

**The Republic of Uganda**

Uganda National Integrated Health Sector Response Plan for Refugees & Host Communities

2018-2023

June 2018

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# Foreword

The Uganda National Integrated health Response Plan for Refugees and Host Communities 2018-2020 (UNIHRPPHC) sets Uganda Health Sector’s medium term strategic direction that bridges the humanitarian and Development programming priorities and implementation strategies for refugees and other displaced population response. This framework contributes to the Health Sector Development Plan which in turn contributes to the Vision 2040 that is aimed at transformation of Ugandan society from a peasant to modern and prosperous country within 30 years.

The development of this framework that is led by the Ministry of Health was informed by lessons from reports, various joint and specific review missions to the refugee hosting districts and products of the coordination platforms. The process of development of the UNIHRPPHC was consultative, participatory and transparent. Stakeholders including public sector, humanitarian partners, health service managers, district leaders, Civil Society Organizations and Development Partners were consulted on several levels and occasions.

I am therefore certain that the UNIHRPPHC not only addresses the key challenges facing refugee hosting districts but will also address the health system challenges caused in mass displacement of people across the borders. The key priority areas will focus on strengthening coordination and strengthening the health care system in the refugee hosting districts to be more resilient to increase burden of hosting additional population which will facilitate faster integration of refugees and asylum seekers into the National Health system for faster achievement of both the health sector goals and the national goals as outlined in the NDPII.

Deliberate efforts will be made to ensure that humanitarian responders implement interventions inline with this framework as a way of alignment and integration as guided by Minstry of Health Compact, the principles outlined in the International Health Partnerships and related Initiatives (IHP+), the Paris Declaration on Harmonization.

I wish to express my appreciation to all of you who worked tirelessly to develop the UNIHRPPHC on behalf of the people of Uganda. I look forward to the acceleration of the implementation of UNIHRPPHC interventions towards attainment of our national and international health goals.

For God and My County

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**Preamble** (By PermanentSecretary)

Coordination of the national response to disasters (including Refugee Crisis) is vested in the Office of the Prime Minister, while the specific responses to health, Education water and sanitation, Shelter and Food needs are carried out by the respective sectors or Ministries. The health response to refugee crisis has been effective and made possible by the number of partners, inspite of the coordination challenges. The Ministry of Health through this strategy will institutionalise the refugee response in its structures and provide the same guidance to the local governments and lower local governments to provide leadership and governance for the refugee health response.

In providing leadership, the Ministry of health will ensure that it plays its role of managing emergencies by setting policies, strategies, guidelines, standards, and protocols for service delivery and mobilise resources; while supporting District, Health Sub Districts and Sub Counties to provide health services as they are mandated by the Local Government Act xxx.

We commit to providing equitable and integrated essential service package to refugees and communities in refugee hosting districts in our bid to develop a sustainable health system. The National Health Policy and HSDP III will guide health sector planning, our interventions, health partnerships and collaboration. The existing government structures and systems will be to reach refugees and host communities. We shall hold each other mutually accountable for results and use of the scarce health resources in line with the Parish Declaration on Aid Effectiveness 2005.

ExecutiveSummary

# Acknowledgements

The Ministry of Health would like to take this opportunity to express its deep appreciation and sincere thanks to all individuals and organizations that supported the process and development of the Uganda National Integrated health Response Plan for Refugees and Host Communities 2018-2020(UNIHRPPHC).

The process of developing this Plan and Implementation Framework was participatory and involved various key stakeholders including: Civil Society Organizations (CSOs); private sector partners; government agencies, ministries and departments; and development partners. National and district consultations were conducted to seek the input of all the stakeholders. The process was mainly coordinated through the drafting committee that met regularly to provide inputs and technical advice.

I specifically thank Hon. Joyce Kaducu, Minister of state for Primary Health Care for her strategic leadership, Dr. Patrick Tusiime the Commissioner NDC-MOH, who stepped in to insure that my overall technical guidance is adhered to, Dr. Jesica Nsungwa Sabiiti, the Assistant Commissioner, Child Health, who deputized Commissioner in coordination of the process. I particularly want to thank Julius Kasozi – UNHCR, Dr. Innocent Komakech- WHO Uganda Country office and Peter Kwehangana NMCP-MOH, who put in extra effort to have this plan produced in time.

The MOH staff including; Albert Lule-Nutrition, Jimmy Opigo- Malaria Control Programme, Joshua Musinguzi- AIDS Control Programme, Shiella Ndyanabangi - Mental Health, Eddie Mukoyo –Resource Centre, David Matsetse – UNICEF for their enormous support towards the development of the plan.

Lastly, I wish to congratulate all development partners especially ECHO, DFID, USAID,CDC, JICA, SIDA, CIDA, UNICEF, WHO for their active participation, technical and financial support in the development of this Strategic Plan and Implementation Framework, and above all for their invaluable and continuous contribution to plight of Refugees and host communities in Uganda.

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Director General of Health Services-MOH

# Introduction:

Uganda has had an open door refugee policy over thelast eight decades by hosting Refugees and Asylum seekers from many countries. Over the years, refugees from Poland, Democratic Republic of Congo, Somalia, Burundi, Rwanda, Kenya, South Sudan, Ethiopia and Eritrea have been hosted in the country. By June 2018, thetotal number of refugees had reached 1,326,750 people settled among host communities, distributed in 16 settlements and 12 districts making it the largest refugee-hosting country in Africa, and the third largest in the world, after Turkey and Pakistan. In view of the high conflict and famine vulnerability of the Great Lakes Region, additional and protracted refugee influxes are anticipated in the coming years.

The open door policy comes with increased demands on the social amenities meant for local communities. For instance, the settlement of refugees among host communities increases the demand for health services from a health system with limited resources; medicines and health supplies, health infrastructure and human resources for health. The sheer scale of the crisis is putting the national and district health systems, host-communities, and refugee response implementing partners under tremendous stress. In the context of limited and diminishing resources for refugee response, operating parallel health systems for refugees and host communities is not sustainable, promotes inequities and conflict between refugees and host communities.

