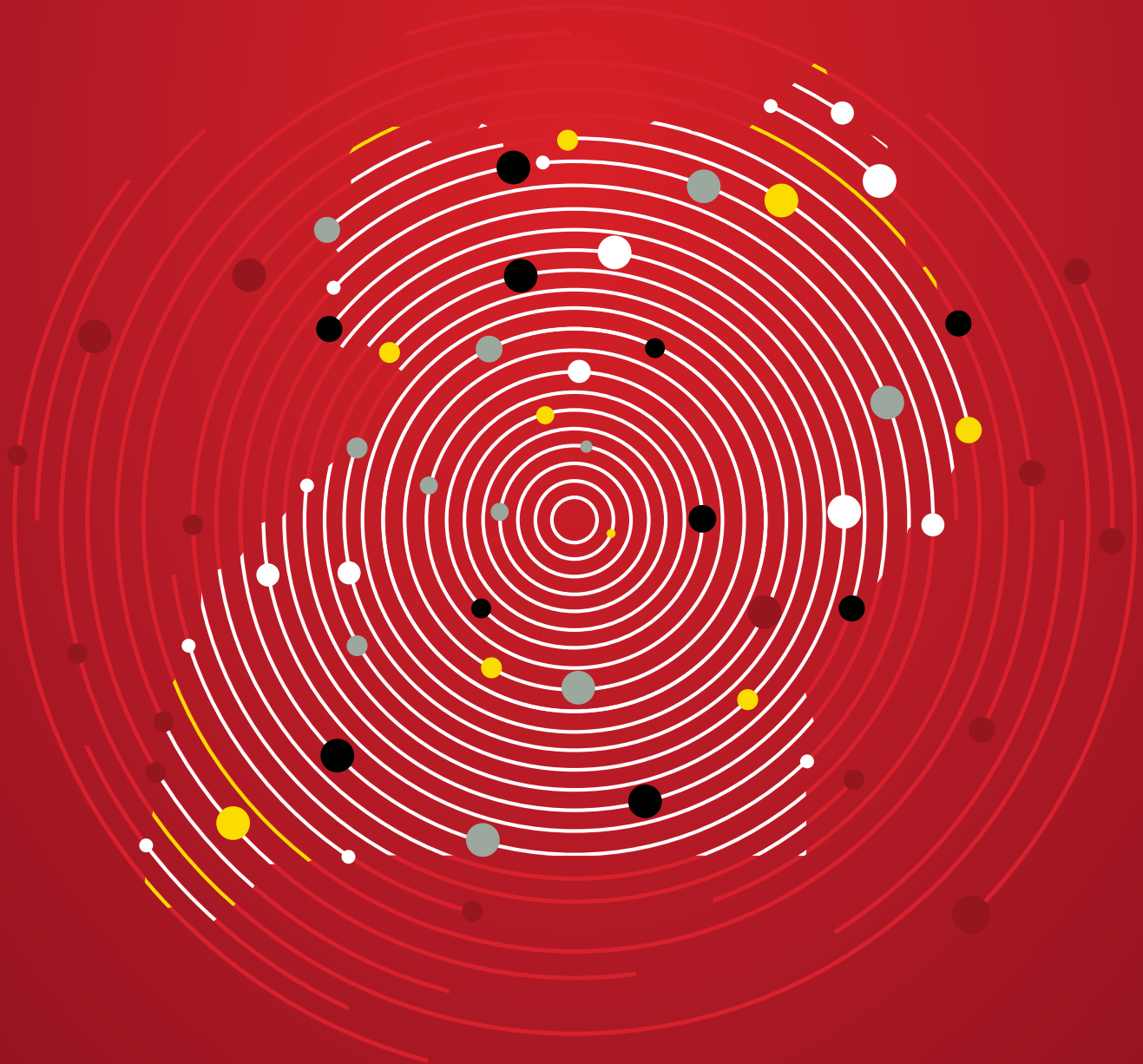
World Health Organization

THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

Refugee and migrant health system review

challenges and opportunities for long-term health system strengthening in Uganda



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Contents

Acknowledgements[1]

Leadership and coordination

The joint mission to review health system capacity to identify opportunities and challenges in Uganda was conducted under the leadership of the WHO Department of Health and Migration (WHO headquarters, Geneva), the WHO Regional Office for Africa (Brazzaville, Republic of the Congo) and the WHO Country Office in Uganda, in close collaboration with the Ministry of Health of Uganda.

This mission would not have been possible without leadership, collaboration and support from several WHO teams:

- **WHO Department of Health and Migration:** Dr Santino Severoni, Director; Dr Saverio Bellizzi, Technical Officer; Ms Camila Polinori Castro, Technical Officer; Dr Mohammad Darwish, Technical Officer; and Dr Apostolos Veizis, Consultant.
- **WHO Regional Office for Africa:** Dr Matshidiso Rebecca Moeti, Regional Director; Dr Abdou Salam Gueye, Regional Emergency Director; Dr Waogodo Joseph Cabore, Director (Programme Management); Dr Alex Ntale Gasasira, Director; Dr Braka Fiona, Programme Area Manager (Emergency Response); and Dr Ernest Dabire, Senior Health Emergency Officer.
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Review and documentation

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[1] This review contains the views of the Joint Review Team and does not necessarily represent the decisions or the stated policy of the World Health Organization

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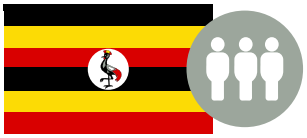
Abbreviations

CRRF	Comprehensive Refugee Response Framework
DHIS2	District Health Information System 2
HIS	health information system
HMIS	health management information system
HSIRRP	Health Sector Integrated Refugee Response Plan
IDSR	Integrated Disease Surveillance and Response
IOM	International Organization for Migration
NCD	noncommunicable disease
NGO	nongovernmental organization
OOP	out of pocket
RCCE	risk communication and community engagement
SGBV	sexual and gender-based violence
SOP	standard operating procedure
TB	tuberculosis
UHC	universal health coverage
UNEPI	Uganda National Expanded Programme on Immunization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VHT	village health team

Executive summary

Over the decades, Uganda has hosted refugees from nations including Burundi, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Somalia, Sudan, Sierra Leone, Senegal, Mozambique, South Africa and Zimbabwe.



As of early 2024 it hosts **1 600 000 refugees**, primarily in refugee settlements in northern and southwestern Uganda and Kampala City. Thirteen districts accommodate 94% of these refugees, with the remainder in Kampala. Recent arrivals, primarily from the Democratic Republic of Congo, Ethiopia, South Sudan and Sudan, include 74 618 individuals recorded from January to October 2023.

Uganda's porous borders facilitate ongoing connections between refugees and their origins, posing risks for infectious disease spread. Frequent Ebola virus disease outbreaks in the Democratic Republic of the Congo and the spread of other diseases such as HIV/AIDS, polio and coronavirus disease (COVID-19) are exacerbated by conflicts in neighbouring countries.

From June to August 2022, **857 000 people** faced acute food insecurity in assessed districts.

The legal rights of refugees are covered under the Refugee Act 2006 and Refugee Regulations 2010, ensuring non-discrimination and granting rights such as property ownership and freedom of movement. Uganda supports refugee integration through the Comprehensive Refugee Response Framework (CRRF) and the Global Compact on Refugees, with health services integration highlighted. The Health Sector Integrated Refugee Response Plan (HSIRRP) (2019–2024) addresses health disparities and effectiveness, nearing review in 2024.

Scope and objectives: a joint review of Uganda's refugee and migrant health system was conducted by WHO, in partnership with Uganda's Ministry of Health and key partners including the International Organization for Migration (IOM), the United Nations Children's Fund (UNICEF) and the United Nations High Commissioner for Refugees (UNHCR). The review aimed to identify health

challenges for refugees and migrants and enhance the capacity of Uganda's health system. Specific objectives included assessing health system capacity, integrating services for refugees and migrants, enhancing international support in line with Uganda's policies and strengthening partnerships and coordination within the country.

Methodology: the review utilized qualitative methods, starting with a comprehensive desk review followed by field visits to key locations in Kampala, Kikuube and Kiryandongo. Insights were gathered through interviews and discussions with health service providers and stakeholders.

Results

Health system governance and leadership. Uganda's health system is led by the Ministry of Health, responsible for policy, planning and oversight, with district authorities handling implementation. The health system supports refugees through policies promoting open borders, non-camp settlements and integration, and granting access to social services, employment and land. The CRRF, launched in March 2017, underpins the HSIRRP. This Plan, aligned with national health policies, aims to enhance health services' effectiveness in refugee-hosting areas, coordinated by the Ministry of Health with support from a steering committee and Secretariat. Health services for refugees and host communities follow the Ministry's guidelines. Oversight is conducted through monthly and annual coordination meetings led by district health officers. However, some district health teams and facility managers show operational capacity gaps, particularly in prioritizing key performance indicators over routine administrative tasks. Refugee health services are included in interagency contingency plans, with ongoing transitions of health facilities from partner support to Government ownership. Despite these efforts, the exclusion of traditional healers from formal health strategies marks a significant gap, suggesting a need for more inclusive health sector approaches. All Government-accredited health facilities provide free tuberculosis (TB) and AIDS treatment, nutritional support and HIV testing and care, with testing based on national guidelines rather than mandatory for all refugees.

