

**HUMANITARIAN ASSISTANCE AND ITS IMPLICATION ON THE
INTEGRATION OF REFUGEES IN UGANDA: SOME OBSERVATIONS**
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1.0 Introduction

This paper outlines the evolution of the 'refugee problem' in Uganda. In addition, an attempt is made to analyze the various modes of assistance offered to refugees by United Nations High Commissioner for Refugees (UNHCR) Non-Governmental Organizations (NGOs) and the state of Uganda from 1960 to present. Finally the paper identifies some obstacles/constraints to the integration of refugees within the existing framework.

Historical Background of refugees in Uganda

The 1951 UN Convention Relating to the Status of Refugees came into force when Uganda was still a British protectorate. Britain acceded to the Convention on behalf of herself and her colonies (including Uganda). Uganda as a state ratified the Convention in 1987 (personal interview with Third Deputy Prime Minister, Hon. Paul Etiang).

The presence of refugees in Uganda dates back to the early 1940's with the hosting of Polish refugees at Nyabyeya in Masindi district and Koja in Mukono district. These refugees were later resettled in Britain, Australia and Canada. However, Uganda's rigorous involvement with refugees and the *refugee problem* started in 1955 when Uganda hosted approximately 78,000 Southern Sudanese refugees (Pirouët 1988:24). In 1959/1960 influxes of Congolese and Rwandese refugees entered the western part of Uganda. Since then, Uganda has played host to thousands of refugees from the following countries: Burundi, Congo, Eritrea, Ethiopia, Kenya, Somalia, Sudan, Sierra-Leone, Senegal, Mozambique, South Africa, and Zimbabwe. However, majority of refugees in Uganda has comprised the nationals of surrounding countries, viz.: Rwanda,

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Congo and Sudan and Kenya. The numbers from Kenya have been minimal compared with the rest.

As a producer of refugees, Uganda in 1972 expelled its own citizens of Asian origin followed by the political and academic intelligentsia. In 1980, almost the entire population of West Nile region was forced to seek refuge in the neighboring countries like Sudan and Congo (former Zaire). The populations residing in the infamous Luwero Triangle, the North and North –Eastern Uganda who could not cross international borders were labeled internally displaced persons – IDPs. On a slightly different note, the 14-year Kony (LRA) war with the government of Uganda affecting mostly the districts of Gulu and Kitgum and the immediate surrounding areas has created a sizeable number of refugees outside Uganda and thousands of internally displaced in Uganda.

Ugandan refugees produced during earlier regimes have been successfully resettled.

National Refugee Policies

Daley (1991) has observed that the political and economic conditions in a host state together with the politics of the international refugee regime to a large extent determine national refugee policies. By the time of the arrival of the refugees in Uganda and the subsequent refugee legislation, external forces were already dominating refugee policy.

Prior to independence, the colonial government had promulgated the *Control of Alien Refugee Ordinance (1960)* which defined certain migrants as refugees. After independence, this Ordinance was inherited and adopted as the *Control of Alien Refugees Act, 1964*. Uganda has since become party to the UN Refugee Instruments and the OAU Convention. Uganda remains one of the few countries where the policy continues to follow the pattern established in Africa by UNHCR (Harrell-Bond and Voutira 1997).

The arrival of refugees in influxes into a country such as Uganda, which in most cases is no better economically than the sending countries, can disrupt the delivery of essential social and economic services. This normally results in the

distortion of the local economy as government may be compelled to share her meagre resources with refugees.

Because governments normally have problems of satisfying these needs, the only alternative open to them is to call upon the international regime to assist in its refugee programmes: something that tantamounts to acquiescing to this regime and therefore comprising its independence and autonomy in prioritizing on issues (Nabuguzi quoting Hastedt and Knickrehm 1988). Under such circumstances, the refugee phenomenon is bound to take on political other than a humanitarian dimension.

Another method that has been set up in Uganda to deal with refugees has been the establishment of refugee settlements. Government and international regime regard the settlements as the best places for easy administration and justification of international aid. Usually the establishment of settlements has an economic motive but in the case of refugee settlements, political and humanitarian factors take major precedent.

