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Integrating refugee and host health services in West Nile districts, Uganda

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Refugees are a common feature in Africa and Uganda is no exception. However, Uganda does not have the resources to provide health care to all its own citizens, let alone to refugees. Refugee health services are therefore usually set up and provided separately by international organizations such as the United Nations High Commissioner for Refugees (UNHCR). However, such services often end up being the only available or reliable services in a particular location for both host and refugee populations. Yet the host populations are often denied access to these services because, in theory, other services are being provided by their government. The case study in the West Nile region of Uganda describes how host and refugee services were integrated in an attempt to address the concerns of inequity of access to care for host populations, when reasonably good health services were available to nearby refugee populations. The paper identifies and discusses the challenges encountered and those remaining.

Key words: integration, health service, refugees, host population, Uganda

Introduction

Since World War II, Uganda has hosted thousands of refugees from several African and European countries (Ginyera-Pinycwa 1998). Today, an estimated 216 830 refugees are settled in 10 districts across the country. Most of these refugees, 188 200 (87%), come from southern Sudan and have lived in Uganda for over a decade (UNHCR 2003).

The policy of the government of Uganda allows refugees to live in settlements as opposed to camps (Government of Uganda 1999). The settlements resemble villages and refugees are allowed to travel freely within the settlements and surrounding villages. They are allocated land to cultivate based on the number of household members. The practice of land allocation for refugees is not common in many other countries. Settlements offer opportunities that have given Uganda a reputation as one of the most generous host countries in Africa (Burnham et al. 2003).

The refugee health system has operated parallel to the host system with minimal interface between the two health systems. Refugee health services are provided by a variety of non-governmental organizations (NGOs) including international, regional and locally based NGOs under the coordination of the United Nations High Commissioner for Refugees (Government of Uganda 1999; Burnham et al. 2003). Refugee health services are better funded, better equipped and have more highly skilled personnel (Burnham et al. 2003). The accessibility to health services (both first-line and referral) is also better.

In 1999, the United Nations High Commissioner for Refugees (UNHCR, the UN Refugee Agency) and the Government of Uganda – Office of the Prime Minister (OPM) developed a strategy to improve refugee self-reliance and integrate refugee health and social services into host systems in the West Nile region (districts of Arua, Adjumani and Moyo), which hosts the majority (70%) of refugees in the country (UNHCR 2002).[1] The integration of services envisioned the elimination of parallel service systems for refugee and host populations. The strategy was developed in a context where the refugee situation in the region had evolved from emergency assistance to post-emergency local settlement.

The goal was to improve the standards of living of all the people (refugee and host) living in the refugee-affected areas (Government of Uganda 1999). This paper describes the process, assesses the consequences and discusses the challenges encountered during the integration of refugee and host health services in the West Nile refugee-affected region of Uganda.

Methods

Data on the integration process were collected using both qualitative and quantitative research techniques. Interviews were conducted with a total of 21 key informants (Table 1).[2] In addition, four focus group discussions were held with refugee and host community opinion leaders in Imvepi and Rhino-camp settlements, respectively, in 2002. A review of monthly statistical records of outpatient department (OPD) service utilization

Table 1. Profile of key informants interviewed

Administrative level/institution	No. of persons interviewed
Central level	
Office of the Prime Minister	4
Ministry of Health	2
District level	
Policy and Administrative Officers	5
District Medical Team	4
UNHCR and NGOs	6

(i.e. curative consultations and referrals) by refugee and host populations in Imvepi refugee health facilities was undertaken. The main sources of health service data/statistics reviewed were OPD treatment records and admission and referral record books. Data were collected from the two refugee first-line health facilities, namely Imvepi HC2 and Yinga HC3, existent in the Imvepi refugee-affected areas. Refugee health services at Imvepi refugee settlement were the first to be integrated in the West Nile region. Data were collected for a period of 5 years, spanning 1999 to 2003. A pre-designed data collection sheet was used. Data were collected on patients who had OPD curative consultations and those referred from the two refugee first-line health facilities to any of the three district referral hospitals (i.e. Arua, Kuluva or Maracha). The data were collected by two in-charges, one each from the refugee first-line health units, i.e. a nurse midwife and clinical officer, a medical doctor and the principal investigator. Data collection (review of records) took place during March to April 2004.

Data on persons referred were categorized under emergency and non-emergency conditions. The categorization was based on analysis of patient case treatment records and referral notes. Emergencies were sub-categorized under obstetric, surgical and medical conditions.

The paper also draws heavily on review of documents pertaining to refugee integration and self reliance strategy; involvement in the participatory evaluation of the integration of refugee and host health services in the West Nile region–Arua district, conducted in 2001; and participation in various planning and sensitization meetings held during 1999–2003 at district, regional and national levels.

Current refugee situation in West Nile region, northern Uganda

There are an estimated 176 000 southern Sudanese refugees living in the West Nile districts of Arua, Adjumani, Moyo and recently Yumbe, as illustrated in Figure 1. The region hosts the bulk of refugees living in Uganda. During 2003, Uganda hosted an estimated 216 000 refugees. The majority of refugees in Uganda (88%) are from the Sudan (Figure 2).

