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A Synthesis of Key Aspects of Health Systems and Policy Design Affecting the Refugee Populations in Uganda

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Acronyms & Abbreviations

CRRF	Comprehensive Refugee Response Framework
FAO	Food and Agricultural Organization
GoU	Government of Uganda
HSIRRP	Health Sector Integrated Refugee Response Plan
NDPII	National Development Plan II
NPA	National Planning Authority
RRP	Refugee Response Plan
UBoS	Uganda Bureau of Statistics
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund

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1. Introduction

Uganda has been host to many refugees and asylum seekers from within Africa, and beyond, since colonial times, most of these fleeing political instability and conflict in their countries of origin or residence. This is attributed to Uganda's long-standing open-door refugee policy and relatively stable political situation. Within Africa, the majority of refugees in Uganda initially came from Rwanda and Burundi, and more recently from South Sudan and the Democratic Republic of Congo (DRC). Other countries that contribute to the refuge population in Uganda include Eritrea, Ethiopia and Somalia, among others (HSIRRP, 2019-2024; UNDP, 2017).

Beyond the open-door refugee policy, Uganda also has exhibited capability, from past experience in handling conflict affected persons. This draws from Uganda's own internal recovery from a politically unstable past, the most recent perpetrated by the Lord's Resistance Army (LRA), which ravaged the northern and eastern parts of the country for over two decades, forcing thousands from their homes to spend many years in camps for internally displaced people (IDPs).

Uganda currently hosts over 1.3 million refugees, with most of the refugees living in protracted settlements in West Nile and Northern Uganda (Adjumani, Moyo, Yumbe, Koboko, Obongi, Arua and Lamwo districts), South-Western Uganda (Isingiro, Kyegegwa, Kamwenge districts), and Mid-Western (Hoima and Kiryadongo districts). There is a small percentage of refugees living among communities in the urban areas, mainly Kampala. The distribution of the 1.3 million refugees is as in Table 1

Table 1. Distribution of refugee population by country of origin

s/n	Country of origin	Percentage
1	South Sudan	65.5%
2	Democratic Republic of Congo (DRC)	26.6 %
3	Rwanda	1.2%
4	Burundi	3%
5	Somalia	2.2 %
	Other Nationalities	1.4%.

This has made Uganda the largest refugee hosting country in Africa, and the third largest in the world after Turkey and Pakistan (UNHCR, 2017a). The major cause of the human displacements from the neighboring countries, particularly South Sudan, the DRC and Burundi, has been civil war and political and tribal conflict (HSIRRP, 2019). The UNHCR operational update on refugees in Uganda for the month of November 2019 shows that the humanitarian situation remains particularly unpredictable in South Sudan and the DRC. There were 5740 new arrivals in November 2019 alone, equivalent to 191 daily arrivals, based on border monitoring records. Most refugees from the DRC cited inter-ethnic violence in the Ituri, area as well as fighting and attacks on civilians in North Kivu, as the reasons for fleeing the

country. Refugees from South Sudan reported insecurity, food insecurity and lack of access to basic services, such as education and health, as the main causes of seeking refuge in Uganda. The refugees from Burundi indicated several reasons for leaving their country including insecurity, family reunification, reported violence, and fear of forcible conscription by militia groups. By and large, civil and political insecurity remains the most common reason for the influx of refugees into Uganda.

The high inflow of refugees has translated into increasing economic pressure on the communities hosting them, and has resulted in major funding shortfalls which have severely affected the capacity of the country to adequately meet the needs of refugee populations and hosting communities[1]. The increasing pressure from the recent refugee influx necessitates more sustainable approaches for their management, to ensure that both host and refugee communities build resilience and sustainable livelihoods.

The underlying poverty and vulnerability of refugees, their acutely limited resilience to shocks and viable economic opportunities contribute to higher overall poverty levels, in often remote and less developed refugee-hosting areas. Besides, displacement is associated with changes in behavior, gender-based violence, and reduced access to resources and community services such as health, education and markets, further exacerbating the vulnerability of refugees in the hosting country (Kasozi, et al., 2018). In particular, access to health services by refugee populations is critical given their large and unpredictable numbers which may overwhelm the public health system in the host community (UNHCR RRP, 2018-2020). The refugee settlement environment makes refugees prone to disease outbreaks, particularly diseases that are associated with congestion and large scale population movements, which requires close attention. This is why refugee-hosting districts are now recognised under the vulnerability criteria of Uganda's National Development Plan 2015/16-2019/20 (NDP II & 2020/21-2025/26 NDP III), making them a priority for development interventions. Following the Comprehensive Refugee Response Framework Declaration in New York (UNHCR, 2017b), Uganda developed a Refugee Response Plan (RRP) which has provided an opportunity to engage various actors to comprehensively respond to the humanitarian and development needs of refugee-hosting districts and the entire population of both refugees and host communities.