As a result of the settlement policy, there are four settlements in the southwest i.e. Nakivale, Oruchinga in Mbarara district. Kabarole and Hoima districts have Kyaka II and Kyangwali respectively; Arua district has two settlements namely, Rhino Camp and Imvepi. Moyo district has only two Kali and Palorinya. Kitgum district has one, Acholpii also known as Agago East and Agago South. Twenty four settlements are in Adjumani district namely, Alere I, Alere II, Arra, Baratuku, Biyaya, Elema, Ibibiaworo, Keyo I, Keyo II, Keyo III, Magburu, Mongola, Nyeu, Nyumanzi I, Nyumanzi II, Olijji, Ukusijioni, Ramogi, Robidire, Umwiya, Uhirijoni, Obilikogo, Kolididi, Maaji. There is one transit camp, Miriye, specially created for Dinka refugees.

Only a small caseload is permitted to stay in urban areas mainly Kampala. This is catered for by care and maintenance projects. Currently, the urban caseload is about 500 refugees and asylum seekers.

Models of Humanitarian Assistance

To respond to acute human suffering and to minimise and control mortality rates, the international regime extends humanitarian assistance to refugees during the emergency period. UNHCR ensures that shelter, food, water and sanitation and health care are provided as soon as possible. But in many cases this assistance arrives after the local hosting areas, normally as poor as the sending areas, are almost depleted of its resources including the natural environment. Moreover the pressure placed on the usually moderate social services particularly the health services cannot be over stressed. In majority of cases hosting areas do not have disaster preparedness plans and the resources to deal with large influxes of people.

Although it is never quite clear how long the refugee stay would be, their arrival means UN assistance and the beginning of the creation of parallel services. The benefits from the care and maintenance project are for the sole benefit of refugees. As Karadawi correctly observes, in this model UNHCR assumes the role of 'father and mother' of the refugees (Karadawi 1983). All basic needs for survival are extended to refugees from whom absolutely no participation is expected. This normally obtains during emergency phase and in camp-like situations. During this time there is massive humanitarian assistance pouring into the refugee camps creating 'islands'/white elephants. Moreover local staff are encouraged to join the refugee organisation due to the very high salaries paid. This depletes the little capacity there might be for the hosting districts (Goyens et al 1996; Harrell-Bond and Van Damme 1996; Wim Van Damme 1998). Although

the *care and maintenance* model targets newly arrived refugees and those in camps, it is still being implemented in Kampala with urban refugees by Inter-Aid² (Inter-Aid 1999) even after many years of refugees presence in a country.

Another model of refugee assistance being implemented in Uganda is *local integration*. This assumes that refugees have been allocated land in organized settlements where they are expected to grow food and sell surplus for other needs. During this period, UNHCR ensures that basic services such as provision of health care and education are catered for. The assumption that all refugees are subsistence farmers was erroneous and led to failure in self-reliance (Harrell-Bond 1986). And as Nabuguzi (1994) observes refugees on many occasions are settled in the most dry and non-productive parts of the host country. This is compounded by the existing refugee policy, which restricts the movements of refugees. This approach isolates refugees, enhances dependency on UNHCR services and does not therefore encourage integration.

In Uganda, UNHCR, since 1995, has adopted a limited version of the '*Refugee Affected Area (RRA)*' approach (Weighill 1997) through which local residents are expected to share the services (health, education, water and so on) established in the settlements. The RRA approach, which, based on the past experience entails:

- That the presence of refugees in a host country was detrimental to both the stability of the host state apparatus (and by extension, regional stability), and to the economic well-being of the host community in closest contact with the refugee population;
- That the provision of relief, based on large-scale administration to refugees in camps or settlements separated from the host community is an inappropriate form of assistance; and

² Inter-Aid is UNHCR's implementing partner for the Care and Maintenance Project for the urban

- That the presence of refugees can be utilised as a “resource for development”, particularly through the development of infrastructure in refugee affected areas (Weighill quoting Gorman).

These three principles combined into what became known as the “refugee affected area” model of assistance – a model, which envisaged the combination of refugee assistance and local/regional development plans (Gorman 1989). The problem is that most settlements are too isolated for local population to benefit. There have been reports of negative attitudes by refugee health workers towards nationals seeking health care and a general lack of information on the part of national regarding use of refugee services. The self-settled must depend on services intended for the hosts. Although implementation of RRA in West Nile has seen the construction, renovation and refurbishment of buildings and road infrastructure, long term sustainability with respect to maintenance and repair is not quite clear.