Heeding the call of the Office of the Prime Minister for sectors to develop sector specific strategies to feed into the Comprehensive Refugee Response Framework, Ministry of Health with partners embarked on developing the Health Sector Refugee Response Strategy.

**The purpose of the strategy** is to strengthen the national health systems for resilience to with-stand shocks and minimize inequities in accessing essential health services for refugees and host communities.

**The objectives of the strategy** are to;

1. Strengthen the MoH structures and district health systems to respond to the health needs of refugees and host communities
2. Harmonize provision of health services to refugees and host communities
3. Develop a tool for resource mobilization
4. Coordinate responses of national actors, Donors, implementing partners and consolidate resources

The development of this strategy was participatory starting with a situation analysis, production of draft 0 and draft 1 involving Ministry of Health, Regional Referral Hospitals, Local Governments, the United Nations Agencies, Foreign missions, Donors, Development and Implementing partners.

## **Background**

*****A history of generosity* -** Currently Uganda has over 1.46 million refugees living among 7.2 million host communities in the refugee hosting district among whom the refugee live. Uganda has a long history of providing asylum and has hosted an average of 168,000 refugees per year since 1961. Uganda is a signatory to the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, and the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa. Today, the country is host to more than 1.4 million refugees and asylum-seekers, making it the third largest refugee-hosting country in in the World and first in Africa.

**A model country -** Uganda’s refugee asylum policy and refugee settlement approach is widely regarded as an inspirational model and is cited as an example for other countries around the world. Rather than being hosted in camps, refugees are settled in villages, located within the refugee-hosting districts. The majority of refugees in Uganda, more than 80%, are hosted in settlements within these refugee hosting districts. The land for the settlement areas has mostly been gazetted by the Government for hosting refugees. Where land has not been gazetted, the government negotiates for land with leaders from the host community. In some areas, refugees make up more than half of the total population.

The settlement approach allows refugees the possibility to live with greater dignity, independence and normality within their hosting community. The refugee-hosting village clusters are administered by the Government, who register and provide documentation to the population, allocates land for shelter and subsistence farming/agriculture, and ensures area security.

Refugees living in the settlements benefit from the humanitarian response coordinated by the Government of Uganda Office of the Prime Minister and UNHCR, in collaboration with the UN agencies and partners.

***The Settlement Approach* -** Uganda demonstrates how a progressive refugee policy is economically and socially advantageous for both refugees and the host communities. The settlement approach allows humanitarian support to be adapted to help refugees achieve self-reliance in a way that allows them to contribute to their local communities. Building upon and seeking synergies with local service delivery, healthcare, is more sustainable and efficient approach to refugee management and protection. In Uganda, refugees have the same access to services as members of the host communities. In recognition of this, as a guiding principle, around 30% of the humanitarian refugee response should go towards benefiting members of the host community.

The settlement approach, combined with these laws and freedoms, provide refugees with some of the best prospects for dignity, normality and self-reliance found anywhere in the world, and creates a conducive environment for pursuing development-oriented planning for refugee and host communities to become integrated with the humanitarian response.

***The Uganda Model***

The Uganda Refugee Policy is progressive and generous with many impressive aspects, including opening its territory to refugees irrespective of nationality or ethnic affiliation and granting them: freedom of movement, land for each refugee family to settle and cultivate, the right to seek employment and establish businesses, access to public services including health and education, and access to travel, identity and other documents. The policy anticipates empowering refugees to become economically self-reliant while granting them many of the same privileges that nationals enjoy.

The contribution refugees make to local economies notwithstanding, refugee-hosting districts face major development and service delivery challenges due to poor infrastructure and lack of investments, which contribute to undermining prospects for meaningful economic and social development. In order to close this gap, Uganda established the Settlement Transformation Agenda (STA), a holistic integrated district-level refugee management approach. STA includes refugees in national development plans, taking into account the protracted nature of displacement and the impact on host communities.

Uganda was also one of the first countries of the world to align its national development plan to the new agenda, and —through the STA—champions the principle of “Leaving no one Behind”. The STA is supported by both the UN and the World Bank through the Refugee and Host Population Empowerment (ReHoPE) initiative. The premise of this synergetic cooperation is that when communities recognize that refugees are agents of development who positively contribute to the sustainable development of their district, the refugee asylum space is both strengthened and expanded. Moreover, in the long term refugees will be better prepared to engage as agents of positive transformation as and when durable solutions are realized.

Until 2015, Uganda had an estimated 500,000 refugee population; however this number drastically increased with the influx of South Sudanese refugee after the resumption of the armed violence in July 2016. With other protracted influxes from the DRC, this number has risen to 1,326,750 people by June 2018 constituting an average of 50% of some of the communities where they live.

For instance (see table comparing refugee populations in the hosting districts with nationals

Whereas the needs of the refugees in settlements and the host communities are met to a large extend, the health needs of refugees in urban areas, prisons and self-settled refugees among the host communities is borne by the national health system. The resultant resource short falls in health service provision are met out of pocket by the two communities. It is imperative that an integrated health response to cater for the health needs of the refugees and host communities is developed to enable districts foster equitable access to health services and harmonious coexistence of the communities in the context of the national refugee policy.

Presently, refugee hosting districts include Arua, Koboko, Yumbe, Adjumani, Moyo, Lamwo, Kiryandongo, Hoima, Kyegegwa, Kamwenge, and Isingiro. Districts without recognized refugee settlements include Kampala, Kaabong, Zombo, and Kisoro.

## **Situation Analysis**

***Population – refugees and hosts***

The Republic of Uganda, located in Eastern Africa, is a landlocked country occupying a total area of 241,550.7 square kilometres - 18% of which is open inland waters and wetlands. It lies astride the equator and is bordered by the Republic of South Sudan to the North, Kenya to the East, Tanzania to the South, Rwanda to the South West and Democratic Republic of Congo to the West. Uganda has an estimated population of about 34.6 million people, 51% of which is female. At 3.2%, Uganda has one of the highest population growth rates in the world (Source; Uganda Bureau of Statistics).