The forced migration of the present Sudanese refugees began in 1986, following escalation of the civil war between the rebel Sudanese Liberation Army (SPLA) and government forces. An influx of most of the refugees occurred during 1990–95 when an estimated 135 000 refugees were received into the districts of the West Nile region. During 1996–2000, the influx of Sudanese refugees into Uganda reduced following the recapture of the southern Sudanese towns of Rumbek and Yambio by the SPLA (Opio, personal communication, 2000).[3]

As shown in Table 2, during 1998–2001, refugees constituted on average 13.3% of the total population of the West Nile region, with nearly half (47.2%) being settled in Adjumani district alone. On average, during 1998–2001, more than a third (36.9%) of the total population of Adjumani district comprised refugees who lived in 33 settlements interspersed within the district. In Moyo district, one in five (20.3%) of the total population were refugees, living mainly in Obongi county where they comprised 44% of the county's population. Refugees comprised 6.1% of the total population of Arua district. They were hosted in two large settlements located in Madi Okollo and Terego counties, where they constituted 24% and 9% of the counties' population, respectively. The majority of the refugees have lived for over a decade in the West Nile region.

Refugee settlement in Uganda

Historically, the first refugee settlements were established in Uganda during World War II to host European and African refugees who had been received into the country. During 1942–1944, the government of Uganda 'gazetted' areas to avoid the mixing of the European refugees with the host population (Ginyera-Pinycwa 1998). In the 1960s, five new settlements, namely Acholpii, Nakapiripirit, Nakivale, Kyaka and Kyangwali, were created in northern, eastern and western regions. Since then, the government of Uganda has adopted a policy of hosting refugees who are officially registered with the government and UNHCR in settlements as opposed to camps (Ginyera-Pinycwa 1998; Government of Uganda 1999). Conceptually, a settlement is a designated habitation to host refugees on a long-term basis. Refugees are allocated plots of land measuring about 0.22 square acres per head, for dwelling and cultivation, in a settlement (Government of Uganda 1999). However, owing to the small size and low fertility of the land, nearly 50% of refugees in the various settlements still depend on food rations supplied by UNHCR (Opio, personal communication, 2000).[3] Nevertheless, settlements are well planned, spacious and have services and amenities such as health, school and recreational facilities. In contrast, refugee camps are often characterized by overcrowding and lack social services and amenities, e.g. schools and recreational facilities. Structurally, camps are designed to host refugees for a short period of time.

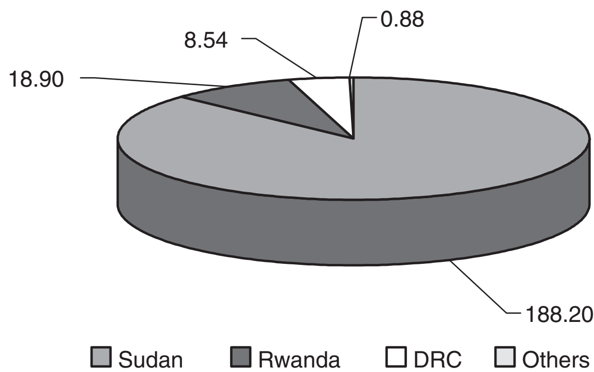
Figure 1. Map showing the study district (Arua) and West Nile refugee-affected districts, Uganda

Three main factors have influenced the establishment of settlements in Uganda. First, the government policy of gazetting/allocating land for refugee habitation, initiated in the 1940s, is still being practised to date. Secondly, settlements are established in rural areas, where population density is sparse. The population density in Uganda has been generally low: 48 persons per km^2 in 1969 and 85 per km^2 in 1991 (Government of Uganda 1994). In 2001, overall, the West Nile region had a population density of 84.4 inhabitants per km^2. The population density in the rural areas of the region was lower, however.

Thirdly, ethnic similarity between refugee and host populations has influenced the establishment of refugee

settlement patterns. For example, most southern Sudanese refugees have been settled in West Nile districts among similar Sudanese ethnic groups – the Lugbara, Kakwa and Madi. The refugees from the Democratic Republic of Congo (DRC) and Rwanda, who belong to the Bantu ethnic origin, are mainly settled in Western Uganda in Kisoro, Kabarole, Mbarara and Hoima districts, among the Bantu kinship.

The first refugee settlement in the West Nile refugee-affected districts was established at Rhino camp, Arua district in the early 1960s (Ginyera-Pinycwa 1998). The establishment of refugee settlement in the region was influenced by several factors: first, the availability of land to host refugees, due partly to the sparse population density in rural areas of the region; secondly, proximity of the area to the refugees' countries of origin, such as Sudan and the DRC; and thirdly, ethnic similarity between refugees and local populations since most of the refugees living in the region from the early 1960s have come either from Sudan or the DRC and are ethnically similar to the main tribes in the West Nile region. Since the 1980s the establishment of settlements in the West Nile region has been further facilitated by the fact that Ugandans from the West Nile region who had themselves been refugees in Sudan and the DRC during the 1980s have been friendly and welcoming to the refugees. The local host population have therefore freely offered land for the refugees to settle.



Data source: UNHCR (2003).

