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Agency of the South Sudanese: Compensating for Health Care in Mungula Refugee Settlement

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Agency of the South Sudanese: Compensating for Health Care in Mungula Refugee Settlement

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SIT: Development Studies of Uganda, Fall 2014
Dedication:

This paper is dedicated to my mother, Jill Schmidt. I cannot express my appreciation for your endless support and unconditional love.
Acknowledgements:

My indebtedness to Charlotte Mafumbo cannot be overstated. I am beholden to the personal and academic attention you afforded me throughout my time in Uganda. Your fearless work ethic and love of knowledge is inspiring. I will forever look to you as an example of humility and grace.

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your support on a multitude of things—including arranging living accommodations, setting up interviews, and securing transport to and from the field.

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Abstract:

In reaction to the endemic violence, which has forced many South Sudanese to flee their homes and seek refuge within Uganda’s borders, the researcher spent the practicum interning with the Uganda Red Cross Society (URCS) in Mungula refugee settlement, under academic advisor Steven Mawa. As the organization is the leading health provider in the settlement, the researcher gained insight into the provision of social services to the population, which allowed an extensive study on the ability of the South Sudanese to compensate for shortages in care and various complications associated with doing so.

The researcher sought to entertain these inquiries by employing various research methods- including: participant observation, informal and formal interviews, independent observation- with the support of maps, surveys, interview guides, checklists, and translators. The primary data was then cross-referenced with existing literature relevant to the subject, analyzed and organized to create a comprehensive project. Although many challenges were present throughout the process of both ethically gathering research, and objectively analyzing it, the investigator was able to gain insight into the topic of interest.

The research revealed the enormous challenges healthcare providers and beneficiaries face when securing the health of Mungula as a result of scarcity of resources. Although the shortages in public health are largely mitigated by way of international intervention, their effects are still experienced by the refugee and host communities. Furthermore, enormous challenges are faced by individuals attempting to compensate for limited health services. The economic, political, and cultural obstacles faced are further complicated by their status as refugees, and often exacerbate the vulnerability of the population.
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1. Introduction:

Since early 2014, episodes of violent political conflict have forcibly displaced millions of South Sudanese, many of whom have sought refuge within Uganda. The nation’s liberal refugee policies accord its asylum seekers many freedoms, including: permanent residency, religious practice, access to social services, movement, etc. Despite such progressive policy, the human rights actually accorded to refugees if often unimpressive in reality. Many reports emphasize the fact limited resources occasionally inhibit such freedoms from being afforded forced migrants, particularly the right to health.

In hopes of generating knowledge about such injustices and insight into how they might be better addressed, the researcher aimed to do research and a practicum focused around resource allocation in public health services accorded the South Sudanese in Uganda. The researcher would utilize various data-collection methods and tools to analyze the possible resource shortages incurred by the government and how international aid agencies and individuals compensate for such.

The researcher conducted the study in concurrence with interning for the Uganda Red Cross Society (URCS) in Adjumani, Uganda. A majority of the related activities- including: community sensitization, aid distribution, and disease surveillance- were carried out in Mungula refugee settlement, allowing the investigator to gain insight into providing health in such an environment. URCS estimates place the household of Mungula at 1,262. The settlement consists of 4,463 inhabitants, of which 3,262 are classified as “new arrivals” (arrived after March 2014) (L. Schmidt, personal communication, November 18, 2014). The inhabitants primarily identify with the larger Dinka ethnic group, and most are cattle-herders by trade. The population
primarily speaks the local tongue of Dinka, though Arabic and Madi are understood by a significant portion.

As these people remain extremely vulnerable, as a consequence of losing the protection and services of their state, it is important to understand the factors which continue to disempower them following seeking asylum. Doing such will enable governmental and non-governmental agencies to foster a sense of agency among the refugees, and work to ensure the vast wealth of human capital within the settlement is not wasted, to the detriment of both the refugee and local populations.
2. Background:

Reasons for Flight: A History of Violence in Southern Sudan

Political violence has ravaged the Republic of South Sudan since its succession from the Sudan on July 9th, 2011 (LeRiche & Arnold, 2014, p. 1). The most recent outbreak is a consequence of the power struggle between current president Salva Kiir and his former vice president Riek Machar. These leaders have militarized and polarized the country, violently exploiting ethnic differences between the Dinka and Nuer groups to achieve political aims. A prolonged situation of extreme poverty, lack of infrastructure, and instability has enabled leadership to transform political unrest into a grassroots endeavor of ethnic cleansing, forcing millions of citizens to seek asylum elsewhere.

The current crisis of South Sudan can largely be attributed to a history of volatile politics, a lack of economic opportunity, and a feeble development of national identity. The independence of South Sudan was achieved fifty-five years after the Sudan’s own independence on 1 January 1956, following two tumultuous civil wars which spanned much of the latter half of the twentieth century (LeRiche & Arnold, 2014, p. 1). The call for sovereignty was primarily the result of continued marginalization and exploitation from the Northern powers, inciting various ethnic groups with dissimilar interests to ally (LeRiche & Arnold, 2014, p. 238).

The discontent unifying the Southern region was harnessed during the 1983 outbreak of the Second Civil War by the charismatic leader of the Sudanese People’s Liberation Army/Movement (SPLA/M), Dr John Garang de Mabior (LeRiche & Arnold, 2014, p. 17). The rebellion was carried out in the name of revolution, culminating with the signing of the Comprehensive Peace Agreement (CPA), by Sudan’s Omar Hassan al-Bashir and his National
Congress Party (NCP) and the SPLA/M, on 9 January 2005. The CPA was essentially a compromise with no democratic legitimacy, “which allowed Southern Sudan a referendum on full independence, but only after a mandatory six-year interim period during which signatories were committed to ‘making unity attractive’” (LeRiche & Arnold, 2014, p. 17-18).

Any attempts at such failed and exacerbated by the untimely death of Garang in July 2005- Southern constituents “voted almost unanimously for separation in the self-determination referendum” of January 2011 (LeRiche & Arnold, 2014, p. 18). SPLA/M figure Salva Kiir assumed the role of president upon independence under the controversial transitional constitution, which stipulated a four-year period during which a new constitution was to be drafted (LeRiche & Arnold, 2014, p. 141). Under this constitution the president held immense power, deemed by some to undermine the “democratic principals of elected office, as well as the system of federalism” (LeRiche & Arnold, 2014, p. 154). Kiir focused much of this political clout on reconciling the immense discord between the numerous Southern factions which had emerged throughout the struggle to autonomy, but at a great cost to national security; “The SPLA/M brought tentative stability by incorporating armed and political opposition into itself... this strategy has the potential to encourage a dynamic of escalating, or revolving, belligerence.” (LeRiche & Arnold, 2014, p. 184).

The political divide characterizing the elite was paralleled by an economic and ethnic division of the masses. In addition to making the national government susceptible to internal divisions, the SPLA/M’s attempt to incorporate discordant parties into their ranks left “an important element of building a national identity and agenda unaddressed: the use of government to improve key national infrastructure and economy” (LeRiche & Arnold, 2014, p. 147).
South Sudanese economy is estimated to be ninety-eight percent oil dependent (LeRiche & Arnold, 2014, p. 171). A profound inability to diversify, compounded by immense food insecurity, has resulted in endemic poverty for much of the state. At independence, ninety percent of the population relied on small-scale agriculture, and nine out of ten lived on less than USD 1 per day (LeRiche & Arnold, 2014, p. 165). Moreover, a lack of investment in education and health services has proliferated a scarcity of human capital, causing the embryonic state to be “confounded by its over-reliance on a small elite of individuals to define its institutions and policy” (LeRiche & Arnold, 2014, p. 141).

Furthermore, the movement for South Sudan’s independence was made possible by drawing upon “collective opposition’, rather than any ‘inherent harmony’. Lacking opposition in the North, the solidarity of being ‘Southern’ and ‘African’” was certain to dissipate (LeRiche & Arnold, 2014, p. 227). The repercussions of such was a “shallow formation” of nationalism (LeRiche & Arnold, 2014, p. 15). As a vast majority of the population continues to identify primarily with their ethnic group, the South Sudan’s social and political viability has been made extremely vulnerable to the internal manipulations of various political actors (LeRiche & Arnold, 2014, p. 229).

The recent militant actions of Salva Kiir and Riek Machar are demonstrative of such susceptibility, able to exploit the vulnerable environment to serve personal agenda, at the expense of their subjects. Fighting broke out in late December 2013. The continued fighting-despite international efforts to facilitate a peace agreement between parties- has proliferated issues of food security, armed groups, and an “uncompromising political culture premised on militarism.” (LeRiche & Arnold, 2014, p. 20). As the conflict between the two escalated,
“President Kiir mobilized his Dinka ethnic group and Machar turned to his Nuer ethnic group for support”, ultimately resulting in “ten thousand people have been killed and more than one million internally displaced” (Refugees and Displaced Persons, para.1). The contemporary experience of conflict-induced displacement “cannot be view in isolation from other causes. Resource scarcity... can lead to political violence as different groups struggle to control the government, and thereby control diverse resources” (Lischer, 2014, para. 26). It follows, that the struggle for control over diminishing oil reserves has often been viewed as the real reason for the violence.

\textit{Asylum Awarded the South Sudanese in Uganda}

The implications of South Sudan’s perpetual turbulence for its population are far reaching. The painful transformation from mere contested region within another country (‘Southern Sudan’) to independent state (the Republic of ‘South Sudan’) produced millions of refugees... (LeRiche & Arnold, 2014, p. 1). Although the International Organization for Migration (IOM) estimates hundreds of thousands of returnees in the immediate months proceeding and following independence (LeRiche & Arnold, 2014, p. 5), many of these repatriated citizens have been forced to repeatedly seek asylum in neighboring countries as a result of recent warfare, many of which are estimated to have sought refuge in Uganda.