***Health status of the population***

Progress at the impact of health care level, the health status of refugee in all the settlements have been stable as indicated by the crude and under-five mortality rates in the graphs below which are with the acceptable ranges (0.75/100/day and 1.5deaths/1000/day respectively).

The crude and child mortality trends suggest more significant improvements. Whereas the Mortality Rate have been achieved over the years, there was stagnation between 2014 and 2016 mainly because of the major influxes from South Sudan. The impact of all this has been an improvement in the quality of life for refugees in Uganda. The leading cause of illness and death among refugees are malaria, respiratory, and diarrhoea diseases. In addition to these major causes, the sector has faced challenges with new / re-emerging conditions that cause minimal burden but are significant public health risks that lead to significant resource implications when they occur. These include cholera outbreaks, Ebola scare, measles, Polio, neglected tropical diseases, Guinea worm some of which were already eliminated by the government of Uganda.

***Refugee Health Service Delivery***

Health service delivery is in line with Uganda Health Policy and Health Sector Development Plan, guidelines, strategies and standard operating procedures. In this vein, the essential health package consist of the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable and consists of the following clusters:

* Health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response
* Maternal and Child Health;
* Prevention, management and control of communicable diseases
* Prevention, management and control of non-communicable diseases.

Greater attention is paid to ensure equitable access to the package including affirmative action for under-served areas, vulnerable populations and continuum of care

***Coordination and leadership*** – refugee health service providers through UNHCR are part of the compact between Ministry of Health and Development Partners for Implementation of the Health Sector Development Plan 2015/6-2019/20 that is intended to mobilize development partners to support and work in line with the Health Sector Development Plan and Ministry of Health chairs the refugee health sector coordination structure at the national and district levels. These coordination roles however are not institutionalized at Central and District levels and some district have not taken up the leadership roles. In line with the National Development Plan II (NDP II), ReHOPE and CRRF, Public health sector contributes to the integration of social services. In this, the integration of Public health is defined and pursued in the four prongs which include accreditation and alignment of health facilities and refugee health workers so that they are recognized by MoH, building the capacity of the District Health Care systems to cope with increased burden of refugees, strengthening strategic coordination and leadership with MoH at central and districts including outbreak response.

In 2017, refugees accessed 97 health facilities across 12 refugee hosting districts and 2 refugee entry districts that provided a total of 2,129,027 medical consultations out of which 22% were to host population.

The highest is in Oruchinga at 74% and lowest in Parolinya at 10% consultations are attributed to host population. A third (36) of the health facilities are temporary because opened up to support new arrival health services while 72% of the permanent health facilities are not coded by the Ministry of health.

Key health indicators remained within the recommended ranges that indicated good health status of the population. Crude mortality rate was at 0.1 against a standard of 0.75 deaths for every 1000 population in a month and Under-five mortality rate stood at 0.2 against a standard of 1.5. Maternal mortality ratio is 95 deaths per 100,000 live births per year against a standard of zero deaths. There were 19,704 live births and approximately 94% of all deliveries were at the health facilities. There were 19 maternal death across all refugee settlements which were all investigated and documented.

The coverage for Prevention of Mother-to-Child transmission of HIV (PMTCT) in 2017 was 100% and 93% of all newborns to HIV positive women were given Antiretroviral therapy (ART) within 72 hours after delivery. The total number of HIV positive patients on ART was 12,019 of which 33% (3,967 were refugees).

From the Food security and nutrition survey report, the global acute malnutrition (GAM) increased from 7.2% in 2016 to 9.5% in 2017 with the settlements with high GAM rates including Arua (10%), Adjumani (12%), Bidibidi (12%), Palorinya (11%) and Palabek (12%) (classified as serious) and 12.5% of children 6-59m had diarrhea in the last 2 weeks of survey. Stunting has reduced from 19.1% in 2016 to 16.4% in 2017 (classified as acceptable); Kyangwali has high stunting (33%) classified as serious. The prevalence of anaemia among children 6-59 months is above 40% which is classified as critical in all settlements (except Nakivale and Oruchinga which are 36.8% and Oruchinga 33.6% respectively. Severe anaemia reported 1.5-4.3%. Anaemia >40% is classified as high according to WHO classification. The prevalence of anaemia among non-pregnant women was highest in Palabek (47.3%), and was followed by Kyaka II (38.8%), Adjumani (34.4%) and Palorinya (33.8%) classified as high and medium public health significance respectively.

The immunization coverage was 92.7% in 2017 and the recovery rate among children admitted with Severe Acute Malnutrition (SAM) was 75.5% - which is within acceptable ranges.

The top causes of illness included malaria (37%), watery diarrhea (5%), respiratory tract infections (24%), skin infections (5%), and intestinal worms (3%).

***Human resources for Health*** – with the refugee hosting districts, there are an additional 2,326 health workers (technical staff) and 40 medical doctors that complement the district health care system that are recruited jointly by the District Health offices and health partners.

The 2,326 health workers included Clinical officers, midwives, Nurses, counsellors, laboratory technologists and technicians. There are challenges of attracting and retaining experience health workforce because of non-competitive pay, remoteness of the operations and lack of accommodation and has resulted in the high workload in some locations with a consultation per clinician rate of above 50 consultations/health worker/day. Despite the challenge, the additional human resources reduced the workload on the few health workers in the districts and improved the quality of services in West Nile and South West.

***Infrastructure*** - Refugee access services at 95 health facilities. A third (36) of the health facilities are temporary because opened up to support new arrival health services while only 72% of the permanent health facilities are coded by the Ministry of health. Of these health facilities, majority are high volume facilities that operate at a higher capacity than their level. Although five Health Centre IIs have theatres they continue to operate under inappropriate nomenclature pending upgrade by Ministry of Health.

***Referral health care*** – there are currently 53 ambulances (1 ambulance to 26,000 population) within the 12 hosting districts. This also includes functionalizing 10 Health centre IVs and support to district referral hospitals. Reverse referrals are being done by specialist medical associations, medical schools and specialized outreaches from District or Regional Referral hospitals to the settlements thereby increasing access to specialized services that routinely would be only be available at the regional referrals.

