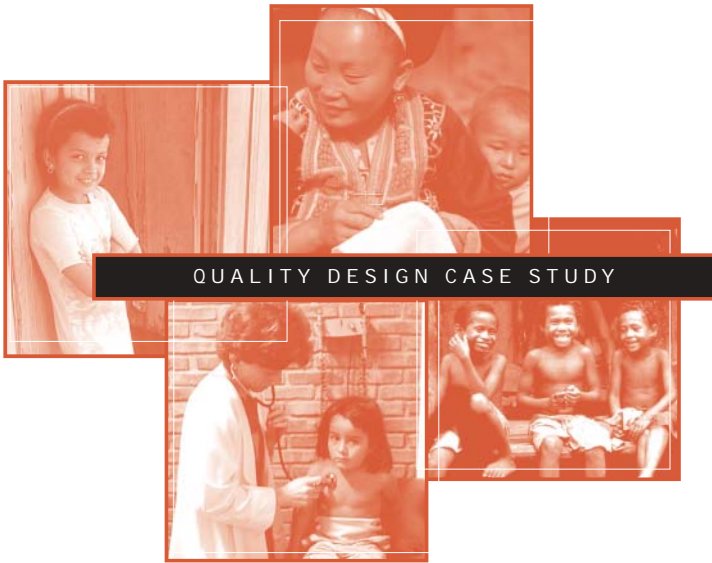


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Designing the Integration of District and Refugee Health Services in West Nile, Northern Uganda

April 2003





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About this series

The Case Study Series presents real applications of Quality Assurance (QA) techniques in developing countries at the national to facility levels, illustrating major quality assurance activity areas, including quality design, quality improvement, standards, and quality assessment. The series covers experiences from diverse geographical and disease areas, such as maternal and reproductive health, child survival, and infectious diseases.

Quality design is the systematic creation of new services or processes or the re-design of existing services. It incorporates features that meet the needs of internal and external clients while taking into account the resources available. In healthcare, external clients include the individuals who use specific services, their caretakers, and their families, but may also include members of the larger community. Internal clients could include healthcare providers, community-based workers, support staff, supervisors, or managers. Quality design is undertaken by a team that can include both internal and external clients of the service to be designed. The Quality Assurance Project has developed a quality design methodology that teams follow to clearly set objectives for the design, identify all clients and their needs, create a design that addresses those needs, and implement and monitor the new design.

This case study outlines the application of quality design in the integration of refugee health care activities and the local health system of a rural district in northern Uganda. It illustrates how stakeholders with diverse interests and concerns in Adjumani District, including district leaders, UNHCR, refugee health NGOs, and refugee representatives, worked together to create agreement and a systematic response to a seemingly overwhelming management challenge. Using quality design, they planned the design of a new integrated system to consolidate certain systems within health services to answer the unique needs and concerns of both the local community and refugee populations in that district. This case study shows the benefits of quality design as a method to build consensus

around a change process, and at the same time create concrete, measurable steps towards a new, integrated system. As most managers know, the best-laid plans can easily fail without the consensus and joint effort of all stakeholders. Many times, this is difficult to achieve, and implementation falls apart. Success at the final phase of quality design may be measured after stakeholders have implemented activities under the new system. Because quality design is above all a methodology to organize new service delivery, this case study focuses more on the planning process than implementation. The lessons learned from this experience in Adjumani District will be valuable to health managers faced with the challenges of simultaneously forging a common vision among stakeholders and creating a new system.

Acknowledgments

The Adjumani District Integrated Health Coordinating Committee undertook the work of the West Nile Quality Design Project described in this case study. This team is composed of managers from the core stakeholder groups involved, including the District Director for Health Services, the District Local Council Secretary for Health, the District Assistant Chief Administrative Officer for Health, the United Nations High Commission for Refugees (UNHCR) field staff, and the field coordinator for Africa Humanitarian Action (AHA).

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Designing the Integration of District and Refugee Health Services in West Nile, Northern Uganda



Background

Close to 120,000 southern Sudanese refugees currently live in the West Nile districts of Arua, Moyo, and Adjumani. The forced migration of Sudanese to Uganda began in 1986, with subsequent waves of refugees entering in 1988, and 1993-94. Health services for refugees in the three districts have been provided by a variety of nongovernmental organizations (NGOs), including both international and regionally based organizations. Most of the NGOs operate through the financial support of UNHCR (The United Nations High Commission for Refugees). UNHCR has provided this support in Adjumani and Moyo districts since 1986 and in Arua district since 1993. In more recent years, UNHCR has decided to phase out financing refugee programs in the West Nile area. This is due to both a shrinking global resource base, and the fact that the West Nile region is no longer considered an emergency and therefore does not directly fall under the agency's mandate. The plans for phasing out UNHCR assistance, through the handover of services to the local governments of each district, are outlined in a document called The Self-Reliance Strategy (SRS), introduced in 1999, by UNHCR and the Government of Uganda (Office of

the Prime Minister). On the government side, there was a desire to eliminate the existence of parallel service systems for refugees and the inequitable resource allocation that those services represented. At the same time, UNHCR wished to redirect resources from a stable, long-term refugee situation to evolving emergencies elsewhere.