Figure 2. Refugees in Uganda by country of origin, 2002 (population in '000s)

Refugee health services organization

Prior to the onset of integration of health services in January 2000, two parallel health systems existed for refugee and host populations in all refugee-affected districts of Uganda (Orach 1998; Government of Uganda 1999). The management of refugee and local host health services had been carried out separately, with limited interface between the two. Organizationally, refugee health services are implemented by a variety of international, regional and local NGOs under the co-ordination of UNHCR (Figure 3). Structurally, refugee health services are composed of only first-line health facilities (health centres) situated within the refugee camps and settlements.

There are, however, no specific refugee hospitals in any of the refugee-affected districts. Hence refugees are referred to designated public or non-governmental health institutions for management of major and/or complicated medical or surgical conditions. In the West Nile region during the 1990s, Arua regional referral hospital, Adjumani and Moyo district public hospitals, and Maracha and Kuluva faith-based hospitals served as

Table 2. Refugee and host populations in Adjumani, Arua and Moyo Districts, West Nile Region Uganda, 1998–2001

District/population category	Year and population									
	1998		1999		2000		2001		Ave. pop ('98–01)	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Arua										
Host	650 066	(95.5)	667 895	(93.9)	686 174	(93.4)	704 953	(93.1)	677 272	(93.9)
Refugee	30 790	(4.5)	43 654	(6.1)	48 867	(6.6)	52 238	(6.9)	43 887	(6.1)
Sub-total	680 856	(100)	711 549	(100)	735 041	(100)	757 191	(100)	721 159	(100)
Adjumani										
Host	104 548	(60.8)	109 351	(60.1)	114 384	(62.7)	119 649	(67.5)	111 983	(63.1)
Refugee	67 438	(39.2)	69 928	(39.9)	67 915	(37.3)	57 676	(32.5)	65 739	(36.9)
Sub-total	171 986	(100)	179 279	(100)	182 299	(100)	177 325	(100)	177 722	(100)
Moyo										
Host	108 757	(79.8)	113 779	(80.5)	119 016	(79.2)	124 494	(79.2)	116 512	(79.7)
Refugee	27 462	(20.2)	27 554	(19.5)	31 187	(20.8)	32 732	(20.8)	29 734	(20.3)
Sub-total	136 219	(100)	141 333	(100)	150 203	(100)	157 226	(100)	146 246	(100)
Region										
Host	863 371	(87.3)	891 025	(86.3)	919 574	(86.1)	949 396	(86.9)	905 842	(86.7)
Refugee	125 690	(12.7)	141 136	(13.7)	147 969	(13.9)	142 646	(13.1)	139 360	(13.3)
Total	989 061	(100)	1 032 161	(100)	1 067 543	(100)	1 091 742	(100)	1 045 202	(100)

Notes: Ave = average.
Sources: Ministry of Finance and Economic Planning (1992a,b); Government of Uganda (1994); Government of Uganda/Office of the Prime Minister (2000, 2001, 2002); UNHCR (1998, 1999, 2000, 2001b).

the referral facilities. In principal, in each refugee-affected district, the district or regional referral hospital serves as refugee referral facility. The district/regional hospitals have been compensated for the services provided to refugees, with modes of compensation varying from fee-for-service payments to the provision of supplies and equipment to the health facilities. For example, in 1993 Maracha hospital received surgical and laboratory equipment from UNHCR and Médecins Sans Frontières (MSF) to help with the treatment of a new influx of refugees settled in Koboko county, Arua district. The support rendered to the local health facilities (secondary and tertiary) is vital in strengthening capacities for both emergency and general operations of host referral health facilities in the region.

The establishment of parallel refugee health services run by expatriate and locally recruited personnel led to the 'poaching' of qualified staff, including doctors, nurses and midwives and other cadres of staff, from the host facilities (public and private) to refugee health units because of better remuneration (personal communication, Medical Superintendent, Maracha Hospital, 2000).

Refugee health services have enjoyed better-equipped facilities, better funding and better staffing in terms of the per capita availability of more highly skilled staff (Government of Uganda 1999). Transport and treatment costs for refugees are paid by the implementing NGOs or UNHCR. Geographic and temporal access to both first-line and referral facilities for populations living in refugee settlements is better than for rural host populations who live in remote areas. For instance, rates of major obstetric intervention for life-threatening maternal indications in the region were significantly higher (1.01% versus 0.45%) in refugee than in host populations living around refugee settlements (Orach and De Brouwere 2004). Overall, the quality of health care in refugee first-line health facilities is better than in host facilities of similar level (Government of Uganda 1999). Moreover, in remote areas, refugee health facilities may be the only facilities available, or the only ones providing quality services. Host community members have therefore often sought treatment in refugee facilities. Access to refugee services by the host populations has been at a nominal fee.

