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LIST OF ACRONYMS

OPM: Office of the Prime Minister

CRR: Comprehensive Refugee Response

CRRF: Comprehensive Refugee Response Framework

MoH: Ministry of Health

HSIRRP: Health Sector Integrated Refugee Response Plan

HSR: Health Sector Response

HSRP: Health Sector Response Plan

IRRP: Integrated Refugee Response Plan

M&E: Monitoring and Evaluation

NHP: National Health Policy

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations Children's Fund

OAU: Organisation of African Unity

STA: Settlement Transformation Agenda

NDA: National Development Plan

ReHoPE: Refugee and Host Population Empowerment

HSDP: Health Sector Development Plan

MTCT: Mother-to-Child transmission

ART: Antiretroviral Therapy

GAM: Global Acute Malnutrition

SAM: Severe Acute Malnutrition

VHT: Village Health Team

HIS: Health Information System

HMIS: Health Management of Information System

IRHR: Integrated Refugee Health Response

HRP: Health Response Plan

RRP: Refugee Response Plan

MHCP: Minimum Health Care Package

NHMIS: National Health Management Information System

HR: Human Resource

DHO: District Health Office

IDS: Integrated Disease Surveillance

IDSR: Integrated Disease Surveillance and Response

WHA: World Health Assembly

RHRC: Refugee Health Response Steering Committee

REC: Refugee Eligibility Committee

RAB: Refugee Appeals Board

NGO: Non-Governmental Organisation

CBO: Community Based Organisation

GCRF: Global Comprehensive Refugee Response Framework

IOM: International Organisation for Migration

HSRRC: Health Sector Refugee Response Committee

IRHRS: Integrated Refugee Health Response Strategy

GoU: Government of Uganda

UBOS: National Bureau of Statistics

FOREWORD

The Government of Uganda is committed to the New York Declaration for Refugees and Migrants, adopted by the United Nations General Assembly in 2016, and the Global Compact on Refugees that urges society to stand in solidarity with refugees and share the responsibility and burden for hosting and supporting refugees. Translating these commitments into practice, Uganda is at the forefront of implementing the Comprehensive Refugee Response Framework (CRRF). As part of the CRRF, the Ministry of Health (MoH) developed the Health Sector Integrated Refugee Response Plan (HSIRRP) to ensure equitable and well-coordinated access to health services for refugees and host communities. The Plan is a critical milestone confirming Uganda's pioneering approach and lead role in shaping the way the international community is responding to large-scale movements of refugees and protracted situations.

Uganda is renowned for its progressive refugee policies that enable refugees to live in dignity, work and trade in the country, access land for farming, live freely together with host communities and equally access available social services including health services. At the same time, with over 1.1 million refugees on our territory, Uganda hosts the largest number of refugees in Africa and ranks among the top refugee hosting countries in the world. The presence of large numbers of refugees has placed overwhelming demands on already-stretched capacities and resources of the State and of host communities, including to cater for health needs of refugees and the Ugandans who are hosting them.

If funded, the Health Sector Response Plan (HSRP) will ensure equitable and well-coordinated access to health services for hundreds of thousands of refugees and host communities in Uganda.

The Health Sector Integrated Refugee Response Plan aligns the refugee health response to the National Health Policy and Health Sector Development Plan and is rooted in values and principles of integration, equity, universal coverage, government leadership, mutual respect and efficiency. It provides the overarching framework for engaging district local governments and implementing partners in developing district-specific Integrated Refugee Response Plans (IRRP). It gives credence to use of the established decentralised district health system and provides for a strengthened coordination mechanism at national, district and sub-district levels.

I am satisfied that the HSIRRP is comprehensive and costed, with an elaborate Monitoring and Evaluation (M&E) framework and focuses on strengthening the health system resilience by directing investments into system inputs, health infrastructure, human resources, medicines and supplies, health financing, health information, to foster integration and a lasting impact.

I look forward to an integrated and more efficient delivery of the Uganda Minimum Healthcare Package that provides: New Refugee Arrivals' Service Package; Emergency and Epidemic Preparedness & Response; Facility-based Health Services; Community Health Services; and Quality Assurance.

I call upon all humanitarian and development partners to mobilise additional resources, align their operations to the new paradigm and a common plan – the Health Sector Integrated Refugee Response

Plan. It is a call for complementary use of district health resources and health partner funding towards efficient service delivery and promotion of peaceful and harmonious coexistence of refugees and host communities.

A handwritten signature in blue ink, appearing to read 'Jane Ruth Aceng', with a stylized flourish at the end.

Dr Jane Ruth Aceng
Minister of Health

ACKNOWLEDGEMENTS

The development of the Health Sector Integrated Refugee Response Plan (HSIRRP) was Government-led and followed participatory consultative and transparent processes. It took time, effort and commitment of a strong multidisciplinary team that worked tirelessly from conceptualising the plan to the related literature searches, and continuous consultations with a wide range of stakeholders that helped give it shape to the HSIRRP. This plan operationalises the provisions for refugees in the Constitution of the Republic of Uganda 1995, the Refugee Act 2006 and the Refugee Regulations 2010. The plan is the first pragmatic step by the MoH in providing technical leadership in aligning the refugee health response to the National Health Policy (NHP) and the Health Sector Development Plan (HSDP) for the mutual benefit of refugees and host communities.

I take this rare opportunity to thank the members of staff, the Senior and Senior Top Management Teams of the MoH for time spent on developing this plan; the staff of the OPM for continuous guidance on CRRF principles; and the political leadership of refugee-hosting districts for welcoming and hosting refugees.

In a special way, I would like to thank the United Nations Agencies –the United Nations High Commissioner for Refugees (UNHCR), World Health Organisation (WHO) and the United Nations Children’s Fund (UNICEF), Foreign Missions and Development Partners for their technical and financial support that facilitated the consultations, drafting, costing and development of the M&E framework. Last, but not least, I would like to thank the CRRF Steering Group and the CRRF Secretariat, NGO implementing partners, all technical and administrative staff, and General and Regional Hospitals in refugee-hosting districts for their invaluable inputs during the consultative process.

I look forward to a successful implementation of the Health Sector Integrated Refugee Response Plan with the promise of developing a resilient and sustainable health system for responding to the current and future health needs of refugees and host communities.



Dr Diana Atwine
Permanent Secretary, Ministry of Health

EXECUTIVE SUMMARY

Uganda hosts approximately 1.1 million refugees making it Africa's largest refugee hosting country and one of the five largest refugee hosting countries in the world. Most recently, throughout 2016-2018, Uganda was impacted by three parallel emergencies from South Sudan, the Democratic Republic of the Congo (DRC), and Burundi. In view of the on-going conflicts and famine vulnerabilities in the Great Lakes Region, more refugee influxes and protracted refugee situations are anticipated in the foreseeable future.

The unprecedented mass influx of refugees into Uganda in 2016-2018 has put enormous pressure on the country's basic service provision, in particular health and education services. Refugees share all social services with the local host communities. The refugee hosting districts are among the least developed districts in the country, and thus the additional refugee population is putting a high strain on already limited resources.

The Government of Uganda serves as a model example in affording refugees in Uganda asylum and access to the same rights as its citizens, including the right to health. In line with the Comprehensive Refugee Response Framework (CRRF), embraced by the Government of Uganda in 2017, there is need for coordinated health service delivery. This entails a paradigm shift from a mainly humanitarian focus to developing integrated services for the long term.

As part of the overall health sector planning framework in Uganda, the Health Sector Development Plan (HSDP) 2015/16 - 2019/20 provides the strategic focus of the sector in the medium term, highlighting how it will contribute, within the constitutional and legal framework, to the second National Development Plan (NDP II), and to the second National Health Policy (NHP II) imperatives of the country, and so to the overall Vision 2040. The HSDP is the second in a series of six 5-year Plans aimed at achieving Uganda Vision 2040 of a healthy and productive population that contributes to socioeconomic growth and national development.

The Health Sector Integrated Refugee Response Plan in Uganda is presented against this background and operates as an addendum to the Health Sector Development Plan (2015-2020), supplementing service delivery in the refugee hosting communities, to meet the needs of everyone in the targeted areas, including refugees. The interventions under the HSIRRP for refugee and host community are premised on a number of international, regional and national commitments and a number of policies, plans and frameworks by the government.

Namely, the Comprehensive Refugee Response Framework (CRRF) for Uganda was launched at a high-level meeting in Kampala in March 2017, with a view to harness a whole-of-society approach in responding and finding solutions to refugee crises in Uganda, building on existing initiatives and policies. The CRRF is part of a rich policy environment including the Refugee Act 2006 and the Refugee Regulations 2010, which states that refugees have access to the same public services as nationals, including health services. Further, Uganda's Second National Development Plan (NDP

II) aims to assist refugees and host communities by promoting socioeconomic development in refugee-hosting areas through the Settlement Transformation Agenda (STA).

The HSIRRP is expected to contribute to the national objective of improving the health status of host communities and refugees through building a resilient health system that can withstand shocks and guarantee sustainable and equitable access to essential health services. In addition, this would contribute to harmonious coexistence of the two communities through better coordination of partners, resource mobilization and integrated health service programming and provision. The strategic interventions under the HSIRRP are categorized into six pillars, namely:

- (i) Service Delivery,
- (ii) Human Resources for Health,
- (iii) Medicines (Health Commodities and Technologies),
- (iv) Health Management Information System,
- (v) Health Financing, and
- (vi) Leadership, Coordination, Management and Governance.

Under each pillar, the issue, policy statement, strategic interventions and actions are described; including inputs, outcomes and indicators all of which are aligned to the Health Sector Development Plan and Uganda's National Health Policy and their combined Monitoring and Evaluation frameworks.

This Plan also aims to bridge humanitarian and development programming and to advocate for predictable and sustainable financing for this emergency and protracted crisis. Under the coordination of the Ministry of Health, this Plan recognizes the comparative advantages of both humanitarian and development actors. It reinforces an interdependent approach over a five-year period that addresses both an immediate humanitarian crisis-response, as well as medium-and long-term investments towards consolidation and development.

Comprehensive implementation of the HSRRP will cost an average of 100 million US Dollars annually with expected contributions from government of Uganda through budget support for Refugee hosting districts and dedicated humanitarian funding from donors, and other partners.

The HSRRP has an M&E framework that is aligned to the HSDP M&E framework for monitoring implementation and attainment of set goals and targets. It will be reviewed and aligned with the NDP III that is currently under development

1 INTRODUCTION

Uganda has had an open-door policy for refugees and asylum seekers over the last eight decades. Since the 1940s, refugees and asylum seekers from Poland, Democratic Republic of Congo, Somalia, Burundi, Rwanda, Kenya, South Sudan, Ethiopia and Eritrea have been hosted in the country at different points in time. Currently, Uganda hosts approximately 1.1 million refugees making it Africa's largest refugee hosting country and one of the five largest refugee hosting countries in the world. Most recently, throughout 2016-2018, Uganda was impacted by three parallel emergencies from South Sudan, the Democratic Republic of the Congo (DRC), and Burundi. In view of the on-going conflicts and famine vulnerabilities in the Great Lakes Region, more refugee influxes and protracted refugee situations are anticipated in the foreseeable future.

The settlement of refugees among host communities exacerbates the pressure on social services and amenities for local communities - a situation that exposes the two communities to competition. In the context of limited health resources for host communities, a parallel health system for refugees is unsustainable and promotes inequitable access to health. In addition, the sheer scale of the South Sudanese and Congolese refugee crises puts the national and district health systems, host communities, and refugee response-implementing partners under tremendous stress.

It is imperative that an integrated health response to cater for the health needs of the refugees and host communities is developed. Refugees living in the settlements benefit from the humanitarian response coordinated by the OPM and the UNHCR, in collaboration with UN agencies and partners. This will enable districts contribute towards equitable access to quality health services and harmonious coexistence of refugees and host communities; in the context of the Uganda Refugee Regulations 2010.

As part of the overall health sector planning framework in Uganda, the Health Sector Development Plan (HSDP) 2015/16 - 2019/20 elaborates the sector contribution to the second National Health Policy (NHP II) and second National Development Plan (NDP II), and so to the overall Vision 2040. The HSIRRP (2019-2024) in Uganda is presented as an addendum to the Health Sector Development Plan (2015-2020), for supplementing service delivery in the refugee hosting communities. It will be reviewed and aligned to the dictates of NDP III

The process of developing the response plan was participatory; involving the key stakeholders namely: the MoH; Regional Referral Hospitals; Local Governments; the United Nations Agencies; Foreign Missions; Donors, Development and Implementing Partners; the CRRF Secretariat within the Office of the Prime Minister and members of the CRRF Steering Group.

The initial draft plan developed with guidance of WHO discussed in a multi-stakeholders meeting was held in Hoima, with financial support from UNHCR, WHO and UNICEF, to collect additional

counties, for example in a district like Yumbe, refugees constitute more than half of the total population. The settlement approach allows refugees the possibility to live with greater dignity, independence and normality within the hosting communities. The refugee-hosting village clusters are administered by the Government, which registers and provides documentation to the population, allocates land for shelter and subsistence farming/agriculture, and ensures area security.

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 in this regard) is a 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. The settlement approach, combined with the relevant laws and freedoms, provides 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 refugees and host communities to become integrated with the humanitarian response.

The Uganda Refugee Model is progressive and generous with many impressive aspects, including opening Ugandan territory to refugees irrespective of nationality or ethnic affiliation. It grants 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.

In order to close this gap, Uganda established the Settlement Transformation Agenda (STA), a holistic integrated district-level refugee management approach. With the STA, refugees were integrated into Uganda's 2nd National Development Plan (NDP II 2015-2020) by annex, thereby making refugees part of the development agenda of Uganda and taking into account the protracted nature of displacement and the impact on host communities.

