funding for refugee health in West Nile was unavailable at the time of field work, the resource indicators

*Table 4*

<b>Key Differences between District and Refugee Health Systems</b>	
West Nile District Systems	Refugee NGO System
<p><b>Funding Mechanisms</b>                      Main funding sources: Government of Uganda, Ministry of Health, and the European Union                      Allocations determined by annual work plans; cash received through the National Accounting Office</p> <p>Planning exercise for MOH funds is primarily driven by pre-determined ceilings based on a national budget allocation formula</p> <p>National allocation formula for government monies does not include refugee populations</p> <p>Budget cycle: July to June financial year</p>	<p><b>Funding Mechanisms</b>                      Main funding source: UNHCR</p> <p>Actual allocations determined by UNHCR on a quarterly basis according to cash availability and per quarterly work plans</p> <p>Budget cycle mirrors UNHCR financial year: January to December</p>
<p><b>Planning and Budgeting</b>                      Planning exercises as per national guidelines and requirements, including the National Health Sector Strategic Plan and/or donor requirements</p> <p>Team-based planning exercise with input from health sub-district and county levels</p> <p>Plans must be reviewed and approved by district-level political and administrative bodies</p> <p>Plans must be submitted to Ministry of Health, and various donors as applicable</p>	<p><b>Planning and Budgeting</b>                      Planning exercises conducted within each organization field level and national level staff</p> <p>Planning based on regular assessment of needs and changes in refugee populations</p> <p>Planning is focused primarily on refugee population and refugee health units with some inclusion of district activities</p> <p>Plans and budgets are negotiated with UNHCR at district and central levels</p> <p>Programme plans (though not necessarily budgets) are submitted to DDHS,<sup>1</sup> when finalized</p> <p>Plans are not submitted to MOH</p>

Table 4 Continued

West Nile District Systems	Refugee NGO System
<p><b>Administration</b>                      All district health staff hired, fired, and disciplined as necessary through the District Service Commission, meeting sporadically                      Staffing according to national requirements and salary structures                      All expenses regardless of funding source must be authorized by the District Chief Administrative Officer                      All construction and other capital investments must be passed through the District Tenders Board</p>	<p><b>Administration</b>                      Staffing issues handled internally between field and central offices of the NGO; neither district authorities, nor UNHCR, participate in staffing decisions; staff salaries and structures independent of national norms and requirements                      Administration of funds uses internal systems only                      Construction and other capital investments according to NGO and donor policies; District Tenders Board is usually not consulted</p>
<p><b>Programme Implementation</b>                      District Health Management Team is responsible for implementation of activities; team members responsible for specific sub-sector activities                      District health staff implement activities according to a wide variety of national and donor work plans                      Coordination with refugee health NGOs for certain activities</p>	<p><b>Programme Implementation</b>                      NGO Field Officer and staff responsible for the implementation of activities; senior field managers share many functions                      One main work plan (UNHCR) with supplemental activities (other donors)                      Coordination with district health management for certain activities</p>
<p><b>Health Service Delivery Policy</b>                      Outreach, referrals, and in-clinic service delivery according to national protocol, within the resource limitations of the district</p>	<p><b>Health Service Delivery Policy</b>                      Outreach, referral, and in-clinic service delivery practices according to NGO work plan; may meet and/or exceed national protocol in some cases; may not reflect national protocol in some cases</p>

