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A Synthesis of Key Aspects of Health Systems and Policy Design Affecting the Refugee Populations in Uganda Report Structure

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A synthesis of key aspects of health systems and policy design affecting the refugee populations in Uganda
Report Structure

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Background to series

CHE Discussion Papers (DPs) began publication in 1983 as a means of making current research material more widely available to health economists and other potential users. So as to speed up the dissemination process, papers were originally published by CHE and distributed by post to a worldwide readership.

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Introduction

REfugees in Africa ClusTer (REACT) project is a joint initiative between the East Central and Southern Africa Health Community, KEMRI, Makerere School of Public Health (MakSPH), University College London (UCL), the London School of Hygiene and Tropical Medicine (LSHTM), and the University of York, aimed at supporting national capacity-strengthening and research in gender-responsive resource allocation, health care organisation and policy decision-making for more efficient and equitable responses to refugee and host communities health needs in east, central and southern Africa.

The project is structured around three work packages on health systems governance, health economics, and gender, which jointly investigate four distinct research themes. REACT will generate theoretical, conceptual and methodological contributions which will benefit academics from a broad range of disciplines researching and teaching forced migration, humanitarian response, gender, public health and health systems. The knowledge generated through this initiative will be shared thorough briefs, reports, papers, presentations and workshops.

Report objectives

This report will provide an introductory background to REACT. The specific objectives are to:

1. Describe the extent and characteristics of the refugee crisis worldwide;
2. Understand the nature of the refugee crisis in Sub-Saharan Africa;
3. Provide an overview of the guidance provided by international organisations on refugee health;
4. Summarise findings from a scoping review on health economics and financing research in refugee settings;
5. Identify priority areas for health economics and financing research.

Characteristics of the refugee crisis

Despite the development gains observed over the past decades, one in every 70 people around the world is caught up in a crisis and requires humanitarian assistance and protection, and 1% of the global population is affected by a major humanitarian crisis. Between 2014 and 2017, the number of forcibly displaced people increased from 5.9 to 68.5 million. In recent years, food insecurity has been rising affecting from 80 to 124 million people. Additionally, some 350 million people are affected every year by natural disasters and climate change events. Overall, the number of people targeted to receive humanitarian assistance through the UN-led Humanitarian Response Plans (HRPs) increased by 31% between 2014 and 2018 [1].

According to recent estimates, in 2019, 132 million people required humanitarian assistance and protection, and there were 86.5 million people of concern for the United Nations High Commissioner for Refugees (UNHCR). These include 43.5 million Internally Displaced People (IDPs), 5 milliion of whom are located in the Democratic Republic of Congo (DRC), 20.4 million refugees and 4.1 million asylum seekers [2]. (**Figure 1**)

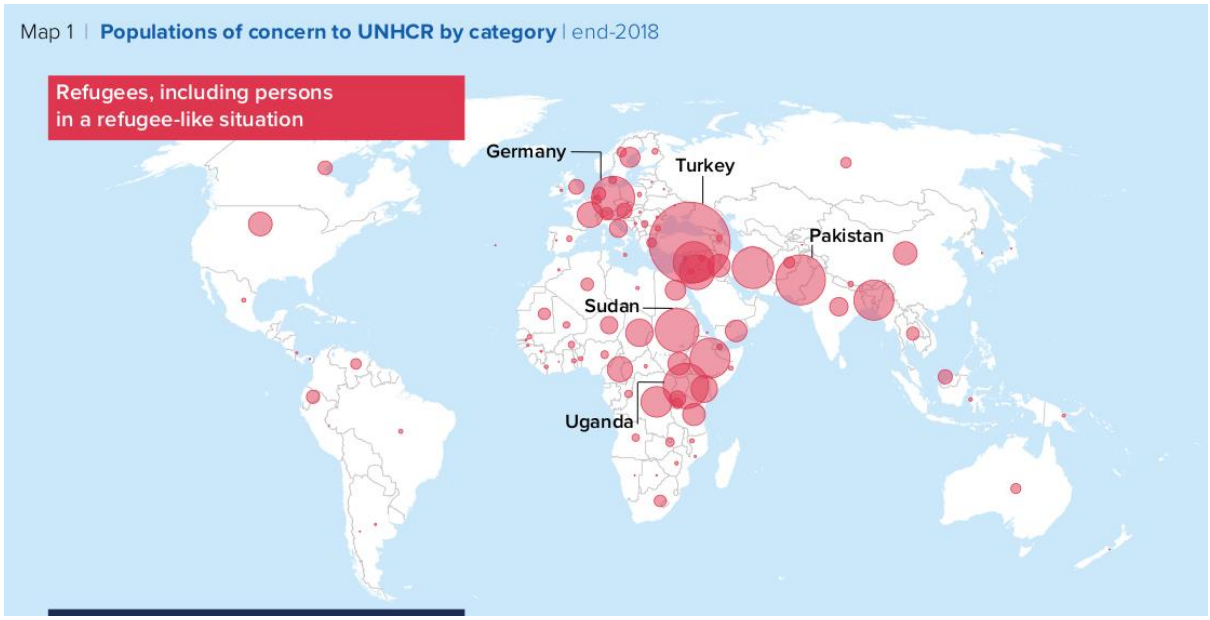

Figure 1. Populations of concern by UNHCR category

Nowadays, the average humanitarian crisis lasts more than nine years. Around 2 billion people live in fragile and conflict affected settings (FCAS) and nearly 75% of the people targeted to receive assistance in 2018 were in countries affected by a humanitarian crisis for at least seven years. In FCAS, 40% of the population are under 14 years of age. Therefore, 25% of children living in the world are living in a setting affected by conflict or disaster, facing threats of violence, hunger and disease.(1) The World Health Organisation (WHO) estimates that 60% of preventable maternal deaths, 53% of under-five mortality, and 45% of neonatal mortality occur in humanitarian crises and FCAS [3].