The people of South Sudan have long sought asylum in Uganda, a state seen as particularly hospitable to SPLA/M members. Such phenomena is often attributed to President Yoweri Museveni’s personal relationship with John Garang (the two were classmates at the University of Dar es-Salaam), and the assistance of the Southern forces in conducting counter-insurgency operations against Joseph Kony’s Lord’s Resistance Army (LRA) (LeRiche &}
Arnold, 2014, p. 204). South Sudan has reciprocated the courtesy in times of unrest, hosting many Ugandan refugees in the period proceeding the return to civil war in 1983 (LeRiche & Arnold, 2014, p. 204). In addition to security relations, economic ties between the two countries contribute significantly to the willingness of Museveni’s regime to accept South Sudanese refugees. Uganda has emerged as South Sudan’s leading trade partner (exports into the country reported to be USD 187 million in 2010), and increasing business has attracted many economic migrants from both countries to cross the border in pursuit of financial opportunities (LeRiche & Arnold, 2014, p. 204).

Aside from fluid borders, a relatively liberal approach to hosting asylum seekers has attracted South Sudanese pursuing the economic, political, and social futures they fail to identify within their homeland to seek refuge in Uganda. Those who choose to migrate are customarily afforded a myriad of rights and services, as stipulated in Uganda’s refugee policy.

**Contextualizing Forced Migration in International Politics**

The policies dictating the treatment accorded refugees in Uganda encompass both international and national literature. Notwithstanding that domestic policy maintains ultimate authority over how refugees are to be protected, it is essential to consider the influence of relevant international legislation upon Uganda’s laws. Refugees are most significantly recognized by the United Nations High Commissioner for Refugees (UNHCR), an institution founded in 1951 following the denouement of WWII. Although initially designed to be a temporary body, the establishment was put on a permanent basis in 2003, mandated to proceed ‘until the refugee problem is solved’ (Goodwin-Gill, 2014, para. 6). The UNCHR set international precedent regarding the interpretation of and rights accorded refugees in the “1951
United Nations Convention Relating to the Status of Refugees”, identify a refugee as a person who

"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there because there is a fear of persecution..." (as cited in Refugees and Displaced Persons, para. 2).

Despite a widely acknowledged definition of ‘refugee’, no international instrument delineates ‘asylum’..., merely Article 14 of the Universal Declaration of Human Rights (1948) declares:

“Everyone has the rights to seek and enjoy in other countries asylum from persecution... Asylum granted by a state, in the exercise of its sovereignty of personas entitled to invoke... the Universal Declaration of Human Rights... shall be respected by all other States.... but it is for ‘the State granting asylum to evaluate the grounds for the grant of asylum’” (Goodwin-Gill, 2014, para. 15).

Although no comprehensive international policy mandates the services hosting nations are expected to accord those seeking asylum in its borders, states are obliged to assure that no refugee in search of asylum is “penalized, expelled, or refouled, that every refugee enjoys the full complement of rights and benefits to which he or she is entitled as a refugee; and that the human rights of every refugee are guaranteed”, the rights to health and livelihood significant among them (Goodwin-Gill, 2014, para. 8). Consequently, Uganda’s policies- rather than international refugee law- “determine the extent to which refugees are able to exercise these rights” (Jacobsen, 2014, para. 4).
Uganda’s Refugee Policy: Implementation & Implications

Uganda’s progressive Refugees Act of 2006 has made seeking asylum in the country desirable when compared to other options in East Africa. The measure grants refugees (those whom are recognized and issued an identity card) many of the same freedoms enjoyed by its citizens, including:

The right to "fair and just treatment without discrimination on grounds of race, religion, sex, nationality, ethnic identity, membership of a particular social group or political opinion..., the right of association with non-political and non-profit organizations..., the right to reside permanently in Uganda..., the right to access employment..., and the right to travel outside Uganda and return” (as cited in Uganda's Refugee Policy, 2006, para. 2-5).

Furthermore, refugees are allowed to access the social services, such as education, healthcare, and livelihood support (Uganda's Refugee Policy, 2006 para. 17-18).

Amongst these, the right to access healthcare proves paramount for those seeking protection within Uganda’s borders. A comprehensive definition of health was adopted by the World Health Organization (WHO) in 1948 to be “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (as cited in Ager, 2014, para. 7). As “health status is a consistent marker of the political subjugation and marginalization within societies” (Ager, 2014, para. 14), forced migrants are especially vulnerable to suffering from ill-health. Not only do refugees often enter the host country in a state of poor health as a possible result of treacherous travel conditions, or the inadequate services of their homeland, but are commonly exposed to health risks following resettlement. Cultural factors—such as “social
disconnection, downward employment mobility and the experience of racial harassment—(may) induce significant social stress that not only contributes to mental ill-health, but also physical suffering” (Ager, 2014, para. 18).

The risk of poor health may be augmented if services provided in the country of asylum are found to be inadequate. Although “the role of civil society and the private sector in public health response is increasingly acknowledged, the foundation for such activity remains state and civic provision” (Ager, 2014, para. 22). It is, therefore, crucial the refugee policy of Uganda acknowledges the importance of awarding refugees care indistinguishable of that provided nationals. As a result, refugees experience healthcare provision in accordance with Uganda’s national health system. Uganda’s healthcare is a referral system, consisting of various local facilities (HCI to HCIV), which feed into the district, regional, and national hospitals, respectively (Kavuma, 2009, para. 1). Each level has specific staff and service standards required by law, though seldom often function at such level due to funding and electricity constraints (Kavuma, 2009, para. 3). Relevant to Mungula, a HCIV should: have separate wards for men, women, and children, be able to admit patients, have a doctor for emergency operations, have a maternity ward and lab, and run a general outpatient clinic (Kavuma, 2009, para. 5).

Despite the many merits of Uganda’s nondiscriminatory healthcare policy for refugees, ramifications are inherent when considering the practicality of its implementation. Analysts have often deemed Uganda’s open-handed refugee customs excessive, to the detriment of the local community’s well-being. Already suffering tremendously from a scarcity of human and medical resources, the provision of healthcare is increasingly burdened by the extra beneficiaries.
Refugees may therefore be seen as not only as a consequence of conflict, but a potential cause of it as well (Lischer, 2014, para. 4).
3. Justification of Study & Practicum:

In order to gain a more accurate understanding of the intricate cultural, political, and economic dynamics of a refugee settlement, the researcher’s time was predominantly spent conducting a practicum with the Uganda Red Cross Society (URCS)- the primary actor in Adjumani’s Mungula refugee settlement. The organization’s distinguished professionals and extensive experience with emergency health response made the opportunity invaluable, as the investigator was able to both observe the work of professionals and directly assess their services. The researcher’s skills were matched to the needs of the URCS at the discretion of the program’s operations manager, Steven Mawa, who concurrently served as the project’s academic advisor.

The aim of the research was to investigate the health situation of the South Sudanese inhabitants of Mungula refugee settlement. By evaluating the nature of the services provided and the availability of resources necessary for their implementation, the researcher sought to identify any shortcomings in healthcare. The implications of such were thus examined to discern how such shortages in public health provision affect the population, and how, or if, households independently compensate. The individual’s ability to compensate was evaluated by considering access to income-generating activities and other financial sources. The researcher further sought to assess merits and disadvantages specific to the structures and policies which dictate the allocation of health and livelihood resources within the settlement.

The investigator spent the period of October 20th to October 31st immersed in volunteer work with the URCS in order to establish professional contacts, understand the operations of major organizations, form a relation of trust with the community members, and gain insight into
how resources are allocated within the camp. From November 1st to the 23rd, the researcher continued to participate with the URCS while simultaneously engaging in data-collection; various interviews, focus groups, and independent observations on the issues of interest were conducted during this period. The data was then compiled, evaluated, and organized to fulfill the remainder of the program.
4. Statement of Objectives:

- To deepen understanding of the intricacies of population health in an emergency situation, including the institutions which are responsible for service provision in such an environment.

- To consider the impact of the current South Sudanese refugee influx on healthcare afforded the local population of Adjumani.

- To identify the services and shortages of Mungula’s HCIV and its referral hospital, Adjumani District Hospital. To assess the extent to which service providers and health professionals are able to compensate for scarcities, in order to adequately respond to the needs of the population they serve.

- To examine how various aid agencies respond to any shortages of preventative and curative care, as well as the merits and limitations of such interventions.

- To consider the ways in which the refugees ultimately compensate for limited healthcare, and any cultural, political, or economic realities which present challenges to the private access of services. To evaluate how the lack of such opportunities might contribute to growing problems associated with protracted asylum.

- To discover the ways in which Uganda’s public policy influences the health opportunities accorded to South Sudanese refugees, as well as how existing literature might be improved to better facilitate agency.

- To learn from the professionals of the Uganda Red Cross Society about the complexities of serving a vulnerable community. To reciprocate the opportunity by offering up my time, hard-work, positive attitude, and experiences to develop creative ways to address problems.
5. Methodology:

**Data-Collection Approach**

A multitude of methods and tools were used throughout the research, allowing for the procurement of both qualitative and quantitative evaluations of the health and livelihood conditions in Mungula refugee settlement. The researcher made use of both primary and secondary sources to understand the human impact of healthcare policy. Despite numerous challenges inherent to the data-collection approaches utilized, the researcher was able to overcome many obstacles through carefully formed questions, conducting extensive surveys, and by acknowledging the limitations of the study. This approach enabled the researcher to gain insight into the complexities of an emergency health situation, as well as various challenges associated with providing services within such an environment.

**Data-Collection Methods**

Data-collection methods- including: informal interviews, formal interviews, independent assessments, and participant observation- were employed in a manner sensitive to the situation in which the study was conducted. The researcher selected methods which would maximize the procurement of information. Informal interviews were primarily practiced when conversing with volunteers, health providers, and community leaders. Consistent interactions between the researcher and these populations allowed for a fluid dialogue and for questions to be asked as they arose in the field. The researcher also concentrated the interview process by organizing community meetings in which the topics of conversation were up to the discretion of the refugees. The organic interviews served well in collecting candid quotes regarding the realities of living and working in Mungula. When meeting with service providers and government actors,
formal interviews were commonly utilized. Interview questions were formulated in reaction to
the information gathered from beneficiaries, in an attempt to validate or disprove any accurate or
inaccurate statements respectively. This method proved extremely useful when obtaining specific
information regarding the scope of services offered and the relations of multiple actors within the
aid sector.

Independent assessments were conducted in addition to interviews. The researcher
surveyed and created maps of the health centers and the settlement to evaluate various aspects.
Touring multiple settlements in the district enabled the researcher to gain a comparative
understanding of Mungula’s health situation- an essential undertaking due to the great variations
in the provision of livelihood and health support given by different aid agencies operating in each
settlement.