<p>Reporting</p> <p>Programme Reporting: District uses national HMIS<sup>2</sup> reporting format as required by Ministry of Health</p> <p>Financial Reporting: To district authorities, national authorities, and donors as required</p> <p>Monitoring and Evaluation</p> <p>Responsibility for monitoring and evaluation with each member of District Health Management Team depending on programme area</p> <p>Indicators for various activities based on work plans, donor requirements, and national policy</p> <p>Occasional supervision from MOH staff, particularly for national, vertical programmes</p> <p>Donor projects monitored by donor organization representatives</p>	<p>Reporting</p> <p>Programme Reporting: Field operations use parallel UNHCR health management information system in addition to national HMIS format. Reports to NGO headquarters at national and international levels, as well as to UNHCR field and national offices; health reports to DDHS; other programme reports not submitted to district authorities</p> <p>Financial Reporting: To UNHCR and NGO national offices; specific donors as required</p> <p>Monitoring and Evaluation</p> <p>NGO senior field staff responsible for monitoring key aspects of programme activities</p> <p>Indicators according to annual work plan submitted to UNHCR</p> <p>Limited programme monitoring by UNHCR at the field and national levels; monitoring if at all focuses on administrative issues</p> <p>Occasional monitoring by UNHCR donors; no regular monitoring by MOH</p>
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<sup>1</sup>District Director of Health Services

<sup>2</sup>Health Management Information Systems

Table 5

**Key Differences between District and Refugee Health Systems Resources, 2000/2001**

Resource indicators	Moyo district services	Refugee services in Moyo	Adjumani district services	Refugee services in Adjumani
Per capita health budget (US\$)	5.79	10.75	3.24	9.32
People served by each doctor	113,054	31,318	176,850	17,108
People served by each clinical officer	37,685	15,659	88,425	9,776
Woman of reproductive age served by each midwife	3,230	1,957	8,843	1,711
People served by each health unit	8,705	10,439	25,264	5,703

Source: The above figures were collected as part of the Health Resource Assessment Report exercises conducted separately in Moyo and Adjumani districts under the Quality Design project activities, in which both district and refugee health NGOs participated. District health budget information was collected separately as part of the Save the Children (UK) Health Resource Mobilization Case Study. The refugee population figure used in the Moyo service provider to population ratios was based on available UNHCR estimates for the time period covered. In planning exercises, the NGO managing refugee health services in Moyo used the higher service user figure to account for unregistered refugees, as well as nationals, who use their services. However, for comparison purposes, the registered refugees figure is used since refugees also use district services but are not counted in the district health services ratios. The ratio of health units to population as calculated for refugee services in Adjumani District uses only 10 of the 22 health units within the refugee system at the time. The remaining 12 refugee health units were categorized at level 1 (health posts) which do not exist within the district system. These were therefore omitted in the calculation for the purpose of comparison between district and refugee systems.

provided in Table 5 above highlight discrepancies which evolved. Less tangible are the years of missed opportunities to strengthen a struggling post-conflict district health system through coordinated planning, implementation, and shared resources.

Moyo and Adjumani districts have among the lowest per capita health resources available in the country, while the refugee health programmes approached the \$12 per person targeted by the World Health Organization. There were also key differences between district and refugee systems in terms of the levels of staffing available. Notably, the numbers of higher cadre health staff (e.g. doctors and clinical officers) in both district and refugee systems were very small in Moyo and Adjumani. However, observations about the concentration of highly trained staff within refugee camps have also been made in other settings (Maybin 1992). In neighbouring Arua District, the issue of human resources became one of the problem areas when refugee health services previously managed by an international NGO were handed over to the district. Differences in staffing norms, remuneration and compensation practices, and hiring practices became problematic, with some staff leaving refugee health units, and others threatening to strike.

Ultimately, resources for refugee services would come to the fore of UNHCR and local district health management concerns. The global funding challenges

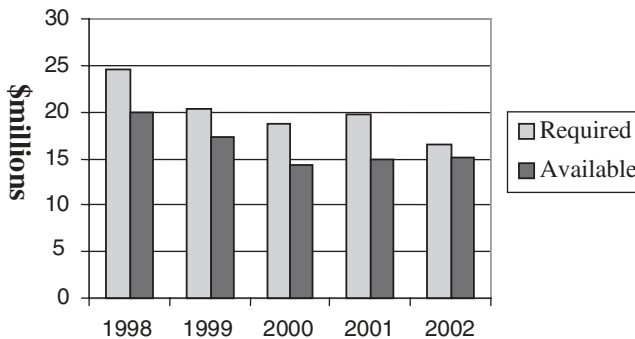
of UNHCR described earlier, coupled with a general concern about operating beyond its emergency-oriented mandate, led the agency to introduce the Self-Reliance Strategy concept with the Government of Uganda in 1999. Authors of the strategy document pointed to ‘inadequate mechanisms for co-ordination and collaboration’ as reasons for health services being provided in a parallel fashion and noted a better health status for refugees than nationals living in the same areas (Government of Uganda and UNHCR Uganda 1999). The following sections of this paper review the introduction of the SRS and an initial attempt to integrate health services through a handover approach.