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 lead to undermining prospects for meaningful economic and social development.

The unprecedented mass influx of refugees into Uganda in 2016-2018 has put enormous pressure on the country's basic service provision, in particular health services. Refugees share all social services with the local host communities. The refugee hosting districts are among the least developed districts in the country, and thus the additional refugee population is putting a high strain on already limited resources. Uganda was the first country to launch the Comprehensive Refugee Response Framework (CRRF) as early as March 2017 to sustain its model approach to refugee management (open borders, no camps) in the face of significant influx. The CRRF is part of a rich policy environment including the Refugee Act 2006 and the Refugee Regulations 2010, which states that refugees have access to

the same public services as nationals, including health services, by engaging a comprehensive approach, harnessed a whole-of-society approach in responding and finding solutions to refugee crises in Uganda, building on existing initiatives and policies.

1.2 Situation analysis

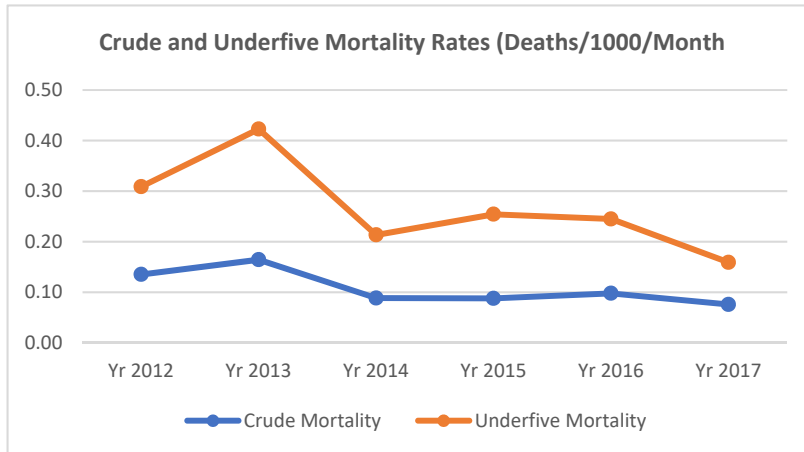
Population – refugees and hosts

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 the 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's population growth rate is one of the highest in the world (Source; Uganda Bureau of Statistics). Specific references to the population numbers within districts will be further articulated in the district development plans which account annually for the estimated population growth rates. This plan takes into account the latest official figures for the refugee populations.¹

Health status of the population

The health status of Ugandan nationals in refugee hosting areas are articulated regularly every 5 years in Health and Demographic House Hold Surveys to track the impact created by District Development Plans and the Health Sector Development Plan. The health status of refugees in all the settlements are monitored annually and have been stable within acceptable ranges as indicated by the crude and under-five mortality rates. 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 people in a month and the under-five mortality rate stood at 0.2 against a standard of 1.5. Maternal mortality ratio was 95 deaths per 100,000 live births per year against a standard of zero deaths.

¹Until 2015, Uganda had an estimated 500,000 refugee population; however, this number drastically increased to 1,154,352 people by November 2018 with the influx of South Sudanese and Congolese refugees. Presently, refugee-hosting districts include Arua, Koboko, Yumbe, Moyo, Adjumani, Lamwo, Kiryandongo, Hoima, Kyegegwa, Kamwenge, Isingiro and Kampala. Districts of Kaabong, Zombo and Kisoro also host a large number of refugees who settle and live with the host communities without being officially recognised or supported.



The crude and child mortality trends suggest more significant improvements. Whereas the mortality rates have improved over the years, rates stagnated between 2014 and 2016. The leading causes 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 scares, measles, polio, neglected tropical diseases, guinea worm; some of which had already been eliminated by the Government of Uganda.

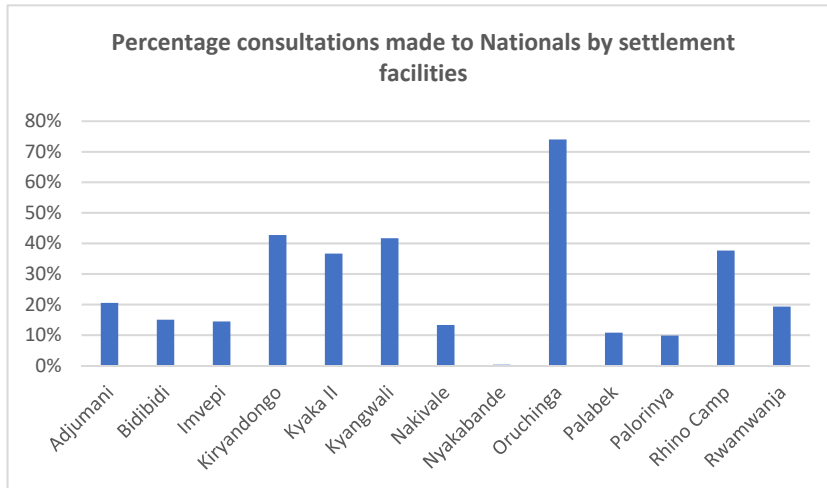
Refugee health service delivery

The HSDP defines a responsive health service package that is aligned to the health care needs of the country, consisting of cost-effective healthcare interventions and services that are acceptable and affordable. The service package consists of four clusters as follows:

- Health promotion, disease prevention and community health initiatives, including epidemic and disaster preparedness and response;
- Sexual, reproductive, maternal, neonatal, child and adolescent health;
- Prevention, management and control of communicable diseases; and
- Prevention, management and control of non-communicable diseases.

Greater attention is paid to ensure equitable access to and coverage of the package including affirmative action for under-served areas, vulnerable populations and continuum of care. While in line with the National Health Policy and Health Sector Development Plan (HSDP), guidelines, strategies and standard operating procedures, health service provision to refugees in Uganda have not been mainstreamed into the national service delivery systems.

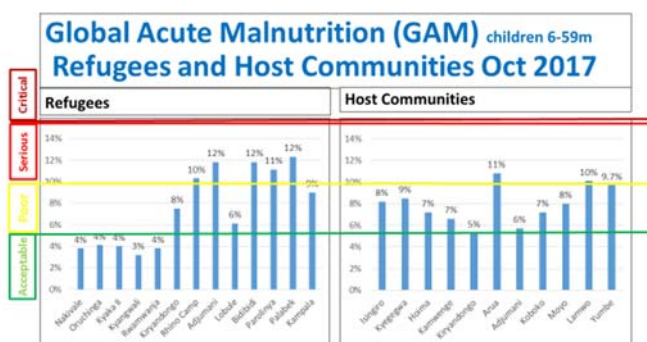
In 2017, refugees accessed 97 health facilities across 12 refugee-hosting districts and 2 refugee entry districts that provided a total of 2,129,027 medical consultations, of which 22% were to the host population.



The highest consultations involving members of the host population were registered in Oruchinga at 74% and the lowest in Palorinya at 10%. A third (36) of the health facilities are temporary because they opened to support health services for new arrivals, while 72% of the permanent health facilities are not coded by the MoH.

There were 19,704 live births and approximately 94% of all deliveries were at the health facilities. A total of 19 investigated and documented maternal deaths were recorded across all refugee settlements.

The coverage for prevention of mother-to-child transmission of HIV (PMTCT) in 2017 was 100% and 93% of all new-born 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 whom 33% (3,967) were refugees.

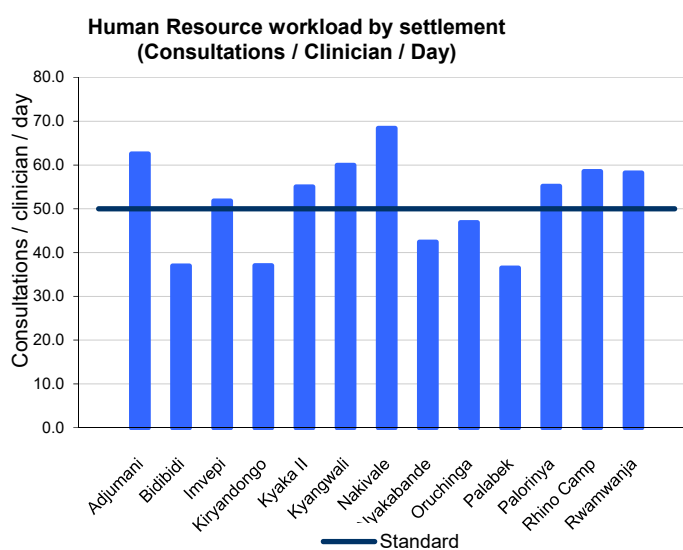
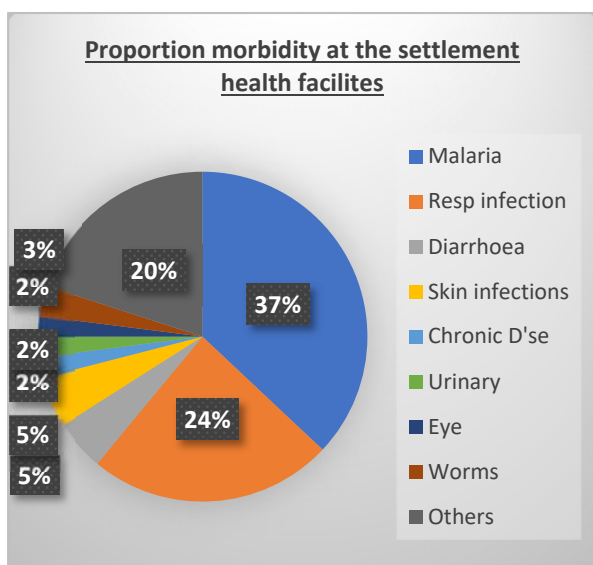


According to the Food Security and Nutrition Survey Report, the global acute malnutrition (GAM) increased from 7.2% in 2016 to 9.5% in 2017; the settlements with high GAM rates including Arua (10%), Adjumani (12%), Bidibidi (12%), Palorinya (11%) and Palabek (12%) (classified as serious) and 12.5% of children (6-59 months) had diarrhoea in the last 2 weeks of the survey. Stunting has

reduced from 19.1% in 2016 to 16.4% in 2017 (classified as acceptable); except for Kyangwali, which has high stunting (33%) classified as serious. Consumption of iron-rich or iron-fortified foods was found high in almost all settlements; e.g. 92% in Adjumani and 97.3% in Nakivale. The prevalence of anaemia among children (6-59 months) was above 40%, which was classified as high in all settlements (except Nakivale and Oruchinga at medium levels at 36.8% and 33.6% respectively). Severe anaemia was reported at 1.5-4.3%. Anaemia >40% is classified as high according to the WHO classification. The prevalence of anaemia among non-pregnant women was highest in Palabek (47.3%), followed by Kyaka II (38.8%), Adjumani (34.4%) and Palorinya (33.8%), classified as high and medium public health significance respectively. The underlying causes of malnutrition associated with nutrition behaviours such as exclusively breastfeeding had continued to improve, ranging from 55.6% in Kyangwali to 89.2% in Adjumani. Timely initiation of breastfeeding for children aged 6-23 months ranged from 66.4% in Palabek to 92.9% in Rwamwanja. Introduction of solid, semi-solid or soft foods for 6-8 months old children was higher in Oruchinga

(71.4%) and Kampala (69%), whereas in most settlements it was below 50%. The rate of bottle feeding was reported high in Kampala (36.7%), Oruchinga(34.3%), Nakivale(29.6%), Kiryandongo(28.4%), Palorinya(25.9%), Lobule (22.1%), Rwamwanja(23.6%) and Palabek(16.5%).

Immunisation 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 diarrhoea (5%), respiratory tract infections (24%), skin infections (5%), and intestinal worms (3%).



Human resources for health

Within refugee hosting districts, there are an additional 2,326 health workers (technical staff) and 40 medical doctors that complement the district health care system, recruited jointly by the District Health Offices and health partners. The 2,326 health workers include clinical officers, midwives, nurses, counsellors, laboratory technologists and technicians. Challenges of attracting and retaining an experienced health workforce remain, because of non-competitive pay, remoteness of the operations and lack of accommodation that has resulted in the high workload in some locations with a consultation per clinician rate of above 50 consultations per health worker per day. Despite these challenges, additional human resources reduced the workload on the health workers in the districts and improved the quality of services in West Nile, Mid-West and South West regions of Uganda.

Infrastructure

Refugees access services at 97 health facilities. A third (36) of the health facilities in the settlements are temporary. They were established to support new arrivals. At the same time, only 72% of the permanent health facilities are coded by the MoH. Of these health facilities, the 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 the MoH.

Referral health care

There are currently 53 ambulances (1 ambulance per 26,000 people) within the 12 refugee-hosting districts, in addition to 10 Health Centre IVs and different kinds of support to district referral hospitals. With support from Regional/National Referral Hospitals to the settlements, specialized outreach services are being carried out by specialist medical associations and medical schools. This has increased access to specialized services that routinely would only be available at the regional referrals.

Community health

Village Health Teams (VHTs) have been established in refugee settlements in line with the MoH's strategy. VHTs are responsible for health promotion, health education, identification and referral of sick/malnourished individuals and follow-up in the community, including linking the sick/malnourished community members to ambulatory services. At the end of 2017, there were 1,980 community health workers against a target of 2,600 due to challenges related to inadequate remuneration leading to high turnover.

Health Management Information System (HMIS)

All the 97 refugee settlement health facilities report to the MoH through the Health Management Information System (HMIS). While those that are coded by the MoH report directly through the districts, the newly established temporary health facilities report through the neighbouring coded government facilities. This is the case for both, monthly reporting and weekly surveillance reports. Delays to code or upgrade health facilities and disaggregate the HMIS tools make the refugee data inaccessible to the MoH.