Paramount to obtaining reliable information regarding the situation of Mungula proved
participant observation, primarily facilitated by the researcher’s internship with the URCS. The
researcher accompanied the volunteer team to the settlement, aiding in various activities, such as:
disease surveillance, data collection, and community sensitization. The community sensitization
meetings served to inform the refugees about various afflictions which posed a direct threat to
the health of the community (including, but not limited to: Marburg, diarrhea, Ebola,
malnutrition, and malaria), as well as basic sanitation practices. Participating in the conducting of
these meetings allowed the researcher to gain an understanding of the complex issues- language
barrier, lack of community participation, and misinformation- the volunteers face when
advocating for preventative measures in the settlement. Sitting in on the internal URCS meetings
proved equally informative, as the researcher gained insight into the workings of implementing
partners. Listening to the employees and volunteers talk amongst themselves illuminated the consequences of resource constraints and disorganization to service provision, as well as what actions are taken to overcome them.

Another advantage to involvement with the URCS was their relation of trust with the community of Mungula. The researcher’s mere affiliation with the organization made possible many of the candid interviews, access to medical records, and visits to other aid organizations. Continuous field visits with the URCS allowed the researcher to form meaningful relationships with community members and evaluate behaviors over an extended period of time. Time spent in Adjumani allowed for considerable immersion into the refugees’ and locals’ ways of life. The investigator utilized the services, latrines, foods, transport, and markets of both the town and settlement, which contributed to an, albeit limited, understanding of the realities of life in the area.

**Data-Collection Instruments**

The methods described were made possible by implementing various data-collection tools, including: maps, surveys, interview guides, checklists, and translators. Four comprehensive surveys were crafted and given to 3 government officials (Appendix 1.2), 13 URCS volunteers (Appendix 1.3), 7 health service providers (Appendix 1.4), and 30 beneficiaries (Appendix 1.5). The surveys contained both definitive and open-ended questions attuned to the specific circumstances of each group. The surveys afforded the participants unlimited time to answer the various questions presented and a heightened sense of confidentiality, creating ideal conditions for thoughtful and honest answers. Additionally, checklists proved useful when conducting independent observations of the health centers. The
researcher was able to assess the extent to which the services mandated in Uganda’s national health policy are provided in the relevant health centers and district hospital. Interview guides facilitated a series of cohesive and professional formal interviews. The researcher made a general map of the refugee settlement (Appendix 1.1) and a detailed map of Mungula’s HCIV (Appendix 1.6). Both maps include a scale, compass, and key to indicate in detail the specific services offered within both areas. The researcher made these maps by cross-referencing pictures, independent observations, and input from various URCS volunteers to create the most accurate depiction possible.

None of the methods or tools mentioned above would have been feasible in the absence of translations services. As the majority of the refugee population have not been formally educated, translators were a vital part of building relations with the community. The researcher utilized the translators vetted and employed by the URCS to ensure legitimacy when interacting with the population of interest.

**Modes of Data-Analysis and Presentation**

The researcher conducted data analysis in multiple phases, primarily: organization, comparison, and analysis. Initially, the researcher went through all the material collected to get a sense of various questions which were raised, and detect if there were any issues which needed additional interviews to resolve. Then the researcher organized the information, identifying major themes and important quotes in the data. Afterwords, the researcher decided to analyze the themes and quotes together, comparing various opinion to identify those underlying topics which might prove important to include in the report.
Upon identifying the ideas the investigator wanted to present, the data was organized in three drafts of detailed outlines, each one more concise than in order to eliminate extraneous information. The outline was then turned into a comprehensive research paper and presentation.

**Challenges to Conducting Research**

Notwithstanding their obvious benefits, numerous challenges arose when exercising the described research methods and tools. Although misinformation, bias, cultural differences, being an outsider, a language barrier, and rationalization proved to be formidable obstacles to gathering authentic information, various actions on behalf of the researcher minimized much of their effects. Misinformation was especially prevalent in the surveys as a plethora of participants recorded vastly different answers for the most objective of questions (such as “how many doctors work in this facility?” or “how many operational ambulances does this hospital have?”). Although knowledge gaps are demonstrative of larger issues at play, they may still prove detrimental when trying to formulate an accurate evaluation of a situation. To combat such problems, the researcher spent significant time cross-referencing multiple answers to each question and confirming claims made by volunteers and refugees with the managers of the hospitals and organizations.

It must be noted that even when information was clearly conveyed, it was subject to the bias’ of its giver and receiver. As it is in their interest to maximize the resources afforded to them, beneficiaries often overemphasized the shortcomings of services provided. Conversely, service providers and government officials tended to illuminate program successes, frequently circumventing inquiries into resource limitations. Communal interviews with both groups may have exposed the intelligence to partisanship, as participants often echoed the concerns of those
who spoke before them. Furthermore, the selection of interviewees may have been subject to the bias of translators and aid workers who, naturally, recommended people with whom they had an existing relationship. As such people are commonly more affluent, connected, and educated, it can be assumed the variety of perspectives and inclusion of minority groups may have been jeopardized.

Prejudice of the researcher, however, proved equally difficult to mitigate. It was difficult for the investigator to avoid comparing services in Mungula to those of Kampala or the developed countries, which could have undermined an understanding of the unique solutions catered to this specific circumstance. To evade the inclination to undervalue Mungula’s health and livelihood programs, the researcher toured comparable settlements within Adjumani district. Objective assessment may also have been further compromised as a result of the researcher’s personal relations with the refugees, empathy swaying the findings in their favor. The many ramifications of bias were attenuated by prioritizing reliability and validity, avoiding the temptation of leading question and confirmation bias, considering all opinions, collating responses with independent assessments, and attempting to select interviewees without regards to personal relations or recommendations.

Bias was potentially augmented by cultural difference between the researcher and the population of interest. The institutional reliance upon religion and patriarchal social structures made identifying with the community an occasionally difficult feat, particularly when such interfered with their reception of services. For example, it was not uncommon for male refugees to reject the provision of HIV tests for their wives. The researcher aimed to reconcile the need
for cultural preservation with the individual’s right to health by evaluating each circumstance in accordance with international human rights standards, though seldom was a balance struck.

The inescapable reality of being an outsider was another challenge to conducting quality research. As the investigator’s status as a foreigner often prompted ideas about wealth and expectations of improved services, it could be inferred that a number of beneficiaries were likely to overdramatize shortcomings in the services they were provided. This problem was curtailed over time by placing repeated emphasis on the researcher’s position as a mere URCS volunteer. The researcher’s foreign appearance may have also engendered a distrust among Mungula’s refugees. Many interviewees were unwilling to be recorded, causing the researcher to hand-write most of the interviews. Such obstacles undoubtedly slowed the dialogue and caused may have resulted in a loss of important quotes and information. The researcher aimed to reduce the impact of mistrust upon the study by initiating relationships with respected members of the community and by learning some of the local languages (primarily Dinka, Arabic, and Madi). The investigator found demonstrating an interest in their community generally led the refugees to be exceedingly more receptive and comfortable when answering question. Despite minor linguistic achievements, an inability to communicate with the population of interest was omnipresent.

The language barrier made the researcher’s time and data tremendously reliant upon translators. It is possible the scope of the study suffered as a result of many instances where the researcher was forced to postpone interviews for lack of a translator. Moreover, as there were no professional or particularly experienced translators within the settlement, the research was made vulnerable to inaccuracy and bias; translators often took it upon themselves to improvise and “improve upon” the reactions of other community members. Restricted diversity among the
translators themselves may also have affected the data. Discriminatory practices limiting women’s education in South Sudan has left the vast majority illiterate. Consequently, most of the translators in Mungula are affluent males, which may have generated gender-biased interpretations of speech. Multiple translators were present at many of the interviews to mitigate impartiality, yet scarce human resources made such modes of compensation difficult to consistently uphold.

Most crucial for the investigator to overcome was, perhaps, the temptation to negatively evaluate the importance of their work. Rationalizing the need for academia in an emergency setting- explaining to the vulnerable population that the inquiries were merely for research-seemed insubstantial at best. Justification for the study was, however, made easier by a conviction that by gaining an understanding of the intricacies of refugee policy and aid, the researcher would be able to better serve those suffering from similar circumstances in the future. Such intent was strengthened by balancing time spent examining with practical assistance, especially through URCS volunteer work.

**Ethical Adherence of Study**

Maintaining a strict adherence to prescribed research ethics further legitimized the study. The investigator acknowledged that the research environment involved working with a particularly vulnerable group of people, owing to the refugees’ diminished political and economic agency. Furthermore, subjects would likely be part of exceedingly vulnerable groups from within the population, including but not limited to: women, children, the elderly, those in a state of protracted unemployment, and those suffering from illness. For these reasons, establishing trust, obtaining a secure interview space, and assuring the confidentiality of all
participants was essential. Members of the government and aid agencies were similarly at risk, as the investigator asked for a critical examination of their employers. The confidentiality measures awarded the refugees were accordingly extended to all subjects to safeguard against professional scrutiny. The researcher drafted a confidentiality agreement to be signed by all participants, securing their legal and academic protection (Appendix 1.7).

**Limitations of the Research**

However disciplined the practice of the described research techniques, limitations of the study must be acknowledged. Logistical constraints significantly restricted the scope of the study. Given additional time and translators, the researcher would have attempted to carry out a comparative analysis of services offered by agencies throughout Adjumani’s other settlements. Additional time could have also enabled the researcher to access some of the more private aid organizations. Minimal knowledge on behalf of the investigator remains another shortcoming of the research. As health is a sector containing copious disciplines and scores of performance indicators, the researcher could only attempt to evaluate the comprehensiveness of medical services offered to the people of Mungula. Comparably, this was the researcher’s first opportunity to work in a refugee settlement; much of the researcher’s time was spent gaining a general understanding of the various policies and actors relevant to Uganda’s refugee system.
6. Research Findings and Analysis:

**Understanding the Health Services of Mungula**

Healthcare is provided the refugees of Mungula predominantly through the HCIV located within the settlement. The health center includes a maternity ward, a lab, an inpatient department (IPD) (comprised of a men’s ward, a women’s ward, and a pediatrics ward), a mortuary, staff housing, and an outpatient ward (OPD). The center sees patients most commonly for malaria, diarrhea, and anemia (L. Schmidt, personal communication, October 22, 2014). The OPD is routinely the most active component of the center, offering a myriad of services, including: drug dispensing, consultations, immunizations, antenatal care, condom distribution, voluntary and routine counseling, couples counseling in sexually transmitted infections (STIs), palliative care, weight/growth monitoring, and referrals to IPD or the district hospital. Moreover, the HCIV extends its catchment health education on various topics daily (L. Schmidt, personal communication, October 22, 2014).