The Self-Reliance Strategy is a conceptual document and as such says little about implementation methods or funding. The introduction of the SRS created political controversy in Adjumani District, in particular. Adjumani District hosts approximately 57,567 refugees, representing 32 percent of the district's overall population. At the same time, it is one of Uganda's most resource-poor districts, challenged by limited poor road and transport infrastructure, an economy driven by subsistence agriculture, and an under-funded, under-staffed social service sector including health services. Under such circumstances, local government leaders could envision a substantial increase in workload for district services with few reassurances for the additional financial support necessary to assume that responsibility. In this way, the Self-Reliance Strategy, as it was presented, raised more questions than it answered.

Theoretically, there may be a number of different ways to achieve systems integration. One approach is not to use a planning methodology, which provided some lessons learned. For example, before starting quality design activities in Adjumani District, project staff observed the handover of health services from an NGO at the Imvepi refugee camp to the office of the District Director for Health Services (DDHS) in Arua District. Stakeholders in that situation did not use a specific planning methodology, and a number of sticking points arose. These included the lack of a common vision among stakeholders, confusion over leadership roles, and the tendency toward ad hoc planning done without data, and without knowledge of user needs and expectations.

This approach led to tangible problems. For example, the refugee and district health units have different staff structures. Upon conversion to a district health unit, the refugee health unit at Arua needed to conform to national staffing norms. This



Service users seek care for a variety of health needs.

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

Table 1. West Nile Quality Design, Assessment of user perception of services before and after the handover of health services (Imvepi, Arua District)

Question		Before	After
		Refugees Imvepi (n = 41)	
Is the health unit usually open when you come for health services?	Yes	36, (.88)*	10, (.24)*
	No	5, (.12)*	31, (.76)*
How long do you usually wait before being attended to? <i>Mean Waiting Time (in minutes)</i>		33*	98.1*
Do you think the staff attending to you spends enough time with you?	Yes	36, (.88)	14, (.34)*
	No	5, (.12)	27, (.66)*
How much time does the staff usually spend with you? <i>Mean Consultation Time (in minutes)</i>		14.95*	8.4*
Do the staff speak your language at the health unit?	Yes	39, (.95)*	21, (.51)*
	No	2, (.05)*	20, (.49)*
Is there anyone doing outreach in your community?	Yes	32, (.78)*	7, (.17)*
	No	9, (.22)*	34, (.83)*

Note: All percentages and means are significant at the 95% confidence level.

The following table highlights the responses of refugee health unit users (both refugees and nationals) to a survey on user perceptions two years after the handover of the NGO-managed health services to the district at Imvepi refugee camp. Responses provided under the “before” column refer to their assessment of service provision before the year 2000 when the handover occurred, while the “after” column represents user perceptions of services from 2000 through today. Although other factors certainly may have contributed to the marked differences in quality of service noted by the healthcare users, issues in the transition between staffing systems as described are likely to have impacted these outcomes to a considerable extent.

To avoid this type of problem in Adjumani District, quality design project staff supported district health managers with the objective of creating realistic plans for integration using quality design. Quality design is the systematic creation of new services or processes, or the re-design of existing services, incorporating features that meet client needs while taking into account the resources available. The Quality Assurance Project has developed a 10-step quality design methodology that teams follow to clearly set objectives for the design, identify all clients and their needs, create a design that addresses those needs, and implement and monitor the new design

In Adjumani District, quality design project staff encountered a situation, which required modification of these 10 steps. More specifically, the traditional 10-step approach is typically used only in single-system situations. The challenge in Adjumani District differed in that there was a need to combine two different systems, managed by two different entities: The District Health Services system, and the UNHCR-supported refugee health system. While activities undertaken were based directly on the traditional quality design principles, the 10-step quality design process was adapted to the complex political and administrative considerations inherent in managing change within two separate systems. Among the most important guiding concepts were the emphasis on a *systems approach*, research into *user needs and expectations*, and the use of *data in decision-making*. The role of the quality design project staff was to offer quality design as a possible planning methodology, and serve as facilitators to the health managers undertaking this process. However, it is important to note that the health managers themselves, and the reality within which they were work, directly shaped the adapted quality design steps. In this way, the exercise was a dynamic process, promoting innovation and flexibility in approach. This case study outlines the 10 steps used in the following section, Methods, and provides comments on how these steps were implemented in the field.