Service delivery and access to essential medical products. Uganda's health service delivery is structured into four main clusters: health promotion and disease prevention; sexual and reproductive health; communicable diseases; and noncommunicable diseases (NCDs). New arrivals undergo health screenings at reception and transit centres, including checks for epidemic-prone diseases and vaccinations for children. There is a focus on treating communicable diseases such as TB and HIV/AIDS, with treatments available at all levels of health facilities. Refugees and asylum seekers receive a comprehensive health package including emergency care, psychological first aid and ongoing access to primary health care services once settled. Despite these services, challenges such as cultural mediation gaps and infrastructure deficiencies affect care quality. Efforts continue to improve service accessibility and effectiveness, particularly for vulnerable populations.

Access to essential medical products and health technology. Refugees in Uganda have access to the same essential medical products and health technologies as the host population, guided by

the Uganda Essential Medicines List and Clinical and Treatment Guidelines. Health commodities are managed through established systems including the National Medical Stores, which supplies health facilities every 2 months based on their needs and allocated budgets. The Uganda Blood Transfusion Services oversees blood collection and distribution. Despite contributions from humanitarian partners and strict regulations by the National Drug Authority, a major challenge remains: recurrent stockouts, intensified by a two-thirds cut in UNHCR funding for essential medicines. This shortage forces districts to redistribute supplies, stockouts persist across facilities, causing significant out-of-pocket (OOP) expenses for medications and related services, including emergency referrals when ambulances lack fuel.

Health financing. Despite an increase in Government funding, resources remain insufficient for achieving universal health coverage (UHC). Government health expenditure as a percentage of gross domestic product is low, ranging from 0.8% to 1.7% over recent years, well below the 5% target for UHC. Health insurance coverage stands at only 2.1%, mostly covering formally employed individuals and their families. A proposed national health insurance scheme aims to increase coverage by mandating a minimal annual contribution from every adult. About 75% of refugee health programme funding is managed by international and local partners, with the remaining managed directly by the Ministry of Health. Collaborations with organizations such UNHCR and WHO focus on developing funding proposals for specific health initiatives. The Uganda Minimum Health Care Package, accessible to both nationals and refugees, includes comprehensive services spanning disease prevention, maternal and child health, communicable diseases and NCDs. Despite similar access to health care for refugees and nationals, the health sector faces funding shortfalls. Transition of health facilities in refugee settlements to Government control is supported by primary health care allocations. However, challenges persist due to the sector's heavy reliance on earmarked donor funding and limited health insurance coverage, which excludes many working in informal sectors or who are unemployed. The implementation of a more inclusive health insurance scheme also faces significant challenges.

Health information system (HIS). The Ministry of Health manages national operations; district biostatisticians handle regional data management tasks and at the health facility level, staff manage data entry into a unified national health management information system (HMIS) known as the District Health Information System 2(DHIS2). Since 2020 DHIS2 has improved integration and reporting by categorizing data for nationals, refugees and foreigners under the regulation of the Ministry of Health. Surveillance follows the WHO Regional Office for Africa Integrated Disease Surveillance and Response (IDSR) guidelines, using both indicator-based and event-based approaches. Community-based village health teams (VHTs) play a key role in detecting and reporting public health events, ensuring wide coverage and timely responses. Data collection varies in frequency to support early detection and trend monitoring, using both paper-based tools and electronic platforms such as DHIS2, mTrac and eIDSR. Uganda's health indicators contribute to key result areas of its National Development Plan, including health care workforce skills, morbidity and mortality rates and UHC. Health records for refugees are maintained on personal forms, with referral notes used for transferring patients between facilities. Challenges include the need for system adaptability to better reflect the specific health requirements of refugees and migrants and the risks associated with reliance on paper-based records.

Health workforce. Health facilities, particularly in refugee-hosting districts, are facing severe staffing shortages; only about half of the approved positions are filled due to constrained funding, which has also led to increased patient-to-health worker ratios following funding cuts. Additionally, there is a shortage of mental health professionals. Translation services in refugee settlements, although available, are limited by the lack of trained intercultural mediators, affecting communication effectiveness. Continuing education for health workers lacks a focus on mental health and NCDs and does not specifically address the unique needs of refugees and migrants. Refugee health workers, particularly those from the Democratic Republic of the Congo, face registration challenges due to qualification discrepancies with east African standards, although a European Union-funded project is aiding their integration by aligning Democratic Republic of the Congo qualifications with Ugandan standards. These challenges highlight the critical need for better recruitment strategies, targeted training and effective integration of health workers to improve health care delivery in resource-limited and vulnerable communities.

Preparedness and response to outbreaks, natural disasters and other emergencies. Uganda is highly vulnerable to public health emergencies due to factors such as its location within epidemic belts, the pressures on ecosystems from climate change and proximity to the Congo Basin. Disaster preparedness and response is managed through a multisectoral approach coordinated by the Office of the Prime Minister. The Division of Public Health Emergency Preparedness and Response within the Department of Integrated Epidemiology, Surveillance and Public Health Emergency at the Ministry of Health oversees these efforts. Furthermore, the national Public Health Emergency Operations Centre acts as the Ministry of Health's focal point for all public health emergency response efforts. Uganda adheres to IDSR guidelines for improving public health surveillance and response for priority diseases, conditions and events at community, health facility, district and national levels. These guidelines are intended for use by International Health Regulations (2005) national focal points, infection prevention and control officers, district health teams, health authorities at points of entry, community leaders, nongovernmental organizations (NGOs) and other stakeholders, including provisions for refugees. Despite the availability of guidelines and tools for stakeholders, there is a recognized need to conduct capacity-building exercises in public health emergency preparedness and response, develop preparedness and response plans, further disseminate existing standard operating procedures (SOPs) and complete the review of SOPs needing updates as highlighted during field visits.

Health promotion, and disease prevention and control, and social determinants of health. Uganda has made substantial strides in improving immunization coverage and reducing child mortality rates since 2000, with under-5 mortality rate significantly reduced. However, challenges persist, particularly in reaching under-immunized populations in remote areas and refugee settlements, where disparities in coverage rates are evident. The Uganda National Expanded Programme on Immunization (UNEPI) has transitioned from its previous plan to the National Immunization Strategy 2024–2028, incorporating a Monitoring and Evaluation Plan that focuses on reaching zero-dose children within refugee settlements. UNEPI ensures that refugees and migrants have access to immunization services equal to that of the host population, including

inclusion in routine and mass vaccination campaigns, provided free of charge. This includes equal access to COVID-19 vaccinations since 2021. Immunization services are delivered through static facilities, community outreach and during outbreaks, with vaccination information and schedules actively shared during postnatal visits and through door-to-door outreach by VHTs. Challenges include dispelling vaccine-related myths and misinformation, addressing training gaps among health workers and managing recurrent vaccine stockouts. Social determinants such as housing conditions significantly affect health outcomes in refugee settlements. Overcrowding and poor ventilation, particularly among Congolese refugees, exacerbate disease transmission risks such as for TB. Educational initiatives aimed at improving living conditions have led some refugees to install windows to enhance ventilation. Additionally, sexual and gender-based violence (SGBV) remains a critical issue within settlements, prompting the integration of SGBV prevention strategies into health programmes to address and mitigate risks among vulnerable populations.

Risk communication and community engagement (RCCE), health communications and social mobilization for health. In 2020 Uganda developed the National One Health Risk Communication Strategy to guide communication and coordination on priority diseases, managed by the Zoonotic Disease Coordination Office. However, within this strategy, refugees are only specifically mentioned in the context of Ebola virus disease, indicating a need for broader integration of refugees and migrants into risk communication strategies. VHTs are pivotal in refugee settlements, selected by the Refugee Welfare Council 1 to drive community health initiatives. VHTs' responsibilities include home visits, community mobilization for health services, health education, management of common health conditions and disease surveillance. The Ministry of Health provides VHTs with training and incentives such as training materials and allowances for specific activities, although they generally work on a voluntary basis.

Research on health and migration. This is regulated by the Uganda National Council for Science and Technology, focusing on protecting vulnerable populations. The HSIRRP aims to develop operational research frameworks in collaboration with academia to better serve refugees and migrants. Despite refugees and migrants currently being excluded from the Ugandan Demographic and Health Survey, commitments have been made to include them in future national statistics to improve the accuracy and inclusivity of health data. District health authorities also play a role in migration health research, using gathered experiences to enhance support systems for refugees and migrants.