1.1. A brief about Uganda's refugee policy framework

The Refugee Response in Uganda is coordinated jointly by the Office of the Prime Minister (OPM) and the United Nations High Commissioner for Refugees (UNHCR). Uganda's legal and policy framework for hosting refugees is considered the most progressive the world over and often cited as a model to follow (UNICEF, 2018; RRP, 2018-2020). The policy is firmly enshrined in Uganda's 1995 constitution, and the 2006 Refugees' Act, which are consistent with international conventions such as the 1951 UN convention, and the 1967 protocol; and regional agreements such as the 1969 OAU convention, and the 2010 local legal regulations that grant refugees protection and freedoms. Overall, the regulatory framework embodies the following key refugee protection principles and freedoms: i) property rights and access to land, ii) right to access employment and engage in income generating activities, iii) right to access public social services including education and health, iv) freedom of movement and association (Uganda is the only country in the horn of Africa with such policy) and v) the right to documentation and equality before the law. Most of the refugees live in protracted settlements (30 settlements in total: 24 in the North & West Nile region, and 6 in the South-West region) where they are provided plots of land for agricultural use to subsidise humanitarian assistance. These rights and entitlements offer refugees a

[1] UNHCR's funding analysis for 2019 shows that 60% (US$ 232m of $386.m) of their budget for refugee response in Uganda remained unfunded as of 30th Nov.2019 (UNHCR operational Update, Nov,2019)

pathway to attaining better livelihoods in terms of some degree of self-reliance, and progressively reducing dependency on humanitarian assistance. Under this framework, the Government of Uganda (GoU) has developed many programs targeting both refugee and host communities. Many of the development initiatives conducted by the GoU, supported by UNHCR and other partners, have focused on promoting the self-reliance of refugees, strengthening the resilience and service delivery of host communities, and promoting a peaceful coexistence between the two communities. Promoting the self-reliance of refugees, and establishing a sustainable source of livelihood and progressively reduce the need for humanitarian aid, is a central part of Uganda's refugee response lasting solution. Moreover, efforts to strengthen the local institutional capacity, and enhance service delivery in hosting areas, are considered essential to minimise disparities in access to basic services and avoid tensions between the communities.

Refugee response planning is an integral part of the Uganda's National Development Plan. Considering the precarious and conflict prone political environment of the region, together with thousands of refugees already living in a protracted refugee situation, the GoU has included the Refugee Response Plan in its National Development Plans going forward, beginning with NDP II (2015/16–2019/20). The underlying rationale is that refugees can contribute to the development of host areas, but that this requires a comprehensive and multi-sectoral approach over the years. Uganda is the first to implement the New York declaration on implementing the comprehensive refugees' response framework (UNHCR, 2017b).

However, the recent refugee influx that doubled the number of refugees in the country in a short spell of time is straining the country's institutions, programs and response mechanisms in place, including putting pressure on the public services delivery system, and some central elements such as land management for refugee use. The prolonged and steady refugee influx is raising concerns about the sustainability of Uganda's approach (FAO 2018). Besides, there are some limitations to the Uganda refugee response approach: i) The legal framework does not provide a permanent solution of citizenship for refugees who can neither repatriate nor resettle elsewhere (World Bank, 2016); ii) The children of refugees born in Uganda (and even if one parent is Ugandan) and their future offspring, are also not entitled to citizenship; and iii) Movement in and out of settlement areas is not easy, which could be negatively affecting the economic integration of refugees.

It is noted that districts in the West Nile region host nearly 65% of the total refugee population (UBoS, 2019). Moreover, the refugees are disproportionately distributed, with some districts hosting a large number of refugees (nearing 50 percent of the total population), for instance in Adjumani 47%, in Moyo about 45%, while in Yumbe 28%. The large numbers of refugees, in relation to total population for these districts, spells significant challenges in the provision of quality public services, such as education, health, water and sanitation. This situation is exacerbated by the fact that these are some of the poorest and less developed districts in Uganda. For example, the poverty headcount rate for Adjumani and Yumbe respectively is 38% and 30%, according to the 2016/17 poverty mapping conducted by the Uganda Bureau of Statistics. These poverty rates are considerably higher than the national average rate of 21.4% for the same year (UNHS, 2016/17).