As illustrated in Figure 4, co-ordination between refugee and host health systems occurs primarily at two levels: at the national level between UNHCR/NGOs and the Ministry of Health and at district level between UNHCR sub-office/NGO and the office of the District Director of Health Services (DDHS). At health facility level, where

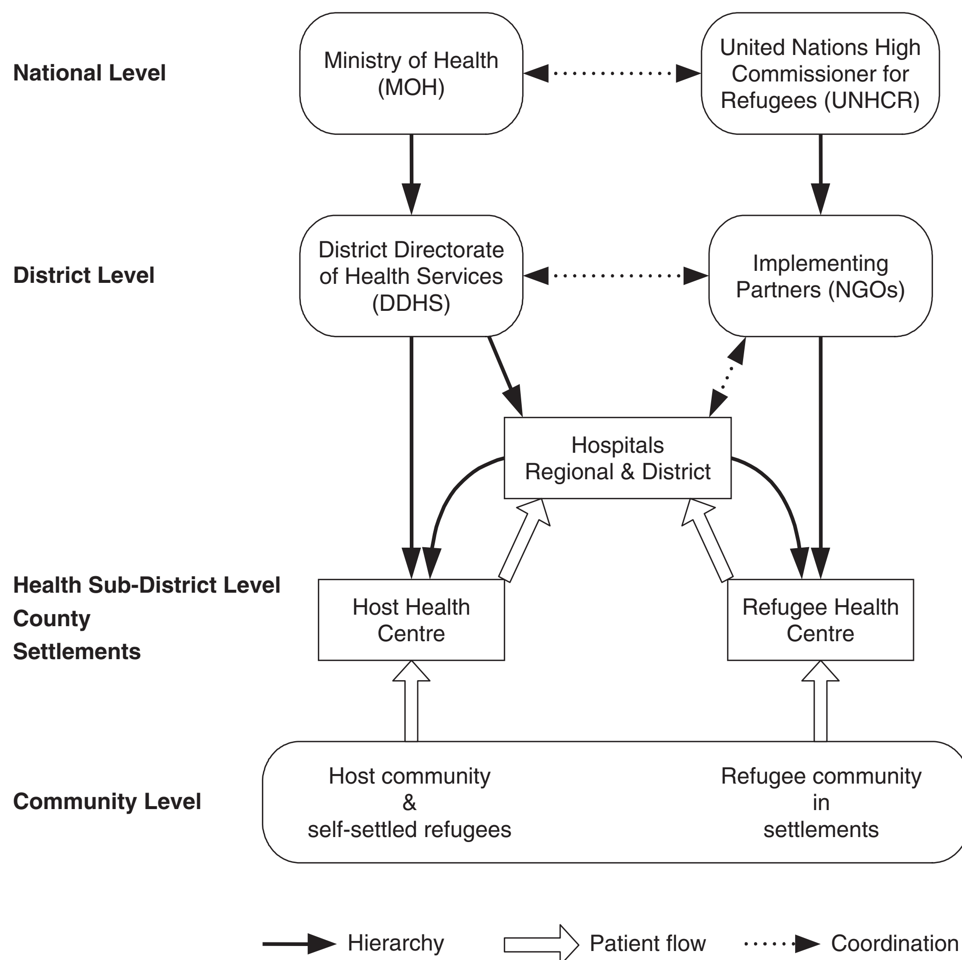


Figure 3. Organizational structure of parallel refugee and host health systems in Uganda

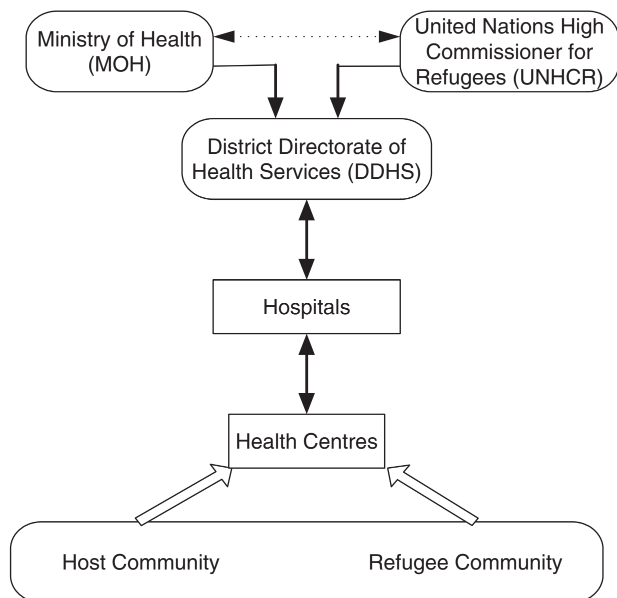


Figure 4. Organizational structure of the integrated refugee and host health system in Arua District, West Nile Region, Uganda

a health centre serves both the refugee and host population, the health unit management committee (HUMC) representatives are selected from both communities. Key functions of the HUMC have been both advisory and liaison between the health facility management staff and the communities served. HUMC members also help sensitize communities on various health matters. Health management information generated by the health facilities is disseminated to key implementing partners including NGOs and UNHCR as well as to the district local health authorities – DDHS and the Ministry of Health.

The integration of refugee and host health services

The strategy

The strategy to enhance the self-reliance and integration of refugee services into the host systems in the West Nile refugee-affected districts of Moyo, Adjumani and Arua was developed by the UNHCR and the Government of Uganda – Prime Minister's Office in 1999 (Government of Uganda 1999). The precursor to the development of the strategy was the evolution of the refugee situation from emergency assistance to post-emergency local settlement. The strategy was based on the premise that while UNHCR usually starts in an emergency by focusing on what needs doing urgently for refugees, in the next phase it looks at what can be done for refugees in a way that also benefits the affected host population. The goal was to improve the standard of living of all the people (refugees and hosts) living in the refugee-affected districts.