**Integration and the Self-Reliance Strategy**

As noted earlier in this paper, ‘local integration’ and ‘self-reliance’ are popular concepts at the moment as UNHCR seeks to address protracted refugee situations in Africa and other areas where neither voluntary repatriation nor third-country resettlement solutions have been feasible. A report from the UNHCR protracted refugee situations initiative notes that self-reliance policies are being widely adopted by agency country programmes in response to the financial costs of long-term care and maintenance programmes (Kuhlman 2002). This was certainly the case in the Ugandan context, as the SRS document notes ‘the phenomenon of diminishing donor interest in funding protracted refugee assistance programmes’ and the concept that ‘where refugees are becoming self-reliant, they should cost less in food aid and other services’ (Government of Uganda and UNHCR Uganda 1999: 3). Figure 2 demonstrates an ever-decreasing UNHCR Uganda budget over the period 1998–2002 despite a relatively stable refugee population in the country over the same time (Burnham *et al.* 2003).

UNHCR and the Government of Uganda agreed to the Self-Reliance Strategy in 1999 and introduced it at the district level in the early part of that year. The SRS outlines a general framework through which refugees in

*Figure 2*  
**UNHCR Uganda Programme Funding 1998–2002**



Arua, Moyo, and Adjumani districts were to become self-sufficient by the end of the year 2003. Services currently provided to refugees would be integrated into local Ugandan public sector services. The Kampala-based UNHCR and Government of Uganda set out the strategy, conceptualization and policy processes for the SRS. The difficult implementation and funding responsibilities were left to the district authorities to work out. Little specific guidance was provided in translating these concepts into reality at the district and community levels. Not surprisingly, confusion and miscommunication between key parties on the ground, including UNHCR, NGO implementing partners, and the district authorities, slowed progress. In Adjumani district, which hosts the highest concentration of refugees in West Nile, local political authorities initially rejected the Self-Reliance Strategy outright.

One of the most obvious sticking points, which arose over and over again, was the question of funding. While the authors of the SRS assumed that 'additionality of funding' on the part of the donor community and the national government would be forthcoming, this proved not to be the case. Progress on the SRS stalled, as local districts, facing severe constraints in maintaining limited services to their own populations, were unlikely to find additional funding for assuming responsibility for the refugee population. When district planners in at least one of the districts approached the Ministry of Finance about incorporating refugees into the Primary Health Care grant, based on land mass and population size, they were told that it would be impossible without policy changes that only the country's president could authorize.

Reaction to the Self-Reliance Strategy from district political and administrative leadership varied somewhat across districts, with Arua district officials most open to the idea, and those in Adjumani most opposed. Moyo district leadership was cautious but did not reject the idea. While political leadership and other factors may explain the differences in how the SRS was received locally, it is notable that Arua district, with the largest local revenue base, though minimal, and smallest refugee population relative to local population was first to attempt system integration. Adjumani district, with a large refugee population (32 per cent of total population in the district), an extremely meagre resource base, and subject to frequent insecurity, was the most vocally opposed. After further discussion with UNHCR and other stakeholders, all three districts eventually accepted the Self-Reliance Strategy through local administrative mechanisms.