1.2. Poverty situation among refugees

According to Uganda National Household Survey 2016/17, about 46% of the refugee population live in poverty (UBoS, 2017). This implies that they do not have enough resources to satisfy the minimum daily calorie requirements and basic non-food needs. The poverty level is considerably higher than the

national poverty rate of 21.4% reported in 2016/17. Region specific poverty data indicates that refugees in the West Nile region are poorer, compared to those in the Southwest region. Poverty rates of 57% and 28% among refugees in the West Nile and Southwest regions respectively have been recorded (UBoS, 2017). The poverty levels among the host communities are considerably lower (29% in West Nile and 11% in Southwest).

In 2018, UBOS conducted a study among refugees and host communities, covering a number of dimensions to inform the Refugee Response Policy in Uganda. This study revealed that the refugee population in Uganda remains poor and experiences high levels of food insecurity (UBOS, 2019). About half of the refugee population in the country (48%) are living in poverty, with the West Nile region having the highest rate at approximately 60%. The report further revealed that food insecurity is higher for both refugees and hosts in the South-West and West Nile regions. Poverty rates were also found to be higher among recent refugees than those who had stayed more than 2 years. Thus, programs aimed at alleviating poverty and food insecurity particularly among recent refugees are needed.

In terms of livelihood, aid dependence among refugees is quite high, with about 54 percent reporting aid as their main source of income. While aid reliance goes down with tenure, it is still the main source of income for 37 percent of refugees that arrived more than 5 years ago. Aid dependency highlights the need to enhance the income generating ability of refugees.

The demographic structure of refugees poses another livelihood challenge. There are very many young people among the refugees, compared to host communities. About 58% of the refugees are below 18 years and 72% below 24 years of age. This demographic structure denotes a high dependency ratio, estimated at 1.7, as opposed to 1.2 among host communities (UBOS, 2018). The refugee scoping study to inform the NDP III revealed that 32% of the households had at least one baby since arriving in Uganda (NPA, 2019). This represents a high population growth rate, considering that over 50 percent of the refugees arrived in or after 2016. Use of family planning methods is also low, with just 9% of the women between 15 – 49 years reported using any family planning method. The large number of young people among refugees has implications for skills development programs, productivity enhancement, and social services delivery for refugee communities.

2. Health and nutrition among refugees and host communities

Uganda has a Health Sector Integrated Refugee Response Plan (2019-2024) which was launched in January 2019 as part of the comprehensive refugee response framework (CRRF) for the country. The main objective of the Health sector under this plan is to ensure full integration of comprehensive primary health care service needs for refugees into the national and local government (LG) system. The key priority is to provide the minimum health care package for all refugees with an emphasis on preventive and promotive health care for new refugee arrivals at entry points, transit and reception centers, and during their initial stay in settlements. The minimum healthcare package includes vaccination, nutrition screening, emergency referrals and provision of life-saving primary health care services, in addition to surveillance and response measures for disease outbreaks.

A number of Health Partners[2] work with government to build the capacity of the health workforce, especially strengthening the role of community-based health workers, and also to implement programs to prevent and treat malnutrition. They also play an important role in raising awareness on reproductive health and HIV/AIDS prevention and treatment among refugees and host communities.

The UNHCR maintains a Health and Nutrition Dashboard where it reports the health and nutrition situation of refugees on a quarterly basis. These quarterly reports highlight the status of refugees on key health indicators including Under-5 mortality rate, acute malnutrition rate, health facility delivery rates, and measles vaccination rates. It also provides information on access and utilisation of healthcare services among refugees and host communities, including outpatient utilisation rates, severe malnutrition recovery rate, Tuberculosis case detection per 100,000 persons, the number of health facilities accredited by the Ministry of Health in refugee-hosting districts, surveillance of disease outbreaks (particularly Ebola) and the health partners across refugee settlements.