The fore going mentioned policies and programmes aimed at refugee settlement have not been successful in achieving the above refugee integration as refugees remain dependent on international assistance. Refugees are isolated in settlements, their movements are controlled and parallel social services maintained. There have been reports refugees/nationals’ conflict resulting in jealousies created by this state of affairs.

With the realisation that refugees are not a temporary phenomenon and given donor fatigue and dwindling funds (GoU/UNHCR 1998), UNHCR is attempting ‘*Self-Reliance Strategy*’ as an integration model as a possible long-term solution to the socio-economic needs of refugees and the hosting areas in West Nile in Uganda. The main goal behind this policy is self-reliance and

development. UNHCR has started off in July 1998 with the integration of health services in Arua District.

Integration of Refugees

The UNHCR, in its 'Special Report on Integration', in fact, places 'integration' at the heart of its 'durable solutions' to refugee crises:

"Durable solutions are vital part of the High Commissioner's mandate, and the essentially three forms: voluntary repatriation, local settlement in the refugee's country of first asylum and resettlement in a third country. One factor is common to all three solutions-integration" (1981:5) Furthermore, UNHCR takes the following position on integration: 'Integration ... entails... a range of adjustments - from logistical to linguistic and climatic to culinary - both on the part of the refugees as on that of his new neighbors. Integration is thus a complex issue on which no generalizations can safely be made. The problems, responses, methods and solutions are bound to vary from country to country and from refugee group to refugee group' (1981:5).

Even with the above quotations, traditionally, humanitarian assistance intervention to refugees has for a long time focused on the refugee problem as temporary in nature, with hope for quick repatriation. The assistance rendered by the international aid regime catered for the immediate survival needs of the refugees including shelter, food, medical etc. However, over the years, it has become evident that this traditional approach is not a cost-effective and sustainable way of using aid resources. For example, the refugees tend to stay in the host country longer than anticipated. The case of the Rwandese refugees who stayed in Uganda from 1960 until they repatriated by force of arms in 1994 is still vivid in our minds. It is during their stay and management by UNHCR that hostilities with nationals occur over resources and services, which are better for refugees. And yet the nationals are in a similar or even worse situation. These and many other factors have led to a re-vision of the traditional approach. Hence a search for a more prudent cost-effective and sustainable approach.

The study

The paper presents findings from research study entitled "*Towards the Integration of Health Services in Refugee Affected Areas*" conducted in Arua, Moyo, Adjumani and Masindi. This paper will discuss Adjumani District only.

Formerly part of Moyo district, East Moyo county was launched as Adjumani district in July 1997. Situated in northern Uganda, Adjumani, internationally, borders Sudan to the North, and internally Gulu district to the east and south, Arua district to the west and Moyo district to the northwest. It covers an area of 3051 sq.Kms.

The population of the district is characterized by a heavy presence of Sudanese refugees whose history in the region dates way back to 1955. However, the current refugee caseload arrived during the late 1980s amidst war and famine in southern Sudan. Approximately 67,000 refugees and 74,000 nationals make up the population of the district. Like all other districts in Uganda, Adjumani has a decentralised form of government, while at the same time depending heavily, perhaps due to its infancy stage, on central government coffers. Furthermore, due to large numbers of refugees in the area, the activities of the United Nations High Commissioner for Refugees (UNHCR), her implementing partners, World Food Programme, and other Non-governmental organizations (NGOs) are highly felt.

The approach entails the integration of refugee services with host services. With particular reference to health services, it is hoped that this would lead to an improvement in staffing, equipment, accessibility, utilisation and sustainability and improve relations between nationals and refugees. The overall desired and anticipated outcome being an improved, well co-ordinated, cost-effective and sustainable health delivery system to both refugees and nationals.

Research Question

The study attempted to answer the following research questions: *Why are refugees in gazetted camps provided with better and segregated health services in parallel to those provided by government to surrounding local population settlements? Should these services be integrated to serve both refugees and local population?*

The Main Hypothesis

The main objective of the research was to test the general hypothesis that integration of services for refugees and local populations is a more effective and sustainable approach to assistance than establishing parallel services, and that such a policy is to the mutual benefit of both. It has focused on health services as a paradigmatic case of services to both groups.