***Community health*:**- Village Health Teams (VHT) are established in refugee settlement line with MoH strategy. These are responsible for community health education, identification and referral of the sick and follow-up in the community including linking the sick community members to ambulatory services. At the end of 2017, there were 1,980 community health workers against a target of 2,600 because of challenges related to inadequate remuneration leading to high turnover

***Health Management Information System****:* – all the 95 refugee settlement health facilities report to the Ministry of Health through the HMIS. While those that are coded by MoH report directly through the districts, the newly established temporary facilities health facilities report through the neighboring coded government facilities. This is both for monthly reporting and weekly surveillance reports. Delays to code or upgrade health facilities and disaggregate the HMIS tools make the refugee data inaccessible to Ministry of Health.

## **Problem Statement**

 -(that has an issue(s) or need(s) or problem(s) to be addressed so that it is known what it willchange).

The on-going refugee health response provides essential health services to refugees and host communities in the immediate settlement areas (on going and role of actors). However, Urban refugees, Self-settled refugees, Refugees in prisons and host communities who live away from refugee settlements compete for services from government health facilities, increased patient overload on health workers, frequent shortage of medicines and the associated out of pocket payments during stock-out periods, a situation that results into inequitable access to essential health services with the potential to degenerate into conflict between the two communities(Break into two).

The contribution of the refugee health response to the long term and sustainable health system development is undermined by weak governance mechanisms for the health sector refugee response such as; the alignment of interventions to the national health policy and strategy, the use of existing governance/management structures at all levels of government, the coordination and management of partnerships, and regulation of interventions. Consequently, the refugee health response operates parallel to the district health system with limited in scope of interventions along the continuum of health care thus less efficient use of available health resources.

## **Vision, Goal, and Objectives**

***Vision:***

*“To have a healthy and productive refugee and host community population that contributes to economic growth and national development‟.*

***Goal:***

*Accelerated progress towards Universal Health Coverage for refugees and host communities is attained.*

***Objectives:***

1. Increase equitable access to and utilization of integrated health services for refugees and host communities
2. Mobilize and improve management of health resources to cope with the increased demand for health services by refugees and host population
3. Strengthen governance, coordination, leadership and management for refugee health response

## **Values and GuidingPrinciples:**

1. Equitable access to health services to both refugees and host communities
2. Integrated programing and service provision
3. All health interventions will aim at attaining Universal Health Coverage
4. Government Ownership & Leadership at all levels
5. Interventions aligned to national priorities and specific refugee health needs: Parish declaration
6. Whole of government and whole of district approaches
7. Inclusive participation
8. Partnership and cooperation
9. People centred and gender sensitive health systems
10. Adherence to humanitarian principle

## **Theory of Change**



## Justification/Rationale:

Health is a human right and inequitable access to health promotion, disease prevention, treatment or rehabilitative essential health services in a community (district) based on one’s socio-economic status (Refugee or host community), and where one stays is a violation of the individuals rights. Refugees and host communities suffer similar patterns of disease with the host communities especially in protracted refugee situations,more often than not; the health services for refugees tend to be better resourced than those for the host communities. (concentrate on what the strategy will do on the +)In fact, parallel health systems for refugees and host communities destabilizes the local health systems due to ensuing staff movements, entrenches inequities in accessing care and creates fertile grounds for conflict among the two communities due to preferential treatment.

The Integrated Health Response to Refugees and Host Communitymodel in districts will ensure that, services are equitably accessed by refugees and host communities for improving their health and harmonious coexistence, more resources are mobilized to augment resources provided by government to support and build a resilient the health system in face of increased workload. The Ministry of health has policies, strategies and guidelines for health service delivery in the country. This strategy provides further guidance on how the existing frameworks can be used to improve service delivery for refugees and host communities, using the existing coordination and management structures in view of efficient use of resources and sustainable development of the national health system in the spirit of the Comprehensive Refugee Response Framework that is coordinated by the Office of the Prime minister.

# Policy Context

## **General Context**

***Legislation*** - Uganda’s initial domestic legislation relating to refugees was the Control of Alien Refugees Act 1960. This law was meant to “control” alien refugees in Uganda rather than ensure their protection. The law was majorly enacted to control refugees on Uganda’s territory with little or no emphasis placed on their rights as human beings. It was also not in tandem with Uganda’s 1995 Constitution as amended.

***The 1995 Uganda Constitution* -** The Uganda Constitution under Chapter 4 provides a broad range of rights that are available to refugees as any other persons on the territory of Uganda. Refugee have freedom to join non-political civil associations, enjoy freedom of movement, right to family, affirmative action, right to property, freedom of religion among others. Also in the constitution, Article 189 (1) and the sixth Schedule, provide for refugee management as a central government function.

***The Refugee Act 2006 and Refugee Regulations 2010*-** The Refugees Act 2006 repealed the Control of Alien Refugees Act of 1962. It is considered progressive because of its human rights and protection orientation in line with international legal instruments relating to refugee protection such as the 1951 Convention Relating to the Status of Refugees and its protocol of 1967. The Act among others establishes the Refugee Eligibility Committee (REC) and a Refugee Appeals Board (RAB) and prescribes the procedures by which each operates. It also establishes the Office of the Commissioner for Refugees, which serves as, *inter alia,* the secretariat of the REC, and RAB. The Act like the 1951 Convention and the 1969 OAU convention provides for durable solutions of voluntary repatriation, local integration and resettlement to a third country. The Act also provides for humanitarian service delivery through International Humanitarian Agencies and Non-Governmental Organisations (NGOs) including Community Based Organisations (CBOs). The Regulations to the Act were made operational in 2010 as the legal requirement for full implementation of the new refugee law.