Although the population of Mungula has access to many health services, there exists resources constraints which severely limit the care health professionals are able to impart. When surveyed, about 86% of staff identified space as the most formidable impediment faced at the HCIV. One healthcare provider lamented the “the ward is too small to accommodate all the cases” (L. Schmidt, personal communication, October 22, 2014). An independent assessment of Mungula’s maternity ward confirmed the problem, revealing only one operational maternity bed for the estimated 2714 woman of child bearing age in its catchment (L. Schmidt, personal communication, November 16, 2014). Moreover, “there is no isolation ward for critical
conditions, The population is exposed to tremendous risk, should someone get seriously sick” (L. Schmidt, personal communication, October 22, 2014).

A lack of space is not exclusively preserved for the patients, but is experienced by the staff as well. One professional explained that “housing for the staff is not enough” (L. Schmidt, personal communication, October 22, 2014). The staffer’s sentiments were shared by many colleagues, 3 out of 7 identifying “housing” as their greatest professional resource constraint (L. Schmidt, personal communication, November 17, 2014). The housing allocated healthcare providers was described as “very limited”, a gross understatement considering, in one example, there are 42 people living in a structure built for 8 employees (L. Schmidt, personal communication, November 11, 2014). The lack of housing- combined with the absence of incentive pay- makes it “hard to retain qualified human resources”, augmenting the shortage’s adverse effects (L. Schmidt, personal communication, November 17, 2014). As an additional consequence of limited on-site housing, a number of professionals are forced to seek accommodation outside the settlement. Doing so produces a number of problems, most notably the commute from town makes it “very hard for the nurses to be timely”, usually causing services to be delayed (L. Schmidt, personal communication, October 22, 2014). It is not surprising, therefore, that all those surveyed who did not identify “housing” as their greatest constraint chose “personal transport” (L. Schmidt, personal communication, November 17, 2014).

Transport of patients is also a challenge. Mungula’s HCIV does not possess its own ambulance, complicating the efficiency of referrals. Transporting ill community members from their place of residence to the health center presents additional quandary: community volunteers
of the URCS have reported cases of having to physically carry infirm refugees from their homes on blankets, and of using an old metal chair attached to a bicycle (Attachment 1.10) (L. Schmidt, personal communication, October 22, 2014) Consequently, the congestion and lack of transport of the health facility and the staff housing undoubtedly diminishes the competence of care provided.

Equipment is another shortage faced by the HCIV. Professionals have identified a substandard supply of beds and mosquito nets in the IPD. An independent assessment of the IPD revealed only 4 of the ward’s 27 beds to have nets. At the time of evaluation 19 beds were occupied, leaving 15 patients unprotected. Laboratory equipment is additionally insufficient. Although the lab has two microscopes and a CD4 count machine, technicians expressed serious need of a centrifuge and functioning refrigerator (L. Schmidt 2014). Another constraint voiced by nurses was that there was only one operational computer, which seldom was used to store patient documents due to power outages and inadequate storage capacity (L. Schmidt, personal communication, October 24, 2014). As a result, those seeking care are required to bring in a medical notebook in which to keep their personal records before receiving any treatment. Electricity is an additional issue faced by the healthcare professionals serving the people of Mungula. Although the center has solar power and a generator, the many cloudy days which occur during the rainy season and a chronic shortage of fuel severely undermines the effectiveness of both methods respectively (L. Schmidt, personal communication, October 22, 2014). Unpredictable power outages renders the HCIV unable to maintain a blood bank, and therefore ill-equipped to perform the minor surgeries Uganda’s health policy has assured would be available at a health center of its level (L. Schmidt, 2014).
The manpower of the center has been scrutinized by its staff as “not enough” (L. Schmidt, personal communication, November 10, 2014). Echoing such concerns is District Health Officer, Adunia Anne, who expressed the biggest of Mungula to be that its “human resources are stretched unimaginably thin” (L. Schmidt, personal communication, November 10, 2014). Mungula’s singular record assistant and lone cleaning staff have placed additional duties on the nursing staff often distracting from their other medical duties (L. Schmidt, personal communication, November 10, 2014). Furthermore, the number of translators- especially in the night hours- is insufficient to serve the demand the refugee population places upon the center. As “none of the healthcare professionals speak Dinka, and very few Dinka understand English”, translators are crucial to diagnose and treat patients (L. Schmidt, personal communication, November 10, 2014). The absence of adequate translators could also undermine the work of the HCIV, as it leaves the relationship between the health workers and refugees vulnerable to miscommunication.

The shortages in Adjumani District Hospital parallel those found in Mungula’s HCIV. The hospital suffers, similarly, from limited human resources, housing, equipment, and electricity. The hospital has about 218 full-time staff, only 2 of which are translators proficient in Dinka (L. Schmidt, personal communication, November 10, 2014). The number of healthcare providers is reported by a medical worker to “have never been enough”, currently operating with about “70-80% of the staff a hospital of this size should have” (L. Schmidt, personal communication, November 10, 2014). Whats more, the buildings remain inadequate to house the present staff (L. Schmidt, personal communication, November 10, 2014). Medical equipment is another resource not up to policy standards, as the hospital does not have functioning x-ray or
ultrasound machines (L. Schmidt, personal communication, November 10, 2014). The district hospital also does not have consistent electricity, and generators and solar panels susceptible to weather and irregular fuel deliveries do not sufficiently compensate. The repercussions of such shortages are similar to those experienced by the HCIV.

The allocation of resources to both Mungula’s HCIV and Adjumani District Hospital is the responsibility of the District Health Office (DHO). Adjumani’s District Health Officer maintains that the recent influx of refugees has not had a major impact on the services awarded the nationals because the operational quota sent to the Ministry of Health for Adjumani is still much higher than its actual population. Currently Adjumani is estimated to have 231,621 inhabitants (about 69,000 of which are refugees), but is still being allocated public resources for an enormous 425,000 people (L. Schmidt, personal communication, November 10, 2014). The overestimation can be attributed to the fact that at the time of last census, there was a much larger population of individuals seeking asylum in the area (the budget has not since been adjusted). However accommodating the budget, Adunia did acknowledge that such inclusiveness may come at a cost to the local population, as the sudden increase in beneficiaries has ultimately “shifted resources away from outreach programs and preventative services” (L. Schmidt, personal communication, November 10, 2014). The DHO also indicated the potential dangers of integrating a new population into an existing community, recalling that “many of the refugees came in with measles, which spread to the nationals” (L. Schmidt, personal communication, November 10, 2014). Equally, the refugees were exposed to illness by an outbreak of measles originating from the host community earlier in the year (L. Schmidt, personal communication, November 10, 2014).
Despite such negative side-effects, The DHO praised Uganda’s Refugee Policy (2006) as it allows refugees to be “considered like any other person”, elucidating: “We don’t segregate when planning resources” (L. Schmidt, personal communication, November 10, 2014). It would appear the strength of the nondiscriminatory policy is that the international attention afforded the South Sudanese refugees has been accompanied by a significant surge in foreign aid, particularly in health. A hospital worker explained that because “settlements are located in areas with existing services, improved services are accessed by more people”. According to UNHCR Nutrition Coordinator, Lucas Machibya, the inclusive approach has allowed the increased access to medical resources to be enjoyed by refugees and nationals alike (L. Schmidt, personal communication, November 19, 2014).

International Assistance: Improving Access to Resources

The vulnerability of their situation has garnered the South Sudanese refugees of Adjumani significant foreign assistance. Various agencies have become involved in providing health services to this group, most notably UNHCR, Medicines Sans Frontiers (MSF), Medical Team International (MTI), Associations for Cooperative Operations Research and Development (ACORD), and URCS. Most of these agencies work within the public health facilities to improve upon the existing services.

International assistance afforded the community is generally coordinated by UNHCR in accordance with the regulations set by the government of Uganda. UNHCR primarily concerns itself data-gathering and risk-monitoring to assess population needs and coordinating a sufficient response. In April 2014 UNHCR appointed the URCS to provide Mungula refugee settlement with services of health and sanitation, shelter, and water. URCS has secured significant resources...
for the task, employing many asylum seekers to serve as translators and nationals to implement programs. The URCS involvement has not only brought a source of income to many who would otherwise remain unemployed, but has also been responsible for instituting preventative measures within the community. Mainly through disease surveillance and community sensitization, the URCS has been successful in increasing the demand for many preventative services, including: antenatal care, HIV and STD tests, and mosquito nets.

MTI can be cited as another agent of the impressive improvements in Mungula’s public health. MTI attracted an additional doctor and anesthesiologist to perform some minor surgeries, enabling the theatre of Mungula’s HCIV to be used for the first time (L. Schmidt, personal communication, October 25, 2014). Now circumcisions are offered the population every Wednesday, mitigating the risk of HIV for many in the settlement, and various other surgeries other surgeries can be accessed on Tuesdays and Thursdays (L. Schmidt, personal communication, November 10, 2014). Increased health staff has freed the other trained professionals to focus on the provision of many other services, such as providing eye screenings and surgeries. MTI was also responsible for hiring a guard to preside over the HCIV full-time, increasing the security of its patients (L. Schmidt, personal communication, November 12, 2014). Recognizing that the introduction of additional health professionals would further exacerbate the housing shortages, MTI has initiated the building of new staff residences for both Mungula’s HCIV and Adjumani District Hospital (L. Schmidt, personal communication, October 22, 2014).