Methodology

The research design was cross-sectional and qualitative in nature. The research lasted 15 months from March 1998 to May 1999. The main instrument used in the collection of data has been interviews aided by a questionnaire and a topic guide. During collection of primary data the research employed face-to-face interviews, focus group discussions, and observations. Collection of secondary data entailed content analysis of relevant published and unpublished documents such as agency reports, UNHCR project submissions, loose minutes, memoranda etc from a variety of sources. Some of these sources included the Health Planning Unit (HPU) of the Ministry of Health, Consultant reports, Non-Governmental Organizations (NGOs), UNHCR, health implementing partners, Ministry of Local Government, Ministry of Planning and Economic Development (MPED), Ministry of Finance, and the Government Archives.

Study Population

Table 1: Indicating the study population

| District | Refugee population | National Populatio | Total Population | Refugee as % of total population | Population ratio refugees: nationals |
|--------------|--------------------|--------------------|------------------|----------------------------------|--------------------------------------|
| Arua | 42,316 | 637,941 | 680,257 | 6.2% | 1:15 |
| Moyo | 25,379 | 79,381 | 104,760 | 24.2% | 1:3 |
| Adju mani | 67,658 | 76,292 | 143,950 | 47.0% | 1:1 |
| Total | 135,353 | 793,614 | 928,967 | 14.6% | 1:5 |

Findings

Health Services in Adjumani District

There is one referral hospital - the Adjumani Hospital with a bed capacity of one hundred, which due to high demand of beds, has been stretched to two hundred and sixty five. In the adjacent area stands a nearly completed new hospital building albeit yet non-operational³. The present staffing situation leaves a lot to be desired. The present District Medical Officer (DMO) is also acting as the Medical Superintendent. These two offices weigh heavily on him as he is constantly away from the district on official duties. In addition there are two other medical doctors.

For effective delivery of health services to the refugee community, the Refugee Directorate has assigned a medical liaison officer as a go-between the district health services and refugee health needs. Other staff includes two medical doctors, and a staff comprising seventy of which only twenty-five are trained. The hospital catchment area is the whole district whose population approximates one hundred and forty thousand people including refugees.

The decentralisation policy is in operation and affects all sectors of local district administration including the provision of health services. There are eight peripheral health units (PHUs) (only six functional as two are newly erected and pending inauguration). One medical assistant, two enrolled nurses, twenty-three nursing aides and one hundred and fifty Traditional Birth Attendants (TBAs) staff these. There are two Catholic Mission dispensaries within the district.

³ At the writing of this paper, the new hospital building now constitutes the hospital.

Table 2: Indicating distribution of District Administration health units and staffing levels

| Name | MA | RNW | ENW | EN | EM | MN | L/AS | L/AT | N/Aid | ptr | wtmn |
|--------------|----|-----|-----|----|----|----|------|------|-------|-----|------|
| Dzaipi | - | - | - | - | - | - | - | 1 | 6 | 2 | 1 |
| Openzizi | 1 | - | - | - | - | - | - | - | 4 | 1 | 1 |
| Ciforo | - | - | - | - | - | - | - | - | 4 | 1 | 1 |
| Pakelle | - | - | - | - | - | - | - | - | 3 | 1 | 1 |
| Arinza | - | - | - | - | - | - | - | - | 3 | 1 | 1 |
| Ofua | - | - | - | - | - | - | - | - | 3 | 1 | 1 |
| Pacara (new) | - | - | - | - | - | - | - | - | - | - | - |
| Palaro (new) | - | - | - | - | - | - | - | - | - | - | - |

Note: The majority of staff are untrained nurse aides, porters and watchmen.

Source Adjumani District Local Government Plan (1997 - 2000)

Refugee health services in Adjumani

AHA is an African based organization, which has previously worked in Angola. It is implementing, on behalf of UNHCR, the health and sanitation sector in Adjumani. Trans-cultural and psychosocial organization (TPO) caters for the psycho social and mental needs of the refugees through counseling, treatment and referrals. This paper will limit its discussion on AHA. AHA employs an administrator, a qualified Ethiopian doctor and two Ugandan trained doctors. In addition, AHA employs several paramedicals and nurses of all grades. Remuneration and allowances are by far better than that of Government and mission hospitals.

Twenty-three health units initiated and sponsored by UNHCR are being implemented in refugee settlements by Africa in Humanitarian Action (AHA) to cater for health needs of 67,000 refugees as well as the nationals in their catchment areas.