Methods

Step 1. Create a common will and vision for change

Inherent to quality design is the concept of change. Either a new system is introduced, or an existing system is redesigned—that is to say, changes are made. The first step in quality design is promoting the will and vision to begin the process of change. Without investing time and effort in this area, it is not possible to create objectives for further activities. In situations where quality design is focused on more than one system (e.g. district and refugee health services each representing a distinct system), it is especially important to set the ground for change with this step. Promoting will and vision for the process can occur in many different ways depending on the specific setting and circumstances in which quality design is applied. Issues to consider include:

- Consensus among those responsible for leading change, about the need for change
- Support for change at higher management levels (e.g. if quality design is used at the district level, are there issues which require support and/or input from the central ministry level?)
- Effective communication of change concepts to the wider stakeholder group, including service users, and the active participation of stakeholders in discussing change concepts whenever possible

The Self-Reliance Strategy had set out the vision and the will to begin the process of integrating district and refugee services. Communicating that will and vision to the district level was an essential part of this first step. Unfortunately, national stakeholders had managed communication poorly in West Nile. This led to reluctance and distrust among various local level stakeholders and the entire integration process had stalled. The quality design project took an active role in getting the integration of services back on the agenda for district health managers and local government. This began as a series of informal but consistent meetings between project

staff, district authorities, and other stakeholders. The necessary political and organizational commitment of stakeholders was ultimately formalized later in Step 3.

Step 2. Understand and document current situation

In situations where quality design is used to plan a single integrated system out of two different systems, it is important that all parties to the change understand each other's systems and concerns, before further quality design activities are introduced. It is likely that the managers of parallel health systems, with different funding sources, different reporting mechanisms, different planning cycles, and different monitoring and evaluation activities, do not have the opportunity to learn about each other's systems to the extent necessary to work together on a new system design. Without this mutual understanding as a basis for further collaboration, other quality design steps can easily hit stumbling blocks. Although the local setting will naturally direct how this step is carried out, one way is through a formal presentation meeting, as the following example from Adjumani illustrates.

The integration of health services in Adjumani District involved a large number of stakeholders with a wide range of opinions about the politically contentious SRS. Specific stakeholder parties included the GOU (Office of the Prime Minister, Bureau for Disaster Preparedness and Refugees), the Ministry of Health, UNHCR, and refugee health NGO offices at both the Kampala and field levels, district politicians, administrators, technical managers, health unit staff, and service users within both the refugee and local populations. In order to apply quality design within such a complicated environment, it was important for facilitators to accurately identify the stakeholders most directly involved, and to understand their concerns. It was crucial for all parties to understand where perceptions were aligned, and from where on-going and potential conflicts were arising. Documenting how the two parallel health services were working provided the necessary background for progress in the integration process. This was achieved during a consen-

sus meeting, The Adjumani Health Coordination Forum, during which district health management, and refugee NGO health management each made presentations about their current systems, the challenges they faced, and the concerns they had about the integration of their systems.

Step 3. Build consensus among stakeholders on priorities

One of the cornerstones of quality design is the identification and prioritization of health service user needs and expectations. Because quality design is a systematic methodology, it is not usually possible to address all aspects of the entire health service system at once. It may be necessary to identify one to three distinct sub-systems (e.g. pre-natal care, emergency obstetrics, infectious disease control) on which to first concentrate efforts. Where there are diverse and numerous stakeholders, this must be done in a consensual manner. Quality Assurance offers various tools to assist in the identification of priorities which may assist the quality design facilitator in promoting this step. However, as with the preceding steps, the local realities will inform the facilitator how best to guide the process of priority area selection. Later, more detailed information about healthcare manager, provider, and user perspectives on each of the priority areas selected will be collected (Step 6).

As noted in Step 2 above, a consensus meeting, The Adjumani Health Coordination Forum, was held early in the quality design process in Adjumani. The forum was facilitated by respected health managers from the national level, and involved key personnel from the Ministry of Health, as well as UNHCR and NGO national offices. The consensus meeting was given a high profile to encourage participation and public commitment to implement decisions reached by stakeholders, who included local healthcare managers, providers, and users. One of the key outcomes of this two-day meeting was the identification of Priority Areas where stakeholders would concentrate efforts through the remaining quality design steps. The facilitators directed the meeting toward areas where broad consensus was already evident (from Step 2) and

A mother brings her child to the clinic.



avoided areas where it was unlikely that agreements could be easily reached. Stakeholders decided to concentrate on immunization, health information systems, and support supervision as priority areas.

Step 4. Establish a quality design team to follow up priorities

Quality design as a planning technique requires a team approach. When it is applied to the integration of two different systems, the team must be able to function well together and reach consensus on key decisions that may require change in the way in which the systems operate. It is also important that the overall stakeholder body be confident in both the persons representing them on this team, and their work. The team should be composed of individuals who represent all of the major stakeholder groups, and they should be able to take decisions on behalf of their groups as necessary. After receiving further orientation and training on quality design (Step 5), the quality design team members will actively undertake the remaining steps in the process, with the ongoing collaboration of quality design project staff. The

remaining steps include data collection (Step 6), feedback of research results to the wider stakeholder group (Step 7), analysis of stakeholder perspectives and incorporation of key issues into a new system (Steps 8-9), and implementation and monitoring of the new system (Step 10).