Furthermore, ACORD and the Belgian government have both taken steps to address the problem of transportation within Adjumani. ACORD has allowed a Nissan Caravan 3000 Super
Ambulance to be utilized for the benefit of those being referred by Mungula’s HCIV (Attachment 1.9), while the Belgian government has donated an ambulance to the district hospital (L. Schmidt, personal communication, November 10, 2014). International involvement has also procured a psychiatric unit for Mungula in recent months, a service very rarely found in other HCIVs of Uganda (L. Schmidt, personal communication, November 21, 2014). MSF has also worked to enhance the competency of Adjumani District Hospital’s services, providing world-class human and material resources, to name a few among the many instances of international assistance (L. Schmidt, personal communication, October 30, 2014).

Despite many accomplishments, the ability of these agencies to compensate for shortcomings in public health provision remains limited; much of the population still experiences shortages when accessing care. To prevent such limitations from endangering the health of beneficiaries, some health workers are calling for increased support from both non-governmental organizations (NGOs) and governmental organizations, claiming: presently “the district officials and UNHCR are not doing enough” (Medical worker at ADH). In the meanwhile, many beneficiaries are independently compensating for the gaps in public healthcare aid agencies have failed to address.

Compensating for Care: the Experience of Beneficiaries

It is crucial the refugees’ experience of privately paying for care is understood by policymakers, healthcare providers, and aid workers alike, to ensure that the individual possesses the agency to do so, in the event resources are found to be insufficient. Upon talking with the refugees of Mungula, the endemic scarcity of resources in their lives becomes apparent. The shortage of preventative care within the settlement warrants significant attention. The mean
number of mosquito nets per household was 1.8, in spite of the fact that, of the thirty households surveyed, the average household is 6.47 people (L. Schmidt, 2014). On average, these families reported 3 people to consistently sleep without a protective net (L. Schmidt, 2014). Equally troubling are the insufficient sanitation provisions maintained by the asylum seekers of Mungula. About 75% of households surveyed had both a completed latrine (with a roof and door) and hand washing station (L. Schmidt, 2014).

The adverse effects of poor prevention are seen in the community. The settlement is rampant with illness. At the time of the survey, twenty-two of thirty households informed the researcher that at least one member of their household was ailing (L. Schmidt, 2014). Some South Sudanese attribute to the profusion of illness to the weather conditions, complaining that “from night up to morning it is very cold”, that such conditions are “unbelievably hard on us” (L. Schmidt, personal communication, November 12, 2014). A lack of drugs and wanting provision of nutritious food rations are also commonly thought to exacerbate the illness of the community, by beneficiaries and service providers alike (L. Schmidt, 2014). Additionally, lines extending out the door and around the building of the HCIV are not uncommon. One beneficiary- making note of the severe shortage of human resources in Mungula- illustrated the largest problem of accessing its services to be “… the lack of staff, if you want to go it takes all day” (L. Schmidt, personal communication, November 12, 2014) (Attachment 1.8). As a result of gaps in service provision, some refugees must spend a substantial portion of their very limited resources to secure the health of themselves and their families.

Challenges to Compensation: A Lack of Agency
It is important to recognize the existence of many factors which may discourage, or even inhibit, an individual from compensating for healthcare. The inability of a refugee to access the necessary means to secure health resources is often a result of the many economic, cultural, and political challenges associated with their status as an asylum seeker. “For refugees, losses incurred during the journey combined with lack of access to assets in their host country means they are deeply disempowered, constrained in their ability to act and to challenge rules and power structures.” (Jacobsen, 2014, para. 3).

The loss of financial and material assets which might be used to obtain healthcare was evident upon surveying Mungula’s population. Of the thirty refugees interviewed, only one reported of having arrived to Uganda with any assets (mainly 250,000 SHS and a solar panel) (L. Schmidt, 2014), as most were found to have “left everything”, explaining that "during a war, you take your child only” (L. Schmidt, personal communication, November 12, 2014). One woman recounted: “I left home without any clothes, I got clothes in Juba” (L. Schmidt, personal communication, November 14, 2014), emphasizing the urgency with which most left South Sudan. In addition to being forced to physically leave many of the assets which could have been used or traded to pay for healthcare, refugees often find accessing capital in times of need impossible. Securing assistance from formal financial institutions is commonly made difficult by the realities of being a refugee, as most report a lack access to micro-finance institutions (MFIs), credit facilities, savings and investment accounts, and insurance (Jacobsen, 2014, para. 10). Owing to endemic poverty, very few households get loans from a proper lending institution like a commercial bank or cooperative. Resorting to informal loans between community members is also complicated as, not only are most in the settlement in similar demand of financial resources,
but existing social networks may be weak-fractured by violence and instability—and thus discourage borrowing.

Furthermore, lack of financial infrastructure makes attempting to access resources from a stable relationship outside the settlement a nonviable alternative. Securing assistance from remittances presents tremendous challenges to compensation. As one refugee described, “There is no way to send money, no bank, no mobile money in Sudan” (L. Schmidt, personal communication, November 14, 2014). Despite Uganda’s policy allowing the unrestricted movement of refugees, personally transporting money to relations in the settlement proves difficult for most. Steven Mawa explained that steep immigration fees for refugees looking to re-cross the border have been reported to deter many primary income earners from employing established economic networks to secure resources (L. Schmidt, personal communication, November 18, 2014). It is, therefore, not unexpected that of those interviewed in Mungula, only one person reported receiving any form of remittance support since arriving at the settlement (L. Schmidt, 2014).

Absence of livelihood opportunities remains, perhaps, the most detrimental circumstance for refugees looking to compensate for shortages in health services. Livelihood is commonly interpreted in line with Chambers and Conway’s 1992 definition, to be “the means of gaining a living, including livelihood capabilities, tangible assets, such as stores and resources, and intangible assets, such as claims and access” (as cited in Jacobsen, 2014, para. 16). The NGO and governmental agencies responsible for providing social services within Mungula recognize that “...it is important that displaced people can be supported in their livelihood efforts so that they can provide for their families when humanitarian aid is insufficient” (Jacobsen, 2014, para. 3).
Though UNHCR has officially tasked the URCS to partner with the European Community Humanitarian aid Office (ECHO) to provide the community with income-generating activities, the settlement has no such programs operating at present. Operational Manager of the URCS Adjumani Branch, Steven Mawa, attributed the delay in service provision to the corruption, occurring earlier in 2014, at URCS headquarters, declaring: “the program should have happened earlier but two rounds of restructuring has slowed the process” (L. Schmidt, personal communication, November 18, 2014). As livelihood remains a relatively expensive program, relevant funds were halted to mitigate the possibility they would end up in fraudulent hands. At present, the absence of livelihood opportunities for the refugees of Mungula has substantial ramifications. Only four interviewees were experiencing stable employment, 75% of whom were employed by the URCS (L. Schmidt, 2014). The remainder of interviewees expressed deep concern over their lack of agency, explaining: “Everything can affect us. We don’t have money. That few money cannot complete your health services” (L. Schmidt, personal communication, November 9, 2014).

More troubling is the nature of the livelihood programs to be implemented. The support given the refugees of Mungula will, according to Steven Mawa, primarily manifest as agricultural assistance (L. Schmidt, personal communication, November 18, 2014). There are several problems to such an approach, predominantly that the land is indiscriminately allocated to each household regardless of its size. The refugees of Mungula have repeatedly indicated that the 30m x 40m plot of land allocated was not yet sufficient to supplement the shortages in food rations needed to adequately feed their families, as they “are suffering of hunger. The rations are not enough for 30 days, maybe lasts two weeks” (L. Schmidt, personal communication,
November 9, 2014). With such information, it is difficult to ration that the population would be able to not only sustain themselves, but also make a living off such limited plot of land. Therefore, livelihood programs emphasizing adult education have been suggested as the most prudent approach within the settlement, allowing individuals to develop human capital which would allow them to economically support their families and avoid endangering household food security.

Because the majority of Mungula’s asylum seekers do not have any form of income or any prospect of generating one in the near future, the refugees often use precious food rations to purchase needed items. Particularly, many refugees reported selling one cup of cereal in order to purchase the notebooks (market value of 500 SHS) necessary to receive medical treatment at the shop located at the HCIV (L. Schmidt, personal communication, November 18, 2014). Eleven out of thirty refugees interviewed described decreasing their food intake in order to compensate for healthcare (L. Schmidt, personal communication, November 12, 2014). The practice of utilizing food rations as economic leverage may exacerbate problems of malnutrition, causing the individual’s vulnerability to illness to proliferate. This sentiment was simply expressed by one refugee: commenting on the phenomena: “…when you sell, you suffer” (L. Schmidt, personal communication, November 18, 2014).

Most importantly, there must be adult education afforded the women of Mungula. At present, a disturbing inequality currently existing between the genders in regards to access to education in Mungula. Of the refugees interviewed, 60% of males had received some form of education, while only 20% of females had (L. Schmidt, 2014), and this number has been estimated by UNHCR to be actually much lower in reality (L. Schmidt, personal communication,
November 19, 2014). South Sudanese women are not traditionally allowed an education, and are customarily not engaged in income-generating activities. When asked about their economic ventures. Most women reported they “stay at home without doing anything” (L. Schmidt, personal communication, November 9, 2014). Although a vast majority of Dinka men have died in the war or are not residing in the camp, many women do not often independently pursue livelihood activities. One woman’s son- the family’s prime income earner- was rehabilitating in a hospital in Juba after having been shot in the leg. He used to be a cattle herder, but, not long after the accident, his cattle has been stolen. She explained, there was no option for her but to “…stay in the hands of UNHCR and the government now” (L. Schmidt, personal communication, November 18, 2014). Similarly, one refugee woman- whose husband had died in the war- asked: “when you don’t have the husband, where do you get the money?” (L. Schmidt, personal communication, November 9, 2014). Her resolve was echoed by another refugee, who stated: “It is simple. There are no jobs for women.” (L. Schmidt, personal communication, November 9, 2014).

In addition to the enormous wasted potential for human capital development, the stark gender inequalities prove problematic for the health of Mungula’s women. “Sociocultural norms may dictate that women have little control over financial resources and transport” (Ager, 2014, para. 31). All 6 of Mungula’s block leaders are male, demonstrating that communal choices about healthcare will often be made by men (L. Schmidt, 2014). Also, interviews with the refugees and healthcare providers alike indicate an overwhelming perception of the father as having the ultimate say in decisions regarding whether household members would seek out care, and if private money would be spent on compensation when confronted with a shortage (L.
Schmidt, 2014). As a consequence, women often experience restricted access to healthcare when compared to their male counterparts.