Table 2 Health facilities being operated by AHA

| Units Name | MA | RN | EN w | EN | EM | MN | L/AS | L/AT | N/A | PTR | wtm n | ss0 |
|-----------------------|----|----|------|----|----|----|------|------|-----|-----|-------|-----|
| Ogujebe Gr 3 | 5 | 1 | | 19 | 5 | | | 5 | 36 | 13 | 6 | - |
| Keyo Gr 2 | | | | 2 | | | | | 5 | | 3 | - |
| Magburu Gr 2 | | | | | | | | | 6 | 1 | 4 | |
| Elema Gr 2 | 1 | | | 1 | | | | | 4 | 1 | 3 | - |
| Agojo Gr 2 | 1 | | | | | | | | 5 | 1 | 2 | |
| Mungula Gr 3 | 2 | 1 | - | 2 | 1 | - | - | 2 | 8 | 4 | 2 | 3 |
| Aliwara Gr 2 | 1 | 1 | | 1 | 1 | | | | 6 | 1 | 2 | 2 |
| Ukusijoni Gr3 | 1 | - | - | 1 | 1 | | | 1 | 5 | 1 | 2 | - |
| Maaji I Gr 3 | 1 | 1 | | 1 | | | | | 4 | 1 | 2 | - |
| Maaji 4 Gr 2 | 1 | 1 | | 1 | 1 | | | | 2 | 1 | 2 | - |
| Maaji 8 Gr 2 | 1 | 1 | | 1 | | | | | 2 | 1 | 2 | - |
| Obilokongo (aid post) | | | | | | | | | | | | |
| Mirieyi (aid post) | 1 | | | | | | | | 3 | 1 | 2 | |
| Kolididi (aid post) | | | | 1 | | | | | | | 2 | |

Source: AHA Quartely report to UNHCR

Note: the fairly equitable distribution of professional staff

Quality and Quantity of staff

As already stated, AHA employs two medical doctors, 15 medical assistants, 6 registered nurses, 30 enrolled nurses, 5 Enrolled midwives, 8 laboratory technicians and several nursing aides for the 67,000 refugees. (During the interview with AHA, it was recognized that these were quite many and that plans were under way to reduce the size. The same opinion was indicated during my interview with UNHCR medical coordinator). The government on the other hand, employs one medical assistant and 23 nursing aides for the six health centres meant to cater for health needs of some 75,000 individuals.

Drug Supply

The referral hospital and the district authority health centres depend on supplies from Entebbe. So do the refugee health units. To do this they have to make returns. The study found that AHA had extra funds from UNHCR to purchase drugs, which are not part of essential drugs list. The study found out that at one point drugs worth millions of shillings, which had been bought before AHA took over the implementation had to be destroyed because they had expired.

Per capita on Health

According to the 1993 White Paper on Health, the Government of Uganda spends US \$ 5 (this figure includes public and private contributions). However, according to an interview held with UNHCR Health Coordinator, UNHCR spends on health approximately US\$ 8 per refugee in the camps. In Arua, they spend US\$ 10 per refugee.

Policies and Inherent Constraints

Uganda's Policies

1) The refugee settlement policy

Refugees are settled in demarcated areas where they are expected to become independent of international aid through agriculture and related economic activities. They are given plots of land and farm implements after which they should grow own food for consumption and surplus for sale so that they are in a position to cater for their health, education and economic needs. This would, it is hoped lead to self- sufficiency of the refugees (GoU and UNHCR 1998 - Long term strategy for Sudanese refugees in Uganda). In Uganda, refugees do not have many options as where to stay. Most settlements in Uganda are physically isolated, often in game reserves and in Tse Tse fly infested areas. Most of them are remote and inaccessible. Kyangwali and Kyaka are such examples. Even the recently established settlements in Adjumani, Moyo and Arua follow similar pattern of isolation. But as recently informed during an interview, by an authority in Government, it would be difficult to give the most fertile piece of one's land to a stranger. Refugee settlements are bureaucratically fenced and gazetted by the state. Nationals are not permitted to 'encroach' on the settlements. There have been constant fights and disputes involving nationals and refugees over land in Oruchinga valley and Rwamwanja. Now that most Rwandan and Congolese refugees have left, nationals have reverted to the use of the land but have been prohibited from doing so. No wonder this measure is a constant source of misunderstandings and could easily cause conflicts.