Coordination and leadership

Refugees living in the settlements benefit from the humanitarian response coordinated by the OPM and the UNHCR, in collaboration with UN agencies and partners. Refugee health service providers through UNHCR are part of the compact between MoH and development partners for implementation of the HSDP 2015/16-2019/20 that is intended to mobilize development partners to support and work in line with HSDP. This policy intention has been achieved to varying degrees. The MoH chairs the refugee health sector coordination structure at the national and district levels. The Nutrition in Emergencies and Integrated Management of Acute Malnutrition (IMAM) thematic working group coordination structure, chaired by MoH, feeds into the health sector coordination. These coordination roles, however, are not institutionalized at central and district levels, although some districts have taken up leadership roles in the refugee health response.

Furthering CRRF implementation and in line with the NDP II, the public health sector contributes to

the integration of social services. In this regard, the integration of public health is defined and pursued in four prongs which include: accreditation and alignment of health facilities and refugee health workers so that they are recognised by MoH; building the capacity of the district health care systems to cope with increased numbers of refugees; strengthening strategic coordination and leadership with MoH at central and district levels, including outbreak response.

1.3 Problem statement

Provision of health services to refugees continues to be planned, resourced and provided separately from that for host communities. Parallel provision of services for co-located communities with the same disease pattern is reinforcing inequitable access to health care services between refugees and host communities, undermining efficient use of scarce health resources as well as the national effort for developing a resilient and sustainable health system.

The parallel systems thrive on inadequate involvement of the MoH and District Local Governments in the governance and management of refugee health response, manifesting itself in poor integration of services and coordination of the required partnerships at all levels of the health system.

Consequently, urban refugees, self-settled refugees, refugees in prisons and host communities who live far from refugee settlements are competing for services from government health facilities. This has led to an increased patient load on health workers, frequent shortage of medicines and the associated out-of-pocket payments for medicines during stock-out periods for refugees and host communities alike. Host communities often perceive the refugee health response as preferential and unfair, a perception that has the potential to degenerate into conflict between the two communities if left unresolved.

Additionally, whereas the needs of the refugees in settlements and the immediate host communities are met to a large extent through the parallel system, the health needs of refugees in urban areas, prisons and self-settled refugees among the host communities are borne by the national health system. The resultant resource shortfalls in health service provision are met out of the pocket by the two communities.

1.4 Vision, goal and objectives

Vision: To have a healthy and productive refugee and host community population that contributes to economic growth, national development and harmonious co-existence.

Goal: A coordinated, integrated and district-led provision of health services for refugees and host communities is attained.

Objectives:

1. To increase equitable access to and utilisation of quality health services for refugees and host communities;

2. To mobilise and manage health resources towards building a resilient health system to cope with the increased demand on health services;
3. To strengthen governance, coordination, leadership and management of the Integrated Refugee Health Response (IRHR).

1.5 Guiding principles

- (a) Equity: Equitable access to health services by both refugees and host communities
- (b) Integration: Integrated service provision, programming and health systems
- (c) Universal Coverage: Services provided by need, leaving no one behind for any reason
- (d) Government leadership and governance: Use of decentralised systems for service delivery
- (e) Respect: Respect for national priorities and specific refugee health needs
- (f) Efficiency: Adherence to aid effectiveness principles

1.6 Justification/rationale

Under international law, everyone has the right to the highest standards of physical and mental health (Article 12, International Covenant on Economic Social and Cultural Rights, 1966); this includes a right to be free from hunger and mal-nutrition and to adequate food, nutrition and clean, safe drinking water including in emergency situations. Refugees should enjoy access to public health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). Inequitable access to health promotion, disease prevention, treatment or rehabilitative health services especially where the patterns of disease are similar based on socio-economic status (refugee or host community) and location (urban or rural) undercuts the goal of access to quality health care services as a human right of both populations.

In some locations, health services for refugees may be better resourced than those for host communities. This leads to a destabilising effect on the local health system due to ensuing staff movements and entrenched inequities in accessing care, thus creating fertile ground for conflicts among the two communities.

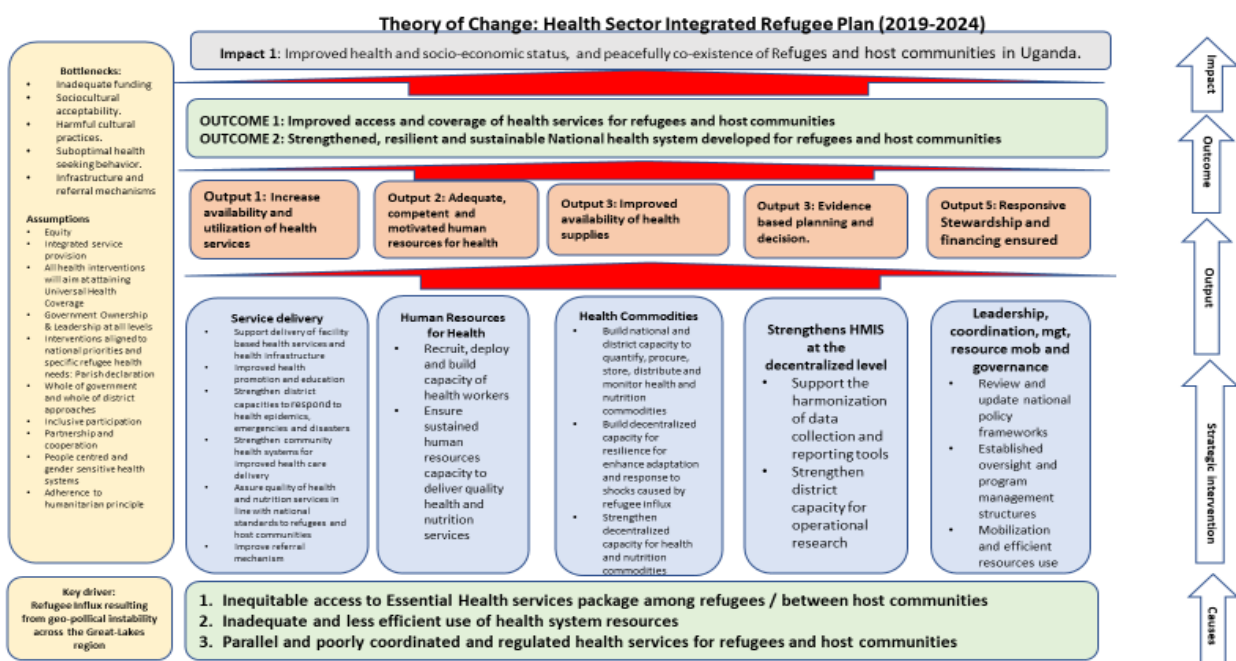
Consolidation and integrating the health response for refugees and host communities in districts will ensure equitable access to quality health services, improved health status and harmonious coexistence, mobilisation of additional health resources to augment resources provided by government to support and build a resilient health system in the face of increased workload and future influx. This plan is modelled along the national health priorities, principles of strengthening health systems, integrated service provision and aid effectiveness. This is to leverage the in-country health resources for the mutual benefit of refugees and host communities through strengthening the existing coordination and management structures, in view of efficient use of resources and sustainable development of the national health system.

1.7 Theory of change

The theory of change provides the results framework for the implementation of the HSIRRP. It outlines the fundamental challenges and inequities in health service provision, health system resource allocation, and coordination. Six strategic pillars for responding to the challenges are proposed with the anticipated results at output, outcome and impact levels. Guiding principles for managing the health system environment are also stated.

The theory of change provides a quick overview of the Health Sector Integrated Refugee Response Plan and expected results as outlined in figure 1.

Figure 1: The Theory of Change



2 THE STRATEGIC INTERVENTIONS - PILLARS

The strategic interventions under the HSIRRP are categorized into six pillars, namely: (i) Service Delivery, (ii) Human Resources for Health, (iii) Medicines (Health Commodities and Technologies), (iv) Health Management Information System, (v) Health Financing, and (vi) Leadership, Coordination, Management and Governance. Under each pillar, the issue, policy statement, strategic interventions and actions are described; including inputs, outcomes and indicators all of which are aligned to the Health Sector Development Plan and Uganda's National Health Policy and their combined Monitoring and Evaluation frameworks.

2.1 Pillar 1: Service delivery

Issue

Consolidation of health service delivery in refugee hosting areas is the strongest measure to ensure equitable access to essential health services between refugees and host communities to avoid the risk of creating social-economic tensions or conflict between the two communities. Utilisation of health services provided in government health facilities to self-settled refugees, urban refugees, prisoners and host communities exerts pressure on health resources that results into frequent stock-outs, increased workload and catastrophic out-of-pocket spending for both communities. For example, refugees contribute up to 30-40% to health services work load in Arua Regional Referral Hospital, which is not supported by the refugee health programme. Whereas host communities living in the vicinity of refugee settlements have free access to health services in refugee settlements, communities which live far from settlements have limited access to refugee health response services. The definition of what is considered as 'host community' remains vague, often not corresponding with clear administrative units, making it difficult to plan for 30% of refugee health services to benefit local communities. Refugee influxes come with increased water and sanitation challenges, risk of disease outbreaks and importation of otherwise eliminated diseases into the country. Such a threat puts the lives of refugees and host communities at risk and the capacity of the district health system may not be adequate to respond to outbreaks.

Statement

Health and well-being of men and women, children and adolescents including persons of specific needs shall be in line with the Minimum Health Care Package. Together with partners, health facilities and community health systems will be strengthened to increase coverage of quality services by recruiting, training and paying honoraria for community health extension workers in refugee-hosting districts. The MoH will, in addition to the minimum healthcare package, prioritise *New Refugee Arrivals' Health Services* for all refugees, as well as surveillance and response to epidemics, disasters and other medical emergencies to respond to refugee-specific vulnerabilities. The table below provides the details of services included in the Minimum Health Care Package and the modes of service delivery.

Table 1: The Uganda National Minimum Health Care Package

The MoH will ensure integrated and equitable access to Health Promotion, Disease Prevention, Treatment and Care, and Rehabilitation services for Protection and improvement of The Minimum Health Care Package		
Clusters	Content	Service channel
Health Promotion and Disease Prevention	Life style education including physical exercise, WASH, housing, solid waste management, prevention of SGBV, management of cultural practises that promote and harm health, disease prevention and response activities, vaccination, sexual, reproductive, maternal, neonatal child and adolescent health, nutrition, screening, treatment and referral of common ailments	Community Health services & School health program; <ul style="list-style-type: none"> • Health Education • Health Inspection • Physical Exercise • Community mobilisation • Mass Drugs Administration for NTDs • Referral services • Community and facility-based surveillance • Integrated Community Case Management
SRMNCAH	<p>Maternal Health: Family Planning, Focused Antenatal Care (IPT, TT, PMTCT), Basic Obstetric Care, Comprehensive management of Obstetric Emergencies, Post Natal care, Breast feeding & Supplementary feeding, STDs/STI management, Sexual & Gender Based Violence</p> <p>Child Health: Breast feeding, supplementary feeding, growth monitoring, Immunisation, management of common childhood illnesses</p>	<ul style="list-style-type: none"> • Facility based maternity care and services • Integrated Management of Childhood Illnesses • Outreach services provided by facility-based staff and Community Health Workers. • Facility based case management of malnutrition • Referral/ Follow ups
Prevention & Control of Communicable diseases	<p>Common diseases: Malaria, HIV, TB, Hepatitis,</p> <p>Diseases of epidemic potential: Cholera, VHF, Meningitis, ...</p> <p>Diseases Targeted for Elimination: Neglected Tropical Diseases, Polio</p>	<ul style="list-style-type: none"> • Preventive measures at home and community. • Care and treatment in health facilities • Mass drug administration in communities
Prevention and Control of Non-Communicable Diseases	Cardio vascular diseases, Diabetes, Chronic Respiratory Diseases, Cancers, Injuries, disabilities, Oral Diseases, Genetic Disorders, Mental Health Conditions,	<ul style="list-style-type: none"> • Physical exercise, • prevention of substance abuse • Facility based care and treatment

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

This should be done during the acute phase of a refugee influx. This service package includes:

Screening for malnutrition and epidemic-prone diseases, vaccination (measles and polio), micronutrients supplementation, high-energy biscuits, psychological first aid, and treatment for the sick and the injured including continuation of chronic care treatment, e.g. TB, HIV and NCD.

Inputs

- i. Human resource
- ii. Transport and logistics
- iii. Training/skills and knowledge
- iv. Medical supplies and vaccines

Outcomes

New refugee arrivals are screened and treated for malnutrition, epidemic-prone diseases, provided immunisation, emergency health services for the sick and injured, referred for continuation of chronic care, etc., during the acute phase of the refugee influx.

Indicators

Percentage of new arrivals screened for malnutrition, epidemic-prone diseases, provided immunisation, micronutrients (Vitamin A and Iron Folic Acid) supplements, nutrition behaviours counselling, the number of sick and injured children and pregnant women as well as the number of emergency preparedness teams trained.

Action 2: Integrated disease surveillance and response to possible epidemics, emergencies and disasters in the refugee and host community

Inputs

- i. Human resource
- ii. Transport and logistics
- iii. Medical supplies and vaccines

Outputs

Prompt detection and response to disease with outbreak potential and low case fatality rate.

Indicators

Detection within 48 hours, fatality rate kept within acceptable levels as per guidelines.

Action 3: Improve delivery of facility-based health services and health infrastructure for providing treatment, care, rehabilitation and referral services to refugees and host communities

Inputs

- i. Targeted refugees' and host communities' populations in a district
- ii. Construct health facilities (health centres, mortuary, accommodation)
- iii. Rehabilitation and partitioning works
- iv. Consolidate the referral system HCIII to hospitals to respond to the referral needs of equipment and furniture

- v. Water
- vi. Electricity
- vii. Referral and ambulance services
- viii. Support to diagnostic laboratories and imaging
- ix. Support to secondary and tertiary facilities
- x. Support to blood transfusion services
- xi. Support to regional workshops
- xii. Construct staff houses (with adequate floor space) according to MoH-defined standards appropriate for each level
- xiii. Construct fencing for all facilities
- xiv. Construct adequate WASH/solid waste management facilities
- xv. Survey and title the land for all facilities
- xvi. Make master plans for each health facility
- xvii. Operations and maintenance

Outputs

Facilities are constructed, rehabilitated, equipped, furnished.

