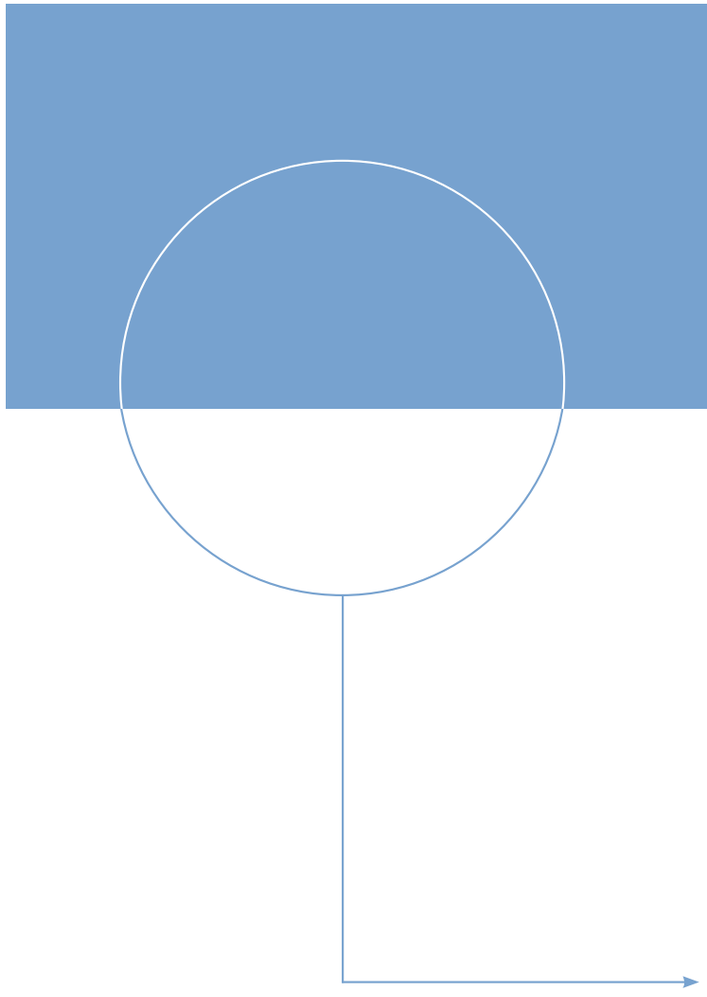

Master's thesis

2019

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Challenges of Health System Delivery in Refugee Affected Environments: A qualitative study from the perspective of Humanitarian Health Workers in Western Uganda

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Challenges of Health System Delivery in Refugee Affected Environments: A qualitative study from the perspective of Humanitarian Health Workers in Western Uganda

Public Health, specializing in Global Health
Submission date: June 2019
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Abstract

Background: The number of forcibly displaced people is on the rise globally and have increased for the 6th year in row. Unable to meet their own needs, Uganda is the largest host country in Africa and are currently hosting 1.2 million refugees. United Nations High Commissioner for refugees (UNHCR), the Government and various partners are working together though an integrated strategy, providing social services to both refugees and the host population in Uganda. The refugee hosting areas is providing support beyond capacity affected by underlying factors as under funding, poverty and limited resources. The enormous pressure is affecting the health service delivery as well as the health workers are working in a challenging, overstrained and unstable context, unable to meet the populations need. Identifying the challenges and gaps in the refugee affected environments is a step towards addressing better solutions.

Purpose: The purpose of the study is to explore, identify gaps and challenges, and understand the health service delivery in the refugee affected environments in western Uganda.

Design and methods: The qualitative study represents 63 semi-structured interviews of national humanitarian health workers conducted in the district of Kyegegwa, Hoima, Arua and Bidi Bidi, west Uganda. Malteruds Systematic Text Condensation (STC) and NVivo software were used to analyse the data.

Results: Exploring the gaps and challenges of the health service delivery from the health workers' perspective, five main themes are identified **1)** Gaps and challenges at the health facilities, **2)** Community factors, **3)** The situation of health workers, **4)** Management and **5)** Inequalities between health workers and between refugees and hosts.

Conclusion: The study indicates a big gap in the health service delivery in refugee affected environments in western Uganda. Better funding mechanisms and access to health services for both refugees and hosts should be addressed. The study provides new insight about the situation of the national humanitarian health workers, suggesting more attention to the difficult situation and the unfair treatment of health workers. The study identifies gaps and challenges, and further research should focus on addressing the gaps and finding sustainable solutions.

K**eywords: Health service delivery, Refugee affected environment, National humanitarian health workers, West Uganda**

Acknowledgements

I would like to take this opportunity to thank my supervisors, professor Valentina Iversen and professor Muhammad H Zaman. They have been supportive through the whole process, from developing the study, making the data collection possible and guidance of analysing and writing the thesis. I'm grateful and honoured to be working with such experienced, professional and motivating supervisors. They have also been a driving force for making the project happen and pushing me out of my comfort zone.

I am also very grateful for my supportive partners in the field from United Nation Population fund (UNFPA) of Uganda. They have provided all the support needed to conduct the study in the four refugee settlements and without their guidance and logistical support, the study had not been possible. Special thanks to the country Representative Alain Sibenaler, the Program Analysts in Kangwali and Kyaka 2 refugee settlement, Denis Bakomeza and Francis Engwau in Rhino Camp and Bidi Bidi refugee settlement. Big thanks to the driver Enos and John for helping me around and keeping up with all my questions. I most also mention the field workers Roger, Joan and the team at CARE in Arua for the good support!

Also, I would like to thank all the participants for sharing their experiences and challenges.

Last, I will thank the faculty of Medicine and Health Science and the department of Public Health at the Norwegian University of Science and Technology (NTNU) for giving me the opportunity and for funding the study.

Abbreviation

UNHCR- United Nations High Commissioner for Refugees

IDP- Internally Displaced Population

DRC- Democratic Republic of Congo

STC- Systematic Text Condensation

NGO- Non- Government Organisation

SRS- Self-Reliant Strategy

ReHope- Refugee and Host Population Empowerment

CRRF- Comprehensive Refugee Response Framework

WHO- World Health Organization

HR- Human Resources

PTSD- Post Traumatic Stress Disorder

SRH- Sexual Reproductive Health

HIV- Human Immunodeficiency Virus

ART- Antiretroviral Therapy

STI- Sexual Transmitted Infections

TB- Tuberculosis

UNFPA- United Nation Population fund

VHT- Village Health Team

Table of content

1. Introduction

There have never been more people forced out of their homes than today. As a result of persecution, conflicts, violence and/or human rights violations, the number of forcibly displaced people have increased for the 6th year in row and remains record high (1). According to the United Nations High commissioner for refugees (UNHCR), approximately 68.5 million individuals are forced out of their homes. Of these, refugees are contributing to 25.4 million of the forcibly displaced people, 40 million are internally displaced people (IDP) and 3.1 million are asylum seekers (1). The driven displacement of today are the conflicts in Syrian Arab Republic, Burundi, Central African Republic, Democratic Republic of Congo (DRC), Iraq, Myanmar, South Sudan, Ukraine and Yemen. Responding to these protracted crises and the high influx of refugees, developing regions are hosting 85 per cent of the displaced people. This means that the least developed countries, unable to meet their own needs, are largely hosting the displaced people and providing humanitarian assistance. This puts enormous pressure on the resources of host communities and the environment, as well as straining the resources of the humanitarian system (1). Especially the health services are constrained as it needs to care for an overwhelming, unstable, war or catastrophic affected population. Lack of funding, human resources, logistics, equipment and other essential resources are making the situations for the refugees, the nationals in the affected areas and the humanitarian workers very challenging.

As one of the largest asylum countries worldwide and the largest in Africa, Uganda is currently hosting over 1.2 million refugees (1). Since independency in 1959 Uganda have continuously hosted refugee and asylum seekers, the open refugee policy is seen as the most progressive in the world (2). Refugees have free access to social services, free movement and freedom to work (2). The Government of Uganda together with UNHCR are providing services through an integrated model, supporting both refugees and the nationals. The humanitarian aid is giving support to a growing population and is severely underfunded (2). According to UNHCR, the financial requirements for Uganda is underfunded by 96 per cent, lacking 429 million to meet the need of the displaced population (3). This put a lot of pressure on the humanitarian response. The health system is suffering and serving a population beyond capacity, and especially the underlying factors of poverty and limited resources make the refugee affected areas vulnerable (2).

According to literature review by Blanchet, Sistenich (4) the focus on research of health interventions in humanitarian crises has increased, and during the period of 2000 to 2012 the

research published had increased by 76 per cent. Even though the focus globally has increased, each setting and crises is different. Looking at the increasing crises and the high numbers of displacements that needs to be supported and cared for (1), the research stays generally limited. Blanchet suggests a need of studies focusing on the diversity of crises, the different contexts and health care (4).

The present study investigates the health service delivery in refugee environments, including four refugee settlements, Kyaka 2, Kangwali, Rhino Camp and Bidi Bidi, as well as two local government facilities in west Uganda. The present study provides a detailed assessment of the gaps and challenges in the refugee environments from the health workers perspective. The study focuses on access of health services for both refugees and host population, the challenges at the facilities and the challenging conditions of the national health workers' working in the humanitarian context.

The structure of the thesis follows the format of IMRAD, the scientific publication standards and guidelines provided by the Norwegian University of Science and Technology (NTNU). Introducing the humanitarian response in Uganda, the thesis presents the health system delivery in the refugee affected environments, the health workers situation, host and refugee environment and the refugees living in Uganda today, as well as other literature from the context. Chapter two present the rational and the study's objectives. The qualitative methodology, the study setting, sample, data collection, Malteruds Systematic Text Condensation (STC) and the process of analyses is presented in chapter three. The result introduces the five main themes; **1)** Gaps and challenges at the health facilities, **2)** The health workers' situation, **3)** Community factors, **4)** Management and **5)** Inequalities. The main findings are discussed in chapter five along with limitations and strengths of the study.

Background

1.1.1 The humanitarian response in Uganda

United Nations High Commissioner for Refugees is the leading humanitarian agency for refugees and serves as a guardian of the 1951 convention, which defines the term refugee and their rights, as well as the legal obligation of a state to protect displaced people (5). Today the face of the humanitarian aid is complex, including a variety of Non-Government Organisations (NGO) and organisations from many countries providing support and development (6). A humanitarian action is according to Development Initiatives (DI) defined as an action intended to *"save lives, alleviate suffering and maintain human dignity during*

and after man-made crises and disasters caused by natural hazards, as well as to prevent and strengthen preparedness for when such situations occur" (7). The humanitarian crises are becoming more protracted and complex and there is a need of long-term development responses in the context of crises. As Dalrymple (8) discusses, there is a need of more joined-up approaches including development, crises and peace agendas to strengthen the effectiveness of the humanitarian action, in order to meet the target of the 2030 agenda "leaving no one behind" (Sustainable Development Goals) (8).

The historical high number of refugees today in Uganda is a response to three concurrent crises in South Sudan, The Democratic Republic of Congo (DRC) and Burundi (1). Uganda has had a long history of receiving migrants looking for economic possibilities and refugees seeking freedom. Before independence in 1962, Uganda received migrants crossing the border mostly for economic reasons or colonial services, and European refugees fleeing from Second World War. The 1950s was the period of liberation wars in the African continent and a start of conflicts, geopolitical strife and ethnicity rivalries and instabilities. As a host state, Uganda has received refuges from most of the neighbouring countries affected by conflicts, instabilities and violence (9). According to the World Bank group (2) Uganda is generously hosting the refugees with the most progressive laws in the world. The 2006 Refugees Act and 2010 Refugees regulation provides freedom and protection for refugees. The open-door policy welcomes all asylum seekers no matter nationality and ethnicity, with the freedom to move and the right of employment. Each refugee family is provided with their own land for agricultural use. The refugees are self-settled or live in organized settlements of 350 square miles provided by the Government (2). The humanitarian response is providing services through an integrated strategy including both refugees and the host population. The Government in collaboration with UNHCR and other partners introduced the Self-Reliant Strategy (SRS) in 1998. The strategy aims to empower refugees and nationals in the area to the extent that they would be able to support themselves and ensure integration of services for the refugees and for the nationals (10). After the SRS was implemented, other host-refugee development initiatives have been taken. Focusing on an integrated strategy, the Refugee and Host Population Empowerment (ReHoPe) is an initiative by the Comprehensive Refugee Response Framework (CRRF) of the New York Declaration on Refugee and migrants and a part of the of the UN Development Assistance Framework for Uganda. Uganda was officially the first country to integrate CRRF. The ReHope strategy aims to provide equal services and support to the refugees as well as the host community around in collaboration between

UNHCR, the Government and other NGO`s. The refugees are also included in the National framework of Uganda focusing on a long-term solution (11). Blanchet systematic literature review found that the majority of studies studying health services delivery in humanitarian setting focuses on acute crises (72 %). As many of the crises is protracted, the humanitarian setting is different from the acute crises, influencing the whole environment, including both the people of concern and the hosts living in the area, the workers, the system at different levels, politics, economics etc. Blanchet, Sistenich (4) included studies form a wide range of geographic areas, and the most common region was the middle east, followed by Asia, East Europe, the Caribbean, Africa and at least South America (4). Indicating a gap of research, and a need of more diversity, including a wider geographic perspective and better understanding of the complexity of the protected crises.