2.1. The burden of disease and access to healthcare services for refugees and host communities

There are no major differences in illness prevalence between refugees and hosts, but refugees seem to have slightly better access to health care. The UBOS report 2019 showed that about 31% of hosts and 28% of refugees reported having some illness in the 30 days preceding the survey (UBOS, 2019). The incidence of illness is relatively similar for hosts and refugees in Kampala (22% and 19%, respectively) and the West Nile (26% and 23%, respectively). However, refugees in the Southwest region reported a higher illness incidence (42%), compared to hosts (37%). This observation in the Southwest region is consistent with the findings of UNICEF (2018).

The presence of health NGOs makes free healthcare slightly more accessible for refugees. Access to health care services is mostly free in Uganda, but there are differences in the type of health facilities that host populations and refugees use. In Kampala, refugees and hosts mostly use private health services. While host populations in the Southwest and West Nile, and refugees in the Southwest, use government health facilities, refugees in West Nile use services provided by the humanitarian health response (UNICEF 2018). About 82 percent of host communities and 89 percent of refugees consulted a healthcare provider when sick. Out-of-pocket payments for healthcare services vary considerably

2 Figure A1 in the Annex shows a range of Health partners supporting programmes in different refugee Settlements across the country

between refugees and host populations. Based on the UBOS 2018 study, only 7 percent of refugees paid for a consultation compared to 20 percent for host populations.

With the exception of Kampala, healthcare centers are more accessible to refugees. Overall, most refugees (75 percent) and hosts (65 percent) must travel between 0 and 3 kms to reach a healthcare center when they are sick. Access to health facilities is far better for refugees living in settlements than those who live within the communities in Kampala. Less than 9 percent of refugees in the West Nile and Southwest regions must travel more than 5 kms, compared to about 30 percent of refugees in Kampala travel more than 5 kms. Utilisation of healthcare also varies between refugees and host communities. In 2019, of all the out-patient consultation visits made at refugee serving health communities, 78% were made by refugees and only 22% by the host communities. Of the children who were vaccinated against measles in May 2019, 78% were refugees and of those that completed polio vaccination, 79% were refugees (UNHCR refugee Health Report, June 2019). Low availability of medicines (19 percent) and bad staff attitude or long wait times (14 percent) were reported as some of the main reasons to not seek healthcare. The host populations, on the other hand, reported high costs (16 percent) and long distance (14 percent) as some of the reasons for low consultation. (UBOS 2019).

Access to clean water within the refugee settlements is very high, with 94% of the households having access to clean drinking water (either piped water, a borehole or protected well), compared to 66% for the host communities (UBOS, 2019; NPA, 2019). The relatively better access to health care services and improved water sources within the refugee settlements could be attributed to the large presence of implementing partners providing services within the settlements, as compared to mostly government provided services within the host communities. While, in principle, host populations are expected to share the services in the settlements, some service points within the refugee settlements (such as water boreholes and health facilities) are deep within the settlements and thus too far for the host populations to access. There is anecdotal evidence that the relatively better service delivery within refugee settlements, and the continued depletion of forest and wood fuel resources surrounding the settlements by the refugees, are sources of tension between host populations and refugees in some areas.

2.2. Nutrition status among refugee populations

In terms of nutrition, and according to the 2017 Food Security and Nutrition Assessment (GOU, UNICEF, UNHCR & WFP, 2018), the prevalence of Acute Global Malnutrition (GAM) remained within the acceptable standard in refugee settlements. However, a nutrition screening of Congolese new arrivals in 2018, through Mid-Upper Arm Circumference (MUAC) measurements, showed that both GAM and Severe Acute Malnutrition (SAM) were above emergency thresholds, at 11.2 percent and 2.5 percent respectively (RRP, 2018-2020). Considering WHO classification, anaemia among children aged 6-59 months was ‘high’ in most refugee settlements across Uganda, except for Nakivale, Oruchinga and Kampala (classified as ‘medium’). Among non-pregnant women aged 15-49 years, anaemia was reported to be ‘medium’ in all settlements, except Palabek at 47 percent. Consequently, more efforts are needed to enhance targeted supplementary feeding programmes, increase skills training for health workers in Infant and Young Child Feeding (IYCF) practices in emergencies, and to expand the use of a newly introduced vaccine in the routine immunisation. Preventive approaches to address acute malnutrition and micronutrient deficiencies are needed to complement the existing curative measures.