Indicators

Number of health facilities constructed; rehabilitated, furnished and supported; number of new staffs 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 systems for the delivery of health-promotion, disease-prevention, care, referral and treatment of selected common health conditions for refugee and host communities²

Inputs

- i. Trained community health workers
- ii. Harmonised incentives for community health workers
- iii. Tools and equipment for community health workers
- iv. Medicines and health supplies for community health services
- v. Registers and reporting forms for HMIS and community-based disease surveillance

Outputs

Community outreaches carried out; children treated; children referred; children vaccinated; children supplemented; linkages between the community and health facility strengthened

Indicators

Number of community outreach activities; number of children treated; number of children referred versus those received at the HF; number of children vaccinated; number of children supplemented

²The service package for community health services shall be defined and standardised by MoH.

with micronutrients.

Action 5: Support government health facilities in urban areas and prisons to provide health services to urban refugees, self-settled refugees and host communities

Inputs

- i. Supplementary medicines and supplies to gazetted³ health facilities in urban areas/prisons
- ii. Additional critical staff, infrastructure, equipment
- iii. Health access and utilisation surveys to monitor impact of interventions

Outputs

Improved awareness for refugees about service availability; improved access to health services; and improved vaccination coverage.

Indicators

Availability of medicine; health access awareness; utilisation rate of health services, and number of people vaccinated.

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

Inputs

- i. Uganda clinical guidelines and other programmatic protocols
- ii. Continuous quality improvement initiatives
- iii. Trained frontline health workers on integrated delivery of the Essential Health Care Package
- iv. Integrated and technical support supervision and mentorship
- v. Regular reviews and update of the health response plan

Outputs

Health workers given clinical treatment guidelines and trained on the provision of integrated essential service package; technical support supervision provided to health facilities; quality of care at all facilities improved.

Indicators

Eighty percent of health workers trained and given clinical treatment guidelines; monthly support supervision provided to health facilities; QI framework and guidelines disseminated; experience sharing session held per year.

2.2 Pillar 2: Human resource for health

Issues

Inadequate staffing and skills mix are limiting the ability of health facilities to provide integrated

³Frequently visited or following the recommendation of MoH or DHT

Minimum Health Care Package (MHCP), and to assure quality and continuity of health service delivery. Poor remuneration and large salary disparity between government health workers and NGO health workers in the same district health system results into low attraction and retention of critical cadres needed for the delivery of essential services in public facilities. The dual health systems for refugees and government presents a challenge to refugee-hosting districts to attract, retain and develop critical cadres, thus causing disruption to the local health system. For instance, the average staffing level in public facilities in Uganda is about 75% with remuneration levels below 40% compared to their counterparts working with NGOs in the health sector. The national health system is over-compensated, and the health facilities are unable to withstand shocks such as increased patient load due to the refugee influx. Conversely, in refugee settlements, lower-level health facilities adapt to increased volumes of work by recruiting highly qualified cadres who start delivering services outside the established level of the health facilities - e.g. HC III conducting caesarean sections.

Statement

The MoH has standard staffing norms for all levels of health facilities in Uganda. Staffing in all health facilities in refugee settlements and host districts will be guided by or harmonised with the staffing norms provided by the Government. Due process under the leadership of the MoH 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. Fair recruitment, deployment, management, remuneration and capacity building will be ensured to enhance staff performance of duties.

Strategic intervention

Mobilise adequate and competent human resources for health to respond to the health needs of refugees and host communities.

Action 1: Recruit, deploy and build the capacity of health workers to respond to acute emergency phase, protracted phase and referral services for refugees and host communities

Inputs

- i. District level and district-owned stand-by emergency health team
- ii. Recruitment of health workers to fill existing gaps in health facilities
- iii. Remuneration/exemplary performance incentives
- iv. Health worker training sessions
- v. Professional development opportunities
- vi. Pre-retirement training for decent life
- vii. 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: Harmonise human resource remuneration packages in participating health facilities

Inputs

- i. Salary survey
- ii. Harmonisation sessions for Human Resource (HR) experts
- iii. Guidelines on health worker recruitment and remuneration criteria
- iv. Selection guidelines issued by Public Service Commission

Outputs

Harmonised human resource remuneration packages for health workers working in refugee settlements and refugee-hosting communities.

Indicators

Salary parity.

Action 3: Review the HR structures for health facilities and HR management parameters to adapt to UNIHRP needs for effective service delivery

Inputs

- i. Sessions for review and realignment of HR structures to correspond with the new levels of functionality
- ii. Copies of the HR structure and management guidelines
- iii. HR needs at the District Health Office (DHO)s and directors to be considered due to the understaffing challenges
- iv. Provide standard staff houses and social amenities as defined by the MoH infrastructure master plan -two-bedroom house for all health workers
- v. 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 utilisation of the recruitment guidelines and plan.

2.3 Pillar 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-gazetted health facilities that depend on redistribution of medicines from other health facilities in the district.

Statement

Adequate quantities and range of health supplies shall be mobilised 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. The quantification of needs, procurement, storage and distribution of the health commodities will be implemented through established government systems and agencies. Importation of any medical commodities and technologies shall 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

- i. Training sessions for health providers in supply chain management
- ii. Development of procurement plans based on a bottom-up approach
- iii. Procurement of medicines and health supplies (ready to use foods, therapeutic milks, ReSoMal, vitamins, minerals, equipment)

Outputs

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

- i. Construct/renovate/equip stores for medicines and supplies to fill the gaps
- ii. Avail cold chain equipment to ensure potency of medicines and vaccines
- iii. Distribution of essential medicines, supplies, assistive devices and vaccines
- iv. 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

- i. Train health providers in rational use of medicines
- ii. Avail Clinical Treatment Guidelines
- iii. 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 situations

Inputs

- i. Dissemination of national guidelines
- ii. Dialogue with the regulator to harmonise emergency importation processes to include refugee situations

Outcomes

Guidance note on management of medicines importation for refugees issued.

Indicators

Number of health commodities imported under emergency conditions.

2.4 Pillar 4: Health Management Information System (HMIS)

Issues

The HMIS used by districts and the Health Information System (HIS) 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 staffing 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 underdeveloped.

Statement

The information for managing, monitoring and decision-making during the implementation of this Health Sector Integrated Refugee Response Plan (HSIRRP) by all partners shall be collected, harmonised, reported and stored using the National Health Management Information System (HMIS), the Integrated Disease Surveillance (IDS) and response system and the systems' research that shall from time to time be commissioned. All efforts shall be focused on ensuring an integrated

and strengthened information system through synergy and efficient use of available resources. The MoH has primary authority over the access and use of the data generated and will ensure that the data is disaggregated to accommodate the peculiar data needs for programming 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

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

Inputs

- i. Sessions for harmonising data sets for HMIS, IDSR
- ii. Registers, reporting forms, and data bases for HMIS, IDSR
- iii. Computers/information technology and source of power for HMIS and IDSR
- iv. Accrediting/coding facilities in refugee settlements
- v. Training sessions for health workers on the HMIS and use of data

Indicators:

- i. Availability of harmonised HMIS tools
- ii. Number of facilities reporting through DHIS-2
- iii. Number of facilities with trained staff in data management

Outcome:

- i. Reliable data for for monitoring and Evaluating the HSIRRP produced

Action 2: Build a framework for operational research to improve programming of the Comprehensive Refugee Response in the health sector

Inputs

- i. Support and carry out research in collaboration with the academia and research institutions
- ii. Document lessons, good practices and evidence-based creation
- iii. Publish and disseminate findings to inform implementation

Outcomes

Use of harmonised HMIS reporting tools; improved data use in decision-making; improved accountability for health outcomes and resources

Indicators

Number of publications; decisions informed by research findings

2.5 Pillar 5: Health financing

Issue

Inadequate financing of the health sector that constrains service delivery and systems performance; exacerbated by fragmented and vertical financing of different health interventions and initiatives, with limited options for financial and social risk protection for the poor and the vulnerable when accessing care. Parallel planning systems for refugees and host communities are inefficient and often at variance with government planning cycle.

Statement

Government will cost the HSIRRP as a tool for advocacy and resource mobilisation to supplement the current health sector funding of the host district, the current partner funding for refugee health services to be compiled in order to identify the resultant resource gap for implementing the plan.

Strategic intervention

Developing integrated national and district health plans and budgets that comprehensively address the needs of refugees and host communities.

Actions

- i. Develop the HSIRRP
- ii. Advocacy and resource mobilisation
- iii. Support the bottom-up planning process for refugee-hosting districts
- iv. Establish mechanisms for enhancing financial accountability and transparency through institutionalising the tracking of resource flows and use within the sector
- v. Review performance and accountability
- vi. Develop a business case

Outputs

- i. HSIRRP produced
- ii. Resources mobilised for the Response Plan
- iii. District plans have strategies that integrate health response plans for refugees and host communities
- iv. Mechanisms for good governance are strengthened
- v. Performance reviewed and resources accounted for timely

2.6 Pillar 6: Leadership, coordination, management and governance

Issue

The overarching coordination for refugee response is under the OPM; however, the health sector response coordination 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 MoH and Local Government frameworks for health service delivery. This results in duplication of efforts and resource wastage.

Statement

The MoH embarked on developing the HSIRRP in compliance with the New York Declaration for Refugee and Migrants 2016 and its Comprehensive Refugee Response Framework (CRRF), the World Health Assembly (WHA) Resolution 70.15 and other applicable international conventions and regulations as well as national laws and legislation. Under the guidance of the OPM, the MoH shall provide leadership and governance, and ensure that the HSR is integrated, strengthened and uses the existing national health system design for responding to the health needs of refugees and host communities. This is done in the spirit of sustainable development of the health system that includes service delivery to refugees. The MoH will institutionalise the coordination of refugee health services at the national and sub-national levels, coordinating key internal and external stakeholders in the humanitarian and development spaces.

Strategic interventions

Strengthen mechanisms for provision of oversight (foresight, insight and hindsight) of the health sector response for refugees and host communities.

Action 1: 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 refugees and hosting districts

Inputs

- i. Review panel
- ii. Stakeholders' engagement costs
- iii. Dissemination costs
- iv. 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-sectoral actors established.

Indicators

Institutional coordination structures are developed and supported to function (Annexed).

Action 2: Set up an oversight structure and programme management unit at the MoH for strengthening planning, implementation, M&E of the HSR

Inputs

- i. Health Sector Integrated Refugee Response Steering Committee (chaired by minister)
- ii. Programme Management Unit (headed by senior officer at commissioner level and with at least eight staff)

Outputs

Committees constituted; integrated annual response plans developed; reviews of the implementation done; resources and results accounted for

Indicators

Resolutions of the Steering Committee; reports of planning and review meetings

Action 3: Set up oversight structure and a programme management unit at the DHO for strengthening planning, implementation, M&E of the HSR; set up oversight structure and a programme management unit at the MoH

Inputs

- i. District Refugee Oversight Committee (meets quarterly)
- ii. Health Sector Refugee Focal Desk
- iii. District Integrated Health Sector coordination meetings (meet monthly)
- iv. District Multi Sectoral Nutrition coordination meetings (meet quarterly)
- v. District Disaster Management meetings

Output

Better coordination, planning and results of health sector response.

Indicators

Number of coordination meetings and decisions influenced by the committees.

3 POLICY CONTEXT

3.1 Linkages to national strategies, policies, regulations and legislations

As part of the overall health sector planning framework in Uganda, the Health Sector Development Plan (HSDP) 2015/16 - 2019/20 provides the strategic focus of the sector in the medium term, highlighting how it will contribute, within the constitutional and legal framework, to the second National Development Plan (NDP II), and to the second National Health Policy (NHP II) imperatives of the country, and so to the overall Vision 2040.

The HSDP is the second in a series of six 5-year Plans aimed at achieving Uganda Vision 2040 of a healthy and productive population that contributes to socioeconomic growth and national development. The applicable legal framework and policies related to the rights to health are articulated in those documents are incorporated herein.

The 1995 Uganda Constitution

The Uganda Constitution under Chapter 4 provides a broad range of rights that are available to refugees as to any other persons on the territory of Uganda. Refugees have the freedom to join non-

political civil associations, enjoy freedom of movement, right to family, affirmative action, right to property, freedom of religion, among others.

The Refugee Act 2006 and Refugee Regulations 2010

Uganda is a signatory to the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, committing the Government to protect persons fleeing from persecution. The commitment was renewed in 1969 with the OAU Convention, granting prima facie refugee status to refugees fleeing from conflicts. These Conventions and the open border policy are crucial for the life and protection of refugees, ensuring the access to the country and avoiding the risks related to repatriation and refusal of entry.

In 2006, the Parliament passed the Refugee Act 2006, followed by its 2010 Regulation, granting protection and freedoms to refugees including, among others, property rights, freedom of movement, the right to work, and the provision of services, allowing for integration of refugees within communities. The Refugee Act has enabled the Uganda settlement approach, where refugees are welcomed, registered, allocated land and provided with documents. In addition, refugees have access to national services, including health services.