Response Funding

Humanitarian aid has been increasing, but not at the same speed as demand. Between 2009 and 2018, the funding requests from the UN-coordinated appeals to respond to humanitarian crises and other emergencies has increased by over 183%, whereas humanitarian funding increased by 139%. This resulted into an average funding gap of 18% over the same period. (**Figure 2**)

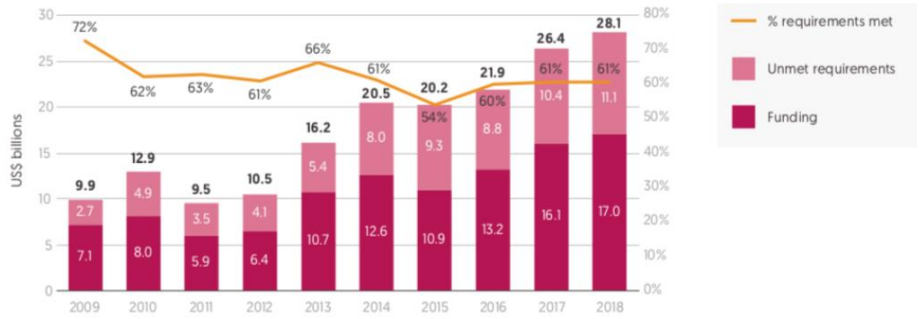

Figure 2. Trend of Un-coordinated appeals

The funding landscape is always dominated by the same donors. Although the US, Germany and the UK reduced their contributions by 7% between 2017 and 2018, their support still represents 52% of the total funding [4].

The large protracted crises have been driving the funding requests and disbursement. Between 2014 and 2018, the Somalia, South Sudan, Sudan and Syria crises have accounted for 55% of the response funding received.

As the duration of the crisis gets longer, the most vulnerable groups become disproportionately affected by the crisis [5].

The nature of the refugee crisis in Sub-Saharan Africa

Sub-Saharan Africa (SSA) hosts over 26% of the world's refugee population and 18 million people of concern to UNHCR. South Sudan, Somalia, DRC, Sudan and Central Africa Republic (CAR) are among the top international displacement situations, whereas Uganda and Sudan are among the top refugee hosting countries [6].

In recent years, the number of refugees and displaced populations has significantly increased. **Figure 3** shows the new displacements in 2018, when new major displacements were registered due to the crises in the CAR, Nigeria, South Sudan and Burundi [7].