At national level, 18% of refugee households were found to have a low food consumption score (poor or borderline), with 32% in Kyegegwa (hosting DRC refugees), 28% in Lamwo (hosting South Sudan and

Kyaka II). 9% of refugee households in Kyegegwa had the highest percentage of poor food consumption score across all those assessed. Sixty-seven percent of refugee households reported insufficient access to food for all the members of the household in the 7 days prior to data collection, and 72% reported non-governmental assistance to be the primary source of food (UBOS, 2019; Refugee Response plan 2019-2020). Refugee households are allocated a small-sized piece of land, and most settlements are located within semi—arid areas where food production is hardly possible without fertilisers. Most refugees therefore rely on food handouts which exposes them to persistent food insecurity, leading to low food consumption and poor nutrition.

2.3. Gaps in healthcare services delivery

The Monthly Refugee Operational Updates highlight the key gaps in services delivery including health, food and nutrition, education, water and sanitation among others. With regard to healthcare services, the common gaps identified across settlements and host communities include: inadequate storage space for medicines and medical supplies at the central warehouse and in the field and health facilities; inadequate staff accommodation in the health facilities; and the lack of permanent health facilities in some zones of refugee settlements where the distance to the nearest health facility is more than the five-kilometer radius. (UNHCR, Operational update, Nov2019).

2.4. Organisation of healthcare for refugees

Uganda's inclusive refugee policy recognises refugees' right to health, education, work and free movement. Primary healthcare needs for refugees have been actively integrated into local government managed healthcare systems (Clements, et al., 2016). The integration of refugee health services into district health services means that the planning and delivery of care for both the refugees and nationals in the hosting communities is done by the refugee hosting district. Refugees and nationals are accorded equal access to the healthcare services (UNHCR, 2019). This arrangement implies that healthcare delivery partners (e.g. UNICEF, Real Medical Foundation-RMF, Inter-Aid, PACE etc.) continue to enhance coordination and inter-sectoral collaboration, and strengthen the provision of equitable, safe, quality and sustainably reinforce health systems in refugee-hosting districts, alongside Government efforts. However, a review of the refugee response plan 2019-2020 indicates delays in the delivery of timely healthcare for life threatening conditions, with the consequence that some refugees independently resort to herbal medicine, self-medication, or seek services for serious medical conditions in small ill-equipped private clinics and retail drug outlets that are not well integrated within the health system (UNHCR, 2019). Unlike their counterparts in the refugee settlements, there are no established referral arrangements where urban refugees are affiliated to a specific healthcare facility. In Kampala, for example, Inter-aid responded to these concerns by setting up a dispensary to provide medicines for refugees who are unable to access care at the general public health facilities and also offer basic curative services for the simple ailments.

2.5. Financing for refugee healthcare

Refugee healthcare financing in Uganda is a key issue and is contained in the HSIRRP 2019-2024. Accordingly, the main sources of financing for the implementation of the HSIRRP comes from: Government of Uganda, the UN, Bilateral and Multilateral organisations, and humanitarian and development partners. To operationalise this, Government (through the ministries and local governments) aims to provide budget support for the development of infrastructure in health facilities. They use budget support for providing health services to refugees and host communities to secure medicine and health supplies, human resources for health, information systems and technologies.

UNHCR, on the other hand, together with partners, provides resources to augment the integrated response effort to provide services to the target populations. It is envisaged that some donors may continue to directly fund implementing partners due to existing contracts and donor restrictions. Such funding modalities would be considered in consultation with Government, if the use of the resources is aligned to the HSIRRP and there is an agreed financing tracking mechanism.

In terms of real financing, enormous amounts of money are required to finance the health and nutrition budget for refugees. According to the refugee response plan, US$165,435,989 is needed to finance the health and nutrition budget during the 2019/2020 phase. Most of this funding is expected to come from the donor community which is experiencing funding fatigue, thus creating huge funding gaps. For instance, in 2018, Uganda's Integrated Refugee Response Plan (RRP) was only 6% funded, causing a critical shortfall. Save the Children argues that where funding has been made available, it is largely short-term, covering 3-6 months, which is unsustainable for the chronic long-term needs of vulnerable refugees (Save the Children, 2019). In her effort to finance the HSIRRP, 2021-2024, the Uganda government is now looking for $100,000 (about Shs 37b) annually to run the HSIRRP for the next five years. According to the Ministry, HSIRRP is expected to contribute to the national objective of improving the health status of host communities and refugees through building a resilient health system that can withstand shocks and guarantee sustainable and equitable access to essential health services. The strategic intervention will be implemented under six pillars, namely: service delivery, human resource for health, medicines (health commodities and technologies), health management information system, health financing, and leadership coordination, management and governance.