1.1.2 The health service delivery in Uganda

According to World Health Organization (WHO), a well-functioning health system is when a health system responds to the population in need and their expectations, including the key components of improving the health status, defending the population, protect financial suffering of ill-health, equitable access and possibility for the patients to take part of the decisions affecting their health (12). In the context of the humanitarian crises, the health services for refugees and host population are often provided through either a parallel or in an integrated system. The parallel system provides health services to refugees through a separate structure than to the host population. An integrated system delivers health services to both host and refugees though one structure. In Uganda, the health system is responding with an integrated system supported by the Government of Uganda, UNHCR and other partners (NGOs) (2). The health services in the settlements provide first-line health care, including maternal and child health, immunisation and family planning and both outpatients and inpatients consultations (13). If there is any serious medical or surgical condition, the patients are referred to government hospitals in the refugee-hosting district or to the nearest region hospitals. All the health centres located in the settlements are free and open to all the nationals in the area as well as the refugees (2). The case study by Orach, Dubourg (14) describes how the host and refugee services in west Nile Uganda have been integrated. The study found that the integrated system contributed to improve the geographic and the accessibility of health services, especially for the populations in the rural area.

1.1.3 The humanitarian health workers

The health workers are working in a challenging context, prone to traumatic events, a variation of diseases and epidemics. The British newspaper Guardian published an article in 2015 were the UN aid worker Brenda McDonald raised an important issue. She stated that "*the humanitarian agencies are failing their staff"* (15). The article discusses the lack of support and welfare for humanitarian aid workers. Challenges of being exposed to stress, traumas, the rising number of attacks on workers and families left behind, lack of insurance and challenging working conditions were reported in the article. McDonald sheds light on the neglected issues facing humanitarian workers (15). Looking at the health workers' experiences of working in a humanitarian setting, McMahon, Kennedy (16), investigated the social and emotional impact of delivering services during Sierra Leone`s Ebola epidemic and emphasizes much on the lack of attention given to the aid providers. The health workers reported experiences of changes in their professional lives, communities and homes, and describe a sense of stigmatizing, suffering, loneliness, isolation, and sadness. The research demonstrates the need of psychosocial attention to the health workers, as well as it addresses the critical shortfalls in Human Resources (HR) for health (16). A longitude-study by Lopes Cardozo, Gotway Crawford (17) looked at the mental health of international humanitarian aid workers from 19 NGOs and found that the workers had an increased risk of depression and burnout after returning from deployment. The study also shows a concern regarding the level of life satisfaction, the aid workers reported lower level after deployment (17). Trauma exposure and Post Traumatic Stress Disorder (PTSD) symptoms with international relief and development personnel were studied by Eriksson, Kemp (18). The study found a high rate of humanitarian workers being directly or indirectly exposed to traumatic events and being at risk of developing PTSD. A high number of the humanitarian workers reported to experience life threatening events, and of those, 30 per cent reported symptoms of PTSD. The study gives attention to the challenging context of an aid worker, the importance of follow-up and support. Even though 90 % of the humanitarian workforce are national workers, studies have generally focused on the international staff, and little attention has been given to the national workers (19). Ager, Pasha (20) examined the mental health of national humanitarian aid workers in the northern Uganda in the Gulu district. The survey was conducted among 376 national staff and found that 50 % of the workers had experienced 5 or more categories of traumatic events. The humanitarian aid workers were from 21 different NGOs and were at high risk for depression, anxiety disorders and PTSD. One quarter and up to half of the workers reported significantly high levels of symptoms of being burned out. The study

reported social support, strong team cohesion and reduction in chronic stressors to be associated with better mental health. The most reported exposed stressors were financial and economic problems, high workload and tension between the international and national staffs because of the different treatment by the employers (20). Working in a humanitarian context, the health workers receive refugees from countries of conflicts where important infrastructure has been destroyed and has been so for decades. Especially the lack of health care puts a high pressure on the health services delivery in the settlements and the refugees have complex health issues often including traumatic experiences. Studying the impact of conflicts on healthcare, Kagabo, Frost (21), conducted a study in Rhino Camp refugee settlement located in the West Nile region of Uganda, showing concerns regarding that healthcare providers' situation. The study reports that issues of poor housing, food shortage, bad roads and difficulties of transportation affect the health worker personally as well as it influences the health services delivery in the settlement. The many refugees arriving in the settlement had led to issues for overpopulation and an increased workload, and many of the health workers were burned out. Lack of protection wear, distances to the facilities, language barriers, over-crowded facilities and being over-stressed were reported among the health workers (21). Mowafi, Nowak (22) reports a growing crisis of human rescores (HR) in the humanitarian health services. They identified four major problems affecting the HR including lack of resources in the most needed areas, lack of recognition of HR to be important by funding agencies, lack of investment in HR by governments and NGOs (even when funds are available), and coordination of training to meet the need in the humanitarian relief. Through the humanitarian working group they identify key strategies for successful development of HR that included mentorship, measures of competence, a wide scope of education focusing on humanitarian assistance and developing capacity to benefit the community's participants in the humanitarian work (22).

Kagabo, Frost (21) and Ager, Pasha (20) paid attention to the national workers in Uganda, reporting burnouts and poor working conditions as affecting the health services and the workers personally. Mowafi, Nowak (22), implies recognition and investment of HR among funding agency to play an important role of improving the health services, health workers' situation and other general working conditions.

1.1.4 Challenges of health service delivery

With the high influx of 1.2 million refugees (1), the humanitarian response system is working beyond capacity, and the healthcare institution are vulnerable and at a constant risk of being overwhelmed by the increasing population (3). The West Nile region of Uganda reports one to two outbreaks of epidemics such as; cholera, meningococcal meningitis, plague, measles or/and hepatitis E every year in each of the districts (23). The hosting of the Sudanese and Congolese refugees has been a key risk factor for the epidemics in the west Nile Region. The poor conditions of living in the settlements make the region prone to outbreaks and affect the host environment. The study concluded that inadequate implementation of prevention and preparedness of epidemics in the West Nile region could affect the occurrence of epidemics and the poor epidemic response could account for the high fatality in the area (23). Adaku, Okello (24) studied the mental health and psychosocial support for South Sudanese in the Rhino Camp refugee settlement, West Nile. The South Sudanese refugees reported lack of basic needs and health care services. Overall the assessment done indicates a largely unmet need of services to promote and protect the psychosocial wellbeing and missing treatment of mental disorders (24). Looking at severe mental disorders in complex emergencies, Jones, Asare (25), discusses why the issue is neglected and how mental health services can be provided in the humanitarian services. The NGOs providing mental health services is often just a small part of what is needed. In this setting, most people with severe mental health disorders remain unidentified, untreated and unable to access the services. Lack of resources, different perception of what is a medical problem, different help seeking mechanisms and stigma are often hurdles for accessing the services. The attention given to the mental services is often neglected as infections and more acute conditions in a humanitarian setting are more prioritised (25). The paper also discusses the minimal training on mental health management and lack of skills to recognize the patients with mental health disorders by the health workers in humanitarian settings (25). A recent study (2018) was conducted on quality of care in children with acute malnutrition at the health centres in the western Nile region (26). The study by Wanzira, Muyinda (26) found that the quality of care provided to the children with malnutrition at a health centres in the district of Arua is substandard with unacceptable low cure rates. Underlying factors as lack equipment, poorly organised services including irregular working hours, long waiting time and weak community linkage, was suggested to explain the low cure rates. The study shows gaps and lack of services in the refugee affected district as well the services in the settlement. The overall health services in Uganda and especially in the refugee district are largely inadequate (26).

Sexual and reproductive health (SRH) knowledge and access to services among girls and young women in crises and humanitarian situation are proven to be challenging. Ivanova, Rai (27), investigated the issue of reproductive health and knowledge in a humanitarian setting. The systematic review showed that young women and girls were lacking knowledge about reproductive issues. The access to information were often hindered because of barriers such as stigma related to young age and challenges related to distance, costs and quality (27). The three-delay model are well known in the literature and provides a framework of understanding the factors affecting emergency presentation resulting in maternal mortality (28). The model shows the importance of timely treatment and the factors affecting the delays. Several factors are contributing in delaying the process of getting timely treatment and can also be reversed by limiting the delaying factors (28). Thaddeus and Maine (29) have investigated the barriers delaying the process of receiving help and affecting the maternal mortality. As time is critical to prevent mortality, each delay puts the patient at an increased risk. The three- delay model describes the phases of delays: *Phase 1) Deciding to seek care, Phase 2) Identifying and reaching medical facility and phase 3) Receiving adequate and appropriate treatment.* Many factors are affecting the delays in each phase, Thaddeus and Maine (29) discuss how the dession to seek help can be affected by distance, cost and other socioeconomic and culture factors. The characteristics of the patient and the perceived quality of care will also influence the decision to seek help. The second delay, *reaching a medical facility* is also affecting *the decision to seek help*, as well as the determine the time spent to reach a facility when deciding to seek help. The location of the facilities, the travel distance and getting the transport needed, is factors delaying the process of reaching a health facility. Even though the patient manages to get pass phase 2 and arrive at the health facility it will not necessary mean that a patient will get help. Given that typically the facility is not equipped for treating the condition, and phase 2 continues to the patient reach an adequate facility as well as the risk of death is significantly high. Reaching phase 3, challenges at the facility will contribute to delays and quality of treatment. The shortage of staff, essential equipment, supplies, drugs, blood and management will all increase the risk of death (29).

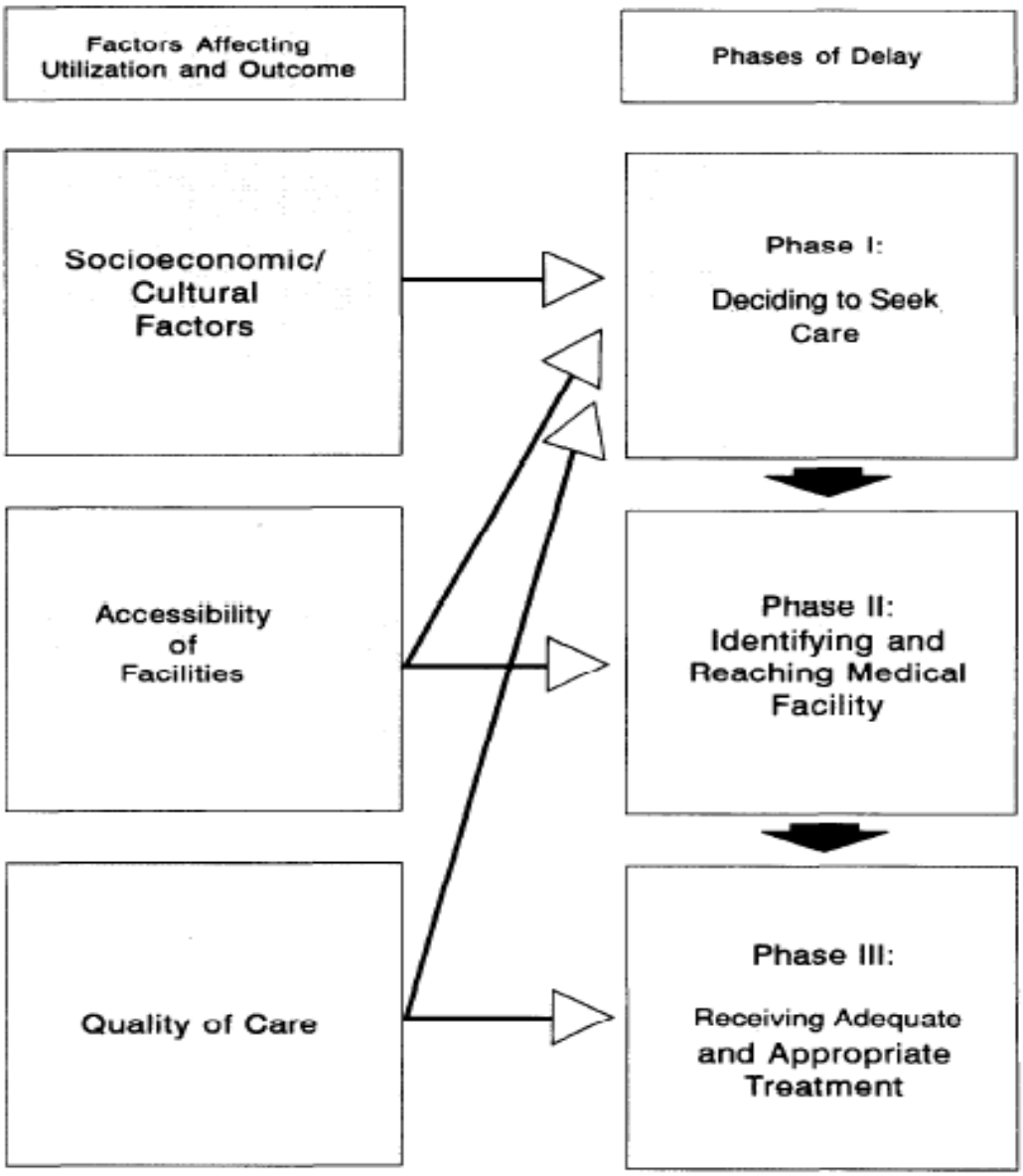

Figure 1: The three- Delay model. (Source: Study of Thaddeus and Maine, accessed 15th of May 2019)