Two main factors were instrumental in the development of the strategy. First, UNHCR faced diminishing funding for its relief operations world-wide. Hence funding for chronic refugee situations, such as for the Sudanese refugees living in the West Nile region, was considered neither a priority nor solely the agency's mandate (Government of Uganda 1999; Burnham et al. 2003). Secondly, locally on the government side, there was a desire to see the elimination of the parallel service system and the unequal resource allocation those services represented. Integration of services was therefore considered an opportunity to improve access to health services for the host population living in the refugee-affected settings (Government of Uganda 1999; Burnham et al. 2003).

The process and implementation

In 2000, the process of integration of health services was initiated in Arua district of the West Nile region. Arua district had an estimated 48 867 refugees, comprising nearly 7% of the total population of the district (Table 2). The refugees in the district live in two settlements, namely Rhino-camp and Imvepi (UNHCR 2001a). The process of integration broadly entailed sensitization, handover, execution and evaluation.

Sensitization of key stakeholders was a critical initial step undertaken prior to the handover of health facilities to the district local government. Several meetings, seminars and mass campaign sessions were conducted by UNHCR and the Office of the Prime Minister to create awareness and solicit support. Sensitization was carried out at national, district and community levels, targeting policymakers, administrators and civic leaders for the host population. For the refugee population, extensive consultations and mass campaigns were conducted by settlement commandants and opinion leaders of the refugee population in the various settlements. The consultations were geared towards enlightening the various stakeholders and community members (refugee and host) on the impending policy change regarding reorganization – restructuring refugee and host health services into a unitary health system in the district and subsequently the region as a whole.

The handover of the management of health facilities in the refugee settlements to the DDHS by the implementing NGOs was carried out in two phases. First, two first-line health facilities in Imvepi settlement (Imvepi HC2 and Yinga HC3) were handed over in January 2000. Subsequent handover of four other health facilities (namely Rhino-camp HC4, Siripi HC3; Ocea HC2 and Olujobo HC2) was undertaken in January 2002. The phased merger of refugee and host health facilities was designed to enable the stakeholders, especially the district local health team, to cope with the additional responsibilities of implementing the integrated health services (Government of Uganda 1999; DDHS 2004).

As illustrated in Figure 4, the integration of services led to the restructuring of refugee and host health services into a single unitary health system. The merger of refugee health facilities into the host health system followed the

Table 3. Sources of finances and estimates of local health service expenditure, Arua District, financial years 2002/2003–2004/2005

Source	Financial Year					
	2002/2003		2003/2004		2004/2005	
	Total	(%)	Total	(%)	Total	(%)
Central GoU*	709 473	(79)	861 111	(81)	1 027 778	(83.5)
UNHCR*	186 316	(21)	205 556	(19)	202 778	(16.5)
Total	895 789	(100)	1 066 667	(100)	1 230 556	(100)

Source: DDHS (2004).
Central GoU: Central Government sources include money received from the Ministry of Finance and project funds.
*Cost estimates in US$.

handover of health facilities to the DDHS. The DDHS assumed direct responsibility for the management and provision of health services to the refugee population.

Several key interventions/activities were undertaken to ensure delivery of quality health services in the immediate aftermath of the merger of health services. Disease management protocols and guidelines were harmonized in all refugee and host health facilities. The disease management guidelines adopted belonged to the national Ministry of Health. Thus, staff in the (refugee and host) integrated health system used similar clinical management guidelines/protocols, e.g. sexually transmitted disease and respiratory tract infection (RTI) treatment algorithms or national treatment and policy guidelines. In addition, refresher training for all senior health personnel working in refugee and host peripheral health facilities was conducted.

The majority (over 80%) of the staff – national or refugee nurses, midwives and clinical officers – were retained to work in the integrated health facilities following the merger. However, all expatriate staff who worked with the implementing NGOs left. The remuneration/salaries of personnel who joined the local health services are paid by the central or local government payment scheme with support from UNHCR.

The financing of health services in the integrated health system is shared between central government and UNHCR. The central government is the principal source of funding to the district local public health service, through the monthly grant disbursements. The UNHCR provides supplementing budgetary support to the district health service. As illustrated in Table 3, during the 2002/2003 financial year, Arua district spent a total of 1.348 billion Ugandan shillings (equivalent to about US$709 473)[4] to provide health services for the refugee and host population. UNHCR contributed 354 million Ugandan shillings (US$186 316) or 21% of the district recurrent health expenditure (DDHS 2003), while refugees represent only 7% of the population. During the 2003/2004 and 2004/2005 financial years, UNHCR spent 370 million Ugandan shillings (equivalent to about US$205 556) and budgeted 365 million shillings (equivalent to about US$202 778), respectively, to finance health care services in the district (DDHS 2004). UNHCR has pledged continued financial support to the district for as long as it hosts refugees. During 2002–2004, UNHCR expenditure on health care ranged between 16.5–21% of the district recurrent heath expenditure. UNHCR therefore finances a significant proportion (nearly one-fifth) of the total local health service recurrent expenditure of the refugee-affected district.