Stakeholders at the Adjumani Health Coordination Forum created the Adjumani District Integrated Health Coordinating Committee as the quality design team, and mandated it to direct the planning of integration activities. The team was composed of managers from the core stakeholder groups, including the District Director for Health Services, the District Local Council Secretary for Health, the District Assistant Chief Administrative Officer for Health, UNHCR field-level program officer, and the refugee health NGO field manager. The District Director for Health Services served as the chair of the team, and Save the Children Fund (UK) field staff provided technical advice through the quality design project. Although healthcare providers and service users were not formally included in the team, their opinions and perspectives were researched and reflected at various points in the team's work (see Step 6). The team carried out critical steps in the QD process from that point onward, including data collection and analysis, the creation of work plans and indicators, and feedback to the larger stakeholder community.

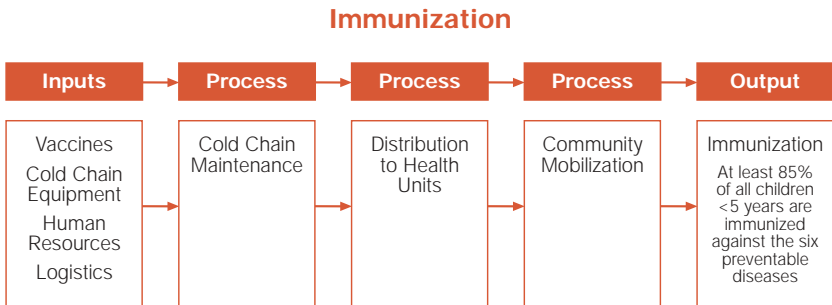
Step 5. Provide training and tools to the team

Planning through a systems approach involves looking at health services in what may be a new way to many managers. It is important that all members of the quality design team be familiar with the benefits of using this approach, as well as the outline of quality design steps and the tasks ahead of them. The extent of training and the order in which it may be best provided will depend on the previous experience of team members. However, in general, training should focus on (1) viewing health services from the systems approach; (2) research and identification of user needs and expectations; and (3) problem identification and mapping of user needs

within the system to be designed. The figure below provides an example of how health services may be viewed from the systems approach. Although immunization is used as an example, the same approach can be applied to any other health system.

The quality design facilitator introduced the basic concepts of quality design to the stakeholder group at the Adjumani Health Coordination Forum. Once the quality design team had been formed (step 4), more detailed information was provided in problem identification and problem solving. Key aspects of the training were the focus on quality design as a systems approach, and the importance of identifying the needs and perspectives of healthcare users, service providers, and managers. Figure 1, below, “Quality Design: The Systems Approach to Integration of Systems,” illustrates the key components of the immunization system—at a general level. In later steps, each of the components is broken down further for more detailed analysis. Although immunization is used as an example, the same was done for the other two priority areas identified: health management information systems and support supervision. Having looked at health services through this systems approach, the team began to consider what data they would need to collect, and how to do so, for the each of the priority areas.

Figure 1. The Systems Approach to Integration of Services



Source: The Adjumani District Integrated Health Coordination Committee

Step 6. Gather data on priority services and assess the health services resource base

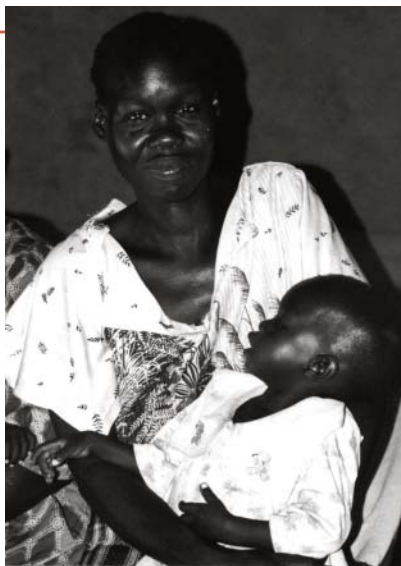
An important feature of quality design is its emphasis on the needs and expectations of those involved in health systems, including health system managers, healthcare providers, and health service users. This is because “quality” is best defined by those interacting with the system at those levels. If there is insufficient information on the perspectives of these health system stakeholders, it is necessary to conduct a focused exercise to gather data on the priority areas that have

Child health services are an important component in the health service system.

been previously defined (see Step 3). The results from this exercise can then be applied in the development of the new system design (see Step 8). There are many ways of collecting this information, including both qualitative and quantitative. As in all data collection, the quality design team must weigh the costs and

benefits of each assessment method and select the most appropriate for their situation, balancing the level of detail needed with the availability of time and other resources.