Unfortunately, as earlier described, the SRS never shifted from conceptual to practical and could not take on a functional form. At the policy level, the manner in which it was conceived and designed at the national level with minimal planning input from the districts, despite the decentralization process that was well underway in Uganda at the time, created inadequate clarity about leadership and ownership of the process. There was a perception among many within the districts that UNHCR was trying to 'off-load' its responsibilities onto the government without addressing funding questions, and without adequate implementation planning (SRS Mid-term Review Team 2004). This did not create an environment conducive to the launching of such an

*Table 6*

**Identification of Stakeholder Motivations and Relationships**

Stakeholder Party	How affected by the SRS	Capacity/motivation to participate in addressing the integration of services	Relationship with other stakeholders
<b>Kampala Level</b> Ministry of Health	Not directly affected; potentially affected indirectly through increase in resource requirements	Limited motivation since health services are decentralized; responsibility lies at the district level	Little contact with Office of the Prime Minister, UNHCR; no contact with stakeholders at the field level other than relationship with the district health services. Perception that refugee issues are handled by other parties.
Office of the Prime Minister for Disaster Preparedness and Refugees	Ultimately responsible for successful protection of both national and refugee interests	Mandated by the government to address refugee-related policy issues; initially limited human resource capacity; no technical health staff	Represents the government of Uganda in negotiations with UNHCR; no regular relationship with MOH; has district-level representation for day-to-day security and protection issues within camps
UNHCR	Originator of the SRS as part of global effort to seek long-term solutions to protracted refugee situations	SRS would allow for scaling back of activities and support; capacities lie in policy and administrative areas; limited 'development-oriented' capacities. Motivated to create 'successful' SRS experience for replication elsewhere	No regular contact with MOH; partnership with OPM (Kampala) for both policy development and financial support. Relatively limited interaction with district leadership, seen by district stakeholders as driving the SRS

Table 6 Continued

Stakeholder Party	How affected by the SRS	Capacity/motivation to participate in addressing the integration of services	Relationship with other stakeholders
Donors	Called upon to support funding for SRS-related needs	Some donors motivated to support the process, but others limited by commitments to channel all funding through national government mechanisms (i.e. SWAps) and/or limited interest in refugee issues generally	Received limited and sporadic information from UNHCR/OPM. No direct relationships at the district level with regard to refugee-related issues. Perception that refugee issues are handled by other parties
<b>District Level</b> District Health Management Team	Responsible for implementation of SRS within health sector	Motivated to incorporate refugees into service delivery if funding is available; shared health concerns of both local and refugee populations (e.g. immunization, epidemic control, etc.)	Functions under the direction of district administrative offices and local council leadership for financial and other management issues. Received technical guidance from the MOH. No direct relationship with OPM Kampala, limited functional relationship with district level OPM
District Political and Administrative Branches	Must approve any policies such as SRS and formally introduce into local policy; responsible for allocation of resources at district level	Motivated to ensure that refugee population services do not overburden district finances and nationals' political and security interests are guaranteed	Leadership relationship with all other stakeholders at district level. Interaction with donors interested in their specific districts; initially very limited interaction with UNHCR Kampala; little interaction with MOH

Office of the Prime Minister	Responsibilities limited to practicalities of ensuring national and refugee security interests are protected; representation in local council meetings but no voting privileges	Limited capacity to participate in integration of services because lacking technical background; focus is on policy and protection	Reports directly to OPM Kampala rather than district level offices. Limited relationships with other Kampala level offices. Participation in discussions when requested
UNHCR sub-offices	Responsible for ensuring local stakeholders implement SRS. Financial support to parties implementing refugee-related services. Successful implementation of SRS results in diminished field presence with focus on protection	Limited capacity within the health sector. Health related activities addressed through general community services function. Over-all focus is on administrative rather than technical issues	Reports directly to UNHCR Kampala. Relationships with many stakeholders at the district levels, generally as source of funding
NGOs serving refugees	Successful implementation of SRS requires eventual phasing out of NGO funding and services	May be motivated to implement SRS for the long-term interests of other stakeholders; in immediate term may be concerned about changes to their systems, quality of services to refugees, and decrease in funding	Collaborative relationships with other district level stakeholders may vary based on interests. Good collaboration on health activities with the district on most issues
Refugee leadership and community	Concerned about costs, quality, and accessibility of services for refugees under implementation of SRS	Not strongly motivated for implementation of SRS unless concerns about service delivery are addressed; perception that UNHCR is abandoning refugees through SRS	Regular contact with district level OPM and UNHCR contacts, at times antagonistic due to changes in service delivery. Limited contact with district health team; closer collaboration with NGOs providing services