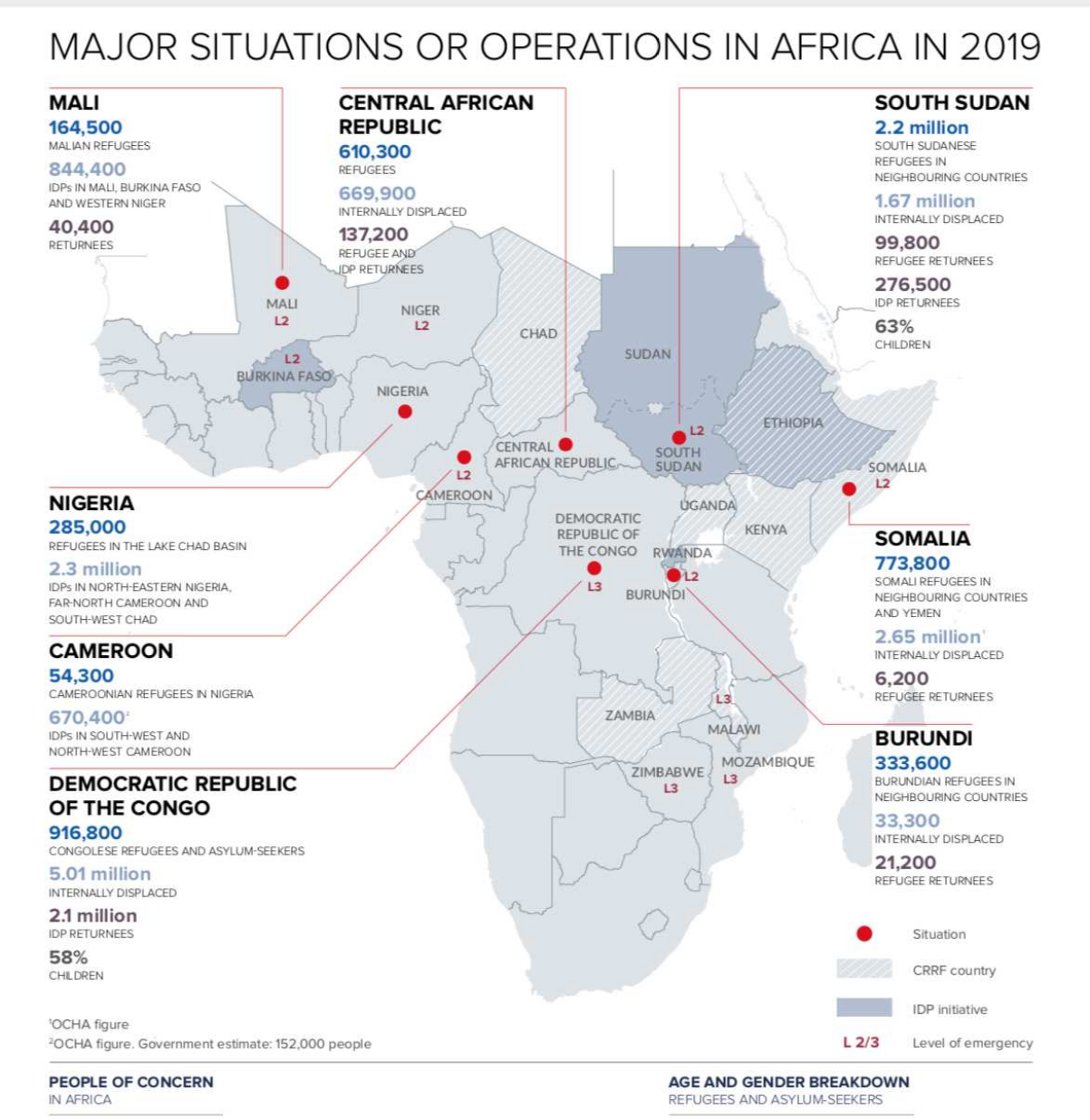

Figure 3. Major displacement situations in Dub-Saharan Africa 2019 [2]

Political instability, violence, socio-economic conditions and extreme climate events are at the roots of the displacement crisis in the continent. The table below summarised the main characteristics of the crisis affecting sub-Saharan Africa.

Country	Political crisis	Other Factors	Population Displacement
Sahel Region			
Mali	In 2019, the jihadist groups strengthened their presence in the Sahel Region. The Liptako Gourma (i.e. the area shared by Burkina Faso, Niger and Mali) has been affected by increased intercommunal violence and security incidents, resulting in civilian casualties. The Islamic State in the Greater Sahel (ISGS) and the Islamic State in the West African Province (ISWAP) have been very active in the region, claiming a high number of attacks [8].	Climatic variations and irregular rainfalls have threatened food security and poverty reduction efforts in the region since 1970 [9].	Over 171,000 people have been displaced by conflict and violence [10].
Burkina Faso	The country has been exposed to the AIQM threat since 2015, when a foreign worker was kidnapped in the north east of the country. In 2019 alone, 399 security events resulting in 1,800 fatalities were reported [11].		Since mid-2019, the number of IDPs has been steadily increasing, reaching 766,000 in mid-2020. There are also 23,000 Malian refugees living in two consolidated camps [12].
Niger	Cross border violence in Tillaberi and Tahoua regions leads to significant population displacement. In 2018, Niger suspended counter terrorism cooperation with the Malian militias and began to counter the Islamic State through community outreaches. Since then, attacks increased [13].		There are over 187,000 IDPs and 218,000 refugees [14].
Lake Chad Basin			
Nigeria	Boko Haram, its break-out fraction Islamic State West Africa Province (ISWAP), and the related counter insurgency led by the Nigerian military and the African Union Multinational Joint Task Force have been ongoing for over 10 years in the North Eastern regions of the country. Conflict and violence have spilled over to Niger, Chad and Cameroon. Additionally, bandits have been active in the same area of the country, especially after the discovery of Gold Reserves in Zamfara State. Nigeria is also hosting a growing number of Cameroonian refugees following the intensification of Cameroon's Anglophone crisis.	The current crisis is rooted upon inequality and long-term political marginalisation, which resulted into deep mistrust between communities and the government [15]. These factors have been coupled with climate change and environmental degradation, affecting rural populations	Over 1.8 million people have been displaced across the Lake Chad region. Due to bandits' activities, 160,000 were internally displaced and 41,000 forced to seek refuge abroad.

Country	Political crisis	Other Factors	Population Displacement
Cameroon	Since late 2016, the protests between the Anglophone minorities in the Northwest and Southwest have escalated, leading to the creation of the self-proclaimed Ambazonian Republic. Cameroon is the second most-affected country by violence and insecurity linked to Boko Haram in the region [17].	particularly severely, and increasing competition over natural resources [16]. The conflict is resulting in the disruption of markets and depletion of food supplies.	Over 650,000 people are internally displaced due to the internal conflict, and 290,000 because of Boko Haram associated conflict, and 60,000 were forced to flee to Nigeria [17].
Chad	Security threats associated to Boko Haram activities and related counter military operations have affected the country since 2014 [18]. Despite the escalation of violent events between 2018 and 2019, 1,200 troops returned to N'Djamena in early 2020 [19].		There are 450,000 refugees, mostly from Sudan and DRC, and 124,000 internally displaced people [20].
Greater Lake Region			
DRC	A complex emergency has been affecting the DRC for over 20 years. In 1996, the First Congo War started. The Uganda-Rwandan armies led by Laurent Kabila invaded eastern Congo and overthrew president Sese Seko Mobutu. Violence continued until 2003, when peace agreements were signed between DRC and Uganda. A proxy war between DRC and Rwanda continued until 2008 [21]. In 2006, Joseph Kabila, the late son of Laurent, became the first democratically elected president. Despite this democratic transition, conflict and violence continued. The conflict has been exacerbated by the interplay between several rebel actors, including the March 23 Movement (M23), Democratic Forces for the Liberation of Rwanda (FDLR), Maï-Maï Sheka, Allied Democratic Forces (ADF), and Lord's Resistance Army (LRA) [22]. In recent years, the conflict has intensified around the Province of Ituri, North Kivu and Tanganyika.		More than 5 million IDPs and 900,000 refugees living in neighbouring countries. In addition, DRC hosts 527,000 refugees from Rwanda, CAR and South Sudan.