The Integrated Health Coordination Committee decided what it needed to know about immunization, health information systems, and support supervision to begin integration. Together, they developed questionnaires that looked in depth at qualitative and quantitative indicators for each of the three subsystems. The data collection exercise included all three key stakeholder groups in health services: users, providers,

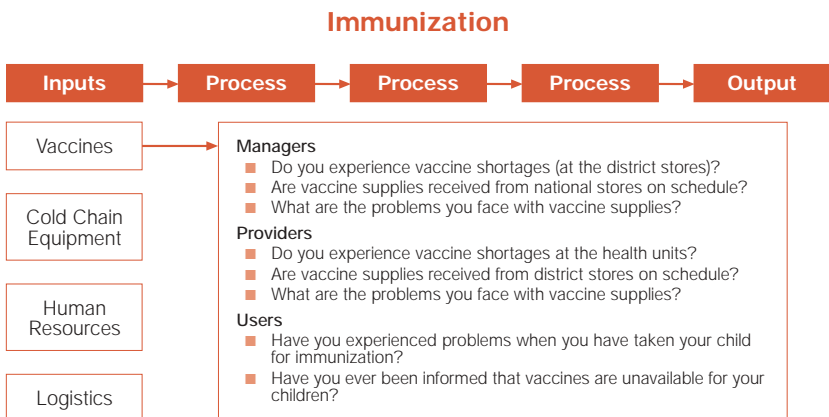


and managers, with separate questionnaires for each stakeholder group. Team members tested pilot questionnaires, trained interviewers, carried out the surveys in both local and refugee settings, and analyzed the data. A second level of assessment focused on an inventory of health resources for the district and refugee services. This step was important in that it facilitated for the team an understanding of resource availability before integration, and looked at financial resources, human resources, and key capital investments.

Data collection

The quality of any health system is defined in large part by the people who are directly involved, including managers, providers, and users. A key feature of the quality design approach is the collection and use of data about stakeholder needs and expectations. In Adjumani District, the quality design team asked these groups—in both the district and refugee systems—about their experiences in the Immunization, Health Information Systems, and Support Supervision areas. The diagram below shows the beginning of this process within Immunization. Each major system block, identified as Inputs, Processes, and Outputs, is composed of specific components. For each component, questions were then developed to identify the concerns of each group—

Figure 2. Data Collection



managers, providers, and users. Although the diagram shows questions about vaccine inputs as an example, the questionnaires covered all of the other components as well, thereby systematically ensuring that user needs were incorporated into the system.

Some interesting results were documented. Within Immunization, for example, all stakeholder groups noted problems in vaccine supplies, as shown in the following table. With this and other information gathered in the data collection exercise, the quality design team (Adjumani Integrated Health Coordinating Committee) could easily pinpoint areas of concern as they discussed the coordination of vaccine supplies. This step ensures the best quality service design, as defined by those involved in the system.

Stakeholder Group	Question	Response
Users	Have you ever been told that vaccines are unavailable for your children?	37% Yes 63% No
Providers	Do you ever experience vaccine shortages (at the health unit)?	78% respond "Occasionally"
Managers	Do you ever experience vaccine shortage (at the district stores)?	100% respond "Occasionally"

Step 7. Provide feedback to stakeholders and solicit responses

While the quality design team may be mandated by the larger stakeholder group to undertake the actual planning activities for the creation of the new system(s), there should be a regular circle of feedback from that team to the rest of the stakeholders. This is particularly important when there are multiple stakeholder groups, and when the system under design has been a point of contention between the stakeholders. The participation of the wider stakeholder group is crucial at this point so that they may understand the work of the quality design team, contribute their opinions and later be in a better position to support the changes laid out in the new design. There are a number of ways for the quality design team to

communicate this feedback. It may be outlined in a report, a presentation, individual discussions, or all of the above. As with the other steps, the local situation will dictate the most appropriate mechanism.

Findings from the surveys offered stakeholders the first concrete information on how the parallel health services were providing services to the two populations. These data also facilitated an understanding of the resources available, and provided an indication of the additional resources which would be required for the districts to extend their services to the refugee population. This information was provided to the District Health Management Team, UNHCR, local government and the NGOs managing refugee health services. Through the UNHCR, this information was available to representatives of the refugee community.

Step 8 Analyze data to determine common and divergent areas

The systems approach, characteristic of quality design, facilitates the application of data results to the decision-making inherent in the creation of a new system. More specifically, by looking at each of the components within a system, and matching feedback from data collection to points within those components, it is easy to see where there are differences between the systems and where there are special problems noted by the users. Moving from the macro view of the system, composed of inputs, processes, and outputs, the quality design team can look at each of these in detail, systematically checking the data results to see where they best apply. Ideally, the quality design team can make decisions themselves about how to handle differences between the two systems and problem areas. If not, they may need to consult with other stakeholders through an appropriate discussion mechanism. The following example from the Adjumani experience further illustrates this step.