Since the onset of the integration (merger) of services, several policy changes have been enacted regarding resource management. For example, emergency transport facilities/services have been extended to cater for the host population who live within the refugee-affected settings. This has led to improved temporal accessibility to referral health facilities/services for the host population, at least potentially. The procurement of materials, drugs and supplies, and distribution to all host and refugee health facilities, is undertaken centrally by the District Directorate of Health Services. However, UNHCR makes a financial contribution towards the purchase of the materials. Personnel recruitment and deployment within the various health facilities (refugee and host) is carried out by the district service commission.

A mid-term review of the process of integration of health services in Imvepi settlement, Arua district, in 2000 revealed, however, that although extensive sensitization of stakeholders had been carried out at national, district and community levels, the handover process was hasty and neither handover report nor inventory of assets was availed to the DDHS (UNHCR 2000).

Implications of health services integration

Consequences

The integration of health services has had important consequences for the delivery of health services in the region. First, refugee and host health services were restructured into a unitary health system. The merger of refugee and host health services enabled the various stakeholders – district local authorities, NGOs, UNHCR and the Office of the Prime Minister – to systematically

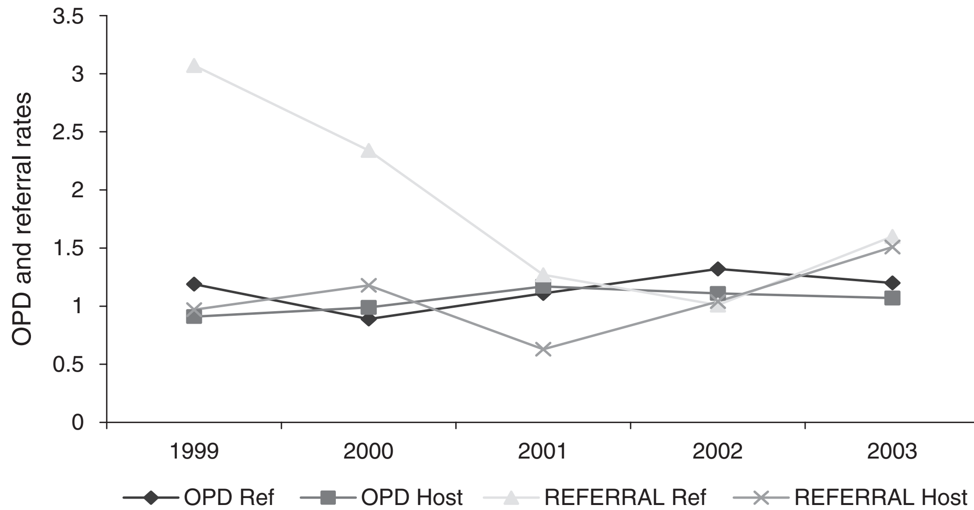


Figure 5. Outpatient department (OPD) curative consultations and referral rates for refugee and host populations in Arua district, 1999–2003

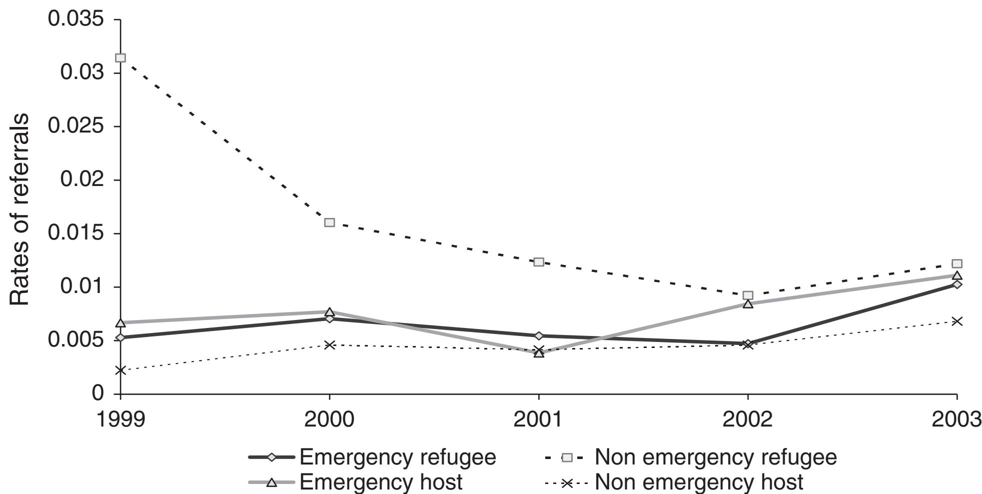


Figure 6. Emergency and non-emergency referral rates among host and refugee populations, Rhino-camp and Imvepi areas, Arua district, 1999–2003

plan for and evaluate the process of integration of the two health systems. The responsibility for providing health services to refugees shifted to the District Local Health System (DLHS). The DLHS receives technical back-up from the Ministry of Health, while UNHCR provides financial support towards running the integrated health system. The integrated health system operates a tiered referral system comprising first-line health facilities levels 2 and 3; health sub-district or level 4 health centre;[5] and the district and/or regional referral hospital.