Refugees in settlements are under some sort of total institution. They are not free to move unless permitted by the Settlement Commandant. Even nationals living within the vicinity have to get permission to enter a refugee settlement (Refugee Act 1964: art 14). Until 1980, refugees were not even allowed to engage in meetings of any sort including that of their welfare. These settlements are also in accordance with donor requirements and policy (Daley 1989:204; Kibreab 1989). It is within these settlements that infrastructure commonly referred to as "white elephant" is created much to the envy and jealousy of nationals who are in most cases not any better off. The marginality of some of these settlements renders them unproductive and with poor marketability of surplus.

2) Decentralization Policy

Currently, the Uganda Government is pursuing decentralization policy whereby power and resources have been transferred to the districts to make development more effective and transparent. The general objective of the health delivery care system is to "decentralize and democratize the organizational and management structures of the system culminating in the devolution of powers and responsibilities to the district and lower levels" (Health Policy draft p6). Furthermore, contributions in form of taxes are supposed to be retained by the districts for development projects. Refugees do not pay tax¹. They are also not allowed to participate in local politics. As such, their contribution in the affairs of the district is not appreciated. In Adjumani, AHA did not seem to be participating in the health planning for the district. The District Planning Unit had said they would invite UNHCR for July meeting. But that meeting never took off. It also appeared from my research and ear to the ground that there is deep mistrust towards UNHCR by Local Government officials. UNHCR on the other hand feels that there is too much dependence on UNHCR by the district.

3) Cost-Sharing Policy

In 1990, the Ministry of Health put in place co-sharing strategy. Patients were expected to pay some money towards their treatment. However, this came at a time when elections were around the corner and no one seemed to want to be identified with it. As a result, the co-sharing scheme lacked guidance as hospitals and health centres seemed uncoordinated in their approach. They would each ask differing charges. But now the scheme has gained momentum, with the charges being arrived at by the District Health Committees. In the refugee camps in Adjumani, co-sharing is in place. Refugee patients are required to pay 100 shillings per month irrespective of number of consultations made.

Despite its being in place since 1990, the policy lacks direction. There is no uniformity with health centres asking different charges. Sometimes the patients pay only to find that drugs are missing. They should be encouraged to pay for what they get. The policy does not come outright on those who may be unable to pay, which would tend to include a big number of refugees, especially the self settled. Also the management of the funds which accrue from the scheme is not quite clear.

UNHCR Policies

1) The short term nature of the policies

UNHCR mission seems to be clashing with reality. In its policy, the Uganda Government stresses on poverty eradication through primary health care, which is a long-term strategy. UNHCR on one hand emphasizes that health programmes should not be different from those of the hosting states (UNHCR 1982:72) and on the other stresses the short-term policies. UNHCR assistance is viewed more as charity although it should be viewed as a moral obligation to the refugees, the internally displaced and the refugee hosting areas.

2) Clash of Policies and Procedures

There are two points to be considered here: First, UNHCR policies do not focus on development oriented projects. Secondly, even if they did, the host countries fear that development oriented projects will in fact result in *de facto* integration (Karadawi 1983).

3) Compromising on Quality and Quantity of UNHCR and Government health services

There is a divergence between policy and practice. Although UNHCR sets out to provide health services as per host countrys' programme, it can not do so because:

- In Uganda Primary Health Care is the basic philosophy underlying strategy of the health policy. This strategy is a long term one, which cannot be satisfied by UNHCR due to the short nature of her policies.

Other Constraints

1) Gender blind policies

With the exception of Oxfam at Imvepi settlement in Arua, the rest of UNHCR partners appeared have a theoretical gender perspective not properly implemented on the ground. However, as has been often observed, failure to design policies from a gender perspective leads to programmes going awry. Although UNHCR has taken great strides regarding the incorporation of gender concerns in policy design, however, the implementation of gender sensitive projects though critical is relatively a new tradition in many of the settlements.

2) Dependency Syndrome

Karadawi says " probably the first lesson would be, in order to achieve self-sufficiency, NOT to think that UNHCR is our father and our mother".

Some Concluding Remarks

The refugee affected area approach to development is a well-conceived idea. However, there are still gaps within its implementation. In order to achieve full benefit of RAA, commitment by UNHCR and government is necessary. There is need as well to address the constraints identified. Most importantly, there is need in trying to harmonize the policies and goals of UNHCR and those of the Government as currently the policies appear to be divergent. Karadawi observes that "African governments must have a say in international organizations' decisions, in order to influence the international policy towards refugee"(1983: 546).

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