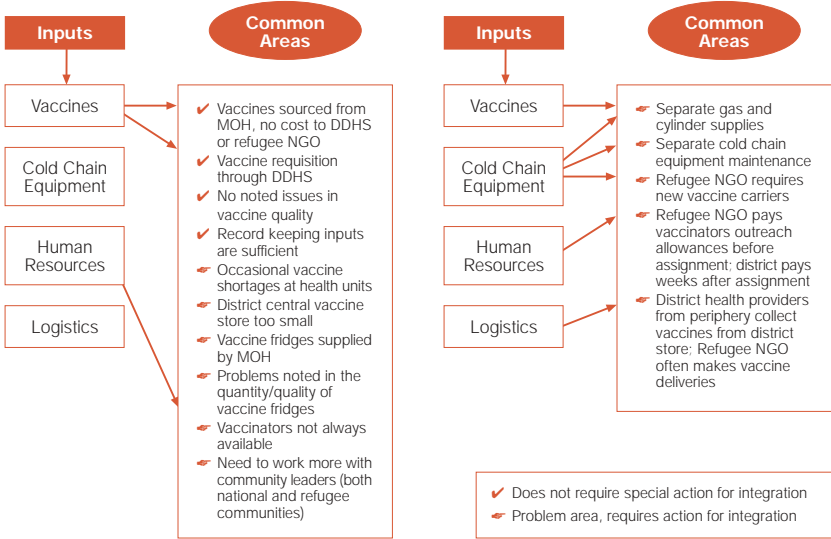
Members of the District Integrated Health Coordinating Committee constructed a sub-systems model for each of the selected priorities, and identified basic activities for the

integrated sub-system. They then examined data collected about both the district and refugee systems (see Step 6) to determine where the two systems functioned in a similar manner, and where the processes differed substantially. It became evident that in many areas the processes were very similar in the three sub-systems examined. These could be combined with little additional effort, and in most cases this would result in a savings of resources. However, in some areas there were substantial divergences in the processes. The survey information used in this step helped delineate the nature and the size of these differences.

Identifying common and divergent areas using the systems approach

With stakeholder feedback in mind, the Quality Design Team met to identify common and divergent areas within their operations. The following examples from the Immunization system highlight this exercise.

Figure 3. Identify Common and Divergent Areas



Step 9. Establish work plans to bring divergent processes together

Having completed the previous steps, it is now a relatively straightforward task to create an Action Plan for the integration of each of the identified health system priority areas. From Step 8, the quality design team has identified divergent areas where some action needs to be taken in order to harmonize systems. Each of these should be included in the action plan. While the format of the Action Plan may be modified to fit the needs of the health system managers who will ultimately be responsible for implementing it, the Action Plan should include at a minimum, a listing of each action point, the responsible party, indicator(s), any budget costs, and the funding source anticipated to cover that action point. Because this Action Plan is driven by a systematic analysis of the needs and perceptions of health system managers, providers, and users, as well as the explicit step of identifying common and divergent areas, it will cover all of the points necessary for the creation of a successful new system.

With these baseline data in hand, the quality design team planned how to redesign processes so they could function to facilitate integration. Team members jointly identified action points where change was necessary to align the two systems. On the basis of these action points, plans were created to implement the changes. Divergent areas were addressed in the Action Plan. In immunization, for example, action points included joint training of district and refugee health care staff in newly established national guidelines, development of common immunization support supervision activities and protocol, harmonized vaccine delivery from the district stores to both district and refugee health units, and coordinated outreach programs, including the development of locally relevant IEC materials in both local and refugee languages.

The Action Plan and Indicators

Having gone through the previous Quality Design steps, managers within the district and refugee health systems could easily identify the specific areas where they needed to design

Figure 4. Develop an Action Plan

System Area	Action Point	Responsible Party	Indicators	Budget	Funding Source
Input: Human Resources	Recruitment of substantive District Health Visitor (responsible for central vaccine requisition, etc.)	District Health Service Commission	DHV ensures vaccine supply needs are filled at both district and refugee health units, verified by orders and stock records	Position is included in district health budget	Adjumani District/ MOH
Input: Cold Chain Equipment	Conduct detailed inventory of immunization equipment and replacement as necessary	District and refugee health management staff	Inventory completed All equipment replaced as necessary	No cost for inventory exercise; Equipment costs to be determined through inventory	Replacement costs are covered through the national immunization program
Process: Cold Chain Maintenance	District cold chain assistants to include refugee health units in their maintenance reviews	District Health Services	Number of preventive maintenance visits per quarter Percentage of functional fridges in the units	No additional costs noted	District Health Services (regular budget)

changes to their systems. They documented these changes in the form of action points, which in turn formed an Action Plan. Having incorporated the feedback of all major stakeholder groups—managers, providers, and users—they could be confident that the new system created through the Action Plan could respond to their needs and in so doing ensure their quality definitions. In some cases, the changes would require additional funding. In other cases, it was simply a matter of doing things differently, with no additional cost, to accommodate stakeholder needs. Regardless of any cost implications, the Quality Design Team identified indicators for all Action Points. A sample of Action Points from the Immunization Action Plan is provided below.