Source: The conceptual content of this table is based on a model presented by AusAID in 'AusGUIDElines', chapter 1: 'The Logical Framework Approach: Analysing the Situation'. Available at: <http://www.ausaid.gov.au/ausguide/ausguidelines/1.cfm>

ambitious effort. But in equal measure, the vision of incorporating refugee health services within the district system was stymied by a focus on integration as an administrative handover without adequately planning for the ways and means by which to address differences between systems in terms of inputs and management processes.

While funding was a critical point of contention between stakeholders as they attempted to translate the SRS from policy to reality, an exclusive focus on that issue leads to an oversimplification of a complex situation. Table 6 above highlights other issues that contributed to the challenges. As the table implies, the large number of stakeholders in the process and the variety of relationships and motivations of each proved fertile ground for suspicions and misunderstanding as UNHCR and the Office of the Prime Minister attempted to unroll the SRS. The next section of this paper describes the practical experience of health services integration in Arua and Adjumani districts.

### **Practical Implementation: Handover of Imvepi Health Services to Arua District**

The first attempt at refugee health integration came in late 1999 in Arua district. Oxfam (UK) had been implementing a variety of refugee programmes at the Imvepi settlement for several years, including health services, but had decided to withdraw by the end of the 1999. UNHCR approached district health management to take over two health units serving 12,500 refugees. In the spirit of the Self-Reliance Strategy, Arua district agreed. In so doing, the district assumed responsibility for the management of all service and administration activities of those health units, such as staffing and salaries, patient management, referral services, cost-sharing, drug supplies, and outreach activities. Because there were key differences between the refugee and district systems in many of these areas, a series of planning meetings were held. These *ad hoc* meetings were managed by UNHCR field administration, and focused almost exclusively on the administrative details of the handover such as inventory, staff lists, and vehicle transfer. The most obvious and immediate differences were discussed on an issue-by-issue basis as a means to achieving the simultaneous and all-inclusive handover of all aspects of the health services.

With the background to this situation as described, it is not surprising that this approach yielded less-than-optimal results. Indeed, plans to hand over health services to the district at Rhino Camp in 2001 were delayed due to the problems in staffing and other administrative issues which had occurred following the Imvepi handover. Underlying problems, such as confusion over leadership roles and lack of a common vision between key stakeholders, led to problems in the administration of resource flows and conflict over the long-term ownership of assets. Decisions were made by managers with very little consultation with other stakeholders such as the health care providers and users. Both providers and users expressed their concerns at the manner the handover was implemented. It was difficult to retain health care providers at

both health units, and a survey of users overwhelmingly indicated a perceived decline in the quality of care (Rowley and Burnham 2002).

This approach led to tangible problems. For example, the refugee and district health units have different staff structures. Upon conversion to a district health unit, the refugee health unit at Arua needed to conform to national staffing norms. This change involved downsizing at the refugee health unit, as well as the transfer of some staff from the NGO salary scale to the government salary scale. Additionally, while the office of the District Director for Health Services and UNHCR had agreed that some of the refugee health centre staff would be retained within the government health unit structure, it was originally assumed that since UNHCR would continue to pay the salaries, they would not have to be formally incorporated into the district system. Instead, the district administrative authorities required that the staff be formally hired by the district and presented with appointment letters. This led to delays in the official deployment of health centre staff. There were also questions about which benefits could continue to be paid within the district system, what to do about health insurance, and whether the staff should be hired on contract or regular appointment. Eventually, this confusion led to difficulties for health unit staff who, within the first months of employment, had not received contracts and threatened to go on strike.