National Development Plan II and Settlement Transformation Agenda

The development of the Settlement Transformation Agenda (STA), annexed to NDP II, is a concerted move to specifically recognize and address the needs of those most affected by displacement in Uganda and to systematically integrate emergency preparedness for displacement into development programming. The STA operationalizes the national legal framework and aims to achieve self-reliance and bring social development to refugee hosting areas through six main objectives: 1. Land management, 2. Sustainable Livelihoods, 3. Governance and rule of law, 4. Peaceful co-existence, 5. Environmental protection, 6. Community infrastructure. The Refugee and Host Population Empowerment (ReHoPE) strategic framework, a joint UN and World Bank strategy, was developed to support the STA, addressing the needs for sustainable livelihoods, infrastructure and integration of social services of both refugees and host communities. The STA, and its incorporated into the NDPII paved the road for a more comprehensive approach addressing both refugees and host community in line with the Comprehensive Refugee Response Framework (CRRF) and created an entry point for the Ministry of Health, enabling the development of the Health Sector Integrated Refugee Response Plan.

3.2 Linkages to international policies, regulations and legislations

The development of this strategy is consistent with international declarations, conventions and national laws and legislation including the Agenda 2030 for Sustainable Development, the New York Declaration for Refugees and Migrants 2016, its Comprehensive Refugee Response Framework (CRRF), the recently adopted Global Compact on Refugees, as well as the **2017 World Health Assembly Resolution 70.15**. Through the latter, in May 2017, WHO member states resolved to develop, reinforce and maintain the necessary capacities to provide health leadership and support to

member states and partners in promoting the health of refugees and migrants in close collaboration with the International Organisation for Migration (IOM) and UNHCR.

Leaving no one behind in line with the **2030 Agenda for Sustainable Development** and the Sustainable Development Goals (SDGs), and in recognition of Uganda's firm commitment to peace and security in the region and the protracted nature of displacement, the Government of Uganda took a bold decision to include refugee management and protection within its own domestic planning framework. As outlined above, the NDPII 2015/16-2019/20 integrated refugees into national development planning through the STA. Efforts already underway in Uganda inspired the **New York Declaration for Refugees and Migrants** and its **Comprehensive Refugee Response Framework (CRRF)**, adopted by the UN General Assembly in September 2016. Thus, in the spirit of responsibility sharing encapsulated in the New York Declaration, in full recognition of Uganda's international commitments to the protection of refugees and in the face of an unprecedented influx into Uganda, Uganda was one of the first countries to officially roll-out the CRRF, building on the existing response model and legal context. Under the CRRF, launched in Uganda in March 2017, the Government of Uganda is leading on the development of comprehensive sector response plans to fully integrate refugees into national sector planning, with the aim to further ease pressure from host communities and enhance access to quality services for refugees and the Ugandans that are hosting them. It is against this background, that the Ministry of Health has developed the Health Sector Integrated Refugee Response Plan to ensure equitable and well-coordinated access to health services for refugees and host communities.

By clearly articulating where concrete contributions are needed, Uganda is at the forefront of fulfilling its commitments enshrined in the **Global Compact on Refugees**, which was adopted by the UN General Assembly in December 2018. Largely based on Uganda's experience in rolling out the CRRF, the Global Compact on Refugees is an international agreement to forge a stronger, fairer response to large refugee movements. It is a commitment by the international community to provide greater support for those fleeing and for the countries that take them in order to improve the lives of refugees and their host communities.

4 IMPLEMENTATION FRAMEWORK AND STRATEGIES FOR PARTNERSHIP FOR COMPLIANCE

4.1 Implementation Assumptions and Risks

The plan holds to a number of assumptions and risks that implementation processes ought to put into consideration for effective realization of the set goal. The assumptions include:

- Upon the launch of this plan, there will be a comprehensive roll-out programme to take the plan down to the district and other lower levels of the sector;
- There will be regular implementation and coordination meetings at strategic, managerial and operational levels to guide the implementation processes;

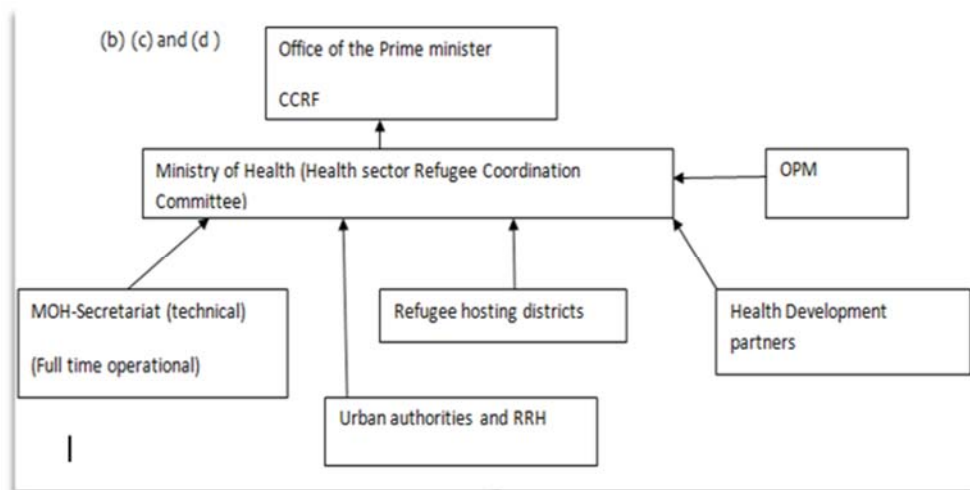
- This plan takes supremacy over other implementation instruments in health sector refugee response;
- There will be a standby health emergency team coordinated at the ministry to respond to supplement local area health team. Internally other emergency teams especially health professional teams from the UPDF and Police may be called upon to boost the Ministry and implementation partners as and when the Minister may guide. The World Health Organization may be called on to intervene when international responders are deemed to supplement the Government of Uganda.

The plan has addressed some of the anticipated risks that may underpin implementation of the plan. However, since the implementation environment is ever changing, certainty on factors and actors may not be accurately in control of the Ministry and its stakeholders. Good practice expects the design of operational level intervention to pay realistic attention to risk management at all stages of implementation.

4.2 Coordination and leadership framework

The overall leadership for refugee response rests with the OPM. The Minister of Health - who is a member of the National Steering Committee - provides the guidance for the HSIRRP through the Health Sector Integrated Refugee Response Plan Steering Committee, supported by a Secretariat. The Steering Committee consists of the Secretariat, representatives of MoH, DHO and RRH, OPM, Ministries of Finance and Public Service, Urban and Prisons Authorities and Development Partners. The Secretariat will, as delegated, coordinate all stakeholders who form the Steering Committee and other Technical Working Groups as deemed necessary.

Figure 2: The coordination structure for the HSIRRP in MoH



The roles of the Steering Committee include, but are not limited to the following:

- i. Resource mobilisation
- ii. Strategic guidance
- iii. Developing guidelines for implementation of the response plan
- iv. Maintaining and nurturing relationships with government and partners
- v. Commissioning assessments, reviews, evaluations and leading the dissemination of results
Tracking and reporting on status of implementation of the response plan
- vi. Multi-sectoral coordination to address social determinants of health
- vii. Overseeing the documentation and dissemination of learning and adaptation of the plan

4.3 Information, education, communication and dissemination

Awareness creation and popularisation of the plan will be jointly carried out by MoH and the OPM. Dissemination workshops, media engagements targeting health professionals, government ministries, departments and agencies, and the general public, including the civil society, will be used as channels to reach the relevant audience.

4.4 Implementation stages

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

4.5 Implementation drivers

Effective communication for change management, the buy-in from related government ministries, departments and 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 implementation of the response plan. Capacity-building and supervision of frontline health workers to deliver an integrated essential service package and health care managers will be central to the success of this strategy.

To contribute to the Comprehensive Refugee Response Framework (CRRF), the plan shall be implemented in synchrony with other response plans for refugees and host communities, developed by various sectors under the framework. This plan has strong synergies with Water and Environment Response Plan, Education Response Plan, Livelihood Response Plan among others.

5 ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

The implementation of the Health Sector Integrated Refugee Response Strategy (HSIRRS) will be district-led, involving the MoH, UN Agencies, Multilateral and Bilateral Agencies, National and International NGOs, local communities, the private sector, community-based, faith-based, cultural organizations and other non-state actors as key stakeholders with clear roles and responsibilities.

Local communities: In this context, local communities refer to refugees and host communities. They will be the primary beneficiaries of the improved services provided through the implementation of the Health Sector Integrated Refugee Response Plan. More importantly, besides providing land to the refugees, local communities will participate in the governance structures (management committees) of the health facilities to ensure adherence to standards, and as community health workers under the community health program.

Local Governments: The Plan recognized the primary role of local governments with regard to health service delivery. Local governments will plan, guide implementation, supervise, monitor service delivery and account for results and resources to the Central Government and partners.

Central Government: Government, through the MoH, will take centre stage in the development, management and governance of the Health Response Plan. The ministry in conjunction with partners will support the development of policies, standards, guidelines, and technical support supervision. They will also look into resource mobilization including accreditation of health facilities, and regulation of professional practice in Uganda.

Development partners: Partners support government to achieve the roles outlined above by providing technical assistance, financial and material resources, thus supplementing the work of government. The MoH will engage with donor agencies, UN Agencies and other health partners to mobilize resources and better coordinate implementation of interventions, including monitoring and evaluation, to achieve results at scale.

Private Sector: The private sector will invest in any service in health care deemed necessary and affordable to meet the health needs of refugees and host communities. The private sector is also seen as having an opportunity to increase access to health services, test innovations/new interventions and inform sustainable approaches to health service delivery. It will be expected to comply with the regulations laid down for health service delivery. This may include contracting services to the private sector in the absence of a public health system.

Non-state actors: CBOs, NGOs, FBOs, and cultural organisations will help raise resources and civic awareness. They will also keep actors, policy makers and regulators in check for the 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. This response plan is aimed at guiding them to supplement government efforts and have a role to cooperate with DLGs to ensure harmonised health service delivery. In addition to liaising with refugees and host communities, NGOs are expected to engage in coordination and reporting as required to ensure success and relevance of programmes.

5.1 Financing the Health Sector Integrated Refugee Response Plan (HSIRRP)

Sources of funds

The main sources of financing for the implementation of the HSIRRP will come from: Government, the UN, Bilateral and Multilateral organisations and humanitarian and development partners. Government, through the ministries and local governments, will provide budget support for the development of infrastructure in health facilities. They will use the budget support for providing health services to refugees and host communities to secure medicine and health supplies, human resources for health, information systems and technologies. UNHCR, on the other hand, together with partners will provide resources to augment the integrated response effort to provide services to the target populations. Cognisant of existing contracts and donor restrictions, some donors may continue to directly fund implementing partners. Such a funding modality will be considered in consultation with Government, if the use of the resources is aligned to the HSIRRP and there is an agreed mechanism to track such funds.

Costing of the plan

Costing of the HSIRRP is intended to provide indicative estimates of resource requirements for its implementation over the plan period. The cost for the plan will, however, not reflect an accurate estimate as it is not feasible to project future costs based on the current basis, implementation modalities and financing mechanisms. These estimates provide a sense of direction on what would feasibly be a conservative estimate of implementation. The costing of the plan took into consideration the growing refugee influx, targeted refugees and host district populations. It also looked at the unit cost of service provision and proposed service coverage. The details of costing can be found in Appendix 4, Costing Report.

The costing has been developed on the premise that the HSIRRP is designed to strengthen the health system and build system resilience within refugee-hosting districts to cope with the health needs of host communities, refugees and anticipated influxes. Thus, the key assumptions for this cost estimates were that:

- i) Staffing of health facilities in refugee-hosting districts will be improved to 95% of the staffing norms;
- ii) Half (50%) of the public health centre II will be upgraded to HC III;
- iii) At least 36 new HC III will be constructed and equipped;
- iv) The capacity of facility-based Health Workers and Community Health Extension Workers will be built; their activities facilitated and are remunerated;
- v) Adequate medicine and health supplies will be distributed to the respective districts using the national distribution channels.

The HSIRRP is estimated to require about US 583.4million during the five-year period. This projection will start to rise from US \$ 100.3 million in the first year of the plan to US \$ 125.2 million in the fifth, with a peak funding of US 139.9 million. The peak period is attributed to the heavy infrastructure investments; construction, reconstruction, upgrading and equipping of health facilities.

Table 2: Annual cost estimates per service input for the HSIRRP

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

The key cost drivers in this plan are medicines and drugs, human resources and infrastructure developments that contribute 44%, 25% and 23% respectively. The medicines and drugs have been estimated to cover both the host communities and the projected refugee influx. The national distribution channels will be used to ensure delivery of the medicines in the health facilities. The human resource needs have been estimated to reflect filled posts, at least not less than 95% of the Public Service staffing norms. The infrastructure costs will include upgrading and equipping expenses of at least 94 HC IIs to HC IIIs, constructing and equipping 36 new HCIIIs and five HC IVs in line with the GoU strategy for improving health service delivery 2016-2020.