## **Economic Context**

## **Socio Political Context**

## **Environmental Context**

# The StrategicIntervention(Pillars)

Expected result1:Increased access and utilization of health services for refugees and host population

## **Pillar 1: Service Delivery**

### Issue:

Un-equitable access to essential health services for refugees and host communities could create social-economic tensions or violence between the host communities and refugee communities. Whereas, host communities in the vicinity of refugee settlements have free access to the health facilities for refugees, the far off host communities tend to lag behind in terms of access to the essential health service package.On the other hand, the spatial distribution of refugees in the settlements, self-settled urban refugees, and aliens settled in host communities limits access to refugee health service response, instead exert pressure on the health services provided in government health facilities resulting into frequent stock-outs, increased workload, catastrophic out of pocket spending for both communities.

### Statement:

The Essential Package of Health Services as defined in HSDP shall be equitably provided to refugees and host communities in all refugee hosting districts in Uganda. The essential service package shall ensure provision of; short and long term public health interventions (Communicable and non-communicable disease control), and Protection and improvement of the health and well-being of women, children and adolescents including persons of specific needs.

Health Promotion and education on determinants of health (WASH, housing, waste management, nutrition, education, life style, conflicts, and cultural practises, as well as disease prevention and surveillance on conditions in the essential health care package e.g. Vaccination, WASH, RMNCAH (Reproductive, Maternal Neonatal Child and Adolescent Health, Nutrition and life style changes, Screening and treatment of common ailments).

### Strategic Intervention:

##### Strengthen the mechanisms/modes of service delivery in order to increase access to essential health services for refugees and host communities.

*Action 1: Provide new arrival health service package*to refugees during the acute phase of the refugee influx. This service package includes Screening for malnutrition andepidemic prone diseases, vaccination, treatment for the sick and the injured among others on arrival*.*

**Inputs:**

1. Human resource
2. Transport and logistics
3. Medical supplies and vaccines

**Out comes:** New refugee arrivals screened and treated for malnutrition, epidemic prone diseases, provided immunization, the sick and injured etc. during the acute phase of the refugee influx

**Indicators:**Percentage of new arrivals screened for malnutrition, epidemic prone diseases, provided immunization, the sick and injured and pregnant women

*Action 2: Responding to possible Epidemics, Emergenciesand Disasters in the refugee and host community*

**Inputs:**

1. Human resource
2. Transport and logistics
3. Medical supplies and vaccines

**Out comes:**prompt detection and response, low case fatality rate

**Indicators:**Detection within 48 hours, fatality rate as per epidemic

*Action 3: Improvedelivery of facility based health servicesand health infrastructurefor providing Treatment, Care, Rehabilitation and Referral Services to refugees and host communities*

**Inputs:**

1. refugees and host communities
2. Construct Health Facilities(health facilities, mortuary, accommodation)
3. Rehabilitation works
4. Consolidate the referral system HCIII to Hospitals to respond to the referral needs of Equipment and furniture
5. Water
6. Electricity
7. Referral and Ambulance services
8. Support to Diagnostic Laboratories and Imaging
9. Support to Secondary and Tertiary facilities
10. Support to Blood Transfusion Services
11. Support to Regional Workshops
12. Construct staff houses (with adequate floor space) according to MOH defined standards appropriate for each level
13. Construct fencing for all facilities
14. Construct adequate WASH facilities
15. Survey and title the land for all facilities
16. Make Master plans for each Health facility
17. Operations and maintenance

**Outputs:**Facilities are constructed, rehabilitated, equipped, furnished and supported through the refugee response plan

**Indicators:**numbers constructed, rehabilitated, furnished and supportedNumber of new staff houses with adequate floor space, number of health facilities with fences, number of new WASH facilities constructed, number of health facility plots titled, number of master plans developed for health facilities

*Action 4: Strengthening Community Health Systemsfor the delivery of Health Promotion, Disease Prevention, Care, Referral and treatment of selected commonhealth conditions for refugee and host communities[[1]](#footnote-2).*

**Inputs:**

1. Trained community health workers
2. Incentives for community health workers
3. Tools and equipment for community health workers
4. Medicines and health supplies for community health services
5. Registers and reporting forms for HMIS and community based disease surveillance

**Outputs:**Community outreaches carries out, children treated, children referred, children vaccinated,

**Indicators:**Number of community outreach activities, numbers of children treated, numbers of children referred, and numbers of children vaccinated,

*Action 5: Support Government Health Facilities in urban areas and Prisonsto provide health services to urban refugees, aliens and host communities*

***Inputs:***

1. Supplementary medicines and supplies to gazetted[[2]](#footnote-3)health facilities in urban areas
2. Additional critical staff, infrastructure, equipment
3. Health access and utilization surveys to monitor impact of interventions

***Outputs:***Improved awareness for refugees on service availability, improved access to health services, and improved vaccination coverage

***Indicators:***Availability of medicine,health access awareness, utilization rate of health services, and number of people vaccinated

*Action 6: Assure Quality of services provided in line with national service standards to refugees and host communities*

***Inputs:***

1. Uganda Clinical Guidelines and other programmatic protocols
2. Continuous quality improvement initiatives
3. Trained frontline health workers on integrated delivery of the Essential Health Care Package
4. Integrated and Technical support supervision and mentorship
5. Regular reviews and update of the health response plan

**Outputs:** Health workers provided the clinical treatment guidelines, and trained on the provision of integrated essential service package, technical support supervisions provided to health facilities,Quality of care at all facilities improved.

**Indicators:**

80% of health workers trained and provided the clinical treatment guidelines

Monthly support supervision provided to health facilities**,** QI Framework and guidelines disseminated, experience sharing session held per year,

Expected result 2: Strengthened health system capacity to cope with the increased pressure on health system from refugees and host population

## **Pilar 2: Human Resource for Health**

### Issues:

Inadequate staffing and inappropriate skills mix in health facilities compromises quality and continuity of health service delivery, while poor remuneration results into low attraction and retention of critical cadre needed for delivery of essential services. The average staffing level in public facilities in Uganda is about 75% with remuneration levels below 40% of their counterparts working with NGO in the health sector. The national health system is overcompensated and unable to withstandshocks such as increased patient loaddue refugee influx. Converselyin refugee settlements, lower level health facilities adapt to increased volumes of work by recruiting highly qualified cadre and start delivering service outside the established mandate of the health facilities; e.g. HC III conducting caesarian sections.The dual health systems for refugees and government, presents a challenge to refugee hosting districts to attract, retain and develop critical cadres causing disruption to the equitable provision of health services to the host communities.