Secondly, geographic and temporal accessibility to first-line health facilities and referral services for the rural host population residing within and in close proximity to refugee settlements was enhanced by officially allowing the host population to use refugee facilities. While Figure 5 indicates that the global OPD referral rate decreased in the refugee population, Figure 6 shows that the population-based referral rates of refugees referred in an emergency condition decreased before slowly increasing in 2003, where the rate is double that of 1999. The global decrease appears to be mainly due to a sharp decrease in non-emergency referrals. In the host population, both the emergency and the non-emergency referral rates progressively increased and kept relatively parallel to the emergency rates for refugees. In general, medical, obstetric and surgical conditions were the leading causes of emergency referrals in both refugee and host populations.

Thirdly, the integration of health services created positive perceptions of refugee assistance programmes among the host population. Access to and quality of host services had been lower than for refugee services, which had been a source of tension between the two populations. However, when the host population was 'officially' sanctioned to use refugee health facilities, which had

reverted to government control, the host population no longer had to pay user fees. In addition, the host population had free access to refugee transport services. According to the DDHS in Arua, improved access to refugee facilities for hosts eased tensions and contributed to better relations between the refugee and host populations. Prior to integration of services, the host population had the perception of being neglected, albeit having provided land for refugee settlement:

> *"We gave our land for the settlement of refugees, but we have been neglected. We too are poor. Humanitarian agencies should consider us as well."*
>
> (host, focus group, Arua 2000)

In the region, the host populations who lived in the remote areas experienced poor access to and low quality of services due to lack of transport, frequent shortages of drugs and supplies, and lack of qualified personnel in host compared with refugee health facilities. However, the reaction of refugees to the integration of health services was one of cautious concern:

> *"We are not against integration. We can share the health facilities with the host population. We hope we shall be treated well and not discriminated against. We hope there will be drugs in the facilities. But UNHCR should not abandon us."*
>
> (refugee, focus group 2000)

Challenges

The integration of refugee and host health services presents several challenges to the district local health service. From the onset, the DDHS took over the responsibility to run the integrated health system without adequate preparation and limited additional financial and logistical resources. Burnham et al. (2003) also alluded to little guidance rendered to the district local government by both central government and UNHCR concerning implementation of integrated health services.

The sustainability of the operations in the integrated refugee health facilities is problematic to the local government because of limited human, financial, logistical and material resources. Central government monthly grant remittances are the main sources of revenue for district health services. Other sources of funds from district local government and NGOs are limited. The increased number of health facilities (previously refugee facilities) taken over by the DDHS calls for more resources – trained personnel, transport and logistics, and finances – for the effective delivery of health services.

The maintenance of quality health services presents a formidable challenge to the health service administrators and providers in the integrated health system. Prior to integration, the quality of health services in refugee health facilities (operated by NGOs and co-ordinated by UNHCR) was higher than in host health facilities (DDHS 2003). The DLHS therefore faces the daunting task of ensuring the availability of, and maintaining, adequate essential resources, i.e. drugs and supplies, equipment and personnel. The availability of an adequate number of skilled personnel, their training and supervision are critical. In addition, attracting and retaining trained personnel to work in difficult circumstances requires the offer of a satisfactory remuneration package/incentives and motivation. The support of UNHCR and other donors in strengthening the capacity of the integrated DLHS to provide effective, sustainable and quality health services is critical.

Discussion

Our data show a sharp decrease in the rate of refugee referrals and minimal increase in both host OPD utilization and referral following the integration of refugee and host services during 1999–2002 in Arua district, Uganda. Several factors related to human, financial, transport and logistics resource limitations associated with the process of restructuring health services may have attributed to the decrease in referral of refugees to health facilities. UNHCR and other implementing NGOs often encounter difficulties in financing services for refugees in chronic post-emergency settings, such as for the refugees in northern Uganda (Government of Uganda 1999; Burnham et al. 2003). Hence, during the process and subsequent post-integration/merger period, human, transport and logistics resources required for effective implementation of health services were limited. In addition, the guidelines for referral were adjusted by the new management of the integrated health system to cater for both refugee and host populations. Thus, the constraints associated with scarce resources and the change in referral guidelines could have affected the processes of referrals to secondary and tertiary facilities. Burnham et al. (2003) also alluded to a lack of guidelines for the district team during the integration of services in the West Nile region.

Our study revealed increases in host OPD utilization and referral to refugee first-line health facilities and host secondary/tertiary level institutions. The rise in OPD utilization may be attributable to the improvement in geographic accessibility of refugee first-line health facilities, while the increase in referrals was due to improved temporal accessibility of secondary and tertiary health services for the host population living in remote rural settings. Although expected, the increase in OPD curative consultations and referrals was rather marginal. The explanation for this could be that the host population already had some limited access to refugee facilities prior to integration. However, it was notable that referral rates for refugee and host populations became similar over the years 2002 and 2003. The similarity may be suggestive of the harmonization of referral guidelines by the DDHS in the later years of integration. In Guinea, Van Damme et al. (1998) observed a delayed effect of offering referral facilities (medical doctors and ambulance), but the effect of referral services was only visible after 2 years, a period apparently necessary to allow behaviour change

and trust to occur amongst stakeholders. The effects of integration on health services utilization and referrals for both the refugee and the host populations need to be monitored.