Figure 3: Distribution of resource estimates

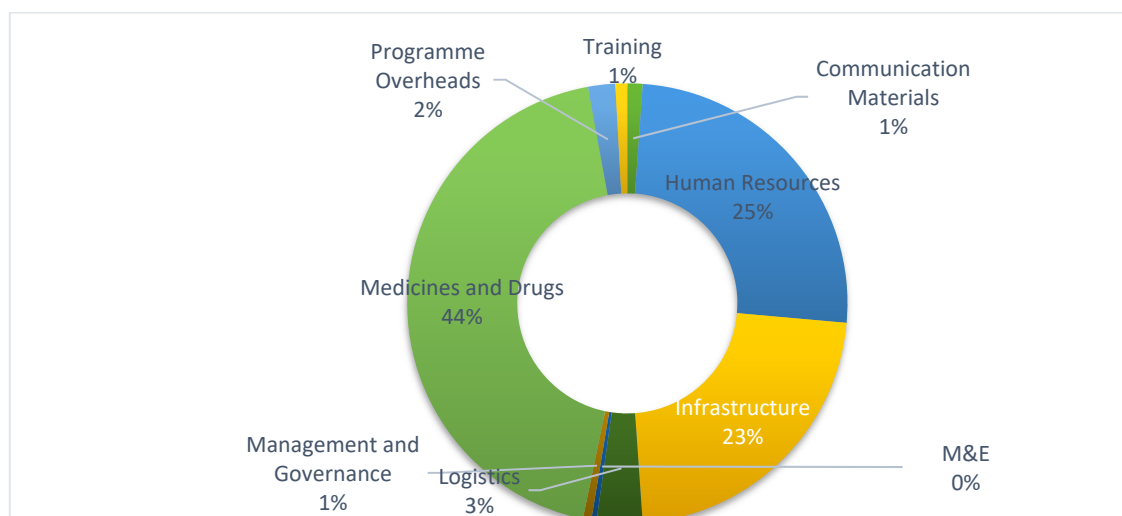


Table 3: Costs of the HSIRRP presented per service type or channel

Summary as per delivery channels							
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals	
New Arrivals Service Package	6,082	6,377	6,708	7,063	7,461	33,690	6%
Emergency and Epidemics	1,345	1,385	1,427	1,470	1,514	7,141	1%
Facility Based care and referrals	59,133	69,532	71,257	59,574	79,623	339,119	61%
Community health Programs	7,326	7,343	7,361	7,379	7,398	36,808	7%
Quality Assurance	863	479	596	508	496	2,943	1%
Health systems and Governance	27,639	27,323	27,715	27,467	28,322	138,466	25%
Totals	102,388	112,440	115,064	103,461	124,815	558,168	

Financing Gap analysis

The Government of Uganda (GoU) and partners commit to identifying priority gaps and financing the HSIRRP by pooling resources towards its implementation. The GoU resources will be channelled through budget support to the health sector and the local governments. Commitments earmarked from GoU and Partners will be compiled every year and discounted against the total annual estimated cost of about 120 million USD to arrive at the annual funding gap to guide resource mobilisation. This requirement will form the basis for establishing a chart of accounts to track finances.

5.2 Monitoring and evaluation (M&E)

At overall level the outcomes set in this plan are geared towards contributing to the strategic pillars of CRRF: Admission and rights; Emergency Response & Ongoing Needs; Resilience & Self - Reliance; Expanded Solutions; and Voluntary Repatriation. The objectives of the HSIRRP will be implemented through five annual work plans and monitored through the M&E framework of the plan that is well aligned with the HMIS to ensure that the intended and achieved benefits of the plan are effectively monitored and measured.

The M&E framework for the HSIRRP is attached as Annex 2. It consists of impact, outcome, output and input indicators for tracking progress. The strategic information and technology-enabled system (DHIS 2) that is already in use will be strengthened and used to track the health outputs and some outcome. Additional information especially outcomes and impact-level indicators which are not

routinely reported shall be collected in collaboration with the National Bureau of Statistics (UBOS), universities and other institutions through research.

The implementation guidelines will be developed and made available to assure minimum quality standards, required institutional capacities, regulations and coordination parameters to be complied with. Through accreditation, supervision and inspection, periodic progress shall be assessed as evidence for instituting corrective actions.

5.3 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 and central government during annual response plan and sector reviews and Inter Agency Coordination Meetings.

5.4 Policy reviews

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

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

ANNEX 1: Health Sector Infrastructure Development Needs of Refugee Hosting Districts

Health Sector Development Response in Refugee-Hosting Districts													
<i>Facilities to be constructed</i>	Arua	Yumbe	Moyo	Adjumani	Hoima	Kiryandongo	Kyegegwa	Isingiro	Lamwo	Kamwenge	Koboko	Kampala	Total
New Health Central III	3	2	0	3	0	3	7	2	4	3	2		29
OPD	3	2	0	3	0	3	7	2	4	3	2	0	29
General Ward	3	2	0	3	0	3	7	2	4	3	2	0	29
Staff Housing units	30	20	0	30	0	30	70	20	40	30	20	0	290
HC II for upgrade to III	13	7	11	11	7	7	8	17	7	4	4		96
OPD	13	7	11	11	7	7	8	17	7	4	4	0	96
General Ward	13	7	11	11	7	7	8	17	7	4	4	0	96
Staff Housing	78	42	66	66	42	42	48	102	42	24	24	0	576
Health Central IV improvement	1	1	1	1	1	1	1	1	1	1	1	0	11
OPD		1	4				1		1	1		0	8
General Ward	2	2	4		2				4	1		0	15
Maternity	2	1	4	1				1	4	1	1	0	15
Theatre		0	0		2		1	1	0	1	1	0	6
Staff Housing	16	8	8	1	12	25	30		8	28	8	0	144
Doctor's House	2	4	2	1	3		2	4	4	3	2	0	27
Ambulance	2	2	2	1	2	1	1		2	1	2	0	16
General Hospital													
MDR TB Ward in RR Hospitals	1							1					

ANNEX 2: M&E Framework for the Health Sector Integrated Refugee Response Plan

Key Result Area	Indicator	Data collection method /Source of data	Frequency of data collection	Agency Responsible	Baseline		Annual Targets				
					Value	Year	2018/19	2019/20	2020/21	2021/22	2022/23
Goal: To improve the quality of life for refugee and host communities in Uganda											
Objective 1: To increase equitable access to and utilization of integrated health services for refugees and host communities (Pillar 1: Service Delivery Pillar)											
OUTCOMES											
Children under 1 vaccinated against Pentax3	DPT3Hib3Heb3 coverage	AHSPR	Annually	MoH	102%	(2014/15)	95%	97% HSDP	95%	97%	97%
Increased % of GoU health facilities in urban areas supported to offer refugee services	% of GoU health facilities and prisons in urban areas supported to offer refugee services	Routine Service Delivery Reports	Annually	MoH	25%	2018	25%	50%	50%	75%	
Increased % of measles cases detected within 48hrs	% of cases of Epidemic prone diseases detected within 48hrs	Surveillance Reports	Monthly	MoH	70%	2018	100%	100%	100%	100%	100%
Access and utilization surveys conducted	Number of access and utilization surveys conducted	Project Reports	Annually	MoH	0		1	1	1	1	1
Objective 2: To improve management of health resources to cope with the increased demand for health services by refugees and host population through mobilization (Pillar 2: Human Resource for Health)											
OUTCOMES											
Reduced staff attrition	Attrition rate	Project Reports	Annually	MoH							
Adequate numbers, well-motivated and competent health workers	Percentage of staffing norms filled	Project Reports	Annually	MoH	75%	2018	80%	85%	90%	100%	100%
Harmonized human resource remuneration packages for health	Salary parity	Project Reports	Annually	MoH	N/A	2018	70%	80%	100%	100%	100%

workers working in refugee settlements and hosting communities.																		
HR structure adapted	Adapted HR structure (binary Indicator) - Yes or No	Project Reports	Annually	MoH	NO	2018	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Remuneration scales/structure in place	Remuneration scales/structure harmonized (binary indicator)	Project Reports	Annually	MoH	NO	2018	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Recruitment plan developed	Number of recruitment plans developed	Project Reports	Annually	MoH	NO	2018	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Performance management mechanisms/rewards for health workers working with refugees and host communities established	Existence and utilization of the recruitment guidelines and plan (binary indicator)	Project Reports	Annually	MoH	NO	2018	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
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 (Pillar 3: Health Commodities and technologies)																		
OUTCOMES																		
Increased number of medicines and antibiotics prescribed per patient	Average number medicines and antibiotics prescribed per patient	Project Reports	Annually	MoH	N/A	2018	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6
Annual Procurement plans developed based on bottom-up approach	Number of procurement plans developed	Project Reports	Annually	MoH	1	2018	1	1	1	1	1	1	1	1	1	1	1	1
Stores for medicines and health supplies constructed/Renovated/equipped	Number of medicine stores constructed/renovated/equipped	Project Reports	Annually	MoH	0	2018	2	2	2	2	2	2	2	2	2	2	2	2
Cold chain equipment procured	Number of Cold Chain equipment procured by type	Procurement Reports	Annually	MoH	0		30	5	5	5	5	5	5	5	5	5	5	5
Health providers trained on rational use of medicines	Number of health workers trained on rational use of medicines	Training Reports	Annually	MoH	80	2018	200	200	200	200	200	200	200	200	200	200	200	200

Support supervision for compliance to guidelines conducted	Number of support supervisions for compliance to guidelines conducted	Supervision Reports	quarterly	MoH	1	2018	4	4	4	4
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 (Pillar 4: Health Management Information System)										
OUTCOMES										
Harmonization sessions for HMIS, IDSR, etc conducted	Number of harmonization sessions for HMIS, IDSR, etc conducted	Meeting minutes	quarterly	MoH	0%	2018	100%	100%	100%	100%
Registers and copies per type printed	Percentage of registers and copies per type printed	Procurement Reports	quarterly	MoH	0%	2018	100%	100%	100%	100%
Reporting forms and copies per type printed	Number of reporting forms and copies per type printed	Procurement Reports	quarterly	MoH	0%	2018				
Health facilities in refugee settlements accredited/coded	Number of health facilities in refugee settlements accredited/coded	Accreditation Reports	quarterly	MoH	72%	2018	80%	85%	90%	95%
Operational researches conducted	Number of operational research studies conducted	Project Reports	Annually	MoH	0%	2018	3	3	3	3
Findings, Lesson Learnt and good practices published and disseminated to inform future implementation	Number of research studies for which findings, lessons learnt, and good practices were published and disseminated to inform future implementation	Project Reports	Annually	MoH	0	2018	10	10	10	10
Strengthen financial base and spearhead innovative financial management approaches at national and subnational levels for refugees and host Districts and communities (Pillar 5: Finances)										
OUTCOMES										
Increased financial allocation to health sector refugee response in Uganda	% increase in funds for health sector refugee response	Project Reports	Annual	MoH	N/A	2018	10%	10%	10%	10%
To Provide oversight (foresight, insight and hindsight) for the health sector response for refugees and host communities (Pillar 6: Leadership, Coordination and management and Governance)										
OUTCOMES										
Oversight structure & program management unit set up at MoH for strengthening refugee	Oversight structure & program management unit set up at MoH for strengthening refugee	Project Reports	Annually	MoH	0%	2018	YES	YES	YES	YES

ANNEX 3: Health Sector Integrated Refugee Response Plan Steering Committee ToRs

1. Introduction

Uganda hosts the largest number of refugees in Africa and is one of the top refugee-hosting countries worldwide. At the same time, Uganda has one of the most progressive refugee model, which includes an open border policy and approach which provides refugees with land, freedom of movement, the right to seek employment and establish business and equal access to Government-provided social services such as healthcare. Indeed, refugees share all social services with the local host communities. The refugee hosting districts are among the least developed districts in the country; and thus the additional refugee population is putting a high strain on already meagre resources and services. In line with the Comprehensive Refugee Response Framework (CRRF), which was adopted by the Government of Uganda in 2016, there is need for coordinated health service delivery. This entails a paradigm shift from a mainly humanitarian focus to development as well in ensuring a broader stakeholder involvement to address these needs and ensure integrated service delivery.

In light of the need for additional support and resources, the Government of Uganda, with the support from multiple health partners, has developed the Health Sector Integrated Refugee Response Plan (2019-2024). A Steering Committee is to be established to ensure efficient and effective implementation of the plan.

These ToRs are designed to guide the work of the Health Sector Integrated Refugee Response Plan Steering Committee (henceforth, “Steering Committee”).

2. Role of the Health Sector Integrated Refugee Response Plan Steering Committee

The primary role of the Steering Committee is to provide strategic guidance and oversight of Uganda’s Health Sector Integrated Refugee Response Plan (HSIRRP). The main roles of the Steering Committee include:

1. Reviewing and approving the Health Sector Integrated Refugee Response Plan, and each subsequent update/revision of the rolling plan on an annual basis
2. Ensuring transparency and accountability to Government of Uganda and its partners on funds allocated towards the Health Response Plan for Refugees and Host Communities
3. Promoting and supporting resource mobilization and improved coordination of all actors involved in the refugee response
4. Providing oversight and guidance to partners on the implementation of the response plan to maintain compliance with identified priorities

5. Establishing and maintaining engagement with various stakeholders (government, local government, NGOs etc.) including existing coordination structures, particularly the CRRF and Health Development Partners, in the implementation of the response plan
6. Conducting periodic monitoring of implementation of the HSIRRP, including commissioning assessments, reviews and evaluations related to the plan and its implementation.

The Steering Committee will report to the Top Management and will feed into the HPAC. The Steering Committee will have decision-making authority at the discretion of the Permanent Secretary and in line with his/her mandate. An HSIRRP Secretariat will support the Steering Committee in implementing its role as stipulated above.

The Steering Committee will operate within the broader coordination arrangements of Uganda's comprehensive refugee response through maintaining a close link to the CRRF Steering Group and by ensuring that the respective Secretariats (CRRF and for the HSIRRP) work closely together. Efforts shall be made to make the steering committee meetings targeted and flexible to minimise additional transactions costs.

Decisions made by the Steering Committee shall be communicated through the appropriate channels by the Secretariat at the appropriate time.

3. Role of individual Steering Committee members

The role of the individual member of the Health Sector Integrated Refugee Response Plan Steering Committee includes:

- understand the strategic implications and outcomes of initiatives being pursued through the plan
- appreciate the significance of the plan for some or all major stakeholders and perhaps represent their interests
- be genuinely interested in the initiative and the outcomes being pursued in the plan
- be an advocate for the plan's outcomes
- have a broad understanding of project management issues and the approach being adopted
- be committed to, and actively involved in pursuing the plans outcomes

In practice, this means the individual members should make every effort to represent the interests of the results to be achieved through the HSIRRP rather than to push for an individual institution's or agency's interest:

- ensure the requirements of stakeholders are met by the plan's outputs
- help balance conflicting priorities and resources
- provide guidance to implementers of the plan

- consider ideas and issues raised
- review the progress of the plan
- check adherence of activities to standards of best practice

4. General

4.1. General Membership

The Health Response Plan for Refugees and Host Community Steering Committee shall be comprised of a high-level representative designated as follows on the list below. It will be expected that the representatives of NGOs and the HDP representative will rotate on an annual basis. In addition, it should be noted that the Steering Committee will draw on the inputs and insights from the CRRF Steering Group.