Actions to be considered

Governance and leadership. Enhance health policies to fully integrate migrants alongside refugees, ensuring equitable access to health services. Recognize and integrate traditional healers into health systems for a holistic approach and strengthen intersectoral collaboration with other ministries to tackle broader health determinants.

Access to essential medical products. Address recurrent stockouts by strengthening logistics and supply chain management. Ensure consistent availability of medical products through robust stock management practices and sufficient budget allocation.

Health service delivery. Integrate cultural mediators to improve accessibility and quality of health care for refugees and migrants. Expand and standardize adolescent health services across all health facilities to ensure comprehensive care.

Health financing. Explore innovative funding mechanisms and consider a national health insurance scheme that includes refugees and migrants to ensure sustainable health financing and manageable contributions for all community members.

Health information system and management. Transition from paper-based to digital health records to enhance the continuity, accuracy and security of health data. Improve system capabilities to ensure seamless health record transitions for mobile populations.

Health workforce. Increase investment in health workforce recruitment and training, particularly in underserved areas and mental health. Implement WHO Global Competency Standards to boost worker competencies in communication and culturally appropriate care.

Emergency preparedness and response. Update and disseminate SOPs for emergency preparedness. Strengthen training and support the integration of the health needs of refugees and migrants into public health preparedness plans.

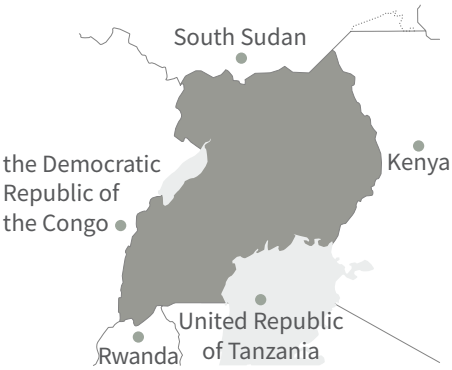
Health promotion, disease prevention and control, and social determinants of health. Implement targeted interventions to improve housing conditions to control and prevent the spread of diseases such as TB. Enhance SGBV prevention and response mechanisms to ensure comprehensive support and resources at health facilities.

RCCE, health communications and social mobilization for health. Formalize the integration of VHTs into the national health system to ensure their critical role in health service delivery is recognized and supported. Use these teams to establish a robust community-based health monitoring and rapid response system.

Specific health programmes. Focus on immunization and mental health services. For immunization, conduct research to understand vaccination behaviours among refugees and migrants and strengthen the supply chain to prevent vaccine stockouts. For mental health, scale up services and develop comprehensive strategies that include systematic screenings and ongoing evaluations to meet the evolving needs of refugees and migrants effectively.

1. Introduction

Uganda, situated in the Great Lakes Region of east Africa, is bordered by



As a founding member of the East African Community, Uganda plays an important role in the regional dynamics.

The country's population was estimated to be **45.5 million** in mid-2023,

with 17.0 million residing in urban areas across 146 districts and 10 cities.

Uganda's demographic trajectory indicates a rapid population growth, positioning it as a significant population centre in Africa *(1)*.

According to the Ugandan Demographic and Health Survey findings for 2022 *(2)*:

Uganda had a total fertility rate of **5.2 births/woman**

teenage pregnancy **rate of 24%**

maternal mortality of 189 deaths per 100 000 live births

under-5 mortality rate of **52 per 1000 live births**

infant mortality rate of **36 per 1000 live births**

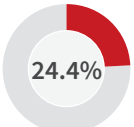
neonatal mortality rate of **22 per 1000 live births**

antenatal care visits **for 75–80%**

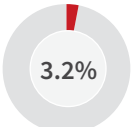
98% of deliveries in health facilities

54% of children aged 12–23 months fully vaccinated, measles first dose coverage of 83%, and three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine coverage of 70%.

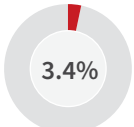
Nutritional assessments of children under-5 years reveal that:



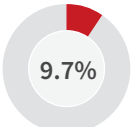
are stunted



wasted



overweight



underweight

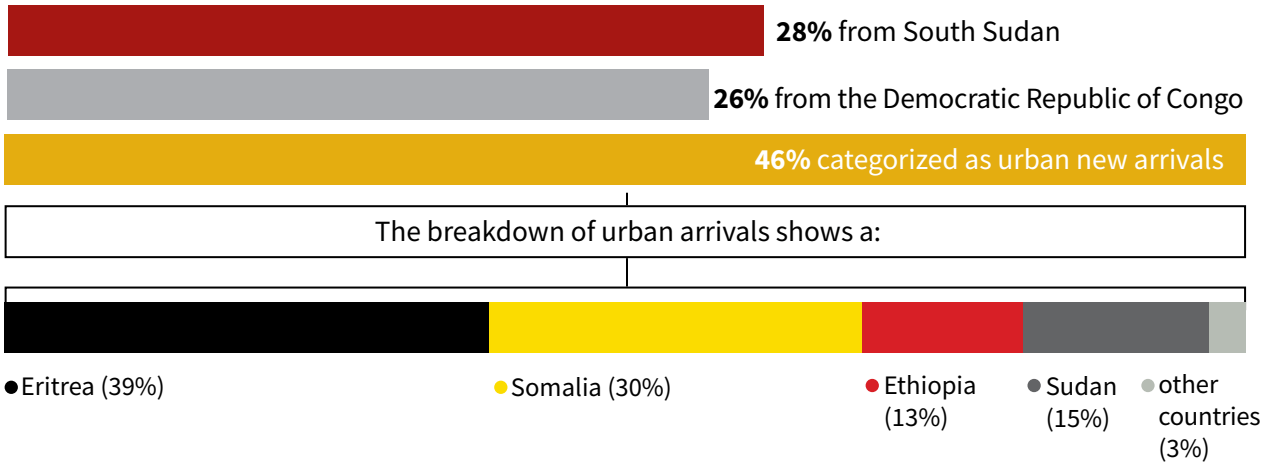
Given the political instability in east Africa, Uganda has historically been and remains a key destination for refugees and migrants. The country maintains a liberal policy environment for asylum seekers, providing comprehensive access to social services such as health, water and education. Additionally, it allows refugees the opportunity to work, further integrating them into society and supporting their self-sufficiency.

1.1 Refugees and migrants in Uganda

Uganda is the largest refugee-hosting country in Africa and the fifth largest in the world *(3)*. The country started hosting refugees in 1940 when the United Kingdom first settled Polish refugees at Nyabyeya in Masindi district and Koja in Mukono district; these were later resettled to Australia, Canada and the United Kingdom. Since then, the country has continued to host refugees from Burundi, the Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Somalia, Sudan, Sierra Leone, Senegal, Mozambique, South Africa and Zimbabwe *(4)*.

The country is currently experiencing a significant influx of refugees from regions actively embroiled in conflict, particularly the Democratic Republic of Congo, Ethiopia, South Sudan and Sudan. Refugees from the Democratic Republic of Congo and South Sudan make up a large proportion, with 57% originating from South Sudan and 32% from the Democratic Republic of the Congo.

From January 2023 through **to 5 October 2023**, there was an influx of **74 618 new arrivals** due to ongoing conflict in their countries of origin *(5)*:



As of February 2024 there were 1600 000 refugees in Uganda primarily situated within refugee settlements in northern and southwestern Uganda and Kampala City. There are 13 refugee-hosting districts (Adjuman, Isingiro, Kampala, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi-Okollo, Obongi, Terego and Yumbe). The country has designated 13 districts as refugee-hosting areas, accommodating 94% of the total refugee population, with the remaining 6% residing in Kampala *(6)*.

1.2 Health status in the main countries of origin of refugees in Uganda

Uganda shares permeable borders with its neighbouring countries, leading to refugees maintaining connections with their communities of origin; consequently, presenting a substantial risk for the bidirectional international spread of infectious diseases *(7)*.

The Democratic Republic of the Congo has experienced frequent Ebola virus disease outbreaks, with nine incidents reported from 2014 to 2022. In June 2018 three individuals from the Democratic Republic of the Congo who entered Uganda for health care were confirmed to have died from Ebola virus disease *(8,9)*.

The ongoing conflict in South Sudan is associated with substantial public health challenges, as reflected by the country's health indicators. The prevalence of infectious diseases, such as HIV/AIDS, polio, COVID-19 and Ebola virus disease, represents persistent public health challenges *(10)*. The building and implementation of International Health Regulations (2005) core capacities in South Sudan is suboptimal *(9)*, which, therefore, increases the risk of international spread of disease, particularly in neighbouring countries.