### Statement:

Ministry of Health has standard staffing norms for all levels of health facilities in Uganda. Staffing in all health facilities in districts and refugees settlements will be guided by the staffing norms provided. Due process under the leadership of the Ministry of health shall be followed to adapt the capacity of existing human resource structures in the health facilities to respond to peculiar health needs/situations of the refugees and host communities. Observance of fair recruitment, remuneration, employment benefits and welfare which are central to staff performance of duties shall be monitored.

### Strategic Intervention:

##### Mobilize adequate and competent Human Resources for Health to respond to health needs of refugee and host communities

*Action 1: Recruit,deploy and build capacityof health workersto respond to acute emergency phase, protracted phase, and referral services for refugees and host communities*

**Inputs:**

1. Stand-by Emergency health team
2. Recruitment of health workers to fill existing gaps in health facilities
3. Remuneration/exemplary performance incentives
4. Health worker training sessions
5. Professional development opportunities
6. Pre-retirement training for decent life
7. support to referral facilities to manage reception of referral cases

**Outputs:**Adequate numbers, well- motivated and competent health workers

**Indicators:**Attrition rate, staffing levels,

### *Action 2: Harmonize human resource remuneration packages in participating health facilities*

**Inputs:**

1. Salary survey
2. Harmonization sessions for HR experts
3. Guideline on health worker recruitment and remuneration criteria
4. Selection guidelines issued by Public Service Commission

**Outputs:** Harmonized human resource remuneration packages for health workers working in refugee settlements and refugee hosting communities.

**Indicators:** Salary parity

*Action 3: Review theHR structures for health facilities and HR managementparameters to adapt to UNIHRP needs for effective service delivery*

**Inputs:**

1. Sessions for Review and realign HR structures to correspond with the new levels of functionality.
2. Copies of the HR structure and management guidelines
3. HR needs at the DHOs and Directors to be considered due to the understaffing challenges
4. Provide standard staff houses and social amenities as defined by MOH infrastructure master plan; 2 bed roomed house for all HWs.
5. Pre-retirement training for a decent life after retirement from active service.

**Outputs:**The adapted HR structure, Remuneration scales/structure, Recruitment plan, performance management mechanisms/rewards for health workers working with refugees and host communities.

**Indicators:**Existence and utilization of the recruitment guidelines and plan

## **Pilar 3: Health Commodities and technologies**

### Issues:

Stock availability for essential Medicines and Health Supplies in most government health facilities stands at 70 to 75% in line with the current levels of financing. This availability drops drastically in facilities used by self-settled refugees, irrational and inappropriate prescription practices, un-gazettedhealth facilities that depend on redistribution of medicines from other health facilities in the district.

### Statement:

Adequate quantities and range of health supplies shall be mobilized for use in health facilities for refugees and host communities. The selection of the medicines and health supplies will be guided by the Uganda Essential Medicines List and used as guided by the Uganda Clinical and Treatment Guidelines. Importation of any medical commodities and technologies should conform to set national standards, guidance and legislation.

### Strategic Intervention:

**Select, quantify, procure, store and distribute adequate quantities of good quality health commodities and supplies for use in health facilities serving refugees and host communities.**

### *Action 1: Secure adequate quantities of health supplies in health facilities of hosting districts*

**Inputs:**

Training sessions for health providers in supply chain management

Development of procurement plans based on bottom-up approach

Procurement of medicines and health supplies

**Out Comes:** Adequate quantities of health supplies availed

**Indicators:** Availability of tracer medicines

### *Action 2: Strengthen the supply chain from national level to the beneficiary health facilities*

**Inputs**

Construct/renovate/equip stores for medicines and supplies to fill the gaps

Avail Cold chain equipment to ensure potency of medicines and vaccines

Distribution of essential medicines, supplies, assistive devices and vaccines

Good practices in storage, issuing and dispensing

**Outputs:** Supply chain strengthened, balanced stock information

**Indicators:**Temperature sensitive, Timely delivery of health supplies

*Action 3: Ensure rational use of medicines and health supplies* ***in all health facilities in the districts***

**Inputs**

1. Train health providers in rational use medicine
2. Avail Clinical Treatment Guidelines
3. Support supervision for compliance to guidelines

**Outputs:**improved treatment outcomes, increased availability of medicines

**Indicators:**Average number medicines and antibiotics prescribed per patient

*Action 4: Engage with the regulator on importation of essential medicines in emergency situations especially refugee situation*

**Inputs:**

Dissemination of national guidelines

Dialogue with the Regulator to harmonize emergency importation processes to include refugee situations

**Out comes:** Guidance note on management of medicines importation for refugees issued

**Indicators:**Number of health commodities imported under emergency conditions

## **Pillar 4: Health Management Information System:**

### Issues:

The Health Management Information System used by districts and the Health Information System used by refugee health services collect the same sets of data on disease conditions and services offered, but the latter is further disaggregated to reflect host and refugee numbers accessing services. The existence of two systems, inappropriate coding of some refugee health facilities and inadequate support for HMIS tools, equipment and utilities including Human resource negatively affects the performance of the information system; timeliness, completeness and accuracy of data for decision making. Besides the facility base information system, the community based information and surveillance systems are weak and the use of research for monitoring the implementation and documenting lessons learnt and sharing knowledge remains under developed.

### Statement:

The information for managing, monitoring and decision making during the implementation of this health response plan by all partners shall be collected, harmonized, reported and stored using the National Health Management Information System. The two systems shall be integrated and strengthened through synergy and efficient use of available resources while accommodating the peculiar data needs for programing for refugees and host communities.