Table 2. Projected healthcare funding as per HSIRRP

Summary as per Service Inputs (US $ '000')						
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals
Communication Materials	1,078	1,125	1,321	1,402	1,637	6,562
Human Resources	29,083	29,265	29,516	29,710	29,942	147,516
Infrastructure	32,803	63,644	33,460	620	638	131,165
Logistics	2,066	2,817	3,623	4,458	6,628	19,593
M&E	658	374	386	397	409	2,224
Management and Governance	719	691	724	751	711	3,597
Medicines and Drugs	30,482	38,894	47,936	57,312	81,534	256,157
Program Overheads	2,233	2,222	2,293	2,357	2,433	11,539
Training	1,266	868	1,077	647	1,289	5,146
	100,388	**139,901**	**120,335**	**97,654**	**125,221**	**583,499**

Source: HSIRRP, 2019-2024

3. Summary of issues related to healthcare access and financial protection

A number of issues have been identified that impede equitable provision of and access to integrated health services for both refugees and host communities. They include low staffing levels, low infrastructure (especially HCIII), limited numbers of Community Health Workers (CHWs), high patient overload, financing gaps, and hard to reach areas/remoteness causing key medical human resources to shy away from working in such places, among others. With an increasing refugee population and anticipated refugee influxes through 2020, the capacity and resources of primary healthcare institutions remain at a constant risk of being overstretched (Uganda country RRP, 2019/2020). In particular, refugees living in urban areas, and outside the settlements, access general public health facilities where provision for additional patient caseload has not been made. The perpetual high workloads are associated with frequent drug shortages, and increased out-of-pocket payments by both refugees and host communities (HSIRRP, 2018).

According to the joint inter-agency MSNA 2018, 51% of the refugees and 17% of host community households are in need of health services. This need is more pronounced among refugees in Mid-western Uganda (64%), where refugees from DRC and South Sudan are hosted, followed by South-West (57%) hosting some DRC and Burundian refugees, and 49% in West Nile (hosting South Sudan refugees). At district level, 71% of refugee households in Kamwenge (hosting DRC refugees) were classified as *"in need",* 69% in Kyegegwa (hosting DRC refugees), 61% in Yumbe (hosting South Sudan refugees) and 56% in Arua and Hoima (hosting respectively South Sudanese and DRC refugees). It was revealed that the most vulnerable refugee households in need of health services are in Kiryandongo district (hosting South Sudan refugees), and that both refugee (55%) and host community households (44%) reported a lack of drugs at health facilities as the biggest challenge in accessing health services for those who sought treatment but were unable to receive it, with the highest percentage in West Nile (56%) (HSIRRP, 2019-2020).

To address apparent refugee health needs, additional health facilities have to be set up in line with the government guidelines, and facilitate them to deliver the full package of health interventions as per the universal health access package. This requires investments for staffing, medical and nutrition supplies, infrastructure, equipment, and referral services, as well as skills training of existing medical personnel. Besides, reports have indicated the need to strengthen reproductive health services across the refugee response to increase the number of deliveries attended by skilled health workers.

To this end, the Government of Uganda is working to strengthen the healthcare system at national, district and local level through investments and measures that enhance the health systems' capacity to respond to current needs and future shocks. For instance, to fill the human resources gap to 95% of public service level, upgrading and equipping of 94 HCIIs to HCIIIs, constructing 36 new HCIIIs and five (5) HCIVs among other intervention.

3.1. Financing gap analysis

According to HSIRRP, Government of Uganda (GoU) and partners commit to identifying priority gaps in financing the HSIRRP by pooling resources towards its implementation. For instance, the GoU is seeking $100M to run the 2019/2020 HSIRRP which resources will be channeled through budget support to the health sector and the local governments. The government of Uganda, with support from the partners, committed resources towards the implementation of the HSIRRP. At the time of finalising the costing

exercise, commitments earmarked from GoU and the Partners had been compiled and estimated to about US $ 142 million leaving a funding gap of about US $ 415.7 million (HSIRRP, 2019-2024).

3.2. Inter-sectoral issues that arise with refugee healthcare provision

Literature indicates that policies aimed at integrating services and fostering inter-sectoral action should consider system-level approaches, such as the colocation of services, transportation support and establishing system navigator roles (Ho et al., 2019). Engaging host communities around a human rights-focused strategy to the health of refugees is also fundamental to address discrimination and stigma. Communication challenges due to language barriers should also be addressed, with a view of providing culturally sensitive programmes. There is also a need to strengthen the capacities of front-line providers and managers, to improve their knowledge of available services, as well as their ability to provide care to specialised vulnerable refugee groups.