The top 10 causes of mortality in the Democratic Republic of the Congo include neonatal conditions, lower respiratory infections, measles, malaria, TB, stroke, ischaemic heart disease, diarrhoeal diseases, road injury and maternal conditions *(11)*.

1.3 Food security and nutrition status of refugees and host communities in refugee-hosting districts

The Integrated Food Security Phase Classification analysis from February 2022 to January 2023 examined the food security and nutrition status of refugees and the host community.

The findings indicate that, between June and August 2022, **21% of the population in refugee-hosting districts, equating to 857 000 individuals,** faced high levels of acute food insecurity (Phase 3 and above). In the assessment of 12 districts, nine were classified as at Phase 3 (Crisis) and the remaining three at Phase 2 (Stressed) *(12)*.

1.4 Legal frameworks and policies related to refugees and migrants

The legal framework governing the rights of refugees in Uganda is established under the Refugee Act 2006. This Act ensures that refugees are "treated without discrimination as to race, religion, sex, nationality, ethnic origin, membership of a particular social group or political opinion" *(13)*.

The Refugee Act 2006, supplemented by the Refugee Regulations 2010, affords refugees several protections and freedoms. These include property rights, freedom of movement, the right to work and access to services, which facilitate their integration within local communities.

Additionally, the Act supports a settlement approach in which refugees are registered and provided with land and documentation.

Uganda is also a signatory to the CRRF and the Global Compact on Refugees, which emphasize the inclusion of refugees into national systems, including health services *(4)*. Uganda acceded to the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol on 27 September 1976.

In alignment with the CRRF, initiated in Kampala in March 2017 and pursuant to World Health Assembly resolution WHA70.15 (2017), Uganda's Ministry of Health developed the HSIRRP for the period from 2019 to 2024. This Plan aims to address health inequalities, ensure access to essential health services and enhance the effectiveness and impact of health services in refugee-hosting and transit districts. To achieve these goals, the Plan was structured around several key pillars: (i) service delivery, (ii) human resources for health, (iii) medicines (health commodities and technologies), (iv) HMIS, (v) health financing and (vi) leadership, coordination, management and governance. As this Plan approaches its end in 2024, the Government is preparing to evaluate the outcomes from this period and define subsequent strategies. Under the CRRF, the Refugee Act 2006 and the Refugee Regulations 2010, refugees are entitled to the same public services as Ugandan nationals, including health services.

While migrants in Uganda have access to the same health services as nationals and refugees, it is important to note that there is currently no separate national policy specifically addressing migrant health.

1.5 Scope and objectives of the review

A joint review mission to review the health refugee and migrant health system in Uganda was undertaken by the WHO Country Office in Uganda, the WHO Regional Office for Africa and the Health and Migration Department at WHO headquarters, in close collaboration with the Ministry of Health and key partners such as the IOM, UNHCR and UNICEF.

The aim of the review was to identify the current and emerging health challenges for refugees and migrants in Uganda and the opportunities to further support Uganda in strengthening health system capacity and ensuring continued access to health services for refugees, migrants and host communities. The review covered the health system building blocks as well as the essential public health functions at national, district and primary health care level.

The objectives of the review were to:

review the health system and essential public health functions, capacities and processes, the current state of health services provided to refugees and migrants and the integration of these into the existing health system;

enable synergized support across international partners, as aligned with existing and future refugee health policies and plans in Uganda;

promote partnership, intersectoral coordination and collaboration led by the Ministry of Health with other ministries and partners in Uganda.

1.6 Methodology

The country review in Uganda was conducted using qualitative methods, initiated with a comprehensive desk review employing the *WHO Refugee and migrant health: country assessment tool (14)*. This review assessed existing information on the six health systems building blocks and five essential public health functions for refugee and migrant health in Uganda.

Preparatory meetings were held involving the WHO Country Office, the WHO Regional Office for Africa and the Health and Migration Department at WHO headquarters. These discussions focused on the tools, designs, timelines and logistics for the review mission.

The mission schedule, timelines and sites for field visits were jointly established by the Uganda Ministry of Health and the WHO Country Office, in consultation with UNHCR. There was also a mapping of key stakeholders in Uganda's refugee and migrant health, who were subsequently invited/notified by the Ministry to participate in the review.

Field visits were conducted to obtain detailed insights into health service provision utilizing the *WHO Refugee and migrant health: country assessment tool*. Sites visited included Kampala (Kisenyi HCIV, the Office of the Prime Minister), Kiryandongo (District headquarters, UNHCR Office,

Panyadoli Health Centre – level 4, Panyadoli Hill Health Centre – level 2) and Kikuube (District headquarters, UNHCR Office, Kyangwali Health Centre – level 4, Maratatu D Health Centre – level 3, Mombasa Health Centre – level 2).

The field visits included different sessions, with some dedicated to semistructured key informant interviews with the directors of the health centres while others involved group discussions with key stakeholders in order to capture diverse perspectives and insights. Each interview session utilized a specific guide, tailored to a specific context, ensuring a comprehensive and varied collection of information.

Key meetings during the review included the following:

- A meeting between the Minister of Health, the WHO Director of Health and Migration and the WHO Country Representative in Uganda.
- A stakeholders meeting at the Ministry of Health headquarters with the Ministry of Health technical team, the Office of the Prime Minister, other Ministry technical staff and partners such as Africa Humanitarian Action, Baylor, the Gavi Learning Hub, IOM, Medical Teams International and UNHCR to explain the mission objectives and gather information.
- A meeting with the Commissioner for Refugees in the Office of the Prime Minister to discuss the process of receiving and granting asylum to refugees in line with international and national legal frameworks and the settlement of refugees granted asylum.

The Ministry of Health invited its technical staff; the technical staff from the Office of the Prime Minister and other ministries including the Ministry of Labour, Gender and Social Development; United Nations agencies and NGOs to a stakeholder meeting (Table 1). District authorities and health facilities were informed 2 weeks in advance about the dates of field visits and the key stakeholders to be interviewed.

Table 1. Stakeholders engaged during the review mission

Stakeholder group	Specific stakeholders
Government departments	The Office of the Prime Minister, Ministry of Health, Ministry of Labour, Gender and Social Development
United Nations agencies	IOM, UNHCR, UNICEF, United Nations Population Fund
NGOs	Africa Humanitarian Action, Baylor, the Gavi Learning Hub, HERP, Medical Teams International
Health facilities	Kampala (Kisenyi Health Centre – level 4), Kiryandongo (District headquarters, UNHCR Office, Panyadoli Health Centre – level 4, Panyadoli Hill Health Centre – level 3), Kikuube (District headquarters, UNHCR Office, Kyangwali Health Centre – level 4, Maratatu D Health Centre – level 3, Mombasa Health Centre – level 2)

2. Results

2.1 Health system governance and leadership

The health system in Uganda is led by the Ministry of Health, which manages policy, planning and oversight functions, while district authorities are tasked with implementation *(15)*.

Uganda's refugee governance framework encompasses policies of open borders, non-camp settlements and integration of refugees. This framework facilitates refugees' access to Government-provided social services, employment opportunities and land for agriculture and shelter.
The CRRF for Uganda was launched in Kampala in March 2017. In alignment with the CRRF, the Refugee Act 2006 and the Refugee Regulations 2010, the Ministry of Health developed an HSIRRP. This Plan aims to reform the health sector to improve the effectiveness and impact of health services within refugee hosting and transit districts. The HSIRRP aligns with the National Health Policy and National Health Sector Development Plan and is overseen by a Steering Committee at the Ministry of Health, supported by a Secretariat *(6)*.

The CRRF is led by the Government, specifically the Office of the Prime Minister, with a steering group composed of Government agencies, United Nations agencies, donors, humanitarian organizations/NGOs and refugee representatives. The Secretariat ensures coordinated planning, programming and resourcing of the CRRF roll-out in Uganda, facilitating cross-pillar information flow and links.

Health services for refugees and host communities in Uganda are provided in accordance with the policies and guidelines established by the Ministry of Health. Oversight is maintained through monthly refugee health coordination meetings led by district health officers at district level *(16)*, with broader issues addressed in an annual meeting to ensure comprehensive management and coordination.

At the district and health facility levels, oversight functions are performed by the sectoral committee of the district council and the health unit management committee, which conducts quarterly reviews and approves the sector work plan. These committees comprise members appointed from the community served by the respective unit.

The district health team also conducts quarterly support supervision visits to health facilities and performance reviews for key health performance indicators. However, it has been identified that these meetings are not always conducted as planned.

From a joint monitoring mission conducted by the Ministry of Health and partners in October 2023, it was observed that some district health teams and health facility managers had operational capacity gaps that need to be addressed for better management of health services. Many of these committees are not fully oriented on their functions and primarily focus on approving work plans and budgets, giving less attention to key performance indicators *(17)*.