Agency over one’s health is further discouraged by environmental factors. Should an refugee choose to compensate, rats and theft present copious challenges to doing so. Rats are rampant throughout Mungula settlement, posing a threat to the community as a possible vector for diseases and danger to food security. Most expressly, half the refugees interviewed informed the researcher that rats had destroyed the preventative materials—mainly mosquito nets, blankets, and mats—which UNHCR had given them upon arrival (L. Schmidt, 2014). Although URCS has plans to fumigate the settlement, they have been waiting for approval from the Ministry of Health since early October (L. Schmidt, personal communication, November 18, 2014). Many refugees are, consequently, reluctant to spend private money on mosquito nets, maintaining the sentiment that they will just be destroyed the rats anyway (L. Schmidt 2014).

Refugees of Mungula might also be discouraged from purchasing their own nets because they are waiting for international agencies to provide the services. The URCS has, indeed, tried to replenish the nets destroyed by the rodents, ordering 15,000 from Nairobi at the end of September 2014 (L. Schmidt, personal communication, November 18, 2014). However, the products have not yet been delivered, leaving the problem unaddressed (L. Schmidt, personal communication, November 19, 2014).

Theft also serves to discourage those with the power to compensate from doing so. 10% of refugees interviewed reported thefts of the plastic containers they used for the household hand-washing stations, and none of the victims had independently purchased a replacement (L. Schmidt, 2014). Refugees are likely to experience decreased interest in replacing stolen items,
even those paramount to preventative health, when they believe they are at risk of just being stolen again. It is evident that the uncertainty and instability- inherent to the status of a refugee- prove to be significant obstacles to encouraging such communities to invest in their own health.

A profound consequence of the complications lack of assets, access to formal and informal financial institutions, infrastructure, livelihood support, gender equality, and a secure environment pose to refugees looking to compensate for shortages in public healthcare is a sense of disempowerment. When observing a community meeting on Marburg sensitization, the researcher was shocked to hear multiple members say “Well its all in God’s hands now, there is nothing we can do” (L. Schmidt, personal communication, October 24, 2014). When URCS was describing the need for protective burial gear, the block leader pointed out that “(they) don’t need of that, if the Lord wants (us) dead, then we will die” (L. Schmidt, personal communication, October 24, 2014). Experiencing a lack of agency over health could be seen as a motivating factor for the South Sudanese refugees to utilize traditional healers, as reported by several nursing staff (L. Schmidt, November 16, 2014). In addition to the possibility that the shortages might induce the South Sudanese to reject the competence of modern medicine, they often strengthen religious conviction, possibly explained by such instances when hope becomes essential.
7. Conclusions:

Though it is essential to acknowledge the limited scope of this research, the intricacies and challenges associated with providing healthcare to the people of Mungula refugee settlement may serve as an indicator of larger issues relevant to delivering services in Adjumani’s multiple settlements and, possibly, throughout Uganda’s refugee-hosting communities.

Despite various constraints experienced in the health facilities of Adjumani as a result of limited public resources, heightened attention of the international aid community has drastically improved services accessed by refugees and nationals alike- the mutual benefit owing to an inclusive refugee strategy. Although the influx of refugees has been successful in securing substantial financial, technological, and human resources, gaps in care remain. Thus, compensation for these shortages ultimately falls under the responsibility of the beneficiaries. As these individuals are extremely vulnerable in the current state of asylum, many obstacles arise which severely impede or prohibit their ability to ensure they receive competent care.

Therefore, it becomes essential that the asylum seekers of Mungula- and other refugees of similar situation- are allocated livelihood support services, so that they may have the economic agency to maintain their health. These refugees are people of tremendous potential. Investing in their health and human capital is sound economic policy for Uganda, as economic interactions with South Sudan are expected to increase in the future. By continually involving the hosting communities to utilize and contribute to the services accessed by refugees, and emphasizing the development of human capital within the settlement, the institutions responsible will avoid the common oversight of making the period of asylum a time of intensified vulnerability, but instead, one of empowerment.
8. Recommendations:

Given the magnitude of the problem, it is impractical to assume international assistance can sufficiently eliminate the chronic resource shortages experienced by the refugees of Mungula accessing public healthcare services. Resources must be reallocated to prioritize assisting asylum seekers to attain economic independence. Empowering the individual with the ability to compensate for care is the most appropriate way in which to secure the health of such a vulnerable population. Imperative to the success of such action will prove the type of livelihood programs instituted. Though current practice in Uganda emphasizes the “sustainability” of the agricultural model, over-reliance on the idea that the allocated land size is sufficient to produce an income, and ignorance regarding the practicality of such a skill following their return from asylum must be addressed.

It follows that the government of Uganda, UNHCR, and the operational partners should refocus livelihood programs towards skills which build human capital and diversify abilities, including increased opportunities for vocational training. Of particular importance should be adult literacy programs geared towards women, who remain among the least able to access the financial resources necessary to pay for care. Such “mobile-skills” would allow those who intend to repatriate, such as do the majority of refugees in Mungula, to do so with an expertise which would allow the refugee to rebuild their lives following the cessation of violence.

Mungula refugee settlement is demonstrative of many of the faults and merits of Uganda’s refugee policy. Though the inclusive manner in which the refugees have been integrated into the local healthcare system has fostered a mutually beneficial and amicable relationship between the two, the tremendous aid awarded the area could be interpreted as enabling the government to avoid many of its responsibilities to provide these services to its
citizens. The reality exists that the HCIV is still operating below standards set by the national health policy, and the referral system’s immense reliance upon transportation, which is often inaccessible, leaves much to be desired of the government’s performance.

Although inherently limited, the government of Uganda should allocate a more significant portion of its budget to the provision of healthcare for its peoples, particularly in areas of heavy refugee influxes. Empowering the forced migrants with the standard of health necessary to rebuild their lives will likely propagate their motivation and ability to become financially stable. Especially in circumstances of protracted displacement, such agency will undoubtedly benefit the hosting populations’ economic lives as refugees become contributors to local production and consumption. It follows, therefore, that investing in health and livelihood is sound economic policy supporting national interests.

With regards to the URCS, although the organization’s promotion of preventative measures and engagement of the community is a paragon of health provision, issues of internal corruption consistently undermine operations. It would serve the organization immensely to hasten securing the resources it has long promised the people of Mungula, especially those under its employment. Failure to do so has already begun to erode the trust the refugees have in the organization’s competence and dedication to their community.

It should not be overlooked that the agencies handling the influx of South Sudanese refugees in Adjumani have accomplished enormous feats with very limited resources, providing lifesaving services in the most unstable and disorganized of situations. Essentially, a financial and social commitment to protecting this vulnerable group of people is the obligation of the
global citizen, who must prevent the immense hardships of the South Sudanese from being overlooked or forgotten.
Appendix 1.1 (Schmidt, 2014).
Refugee Public Health Survey 2014: Adjumani Settlement, Uganda
Office of the Prime Minister & UNHCR Edition

Name of Enumerator: ___________________ Questionnaire Serial Number: ______
Name of Translator: _____________________ Date of Interview: ______________

--- Section 1: Professional & Background Information ---
1.1- Settlement/Organization: _________________________________
1.2- Profession: _________________________________
1.3- Specific duties: _________________________________________________
1.4- Age of participant:_______    1.5- Gender of participant: Male    Female
1.6- Category of professional:
   Refugee          International Aid Worker       National (not local)       National (local)
1.7- Date of arrival (duration of job): ______________ ( _______ mo.)
1.8- Highest completed education level of participant:
   None        Primary       Secondary       University       Masters       Doctorate

--- Section 2: Role of Organization ---
2.1- How large is the population you serve?: ________________
2.2- What is your role within the settlement? ________________________________
2.3- How long has this organization been involved in the settlement?: _______________
2.4- How many people work for your organization?: ________________
2.5- Who funds this organization?: _______________________________________
2.6- What is the monthly operating budget?: ______________________

--- Section 3: Methods of Implementation ---
3.1- Please describe how you implement your services: _________________________
3.2- How do you ensure accountability for your services provided?: _________________
3.3- How do you ensure accountability for services provided by implementing partners?:

3.4- What steps is your organization taking to mitigate the possibility of corruption?: _____
3.5- How has the organization's presence within the settlement changed over the past 6 mo.?
   Almost Gone  Downsized  About the Same  Grown  New

3.6- Are there any services this organization used to provide but now do not?: Yes__ No ___
   If yes, what and why is is not still being implemented?: ____________________

3.7- Do you feel you are able to freely communicate with the population (Quality/accessibility of translation services)?:
   Never  Rarely  Sometimes  Usually  Always

3.8- Please evaluate the availability of the organization's professional resources:

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Please describe any shortages in detail:
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How do you deal with these shortages?: ________________________________
_______________________________________________________________

3.9- Please evaluate the availability of the organization's service resources:

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Please describe any shortages in detail:
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How do you deal with these shortages?: ________________________________
_______________________________________________________________
3.10- How do you make decisions regarding services with limited resources? Please prioritize spending: ____________________________

3.11- Why do most of these shortages occur? Who (if anyone) is responsible?: __________

3.12- When do most shortages occur (time of month)?: ____________________________

3.13- Do such shortages affect your ability to do your job?: Yes____ No ____.
Please explain: ____________________________

3.14- If shortages occur, do you advise that patients independently compensate for services?: Yes____ No ____.
If yes, how often are patients able to do so?:

Never  Rarely  Sometimes  Usually  Always

Why do you think this?: ____________________________

3.15- Have you done work for this organization for which you have not been paid?:
Yes___ No ___ If yes, please explain ____________________________

3.16- Do you have an alternate source of income?: Yes____ No ____
If yes, circle all that apply: Spouse's Income  Additional Job  Other: __________

3.17- Have you ever personally compensated for the care of a patient?: Yes____ No ____
If yes, please explain: ____________________________

--- Section 4: Evaluating Services ---

4.1- How would you evaluate your relationship with the beneficiaries of your services?:

Very Poor  Poor  Neutral  Good  Excellent
Why?: ____________________________

4.2- How do you maintain a close relationship with the population you are serving?: ______

4.3- Please rank the overall availability of your service in the settlement:

Very Poor  Poor  Neutral  Good  Excellent

4.4- What are the most visible strengths of your service in the settlement?:___________________

4.5- Do you see any disconnect between national refugee policy and implementation?:
Yes____ No ____.
If yes, please explain: ____________________________

4.6- How effective do you believe implementing health services has been?