4. Coordination and leadership

The OPM and the UNHCR, in collaboration with other UN agencies and partners, coordinate all humanitarian responses to refugees living in the settlements. Refugee health service providers through UNHCR are part of the compact between MoH and development partners for implementation of the HSDP 2015/16-2019/20. The MoH chairs the refugee health sector coordination structure at the national and district levels. The Nutrition Emergencies and Integrated Management of Acute Malnutrition (IMAM) thematic working group coordination structure, chaired by MoH, feeds into the health sector coordination. However, these coordination roles are not institutionalised at central and district levels, although some districts have taken up leadership roles in the refugee health response.

5. Key outstanding policy questions in relation to governance, gender & economics

- Inconsistency between the roles of OPM and UNHCR and LGs on management of refugees, especially service delivery, planning and financing issues, including for health (governance and livelihood programmes). This is can be attributed to the lack of a substantive National Refugee Policy.
- The limited prospects for voluntary repatriation under the current conditions in the countries of origin has implications for government's efforts towards peace building and conflict resolution in the great lakes region. The Refugee scoping study 2019 showed that only 28% of the households interviewed had any member who had considered returning home.
- Critically examining the long-term implications of Uganda's distinct open-door approach to hosting refugees compared to other EAC member states, and explore the implementation of harmonious approaches to refugee hosting within the member states.
- Donor-reliant and project driven financing for refugee interventions poses a great risk for government to achieve sustainable financing for refugee programs.
- It is not clear how resources are pooled from the different funding partners and government, and how they are allocated to the various refugee needs. How the needs are prioritised for funding, and the mechanisms and processes through which this may happen, are not explicit. Yet, given the challenge of resources, optimising resource use and ensuring efficiencies are leveraged would be an apparent focus of government and all collaborating partners.

6. Suggestions for future research priorities within the context of governance, gender & economics

The Health Sector Response Plan (HSRP) was designed to ensure equitable and well-coordinated access to health services for hundreds of thousands of refugees and host communities in Uganda. This is premised on adequate resources being mobilised to finance the plan. It is important to assess the resource gaps in financing the HSRP and how this influences service delivery, particularly for women and other vulnerable populations, like people with disabilities, among the refugee and host communities.

There are a number of implementing partners (IPs) providing different services across refugee settlements and host communities. Due to differences in source of funding, duration of operations and focus of service area provided, these IPs tend to operate in silos, thereby implementing activities without proper integration to maximise impact. Lack of effective coordination between IPs and the district local governments (DLG) has also hampered proper planning and delivery of services. Research to develop effective models of governance and coordination of services delivery between IPs and DLGs, and among IPs providing services within refugee settlements and host communities is necessary to improve the governance of service delivery structures for refugees.

Whereas the HSRP provides the overarching framework for engaging district local governments and implementing partners in developing district-specific Integrated Refugee Response Plans (IRRP), it is not known how this framework is being implemented at the LG level and how this is affecting services delivery. It is important to examine how the HSRP is being implemented, and which governance and coordination challenges need to be addressed at national, district and sub-district levels.

Exploring sustainable financing models for the increasing demand for services among refugee settlements is essential to ensure adequate levels of service delivery. The increasing number of refugees is likely to place a heavier strain on finances and the current financing models may not be forthcoming. There is an urgent need to explore more sustainable financing models to meet the increasing demand for healthcare and other services within the refugee host districts. Beyond this, however, tools that facilitate prioritisation in resource allocation, optimisation, and efficiency need to be explored and applied. This may require comprehensive capacity building at the different levels of refugee planning – from the district local governments that host refugees, to national level and also among funding and collaborating partners.

Despite the HSRP being in place, provision of health services to refugees continues to be planned, resourced and provided separately by IPs from that for host communities. This situation is reinforcing inequitable access to health care services between refugees and host communities, undermining efficient use of scarce health resources, as well as the national effort for developing a resilient and sustainable health system. The parallel systems thrive on inadequate involvement of the MoH and District Local Governments in the governance and management of refuge health response, manifesting itself in poor integration of services and coordination of the required partnerships at all levels of the health system. Research into the underlying causes of the limited coordination between IPs and DLGs, and limitations to the full implementation of the HSRP is required to inform the necessary improvements in the existing policy or regulatory frameworks.