The health sector is represented in the interagency contingency plans for sudden influxes of refugees and migrants in Uganda. Refugee health services are delivered by the Government in collaboration with various partners. According to the HSIRRP, health facilities supported by partners are currently transitioning to Government ownership. The scope of health service delivery includes prevention, sexual and reproductive health, communicable diseases and NCD management. However, it is important to note that not all relevant stakeholders are included in these partnerships. Specifically, traditional healers, who are integral to the local health landscape, are often excluded. This exclusion can compromise the comprehensiveness of the health sector's approach, highlighting a gap in integrating all community-based health practices into formal health strategies.

All health facilities are accredited by the Government and accessed by both refugees and host communities. TB and AIDS treatment and nutritional support are provided without fees. HIV testing and care services are provided to both refugees and the host community, with no mandatory HIV testing for all refugees; testing is conducted based on the eligibility criteria as guided by the national Consolidated Guidelines for Prevention and Treatment of HIV in Uganda.

2.2 Health service delivery and access to essential medical products

The essential health service delivery package for nationals, refugees and migrants is structured into four key clusters.

1. Health promotion, disease prevention and community health initiatives, including epidemic and disaster preparedness and response.
2. Prevention, management and control of communicable diseases.
3. Sexual, reproductive, maternal, neonatal, child and adolescent health.
4. Prevention and management of NCDs.

For newly arrived refugees and migrants an arrival health package has been set up (Table 2). The main causes of morbidity reported include malaria, acute respiratory tract infections, skin diseases, diarrhoea, NCDs and mental health issues.

Table 2. New refugees/asylum seekers' arrival health package

Stage	Services provided
Border crossing	• Emergency health care services/first aid • Fit to travel and provision of ambulance for the critically sick • Provision of high-energy biscuits • Psychological first aid • Emergency preparedness and response plan including staff and supplies • Minimum initial service package for reproductive health • Travel manifest for those who need urgent treatment on arrival
Reception/transit centres	• Nutrition screening • Immunization (measles 6 months–15 years; polio 0–59 months) • Vitamin A supplementation • Deworming • Provision of antenatal care for pregnant women • Screening for pre-existing medical conditions/SGBV for referral • Treatment of minor ailments • Ambulance services • Notifiable diseases • Psychological first aid • Epidemic preparedness and response • Provision of hot meals/high-energy biscuits
Transport to the settlement	• Fitness to travel • Provision of refills for long-term medications • Travel manifest for those who need urgent treatment on arrival • Ambulance for severely ill • Provision of high-energy biscuits and 1 litre of drinking-water per 8 hours • Emergency preparedness and response plan including staff and supplies
Settlements, week 1	• 24-hour primary health care services • Referral mechanism • Routine expanded programme on immunization • Establish basic emergency obstetric and newborn care • Ambulance services • Community management of acute malnutrition: establish community health services

2.2.1 Health screening protocols

Screening of new arrivals is conducted at both reception and transit centres. At reception centres, the process is rapid, primarily assessing fitness to travel. In contrast, screenings at transit centres are more comprehensive, including temperature checks, assessments for signs and symptoms of epidemic-prone conditions such as cholera, ongoing treatment for chronic conditions and nutrition assessments. Children also receive vaccinations, vitamin A supplementation and deworming tablets. However, the absence of cultural mediation can challenge the quality of screening service provision, follow-up and confidentiality. It is also noted that psychological first aid is provided, although this service faces its own challenges.

2.2.2 Communicable disease treatment and screening

TB is a significant communicable disease affecting refugees and host communities, exacerbated by poorly ventilated housing. The national TB and Leprosy Programme provides guidelines for TB screening, treatment and prevention at health facilities and community levels. TB screening occurs at all outpatient department clinics and during community-based TB community accelerated screening and treatment campaigns. Treatment is initiated at accredited health centres at level 3 and above, with patients diagnosed at a level 2 health centre being referred to higher facilities for the intensive treatment phase.

Free HIV testing and antiretroviral treatment are accessible to refugees, migrants and nationals across all health facility levels. However, antiretroviral therapy initiation is limited to accredited health centres at level 3 and above, potentially restricting access to treatment and follow-up. In 2020 Uganda implemented differentiated service delivery models for HIV and TB services to improve access and utilization *(18)*. These models include facility-based individual management, facility-based groups, fast-track drug refills, community client-led antiretroviral therapy and community drug distribution points.

Despite support from the Global Fund for HIV/AIDS and TB treatments, challenges arise when patients face other medical conditions not covered under these programmes. This gap in coverage can lead to difficulties in accessing comprehensive treatment.

2.2.3 Sexual, reproductive, maternal, neonatal, child and adolescent health

Sexual, reproductive, maternal, child and adolescent health are integral components of the Uganda minimum health care package. Health facilities and community outreaches provide antenatal care and both short-term and long-term contraceptive methods free of charge. A significant majority of women attend more than four antenatal visits. Skilled birth attendance is available at health facilities. Postnatal care for mothers and babies is also offered at health facilities and integrated community outreaches. A significant infrastructure gap exists, with some maternity wards operating in temporary makeshift structures such as tents, and overcrowding is a common issue. Adolescent health services are emphasized to address the specific needs of young people, including education on sexual health and access to age-appropriate health services, which are critical for

preventing health issues and ensuring healthy transitions into adulthood. Health facilities also offer clinical care for SGBV and refer survivors to protection centres for psychosocial and other forms of assistance, although the lack of post-exposure prophylaxis is noted in some facilities.

2.2.4 Mental health services

Common mental health conditions reported among refugees include depression, post-traumatic stress disorder, anxiety, illicit drug abuse and stigma. The prevalence of mental health issues in the country is not well documented, indicating a need for comprehensive prevalence studies.

Community and institutional psychosocial counselling is provided by partners. However, the current approved staffing structure for health centres at levels 2 to 4 does not include some key mental health professionals, such as psychiatric clinical officers. The HMIS captures limited details on mental health, necessitating a review. Traditional healers often serve as the first point of contact for most people needing mental health care, highlighting the need for the health system to collaborate with traditional healers to improve timely access to quality care. Additionally, there are issues with the referral pathways for those with mental health problems.

2.2.5 Access to health services for refugees and challenges

Despite these strengths, there remains a need to address the disparities in health outcomes among different population groups, with a focus on understanding and improving the social determinants of health that disproportionately affect refugees and migrants.

2.2.6 Access to essential medical products and health technology

Refugees in Uganda have access to the same essential medical products and health technologies as the host population. The selection and use of medicines and health supplies are guided by the Uganda Essential Medicines List and the Uganda Clinical and Treatment Guidelines. The quantification, procurement, storage and distribution of health commodities are managed through established Government systems and agencies, including the National Medical Stores, which supplies commodities to health facilities every 2 months based on facility quantification and allocated budget. The Uganda Blood Transfusion Services manages the collection and supply of blood and blood products. Humanitarian partners also contribute essential health commodities and medicines. The importation of medical commodities and technologies is regulated by the National Drug Authority in accordance with national standards, guidance and legislation *(16)*.

A major challenge affecting access to essential medical commodities is recurrent stockouts, exacerbated by a two-thirds reduction in UNHCR funding for essential medicines and medical supplies. This funding reduction has contributed to further stockouts. Districts attempt to manage these shortages by redistributing commodities from health facilities with adequate stock to those experiencing stockouts. However, in all health facilities, stockouts were reported, leading to significant OOP expenditure for medications and other medical needs, including referrals when no fuel is available for ambulances.

2.3 Health financing

2.3.1 Health sector funding and coverage in Uganda

In Uganda, the allocation to the health sector ranges from 6.1% to 7.6% of the national budget, falling short of the 15% recommended by the Abuja Declaration, which is the amount deemed necessary to meet the health care needs of the population effectively. As reported in the latest Uganda's National Health Accounts for the financial year 2020/2021, total health expenditure amounted to 8708 billion Ugandan shillings. The funding sources included 25.6% from the Government, 29% from private sector OOP expenditure and 45.4% from development partners. Despite an increase in Government funding in the financial year 2021/2022, the financial support for health remains suboptimal to achieve UHC objectives *(19)*.

2.3.2 Government expenditure and health insurance coverage

Government expenditure on health as a percentage of gross domestic product has ranged from 0.8% to 1.7% over the past 7 years, significantly below the 5% target set for achieving UHC and preventing catastrophic health expenditure among households. Health insurance coverage is notably low, at only 2.1%, limited to formally employed individuals and their families. The Ministry of Health is reviewing a proposed national health insurance scheme, which would mandate an annual contribution of 15 000 Ugandan shillings (around US$ 4) from every adult. This scheme aims to broaden health insurance coverage and enhance health care accessibility across the population *(19)*.

2.3.3 Health care package

The Uganda minimum health care package, available to both nationals and refugees, includes a comprehensive range of services. These services encompass health promotion and disease prevention, maternal health and child health and the prevention and control of communicable diseases and NCDs. This package ensures a standardized approach to health care, aiming to meet the diverse health needs of the population effectively.

2.3.4 Refugee health programme funding and services

Approximately 75% of funds for refugee health programmes are managed off-budget by international and local partners, while the remaining 25% is directly administered by the Ministry of Health and districts hosting refugees. The Ministry collaborates with organizations such as IOM, UNHCR, UNICEF and WHO to develop joint funding proposals. These proposals focus on specific health initiatives, including vaccination programmes and infrastructure enhancement, aiming to secure financial support from donors such as GAVI and the Global Fund *(19)*.

2.3.5 Health financing challenges

Refugees in Uganda are entitled to the same access to health care as nationals. Initially, most health facilities in refugee settlements were established by partner organizations. Currently, there is a transition underway to transfer ownership of these facilities to the Government. A substantial number of these facilities have already transitioned and are now funded by primary health care allocations and supplied with essential medicines and health commodities. Beyond the contributions from United Nations agencies such as IOM, UNHCR, UNICEF, United Nations Population Fund and WHO, numerous other international and national NGOs also receive donor funding to facilitate health services for refugees and migrants.

In Uganda, the financing of health services for refugees and migrants presents critical challenges. The health sector is allocated less than the recommended 15% of the national budget according to the Abuja Declaration, resulting in insufficient resources to meet the complex health needs of these populations. Additionally, the reliance on external funding from international donors and humanitarian organizations, although vital, leads to vulnerabilities in sustainability. Such funding is typically earmarked for specific projects, reducing flexibility in responding to unforeseen health challenges. Moreover, health insurance coverage is predominantly available to those in formal employment, excluding a large number of refugees and migrants, who often work in informal sectors or are unemployed. The proposed national health insurance scheme, intended to be more inclusive, faces significant implementation challenges, particularly the burden of mandatory contributions on refugee communities.

2.4 HIS and health information management

2.4.1 Roles and responsibilities across levels

In Uganda, the management of the HIS is structured across various levels of the health care system. The Ministry of Health's Division of Health Information Management has national oversight of these systems. At the district level, the district biostatistician is responsible for the comprehensive management of the HIS, which includes tasks ranging from user account creation, supervision of data entry and data verification to validation, analysis and capacity-building for health workers. At the health facility level, the person in charge of the facility and HIS assistants are tasked with data capture using primary HMIS tools and data entry into the DHIS2 *(20)*.

2.4.2 Integration and reporting

In Uganda, prior to 2020, different HISs were utilized by districts and refugee health services to gather comparable datasets on disease conditions and provided services. This approach was streamlined in 2020 with the integration of these systems into a unified national HMIS utilizing the DHIS2 software. The DHIS2 system disaggregates data by three nationality groups: nationals, refugees and foreigners. This integration significantly enhanced data integration and the utility

of the health information collected. The Ministry of Health regulates the data capture and access, establishing user accounts for web-based HMIS databases. User access rights are delineated based on the specific roles of the users, ranging from data entry to data utilization, to ensure secure and role-appropriate access to health data.

2.4.3 Surveillance, notifiable conditions and data collection

Uganda has been implementing the third edition of the WHO Regional Office for Africa IDSR Guidelines *(21)* since 2021, which guide epidemiological surveillance among both host and refugee populations. This system incorporates both indicator-based and event-based surveillance mechanisms. Event-based surveillance involves the use of hotlines and media scanning to detect alerts, which are then triaged to identify true public health events. Subsequent steps include verification, risk assessment and communication of risks.

Additionally, community-based disease surveillance is conducted by VHTs, which play a crucial role in detecting and reporting events of public health significance within their communities. This grassroots approach to surveillance ensures a broad coverage and timely response to public health threats across different population segments, including underserved areas.

In the IDSR system in Uganda, data collection and reporting are tailored to various timelines to serve specific purposes. Immediate case-based reporting is crucial for the early detection of unexpected or highly pathogenic public health events. Weekly reports from health facilities (HMIS 033B) aggregate data on epidemic-prone diseases and diseases of public health concern, aiding in the monitoring of disease trends to facilitate early outbreak detection. Additionally, data are aggregated monthly (HMIS 105 and HMIS 108), quarterly (HMIS 097) and annually (HMIS 107) to monitor the overall health status of the population, assess the impact of disease-specific programmes and plan resource allocation *(22)*.

Data capture in the IDSR system is performed using paper-based HMIS tools, while reporting is conducted through electronic applications primarily using DHIS2, mTrac and eIDSR. The main national health data sources include DHIS2 and the Ugandan Demographic and Health Survey, which is conducted every 5–6 years.

2.4.4 Health sector monitoring indicators

Uganda's health sector directly contributes to six key result areas of the third National Development Plan, encompassing a total of 32 indicators. These indicators are organized into six strategic result areas that are designed to capture a broad range of health and societal issues *(24)*.

1. Improved skills mix focuses on increasing the health care workforce density, such as the number of health workers, including doctors, midwives and nurses per 10 000 population.
2. Reduced morbidity and mortality includes tracking the incidence of diseases such as TB, HIV, malaria, hepatitis B, as well as cancer and cardiovascular diseases, alongside metrics for road accidents and under-5 diarrhoeal diseases. This area also includes maternal, neonatal and under-5 mortality rates, along with hypertension and diabetes prevalence.

3. Improvement in the social determinants of health and safety aims to monitor and improve factors such as teenage pregnancy rates, child nutrition (stunting and wasting) and broader public health metrics such as obesity and alcohol abuse rates. It also includes infrastructure-related indicators such as sanitation coverage and handwashing facilities.
4. Reduced fertility and dependence ratio targets demographic factors including total fertility rate and adolescent fertility rate, as well as the unmet need for family planning.
5. UHC assesses the proportion of the population with health insurance, the financial burden of OOP health expenditure and the overall readiness of health facilities to provide general services.
6. Reduction of all key forms of inequalities focuses on ensuring equitable access to health care and reducing disparities, encapsulated by the proportion of the population accessing UHC.

In addition to these strategic areas, outcome indicators specific to public health programmes are also monitored, including vaccination coverage (three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine, *Haemophilus influenzae* type b vaccine and three doses of hepatitis B vaccine), measles immunization, use of insecticide-treated bed nets for malaria prevention and HIV/AIDS treatment metrics such as antiretroviral therapy coverage and retention rates. These outcome indicators help to assess the effectiveness of various health interventions and guiding resource allocation to optimize public health outcomes.

2.4.5 Management of health records for refugees

Refugee or migrant personal health records are maintained on medical forms and books, which are held by the clients themselves. When referrals are necessary, referral notes are utilized to facilitate the transfer of patients to other health facilities for further care.

There are challenges in HIS for refugees and migrants in Uganda. The consolidation of HISs into the DHIS2 in 2020 categorizing health data by nationality was a critical step towards streamlined data management in Uganda. However, the effectiveness of this system is often limited by several key challenges that need continuing attention. One significant issue is the adaptability of the system to capture detailed health data that can accurately reflect the complex needs of refugees and migrants, who may have health profiles and requirements that differ from the local population.

Additionally, the reliance on paper-based health records held by the patients themselves poses considerable challenges in maintaining the continuity and accuracy of health data. This method increases the risk of data loss and errors during patient referrals and transitions between health facilities. The integration of electronic systems such as DHIS2, mTrac and eIDSR has been instrumental in improving data capture and surveillance capabilities through both indicator-based and event-based approaches. However, these systems demand continuous technical support and capacity-building to ensure their effective utilization at all levels of health care provision.

Document management practices need to evolve to enhance data security and integrity, ensuring that the HIS is robust, reliable and capable of supporting effective health service delivery to all individuals, including vulnerable refugee and migrant populations. This will require sustained investment in system infrastructure and training for health care workers.

2.5 Health workforce

2.5.1 Staffing levels and challenges

Health workers with diverse skill sets are recruited to provide health care services at health facilities and community outreaches. These professionals are supplemented by additional personnel recruited by humanitarian organizations, complementing the staff hired by the Government. It is reported that most health facilities operate significantly below their full staffing capacity due to limited funding for staff recruitment. Specifically, in refugee-hosting districts, only about half of the approved staff positions are filled, with a small percentage of these workers being directly employed by the Government.

The reduction in funding for refugee response programmes has led to an increased patient-to-health worker ratio, as financial constraints have forced humanitarian organizations to stop employing a significant proportion of the health workers previously recruited to serve in refugee settlements. There is also a notable shortfall in available mental health professionals.

2.5.2 Language and cultural barriers

Translators are provided by partners at health facilities in refugee settlements and transit centres to assist in communication between refugees and health workers. However, there is an absence of trained intercultural mediators, which limits the effectiveness of these translation services.

2.5.3 Professional development and training

Continuing professional education for health workers targets various health areas. However, there is insufficient focus on mental health and NCDs. Notably, there is no specific training package addressing the provision of refugee- and migrant-sensitive health care services, highlighting a gap in the current training programmes that could improve the quality and effectiveness of health service delivery to these populations.

2.5.4 Integration of refugee health workers in health care delivery

Refugee health workers who are licensed by respective professional bodies, such as the Uganda Medical and Dental Practitioners Council for doctors and dental surgeons, the Allied Health Professional Councils for paramedics and Uganda Nurses and the Midwives Council for nurses and midwives, are employed to provide services. These professional councils license both citizens and non-citizens, with refugees and migrants from countries such as the east African countries, the United Kingdom and the United States of America exempt from registration examinations.

There are challenges in registering refugee health workers from the Democratic Republic of Congo, as their qualifications do not always align with east African standards. Those trained in the Democratic Republic of the Congo are advised to undertake further studies to meet registration requirements. A European Union-funded project is currently supporting the registration of these refugee health

workers. Under this project, the Business Technical Vocational Education and Training Department of the Ministry of Education and Sport is developing a framework to equate Democratic Republic of the Congo academic qualifications to Ugandan standards, enabling Democratic Republic of the Congo nationals to work in Uganda.

2.6 Preparedness and response to outbreaks, natural disasters and other emergencies

Uganda is highly vulnerable to public health emergencies due to several factors, including its placement within epidemic belts, pressures on ecosystems posed by climate change and its proximity to the Congo Basin. In this context, disaster preparedness and response is conducted through a multisectoral approach coordinated by Uganda's Office of the Prime Minister. The roles and responsibilities are outlined for stakeholders and committees at the national, district and subcounty levels. The Division of Public Health Emergency Preparedness and Response is among the three divisions within the Department of Integrated Epidemiology, Surveillance and Public Health Emergency that coordinate Uganda's public health emergency preparedness and response. Within the Ministry of Health, the country established the national Public Health Emergency Operations Centre, which acts as the Ministry of Health's focal point for all aspects related to public health emergency response efforts.

Uganda has adopted and implemented the guidelines for IDSR to improve public health surveillance and response for priority diseases, conditions and events across community, health facility, district and national levels. These are intended to be used by International Health Regulations (2005) national focal points, infection prevention and control officers, district health teams, health authorities at points of entry, community leaders, NGOs and other stakeholders. Uganda's third and latest edition of the guidelines includes refugees in different sections *(21)*.

While guidelines and tools are distributed among relevant stakeholders, the need to conduct capacity-building exercises in public health emergency preparedness and response and to develop preparedness and response plans was raised during field visits. Equally important was the need to further disseminate existing SOPs for emergency preparedness and response activities and to complete the review of those requiring updates.

2.7 Health promotion, disease prevention and control, and social determinants of health

2.7.1 Immunization

Over the years, Uganda has led significant efforts leading to improvements in immunization coverage and child mortality rates, with a reduction of under-5 mortality by more than two thirds since 2000 *(24)*. Despite substantial progress over time, challenges remain to improve immunization

coverage and reach under- and un-immunized populations in hard-to-reach areas, including refugees in settlements. This is reflected through disparities in coverage rates among different regions in the country.

Under the Ministry of Health, UNEPI developed the National Immunization Strategy 2024–2028, which is a transition from the former Comprehensive Multi-Year Plan 2017–2021. With the aim of tracking the overall performance of the Strategy, UNEPI developed a Monitoring and Evaluation Plan, which includes among its key performance questions a component on the extent to which zero-dose children within refugee settlements are reached *(25)*. In addition, under the pillar on service delivery, the HSIRRP includes vaccination in the health service package newly arrived refugees in Uganda receive and uses an indicator on the number of children vaccinated to track progress.

Beyond progress at a policy level, in practice, refugees' and migrants' equal level of access to immunization services as the host population signals Uganda's commitment to ensuring their inclusion in measures to reduce vaccine-preventable diseases. Refugees and migrants are included in routine immunization and mass vaccination campaigns and services are provided free of charge. Similarly, the Government has promoted the same level of access to COVID-19 vaccination since 2021 when Uganda received its first doses.

2.7.2 Immunization programmes and services

UNEPI provides routine immunization services through static health facilities, community-based outreach services within catchment areas, periodic supplemental immunization activities during outbreaks and accelerated routine immunization. In addition to vaccination services provided in transit centres, as discussed above, vaccines are also administered to refugees at health facilities in refugee settlements. If refugees are unable to share the vaccination card provided to them at the transit centre, they are given a new one at the health facility and are incentivized to keep them. Flyers with information to promote the use of vaccines have been posted inside most but not all facilities, with a few also in different languages, such as Swahili to reach Congolese refugees.

To improve awareness about vaccination benefits, schedules and services among mothers, health workers share vaccination information during postnatal visits. The administering of vaccines is also promoted during the same visit to reduce the mother's travel arrangements to and from health facilities. In addition, Uganda has implemented with VHTs a door-to-door social mobilization and sensitization strategy, which was highlighted during field visits as a practice that has helped to increase uptake. As VHTs have knowledge of the households in each catchment area and, in many cases, the number of members in each household, they are deployed to households to follow-up on vaccination schedules and to identify members who have not received a single dose.

Among the challenges mentioned by VHT members was the difficulty in dispelling myths and combating misinformation related to specific vaccines and their efficacy and safety. This is linked to points raised among stakeholders on the importance of furthering the understanding of behavioural and social drivers of vaccination among these communities in order to tailor interventions and strategies. Equally important is the need to identify improvements needed for vaccination training and knowledge gaps among health workers providing immunization services. The last UNEPI training needs assessment conducted in Uganda was in 2016. Conducting a new training needs assessment

would allow for the tailoring of capacity-building activities such as workshops, online courses and drills based on updated findings. Another challenge raised at nearly all facilities visited was the recurrent vaccine stockouts, leading to patients being referred to other facilities hoping they would have the vaccines needed.

2.7.3 Social determinants of health

Social determinants critically influence health outcomes among refugees in settlements, with particular emphasis on housing conditions such as overcrowding and poor ventilation, which are significant factors in the transmission of diseases such as TB. Congolese refugees in Uganda face specific challenges due to inadequate housing that lacks essential features such as windows and proper air circulation. In response to these challenges, health initiatives have been launched to educate refugees about the health risks associated with poor ventilation. These educational efforts have prompted some refugees to improve their living conditions by installing windows in their homes, showcasing proactive community engagement to mitigate health risks.

SGBV presents a significant risk to women, men and children of both sexes within refugee settlements, increasing their risk of intimate partner violence and traditional harmful practices such as early marriage. Often, these incidents remain concealed by survivors and their families due to prevailing stigma and other social concerns. In response, various awareness, prevention and response initiatives have been enacted. This includes the integration of SGBV prevention strategies into specialized adolescent programmes at health facilities, which are designed to actively mitigate and address SGBV in these vulnerable populations.

2.8 RCCE, health communications and social mobilization for health

In 2020 Uganda developed the National One Health Risk Communication Strategy *(26)*, which provides guidance on key messages, communication and distribution channels for each priority disease, as well as coordination strategies. The coordination of the strategy is handled by Uganda's Zoonotic Disease Coordination Office and each stakeholder involved implements the strategy by integrating it into their routine communication strategy. Within the strategy, refugees are only mentioned in the section on primary, secondary and tertiary audiences of the Ebola virus disease, which highlights the need to further integrate refugees and migrants into risk communication strategies being implemented in the country.

2.8.1 Role of VHTs

In all refugee settlements, community health workers in the VHTs play a crucial role. These individuals are selected by the Refugee Welfare Council 1, which functions similarly to the local government council at the lowest administrative unit in refugee settlements. VHTs are chosen from the refugee members of a cluster, facilitating community-driven health initiatives.

The primary responsibilities of VHTs include home visiting, mobilizing communities for health service utilization, health promotion and education, community-based case management of common health conditions and follow-up care. They also distribute health commodities, manage community information and conduct disease surveillance. The Ministry of Health has developed a VHT training package to equip them with necessary skills and knowledge. VHTs receive in-service training on various health issues, including malaria, TB, COVID-19, psychosocial support, nutrition, integrated community case management, disease surveillance, outbreak prevention and control, as well as water, sanitation and hygiene. Upon accepting their assignments, VHTs are provided with incentives such as quality training, certificates, T-shirts, bags, job aides, Information, education and communication materials and registers. Currently, VHTs operate on a voluntary basis and receive allowances only to support specific programme activities.

2.9 Research on health and migration

Research involving human participants in Uganda is regulated by the Ugandan National Council for Science and Technology. The national guidelines address research involving vulnerable populations such as children, minors, street children, prisoners, the homeless, refugees, internally displaced people, substance abusers, individuals with disabilities, armed forces personnel, the terminally ill and pregnant women *(27)*.

One of the strategic interventions of the Uganda HSIRRP is the development of a framework for operational research to enhance health sector programming for the comprehensive refugee response. This includes collaboration with academia and research institutions to ensure that research aligns with the needs of both refugees and migrants *(16)*.

Despite the exclusion of refugees and migrants from the Ugandan Demographic and Health Survey, the Government of Uganda has committed under the Global Compact for Refugees to include refugees in its national statistics. That will extend the inclusion to refugees in the Demographic and Health Survey in order to enhance the inclusivity and accuracy of health data *(28)*.

There is an ongoing involvement of district health authorities and health facilities in migration health research. The experiences gathered from these activities are crucial and can be systematically presented and utilized to improve support systems for refugees and migrants.

3. Actions to be considered

To strengthen and build the resilience of the health systems for the Ugandan population and for refugees and migrants in the country, the Joint Review Team recommends the following priority areas for consideration.[2]

3.1 Health system building blocks

3.1.1 Governance and leadership

- **Ensure policy inclusion and development.** While refugees are already considered in current health policy frameworks, it is crucial to further integrate migrants' specific needs to ensure comprehensive and inclusive health policies. Policies that grant migrants equitable access to health services should be developed and refined, paralleling the existing frameworks for refugees.
- **Integrate traditional healers within the policy and planning frameworks.** Acknowledging and formalizing the role of traditional healers would enhance a holistic approach to community health systems and broaden the scope of public health strategies to include culturally relevant practices.
- **Strengthen intersectoral collaboration.** Collaboration between the Ministry of Health and other relevant ministries, such as those in charge of education, finance and gender, labour and social development, would help to address broader determinants of health such as education, employment and social protection, which significantly impact the health outcomes of refugees and migrants.

3.1.2 Access to essential medical products

- **Strengthen logistics and supply chain management systems.** Reduction of the recurrent stockouts of essential medicines and supplies will support efficient health care.
- **Implement robust stock management practices and ensure adequate budget allocation.** Such practices would help to ensure consistent availability of medical products.

3.1.3 Health service delivery

- **Integrate cultural mediators within health service delivery.** Cultural and language barriers affect the accessibility and quality of health care for refugees and migrants. This should involve training and employing individuals from within these communities to act as bridges between health care providers and patients.

[2] This section contains the recommendations of the Joint Review Team and does not necessarily represent the decisions or the stated policy of the World Health Organization.

- **Expand and standardize adolescent health services across all health facilities.** Uniform access to comprehensive sexual and reproductive health education and services across the country should particularly focus on enhancing outreach and educational programmes to address the unique challenges faced by refugees and migrants.

3.1.4 Health financing

- **Explore innovative funding mechanisms.** Some mechanisms could enhance the sustainability of health financing.
- **Explore the potential of a national health insurance scheme that includes provisions for refugees and migrants.** Contributions need to be manageable for all community members, including the most vulnerable.

3.1.5 Health information system and health information management

- **Update record-keeping methods.** Transition from paper-based health records to a more robust digital health record system will help to ensure continuity of care and improve the accuracy and security of health data.
- **Ensure mobility of health data.** Existing systems could be enhanced to ensure seamless transitions of health records when refugees are referred between health facilities or relocate within the country.

3.1.6 Health workforce

- **Increase investment in the recruitment and training of the health workforce.** A focus on underserved areas and specialties such as mental health would be beneficial.
- **Increase training for health workers.** The WHO *Refugee and Migrant Health: Global Competency Standards (29)* could be incorporated into national training programmes to enhance competencies in communication, ethical practice and culturally appropriate care.
- **Support community health workers.** Increasing the capacity and integration of community health workers will help both refugee and host communities.

3.2 Essential public health functions

3.2.1 Emergency preparedness and response

- **Ensure SOPs for emergency preparedness and response are up to date.** Regular review is needed to ensure that updates and modifications are reflected and disseminated.
- **Conduct training to strengthen capacities in public health preparedness and response.** This should include for effective leadership in all-hazards responses.
- **Review and support the testing of public health preparedness and plans to ensure inclusion of refugees and migrants.** The health needs of refugees and migrants and the current migration and displacement context should be included, in close collaboration with diverse stakeholders.

3.2.2 Health promotion, disease prevention and control, and social determinants of health

- **Implement targeted interventions to improve housing conditions with a focus on ventilation to control and prevent the spread of disease.** These interventions should integrate considerations of social determinants of health, ensuring that efforts to improve physical health conditions are accompanied by measures to enhance the overall living conditions of refugees and migrants.
- **Strengthen mechanisms for SGBV prevention and response.** Health facilities should be equipped with necessary resources such as post-exposure prophylaxis and trained personnel to handle SGBV cases effectively. This also includes expanding community-based prevention programmes to raise awareness and educate on SGBV, focusing on both prevention and the availability of support services for survivors.

3.2.3 RCCE, health communications and social mobilization for health

- **Formalize the integration of VHTs into the national health system.** This will help to ensure sustained support and would recognize their critical role in health service delivery within refugee settlements.
- **Leverage the existing network of VHTs to establish a more robust community-based health monitoring and rapid response system, particularly for outbreak prevention and control.** This requires equipping VHTs with the necessary tools and technologies to report health data in real time, allowing for quicker interventions and better management of health emergencies. This approach should be supported by a clear framework for collaboration between VHTs and local health authorities at district level.

3.3 Specific health programmes

3.3.1 Immunization

- **Conduct research aimed at further understanding the behavioural and social drivers of vaccination among refugees and migrants in Uganda.** This would inform the implementation and evaluation of targeted strategies for improved service delivery, the expansion of target populations and their needs, and the planning of catch-up vaccination activities.
- **Strengthen door-to-door social mobilization and sensitization with VHTs.** This practice around immunization has helped to identify refugees in settlements who have not been reached by other strategies. This strategy is also encouraged in urban slums.
- **Improve the design of the immunization supply chain system.** A more efficient system will help to prevent vaccine stockouts, particularly at the last mile.
- **Promote equity in vaccination microplanning.** The inclusion of refugees and migrants in designing and implementing microplans will support overall population protection against vaccine-preventable diseases.

3.3.2 Mental health and psychosocial support

- **Provision of support for refugees and migrants.** Mental health and psychosocial support services could be scaled up within refugee settlements and in urban areas with high concentrations of migrants.
- **Develop a comprehensive mental health strategy for refugees and migrants.** Systematic screening would help in accurately assessing their mental health needs. This strategy should include ongoing monitoring and evaluation to ensure that interventions are effective and responsive to the evolving needs of these populations.

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Annex.
Agenda for the joint review mission

		Agenda for the Refugee and Migrant Health System Review - Uganda	
Day	**Date**	**Activity**	**Time**
0	Sunday 11/2/2024	Arrival- Team meeting	
1	Monday 12/2/2024	Travel to MoH headquarters	8:00–8:20 am
		Meeting with MOH technical team and partners; briefing on the review process/activities and gathering necessary information.	8:30 am – 13:00 pm
		Meeting with MOH senior top management; briefing on the review process/activities.	5:00–6:00 pm
2	Tuesday 13/2/2024 (Field Visit)	Field visit – Kampala	
		Kisenyi HC IV	8:30–10:30 am
		Travel to Kiryandongo/ Panyadoli Refugee Settlement	11:00 am – 4:00 pm
		Team meeting – Reflections on field visits (Kabalega Resort Hotel)	5:00–6:00 pm
3	Wednesday 14/2/2024 (Field Visit)	Field visit – Panyadoli Refugee Settlement	
		Meeting with CAO, DHT, the Office of the Prime Minister settlement level – Kiryandongo District Headqarters	9:00–10:00 am
		Panyadoli HC IV – HF assessment + Meeting with VHTs + RWC	10:30 am – 1:00 pm
		Panyadoli Hill HC III	2:00–3:00 pm
		Travel to Hoima Municipality	3:00–6:00 pm
4	Thursday 15/2/2024	Field visit- Kwangwali Refugee Settlement	
		Meeting with CAO, DHT, the Office of the Prime Minister settlement level – Kikuube District Headquarters	8:30–9:30 am
		Field visit to health facilities (Maratatu D, Kavule, Mombasa)	9:30 am – 3:00 pm
		Team meeting to prepare presentation	5:00–6:00 pm
5	Friday 16/2/2024	Travel to Kampala	8:00 am – 12:00 pm
		MoH and partner debriefing meeting - verification/clarification of findings – WCO Kampala	2:00–3:00 pm

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