A study on HIV care was conducted in the Nakivale Refugee settlement located in the southwest of Uganda and found that less than a quarter of newly HIV diagnosed clients completed the Antiretroviral Therapy (ART) assessment, lower than what other reports from the sub-Sahara region reported (30). A follow up study was done the year after in the same settlement, and O'Laughlin, Rouhani (31) investigated the refugees experiences using antiretroviral therapy (ART). Barriers to follow up the ART treatment were reported to include difficulties of accessing the clinic when ill, food security, drug stockouts and violence and unrest in the settlement (31). Kagabo, Frost (21) study also looked at the challenges of the healthcare system. Their findings reveal challenges at different levels: health system and government level, healthcare providers and refugee level. The factors identified at the different levels are interconnected and influence the refugees` health outcome and the

healthcare system of the host country. They reported an overstrained system with lack of health providers, medicines, food and water, other resources like beds and admission wards in the facilities. An over strained budget with inadequate services due to over-population were factors reported to affect the health services. Too few healthcare facilities, the camp to be too big to cover and loss of follow up of patients were also issues reported in the study (21). Meyer, Meyer (32), studied protection and well- being among South Sudanese refugees in Uganda and found that refugees worried about the lack of basic needs and food security. They worried more when new refugees arrived in the settlement, as much attention by the humanitarian services were given to the new arrivals. They also experienced the new arriving refugees to be more aggressive and violent mainly affecting the security of the adolescent. Food security and lack of provision of basic needs in the settlement were also closely associated with the caregivers preforming violence against the adolescents, due to stress of household. Protection, food and other basic need were reported as important issues to address (32).

How the illness impacts an individual, a household, the community and how the state shapes the medical knowledge are all important questions in understanding how health is understood and perceived. What becomes a value and how the population are adapting to it will affect their health and health behaviours (33). Napier, Ancarno (33), and their colleagues discuss the importance of not ignoring the cultural values when investigating health and the importance of identifying how the culture can promote health, especially in the context where resources are limited. The study implies challenges of communication as barriers to seek help or to get the needed help. Language barriers and the use of difficult medical words for a not educated individuals could also be a barrier for seeking services. How the perception of health is perceived varies across and within systems of value, individual experiences within diverse contexts and behaviour patterns. As the refugees changes their environment and living conditions, they often change how they act and how they perceive health and wellbeing (33). Roberts, Odong (34), explores the social determinants of health among IDP in north Uganda and found changes in social and culture norms. The displaced people reported activities of prostitution, adultery, violation and thieving to increase as effect of war, displacement and the living conditions in the settlement. Alcohol consumption was also reported as a contribution to poor mental health. The study also found traditional local practices for treatment both for physical needs and more for mental health were used instead of the health services provided or beside of the health services. Religion was also an

important factor when it came to support their health. Religion, traditional treatment and health care at the facility could both be combined or used separately. Tackling mental health or emotional problems, many used their family and friends, while others reported isolation for dealing with emotional or mental health problems (34). Poor health seeking behaviours were found among adolescent pregnant girls and for their children in central Uganda (35). Community stigmatization and violence were suggested as making it challenging to get social support. The study also found that the adolescent mothers were less likely to seek for second and third dose of vaccination for their infants compared to the adult mothers (35). High number of teenage pregnancies were also reported in Rhino Camp. The number of teenage pregnancies had dramatically increased the last months. As affecting the problem, the study suggests birth control only to be provided for girls over 18 years old (21). Social and cultural factors have shown to be barriers for seeking sexual and reproductive health (SRH) knowledge and services. Metusela, Ussher (36) found that among the migrant and refugee women, many of them had inadequate knowledge about SRH due to taboos associated with contraception and experiences of menstruation and sexuality. The lack of knowledge and their perception of SRH were barriers to seek knowledge, preventive screening methods including contraceptives, accessing education and information, sexual health screening, which made them vulnerable to SRH problems such as sexual transmitted infections (STI) and unplanned pregnancies (36).

Betancourt, Speelman (37) investigated the local perception of mental health problems among Acholi children and the adults displaced by war in northern Uganda. The study was conducted in Gulu district and in the IDP camps. The study found that the local perception of mental health included culture specific defined symptoms. The locally defined mental health problems were similar to western medicine definition of mood, anxiety and other known mental health disorders, but include culture specific symptoms and different names. Other problems identified by the war affected population raged from lack of food, lack of clothes and lack of school fees, concerns about insecurity, fear of abduction, rape, dropping out of school, fighting, being stubborn and disinterested (37).

The three-delay model shows several factors contributing to the different phases of delays, and are affecting when (timely) and even if the patient gets the needed health care (29). Other community factors as stigma, lack of knowledge, religion, traditions and perception of health was reported to affect the access of health services (27, 33-35, 37), as well as the lack of

basic needs and the challenging living-conditions introduced new activities in the settlements affecting the health of the refugees or IDPs (34, 37, 38).

1.1.5 Host and refugee population

The refugee hosting district in Uganda includes Adjumani, Arua, Koboko, Moyo, Yumbe and Lamwo in the North Uganda, Hoima, Isingiro, Kamenge, Kiryandongo and Kyegegwa in the South- and Mid-west of Uganda and the capital, Kampala (39). Within the refugee hosting districts, the refugees and the Ugandans face similar challenges of development and access to basic services. The refugee impacted districts compared to the not hosting district are also more vulnerable to tackle the impact of conflict, economic shocks and environmental challenges (11). “Is it better to be a refugee?” the host population in Kakuma, Kenya asked (40). Aukot (40) discusses areas of conflict in the relationship between the host and refugee populations in Kenya. The failure of local integration is affecting the refugee-host relation negatively. Legislation that enhance refugees’ rights will not improve the refugees living conditions if the impact on the hosts and their economy is not accounted for. The host population in Kakuma faces the same problem as the refugees as they are living in a poor context. But due to the aid provided for the refugees, the refugees were better off than the host is the same area. Conflicts of crime, resources and blaming each other were reported to affect the relation negatively. The study also found that the host population desired to be involved with hosting the refugees (40).The demands in the refugee-hosting district in Uganda are already stressed of sharing the base of resources. A study on post emergency health services for refugees and host population in West Nile region from 1999 to 2002, found that rates of major obstetrics interventions were higher among the refugees than the hosts and the maternal mortality rate was 2.5 times higher for host population compared to refugees living in the same area. The findings indicates that refugees had better access to health services than the nationals (41). More attention has been given to the host communities through different interventions, and last the ReHope strategy implemented in 2016 (11). Focusing on harmony between the host community and refugees, providing support to the integrated health system and as well as equal access to services. A study conducted in Kyaka 2, Kangwali and Nikavlae in the Mid- South-west of Uganda focused on the effect of refugees on the local population in Uganda (42). Kreibaum (42) findings suggest that the Ugandan population living nearby the refugee settlements could benefit from some of the interventions and public services, for example schools run by NGOs were mentioned as beneficiary for both. The health services appear to be overrun by the demands, and the

communities in the refugee hosting districts were less likely to have access to public clinics compared to other not hosting districts in Uganda. Some employment groups in the host environment benefit from the increased population while other groups are vulnerable to a negative effect and losses due to the high influx of refugees (42). They were forced into competition with the refugees in the labour market. The study underlies importance of including the host population in the refugee relief as well as more information about the benefits the refugees bring should be given to the host population. The study also implies better coordination between international donors and the local government, ensuring the refugee- hosting districts equally off with the not hosting districts, not better or worse (42). Kasozi, Kasozi (43), studied the access to health care by the urban refugees living in Kampala. They found that the access was influenced by the availability of health care and closeness to health facilities, hindered by the cost of the health care, long waiting lines and low acceptability of the services. The refugees had a low perception of the health care compared to the nationals. The availability of services includes geographically, affordability and availability. Language barriers was also reported by the urban refugees, not understand Luganda or English was a challenge when seeking help in the city (43).

1.1.6 The refugees in Uganda

The first waves of refugees came from Sudan after the Egyptian-Britain condominium was lifted, and the civil war brook out 1955. Followed by another wave from Rwanda and DRC after Belgium relinquished its mandate in 1959 and the 1960s (9). As a host country Uganda has received refugees from Somalia, Kenya, Ethiopia and smaller groups of refugees from South Africa, Mozambique, Angola, Liberia, Chad, Cameroon, China and Iraq during their history (13). With a history of political instabilities, Ugandans have experiences of being both internally displaced and refugees. During the military rule of Idi Amin Dada from 1971-1979, internal conflict and government persecution led to over 500 000 deaths and thousands of academics fled for exile and over 70 000 Uganda Asians were expelled from Uganda. Unable to restore the economic and political stability, battles between the resistance group National Resistance Army (NRA) and the government continued. Even after NRA occupied Kampala in 1986, the civil war in the north continued. Rebel activity in the north and eastern Uganda escalated, first by the Uganda people's Democratic Army, the Holy Spirit by Alice Lakwena and continued by Lord`s Resistance Army (LRA). Forced Internally displacements (IDP), kidnapping of civilians (including children), child soldiers, attacks on refugee camps, loss of life and property, violence and rape are some of the unspeakable damage (9, 13, 44). As

Jacobsen (45) discuss, the history of the host country can also effect the refugee policy and how the refugees are perceived in the community. Uganda's history of being refugees themselves, fleeing from violence and persecution it`s suggested to influence the hosts perspectives on refugees and the community is often seen to be more sympathetic and welcoming towards refugees (45). It may also influence the open-door policy of Uganda. Today South Sudanese, Congolese and Burundians is the majority of refugees in Uganda (3).

Figure 2: Uganda and their neighbouring countries, including DRC, South Sudan and Burundi. (Source: Google maps website, accessed 22 of May 2019)

The south Sudanese have a long history in Uganda. Even before the 1950s many migrated to Uganda looking for work as well as the government recruited workers to the sugar and rubber plantations in the southern parts of Uganda. The first war in Sudan started after independency in 1955 and the first wave of refugees fled to Uganda. They were settling in camps in north before looking for work in the sugar plantations (13). South Sudan became independent in 2011 and not long after the civil war brook out. From a political conflict between the President and the Vice-president in 2013, the civil war has killed thousands of civilians and forced almost four million to flee from their homes. The conflict of perceived political alliances and ethnicity is an ongoing conflict and have been since the civil war started in 2013. In September 2018 a peace deal was signed, and some of the fights are reported to reduced but conflicts and related abuses are continuing in parts of the country (46). By

entering its sixth year in 2019, the numbers of the South Sudan refugees are increasing and remains the fastest and largest growing refugee crises on the African continent. Many are displaced inside the country, and 2.2 million refugees have fled to neighbourhood countries (47). The conflicts have put the whole system under tremendous stress and destroyed essential infrastructures such as schools, clinics and hospitals. The numbers of South Sudanese refugees in Uganda is close to 800 000 and most of them cross the border in the south through Lamwo, Koboko or Adjumani districts and settle in the refugee settlements nearby (3).

The Congolese refugees arrived first in the mid-1960s and continued to cross the border to Uganda as rebel activists plunder the eastern Congo (13). The refugees from Congo were settled in the western districts nearby the border. The Rwanda civil war and genocide sparked the violent conflicts of Congo and lasted for five years. After that civil war officially ended in 2003, the violence had killed 3.5 millions and 3.6 millions were displaced. Even though the conflicts were fought of ethnicity, there were a clear economic interest as well, as DRC are rich in natural resources as gold, diamonds, timber and coltan. As the conflict ended in 2003, rebel groups still controlled different parts of the country. And two major influx to Uganda can be noted, in 2005-06 and in 2008, settling in the west (42). According to UNHCR, the situation in DRC is one of the most complex and challenging humanitarian situations worldwide, as different parts of the country are affected by multiplied conflicts. President Joseph Kabila's mandate of two-terms limit ended in December 2016. Yet, any implementing progress has not been stalled (48). Violent conflicts across the country including numerous of armed groups, and in some cases government security forces attacking civilians, have led to 4.5 million internally displaced and 826 000 refugees in the African continent (49). The arrivals from The Democratic Republic of Congo has been on the rise since 2019 and Uganda hosts 319 461 Congolese (3). The Congolese are mainly crossing into Uganda nearby or though Lake Albert in the west and are mostly settled in Kyaka 2, Nakivale and Kyangwali refugee settlements (Kegegwa, Isingiro and Hoima district).

Since gaining independence in 1962, Burundi has experienced an on-off violence conflict. The conflicts have political and ethnical roots caused by tension between different social groups, usually between the Tutsis and Hutus. The civil war lasted for 12 years (50). Extreme poverty, lack of law and ongoing human violations have made it difficult to regain stability and peace in the country. In 2015 the president announced his plan to seek a third term and the street protests lead to violence and hundreds of thousands fled to nearby countries looking

for safety (51). The political instability, threats, abuse and economic suffering is continuing and still leads to displacement inside and outside the country. Most refugees from Burundi lives in Tanzania, Rwanda, DRC and Uganda, with a number of 351 975 people (52). Uganda hosts about 38 526 (52) refugees and the majority of refugees from Burundi live in the refugee settlements of Nakivale (Isingiro) (53). The situation of Burundi remains complex and according to UNHCR one of the most underfunded crises of refugees in 2018 (53).

2 Rationale

2.1 Rational of the study

As other countries close their borders, Uganda practices an open-door policy and welcomes the new refugees. As a host nation, Ugandan are providing services for 1.2 million refugees, underfunded and at a constant risk for being overwhelmed (3). The host environment is suffering, the refugees and the health workers are operating with inadequate resources and beyond capacity. Understanding why, what and how the health services are operating, the dynamics and status of the service delivery as well as who's affected, are all questions that needs to be investigated in order to provide universal health coverage and sustainability. The results from the current study provide an overview of assessment of gaps and challenges that can provide guidance to the Ministry of Health, district health officials, and the relevant stakeholders across the refugee hosting districts. The study will also provide insight of the national humanitarian health workers´ neglected situation.

In a long run, understanding the context and how to maximize the use of resources, as well as promote inequity will contribute towards the agenda 2030, the Sustainable Development Goals (SDGs), including goal 3 "Health for all" and goal 16 "Promoting peaceful and inclusive societies for sustainable development".

2.2 Objectives

The study aims to assess the health system delivery in refugee-affected environments in the western Uganda and identifies the lack of necessary facilities. Understanding the factors that are affecting the access to health care, the quality of care, and other concerns regarding the communities and service delivery, is very important.

Specific objectives

- To explore the health service delivery in refugee affected environments
- To identify gaps and challenges regarding the health service delivery

3 Methodology

3.1 Study design

A qualitative research design was chosen to explore the health system delivery in refugee affected environments. A qualitative researcher looks for a deeper meaning of the local setting in context and time, focusing on the people and their surroundings, how they see the world and try to make meaning out of it (54). To gather information, individual semi-structured interviews were developed and used to collect the data. The semi-structured interviews gave the researcher possibility to freely include additional questions in response to the answers, comments and/or reactions from the participants. The interview guide was helpful and ensured the coverage of specific topics. Following up the response and dig in to a wider understanding of new ideas and concepts during the interviews were needed in order to explore the setting (55). All interviews were audio-taped, transcribed and analysed using Maltrud`s Systematic Text Condensation (STC).

3.2 Study setting

The study was conducted in four refugee settlements Kyaka 2, Kangwali, Rhino Camp and Bidi Bidi, as well as from two local government facilities nearby Kangwali refugee settlement and Bidi Bidi refugee settlement.

Kayka 2 refugee settlement is in Kyegegwa district and have a total surface of 81 square kilometres. The refugee population in March 2018 was 44 988 and accounted for 12% of the district population. The settlement was established in 2005 receiving the remaining population of Kyaka 1 after the return of the Rwandan refugees. The violence in DRC have led to a high influx of Congolese refugees in Kyaka 2 (56).

Kangwali refugee settlement is located in Hoima district nearby the border of DRC, in the mid-west of Uganda. The total refugee population is 83 558 and accounts for 12 % of the district population. Most of the population is Congolese but there are also Rwandese, Burundians and South Sudanese, Somalis and Kenyans refugees. The settlement was first established in 1960 (57).

Rhino Camp refugee settlement originally opened in 1980 and was a response to the South Sudanese civil war and the influx into the northern Uganda. The refugee settlement is in the

West Nile region in Arua District. Rhino Camp hosts 123 243 refugees, mostly from South Sudan. Refugee in Rhino Camp account for 11.5 % of the district population, but the numbers of refugees in Arua district is much higher and estimated to be 250 327 (58).

Bidi Bidi refugee settlement located in Yumbe District in the West Nile Region, hosts 286 859 refugees (June 2018). The settlement was established in September 2016 to host the rapid influx of South Sudanese refugees. The population increased rapidly, making it one of the largest in the world. The maximum capacity of the settlement was reached in December 2016, and they stopped accepting new refugees. The population accounts for 33 % of the district population (59).

Figure 3: Study Location Map: *This map shows the four refugee settlements were the interviews were conducted; Kyaka 2 (Kyegegwa), Kangwali (Hoima), Rhino Camp (Arua) and Bidi Bidi (Yumbe) (Source: The figure is from UNCHRs website; Operational status of Uganda, accessed 9th of May 2019)*

3.3 Sample

The health workers working in the refugee settlements and at the local health centres nearby the settlements were selected for the purpose of the study. The health workers were Ugandans by nationality and most of them lived in the refugee settlement or nearby. The health workers receive both refugees and the local population living in the area. The health workers were chosen as participants because of their valuable experiences, insights and information about the health system delivery. As they are working in the health facilities, having contact both with the patients in need, the organisations providing the services and support, leaders and the

community around, they are able to provide a wide understanding of the context and challenges affecting the service delivery.

Both genders and different disciplines within the health sector were included in the sample. A total of 63 health workers, representing 20 health facilities located in the settlements and 2 local facilities in the host environment. All the interviews were held within the facility and face to face.

3.4 Data collection: Recruitment process and sample

The data was collected in the time period between the 11th of October and 2nd of November 2018. As a supportive agency working in the refugee settlements, the United Nations sexual and reproductive health agency (UNFPA) provided support to conduct the data in the field. The field officer and coordinator introduced the researcher to the key informants and provided transport in the settlement.

The process of recruitment was performed in three steps:

1. Acceptance of study: The coordinator/ field analysist of UNFPA introduced the researcher and the study to the leaders in the different settlements to get acceptance.
2. Connection with a liaison: The researcher was later introduced to one of their working partners, an NGO worker, knowing the settlement and the health facilities. The NGO-worker and the driver helped the researcher around in the settlements and introduced her to the different health centres.
3. Recruitment at the health centres: When arriving at the health centres, the in-charge approved the study and were helpful in organising and finding a place to conduct the interviews, as well as he/ she helped recruit workers at the facility. The health workers were interviewed at the facilities in a private room or outside at a bench, depending on the availability.

The data sample is presented in the tables below. The first table includes health centres, age and time working in the facility. Most of the health workers at the local government facilities (Bidi Bidi and Kyangwali) reported to have worked for a longer time compared to the workers in the settlement. The second table shows the sample by gender and disciplines.

***Table 1**: Included Health Facilities and the characteristics of the health workers*

Refugee settlement	Health facilities	Local Government facilities	Age of health workers	Time working at the health facility
Kyaka 2	5		29, 72	1, 3 years
Kyangwali	5	1	33,53	2,98 years
Rhino Camp	5		29,71	3,6 years
Bidi Bidi	5	1	29,38	3,52 years
Total	20	2	30, 58	2,85 years

***Table 2:** Health workers by gender and work title*

Work title	Female	Male	Total
Dispenser	2	2	4
Leader/ coordinator	3	5	8
Midwife	11		11
Nutritionist	2	3	5
Clinician/ doctor	2	6	8
Lab worker (lab-officer, lab- assistance)	2	6	8
NGO	1	2	3
Nurse	3	7	10
Mental health worker (nurse, psychologist, specialist)	2	2	4
Medical translator		1	1
Data analyst/ recorder	1		1
Total	29	34	63

3.5 Transcription and Analysis

All the interviews were audio-taped and transcribed manually by the researcher. The interviews conducted varied from six minutes to one hour, with an average time between 20 and 30 minutes.

The interviews were analysed using Maltrud`s Systematic Text Condensation (STC). Maltrud`s STC is a strategy developed and shared by most traditions of qualitative data analysis. The method implies an analytic reduction with specific shift between decontextualization and reconstruction of the data (60). The STC analyse can be described in four steps; *1) The total impression- from chaos to themes:* By looking at the overall impression and the main themes emerged from the data, the findings were summarised without going into detailed coding. *2) Identifying and sorting meaning units – from themes to codes:* Line by line coding was performed in the in-depth analyses. Each transcript was taken apart and merged into 68 nodes. *3) Condensation – from code to meaning:* Identifying all codes, the meaning and similarities of the different codes were performed. The codes were sorted in to 5 main themes. *4) Synthesizing – from condensation to descriptions and*

concepts: From condensation of the codes, the different concepts were defined and the meaning was investigated (60).

As a helping tool, NVivo software (61) was used for the analysis. After transcribing the interviews, all the interviews were imported into the software, classified and coded into themes. The interviews were classified by settlement, age, gender, work disciplines and time working in the health facility. Line by line coding emerged in nodes and were put into different categories. NVivo provided well-organised data and showed the connections between the codes, themes and concepts.

3.6 Ethical considerations

The participants were informed about the purpose of the study both orally and in writing. All the participants signed a form of consent before the interview and were free to resign their participation during the interview as well as after. All the participants spoke English, and the researcher was the only one in the room. The audio files were coded with numbers and the researcher were the one listening to the files and transcribing. To ensure confidentiality of the participants, the interviewees are presented by disciplines and gender in the result. As the researcher gathered useful information that could help the stakeholders improve the health services, a summary of challenges, gaps and suggestions for improvements in each settlement were provided to the relevant stakeholders in the settlements after the data collection.

4 Results

Exploring the gaps and challenges from the health workers' perspective, five main themes emerged during the analysis: **1)** Gaps and challenges at the health facility, **2)** Community factors, **3)** The situation of health workers, **4)** Management and **5)** Inequalities. The five main themes consist of many sub-themes that emerged from line by line coding and represent the gaps and challenges explained by the health workers.

4.1 Gaps and challenges at the health facility

The health workers reported several gaps and challenges at the facilities that affected the health services. The lack of important infrastructure, equipment and resources, challenges of follow-up and support the patients, lack of mental health services, the use of unnecessary referrals and language barriers were themes that emerged when asking about the challenges at the health facilities. The main themes were reported in all the settlements as well as the local health facilities with some variation in the frequency of occurrence between the departments and health centres.

4.1.2 Follow-up and support to the patient

The lack support of basic needs, like food, hygiene articles, water, clothes and shelter were a concern, and the health workers reported it to affect the health behaviours of communities. Promoting good health to the communities and to their patients was often a challenge as many of them lacked the necessary resources to practice good behaviour. The health workers expressed frustration and felt helpless as they couldn't do much to support them. A lab-assistant expressed her frustration with the quote;

> *"Yes, like if you talk to them about bathing, they will ask you "where is the bensin, where is the water, where is the soap, we need money!" You know? That is very difficult." – Female, Lab assistant*

A Nurse working with TB and HIV talked about the treatment not being effective as many of the medicines needed to be taken with food.

> *"And sometimes the clients have challenges, like sometimes the food given to them is not enough to take the drugs." – Female, Nurse working with HIV and TB clients*

The health workers reported challenges of patients not seeking help in time and not coming back to the health centres for follow-ups. Long distances to the health centres, lack of transport and money were frequent mentioned by the health workers as affecting the patients to seek help. The mental health specialist and midwife summarises the challenges, they were especially concerned about the sick patients walking the long distances to the health centres and the high default rate.

> *"So, you can see this kind of distance for the patients to walk, all this distance to reach here, it's not possible! So, like to have frequent reviews is a problem, that's why we have high default rates (..). So, it means if we had enough logistics, in form of vehicles, transportation, like to have mobile things to take the services closer to the community, that will reverse their suffering" – Male, Mental health specialist*

> *"There are others like who have had problems and therefore they can't come walking here, and they don't have money to buy transport. If they only could provide such transport! That would bring such problem here to the facility to get treatment." – Female, Midwife,*

Many of the health centres didn't have transport means for emergencies and had to wait for a long time. Especially the midwifes were very concerned about the mothers with complications. Due to the lack of transport, the possibilities to follow up patients in the community, sensitization, health education and other community activities were challenging.

> *"Also, even like with a simple transport, like you find I´m supposed to move to the community to attend to sick, like TB- patients, HIV, but because we don't have transport. It´s in their own hands." – Male, clinical nurse*

Another problem were the delays, the health workers reported coming late for work and arriving home late due to the issue of transport.

> *"Some days is very hectic and there are not enough cars. The few cars have gone to do other things and we have to wait for that car. You find that you are tiered, exhausted." - Male, Doctor/ In-Charge of the health facility*

4.1.3 Lack of essential infrastructure

All the four refugee areas reported challenges due to the lack of essential infrastructures. The facility lacked space, separate rooms for different cases and permanent buildings. The bad roads were also a challenge affecting service delivery. Lack of space was frequent, and especially in the maternal departments. The midwifes reported mothers giving birth on the floor and babies with special needs sharing room with other healthy babies. The Maternal health in-charge was angry and felt sad as they couldn't meet the need of the mothers in the targeting area. The place like she expressed, was overcrowded, busy and women were laying around on the floor, midwifes running around and mothers waiting to be treated.

> *"Maybe another challenge is the space, the small space! That's why you see the mothers in the tent on the floor and you find that the mothers have increased. So, we have to make sure that we attend to them all when they come, and the space is small, so we can´t store many you send them back." – Female, Midwife/ In-charge of the Maternal health department*

Not having separate rooms for different cases were a problem, and the workers worried about the privacy of the patients and transmission of infectious diseases. As the nurse/nutritionist said, the lack of isolation rooms for patients with TB, and the malnourished cases with low immunity were big health concerns.

> *"And then more rooms are needed, like the ones that is malnourished, we do not want to put them together with medical infections. They have like shorten, or like low immunity, so they are prone to get more infections if they are put together. (..) And then an isolation wing for those who have what? Cuff and HIV. (..)And there is some domestic violence, we don't have any room that they can be in (the victims). Because these are traumatized clients that needs specific counselling (…) And like we lack that kind of room and equipment." – Male, Nurse/ Nutritionist*

Lack of privacy and ensuring confidentiality was also challenging. The workers were especially worried about private conversations when counselling patients with HIV, STI and those suffering from mental health conditions. A nurse treating patients with HIV and TB were interviewed in his open "office" in the end of the hall just after passing the crowded waiting area, the lab and clacking rooms. He expressed concerns about the confidentiality of the patients when seeing them in his office, "*like these patients, like it`s stigmatising".*

Another challenge was associated with the tented structurers used in many of the health centres. The tents were very much affected by the weather. The services were affected by rain leaking inside the tent, the hot weather and cold nights. The health workers explained that they had to stop working and seek lee every time it started raining heavily. A HIV and TB nurse expressed frustration as the tented room was a mess.

"I also have rats in my room where I sit. They come and destroy, and they eat the files. You also find that, when it rains, the carpet (tented structure) leaks inside and that also affects the files. Like the room is a mess." – Female, clinical nurse working with HIV and TB clients

The bad roads were also reported to affect the health services. Follow up patients, referrals, emergencies and other community work were often affected by the bad roads and especially in the rainy days. The bad roads were a shared concern among the health workers and as many of the patient were referred to government hospitals outside the settlement for treatment, they often needed to drive long distances.

"When we are here, we are moving every day, but these roads are not good. So, they should be able to develop more infrastructures and maintenances. And there is a facility outside the settlement, most of the referrals goes out to there." – Male, NGO worker

4.1.4 Lack of resources at the facility

Drug stockout was a frequent problem in all the facilities except one health centre located in Bidi Bidi. All the other twenty-one health centres reported drug stockouts as an issue. Antibiotics, tuberculosis (TB) and malaria medicines were most frequent lacking. When the drugs were out of stock, the patients had to wait or buy it themselves, but as many of the patients didn't have any money, they were not be able to get the needed drugs. The doctor summarises the frequent problem in the quote;

"If the drugs are not here (..) Sometimes what we do is to make a requisition from the nearby facility, but often, in most cases they also have the same problem, the same challenge. Most of the drugs is out of stock. So, the refugees don't have the money to buy the drugs, so we refer." – Male, Doctor, Next in-charge

Lack of electricity and water was also a challenge for some of the health centres. Lack of water was not mentioned by any of the health workers in Bidi Bidi refugee settlement. A midwife explained improvising lights with her phone when treating the mothers.

"You know there are mothers who come at night to deliver. Sometimes when the lights have gone off, because of that issue, and there is not water in the down block. (..)We use the other room here, but the lights here are so dim, sometimes if a mother get teared, you use your phone to light so you can stich here." – Female, Midwife

Gloves, delivery kits for mothers, equipment for examination, blood bank, oxygen machines, oxygen masks, microscopes, HIV-tests and other test equipment for the lab were mentioned as lacking in the facilities. This was critical for treating the patients, and the workers expressed a lot of frustration and low motivation.

"The most challenges are stockouts, drugs, glows and everything. (..) And other challenge that I forgotten is the delivery kits´- – Female, Midwife

Lack of staff was a frequent problem in the settlements and at the Government facilities. The health workers reported heavy workload, long waiting time for patients and little time with the patients as challenges due to manpower. The overwhelming number of patients and the

few staff were affecting the quality of care. A male doctor explained that it was no time for a full detailed clack of a patient "*Because now you may need to see all (patients), and you may not take a full detailed clack.".* As a psychiatric nurse were finishing her night duty and then again staying for the dayshift, she was interviewed and talked about the issues of HR.

> *"So, the issue of HR is here. (…) Human resources, if we have enough then we will also make the work easier." – Female, Psychiatric Nurse*

Due to the lack of infrastructures, drugs, the needed staff and equipment, the health workers were often forced to refer the patients. Many of the health workers thought the referrals were too much and unnecessary. They felt bad referring the patient, as most of the patients wanted to be treated nearby home.

> *"They come, you have to refer them because we don't give all the comprehensive emergency cases, we have to refer them. Like someone comes all alone, no attender, she refuses to be referred, they want to be treated here but you are not supposed to." – Female, Midwife*

The lack of resources at the facilities was frustrating for the workers, and the lack of necessary equipment and human resources were major challenges.

4.1.5 Language barriers

Language barriers were frequent problems in all the refugee settlements. Language barriers took a lot of energy, time and caused much misunderstandings between the patients and the health workers. There were few translators in the settlements and there were many different languages spoken by the refugees and the nationals. Sometimes they experienced patients speaking languages none of the translators could understand. Often, they had to use other patients to translate, and they could experience that the interpreter was not translating correctly and some patients didn't trust a third person. This made it very difficult to give the right diagnose, treatment and explain how to use the medications. As the NGO worker explained, interpreting wrongly was a big risk.

> *"In a health system we have a problem of language barriers, were the interpreters are not interpreting well. Imagine you are sick, and you go to the facility, and the person attending to you is a nurse or a doctor that doesn't speak your language, what happened is that we need to bring a refugee that understand you and a little English. You know this one speaks, and the interpreter are interpreting wrongly. For example, you say you have pain in the neck and then this one is interpreting you have pain in the ribs, and then the doctor could not find out what`s happening." – Male, Social/ health worker, NGO*

4.1.6 Lack of mental health services

Many of the workers reported a big gap of psycho-social support in the settlement and in the host community. Mental health issues are not very well understood, and the mental health workers reported challenges of collaboration, funding and support for mental health services.

Awareness in the communities and among workers, recognizing and prioritizing the mental health support was all important factors for ending stigma and providing the needed services.

> *"The priority should be given to the phyco-social support. Counselling is very important, it will not help for us to give food to the people, yes, they need food they need to be clean, but looking at the situation (..) Imagine it's you, you seen horrible things on your way running to place where it is safety (..) you can imagine the nightmares going though? All the traumas." – Male, NGO worker*

The mental health officer explained lack of awareness among the health workers as a big challenge. He explained patients coming to the health centres thinking they are sick but are suffering from traumatic events. As most of the refugees have experiences of war and/or other traumatic events, the need of mental health services was reported as critical.

> *"Like I feel there is many NGOs that take mental health for granted, they think like when a patient comes for anti-malaria, maybe they have some abdominal pain or what, give them some drugs and then they will be fine. This is not the problem, there are those who come here, and they test for malaria and it's not malaria, but they are having chronic diarrhoea, lack of sleep, headache, they are thinking about their lost relatives or the missing relatives. There are many who have experienced war and others have been victims themselves, they have lost their relatives and others have seen their own husband been killed. (..) So, you can see, the time they leave the place, they are traveling, then they come here and the context of life here, when they look at the future there is no hope. So, that's why many processes are breaking down. So, making other NGOs to recognise mental health as a key component." – Male, Mental health Clinical Officer*

4.2 Community factors

The health workers reported negative health behaviours, lack of knowledge, drug abuse and lack of caretakers as negative factors affecting the health service delivery and the health status of the patients.

4.2.1 Lack of knowledge and negative attitudes in the community

Negative attitudes against family planning and vaccination, hygiene practices and drug and alcohol abuse, their understanding of nutrition, stigma and lack of caretakers in the community were all factors that emerged from the interviews considering the community beliefs and practices. Family planning and stigma were both reported from the host and refugee communities while the other factors were more about the refugees. A nurse explained that many of the refugees didn't go for family planning as "*They think that they have to produce more people to replace those they lost"* and expressed challenges of convincing as its "*her right to produce".* Many of the workers also emphasis much on lack of education and awareness in the community.

> *"Like the education part! Like some of the diseases is like really preventive, it's just hygiene! Like you see like scabies all the time, like scabies scabies scabies, it's just like bath, like hygiene. (..) They don't think like the public health is important, like the health you do for yourself, you can spend your time doing other things, like they don't think that's important! They come and waste a lot of time here that could be prevented." - Female, Recorder*

> *"One is that the level of health education here is low. The truth is that maybe like a person finds out about knowledge about health issues, yeah, you can take care of yourself, right." - Female, Midwife*

Some of the health workers talked about the refugees not being used to have available services for vaccination and drugs as a reason for the communities to use old traditional methods like cutting to treat the babies and abuse the drugs.

> *"Last time we asked them (refugees), like most of the people in Sudan they have not immunized, so what they do is that they do cutting. That one is also affecting us here." Female, Nurse*

> *"The problem can be drug abuse, you find like in their places they have not been using the drugs, so when they come here, and the drugs are here they tend to misuse. But as a health centre person we try to go on and changing the attitude." - Male, Nurse*

The lack of knowledge was affecting many of the negative attitudes in the community. It was mention as a big challenge and more knowledge in the community were suggested to improve the health outcome. The countries of region have been out of system for a long time, both lacking education and health services.

4.2.2 Negative attitude against the health works

The negative attitude from some the patients was a challenge for the health workers. Looking at the overall reporting from all four settlements the negative attitudes was more frequent reported in Kyaka2 and Bidi Bidi refuge settlement. The health workers reported it to be time-consuming, affecting their motivation and security, A male in-charge said, *"the community we serve here rarely apricate, they don't appreciate the services".* They also explained that patients often were upset by the waiting lines, not getting the needed medicines or the services they expected, the working hours or due to communications barriers. Being referred could also make patients really frustrated as they want to be treated nearby their home. Even though many of the health workers emphasize much with the patients it was still a challenge and affected their work.

> *"And the patients here are rude, they corral you, they abuse you, (..) Like for malaria, you are supposed to wait for the test between 20- 30 mins, but the patients want it in 2 min! 3 min! They start bothering you and that's how the work goes on. (..) Yes, that was some of the challenges that I meet in the lab. Someone that are frustrated, some of them come and are angry at us, ask for us to give them something. - Male, Lab- worker*

4.2.3 Patients arriving at advanced stages of the disease at the health centres

Many of the patients in need delayed seeking help and came to the facility in a critical condition. The health workers were especially concerned about the pregnant women and children. Coming late to the health centres were affected by many factors, and as presented earlier, long distances, lack of transport and knowledge was suggested to affect the problem of the behaviour, but some of the health workers also suggested the attitude to be a problem.

"I don't think that they think it's very necessary to come to the health centre. I don't know if it's the talent they have? Because they come when it's too late, and we lost some children because they come late. The parents see their child is sick later the day and they just think its malaria and then they wait" - Female, Data analysist and recorder

"Sometimes the mothers stay home and deliver from home! And they come when they are bleeding and collapsed, so they delay too come to the health facility." - Female, Midwife

4.2.4 Lack of caretakers

Some of the health workers were also worried about the care of the patients at "home". Many of the patients had lost their relatives and were living by themselves, as they were weak and sick, they needed assistance to do daily activities and general care. The elderly patients and the patients with mental health conditions were mentioned as particularly in need.

"The patients come and then the patient doesn't have any caretakers, and the patients is very sick and no one is to take care of them. Like the elderly are too weak to come to the hospital, but once they come to the hospital you see that there are several things you need to do for them, but there is this requirement for caretakers. They tell you there are no caretakers, no one to cook for them at home and those kinds of things. So, it will be hard to attend to the medicines because some of the requirements is that they are eating something, and they also need someone to follow up and make sure that they are taking their medicines." - Male, Doctor/ In-Charge of the health centre

A psychiatric nurse expressed her concern of patients living with HIV, TB and other mental conditions, feeling sad she explained that many are abandon.

"You try to counsel, and you bring on board the relatives if they are there. But most of them they don't have like someone to monitor their conditions, they have not. A lot of stigma in the community, those are like abandon, and they come alone." - Male, Psychiatric Nurse

4.3 The situation of the health workers

Providing health services for overwhelming number of patients, the health workers work in a hectic and challenging setting. The health workers expressed frustration when talking about support, salary and their general working conditions.

4.3.1 Motivation and support

Many of the health workers reported lack of motivation. Meeting challenges of support, staying away from family and friends, little time off, living in a remote area, bad working conditions, heavy workload, hectic days, lack of staff accommodation and poor payment were often mentioned. A drug dispenser explained how motivation was the most important component of the service delivery. He mentioned the long working hours, little payment, a gap between the workers on the ground and their bosses, psychological things and stress related to the low payment and for providing support home. He summarises many of the challenges affecting the health workers and their motivation in this quote;

"I emphasis much on the health workers motivation. That's the most affecting thing, the most affecting factor in our health service delivery. Is the main problem. You can provide everything, but if a worker is not motivated, it's going to affect the health services. (..)I have a feeling like if you can reach the gap

between the people who sits and plan and those people on the ground doing the work. It's a big gap! (..)You are demoralized, you have psychological things, you are working all those hours, from Monday to Saturday, and you can imagine! You are getting around 1 dollar per day. (..) That's around little money, little pay for someone handling the big number of clients. Without motivation? What do they expect, we cannot perform our best? Like, you think about what am I going to have at home? Now when the end of the month they pay you little you find it is so challenging. So, it's about motivation. Me personally I think that motivation would make me preform my full ability."- Male, Dispenser of drugs

Living in a remote area made it challenging for the health workers to see their family, as well as accessing food. A clinical officer felt sad as he didn't have time to see his family *"Otherwise it's hard to stay here, away from your family".* Heavy workload and long days were also factors repeated by the workers, a lab analysist explained that he sees 140 to 180 patient a day, he reported to feel tired and challenges of accessing food made it even harder to work in the settlement.

"And then I start receiving the patients, and then in a day I can work like for on 140 and sometimes 180 patients. And the work is sooo hectic. Yes, so by the time we go back you´re tiered. (..) you go back you are hungry, and you have not eaten any food. (..)And around here there´s not any shops where you can go and get something to eat. Accessing food is very hard." - Male, Lab analysist

Lack of job security were also a theme emerged when talking about the workers motivation and support. Most of the workers reported to lack insurances, having short term contracts and lack of protection wear at the health centres. Many of the health workers also expressed feeling uncomfortable treating the patients due to the lack of space, a nurse working with TB and HIV clients said she was scared and felt uncomfortable working because of the small and congested room. Some workers also reported not to get support and to be afraid of speaking up. A health worker explained that he often kept quiet about the challenges at the facilities, *"There are cases that you find that someone brings issues and your contract is expiring in January, they have a reason to terminate you.".* The male lab- assistant worried about the transmitting of the infectious diseases and summarises the problem;

"But like maybe you get an infection, it means that you are dying at one point, and there are no policies that like says like if you get these diseases you will get this or if you get this you will get this one. There are no! (..) Now, if you look at the supplies in the health system here, the drugs are not there, the gloves are not there, people work without gloves. And it´s not convenient, it means that the health workers are seriously exposed. Even here we are forced to work without gloves, like you see a child that have malaria and you cannot see somebody dying, and you cannot just look at that. - Male, Lab- assistant

Some of the workers also expressed concerns about the need of insurance of both them self and their children. They worried about how to take care of their children and husband/ wife if something happened to them. As motivating factors, support from their colleagues was essential for manage the hectic work, many of the workers reported "working as a team" and helping each other out as important. Self-motivation was also reported by some workers, the feeling of wanting to help someone was very strongly for many of the workers.

"I can also say that the staff here is self-motivated, like the staff here are our friends, they know us, so you just feel like you need to help someone, and help."- Male, Doctor

The workers received various support, and support in form of supervision and knowledge seams to affect the motivation of the workers positively.

4.3.2 Issues with payments, salary and allowances

Low salaries, not getting payed for overtime, working over-time and inequalities between workers was some of the factors affecting the health workers.

"Our leaders are not seen our pay, you can work for 8 hours and you paid like 5 US dollars. I don't know if I can count that, it's very little, it's not the pay that would pay a cleaner for one hour(..). Someone that have never gone to school, it's very difficult. You would work extra hours, and it's not accounted for, or payed but we are working, we work extra hours. Even night duty it's extra hours. We want them to consider hours to be paid. "- Female, midwife

Not getting payed in time was also reported, "*And then, I would appreciate if the NGO people consider giving you the salary in time.".*

4.3.3 Welfare

Staff accommodation was a challenge for many of the health workers. Many of the workers are staying in tents provided by UNHCR and reported it to be challenges due to the weather, it was either too cold or too hot and sometimes flooded by rain. Sleeping in a tent defiantly affected their health, welfare as well as their motivation. When talking about it they expressed a lot of frustration.

"The housing is not there, private housing. Currently they are sleeping in tents and it's really cold, you find all kind of creatures there, cantabiles etc. Quite challenges, sometimes they were supposed to come in the morning, but they say "our tents are flooded" so it definitely affects their work and their reporting, and me thinking of the staff. (..) You leave the place here and you go back to our complex and only to find water." - Female, Nurse

Analysing the data there were some differences between the settlements, the workers in Rhino Camp reported to be satisfied with their accommodation as most of them were enrolled in permanent structures. Some of the NGO- workers also expressed frustration of the health workers situation. Because of the working conditions in the settlement many of the health workers didn't stay for very long. As the NGOs used much resources on providing trainings and knowledge to the workers it was challenging that so many left the settlement just after a short period, looking for better options. There was a need of experienced health workers.

4.4 Management

Lack of funds, challenges of short-term interventions and other administrative factors were mention as challenges and affecting the potential to provide good quality services. When asking the health workers about what they thought was the reason for some of the challenges or the barriers they were facing, finance was often mentioned. Lack funds and the need of

more donors to support were common answers. As the lack funds were suggest as a reason, some of the workers were not sure but repeated what their employers had told them.

> *"Because now you will look for staff, a nurse, you need shelter, they look for finance, you want the staff to be motivate with water you need finance. So, the finance problem is always on top."- Male, Doctor/ In-Charge*

Some of the health workers in the field reported the interventions to be emergency driven and too short to reach the community. Sexual reproductive health, mental health and other chronical illness were examples of issues that needed to be addressed with more long-term solutions.

> *"But from the perspective of pregnant sexual reproductive rights of these young girls, it's hard. This are the issues we cannot address in this short period, this need a longer term. It all depends on funding. (..) Like if we got a longer program of course this will be obviously a change in our structural change in the way we program. If we got a bigger program, we will have more staff, we will have geographic scoping views, and all that means the number of people will receive something. (..)the people (refugees) has been here over 8 years, and people are still doing things in an emergency. But we need to think more long-term solution." - Male, NGO- worker*

The NGO- worker and the mental health officer talked about a need of structural changes with more long- term solutions. Providing emergency interventions in a long-term situation were frustrating as many of the refugees had been in the settlement for over 8 years and the conflicts in South Sudan were still producing refuges.

> *"If you look at the mental health, is not something you can like provide for like 1 month or 2 months and then someone is okay. So, is rather a long program that can take like six months up to a year. Having stability, like good programs that can run for a sustainable time would be a good outlook. (..) I think would be a good outlet for those who are chronical ill and also giving the fact that the situation in South Sudan is still not promising. The peace deal that have been sign recently, yesterday, celebrating the peace accords been sign, but this is just a paper, what's on the ground is totally different. We get still new arrivals because war is still going on. People are celebrating in Jumbo, but in Torit, in Yei war is going on (..). For example, if you look at 3 years and maybe 5 more years." - Male, Mental Health Clinical Officer*

Another NGO worker also talked about the management of the growing population. As she said it was a need of better management to account for the increasing and continually changing population.

> "*I think that the population is increasing every day, they plan, and they think that the population will be the same, it will be stable. (..) But you see the situation on how the refuges are increasing, every week they come. 500, 200, so as their plans cannot account for this big population, it's the same with the nationals also, we don't segregate we give the same services to the host communities also. Meaning there is a lot of movement. (..)The population keep on increasing, family planning is low, we have plan for few but there are very many that need the services." - Female, NGO- worker*

4.5 Inequalities

Analysing the transcripts there were some very clear differences that emerged. The health workers reported to receive various support from their employers, and many felt they were

treated unfairly. Also looking at the refuges and host population, the facilities received few nationals compared to refugees and there was suggested some differences.

4.5.1 Inequalities between the health workers

Inequalities in the support received by the health workers were reported. Payment system, trainings, recourses and time off was the variations reported. The workers could have the same education and doing the same job but receiving different support, as the staff were employed by different organisations. Many of the health workers felt neglected and expressed both frustration and anger. Especially differences in the payment systems between the Government and NGO`s health workers were often mention and affected their moral.

> *"You find that in this health centre there are those different kinds of staff, there are the kind of staff you find are supported by UNHCR and there are others that are employed by NGO, and then there are those who are supported by the government. That are those different kind of staff at the health centre. For us we attend to projects and are on contract, so you find that the other staff have high moral, the other one has bad because of the differences in payment system. Yes, because the UNHCR have a system, were they, maybe they will give money after every three months, which the Government will do constant. UNHCR, don't know the consume they are going to, because the staff are taking long before they get payed, you find the moral of staff is variating." - Male, Clinical nurse*

The health workers reported different resources in the facilities.

> *"Yeah, mostly some of the equipment is not available at the facility. Now like, you may find that some of the other places have not received. Sometimes we have a huge number, but you find that other people have more resources, but we don't have." - Male, Doctor*

Variation of support, payments and rights were demoralizing and a challenge. Having one humanitarian body equal for all the humanitarian workers were essential to create harmony, support and motivation. It was also mentioned a gap between the management and the health workers on the ground. As a midwife expressed "*We feel like they are corrupting us, they are paid well, they are sleeping in good houses, they have allowances, but us the staff on the ground we are being neglected and abended.".* Another midwife talked about their conditions and terms as humanitarian health worker should be the same and respected by the humanitarian agency.

> *"We have read that the conditions and terms of the international labour law, and we are working in a humanitarian body of which our expectation is, like we work of providing these services, we are expecting that those are the policies to be equal. (..)One thing that can be done to overcome this challenge, would want the terms and conditions for all of the organisation to be one. Because if I see another NGO – staff they are paid well and giving allowances. Yet, we are doing the same job. We want the humanitarian body to have one policy."- Female, Midwife*

A female lab-worker were looking for other possibilities because of the condition in the settlements and the unfair treatment.

> *"Me I`m just like down, even that's why I`m looking for more possibilities to get somewhere which can aloud you to travel, like the government they can even aloud you to travel, come and back. The trainings, meetings and stuff like that its always there. But here there is no, like maybe someone is getting, but me I`m personally, like the salary would not changes." - Female, Lab-worker*

4.5.2 Inequalities between Refugees and Nationals

The health services are open and free to use for both nationals and refugees, but almost all the health workers reported to see more refugees then nationals, except at the Government facilities located outside the settlements. As they were asked about why, many of the workers didn't actually understand why and said that the nationals were welcome as well. Some of the workers had reflected over the situation and suggested barriers like the refugees to feel uncomfortable seeking services, long distances, lack of information in the host communities, language barriers and bad health seeking behaviours. The midwife said she experienced the nationals to feel out of place and unconfutable at the health facility even though they were treated equally at the health centres;

> *"Like nationals, in the way they feel, those are not like the refugees are, confident when they come. But like nationals like when they come, I think they feel out of place. As the nationals they feel a little neglected. (..) They just feel for themselves I think, yeah because they are equal like the refugees(..) I think they feel this facility is here because of the refugees and for them they are to the facilities that they used to go. So, when they come, I think like they feel like they are not comfortable." - Female, Midwife*

The quote suggest that the perception of the nationals was different even the health services were equal for both refugees and nationals. It was reported that the nationals felt neglected and less priorities. Some of the health workers said there were some differences of the social strategies and the nationals didn't benefit the same way as the refugees. The examples mention were the nationals not being allowed to operate businesses in the settlement, no ambulances attending to the national side and some interventions were more beneficiary for the refugees then the nationals.

> *"Phycological they fear that NGOs have given all the social strategies, they feel like we are neglecting them, that we are discriminating them. And then nationals are not allowed to stay in the settlement. National are not allowed to operate any businesses in the settlement, only business should be for refugees." - Male, NGO worker*

> *"Yeah, one recently there have been something that has donated that has only benefit to the refugee community and not the nationals. Like they get a lot of challenges with malarias in the community, so if there could be a way of distributing mosquito nets to the nationals also, that would improve. Second, I seen the nationals VHTs (Village Health Teams) are more passive than the refugees, the refugees are more active, so like if there could be a way of motivating the VHT to be more active to help and extend the services in the national community." - Male, Clinical officer*

Language barriers, lack of knowledge and challenges of communication were suggested factors affecting nationals to seek health services.

> *"And we were talking about some barriers of the languages. Like most of the workers they don't know the national language here yeah. So, they are facing some little challenges in the language's translation. Sometimes they end up looking for nurses that can speak their language when their nurse is not there, that means that they go back in the community."- Female, Nurse*

As the refugees lived more congested than the nationals, the information spread fast in the refuge environments compared to the national.

"But maybe because of communication, you know like most of this people lives in a rural setting and most of the families doesn't have like phones, so you find that communication is a bite challenges, like passing information to the nationals becomes very hard. If you don't have a number. You can find like 1 in 5 maybe have a number. So, you wait for one to come for drugs, so you have to plan yourself for the schedule of activity comes." - Female, Clinical nurse working with HIV and TB

A clinical nurse suggested the health seeking behaviours of the nationals to be poor, telling that they come to the health centres very late and need to be referred.

"Yes, then there is also community health education, checking, that for the nationals, the refuges have their health seeking behaviour, but the indigos/ nationals have very very poor health seeking behaviour. Most of them come to the health centre when they already, like when they are really bad off, and they need referrals. - Male, Clinical nurse

As the Clinical nurse experienced, the national delayed seeking help and came to the health centre when their condition was critical and needed to be referred.

5 Discussion

5.1 Main findings

The purpose of the study was first to explore the health system delivery in the refugee-affected environments from the health workers perspective, starting with an open mind, catching the themes merging from the interviews and understanding why. The second purpose was to identify the gaps and the challenges of the health service delivery. The main findings show a wide scope of challenges and gaps in the health service delivery.

The health facilities were lacking essential resources as medicine, transport, infrastructures, human resources and other equipment to treat the population in need. Challenges of psycho-social support were a big concern and the settlements were lacking mental health services. Also, different barriers were identified in the community as affecting the access of health services. Negative attitudes about family planning and vaccination, bad hygiene practices and drug abuse were factors reporting to affect their health. Other barriers like distance, language, lack of transport and knowledge about health were also challenges affecting the patient to seek help or delaying the process. The lack of basic needs was reported to affect the health of the refugees, as the health workers explained, it made it challenging for the refugees to practice good hygiene and take care of themselves. Also, too many referrals were a challenge, the patients came late to the facilities and the health centres didn't have the resources needed to provide adequate health care. Interventions to be too short and funding not being adequate was identified as affecting the quality of services. The health workers were lacking motivation, many were burned-out, lacking welfare and reported limit support from their employers. Furthermore, several disparities between health workers were found. As the NGOs, Government and UNHCR treated the health workers differently, operating with

different policies, payments, insurance, working hours, seminars and other benefits varied between the health workers. The host population were less likely to seek help at the facilities in the settlements and the health workers thought the reason could be the hosts' perception of the health services. They said the hosts didn't feel welcome and thought the services were more prioritised to the refugees. Other suggested reasons were the long distances and/or lack of communication with the hosts.

The policies, attitudes and the resources of the host countries vary between the nations and affect the access to and quality of the health services. According to Assi (62), the main challenge of the health services provided for the refugees in biggest hosting country, Turkey is sustainability. Also, in opposite to the host population in Uganda, the hosts in Turkey pay social security and treatment fees. The effectiveness of the medical care of the refugees in the public hospitals is facing challenges of language barriers and restrictions limiting refugees to seek health care in other province then registered, as well as mental health services are weak (62). Language barriers and lack of mental health services were similar to the findings in Uganda. As Lyles, Hanquart (63) found, the Syrian refugees and the host communities in Lebanon had difficulties accessing health services. The barrier was mostly affected by cost. The health services and medication were less accessible for the refugees than the hosts. No formal camp for the Syrian refugees has been established in Lebanon and there is no health service dedicated to the refugees, which is different from the policies in Uganda. Out of pocket payment were considered as a barrier for both groups for seeking help, but lower in absolutely terms for the refugees. As Uganda provide free and dedicated health services in the settlements for both refugees and host, the challenges of cost could be a barrier when the needed medicines were lacking, which were reported as a frequent problem in the refugee affected areas. Wali, Chen (64) reported human rights related health issues contributed to the poor health outcomes of the Rohingya refugees in Bangladesh. The basic healthcare is provided by NGOs in the camp and if needed they were referred to hospitals, however the study implies the government authorities to limit the access by discriminating the Rohingyas, different from the integrated strategy of Uganda. Structural factors, poor living conditions, restricted mobility and lack of working rights were all factors affecting the heath of the refugees. The study suggests policy action for better integration and long-term solutions. Even though the contexts and challenges of the health services vary between the big host nations, the same issues of sustainability and lack of long-term solutions are found (62-64), including Uganda.

5.1.1 Gaps and challenges in the health facilities

Looking at the gaps and challenges in the health facilities, major issues are identified as affecting the quality of healthcare and even the possibility to treat the patients in need.

Providing support to the patients, and basic needs was discussed as a challenge for promoting good health. The mental state of the already traumatized refugees was affecting the refugee patients. Adaku, Okello (24) and Meyer, Meyer (32) reported lack of basic needs among the South Sudanese refugees and the IDP in North Uganda; the studies found the stress to be related to lack of basic needs and food insecurity. In present study, the issue of lacking basic needs was related to the health behaviour of the refugees and lack of food affected the health and treatment of refugees.

Looking at the problem from a mental health perspective, the mental health specialist reported the issue of poverty and worries about food, water, shelter, cloths, soap to strengthening mental health related problems. The lack of mental health services and support were mentioned by many of the health workers. The workers suggest that one reason could be the no recognition of the importance of mental health services. The findings are similar to what Adaku, Okello (24) and Jones, Asare (25), indicating an unmet need of mental health treatment and promotion of psycho- social well-being. Jones, Asare (25) reports lack of resources, different perception of what's a medical problem, different help seeking mechanisms and stigma related to seeking mental health services, much like what's found in this study. The health workers reported challenges getting funding for mental health services and the funding agencies not recognising it as important. This can be explained by the fact that more attention is given to infections and more acute conditions in a humanitarian setting (25). Minimal training on mental health management and not being able to recognize the mental health disorders among the health workers were also reported in the present study as well as by Jones, Asare (25). As the present study didn't specifically focus on mental health challenges there are some limitation in explaining why the mental health services are neglected.

Lack of important infrastructure, lack of resources including HR, medicines and other equipment were reported by the health workers. Studies done in the district of Arua and Rhino Camp report lack of equipment, poor organisation of services, lack of health care providers, medicines, food and water (21, 26). As well as Kagabo, Frost (21) found, lack of beds and admission wards in the facilities due to over-population and an over strained budget. Lack of space and not having separate rooms for different cases were critically and affect the

spread of infectious diseases and risk the confidentiality of the patients. Other issues found were the lack of emergency transports and the use of tented structures.

Language barriers were reported by Kagabo, Frost (21) in Rhino Camp and from the refugees in Kampala (43), suggesting inadequate treatment due to the communication barriers and misunderstandings. Frustration of not being understood and not getting adequate services were suggested by the health workers to affect the negative attitudes towards the health workers.

5.1.2 Community factors

The health workers experienced challenges perceived in the community to affect the health behaviours and status of the refugees and hosts. Lacking knowledge about health, stigma, long distances, low education, negative attitudes and not seeking help in time were reported. Some of the health workers experienced particularly negative attitudes towards family planning and vaccination. A nurse explained in the interview that the population had their own traditional practices as well as they were not used to the health services in the settlement like vaccination. Studies of SHR among young girls and women suggest barriers as stigma in the community, challenges of distances, cost and quality to affect the access to knowledge and health services (27, 35). As Roberts, Odong (34) investigated the IDP in North Uganda, traditional healers, rituals and religion were a part of their health behaviour and could also be barriers for the community to seek help. A mix of many barriers are suggested in the previous studies correlating with the findings. The three-delay model implies factors as social and culture to affect the decision to seek help (29). The negative attitudes against family planning were explained by some of the health workers as refuge mothers wanting to reproduce the population they lost during the conflicts, suggesting culture factors to be important. As Jones, Asare (25), discusses, it is important to include the perspective of culture in health and in the promotion of health.

The long distance to a facility and challenges of transport were also challenges reported by the health workers, similar to the what Thaddeus and Maine (29) discusses in the three-delay model. It's also important to notice that this study provides knowledge from the health workers' perception and their experiences of interacting with refugees and hosts- It may not be how the community perceives the challenges, even though other studies indicates many of the same challenges from the perspective of workers and refugees.

Drug and alcohol abuse were reported as affecting the health of the population in the four refugee settlements, similar to findings in the study of IDP in north Uganda (65). The study reported war, displacement and the living conditions in the settlement to influence the choice of activities. Alcohol use, prostitution, violence and thieving had increased when becoming displaced. Patients with HIV and tuberculosis (TB) were reported to be seeking help alone as they were abandoned by their family due to stigma, similar to other studies of SRH (27, 35, 36). Patients lacking caretakers were a concern amongst the health workers. Many of the refugees had lost their family and friends during conflicts and didn't have anyone to take care of them, especially the old sick patients were a concern, as well as HIV and TB patients. As the knowledge of the researcher little attention has been given to the role of caretakers and health in a humanitarian context.

5.1.3 The humanitarian health workers

The study emphasizes much on the health workers' situation. The health workers reported heavy workload, overwhelming number of patients, sleeping in tents, being stressed and burned out, lack of security, low payments and not getting payed in time. Studies of international humanitarian workers indicate challenges of depression, stress, burnouts and increased risk of PTSD (17, 18). From the researcher knowledge, little attention and few studies focusing on national humanitarian health workers are found. Kagabo, Frost (21) and Ager, Pasha (20) provides knowledge about their situation in Gulu and Rhino Camp, Uganda. Similar findings as burnouts and poor working conditions to affect the health services and the workers personally were found. The results from our study indicates that NGOs and the UNHCR have neglected their health workers, similar to what McDonald (15) stated in the Guardian. The motivation of health workers was negatively affected by the lacking support and resources. The positive factors reported were the good teamwork and support they experienced from their co-workers, similar to Ager, Pasha (20).

The health workers were also worried about issues of protection and getting transmitted at work, lack of protection wear and working in a congested environment. Lack of protection wear was also found in the study of Kagabo, Frost (21). The research did not do any investigation on the mental health of the health workers, but the reported stressors as finance, security, family and high workload can be associated with mental health issues as found by Ager, Pasha (20). Hectic work and lack of human resources were big challenges for the health workers and affected the service delivery. As Mowafi, Nowak (22) suggest, lack of recognition and investment of HR by the funding agency can play a role in why little support

is provided. Motivation, stress, lack of support and working condition are all factors affecting the health workers personally as well as the health service delivery.

5.1.4 Management and funding

Lack of funds and the need of donors were mentioned by most of the workers when asking about the challenges. As the three- delay model discuss, the lack of services will also affect the perception of the services and can affect people not seeking services (29). It's also challenging to separate if a challenge is affected by the lack of funding, the management or both. As discussed in the previous chapter, Mowafi, Nowak (22) suggested the funding agencies not to give the needed support to HR even when funding were available. Also, the current study focuses on the perspective of the health workers, and information and better understating of the management and funding mechanisms should be addressed from other perspectives, as leaders and/or people working in the area of management and funding.

Although the ReHoPe strategy are focusing on a long-term approach (11), some of the 'workers reported challenges of short-term interventions and emergency driven activities. The findings indicate a need to investigate the management of the interventions in the settlements as well as follow up the strategy. Concerns about the issue of mental health illness, reproductive health and chronical illnesses were especially reported as in-need of long-term approaches. As Blanchet, Sistenich (4) found, most of the studies of health service delivery in a humanitarian context focuses on acute crises, also may be the focus of the interventions in the field, similar to the impression of Jones, Asare (25). The overwhelming population and a continue influx of new arrivals were reported as a challenge, better monitoring and management of the growing population were needed. Over population was also reported to affect the service delivery by Kagabo, Frost (21) and may indicate similar need of better population management.

5.1.5 Inequalities

As found in the current study, the host population was less likely to seek help in the health facilities compared to the refugees. Within the refugee hosting districts, the refugees and the Ugandans faced similar challenges of development and access to basic services (2). Even though all the health services were meant to be equal provided for both the refugees and hosts, some of the health workers suggested implications to affect the host population not seeking help. The main challenge was their perception of the health services, the workers reported the hosts to think that the services were prioritised for the refugees. The health

workers also reported that the hosts to feel uncomfortable at the facilities as well as neglected. As the Three delay-model describes how the perception is affecting the patient to seek help, similar suggestion for why the host don't seek the services (29). Lack of communication with the host population was also suggested as affecting the access. As the hosts often lived outside the congested areas of refugees, information about the services did not reach the long distances to the host communities. Issues of the refugees benefiting from the business in the settlement and some intervention focusing more on the refugees than the hosts, were factors strengthening the perception of the host population. The research agree with the findings of Kreibaum (42), suggesting better communication with the host communities and provide more information about the benefits the refugees brings to the area could help.

The humanitarian health workers reported inequalities between the support received. Different support and treatment among the workers employed by the Government and by an NGO, as well as between the NGOs were found. Working hours, payment and insurance were some of the variations reported. The differences varied mostly between the government workers and the NGO workers. Few studies are found concerning the inequalities in-between health workers working in the humanitarian setting. Ager, Pasha (20), reported the national workers to be stressed about the tension between the international and national staffs as the employers treated them different.

The present study also found some differences between the different settlements. When asking about the challenges, none of the facilities in Bidi Bidi refugee settlement reported any problems regarding access to water. As the researcher didn't asked specifically about the water its challenging to know if the problem is there or if the workers didn't think about it. Another explanations could be that Bidi Bidi refugee settlement is the newest one among the four investigated, established in 2016 (59). All health centres reported lack of medicines to some extent except one facility in Bidi Bidi. The facility was run by Medicine Sans Frontiers (MSF) and were just a temporary solution, the workers explain that another NGO were to take over as MSF was just operating for a short term. Also, the different reporting regarding accommodation for the workers. None of the health workers in Rhino Camp complained about the housing, and it seems like all workers that mention housing were satisfied and enrolled in houses. Negative attitudes were found to be more frequent in Kyaka 2 and Bidi Bidi compeared to the other settlements.

5.2 Methodological discussion

As Malterud (66) suggest, reflexivity, transferability and interpretation and analysis should be addressed when considering the validity of qualitative studies. The effect the researcher has on the study cannot be avoided, but different aspect of validity can be discussed. The process of organisation and how the data is interpreted during analysis will all affect the research, as well as the contexts and other biases (66).

5.2.1 Limitations

The recruitment of participants was done with the help of an NGO-worker, going from health centre to health centre. The approach could affect the positive reception at the health centres and the willingness to participate in the study. Also getting help form the in-charge to find interview subjects may put pressure on the health workers to participate. Changes in their everyday life could be a factor for participating in the study as well as many seems hopeful for changes. Individuals who feel poorly treated and frustrated about the health service delivery could also in more general be more likely to participate in the study, due to a purposive sampling the bias should be limit.

Being the majority of the workforce at the health centres, midwifes, clinicians/doctors, in-charges, lab- workers and nurses are most represented in the study. Nutritionist, translators and mental health workers were fewer and often out in the field. During the field work, it was epically challenging to recruit mental health workers. Only one psychologist was interviewed, and nurses and health workers focusing on mental health were included to get more insight of the mental health services. During the time period in Kyaka 2 refugee settlement it was not possible to find any mental health workers. The challenges correlate with what the findings revealed, lack of mental health services. Looking at a problem from one group perceptive of course limit some understanding of the context, but on the other side it provides an in-depth understanding of their stories and their perspective of the context.

Bias of stress, time and other environmental challenges could affect the interview. The interviews were held at the health centres where the interviewee worked, either in an office or under a tree. Interruptions of cars, babies screaming, patients making noise, colleagues asking questions and the general life around could affect the concentration and the possibility for the participate to share. Also, some question asked could be sensitive for the health workers, especially questions about health workers' feeling of being supported. Being afraid to say something wrong, affecting others or their own position could influence their answers, even

though confidentiality was ensured. From the experience of the interviewer, how much the health workers expanded on the issue of support varied much more than on the other questions asked. Even though most of the interviews were long, time and the hectic work could be factors stressing the participant.

Being one researcher conducting, transcribing and analysing the interviews can have some negative sides. Multiple researchers might strengthen the design of the study by supplementing and challenging each other's statements (66), as well as it can limit the influence of a researchers subjective perception.

5.2.2 Strengths

The recruitment of health workers was a positive experience and most of the health workers were open to participate in the study. During the recruitment of workers, variation in gender and discipline were considered. As the purpose of the study was to explore, identify gaps and understand the setting, the health workers were, from the researcher perspective, the ones with most in-depth information about the health service delivery. Overall, from the researcher experience, the impression was that most of the interviewees were open and happy to share, as well as the length of the interviews indicates depth and quality.

Being one single researcher, a good strategy for validation of the findings is needed. Cross checking information from audio, transcript and analysis were therefor important, as well as discussing issues and methodology with supervisors. As the researcher had limit experiences in advance, the NVivo program was very helpful keeping control of all the data and especially during the text condensation and coding process. The STC method is applicable to all type of analysis of interviews and provides easy systematic steps to follow and the method is seen as a good starting point for beginners (60). Being one researcher provides full oversight at all time, the use of one systematic method and get to know the data very well. During the collection of data, notes after each interview and each field visit were conducted, remembering the setting and expression of the interviewee. The audio files were also transferred from the audio recorder to the computer every night, as well as field notes was typed. Both an academic and personal dairy were kept during the process, ensuring to get all the information right. The transcribing process were done after leaving Uganda due to the little time, access of electricity and quiet spaces.

The research represents a purposeful and diverse sample, including different disciplines, health centres, as well as data from four different geographic areas. The perspectives from

five different health centres in each settlement and two local government facilities in Hoima and Yumbe were included to represent det whole settlement and the perspective from the host district. The study represent data from four different geographic areas including Mid-west (Kyegegwa and Hoima) and the North-west region (Yumbe and Arua) of Uganda. The geographic diversity suggests the findings to be generalised for refugee affected areas in Uganda. A wide range of perspectives and knowledge are representing the sample of health workers and their situation, the challenges reported can be consider to have a more external validity, but as little studies are found in this area, research in other geographic areas should be addressed to build more evidence.

6 Conclusion

The current study provides knowledge about health service delivery and the experiences of health workers working in a refugee affected environment. The research identifies a big gap of needed resources in the health service delivery, community factors affecting the health of refuges and host population, neglect of health workers, challenges of management and barriers for the host population to seek help. The study emphasizes much on the health workers situation and how the humanitarian context influences their motivation, work and their personally life. The results correspond with some of the early findings done in similar contexts (20, 21, 43), but are unique in the way that it provides qualitative information and understanding from a wide range of health disciplines, a perspective of national health workers and from four different refugee affected areas.

Not many studies focus on the perspective of national health workers and their situation, and the challenges and gaps are not very well understood. The difficult and complex situation and the unfair treatment of health workers needs to be addressed. One universal policy for all health workers working in a humanitarian context, including government- and aid workers should be defined. Recruitment of more health workers, follow-up, education and basic needs to the health workers is needed to be addressed and prioritised. In order to provide sustainable solutions, the existing funding mechanisms needs to be further investigated and improved.

Research and interventions in a humanitarian context should be addressed with a holistic approach, including the workers, the affected population (refugees), the host community and the management. The study can be used to improve the health service delivery, give attention to the national health workers working in the humanitarian context and inform relevant stakeholders such as aid agencies, the Government of Uganda and UNHCR. The study is also transferable to similar contexts. The challenges and gaps identified in the present study need to be looked at with a holistic point of view, as interconnected and as effecting several aspects.

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Appendix 1

Interview guide- Questions

1. How old are you?
2. How many years have you been working in….
3. What is your responsibility and tasks?
4. Can you tell how a normal day at work look like?
5. What challenges do you face on a normal day?
6. How do you feel about managing your tasks?
7. What factors influence the way your tasks are carried out?
    - Elaborate:
8. In what way do you feel support around you? (From your colleagues, leader, organization, system etc. and how?)
9. What are the barriers of this challenges?
10. What can be done to tackle these challenges?
11. In your time of working here, have you experience changes in the way services are organized?
    - What kind of changes?
    - How did that effect your job?
12. Who are the patient target group?
13. Do you have any suggestions on what you think can be done better to provide “the best health system delivery`” in a refugee setting?
14. Do you have additional comments you find relevant?

Appendix 2

Consent form

Health system delivery in a refugee environment

Introduction

Thank you for taking time to meet me. My name is Anne Christine Abrahamsen, I`m a master student in Global health at the Norwegian University of science and technology. For my master project I`m doing a study on health service delivery in refuge effected environments here in Uganda. I would like to talk to you about your experiences as a health worker. The aim of the interview will be to explore and to get a better understanding of the health service delivery and how the system can be improved.

The interview will be recorded on audiotape, as well as I will take some notes during the interview not to miss any of your comments. Our meeting will take about 30 minutes and all responses will be kept confidential, meaning that your interview only will be analysed by me. I will also ensure you that the information used in the report not will identify you as a respondent. You can at any time during the interview withdraw your participation, as well as its important that you remember that you don't have to share anything you don't want to. If you decide to withdraw participation in the project, you can demand that your interview will be deleted.

The information that is recorded will only be used to describe the purpose of the study. You have the right to access the information recorded about you and the right to stipulate that any error in the information that is recorded is corrected. The final thesis will be submitted 1st June and I would be happy to shear it with you.

Would you still like to participate in this interview?

Signature

_____	_____	_____
Interviewee	Interviewer	City and Date

Thank you very much for your time and for your participation in this study.

If you at a later point, wish to withdraw consent or have questions regarding the project, you can contact me: **Anne Christine Abrahamsen, +47 48024959, anneab@stud.ntnu.no**

Appendix 3

Feedback from REK

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Executive officer:	Phone:	Our date:	Our reference:
REC Central Norway	Marit Hovdal Moan	+47 73597504	03.10.2018	2018/1205/REK midt

To whom it may concern,

Project title: "The gaps of health system delivery in refugee and host settlements in two west Nile districts in Uganda: A qualitative study".
Institution responsible for the research: Norwegian University of Science and Technology (NTNU).
Chief investigator: Valentina Cabral Iversen.

The Regional Committee for Medical and Health Research Ethics, REC Central Norway, hereby confirms that the above project was originally evaluated by the entire committee in its meeting on 22.08. 2018.

The Committee decided that the project does not appear to involve medical and health research, but another type of research, focusing on identifying gaps in a health system delivery. Under the provisions of Section 2 and Section 4 of the Norwegian Health Research Act, the project does not need to be submitted for ethical review, and can therefore be implemented and published without REC approval.

Kind regards,

Vibeke Videm
Professor dr.med./Head clinician
Chair, REC Central Norway

Marit Hovdal Moan
Senior adviser to the Committee

CC: anneab@stud.ntnu.no