The refugee health reports give key highlights of the health status of refugees and host communities, including disease prevalence and burden of illnesses, access and utilisation of health services. These reports, however, do not provide disaggregated figures by gender, which is important to assess the

extent to which women access available services compared to men, and if there are gender-related constraints to accessing and utilising the available health services within the refugee settlements.

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Annex A1

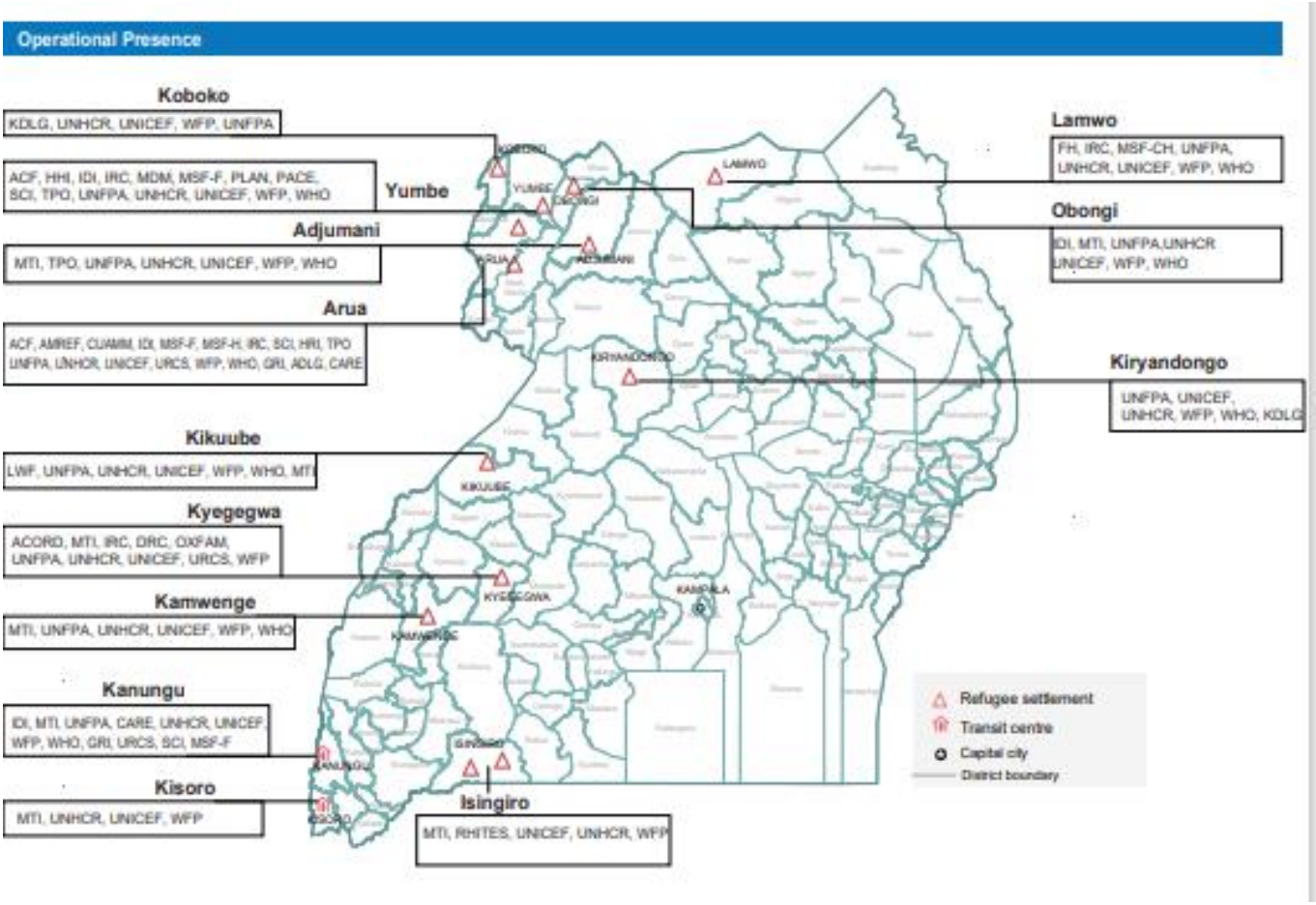

Figure 1A: Health partners operating in refugee settlements in Uganda