### **Quality Design Approach for Planning Systems Integration in Adjumani District**

In Adjumani district, where there were 22 refugee health facilities compared with seven in the district system, it was clear that an alternative approach to health service integration was needed. As difficult as the handover of two health units proved to be in Arua, the idea of handing over many more in Adjumani, even in a phased manner, was problematic. Additionally, Adjumani was a new district, only created in 1997 out of what had been part of Moyo district, and was struggling to meet the health needs of the local population. The Johns Hopkins Bloomberg School of Public Health, in collaboration with Save the Children (UK), introduced Quality Design as an alternative planning mechanism. Quality Design is an approach that brings user expectations together with technical standards to design a new product or process. Its emphasis is on the design of a new product or process that produces a quality outcome, rather than the more conventional quality improvement methods that focus on strengthening existing processes.

#### *Building Consensus*

Quality Design, as adapted for this project, built heavily on identifying the users and stakeholders, documenting their needs and understanding the organizational environment in which services are provided. Although the Sudanese refugees and Ugandans living in West Nile were the ultimate users of the

integrated health services, the district health service personnel were the user segments of primary concern to the project. It was they who had to make the integrated planning process work. Other key stakeholders included the various district and national administrative units, UNHCR, NGOs and the refugees themselves. Building consensus among users and stakeholders on priorities was at the heart of the process, which was achieved at a two-day workshop with wide participation from refugee and national community representatives, health care providers, managers, district political and administrative officials, and national level policy makers. The plenary mandated a quality design team (the District Integrated Health Coordination Committee) to plan for the integration of key health management areas, and project staff later provided training in Quality Design concepts, methods and tools to this team to carry the process forward. With these tools, the committee worked as a team to develop strategies that were heavily data driven.

### *Quality Design Overview*

Team members thought about health service delivery from a system perspective, rather than focusing on specific health units. They looked at Primary Health Care services in Adjumani as divided into various subsystems, including reproductive health, health promotion, supervision, immunizations service, nutrition, child health/IMCI, school health, disease control, and the health information system. As a starting point, health managers selected immunization, health information, and supervision activities as areas where the integration process was most likely to succeed within existing structures and resources. The data for these activities, from both refugee and district health programmes, were collected and analysed to guide creation of integration action plans. These specific action plans were then incorporated into annual work plans for 2002 by Adjumani district and NGOs implementing the refugee health services. While a more complete description of Quality Design as used in this context is the subject of a previous paper (Burnham *et al.* 2003), a brief outline of steps in this adapted planning methodology follows:

1. Create a common will and vision for change
2. Understand and document current situation
3. Build consensus among stakeholders on priorities
4. Establish a quality design team to follow up priorities
5. Provide training and tools to the team
6. Gather data on priority services and assess the health services resource base
7. Provide feedback to stakeholders and solicit responses
8. Analyse data to determine common and divergent areas
9. Establish work plans to bring divergent processes together
10. Implement and monitor work plans for integration of processes

## **Key Differences between Quality Design and the Handover Approach**

### *Team-building*

One of the most important components of the quality design approach to integrating services is the establishment of effective teams. In the case of Adjumani district and refugee health services, it was particularly important to bring together parties that had previously been suspicious about the idea of integration. As a team, the key stakeholders could create a common vision for the integration, which in itself allowed the process to begin. While team members were able to participate fully and freely in the rest of the Quality Design steps, the establishment of the District Director for Health Services as the chair of the District Integrated Health Coordination Committee clearly identified his leadership role. Acting on behalf of the team, he could make progress more quickly than if he had acted on his own. This contrasted to the handover approach which did not rely on a team mandated by a wider stakeholder group.