### Strategic Intervention:

**Strengthen the Health Management Information System to collect timely, accurate and complete set of data to enable use in decision making and assessment of the health response.**

*Actions 1: Harmonisation of data collection & reporting tools,and health system capacity building to collect, collate, analyse and utilise data for decision making*

**Inputs:**

* Sessions for harmonising data sets for HMIS, IDSR,
* Registers, Reporting forms, and data bases for HMIS, IDSR
* Computers/Information technology and source of power for HMIS and IDSR
* Accrediting/coding facilities in refugee settlements
* Training Sessions for health workers on the HMIS and Use of data

*Action2:Build a framework for operational research to improve programing of the Comprehensive Refugees Response in the Health Sector.*

**Inputs:**

* Support and carry out research in collaboration with the academia and research institutions
* Document lessons, good practices and
* Publish and disseminate finding to inform implementation

**Outcomes:** Use of Harmonized HMIS reporting tools, improved data use in decision, improved accountability for health outcomes and resources

**Indicators**: Number of publications, decision informed by research findings

## **Pilar 5 : Financing**

* 1. **Explore innovate financing mechanism (PBF, Voucher system, contract service delivery etc)**
	2. **Advocate for additional resources for health sector response through the OPM and Ministry of Finance**
	3. **Expenditure framework**

**Expected Result 3: Strengthenedhealth systems governance, leadership and management at national and subnational levels for refugees and host Districts and communities**

## **Pilar 6: Leadership, Coordination and management and Governance**

### Issues:

The overarching coordination for refugee response is under the Office of the Prime Minister; however the health sector responsecoordination at national and district levels is weak and lacking in institutional structures, dedicated personnel, clear terms of reference, financial support, coordination of humanitarian work, actors, and partnerships. In consequence, some critical decision-making and health-sector planning happens outside the Ministry of Health and Local Government frameworks for health service delivery resulting in duplication of effort and resource wastage.

### Statements:

The Ministry of Health embarked on developing the health sector refugee response plan in compliance with the New York declaration on the Comprehensive Refugee Response Framework (CRRF) and other preceding international refugee conventions and national laws and legislation. Under the guidance of the Office of the Prime Minister, the Ministry of health shall provide leadership, governance, and ensure that the health sector response is integrated, strengthens and uses the existing national health system designfor responding to the health needs of the refugees and host communities in the spirit of sustainable development of the health system. The Ministry of Health will institutionalise the coordination of refugee health services at the national and subnational levels, with taking care of the roles of key internal and external stakeholders in the humanitarian space.

###

### Strategic interventions:

**Provision of oversight (foresight, insight and hindsight) for the health sector response for refugees and host communities.**

*Action1:Review and update national level policies, strategies and technical guidance, coordination structures at all levels, and partnership framework within government and non-state actors to accommodate the unique health needs of refugee and hosting districts*

**Inputs:**

1. Review panel and
2. Stakeholders engagement costs
3. Dissemination costs
4. Planning, Coordination and review costs

**Outputs:** Institutional structures for national and sub national coordination governance and accountability of refugee health response is produced and partnership frameworks with CSOs, private sector and multi-sectorial actors established

**Indicators**: Institutional coordination structures are developed, and supported to function (Annexed)

*Action 2: Set up oversight structure & program management unit at the MoH for strengthening planning, implementation, monitoring and evaluation of the health sector response*

**Inputs:**

* Refugee Health Response Steering Committee (chaired by Minister)
* Program Management Unit (headed by senior officer at Commissioner level and with at least 8 staff)

**Output:** Committees constituted, annual response plans made, reviews of the program done, resources and results accounted for.

**Indicators:** Resolutions of the steering committee, report of planning and review meetings

*Action 3: Set up oversight structure & program management unit at the DistrictHealth Office for strengthening planning, implementation, monitoring and evaluation of the health sector responseSet up oversight structure & program management unit at the MoH*

* District Refugee Oversight committee ( Meets Quarterly)
* Health sector refugee Focal Desk

**Output:**better coordination, planning and results of health sector response

**Indicators:** Number of coordination meetings and decisions influenced by the committees.

# Linkages to Existing Strategies, Policies, Regulations andLegislations

## Linkages to International Policies, Regulations andLegislations:

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The development of this strategy is consistent with International declarations, conventions and national laws and legislation namely; the New York Declaration 2015, The 2017 World Health Assembly (WHA) Resolution 70.15, Refugee and Host Community Empowerment Strategy (Re-HOPE), the Global Comprehensive Refugee Response Framework, The Refugee Act 2006, Refugee Regulations 2010 and Draft Refugee Policy, Settlement Transformation Agenda

***New York declaration 2015***

Based on humanitarian premise to save lives, protect rights and burden sharing, the New York declaration urges countries to move towards open door policy for admission, protection and assistance to refugees. The declaration commits countries to free access to social services by refugees including participation on economic endeavors.

***The 2017 World Health Assembly (WHA) resolution 70.15***

In May 2017, the member states of the World Health Organization resolved to develop, reinforce and maintain the necessary capacities to provide health leadership and to provide support to Member States and partners in promoting the health of refugees and migrants in close collaboration with the International Organization for Migration (IOM), and the United Nations High Commissioner for Refugees (UNHCR).

***The Comprehensive Refugee Response Framework (CRRF)***

This plan has been aligned into a national planning framework, National Development Plan II, under the Settlement Transformation Agenda (STA). It is based on the principle of ‘international cooperation and on burden and responsibility sharing’. The framework transfers the biggest burden for protection, assistance and support of refugees to host States and communities. It recommends a comprehensive refugee response with involvement of national and local authorities, international organizations, international financial institutions, regional organizations, regional coordination and partnership mechanisms, civil society partners, including faith-based organizations and academia, the private sector, media and the refugees. It is intended to enable smooth transit of refugees and host communities from admission to resettlement with due attention to the needs such as protection, health, and education and in close collaboration and assistance to national/local institutions and communities receiving refugees.