Very Poor  Poor  Neutral  Good  Excellent
4.7- How effective do you believe implementing livelihood support has been?

Very Poor  Poor  Neutral  Good  Excellent

Why?: _____________________________________________________

4.8- How might your services be improved in the future?: _______________________

--- Section 5: Gender Based Violence in Public Health ---

5.1- Do you feel men and women receive equal care within the settlement? Please explain:

5.2- Who typically decides if the household will seek your services?:

Father  Mother  Both  Other: ____________

5.3- Who typically decides if the household will spend personal money on your services?:

Father  Mother  Both  Other: ____________

5.4- Are their any examples of gender affecting the services you provide?: ____________

If so, what do your organization do to mitigate them?: _____________________

--- Section 6: Additional Inquiry ---

6.1- What is your greatest concern within the settlement?: _______________________

6.2- What is the greatest challenge you face within your job?: _____________________

6.3- How, if at all, have services improved since you began work here?: ______________

6.4- How does the care provided compare to your expectations?:

Extremely Below  Below  Meets  Exceeds  Extremely Exceeds

Please elaborate: ____________________________________________

6.5- Anything else you would like to add regarding services within settlement?: ________

6.6- Do you plan on continuing to work in this settlement for the next three months?:

Yes_____ No ____. Why or why not?: ________________________________

Appendix 1.2 (Schmidt, 2014).
--- Section 1: Professional & Background Information ---

1.1- Settlement/Organization: _________________________________
1.2- Profession: ________________________________
1.3- Specific duties: _________________________________________________
1.4- Age of participant:_______  1.5- Gender of participant: Male    Female
1.6- Category of professional:
    Refugee          International Aid Worker       National (not local)       National (local)
1.7- Date of arrival (duration of job): _______________ ( _______ mo.)
1.8- Highest completed education level of participant:
    None        Primary       Secondary      University     Masters       Doctorate

--- Section 2: Role of Organization ---

2.1- How large is the population you serve?: ________________
2.2- What is your role within the settlement? ________________________________
2.3- How long has this organization been involved in the settlement?: _______________
2.4- How many people work for your organization?: ________________
2.5- Who funds this organization?: ____________________________
2.6- What is the monthly operating budget?: ______________________

--- Section 3: Methods of Implementation ---

3.1- Please describe how you implement your services: ________________________________
3.2- How do you ensure accountability for services provided?: ____________________
3.3- What steps is your organization taking to mitigate the possibility of corruption?: ____
3.4- How has the organizations presence within the settlement changed over the past 6 mo.?  
    Almost Gone          Downsized                About the Same       Grown              New
3.5- Are there any services this organization used to provide but now do not?: Yes__ No __
   If yes, what and why is is not still being implemented?: ____________________

3.6- Do you feel you are able to freely communicate with the population (Quality/accessibility of translation services)?:
   Never                 Rarely                Sometimes                   Usually                 Always

3.7- Please evaluate the availability of the organization’s professional resources:

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Please describe any shortages in detail:
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How do you deal with these shortages?: _____________________________________
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3.8- Please evaluate the availability of the organization’s service resources:

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Please describe any shortages in detail:
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How do you deal with these shortages?: _____________________________________
________________________________________________________________________
________________________________________________________________________
3.9- How do you make decisions regarding services with limited resources? Please prioritize spending: ________________________________________________________________

3.10- Why do most of these shortages occur? Who (if anyone) is responsible?: __________

3.11- When do most shortages occur (time of month)?: ______________________________

3.12- Do such shortages affect your ability to do your job?: Yes____ No ____.
   Please explain: ____________________________________________________________________

3.13- If shortages occur, do you advise that patients independently compensate for services?: Yes____ No ____.
   If yes, how often are patients able to do so?:
   Never                     Rarely       Sometimes     Usually          Always
   Why do you think this?: _____________________________________________________________

3.14- Have you done work for this organization for which you have not been paid?:
   Yes___ No ___ If yes, please explain ____________________________________________________

3.15- Do you have an alternate source of income?: Yes____ No ____
   If yes, circle all that apply: Spouse’s Income   Additional Job    Other: __________

3.16- Have you ever personally compensated for the care of a patient?: Yes_____ No _____
   If yes, please explain: ______________________________________________________________

--- Section 4: Evaluating Services---

4.1- How would you evaluate your relationship with the beneficiaries of your services?:
   Very Poor    Poor    Neutral    Good    Excellent
   Why?: ________________________________________________________________

4.2- How do you maintain a close relationship with the population you are serving?: ______

4.3- Please rank the overall availability of your service in the settlement:
   Very Poor    Poor    Neutral    Good    Excellent
4.4- What are the most visible strengths of your service in the settlement?:________________

4.5- Do you see any disconnect between national refugee policy and implementation?:
   Yes_____ No _____. If yes, please explain:___________________________________________

4.6- How might your services be improved in the future?: ________________________________
--- Section 5: Gender Based Violence in Public Health ---

5.1- Do you feel men and women receive equal care within the settlement? Please explain:

________________________________________________________________________

5.2- Who typically decides if the household will seek your services?:

Father       Mother       Both       Other: ____________

5.3- Who typically decides if the household will spend personal money on your services?:

Father       Mother       Both       Other: ____________

5.4- Are there any examples of gender affecting the services you provide?: ____________

________________________________________________________________________

If so, what do your organization do to mitigate them?: ____________

________________________________________________________________________

--- Section 6: Additional Inquiry ---

6.1- What is your greatest concern within the settlement?: ____________

________________________________________________________________________

6.2- What is the greatest challenge you face within your job?: ____________

________________________________________________________________________

6.3- How, if at all, have services improved since you began work here?: ____________

________________________________________________________________________

6.4- How does the care provided compare to your expectations?:

Extremely Below       Below       Meets       Exceeds       Extremely Exceeds

Please elaborate: ____________________________________________________________________________

________________________________________________________________________

6.5- Anything else you would like to add regarding services within settlement?: ____________

________________________________________________________________________

________________________________________________________________________

6.6- Do you plan on continuing to work in this settlement for the next three months?:

Yes_____ No ___. Why or why not?: ________________________________________________________________________

________________________________________________________________________

Appendix 1.3 (Schmidt, 2014).
Refugee Public Health Survey 2014: Adjumani Settlement, Uganda
Health Care Provider Edition

Name of Enumerator: ___________________ Questionnaire Serial Number: ______
Name of Translator: _____________________ Date of Interview: ______________

--- Section 1: Professional & Background Information ---
1.1- Settlement/Health Center: ______________________
1.2- Profession: __________________________
1.3- Specific duties within center: ________________________________
1.4- Age of participant:_______ 1.5- Gender of participant: Male  Female
1.6- Category of professional:
   Refugee        International Aid Worker       National (not local)       National (local)
1.7- Date of arrival (duration of job): ______________ ( _______ mo.)
1.8- Highest completed education level of participant:
   None         Primary     Secondary        University      Masters      Doctorate

--- Section 2: Inquiry of Common Services ---
2.1- How large is the population you serve?: __________________
2.2- In a typical day...
   How many patients do you see?: __________
   How many referrals do you make?: __________
   How many births are there?: __________
   How many deaths occur?: __________
   How many professional are present in the center?: __________
2.3- How many hours is the center open on weekdays/weekends?: ________/________

--- Section 3: Availability & Utilization of Health Services ---
3.1- What do you perceive to be the greatest risks to the health of the population?: ______
3.2- What typically gets referred?: __________________________________
3.3- How far away is the referral hospital?: _________ km ~ __________ min
3.4- Is an ambulance accessible?: Yes___ No ____.
   How often does the ambulance functioning?
   Never             Rarely              Usually              Always
3.5- Do patients ever pay for transport?: Yes _____ No ______.
   If so, how much does it cost?: __________________
3.6- If you refer a patient, how likely do you think they are to seek care at the referral hospital?: Very Unlikely  Unlikely  Neutral  Likely  Very Likely
   Why?: ______________________________________
3.7- Have you ever had to deny a patient care because they did not have a notebook?:
   Yes _____ No _____. If so, please explain: ________________________________
   How often does this occur?
   Never Rarely Sometimes Usually Always
3.8- What are the most common cases you treat?: ____________________________
3.9- How often do you have the resources to treat these cases?:
   Never Rarely Sometimes Usually Always
3.10- Where do most of the health resources come from?: _______________________
3.11- Please evaluate the availability of professional resources in the health center:

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Please describe any shortages in detail: ____________________________________
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How do you deal with these shortages?: ______________________________________
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3.12- Please evaluate the availability of care resources in the health center:

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Please describe any shortages in detail: ____________________________________
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___________________________________________________________________________
How do you deal with these shortages?: ___________________________________________

3.13- When do most shortages occur (time of month)?: ________________________________

3.14- Do such shortages affect your ability to do your job?: Yes____ No ____.
Please explain: ________________________________________________________________

3.15- How accessible is the facility (open when patients need it)?:
Never                 Rarely                Sometimes                   Usually                 Always

3.16- Do you feel you are able to freely communicate with the population (Quality/accessibility of translation services)?:
Never                 Rarely                Sometimes                   Usually                 Always

3.17- Please rank the overall availability of health care in the settlement:
Very Poor               Poor                    Neutral                    Good                      Excellent

--- Section 4: Methods of Compensating for Care ---

4.1- If shortages occur, do you advise that patients independently compensate for care?:
Yes_____ No _____  If yes, how often are patients able to do so?:
Never                 Rarely                Sometimes                   Usually                 Always
Why do you think this?: __________________________________________________________

4.2- Have you done work in the center for which you have not been paid?: Yes___ No ___
If yes, please explain: __________________________________________________________

4.3- Do you have an alternate source of income?: Yes____ No ____
If yes, circle all that apply:  Spouse’s Income     Additional Job      Other: ____________

4.4- Have you ever personally compensated for the care of a patient?: Yes_____ No _____
If yes, please explain why: _____________________________________________________