### *Using Data for Planning*

Data played an important role in the entire process and had been absent in the handover approach. Data helped members of the District Integrated Health Coordinating Committee understand how the present system was functioning. The flow charting of activities with data about the individual steps within sub-systems, such as immunization, was eye opening for many members and gave them an understanding of where refugee health services and those of the district were managed in either a common or divergent manner. Armed with this information, the new integrated processes could be designed and flow charted. The experience of using data-based methods gave team members the capacity to apply this approach to other sub-systems. In contrast, an independent review of UNHCR community services notes that with regard to the experience in Uganda, the agency's lack of data was very detrimental to the process:

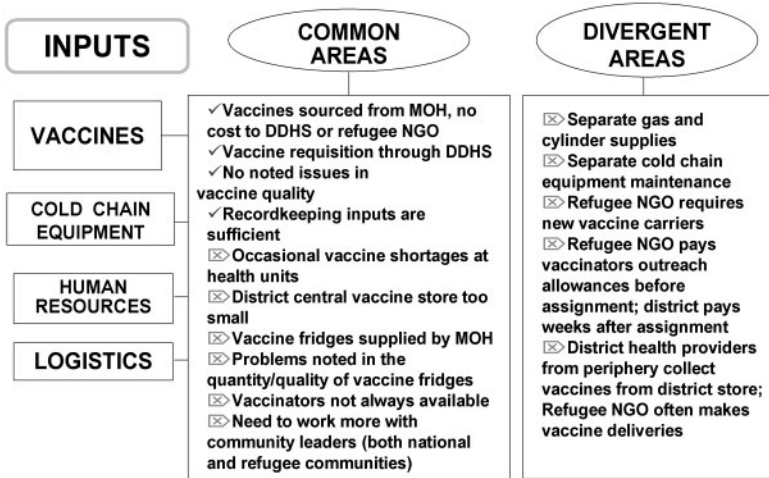
we find that UNHCR has invested little in gathering and analysing basic information required to develop strategic initiatives... This low level of investment in information and learning on the part of UNHCR is reflected in low credibility among [implementing partners] and other actors who question the role of UNHCR as lead agency when it does not have the tools or analysis to coordinate resources and activities that actually lead to refugee self-sufficiency (CASA Consulting 2003).

### *Viewing Health Services as Systems*

Quality Design considers health care services as systems, both *programme-related*, such as an immunization system or community outreach system, and *administrative*, such as health management information systems and personnel management. While issues may arise in a specific system, the entire range of inputs

Figure 3

**Identification of Common and Divergent Areas within Refugee and District Immunization Inputs**



**Legend:**

- ✓ = Does not require special action for integration
- ⊗ = Problem area, requires action for integration

and processes within each is reviewed to identify and resolve differences. As an example, Figure 3 above illustrates how the team identified common and divergent areas in refugee and district immunization systems. This approach contrasts to the Imvepi/Arua experience in which health services were viewed as the handover of a physical infrastructure, staff, and all systems, from one party (NGO) to another (district). The latter approach is problematic because it forces stakeholders to deal with multiple issues simultaneously while not seeing the problems before they arise, as is possible when taking a systems approach.

*Results*

As a result of the quality design process, Adjumani District today has one immunization system. Although jointly managed by the district health services and AHA, the non-governmental organization contracted by UNHCR to deliver health services to refugees in the district, it is run according to district policies. In early 2005, project staff revisited Adjumani District to learn about the results of the integration of the immunization function. Among the divergent areas initially identified in the figure above, as well as the common areas requiring improvement, all have been addressed. The district health services now manage a single system for gas and cylinder supplies that incorporates both district and refugee health units. The district also manages all cold chain

equipment maintenance, includes refugee health units in its schedule of updating vaccine carriers, and ensures that refugee health units receive new vaccine fridges as necessary from the national immunization programme. Upon completion of a new district vaccine store, all vaccine supplies for both district and refugee health units are warehoused within the district's system which helps to ensure a harmonized distribution system.

While all staffing continues to remain separate between the district and refugee health services, the vaccinator vacancies have been filled and all are trained together under the district system. As well, where refugee and district systems had previously differed in terms of allowance payments to vaccinators, all staff involved in immunization outreach are currently paid under the district's system.