1. Two co-chairs (PS and HDP)
2. Director Clinical Services, MoH
3. Four Representatives of MoH;
 - CHS/ACHS; Clinical, Community, Planning, and Quality Assurance
4. One Representative, District Health Officers
5. One representative, OPM
6. One Representative, Ministry of Finance and Economic Development
7. One Representative, Ministry of Local Government
8. One Representative, Health Development Partners (HDP)
9. One Representative, National NGOs
10. One Representative, International NGOs
11. One Representative, Private Sector
12. One representative, UNHCR
13. One representative, UNICEF
14. One Representative, WHO
15. One Representative, World Bank
16. Representative of the Academia

4.2. Co-Chairs

The Co-Chairs shall be the Permanent Secretary MoH alongside the chair of the Health Development Partners. The co-chairs shall convene the Health Sector Integrated Refugee Response Plan Steering Committee meetings. Chairing of the meetings shall alternate between the co-chairs.

If the designated Chair is not available, then the co-chair will be responsible for convening and conducting that meeting. The Co-Chairs are responsible for informing each other as to the salient points/decisions raised or agreed to at that meeting.

4.3. Secretariat

An HSIRRP Secretariat will be set up in MoH whose role will include servicing the Steering Committee, including drafting of the agenda items (on the instruction of the co-chairs). All Steering Committee agenda items (with accompanying meeting papers) must be forwarded by the Co-chairs to the Steering Committee members by C.O.B. five working days prior to the next scheduled meeting.

Members may raise an item under ‘Other Business’ if necessary and as time permits.

4.4. Minutes & Meeting Papers

The format of the Health Sector Integrated Refugee Response Plan Steering Committee minutes shall be agreed in the first meeting. The minutes of each Steering Committee meeting will be prepared by the Secretariat.

Full copies of the minutes, including attachments, shall be provided to all Health Sector Integrated Refugee Response Plan Steering Committee members no later than 7 working days following each meeting.

By agreement of the Steering Committee, out-of-session decisions will be deemed acceptable. Where agreed, all out-of-session decisions shall be recorded in the minutes of the next scheduled Health Sector Integrated Refugee Response Plan Steering Committee meeting.

The minutes of each Steering Committee meeting will be monitored and maintained by the Secretariat as a complete record.

4.5. Frequency of Meetings

The Steering Committee shall convene meetings as required with an expectation of a minimum of one meeting per quarter. It is expected that the meetings will be more frequent in the early stages of

the support while implementation plans, M&E framework and other project documents need approval. A meeting schedule will be developed and agreed on an annual basis by the committee.

Due to the nature of the plan, where urgent, decisions may be made out-of-session this will be by the co-chairs calling for an extraordinary meeting. In these situations, quorums for agreement will still be observed.

4.6. Proxies to Members

Members of the Health Sector Integrated Refugee Response Plan Steering Committee shall nominate a designated proxy to attend a meeting if the member is unable to attend. It is important that this proxy is the same person over time.

The Chair will be informed of the substitution at least 2 working days prior to the scheduled nominated meeting.

The nominated proxy shall have voting rights at the attended meeting. The nominated proxy shall provide relevant comments/feedback, of the Steering Committee member they are representing, to the attended meeting.

4.7. Quorum Requirements

A minimum of 50% of Health Sector Integrated Refugee Response Plan Steering Committee members is required for the meeting to be recognised as an authorised meeting for the recommendations or resolutions to be valid. The quorum must contain at least both co-chairs or designated proxies.

Annex 4: Health Sector Integrated Refugee Response Plan Costing Report.

Uganda has had an open-door refugee culture over the last 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, the total 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 potential for conflict and famine vulnerability in the Great Lakes Region, more refugee influxes and protracted refugee situations are anticipated in the coming years.

Uganda's open-door policy exerts pressure on the social amenities meant for local communities, a situation that exposes refugees and host communities to competition for available health resources. The sheer scale of the crisis is putting the national and district health systems, host-communities, and implementing partners under tremendous stress. Operating parallel health systems for refugees and host communities, in the context of limited and diminishing health resources is not helping this situation as it is not sustainable and promotes inequities.

Against this background, the Ministry of Health (MoH) with partners embarked on developing the Integrated Health Sector Refugee Response Plan to feed into the Comprehensive Refugee Response Framework that is being coordinated by the Office of the Prime Minister.

It is hoped that the integrated health sector refugee response plan will improve the national health systems resilience to with-stand shocks and the existing inequities in accessing essential health services for refugees and host communities, through better coordination of partners, resource mobilisation and integrated health service programming and provision.

The process of developing the response plan was participatory involving the key stakeholders; Ministry of Health, Regional Referral Hospitals, Local Governments, the United Nations Agencies, Foreign missions, Donors, Development and Implementing partners. A draft 0 response plan was developed by a team of consultants, MoH constituted a Technical Working Group that produced the draft 1 that was presented to the CRRF secretariat in OPM for inputs and comments on the overall direction of the response of the plan. The document was presented to the Senior Top Management of the Ministry of Health which made inputs to the document and approved it for presentation to the Steering committee in the OPM.

5.5 Costing the plan.

The costing of the plan is intended to provide indicative estimates of the resource requirements for its implementation over the plan period. The costing has been developed on the premises that the IRRP is designed to strengthen the Health system within the affected districts in order to cope with the unpredicted influx of displaced persons and to ensure equitable provision of Health care services

to the people in the districts. 12 districts have been covered under the IRRP cost estimates. These are shown in Table 1 below.

The amounts reflected in the costing largely indicative in nature and may not reflect a very accurate estimate as it is not feasible to project future costs based on the current bases, implementation modalities and financing mechanisms. This estimate only indicates what would feasibly be a conservative estimate for the IRRP implementation.

The costing estimates have taken into consideration the growing number of refugee influx, targeted populations for whom services are planned for, the unit cost of service provision and proposed service coverage.

Table 1; District under the IRRP.

DISTRICT		POPULATION			DISTRICT ADMINISTRATIVE UNIT		PUBLIC HEALTH FACILITIES			
Name	Total population	Host population	Refugee population	Sub-Counties	S/C with refugees	HCII	HC III	HC IV	Hospital	
1	Arua	1,101,349	846,491	254,858	27	4	25	24	4	1
2	Yumbe	872,022	584,221	287,801	13	5	13	11	1	1
3	Moyo	311,319	147,997	163,322	9	1	22	11	1	1
4	Adjumani	409,472	170,029	239,443	10	8	21	7	1	1
5	Hoima	706,568	625,568	81,000	15	1	13	27	2	1
6	Kiryadongo	335,083	277,444	57,639	8	2	13	5	0	1
7	Kyegegwa	391,997	349,067	42,930	9	3	7	6	1	0
8	Isingiro	603,770	492,721	111,049	19	6	33	17	4	0
9	Lamwo	176,500	139,093	37,407	11	1	13	7	2	0
10	Kampala	1,586,370	1,482,676	103,694	5	5 div	3	8	4	5
11	Kamwenge	506,271	429,236	77,035	16	1	16	9	2	0
12	Koboko	220,300	215,894	4,406	7	1	8	5	1	0
	TOTAL	7,221,021	5,760,437	1,460,584	149		187	137	23	11

5.6 The Costing Approach :

The costing was undertaken using the ingredients approach. This approach identified the all the relevant inputs necessary for an activity or service, the populations in need of the services and the unit costs for each input. The resources estimates are determined according to the equation:

$$\text{Cost of services} = \text{Number of service} \times \text{Unit cost of the service}$$

Where the number of services required in the tool are determined using the formula:

Number of services= Population in Need X Service Coverage.

In addition estimates were provided for improvements in the infrastructure and re equipping the Health facilities, staffing at health facilities, operationalizing the governance and key management units both at the national and the sub national levels, capacity building for the health, and other front-line workers, as well as community sensitization and mobilization programs in the districts

Data and assumptions.

The key assumption for this cost estimates included:

- vi) Staffing at Health Facilities will be improved to not less than 95% of the staffing norms to be able to deal with a refugee influx.
- vii) 29 new HC III will be constructed and equipped in sub-counties without any HC III
- viii) About 96 public HC IIs be upgraded to HC III
- ix) Capacity will be built for Health workers both at the Health facilities and the community health workers.
- x) Adequate medicine and health supplies will be distributed to the respective districts using the national distribution channels.

Population in Need.

The costing was based on an assumption of a population growth in the host communities assumed at the national population growth of 3.28%. and an annual net increase of the refugee population in the 12 districts at 1%.

Table 2: Population data for the 12 districts for year to 2020.

DISTRICT		2018			2019			2020		
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Units' costs:

These were derived through a concerted process that included: review of relevant literature on program expenditures from MOH, key implementing partners, costing studies and reports, as well as consultations with key implementing agencies.

- Medicines and Supplies costs were based on the essential medicines package of the Ministry of Health, as well other key procurement mechanisms such as UNICEF GF and other major supplier's related procurement overheads costs.
- HR related costs were based on the Uganda Public service pay structure.

5.7 Result of the Plan.

The IRRP plan is estimated to require about US 558.16 million during the five-year period. This is projected to raise from US \$ 102.3 million in the first year of the plan to US \$ 127.2 million in the fifth year, with a peak funding of US 115 million. The Peak period is attributed to the investments in the infrastructure for reconstruction, upgrading and equipping health facilities.

Table 3 Summary of Resource estimates for the Plan.

Summary of Resource Estimates (US \$ "000").						
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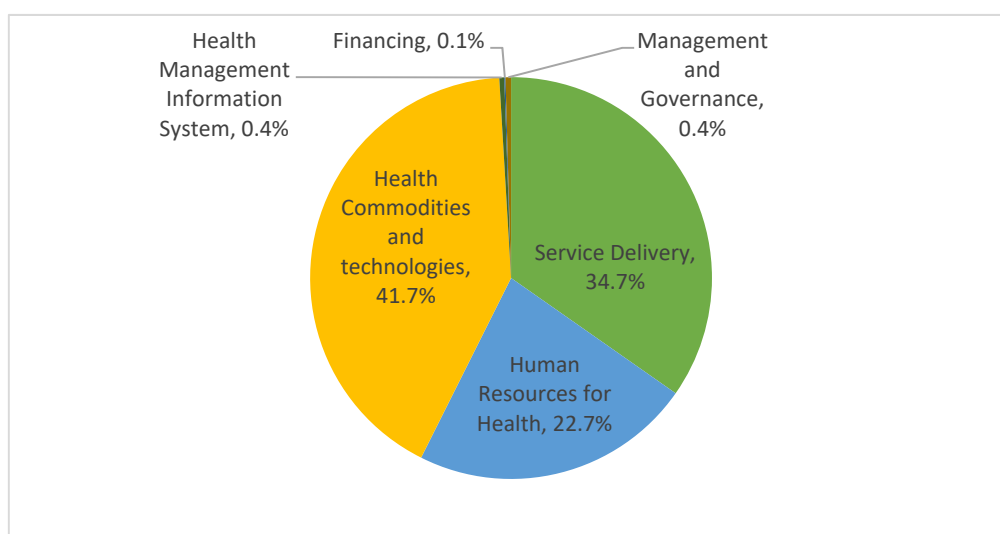
Figure 1: Distribution of Resource Estimates.

The key cost driver in this plan are medicines and Drugs, Human resources and infrastructure developments with 45%, 28% and 19% respectively. The medicines and drugs have been quantified to cover both the host communities and the anticipated refugee influx. The national distribution channels will be used to ensure delivery of the medicines to all Health facilities. The Human resources needs have been estimated to reflect filled posts to not less than 95% of the Public service staffing norms. The infrastructure costs will include costs of construction and equipping of 5 HC IV and 29 HC IIIs. Other major costs included upgrading 96 HC IIs to HC III, and equipping a total of 262 HC III least facilities line with the GoU strategy for improving health service delivery 2016-2022.

Financing of plan.

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 organizations, development partners will constitute the main sources of funding for the implementation of this strategy.

Financing Gap analysis



The government of Uganda with support from the partners committed resources towards the implementation of the IRRP. The GoU resource will be channeled through the budget support to the Health sector and the Local governments. At the time of finalizing the costing exercise, commitments earmarked from GoU and the Partners had been complied and estimated to about US \$ 142 million resulting into a funding gap of about US \$ 415.7 million

Table 4: Funding gap Analysis

Funding Gap Analysis (US\$ '000')						
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals
IRRP Estimates	102,388	112,440	115,064	103,461	124,815	558,168
Government of Uganda	12,577	13,206	13,866	14,560	15,288	69,497
Development Partners.						
IOM						
UNCHR	21,973	18,166	20,891			61,030
UNDP						-
UNFPA						-
UNICEF	4,059	4,059				8,119
USG						-
WHO	1,250	1,250	1,250			3,750
DFID						
Projected resources	39,859	36,682	36,008	14,560	15,288	142,396
Funding Gap	62,529	75,758	79,056	88,901	109,527	415,772

Note: The costing gap analysis above is not accurate though informative. Lack of an established funds tracking mechanism could not allow obtaining accurate information within the time that was available for this assignment.