Country	Political crisis	Other Factors	Population Displacement
South Sudan	South Sudan became an independent state in 2011. Soon after, in 2013, a civil war broke out. In 2018, the Khartoum Declaration of Agreement which included a cease-fire and a pledge to negotiate a power-sharing agreement to end the war, was signed by President Salva Kiir and the opposition leader Riek Machar [23]. However, attacks continue to be reported and the delivery of assistance is limited by the frequent attacks on humanitarian workers.	The protracted conflict and displacement have resulted into the disruption of food production and supply chains, and the overall deterioration of the economy. The desert locust outbreak is further worsening the food security situation.	The conflict led to the death of over 50,000 people, the internal displacement of 1.5 million people and 2.2 people seeking refuge abroad. South Sudan also hosts around 300,000 refugees from Sudan, DRC, Ethiopia and CAR [24].
Uganda	The unprecedented mass influx of refugees into Uganda in 2016-2018 has put enormous pressure on the country's basic service provision, in particular health services. The sheer scale of the South Sudanese and Congolese refugee crises puts the national and district health systems, host communities, and refugee response-implementing partners under tremendous stress [25]. Uganda is praised world-wide for its progressive open-door refugee policies. It was the first country to launch the Comprehensive Refugee Response Framework (CRRF), as early as March 2017. The CRRF is part of a rich policy environment, including the Refugee Act 2006 and the Refugee Regulations 2010. As part of the overall health sector planning framework in Uganda, the Health Sector Integrated Refugee Response Plan (HSIRRP) (2019-2024) in Uganda is presented as an addendum to the Heath Sector Development Plan (2015-2020), for supplementing service delivery in the refugee hosting Districts [26].		Uganda is currently hosting over 1.4 million refugees, with an average monthly influx of an additional 30,000 refugees, primarily coming from the Democratic Republic of the Congo and South Sudan. Refugees are hosted in 13 districts, where an additional 7 million local people live [27].
Burundi	Since President Nkurunziza announced a run for a third term in April 2015, Burundi has been in a political crisis [28].	Due to political instability, the economy has significantly declined and foreign aid, representing 48% of the national income in 2015, was suspended [29].	Over 300,000 Burundian refugees fled to Tanzania, Rwanda, the DRC and Uganda and 750,000 face severe humanitarian conditions [28].

Country	Political crisis	Other Factors	Population Displacement
Horn of Africa			
Ethiopia	Ethiopia has encountered numerous civil-wars in the region, including the Eritrea liberation movements (1961–91), the Tigrai People's Liberation Front (TPLF) (1975–91); the Western Somali Liberation Front (WSLF) (1974–78), the Oromo Liberation Front (1975– present) the Afar Liberation Front (1975–97) and the Ogaden National Liberation Front (1984–present) [30]. Between 1997 and 2015, a number of conflicts were reported in the region. In 2015, anti-regime movements escalated across the country and protests peaked in major cities. Since 2018, an increase in ethnic-based violence was recorded, associated to the rise in ethno-nationalism and state fragility [31].	The countries in the region are characterised by fragmented economic and institutional systems which expose segments of the population to economic and political marginalisation. Since independence, there have been four major interstate wars and three violent conflicts. These include the two wars between Ethiopia and Somalia over Somalia's claims over the Somali-inhabited Ogaden region of Ethiopia (1961-1967 and 1977-1978), the war between Ethiopia and Eritrea following the border dispute over Badme (1998-2000), and the third Somalia-Ethiopia war (2006-2009) [30]. Consecutive years of natural hazards, drought and violence have resulted in an increase in humanitarian needs, due to increased food insecurity. Rural household livelihoods are highly dependent on climate seasonal cycles.	With 740,000 refugees, the country is the second largest recipient of refugees in Africa, the majority of which depends on humanitarian aid [32]. Estimates indicate that over 10 million people are in need [33].
Somalia	Since the overthrow of Mohammed Siad Barre in 1991, Somalia has been affected by severe state fragility and widespread insecurity. In 2004, a Transitional Federal Government (TFG) was created as a ruling body, composed of representatives from Somalia's largest clans, and ruled until 2014, when it was superseded by the Somali Federal Government [34]. In 2006, a number of Islamist organisations established a network of sharia courts in Mogadishu, called the Islamic Courts Union (ICU) and seized Mogadishu.(35) Al-Shabaab ("the youth"), an affiliated jihadist fundamentalist group operating in East Africa, was created as a faction of the ICU, representing initially a hard line militant youth movement and subsequently a splinter of ICU. In 2006, the US backed Ethiopian military action successfully removed the ICU and allowed the TFG to relocate to Somalia [36]. With the defeat of ICU, Al Shabaab gained increasing strength and took control of most areas of the country by 2008. By 2009, the group controlled most of southern Somalia [37]. As of 2010, the group was officially allied with al-Qaeda.		There are more than 2.6 million people internally displaced, mostly due to conflict, violence and extreme weather events. [39].