Despite promising results in the area of an integrated immunization system as described above, the overall direction of SRS implementation continued along the lines of a handover approach. As noted in the introduction to this paper, a mid-term review of the Self-Reliance Strategy undertaken in April 2004 found many issues at the community, district, and national levels which prevented any meaningful progress in the implementation of the SRS. With regard to the integration of services, the report authors found that concerns about financial sustainability, quality of services, and a lack of common integration guidelines across districts and across sectors had contributed to the failure of the SRS. Referencing the education sector, they also noted that the transfer of functions (i.e. systems) within a sector was more successful than the transfer of service units. The same could be said for health services where, in the case of both Adjumani and Moyo districts, certain health units were handed over from the refugee NGO to the district only to be taken back some months later. UNHCR was not satisfied with the quality of services provided and had serious concerns about the administration of funds within the district administrative offices. Today, the health units originally under UNHCR through its implementing partners have reverted back to management under those organizations. Any further efforts to integrate services will likely fail so long as those managing the process perceive the change as an administrative function, based on the transfer of resources represented by the health unit itself. The experience with the immunization system in Adjumani shows that service delivery integration from a systems approach has a much better chance at success and one of the recommendations from the SRS mid-term review states that, 'transfer and integration should be based on functions in a sector (based on assessment of those functions the districts have a capacity to handle), and be accompanied by capacity building efforts' (SRS Mid-term Review Team 2004: 36).

After the mid-term review of the SRS, UNHCR redoubled its efforts to create a durable solution through local integration in Uganda. This has resulted in the replacement of the SRS with another policy document, the 'Self-Reliance Strategy–Development Assistance for Refugee Hosting Areas in Uganda', which forms part of the effort to work within the agency's Framework for Durable Solutions and Convention Plus commitment, emphasizing more

targeted development assistance to affected communities. The document sets out to address many of the shortcomings of the SRS (Government of Uganda (OPM) and UNHCR Uganda, 2004). Nevertheless, most of the health sector plans revolve around the expansion of physical infrastructure, and technical training for a limited category of staff. The benefits of service integration through functions within a sector highlighted in the SRS mid-term review have not yet clearly translated into plans under the SRS-DAR.

## Conclusions

Protracted refugees situations in Africa and many other areas are not a new phenomenon. Since the 1960s the international community has struggled to meet the challenges of local integration and refugee self-reliance. Current financial pressures within UNHCR have forced the issue to the forefront once again and there is renewed interest in refugee self-reliance and local integration concepts. Local integration can be defined both from the perspective of the integration of refugees into local societies, and the integration of refugee services into local systems. This paper has focused on the integration of refugee health services into district health systems in West Nile, Uganda, highlighting the impact of parallel refugee services on health management and resources, and two different approaches to service integration.

In the case of Uganda, the integration of health services has been problematic. The handover approach as described in Arua district resulted in confusion over a number of issues including the critical staffing function. Integration was perceived as the physical handover of equipment and facilities, and an overall shift in responsibility for staff and recurrent cost inputs from the international community to the district. In contrast, Quality Design is a planning tool that can help health managers tackle services integration through consensus-building, team work, the collection and application of data, and perhaps most importantly—viewing health service delivery as a set of *systems* rather than simply as health units, equipment, and staff. As described elsewhere, district and refugee health managers used Quality Design to plan specifically for the integration of immunization services in Adjumani district.

If UNHCR is to pursue the objectives of local integration and refugee self-reliance in response to protracted refugee situations and continued financial pressure, it is critical that both the agency and the international community as a whole look carefully at how these aims can be achieved in ways that ensure the best possible services for both refugee and host country populations. Quality Design is not a one-stop answer for all systems integration problems. However, it is a team-based, systems-oriented, and data-supported planning methodology that builds a locally-generated action plan to facilitate implementation by the involved parties. It is offered as a concrete, field-managed mechanism with potential for application in other sectors and settings as UNHCR and other refugee and host country stakeholders search for ways to manage systems integration in protracted refugee situations.

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