Closing the Gap

The challenges of the refugee situation continue to hit the IRRP districts and the country at large, resources to deal with this are in short supply. The GoU allocations to the IRRP district for the year 2018/19 is estimated at about Ugx 45.9 billion (US \$ 12.7 Million), the need for the response plan is estimated at US \$ 102.5 Million, representing a 12% government of Uganda commitment. The funding gap of about 88% needs to be filled in by additional domestic resources and support from the development partners and private sector players.

The government need to mobilize addition resources as listed below.

- Advocate and lobby for addition Domestic resources to the Health sector, and the District Local Government for the decentralized health services.
- Seek to strengthen relations with existing development partners as well courting new Funding/ Donor Partners for external support. These will include both the Multilaterals and bilateral partners.
- Explore other funding mechanism through Grants and proposal Applications from Humanitarian Agencies
- Engage the Private sector players for more involving partnerships in the IRRP
- Improve program efficiency.
- Ensure timely program and financial accountabilities as well as transparency in program implementation.

- Joint planning for the Response to minimize duplications and ensure equity in service delivery.

Annexes

Table 5 Resource Estimates as per Service Pillars

Summary as Program Pillars							
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals	
Service Delivery	51,443	53,242	45,598	24,344	19,122	193,750	34.7%
Human Resources for Health	25,481	25,095	25,443	25,112	25,450	126,582	22.7%
Health Commodities and technologies	24,076	33,274	42,900	53,108	79,245	232,603	41.7%
Health Management Information System	781	252	516	267	412	2,228	0.4%
Financing	113	120	136	84	87	540	0.1%
Management and Governance	494	457	470	545	499	2,466	0.4%
	102,388	112,440	115,064	103,461	124,815	558,168	

Table 6: Provisional District Allocation

Summary as per District Allocations

Name	2018/19	2019/20	2020/21	2021/22	2022/23	Totals
Arua	14,727	13,490	14,792	13,567	15,516	72,092
Yumbe	11,283	9,522	9,330	9,862	12,067	52,065
Moyo	5,889	5,711	7,242	7,561	8,780	35,182
Adjumani	7,595	7,531	8,991	7,977	9,277	41,371
Hoima	10,363	8,284	9,727	10,215	12,312	50,900
Kiryadongo	6,352	8,453	7,707	6,656	8,387	37,556
Kyegegwa	5,495	5,508	6,869	6,341	8,111	32,325
Isingiro	10,050	10,555	10,696	10,639	11,634	53,574
Lamwo	5,632	5,357	8,286	5,807	7,654	32,735
Kampala	11,366	15,038	16,420	11,101	15,940	69,866
Kamwenge	8,964	12,539	10,409	8,364	9,554	49,829
Koboko	4,672	10,453	4,595	5,370	5,583	30,672
Totals	102,388	112,440	115,064	103,461	124,815	558,168

Table 7: Provisional Government of Uganda Allocation to selected IRRP districts for the year 2018/19

S/N	Vote No.	District	HEALTH DEVELOPMENT GRANT (IGFT LOAN)		TRANSITIONAL DEVELOPMENT AD HOC HEALTH (UGX)	Wage Bill (UGX)	Non-Wage Bill (UGX)	Total FY 2018/19 (UGX)
			Allocation of Health Infrastructure Maintenance (UGX)	Allocation for upgrade of HC IIIs to HC IIIs (UGX)				
1	501	Adjumani District	54,208,123	500,000,000		4,517,655,759	484,550,057	5,556,413,940
3	503	Arua District	162,348,223	-		4,263,719,946	701,701,135	5,127,769,305
9	509	Hoima District	48,103,177	-		3,122,435,996	141,378,920	3,311,918,093
17	518	Kamwenge District	86,440,626	1,000,000,000	250,000,000	2,862,862,744	259,604,907	4,458,908,277
25	526	Kisoro District	102,311,301	500,000,000		4,947,241,216	583,862,464	6,133,414,980
29	530	Kyenjojo District	80,427,729	1,000,000,000		3,228,061,377	395,914,769	4,704,403,875
55	556	Yumbe District	68,401,935	1,000,000,000		3,155,964,551	390,495,412	4,614,861,898
59	560	Isingiro District	126,362,889	500,000,000		2,842,470,451	327,833,679	3,796,667,019
62	563	Koboko District	42,090,280	-		581,971,077	191,362,790	815,424,147
83	584	Kyegegwa District	42,182,329	500,000,000		1,666,936,708	111,802,656	2,320,921,693
84	585	Lamwo District	60,221,021	500,000,000		1,646,489,378	133,805,135	2,340,515,534
		Kiryandongo District	30,064,486	-		224,363,862	452,180,523	2,725,883,629
			903,162,119	5,500,000,000	250,000,000	35,079,447,824	4,174,492,447	45,907,102,389

MPS MOH 2018/19

6 Introduction

Uganda has had an open-door refugee culture over the last 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, the total 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 potential for conflict and famine vulnerability in the Great Lakes Region, more refugee influxes and protracted refugee situations are anticipated in the coming years.

Uganda's open-door policy exerts pressure on the social amenities meant for local communities, a situation that exposes refugees and host communities to competition for available health resources. The sheer scale of the crisis is putting the national and district health systems, host-communities, and implementing partners under tremendous stress. Operating parallel health systems for refugees and host communities, in the context of limited and diminishing health resources is not helping this situation as it is not sustainable and promotes inequities.

Against this background, the Ministry of Health (MoH) with partners embarked on developing the Integrated Health Sector Refugee Response Plan to feed into the Comprehensive Refugee Response Framework that is being coordinated by the Office of the Prime Minister.

It is hoped that the integrated health sector refugee response plan will improve the national health systems resilience to with-stand shocks and the existing inequities in accessing essential health services for refugees and host communities, through better coordination of partners, resource mobilisation and integrated health service programming and provision.

The process of developing the response plan was participatory involving the key stakeholders; Ministry of Health, Regional Referral Hospitals, Local Governments, the United Nations Agencies, Foreign missions, Donors, Development and Implementing partners. A draft 0 response plan was developed by a team of consultants, MoH constituted a Technical Working Group that produced the draft 1 that was presented to the CRRF secretariat in OPM for inputs and comments on the overall direction of the response of the plan. The document was presented to the Senior Top Management of the Ministry of Health which made inputs to the document and approved it for presentation to the Steering committee in the OPM.

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6.3 Result of the Plan.

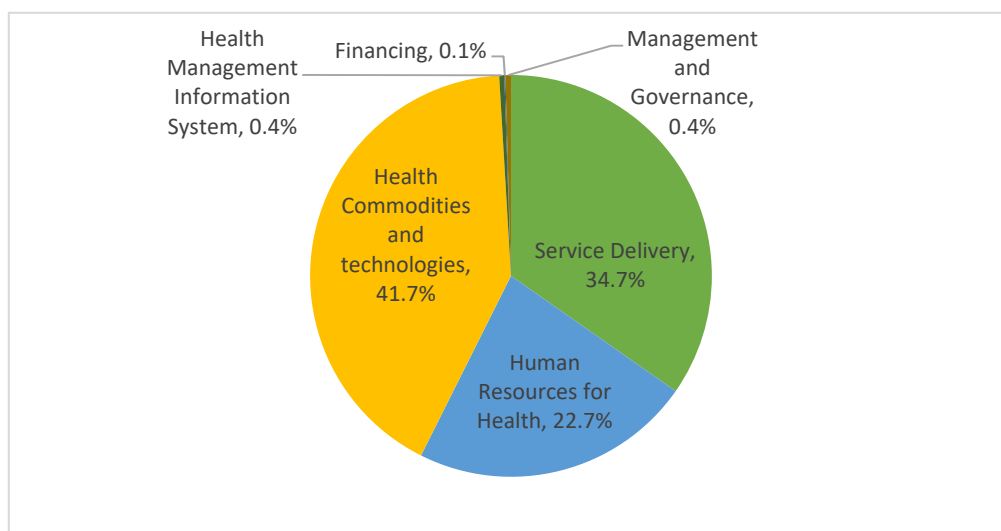
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Figure 1: Distribution of Resource Estimates.



6.4 Financing of plan.

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 organizations, development partners will constitute the main sources of funding for the implementation of this strategy.

Financing Gap analysis

The government of Uganda with support from the partners committed resources towards the implementation of the IRRP. The GoU resource will be channelled through the budget support to the Health sector and the Local governments. At the time of finalizing the costing exercise, commitments earmarked from GoU and the Partners had been complied and estimated to about US \$ 142 million resulting into a funding gap of about US \$ 415.7 million

Table 4: Funding gap Analysis

Funding Gap Analysis (US\$ '000')						
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals
IRRP Estimates	102,388	112,440	115,064	103,461	124,815	558,168
Government of Uganda	12,577	13,206	13,866	14,560	15,288	69,497
Development Partners.						
IOM						
UNCHR	21,973	18,166	20,891			61,030
UNDP						-
UNFPA						-
UNICEF	4,059	4,059				8,119
USG						-
WHO	1,250	1,250	1,250			3,750
DFID						
Projected resources	39,859	36,682	36,008	14,560	15,288	142,396
Funding Gap	62,529	75,758	79,056	88,901	109,527	415,772

Closing the Gap

The challenges of the refugee situation continue to hit the IRRP districts and the country at large, resources to deal with this are in short supply. The GoU allocations to the IRRP district for the year 2018/19 is estimated at about Ugx 45.9 billion (US \$ 12.7 Million), the need for the response plan is estimated at US \$ 102.5 Million, representing a 12% government of Uganda commitment. The funding gap of about 88% needs to be filled in by additional domestic resources and support from the development partners and private sector players.

The government need to mobilize addition resources as listed below.

- Advocate and lobby for addition Domestic resources to the Health sector, and the District Local Government for the decentralized health services.
- Seek to strengthen relations with existing development partners as well courting new Funding/ Donor Partners for external support. These will include both the Multilaterals and bilateral partners.
- Explore other funding mechanism through Grants and proposal Applications from Humanitarian Agencies
- Engage the Private sector players for more involving partnerships in the IRRP
- Improve program efficiency.
- Ensure timely program and financial accountabilities as well as transparency in program implementation.

- Joint planning for the Response to minimize duplications and ensure equity in service delivery.

Annexes:

Table 5 Resource Estimates as per Service Pillars

Summary as Program Pillars							
	2018/19	2019/20	2020/21	2021/22	2022/23	Totals	
Service Delivery	51,443	53,242	45,598	24,344	19,122	193,750	34.7%
Human Resources for Health	25,481	25,095	25,443	25,112	25,450	126,582	22.7%
Health Commodities and technologies	24,076	33,274	42,900	53,108	79,245	232,603	41.7%
Health Management Information System	781	252	516	267	412	2,228	0.4%
Financing	113	120	136	84	87	540	0.1%
Management and Governance	494	457	470	545	499	2,466	0.4%
	102,388	112,440	115,064	103,461	124,815	558,168	

Table 6: Provisional District Allocation

Summary as per District Allocations

Name	2018/19	2019/20	2020/21	2021/22	2022/23	Totals
Arua	14,727	13,490	14,792	13,567	15,516	72,092
Yumbe	11,283	9,522	9,330	9,862	12,067	52,065
Moyo	5,889	5,711	7,242	7,561	8,780	35,182
Adjumani	7,595	7,531	8,991	7,977	9,277	41,371
Hoima	10,363	8,284	9,727	10,215	12,312	50,900
Kiryadongo	6,352	8,453	7,707	6,656	8,387	37,556
Kyegegwa	5,495	5,508	6,869	6,341	8,111	32,325
Isingiro	10,050	10,555	10,696	10,639	11,634	53,574
Lamwo	5,632	5,357	8,286	5,807	7,654	32,735
Kampala	11,366	15,038	16,420	11,101	15,940	69,866
Kamwenge	8,964	12,539	10,409	8,364	9,554	49,829
Koboko	4,672	10,453	4,595	5,370	5,583	30,672
Totals	102,388	112,440	115,064	103,461	124,815	558,168

Table 7: Provisional Government of Uganda Allocation to selected IRRP districts for the year 2018/19

S/N	Vote No.	District	HEALTH DEVELOPMENT GRANT (IGFT LOAN)		TRANSITIONAL DEVELOPMENT AD HOC HEALTH (UGX)	Wage Bill (UGX)	Non-Wage Bill (UGX)	Total FY 2018/19 (UGX)
			Allocation of Health Infrastructure Maintenance (UGX)	Allocation for upgrade of HCIs to HC IIIs (UGX)				
1	501	Adjumani District	54,208,123	500,000,000		4,517,655,759	484,550,057	5,556,413,940
3	503	Arua District	162,348,223	-		4,263,719,946	701,701,135	5,127,769,305
9	509	Hoima District	48,103,177	-		3,122,435,996	141,378,920	3,311,918,093
17	518	Kamwenge District	86,440,626	1,000,000,000	250,000,000	2,862,862,744	259,604,907	4,458,908,277
25	526	Kisoro District	102,311,301	500,000,000		4,947,241,216	583,862,464	6,133,414,980
29	530	Kyenjojo District	80,427,729	1,000,000,000		3,228,061,377	395,914,769	4,704,403,875
55	556	Yumbe District	68,401,935	1,000,000,000		3,155,964,551	390,495,412	4,614,861,898
59	560	Isingiro District	126,362,889	500,000,000		2,842,470,451	327,833,679	3,796,667,019
62	563	Koboko District	42,090,280	-		581,971,077	191,362,790	815,424,147
83	584	Kyegegwa District	42,182,329	500,000,000		1,666,936,708	111,802,656	2,320,921,693
84	585	Lamwo District	60,221,021	500,000,000		1,646,489,378	133,805,135	2,340,515,534
		Kiryandongo District	30,064,486	-		2243638620	452,180,523	2,725,883,629
			903,162,119	5,500,000,000	250,000,000	35,079,447,824	4,174,492,447	45,907,102,389

MPS MOH 2018/19