Country	Political crisis	Other Factors	Population Displacement
	In August 2011, Al-Shabaab was forced to withdraw, following the operations led by the UN-mandated African Union Mission in Somalia (AMISOM). In the same year, the UN declared famine in two southern regions of the country which cost the lives of some 260,000 people. Conflict and the US anti-terrorism legislations, preventing aid from reaching the affected areas, were at the roots of the famine [38]. In 2015, a small faction of Al Shabaab under the leadership of Abduqadir Mumin broke off and created the Islamic State in Somalia (ISS). The group claimed 81 assassinations between February 2017 and July 2018, few of which have been verified. Clan disputes and protests, coupled with the progressive withdrawal of the African Union Mission, due to the end of its mandate. The attacks from the Islamic State and Al Shabaab contribute to the increased insecurity in Somalia. In 2019, a total of 4,017 fatalities were reported. Besides the attacks linked to Al Shabaab's insurgency against the Somali government and its allies, rural populations are exposed to clan-based violence [11]. Over 5.2 million people are in need of humanitarian assistance, 3.2 million people are in need of protection and 3.6 million people have been displaced by conflict, insecurity, forced evictions, droughts and floods. Additionally, 30,000 Ethiopian refugees and asylum seekers are registered in Somalia. Estimates indicate that 3.5 million people won't be able to meet their minimum food needs between July and September 2020 [39].		
Kenya	Until the 1990s, the Kenyan refugee policy favoured integration. Subsequently, a reversal occurred and a new strategy promoting only temporary protection was introduced. Although the 2010 Constitution guarantees freedom to all refugees to enter, remain and reside anywhere in the country, *de facto* the encampment policy prohibits freedom of movement, and therefore access to employment and higher education. Whilst refugees may theoretically work, in practice this is proven to be difficult because of the labour market structure which is characterised by a high unemployment rate and heavy reliance on the informal economy [40].		As of February 2020, Kenya is hosting a total of 492,802 refugees, 84% of which are living in refugee camps (Kakuma and Dadaab). Refugees from Somalia form the largest group (54.5%), followed by those from South Sudan (24.4%) and the Democratic Republic of the Congo (8.8%) [41].

Responding to humanitarian, refugee and IDPs crises

As part of the efforts to improve the coordination of the response to humanitarian crises and emergencies, in response to the United Nations General Assembly Resolution 46/182, in June 1992 the Inter-Agency Standing Committee (IASC) was established as a unique interagency forum for coordination, policy development and decision making involving key UN agencies and non-UN humanitarian actors. Subsequently, the role of the IASC was affirmed with the General Assembly Resolution 48/57. The committee is chaired by the Emergency Relief Coordinator [42].

Following the Great Lakes Refugee crisis of 1994, an international movement started to improve the quality of humanitarian assistance. These efforts led to the development of Sphere, which set the internationally recognised set of common principles and universal minimum standards in humanitarian response, published in the Sphere Handbook [43].

Figure 4. History of humanitarian assistance

In 2005, following the recommendation of an independent Humanitarian Response Review, the clusters approach was adopted with the purpose of addressing gaps and strengthening the effectiveness of the humanitarian response. The Emergency Relief Coordinator can activate up to 11 clusters (i.e. camp coordination and management, early recovery, education, emergency telecommunications, food security, health, logistics, nutrition, protection, shelter, water, sanitation and hygiene) [44].

In 2012, 15 member states of the 2009 African Union ratified the Kampala Convention for IDPs. The document is framed in terms of state obligations in relation to internal displacement, covering prevention, protection and assistance obligations during displacement, and obligations in relation to return and compensation. The Kampala Convention also recognises the important roles of various groups, including international organisations and humanitarian agencies, and addresses the responsibilities of armed groups in situations of armed conflict [45]. To date, 30 AU members have ratified the Convention.

Efforts to increase the standards of humanitarian assistance continued and in 2014 the Core Humanitarian Standard on Quality and Accountability (CHS) set out nine commitments that organisations involved in humanitarian response can use to improve the quality and effectiveness of the assistance they provide. With the CHS, affected communities and individuals are put at the centre of humanitarian action [46].

In May 2016, the World Humanitarian Summit was held in Istanbul with the objective of increasing the commitments to deliver better quality services for people affected by humanitarian crises and reaffirm the support for the new Agenda for Humanity. An online Platform for Actions, Commitments and Transformations (PACT) was created with the purpose of tracking progress against the stated objectives until 2019 [47].

In the same year, the Comprehensive Refugee Response Framework (CRRF) was launched as the first of two Annexes to the New York Declaration for Refugees and Migrants, as a set of commitments to be implemented in situations involving large scale movements of refugees. The CRRF strives to promote sustainable approaches linking humanitarian operations to development assistance and is based on the premise of greater engagement between national and local authorities, international organisation, civil society, refugee and host communities [48]. This model was first pioneered in Uganda, a country with a longstanding history of progressive approaches to durable refugee responses.

Health Services Delivery in Refugee Settings

Over the years, a number of organisations have been producing guidelines to provide refugee assistance. The UNHCR Emergency Handbook is a reference document outlining best practices among the entire emergency response cycle.

A number of documents have also been produced over the years to provide health services among refugees and migrants. Besides country-specific guidelines, like the U.S. Centre for Disease Control (CDC) Refugee Health Guidelines, international guidance and best practices are regularly published by the Health Cluster and UNHCR. Additionally, Médecins sans Frontières (MSF), has produced several seminal guidance documents (e.g. Refugee Health: an approach to emergency situations) and open-source training materials (e.g. Humanitarian priorities in refugee camps).

In 2014, the UNHCR released a Global Strategy for Public Health 2014-2018 with the purpose of fulfilling refugee's rights to access life-saving and essential care, with a focus on HIV and Reproductive health, Food security and nutrition and Water, hygiene and sanitation. The strategic objectives include:

1. Improve access to quality primary health care programmes
2. Decrease morbidity from communicable diseases and epidemics
3. Improve childhood survival
4. Facilitate access to integrated prevention and control of Non Communicable Diseases (NCDs), including mental health services
5. Ensure rational access to specialist referral care
6. Ensure integration into national services and explore health financing mechanisms

On a yearly basis, the Public Health section of UNHCR produces a report on Public Health in refugee settings. Data from the Integrated Refugee Health Information Systems (IRHIS) is analysed to assess the main morbidity and mortality trends in refugee settings, with a focus on reproductive health, nutrition, water, sanitation and hygiene. In 2018, despite major refugee influx in Myanmar, South Sudan and DRC, mortality standards were mostly below emergency thresholds.

Over the past years there has been an increasing recognition that camps should be only temporary solutions to host refugees. However, alternatives are highly dependent on the legislative framework of the hosting country. Whether possible, the integration within local communities seems to be the preferred alternative as it forms the basis of more durable solutions and refugees' skills and assets can greatly benefit host communities as well. According to recent estimates, 6 out of the 10.5 million world's refugees now live in slums, cities and urban settings [49].

The characteristics of refugee settings have major impacts on the delivery of assistance to the affected populations. Unlike in camps, urban settings provide greater autonomy to refugees. At the same time, urban refugees do not have the same legal protection in their hosting country and are

therefore exposed to greater vulnerabilities, including exploitation, violence and narrower social protection. New approaches, mostly through the collaboration with national authorities, are emerging to assist refugees in such settings [49].

Table 1. Refugee health services in urban settings

Urban Refugees in Kampala	Urban Refugees in Nairobi
As of January 2020, Kampala hosts almost 60,000 refugees and 18,500 asylum seekers, the majority of whom comes from Somalia and DRC [50]. Legally, refugees are required to register with the Police and then with the Office of the Prime Minister (OPM) to obtain a refugee identification card to access public services. Despite the progressive refugee policies in Uganda, refugees still face major issues accessing (health) services. The state is in fact unable to guarantee equitable access to quality services, which are only in theory free. Refugees need to cover both direct and indirect services delivery costs. Moreover, the overcrowded living conditions of urban refugee settings create the perfect environment for disease outbreaks. Established refugee led organisations contribute to address the institutional, linguistic and cultural challenges faced by newly arrived refugees [51].	Although most refugees in Kenya live in camp settings, some are residing in urban settings, namely in Eastleigh, the large trading district in Nairobi. A large proportion of the population lives in overcrowded, dark and poorly ventilated apartment blocks with poor hygiene, which are conducive to the spread of tuberculosis (TB), cholera and other communicable diseases. 8,771 refugee families have been registered to the National Hospital Insurance Fund (NHIF) which is providing unrestricted secondary and tertiary healthcare to subscribers after paying US$ 5 per family per month [52].

Need for health economics and financing research

Fragile and conflict affected states (FCAS) are characterised by rapidly changing disease burden, due to increased risk of outbreak with epidemic potential, conflict-related injuries, malnutrition and micro-nutrient deficiencies associated to food insecurity, and mental health. In these settings, health services utilisation often diminishes due to services disruption and high reliance on out of pocket expenditures. The fall in publicly funded health services provision and the reduced household ability to pay exacerbates existing inequity of health services utilisation.

With the fall in domestic public revenues in FCAS, government purchasing is focused on salaries. Humanitarian financing often represents the largest share of health spending and is project-based, thus leading to fragmentation in purchasing arrangements and leading to sustainability challenges.

Although some humanitarian organisations have developed minimum standards for the health services package, the notion of benefit entitlement varies across crises. The involvement of some external organisations has led to the introduction of explicit benefit packages in some settings (e.g. Afghanistan, Liberia, South Sudan, Somalia and DRC). In some countries, like Iran and Uganda refugees have access to the same services as the host populations [53].

A recent scoping review on health financing in FCAS, found that the related body of evidence has increased over the past years. Whilst the literature seems to be biased towards countries with a large donor presence, and focused on aid coordination and domestic resources mobilisation, a growing number of studies on the following topics were identified:

- *Raising and pooling revenues*: Aid coordination and effectiveness, tax revenue mobilisation, health insurance, health equity funds, demand side financing;
- *Purchasing*: Contracting, performance-based financing;
- *Benefit packages and services provision*: Benefit packages of health services, accreditation and regulation of providers, public financial management;
- *UHC goals and objectives related to health financing*: Equity and efficiency in resource allocation, Transparency and accountability, Utilisation relative to the needs, financial protection and equity in finance [54].

A number of studies have also been published on the use of economic evaluations in health-related humanitarian programs. A recent systematic review of the literature revealed that there is limited use of economic evaluations to determine health interventions in humanitarian settings, resulting in lost potential to support operational and policy decision making to improve efficiency in health programming and services prioritisation. Data and quality availability pose major challenges to undertake full economic evaluations, as most studies relied on non-governmental organisations (NGOs) data. The lack of research studies on economic evaluation is also potentially linked to the limited awareness of the benefits among donors, misunderstanding of the role of economic evaluation and lack of political will to conducting studies on outcomes.

Concluding remarks

The use of health economics tools in decision making processes is pivotal in settings experiencing protracted refugee crises, as hosting governments are called to rely on health economics tools in decision making processes. Despite the above-mentioned challenges, related to the use of economic evaluations in these settings, efforts shall be made to promote the utilisation of these approaches in these settings.

These could be of greatest relevance in countries like Uganda and Kenya which have a stable internal political situation and host the largest numbers of refuges in the region. Refugees hosted in both countries come from settings affected by highly protracted crises, and therefore having limited chances to return to their country of origin. Therefore, durable solutions to be found to deliver services to the refugee population relying on domestic financial resources.

Uganda may benefit from the use of costing models and economic evaluations to support health services prioritisation for the design of benefit packages in refugee hosting districts, and the use of cutting edge tools to conduct empirical analysis on domestic and external trends towards refugee hosting areas, to improve equity of resources allocation decisions. Despite having different refugee policies, Kenya may also benefit from relying on health economics tools in decision making processes, especially to streamline the package of health services provided to refugees living in refugee camps.

References

1. UNOCHA. Global Humanitarian Overview. 2019. Available from: www.unocha.org/datatrends2018.
2. UNHCR. Global Report. 2019. Available from: https://reporting.unhcr.org/sites/default/files/gr2019/pdf/GR2019_English_Full_lowres.pdf#_ga=2.50494761.1677727819.1593786166-68504584.1593786166
3. WHO. WHO says address protracted emergencies to achieve Sustainable Development Goals. World Health Organisation; 2016. Available from: http://www.who.int/hac/crises/ssd/releases/who_suistainable_development_goals/en/
4. Development Initiatives. Global Humanitarian Assistance Report 2019. 2019.
5. Urquhart A. 4 trends in global humanitarian aid. Bond. 2019. Available from: https://www.bond.org.uk/news/2019/08/4-trends-in-global-humanitarian-aid
6. UNHCR. Global Trends Forced Displacement. 2019.
7. UNHCR. UNHCR - Africa. Available from: https://www.unhcr.org/africa.html
8. ACAPS. Conflict in the Sahel. 2019. Available from: https://www.acaps.org/sites/acaps/files/key-documents/files/acaps_humanitarian_perspectives_2019-2020_conflict_in_the_sahel.pdf
9. Essoungou AM. The Sahel: One region, many crises. Africa Renewal. 2013. Available from: https://www.un.org/africarenewal/magazine/december-2013/sahel-one-region-many-crises
10. UNOCHA. Plan de Réponse Humanitaire Mali 2020. 2020. Available from: https://www.humanitarianresponse.info/
11. Kishi R, Pavlik M, Jones S. Year Review 2019. 2020.
12. UNHCR. Burkina Faso. Available from: https://www.unhcr.org/burkina-faso.html
13. International Crisis Group. Sidelining the Islamic State in Niger's Tillabery. 2020. Available from: https://www.crisisgroup.org/africa/sahel/niger/289-sidelining-islamic-state-nigers-tillabery
14. UNOCHA. Aperçu des besoins humanitaires Niger 2020. 2020. Available from: www.unocha.org/niger
15. Vivekananda J. Climate Change and the Conflict Trap in Lake Chad. ISPI. 2020. Available from: https://www.ispionline.it/it/pubblicazione/climate-change-and-conflict-trap-lake-chad-25442
16. Vivekananda J. Lake Chad Risk Assessment: The role of climate change in the current crisis | adelphi . Adelphi. . Available from: https://www.adelphi.de/en/project/lake-chad-risk-assessment-role-climate-change-current-crisis
17. ACAPS. Cameroon. Available from: https://www.acaps.org/country/cameroon/crisis/country-level
18. ACAPS. Chad. ACAPS. Available from: https://www.acaps.org/country/chad/crisis/complex-crisis
19. Iocchi A. Chad's Pivotal Role in the Regional Crisis. ISPI. 2020. Available from: https://www.ispionline.it/it/pubblicazione/chads-pivotal-role-regional-crisis-25443
20. UNOCHA. Chad: Response Plan 2019. 2019. Available from: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/tcd_viz_hrp2019_onepager_20190304.pdf
21. Democratic Republic of the Congo. World without Genocide. Available from: http://worldwithoutgenocide.org/genocides-and-conflicts/congo
22. International coalition for the responsibility to protect. The Crisis in the Democratic Republic of Congo. Available from: http://www.responsibilitytoprotect.org/index.php/crises/crisis-in-drc
23. Council on foreign relations. Civil War in South Sudan | Global Conflict Tracker. Global conflict tracker. Available from: https://www.cfr.org/global-conflict-tracker/conflict/civil-war-south-sudan

24. ACAPS. South Sudan. ACAPS. Available from: https://www.acaps.org/country/south-sudan/crisis/complex-crisis
25. Uganda: Refugee Response Plan - Uganda | ReliefWeb. 2019. Available from: https://reliefweb.int/report/uganda/uganda-refugee-response-plan
26. UNCHR. Country Portal Uganda. Uganda Comprehensive Refugee Portal. 2020. Available from: https://data2.unhcr.org/en/country/uga
27. ACAPS. Burundi. ACAPS. Available from: https://www.acaps.org/country/burundi/crisis/complex-crisis-
28. CCCM Cluster. Burundi. CCCM Cluster. Available from: https://cccmcluster.org/operations/burundi
29. Mengisteab K. Critical factors in the Horn of Africa raging conflicts. Uppsala; 2011.
30. Yusuf S. What is driving Ethiopia's ethnic conflicts? 2019 Nov.
31. European Civil Protection and Humanitarian Aid Operations. Ethiopia. 2020. Available from: https://ec.europa.eu/echo/where/africa/ethiopia_en
32. UNOCHA. Humanitarian Needs Overview Ethiopia 2020. 2020.
33. Wise R. Al Shabaab. Center. 2011 Jul. Available from: http://www.operationspaix.net/DATA/DOCUMENT/4039~v~Al_Shabaab.pdf
34. Barnes C, Hassan H. The Rise and Fall of Mogadishu's Islamic Courts. Journal of Eastern African Studies. 2007 Jul ;1(2):151–60. Available from: https://www.tandfonline.com/action/journalInformation?journalCode=rjea20
35. West S. Hardline Islamist Militia Group Shabbab Emerges in Somalia. Global Terrorism analysis. 2006. Available from: https://web.archive.org/web/20081010201753/http:/jamestown.org/terrorism/news/article.php?articleid=2370096
36. Somalia News & Current Events. Infoplease. Available from: https://www.infoplease.com/world/countries/somalia/news-and-current-events
37. Seal A, Bailey R. The 2011 Famine in Somalia: Lessons learnt from a failed response? Conflict and Health. 2013 ;7(1):22. Available from: /pmc/articles/PMC3829375/?report=abstract
38. ACAPS. Somalia. ACAPS. . Available from: https://www.acaps.org/country/somalia/crisis/complex-crisis
39. O'callaghan S, Sturge G. Against the odds: refugee integration in Kenya Humanitarian Policy Group iii. 2016.
40. UNHCR. Kenya. UNHCR. . Available from: https://www.unhcr.org/ke/figures-at-a-glance
41. IASC. Available from: https://interagencystandingcommittee.org/
42. Sphere. Available from: https://www.spherestandards.org/
43. Humanitarian Response. What is the Cluster Approach? Available from: https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach
44. UNHCR. 2009 Kampala Convention IDPs. 2019 May. Available from: https://www.unhcr.org/5cd569877.pdf
45. Core Humanitarian Standard. Available from: https://corehumanitarianstandard.org/the-standard
46. Agenda for Humanity. World Humanitarian Summit 2016. Available from: https://agendaforhumanity.org/summit
47. UNHCR. Comprehensive Refugee Response Framework. Available from: https://www.unhcr.org/comprehensive-refugee-response-framework-crrf.html
48. International Rescue Committee. Urban Refugees.
49. UNHCR. Uganda - Refugee Statistics January 2020. 2020. Available from: https://reliefweb.int/report/uganda/uganda-refugee-statistics-january-2020-kampala
50. Walnycki A, Earle L, Monteith W, Muindi K. Towards more inclusive urban health systems for refugee wellbeing Lessons from Kampala, Uganda. 2019 Dec. Available from: www.iied.org
51. WHO African Region. Health of refugees and migrants. 2008.

52. Jowett M, Dale E, Griekspoor A, Kabaniha G, Mataria A, Bertone M, et al. Health Financing and Policy Implementation in Fragile and Conflict Affected Settings: A synthesis of evidence and policy recommendations.
53. Bertone MP, Jowett M, Dale E, Witter S. Health financing in fragile and conflict-affected settings: What do we know, seven years on? Social Science and Medicine. 2019 Jul 1;232:209–19.
54. Makhani LA, Moran V, Sadique Z, Singh NS, Revill P, Roberts B. Examining the use of economic evaluations in health-related humanitarian programmes in low- and middle-income countries: A systematic review. Health Policy and Planning. 2020 Mar 1 ;35(2):210–8. Available from: https://academic.oup.com/heapol/article/35/2/210/5614357