The main challenge posed by integration is how the local health system can deliver effective services to meet the needs of both refugee and host populations. Its aim is an improvement in the cost-effectiveness of health services delivery to both refugee and host populations. The establishment of an effective and sustainable integrated health service has important implications for investment to strengthen the capacity of the district local health system in areas of finance, manpower, materials/supplies, drugs and availability of equipment in order to provide quality services. The developing countries that host the majority of refugees have limited resources to provide adequate health services to their own citizens let alone to refugees. In these countries, access to and quality of host health services is often poor (Girald and Waldman 2000; Andaleeb 2001). Refugee health services tend to be better funded and equipped and have more highly skilled personnel (Government of Uganda 1999; Burnham et al. 2003) compared with the host national and sub-national (district) health systems, which usually lack the essential resources – human, financial, logistical and material – required for effective delivery of health services. Thus, the provision of services for refugees to the exclusion of the hosts, who are not offered the same level of care, may create resentment among local populations (Goyens et al. 1996; Lawrie and Van Damme 2003).

In an analysis of the relationship between disaster assistance and long-term development in disaster prone, refugee-affected settings, Fernandez (1979) indicates that the health services delivery systems are often inadequate and inappropriate. Such areas often lack health service infrastructure and have poor communication in terms of transport facilities, hence people have to walk long distances to reach health facilities. In addition, medical staff and material supplies are often in short supply. These constraints increase the vulnerability of the populations residing in such places.

Implementation of the integrated health service is undertaken jointly by two key partners: the host government (central and local) institutions and UNHCR. To ensure the host government institutions effectively and efficiently implement integrated health services, strengthening the capacity of the district level (first-line, secondary and tertiary) health facilities is critical (Hafeez et al. 2004). Strengthening the capacity of the local health system enhances accessibility to basic as well as referral services, for major interventions for both host and refugee populations.

The UNHCR is mandated to protect and assist refugees (Médecins San Frontières 1997). UNHCR coordinates the services rendered by various international, regional and locally based NGOs that assist refugees. The availability of and access to human, financial, material and logistical resources by the local health system in the framework of a refugee assistance programme helps to strengthen the capacity of local host facilities to provide better quality services. Host government health institutions (first-line and secondary) often play vital roles in providing services to refugees during both emergency and post-emergency phases of displacement. Studies by Porignon et al. (1995, 2004) revealed that although the Zairian (currently DRC) health system lacked adequate human and financial resources, the existent local health system was instrumental in providing health services for thousands of Rwandan refugees who fled to Goma during the 1994 crisis. Thus the support of international agencies and donors to host government health institutions is crucial for developing the capacity, and promoting the sustainability and quality, of health services offered by the local health system in refugee-affected settings.

The policy of integration of refugee and host health services signifies a fundamental shift in the organization of health services in refugee-affected settings. The integration of services heralds a move from relief to a development assistance continuum in refugee-affected areas. The integration of services creates an enabling environment to harmonize mutual relationships between refugee and host populations, as well as enhancing accessibility to health services for vulnerable populations living in remote resource-constrained, refugee-affected settings. Developing countries hosting refugees therefore need to consider the policy of integrating services for the benefit of both the refugees and their own citizens.

Conclusion

The policy of integration of refugee and host health services in Uganda has led to the re-organization/ restructuring of refugee and host health services into a unitary health system. The integrated health system is managed by the district local health service with financial and logistical support obtained from both central government and the UNHCR. In general, the integrated refugee and host health system has contributed to improved geographic and temporal accessibility of health services, particularly for the rural host population. A further benefit is an enhancement in the harmonious relationship between refugee and host populations in the refugee-affected areas, which is essential for the welfare and health of the two populations.

However, the integration of health services presents challenges to the district local health system in the areas of sustainability and delivery of quality health services. Addressing these challenges has important implications for strengthening the capacity of the local health system to render effective health services for entire refugee and host populations. The support of international organizations such as UNHCR and other donor organizations towards the operations of the integrated refugee and host health system remains vital.

Endnotes

[1] The West Nile region of northern Uganda comprises five districts, namely Arua, Adjumani, Moyo, Yumbe and Nebbi. All now host refugees except for Nebbi.

[2] Key informants comprised four officials from the Office of the Prime Minister (Refugee Desk Officers Arua and Commissioner for Refugee Services); two Officers from the Ministry of Health (Commissioner for Community Health and Senior Principal Planner). At the district level, interviews were conducted with five district policy and administrative officers, namely the Chairman, District Local Council 5; Chief Administrative Officer (CAO); Assistant CAO In-charge of Health; Chairman, Health Committee LC5; Secretary for Health LC5. Four members of the district health management team (the DDHS, Refugee Reproductive Health Co-ordinator, District Health Visitor and Assistant DDHS or Head, Health sub-district serving refugee and host population situated in Terego County) were interviewed. Six UNHCR and NGO personnel comprising the UNHCR Health Co-ordinator, AHA-NGO Country Representative, Health Programme Co-ordinator and three Medical Officers were interviewed.

[3] Opio G. 2000. The influx of Sudanese refugees in northern Uganda. Adjumani Settlement Commandant, personal communication, September.

[4] Exchange rate in 2003: 1US$ = 1900 Ugandan shillings; rate in 2004: 1US$ = 1800 Ugandan shillings.

[5] The health sub-district corresponds to grade 4 health centres, which provide basic curative, preventive, promotive, maternity and laboratory services. In addition, they provide emergency obstetric and surgical interventions. The health sub-district is headed by a medical doctor.

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