Step 10. Implement and monitor work plans for integration of processes

Having completed an Action Plan, quality design team members must finally incorporate the agreed upon points into any other planning mechanisms which they may each have. This will ensure that the change process, and thereby the new system, is streamlined into their overall program activities. Generally speaking, these points will be reviewed and accepted by upper level management as part of each manager's own planning mechanisms. Because the wider stakeholder group has already been consulted about the process through both the early stage of consensus-building, and the later step of feedback, there should not be problems in approving the points for action. Monitoring of these points should occur both within each system's own mechanisms as well as jointly through the continued work of the quality design team.

To implement these action plans, district and NGO managers need to incorporate the action points into their regular management systems. Therefore these action plans were

A nurse weighs a baby in growth monitoring program.





A health worker provides routine child immunization services.

streamlined into the 2002 annual work plans and budgets for district and the NGO providing refugee health services. Monitoring of the implementation process will be part of the management information system at the district level. The Integrated Health Coordination Committee itself, as well as the larger stakeholder group, each have a role to play in this function.

Results

The results of the West Nile quality design project are most clearly evidenced in terms of process outputs, which are outlined in the following points. Of course, it is equally important to consider the consequences and impact of these results. However, because project staff left the field site while Step 10 was under implementation, the final impact of the quality design intervention will be measured later, when stakeholders have addressed the action points through implementation of their work plans.

Team building and consensus

One of the most important components of the quality design approach to integrating services is the establishment of effective teams. In the case of Adjumani district and refugee health services, it was particularly important to bring together

parties that had previously been suspicious about the idea of integration. As a team, the key stakeholders could create a common vision for the integration, which in itself allowed the progress to begin. While team members were able to participate fully and freely in the rest of the quality design steps, the establishment of the District Director for Health Services as the chair of the Integrated Health Coordination Committee clearly identified his leadership role. Acting on behalf of the team, he could make progress more quickly than if he had acted on his own.

Data collection and reports

Data played an important role in entire process. Data helped members of the District Integrated Health Coordinating Committee understand how the present system was functioning. The flow charting of activities with data about the individual steps within sub-systems such as immunization was eye opening for many members and gave them an understanding of where refugee health services and those of the district were managed in either a common or divergent manner. Armed with this information, the new integrated processes could be designed and flow charted. The experience of using data-based methods gave team members the capacity to apply this approach to other sub systems.

Action plans

The establishment of a work plan, in the form of the Action Plan, based on a team effort, and well-researched observations about previous systems, is an important result. While the Self-Reliance Strategy had outlined a policy intent to integrate local and refugee health services, its authors could not provide a clear definition of how to manage that change process. With a concrete Action Plan in hand, managers responsible for the implementation of integration now have an agreed-upon way to go forward in a tangible and measurable manner.

Quality Design Insights

The environment of the quality design process must be considered and adjustments be made as necessary

Initially, the process of integrating health services in West Nile was hampered in several areas. The very low resource base available to districts meant that the national essential health package will not be immediately achievable in an integrated system. The inconsistent support provided by UNHCR, for reasons described above, was also problematic. Although UNHCR was heavily involved in the conceptualization of the Self-Reliance Strategy, the turnover of personnel in the Uganda office hindered that support. Without doubt, the Self-Reliance Strategy itself caused a considerable degree of confusion. In terms of planning, key ministries including the Ministry of Health were not actively involved, while activity at the district level was also slow since it lacked the details needed for implementation. The failure of the designers of the SRS to communicate effectively to the refugees themselves was also a problem. These issues all contributed to an environment in which there were more questions than answers about how integration would occur. Indeed, it is largely in response to this environment that the quality design project staff adapted the original quality design steps to what is presented in the preceding sections.

Quality design can be used in a complex change environment

The quality design approach proved to be a valuable paradigm in creating a process for integration of refugee and district health services in Adjumani district. The structure it provided was key in charting out a direction through a vague policy environment that was highly charged with emotions and misperceptions. Using this approach helped bring together the various stakeholders in the district to consider not only the health of the

Sudanese refugees, but the health services for the Ugandan population as well. This was made possible by taking the time needed to:

- Create a common will for change (Step 1)
- Understand and document the current situation (Step 2)
- Build consensus among stakeholders on priorities (Step 3), and
- Establish a quality design team (Step 4)

Without undertaking these first four steps as the foundation to the process, the remaining quality design activities will be difficult if not impossible to implement in a complex change setting like the integration of refugee and district health services.

Investments in consensus building and partnership are critical in the integration of systems

The initial focus on understanding the system and the roles of the various stakeholders was critical to the success of the design process. This was a time consuming undertaking, but proved to be important in the later problem-solving steps. Partnership with Save the Children (UK), which was respected for its management-strengthening efforts, played a vital role giving credibility at the start of the quality design process. These early discussions with the stakeholders prepared the ground for the Health Coordination Forum. Making this a high-profile event with national representation was important to its success. The process could have been further strengthened if on-going monitoring of the integration process by the MOH had been maintained. However, due to both constraints in time, personnel, and logistics, it was a challenge for the MOH to be more directly involved. Ideally, a stronger engagement from UNHCR could have strengthened the follow-on process as well. As the agency's Uganda activities are being rapidly downsized, this has also proven difficult.