4.5- Have you had instances of patients utilizing traditional methods instead of seeking
modern care?: Yes_____ No _____
If so, please explain why: ______________________________________________________
How do you handle this situation?: ______________________________________________

--- Section 5: Gender Based Violence in Public Health ---

5.1- Do you feel men and women receive equal care within the settlement? Please explain:

5.2- Who typically decides if the household will seek health services?:
Father      Mother      Both      Other: ________________
--- Section 6: Additional Inquiry ---

6.1- What is your greatest concern within the settlement?: _______________________

6.2- What is the greatest challenge you face within your job?: _____________________

6.3- How, if at all, have health services improved since you began work here?: ______

6.4- How does the health care provided compare to your expectations?: ______

6.5- Anything else you would like to add regarding services within settlement?: ______

6.6- Do you plan on continuing to work in this settlement for the next three months?: ______

--- Section 7: Independent Evaluation of Center ---

7.1- Separate wards for women, men, and children?: Yes____ No ____

7.2- Total no. beds: ________  7.3- Total no. bathrooms: ________

7.4- Total no. operational CD4 machines: ________

7.5- Total no. operational microscopes: ________

7.6- Total no. delivery beds: ________  7.7- Total no. delivery beds: ________

7.8- Senior medical officer present/ on call?: Yes____ No ____

7.9- Total no. staff (>18?): ________

7.10- Functioning lab?: Yes_____ No ____, how often operational?: ______________

7.11- Blood bank?: Yes_____ No ____, why: __________________________________

7.12- Theatre (operational)?: Yes_____ No ____, why: __________________________

7.13- Able to admit patients?: Yes_____ No ____, why: __________________________

7.14- Proper waste disposal site/process: Yes_____ No ____, why: __________________

Appendix 1.4 (Schmidt, 2014).
--- Section 1: Demographic & Background Information ---

1.1- Settlement: ______________________

1.2- Block: A B C D E F  

1.3- Ethnic identification (optional): ______________

1.4- Age of participant:_______  

1.5- Gender of participant:  Male    Female

1.6- Category of household:
- New Refugee  Asylum Seeker  Protracted Refugee  National  Returnee

1.7- Date of arrival (duration of stay): ______________ ( _______ mo.)

1.8- Highest completed education level of participant:
- None  Primary  Secondary  University  Masters  Doctorate

1.9- Number of adults in household (18 years and above): Male:_____  Female:____

1.10- Number of youths in household (between 5 to 17 years): Male:_____  Female:____

1.11- Number of children in household (below 5 years): Male:_____  Female:____

1.12- Other family members currently not residing in household:
- Please specify: _____________________________________________

--- Section 2: Inquiry of Livelihood & Spending Habits ---

2.1- Please estimate the original amount of money with which your household entered the settlement: __________. How much of it have you presently spent? __________.

- What did you spend it on? ______________________________________

2.2- Please indicate other major items with which you entered the settlement: __________

- ____________________________________________________________

2.3- Have you had to sell any of these assets? If so, why?: ______________________

- ____________________________________________________________

2.4- Number of adults (18 years and above) involved in activities (agricultural and non-agricultural) which support household: Male:_____  Female:_____

2.5- Specify activities (average monthly income):
- Agriculture (Crop Sales): Male:_____  Female:_____ (_______/mo.)
- Livestock and Livestock Products Sale: Male:_____  Female:_____ (_______/mo.)
- Trade: Male:_____  Female:_____ (_______/mo.)
- Unskilled/Casual Labor: Male:_____  Female:_____ (_______/mo.)
- Remittances & Assistance: Male:_____  Female:_____ (_______/mo.)
-Transportation (Boda-Boda, etc.): Male:_____  Female:____ (______/mo.)
-NGO: Male:_____  Female:____   (Specify:______________) (_______/mo.)
-Other: Male:_____  Female:____  (Specify:______________) (_______/mo.)

2.6- Who is the main income earner?:____________________

2.7- Highest education level of main income earner:
   None     Primary     Secondary     University     Masters     Doctorate

2.8- Total monthly income for household: ___________________

2.9- How does the household typically receive the money?:
   In Person   Mobile Money   Sent with friend/family member   Other:_____________

2.10- Have you done work for which you have not been paid? Yes___ No ____
   If yes, please explain: ____________________________________________

2.10- How much of household’s monthly income do you typically spend on:
   _ Education: _______________    _ Travel: _______________
   _ Health: _________________    _ Home: ________________
   _ Food: _________________    _ Saving: ________________
   _ Entertainment:___________    _ Other (specify): __________

2.11- Please rank importance (1=most important, 8= least important): (indicate above)

2.12- For monthly health expenditures, how much is spent on:
   Mental: _______________ Emergency: _______________
   Occasional: ______________ Nutrition: _______________
   Prevention (nets, vaccinations, etc.): ____________________

2.13- Is anyone in your family currently receiving livelihood support?: Yes___ No ____
   If so, who is providing assistance and what does it consist of?: ______________________

2.14- Are you satisfied with available livelihood support? Please explain: _______________

--- Section 3: Current Health Status ---

3.1- Is any member of your household currently sick?: Yes___ No ____
   If so, please specify:__________________________________________

3.2- Are they currently seeking care?: Yes___ No ____
   Why or why not?:____________________________________________

3.3- Latrine status:
   None     Slab     Structure     Completed (roof & door)

3.4- Possession of hand-washing station: Yes___ No ____

3.5- Number of mosquito nets in household: _______________
3.6- How many members do not consistently sleep under a net, why:________________
3.7- Number of medical notebooks in household: ___________
3.8- Has anyone in this household ever been rejected care because they did not have a notebook?: Yes____ No _____. If so, please explain: ________________________________

--- Section 4: Availability & Utilization of Health Services ---
4.1- Has an adult member (18 years and above) of your household received services in the HCIV in the past month?: Yes___ No _____
If so, please elaborate on care (date): ________________________________

4.2- Has a youth member (between 5 and 18 years) of your household received services in the HCIV in the past month?: Yes___ No _____
If so, please elaborate on care (date): ________________________________

4.3- Has a child (under 5 years) of your household received services in the HCIV in the past month?: Yes___ No _____
If so, please elaborate on care (date): ________________________________

4.4- Have you or a household member ever forgone seeking care in times of illness?: Yes___ No _____. If so, please explain: ________________________________

4.5- Has the facility been accessible (open when you need it)?
Never                 Rarely               Sometimes                   Usually                   Always

4.6- Do you feel you are able to freely communicate with the health staff? (Quality/accessibility of translation services)
Never                 Rarely               Sometimes                   Usually                   Always

4.7- Please rank the overall availability of health care in the settlement:
Very Poor               Poor              Neutral                   Good                      Excellent

--- Section 5: Methods of Compensating for Care ---
5.1- Have you had to spend personal money on healthcare since entering the settlement?:
Yes___ No _____, explain: ________________________________

5.2- How did you obtain the money for care?:
Income           Brought          Borrowed         Bank Loan         Sold Asset          Begging
Charity of Friends/Family           Other: ________________________________
5.3- How did your household cope with the added expense?:
   No effect  Decrease spending  Decrease food  Other: ___________________
5.4- Have you ever had an instance where you or a household member was advised by a healthcare professional to pay for own care? Yes___ No _____
   Please explain: __________________________________________________________
5.5- Besides lack of money, are there any reasons you might not pay for healthcare?:
   Yes___ No _____, explain: ______________________________________________
5.6- Have you personally bought a mosquito net since entering? Yes___ No ____, Amt: _____
5.7- Since entering the settlement, has a member of your household gone to a traditional healer instead of seeking modern care? Yes___ No ____.
   If so, please explain why: _____________________________________________

--- Section 6: Gender Based Violence in Public Health ---
6.1- Do you feel men and women receive equal care within the settlement? Please explain:
   ______________________________________________________________________
6.2- Who typically decides if the household will seek health services?
   Father  Mother  Both  Other: ______________
6.3- Who typically decides if the household will spend personal money on health services?
   Father  Mother  Both  Other: ______________

--- Section 7: Additional Inquiry ---
7.1- What is your greatest concern within the settlement?: _______________________
   ______________________________________________________________________
7.2- How does the health care provided compare to your expectations?:
   Extremely Below  Below  Meets  Exceeds  Extremely Exceeds
   Please elaborate: _______________________________________________________
   ______________________________________________________________________
7.2- Anything else you would like to add regarding services within settlement?: __________
   ______________________________________________________________________
7.3- Do you plan on remaining in this settlement for the next three months? Why or why not?
   ______________________________________________________________________

Appendix 1.5 (Schmidt, 2014).
Appendix 1.6 (Schmidt, 2014).
Consent Form

Brief Description of the Purpose of this Study
This study is intended to generate information regarding the health services and economic activities of Adjumani’s refugee settlement in order to gain insight into the ways in which to improve public policy with regards to Uganda’s asylum seekers.

Rights Notice
In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT International Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

Privacy
All information you present in this interview may be recorded and safeguarded. If you do not wish to have such information recorded, you must inform the interviewer prior to the start of the interview.

Anonymity
All names in this study will be kept anonymous unless the participant chooses otherwise.

Confidentiality
All names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to the participant.

Participant’s name printed ___________________________ Participant’s signature ___________________________

Date ___________________________

Interviewer’s name printed ___________________________ Interviewer’s signature ___________________________

Date ___________________________

Appendix 1.7 (Schmidt, 2014).
Appendix 1.8 (Schmidt, 2014).
Appendix 1.9 (Schmidt, 2014).
Appendix 1.10 (Schmidt, 2014).
10. Glossary of Terms:

ACORD-Associations for Cooperative Operations Research and Development

CPA- Comprehensive Peace Agreement

DHO- District Health Office

ECHO- European Community Humanitarian aid Office

IDP- Inpatient Ward

IOM- International Organization for Migration

LRA- Lord’s Resistance Army

MFI- Micro-finance Institution

MSF- Medicines Sans Frontiers

MTI- Medical Team International

NCP- National Congress Party

NGO- Non-governmental Organization

SPLA/M- Sudanese Peoples Army/ Movement

UNHCR- United Nations’s High Commissioner for Refugees

WHO- World Health Organization
11. Bibliography:


