JOINT MONITORING REPORT IN REFUGEE HOSTING DISTRICTS

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EXECUTIVE SUMMARY

The Joint Monitoring Report provides an analysis of the health sector performance in respect to refugee health focusing on quality of serviced delivery, level of integration of refugee health in the public health system, access to essential health care by host communities, challenges and mitigation measures to address them.

The finding and challenges identified are based on the health systems building blocks that describe the health system according to WHO framework, categorized under the HSIRRP as strategic interventions in line with the National Health Policy and Ministry of Health Strategic Plan. These building blocks include; Service delivery, Medical products, vaccines and technologies, health workforce, health information systems, health systems financing and leadership and governance. There has been overall improvement in the integration of refugee health services as well as the quality of health services however there is strong need for multi-sectoral coordination.

The Recommendations made from the Joint Monitoring Report focus on reprogramming community-based delivery systems and strengthening the medicines supply chain to ensure proper quantification, timely procurement, redistribution, prepositioning and management of medicines and medical supplies.

INTRODUCTION

BACKGROUND

The refugee health response is guided by the Health Sector Integrated Response Plan for Refugees & Host Communities (HSIRRP) and UNHCR Public Health Strategic Plan 2018-2022. The Health Sector Integrated Refugee Response Plan (HSIRRP) is an addendum to the National Health Sector Development Plan supplementing service delivery in the refugee hosting communities, to meet the needs of everyone in the targeted areas (refugee host districts). The Health Sector Development Plan (HSDP) provides the strategic direction and guides the operations in the health sector in the medium term, highlighting how it will contribute to Uganda's 3rd National Development Plan (NDP III).

The interventions under the HSIRRP for refugees and host communities are premised on a number of international, regional and national commitments, notably the New York Declaration for Refugees and Migrants and its Comprehensive Refugee Response Framework, and will support Uganda to meet its commitment to the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3 to ensure healthy lives and promote wellbeing for all at all ages by 2030 and the principle of leaving no one behind.

The health sector receives 6.1 % of the national budget which is below the expected 15% as per the Abuja Declaration that is considered adequate to meet the population health care. Over 41% of expenditure in health is out of pocket, which the population pays to access the health services. The Health partners supplement the provision of services within the refugee hosting districts hence ensuring access and utilization of services by the communities.

OVERVIEW OF HEALTH SERVICE DELIVERY IN REFUGEE HOSTING DISTRICTS

In line with Comprehensive Refugee Response Framework (CRRF), the health services for refugees are integrated into the District Local Government health services and are implemented in-line with national health policy, Health Sector Development Plan and guidelines. The integration of health services for refugees focuses on ensuring refugees' health care is part of the

Ministry of Health programmes and management structures. UNHCR is represented at Health Development Partners, Health Policy Advisory Committee of the Ministry of Health and Technical working groups at the national level and at the District level, which provide an opportunity for integration of refugee issues in policies and decisions. Refugees are represented in the oversight committees of Global Fund, National Coordination Committees for Malaria, TB etc. Ministry of Health established a Directorate of Health Governance and Regulation with a Commissioner for Health Sector Partners and Multi-Sectoral Coordination under which the secretariat of the Health Sector Integrated Refugee Response Plan is hosted.

The health services for refugees are provided at 100 health facilities of which 72% of the health facilities are coded and accredited by the Ministry of Health hence receive support (medicines, grants, health workers) from the Government of Uganda, while the remaining 28% are either temporary or semi-permanent structures that cannot be accredited at their current state and these entirely rely on UNHCR funded partners (NGOs). The health partners support health service delivery at the government and non-government health facilities in all the 12 refugee hosting districts which includes additional human resources, medicines, medical supplies, equipment, ambulances, community health interventions and infrastructure development.

All services provided (medical consultations, laboratory tests, medicines, vaccines, inpatient admissions, deliveries) at the health facilities within the refugee settlement are free, both at the government health facilities and NGO run facilities. In addition, the ambulances supporting medical referrals within the refugee settlements provide free transport to both refugees and Ugandan nationals. About 30% of the patients seen at the health facilities in the refugee settlements are Ugandan Nationals who prefer to walk long distances to these health facilities in the refugee settlements because of good quality and free medical care.

The refugees referred to district and tertiary hospitals for care incur no costs since transportation and all related medical costs as well as upkeep are provided by UNHCR and its partners. The refugees living in urban towns/cities like Kampala accessing free medical care at any government health facility. In situations where the government health facility in urban towns lacks specialized investigations or medicines, UNHCR supports the refugees to have medical investigations and medicines from private specialized facilities.

Ministry of Health, UNHCR and partners ensure availability of essential medicines for refugees and host communities. The Health partners supplements medicine provided by the government with medicines from international and local (emergency) medicine procurements. In situations, where special medicines are not available at the health facilities, the health partner will procure these medicines for the patients

Ministry of Health vertical programmes integration

Refugees are now part of the key vertically funded programmes and are therefore included without additional cost to UNHCR and partners:

- Immunization programmes – Refugees are included in the Ministry of Health quantification of the vaccines as such UNHCR does not procure any vaccines. Ministry of health with partners like UNHCR, UNICEF, IOM and WHO prepare joint proposals to various donors for refugee specific vaccinations.
- Malaria – Refugees are included in the country quantification for the Malaria commodities that are funded by Global Fund for Ministry of Health.
- Tuberculosis – The Refugees settlements are part of the hub-system for collection, transportation and testing of samples and medicines have been provided free for all forms of Tuberculosis.
- HIV/AIDS – Refugees are integrated in the quantification of the antiretroviral therapy treatment for the country as well as condoms and HIV testing kits.
- Nutrition – Refugee settlements receive nutrition commodities from the Ministry of Health through the district health offices. Health workers within the refugee settlements receive technical support of the regional and district nutritionists.
- Health Information System – Refugee health information system has been integrated into the national system and all the refugee health facilities report directly into the national system.

OBJECTIVES OF THE JOINT MONITORING MISSION

The goal of the assessment was to get better understanding the quality-of-service delivery, level of integration of refugees in the public health system looking at opportunities, barriers and challenges facing refugees, host communities accessing essential health care, and propose interventions where necessary and feasible.

Specific Objectives of the Joint Monitoring Mission

1. Determine the uptake of primary and secondary health services as well as explore opportunities, gaps and propose measures to overcome the barriers to health care.
2. Strengthen COVID-19 infection prevention and control measures
3. Determine whether essential health care commodities are requested according to needs of population (refugees and host community)
4. Develop 2022 public health priorities in the face of the dwindling funding

METHODOLOGY

The joint monitoring was conducted in all the Refugee hosting districts. The assessment was carried at the District Health Office as well as at the Health facilities. Within each refugee hosting districts, 4-8 health facilities were assessed, and these were equally distributed in the host community and in the refugee settlements. The health facilities assessed in the refugee settlements comprised of government and NGO-run health facilities.

The joint monitoring mission assessed all the health system building blocks using a number of approaches which included; Interviews, questionnaires, document reviews, focused group discussions and direct observation.

FINDINGS

A. SERVICE DELIVERY

The quality of health services was assessed at all the health facilities visited. All the health facilities were providing primary health care according to the Ministry of Health standards

SEXUAL REPRODUCTIVE HEALTH SERVICES

Key Findings

- Maternal Death Audits were being conducted in all the health facilities
- ASHR services are available at all the health facilities
- Majority of the deliveries were by skilled birth attendants
- Most of the settlements were conducting pregnancy mapping

Challenges

- Lack of specialized neonatal equipment eg infant warmers, phototherapy machines, incubators, etc
- Occasional shortage of blood for transfusion of anaemic mothers contributing to some maternal deaths
- Stockouts of long term family planning methods
- Lack of knowledge and skills in IUD insertion/removal, cervical cancer screening
- Some health facilities are missing guidelines and committees for Maternal Perinatal Death Review surveillance (MPDSR)
- Traditional beliefs and practices in the community (women use traditional remedies to augment labour/align the baby to avoid Cesarean section)

HIV/AIDS & TUBERCULOSIS SERVICES

Key Findings

- Differentiated Service Delivery models are being implemented in majority of the health facilities

- Elimination of mother-to-child transmission (eMTCT) is being provided at all health facilities
- All health facilities visited have adopted the young adolescent program strategy (YAPS) including expert clients who provided support and escorted newly identified HIV/AIDS clients

Challenges

- Stock out of TB and HIV drugs especially for children
- Tracking of adverse events of clients ARV – DTG (Dolutegravir) containing regimens was poorly documented as facilities lacked tracking forms
- Long Turnaround time (2 weeks to 3 month) for DNA Polymerase Chain Reaction (PCR) test for infants

NUTRITION SERVICES

Key Findings

- Nutrition services both curative and preventive interventions, and complementary are provided at Health Facilities within the refugee settlements while health facilities outside the refugee settlements mainly provide curative services.
- Most facilities have nutrition services integrated into their facility work plans.Nutrition assessment and classification conducted at all contact points of the health facilities. Use of only MUAC to assess mainly observed outside refugee settlements.Nutrition education and sensitization activities e.g. MIYCAN counseling and support, food and cooking demonstrations, demo gardening etc., were majorly conducted in health facilities within refugee settlements
- The use community engagement structures such as (VHTs and care groups) to support continuum of care and strengthen community-facility linkages mainly exists or operational at health facilities within refugee settlements

Challenges

- Inadequate anthropometric equipment in both Host and Refugee facilities
- Nutrition commodity stockouts and expiries, looming stockouts, gaps in forecasting, gaps in implementation of FIFO/FEFO, and substandard storage mostly in host community facilities.
- Quality Improvement (QI) projects, Work Improvement Teams (WITs), and QI documentation are nonexistent or inconsistent.
- Gaps in nutrition guidelines, handbooks, and job aids (IMAM, MIYCAN, NACS etc.) in both refugee and host.
- Gaps in human resource for nutrition (skeletal to nonexistent staff, lack of training and mentorship) especially in lower grade facilities.
- Targeted Supplementary Feeding (TSFP), and Maternal Child Health and Nutrition (MCHN) services mostly offered in refugee settlements, which a few outside refugee catchments.

EMERGENCY RESPONSE SERVICES (COVID-19 PANDEMIC)

Key Findings

- All the districts visited had active district task forces for COVID-19 response
- Health workers had adequate knowledge on infection prevention and control.
- Village Health Teams were highly engaged in disease surveillance and response.
- Screening and testing for COVID-19 was being done in all health facilities.
- COVID-19 vaccination was on going in all the refugee hosting districts
- All the refugee hosting districts were on alert for Ebola following the confirmed outbreak in Congo.
- Awareness and community engagement across all the refugee hosting districts

Challenges

- Lack of standby oxygen in some health facilities especially in the health facilities outside the refugee settlements
- There is non-adherence to SOPs for various reasons including ignorance, reluctance, myths and perception that COVID-19 is not real or a disease of people from the big towns.

- Periodic stock outs of some Personal Protective Equipment
- Vaccine hesitancy is still common challenge due to more myths and rumors on social media about the vaccines.

COMMUNITY PUBLIC HEALTH

Key Findings

- Village Health Teams (VHTs) were functional across all the districts.
- The VHTs are knowledgeable and aware of all their roles and responsibilities**.**
- The VHTs in refugee settlements have extra roles in other thematic areas such as WASH
- Multi-sectoral support for VHTs from various partners including UNHCR, MTI, Baylor, TASO, Oxfam, Nsamizi, Care, IRC, RHITES, EGPAF and ACF was evident.
- There is a functional linkage between the community and the health facilities.

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Challenges

- Stock-out of some essential drugs for implementation of the ICCM program
- Self-medication of community members in private unauthorized facilities (clinics and pharmacies)
- Poor storage for the iCCM commodities
- Low incentives and Remuneration for the VHTs
- low formal recognition and appreciation for VHTs for the work (certificates, verbal appreciation, awards for good performance).
- Segregation of Village Health Teams (refugees vs national)
- Un-harmonized reporting-multiple reports by partners
- High workload that occupies most of their time.

WATER SANITATION AND HYGIENE

Key Findings

- All the facilities visited had running water either from motorized boreholes or pipe connections.

- Some of the facilities had water-harvesting tanks
- All the health facilities had VIP latrines as well as bathrooms with gender segregation

Challenges

- Occasional shortages of water at some of the health facilities

HEALTH CARE WASTE MANAGEMENT AND INFECTION PREVENTION AND CONTROL

Key Findings

- All the health facilities had functional incinerators, placenta pits and ash pits with the exception of Kyegegwa hospital and Panyadoli Hills H/C II that lacked an incinerators
- All the health facilities had IPC focal persons and good IPC practices
- All the health facilities had adequate stock of IPC materials.

Challenges

- Some of the isolation units had flushable toilets
- Inadequate handwashing facilities in some the health facilities

INFRASTRUCTURE

Key Findings

- Majority of the health facilities are permanent health facilities with afew exceptions in the refugee settlements

Challenges

- There is unreliable power supply in all facilities where most of them rely on solar, which is mostly non-functional.
- Poor infrastructural in some health facilities characterized by temporary structures as well as leaking roofs and cracked floors

B. MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

Key Findings

- Redistribution of medicines and medical supplies was being done in all the refugee hosting districts
- Majority of the health facilities have skilled health workers eg dispensers, pharmacy assistants or technicians.
- All facilities had their commodities organized on shelves and pallets.
- Majority of the health facilities had good cold chain management

Challenges

- Lack of computers for ELMIS such as RX solution
- Equipment inventory was not regularly conducted
- Occasional stockout of medicines and medical supplies especially in health facilities outside the refugee settlements due to delayed delivery of essential medicines by NMS
- Weak medicine management controls in the health facilities outside the refugee settlements ie no stock reconciliation in departments, no clear requisition and documentation process.
- Majority of the health facilities had inadequate storage spaces for medicines/supplies.
- Majority of the laboratories were lacking basic diagnostic equipment such as microscopes

C. HEALTH WORKFORCE

Key Findings

- The average staffing levels were 75% with the health facilities in the refugee settlements having upto 300% of the recommended staffing level
- Appraisal systems are in place although not standardized
- All the health facilities had manual attendance records
- All the facilities have Continuous professional development (CPD) plans

Challenges

- Lack of adequate staff in some of the health facilities such as Kyegegwa Hospital and Bisozi Health Centre 1V, where the staffing levels were at 24.3% and 24.5% respectively
- Lack of biometric-automatic attendance machine
- Majority of the health facilities were not conducting Continuous Medical Education (CMEs)
- Absenteeism by some health workers especially government health workers stationed in the refugee settlements
- Inadequate training database of health care workers in health facilities making it difficult to track staff that have attended trainings.

D. HEALTH INFORMATION SYSTEMS

Key Findings

- All the health facilities had a designated / appointed HMIS focal person
- Health workers were trained in death & birth registration systems.
- All facilities had IDSR system

Challenges

- Some health facilities are not reporting directly in DHIS2
- Most of health facilities did not have performance target
- Lack of data quality improvement plans
- Inadequate HMIS tools (registers, mother passports and referral forms) especially in the host-community facilities

E. HEALTH SYSTEM FINANCING

Key Findings

- Recently upgraded health facilities are receiving PHC with exception of Belle HC II that missed out due to dormant accounts & Ofua HCIII due to mismatch in facility name.

- Majority of the health facilities had PHC guidelines and approved work plan for the health facility
- Most facilities recently upgraded indicated receiving fund at the previous budget levels despite the change in the health facility grade.
- All Government health facilities received PHC funds quarterly.
- Approximately 40% of the health facilities visited receive Result Based Financing (RBF).
- No health facility indicated capital investment in their PHC funds

Challenges

- Delayed release of PHC was reported in some health facilities especially in Terego
- Majority of the health facilities didn't have procurement committees

F. LEADERSHIP AND GOVERNANCE

Key Findings

- All facilities had functional Health Unit Management Committee with minutes of the previously meetings.
- Most of the partner-supported facilities participated in stakeholder meetings at district and sub county levels.
- Majority of the health facilities were having routine general staff meetings

Challenges

- The newly transitioned facilities lack staff with knowledge in PHC grant management and workplan preparation
- There was display of client charter and services offered by the facilities
- There was irregular support supervision visits and none-documentation in the support supervision books
- There was poor documentation for some of the meetings, no minutes and proof of attendance

PRIORITIES FOR 2022

1. Health promotion and disease prevention through empowering people and communities
2. Strengthening the health system leadership, governance, and accountability to stakeholders
3. Multisectoral collaboration with the private health sector and other actors to achieve Universal Health Coverage.
4. Decreasing morbidity from communicable and non-communicable diseases through improving access to quality primary health care programmes
5. Full Integration of refugee health services into national services and explore health financing mechanisms

RECOMMENDATIONS

A. REPROGRAMMING COMMUNITY-BASED DELIVERY SYSTEMS

i. Identifying interdependencies, mapping, and addressing determinants of health

ii. Empowering individuals and the communities to identify their needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being through increasing health literacy and access to health information at home, school, workplace and social hangout places

iii. Integrating health promotion, prevention, and care services within and across levels of care (Linking individuals seeking health services at health facilities (OPD clients and discharged patients) to the entire range of disease promotion, prevention, care, rehabilitation, and palliative care services)

iv. Co-locating routine chronic care towards outreaches, self-care, home-care and lay care-givers within families and community.

v. Integrating care pathways and mechanisms for people to ensure continuity of care within the communities

vi. Stronger partnerships with patients, families and communities in health services planning, implementation, and review

vii. Establish appropriate community health service packages based on the life stages (age specific)

viii. Support individuals and communities in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals while protecting and promoting solidarity, ethics and human rights

ix. Strengthen e-health within the communities ensuring access to information as well as linkages to community interventions

x. Strengthen the capacity of health workers in community-based programming to transform the existing curative, hospital-centred health care mindset to a new one more focused on primary care, prevention, and health promotion mindset.

xi. Strengthening the integration of community health services packages with the community-based delivery systems to optimize reach e.g. deworming, iCCM, nutrition screening through community structures.

xii. Adoption of promotive and preventive best practices to increase demand and uptake of community health and nutrition services e.g., Social Behavior Change Communication for optimal maternal and child nutrition, the Family MUAC approach, scale-up of kitchen gardening et cetera.

B. SUPPLY CHAIN

i. Strengthening the medicines supply chain to ensure proper quantification, timely procurement, redistribution, prepositioning and management of medicines and medical supplies