## Linkages to National Stratégies, Policies, Regulations andLegislations:

***The Refugee Act 2006, Refugee Regulations 2010 and Draft Refugee Policy***

This Act formally launched in 2009 provides an overarching instrument from providing protection and assistance to refugees in Uganda. The Act provides the ideal requirements with international standards for legal protection of refugees. The provisions in the instruments provide an enabling environment for integration of refugees within host communities with refugees having access to the same public services as nationals.

***Settlement Transformation Agenda***

In order to provide an enabling environment for operationalization of the Refugee Act 2006 and the Refugee Regulations 2010, the national planning framework NDP II, requires OPM to “develop and implement a Refugee Settlement Transformative Agenda,” and under the NDP II Section on Public Sector Management projects. The first project developed in 2015; “Settlement Transformation Project” a five-year Project is under implementation. This framework presents the indigenous response to the refugee crisis. It provides an entry point for the districts which are decentralized) to make provisions for the refugees.

***Refugee and Host Community Empowerment (ReHOPE)***

Refugee and Host Population Empowerment (ReHoPE) is a transformative strategy in support of the government Settlement Transformative Agenda. It aspires to coordinate a wide range of partners in a harmonized programming platform. The ReHOPE is a joint United Nations – World Bank strategy and provides a framework for integration of refugee host communities’ requirements.

# Roles and Responsibilities ofStakeholders

The implementation of the integrated refugee health response strategy will involve local communities, private sector, community based, faith based, cultural organizations and other non-state actors as key stakeholders with clear roles and responsibilities.

*Local Communities:* will benefit from improved services provided through the refugee health response. More importantly local communities besides providing land to the refugees will participate as community health service and service providers as resource person, and in the governance structures (management committees) of the health facilities to ensure adherence to known standards.

*Local Governments:*The primary role of local governments is health service delivery. It follows that Local governments will plan, guide implementation, supervise, monitor service delivery and account for results and resources to the central government and partners.

*Central Governments:* Under the overarching coordination of the Officer of the Prime Minister, the Ministries of Health will develop, manageand govern the implementation of the Integrated Refugees Health Response. The Ministry in conjunction with partners will support thedevelopment of policies, standards, guidelines, and technical support supervision, resources mobilizationincluding accreditation health facilities, regulation of professional practice in Uganda.

*Development Partners*: support government to achieve its role outlined above by providing, technical assistance, financial and material resources.

*Private Sector*: will to invest in any service in health care deemed necessary and affordable to meet the health needs of refugees and host communities. It will be expected to comply with the regulations laid for health service delivery.

*Non State Actors*: Community Based Organizations, Non-Governmental Organization, and Faith Based Organization, Cultural Organizations will help raise resources and civic awareness, keep in check actors, policy makers and regulators for effectiveness of health service delivery on quality, access, coverage and equity. Community health services can be provided by or contracted to this sub sector of stake holders.

# Implementation Framework and Strategies for Partnership forCompliance

## Coordination and Leadership Framework

Overall leadership for refugee response rests with the Office of the Prime Minister. The Minister of Health who is a member of the National Steering committee provides the guidance for health sector response through the Health sector Refuge response committee to be managed by a secretariat. The committee consists of The Secretariat, the Representative/s of DHO &RRH, Office of the Prime Minister, Ministry of Finance and Public Service, Urban and Prisons Authorities and Development Partners. They secretariat willas delegated for coordinate all stakeholders who form the committee and other Technical Working Groups as deemed necessary from time to time.

**Suggested organogram**



## Information, Education, Communication and Dissemination

Awareness creation and popularization of the policy will be jointly carried out by Ministries of Health and the office of the Prime Minister. This will be through dissemination workshops, media engagement targeting health professionals, government Ministries, Departments and Agencies, and the general public including the Civil Society.

## Implementation Stages

The implementation of this policy will go through extensive dissemination, development of standards and guidelines, multi-stakeholder strategic planning, resource mobilisation, institutional capacity building, implementation, continuous reviews and improvements.

## Implementation Drivers

Effective communication for change management, the buy in from government related Ministries, Departments Agencies and Local Governments, mutually beneficial Public-Private Partnerships, constructive engagement of civil society and the media, establishment of good governance structures and practice, shall be critical to successful. Capacity building and supervision of frontline workers to deliver integrated essential service package and health care managers will be central to success of this strategy.

## Funding

Government through the ministries and local governments will provide budget support for the development of infrastructure in health facilities, medicines and health supplies, human resources for health, information systems and technologies through budget support for providing health services to refugees and host communities. UNHCR together with its partners will provide resources to augment the government effort to provide services to the target population. Government, the United Nations, Bilateral and Multilateral organisations, development partners will constitute the main sources of funding for the implementation of this strategy.

## Monitoring and Evaluation

The objectives of this strategy will be implemented through a five annual work plans and monitored through the M&E framework of the strategy that is well aligned with the HMIS to ensure that the achieved intended benefits of the strategy are effectively monitored and measured.

A strategic information and technology enabled system (DHIS 2)that is already in use will be used to track health information on health outputs, and some outcome. Additional information especially some outcomes and impact level indicators shall be collected in collaboration with Universities and research institutions.

The implementation guidelines will be developed and provided from time to time to assure minimum quality standards, institutional capacities, and regulation and coordination parameters to be complied with. Through accreditation, supervision, inspection, periodic and annual report progress shall be assessed as evidence for instituting corrective actions.

## Feedback Mechanisms

Information generated from the information system will be shared with stakeholders through the established coordination platforms and governance bodies in the local governments.

## Policy Reviews

The implementation and progress of the strategy will be continuously monitored and lessons learnt used for improvement annually. The significant finding can be channelled appropriately to influence the refugee policy, law or modify application of existing regulation or legislation.

 The development of this strategy come midway of the National Development Plan II. The end of the NDP II will coincide with the mid-term review of this strategy. This coincidence will allow for its modification and alignment with the dictates of NDP III.

==========the End=========

1. ###### The service package for community health services shall be defined and standardized by MoH.

 [↑](#footnote-ref-2)
2. Frequently visited or following the recommendation of MoH or DHT [↑](#footnote-ref-3)