Health managers are the driving force behind quality design

In one way, the quality design process can be criticized for not directly involving the Sudanese and Ugandans who use the refugee health units as primary system users, beyond researching their needs and perceptions as earlier discussed. However the project identified its main customer segment as health managers and local government. As noted elsewhere in this case study, the outcome sought was to establish a high quality planning process to integrate two health systems despite the many challenges. Ultimately, managers within the district health services and political administration have the day-to-day responsibility for ensuring a smooth and equitable transition. To this end, project staff functioned as the facilitators of quality design, working directly with those leading the change.

The systems approach

Looking at health services through a systems framework such as quality design helps to ensure a comprehensive and organized review of all key issues so that important considerations are not neglected. This is one of the most important aspects of quality design, and a feature that distinguishes it from other planning approaches or not using a specific planning approach at all. While the task of integrating two systems, such as district and refugee immunization systems can be a daunting challenge, it is made more manageable by breaking the system down into inputs, processes, and outputs. Stakeholders can then make separate inventories of materials, human resources, activities, etc. that are included within each of these areas. A systems-based approach contrasts to ad hoc, issue-by-issue planning that characterizes less organized attempts at integration.

Focus on simple areas first

As mentioned in Step 3, stakeholders in the integration of district and refugee health systems decided to first focus on immunization, health information systems, and support supervision. These three areas were among the less difficult systems requiring integration, in contrast to others such as personnel management, referral, and drug procurement—all of which require larger financial decisions and, in the case of personnel management, legal considerations. Dividing up the larger health system into sub-systems and focusing on less contentious areas, helped build team work which could then be better positioned to handle the more difficult areas later. It is easier and more efficient to build upon successes, than struggle with difficult areas with questionable success.

Next Steps

Beyond Immunization

Having completed an Action Plan for integrated immunization services, the Integrated Health Coordination Committee is prepared to complete the rest of the steps for the other two priority areas that has been identified at the Adjumani Health Coordination Forum. These are health management information systems, and support supervision. The next steps in quality design for those two systems are Steps 8 to 10. Since the data has already been collected, the quality design team now needs to analyze the common and divergent areas in each system, establish an Action Plan for each, and implement and monitor the necessary activities in the same way as planned for immunization.

After completing the process for the first three priority areas (immunization, health management information systems, and support supervision), the quality design

team will be ready to apply the same planning process to new areas which also require integration. The decision about which other systems to integrate should be made through a consensual process, with stakeholder representation. If necessary, the quality design team can use prioritization exercises provided through training (Step 5).

Service integration in West Nile is a continuing process

The integration process reported here is in many ways incomplete since we were not able to follow the process through to the final integration of services. It was not clear when this will occur, given the uncertainties of continuing UNHCR funding for Uganda. We do intend to follow developments in West Nile to assess how the quality design initiative fares with time. Since Quality Design was a new process in this setting, it required substantial technical assistance to achieve the objectives of implementing planning methods. However, having now gone through the Quality Design cycle with outside technical assistance, the quality design team can now has the tools and experience to move forward on their own. Because this was a new methodology being applied in a new environment, substantial adaptation and innovation were required at the field level. We feel that the Quality Design approach has been an effective planning tool for the integration of refugee and host country services that can be applied in similar situations elsewhere.



Designing the Integration of District and Refugee Health Services in West Nile, Northern Uganda: Summary

This case study demonstrates the use of Quality Design in the integration of refugee healthcare into the district system in Adjumani District, northern Uganda. This is a common challenge around the world where services have been established for refugees in parallel to local systems. It is a daunting task under the best of circumstances and requires more than an ad hoc approach to planning. The experience presented in this case study shows that health managers can use quality design to create practical plans for implementing successful change. Whereas quality design had previously been used primarily in single-system hospital-based settings, this case study further illustrates how quality design can be used to bring together two distinct service delivery systems at the peripheral levels.

The hallmarks of Quality Design underlined in this document are:

- Establishment of leadership in the change process
- Creation of a common vision (consensus) among all stakeholders involved on who is implementing change, and in what areas
- Use of a systems approach, viewing health service delivery in terms of inputs, processes, and outputs, and
- Collection and application of healthcare manager, provider, and user feedback on services in place

Finally, this case study shows that quality design should not be viewed as a static or inflexible set of directions. The 10 Steps developed through the experience in Adjumani build on the key features of quality design listed above, and have resulted in an approach that is particularly relevant in the circumstances described. It is the role of health managers, and Quality Design facilitators, to analyze the setting in which they are to introduce change, and use Quality Design in response to that environment.