



# Access to Health Care by Urban Refugees and Surrounding Host Population in Uganda

Julius Kasozi<sup>1,\*</sup>, Gloria Kirungi Kasozi<sup>2</sup>, Roy William Mayega<sup>3</sup>, Christopher Garimoi Orach<sup>3</sup>

<sup>1</sup>Public Health Office, United Nations High Commissioner for Refugees, Kampala, Uganda

<sup>2</sup>World Vision International, Kampala, Uganda

<sup>3</sup>School of Public Health, Makerere University, Kampala, Uganda

## Email address:

[jmkasozi@gmail.com](mailto:jmkasozi@gmail.com) (J. Kasozi), [gkirungi@gmail.com](mailto:gkirungi@gmail.com) (G. K. Kasozi), [wroymay2000@yahoo.com](mailto:wroymay2000@yahoo.com) (R. W. Mayega),

[cgorach@musph.ac.ug](mailto:cgorach@musph.ac.ug) (C. G. Orach)

\*Corresponding author

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**Abstract:** Uganda hosts an estimated 34,200 urban refugees who are living within the peri-urban areas among nationals in Kampala city. The study assessed factors that affect access to health services by the urban refugees and host communities. A cross-sectional study was conducted between July 2011 and June 2012 employing qualitative and quantitative techniques of data collection. Using structured questionnaires and guides, 944 heads of households interviews who were randomly selected using cluster sampling, 6 key informant interviews and 2 focus group discussions were conducted. SPSS, STATA and manifest-content analysis was used for analysis. The factors found to promote access to health services for refugees and host communities were availability of health facilities, (91.2%, 229/246) for refugees compared to (97.8%, 220/224) for nationals (OR = 2.61; 95%CI 1.36-5.03; p<0.05); and geographical accessibility to health facilities within a 5 km distance, (75.6%, 291/384) for refugees compared to (95.5%, 340/356) for nationals (OR=1.64; 95%1.25-2.16; p=0.000). Access was hindered by affordability of health services, refugees (44.9%, 173/385) compared to nationals (80.9%, 288/356) (OR = 4.68; 95%CI 3.33-6.59; p<0.05) and temporal accessibility of health services, refugees (23.5%, 53/226) compared to nationals (67.4%, 203/301) (OR = 2.61; 95%CI 1.36-5.03; p<0.05). Nationals (55.7%, 234/420) compared to refugees (21.3%, 76/356) (OR=0.41; 95%CI 0.23-0.73; p=0.003) perceived health services provided by the public facilities as good. Access to health care by urban refugees is enhanced by availability of and the proximity to health facilities while it is hindered by cost of health care, long-waiting time and low acceptability of the services. Refugees have a poorer perception towards the quality of health services compared to nationals. There is need to invest in the availability of comprehensive health services, demand creation initiatives, refugee skills trainings and income generating activities, establishment of a refugee buddy-system to facilitate communication and institutionalization of a refugee-based village health system.

**Keywords:** Refugees, Urban Refugees, Community Based Health Care, Integrated Health Care, Parallel Health Care, Accessibility

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## 1. Introduction

Conflict and displacements increase people's vulnerability to disease conditions because of the changes in their physical, socioeconomic and environment protection mechanisms. Food insecurity and poverty make displaced populations more vulnerable to many disease conditions that would otherwise be prevented if they were not displaced. Factors including changes in behaviour, gender-based violence,

reduction in and accessibility to resources and services (such as health education, community services, food production) increase vulnerability of refugees. [1]

Access to health services by refugee populations is critical given their large and unpredictable numbers which may overwhelm public health systems. They may also be subject to disease outbreaks associated with congestion and large scale population movements. There is a possibility of importation of non-endemic diseases to the asylum/host

countries from the refugee home countries because of differences in local environments and exposures in the two countries. It is therefore important that these are identified early by the host country's public health system before outbreaks occur.[2] Globally, refugees living in towns tend to seek health services from government-supported facilities in the health system with exception of situations where the national health system is non-functional, in which case UNHCR supports them to access health services from private establishments. Despite this global pattern, an analysis of proposals submitted to the Global Fund by countries that are hosting refugees, showed that about half (52%) of the countries hosting refugees mentioned them in their national HIV strategic plans and less than half (47%) of the countries hosting refugees mentioned refugees in their national malaria strategic plans [3]

Uganda currently hosts over one million refugees from Democratic Republic of Congo, Rwanda, Kenya, South Sudan, Burundi, Somalia and some from European countries [4]. Although majority of the refugees are settled in rural environments located in the districts of Adjumani, Arua, Hoima, Isingiro, Kyegegwa, Kamwenge, Masindi and Moyo, where land has been donated by the communities, however, self-settlement outside of the designated refugee settlement areas has also been possible. The principal source of humanitarian assistance to refugees during their stay in the settlements has been United Nations High Commission for Refugees (UNHCR). UNHCR responds to the specific protection and basic needs of refugees with short- and long-term assistance programs, some of which include education, health care, food and non-food support, shelter, and income generating activities. Over 34,200 refugees live in Kampala as per the Uganda government's policy that encourages refugees who can support themselves to live in urban areas because of the increasingly limited availability of land in Uganda. [5]

Residents and refugees in Kampala seek basic health services from public health facilities and are referred to the national referral hospitals (Mulago and Butabika hospitals) for complicated cases. Unlike refugees in rural settlements whose health care is fully supported through partners, UNHCR's support for urban refugees has a three-pronged strategy that includes advocacy, support to the national system, and monitoring and evaluation of the urban health interventions. Anyanzu (2015) in his survey entitled 'the case of Urban refugees and Internally displaced Persons in Kampala' noted that the refugee women confirmed that they use the money they earn from crushing stones for basic needs including health care. This reaffirms the fact that Urban refugees do not have access to exclusively free health care like their rural settlement counterparts. Those who need existing health services should be able to obtain them regardless of status, gender, age, marital status, race, religion, sexual orientation or disability. The guiding principle is that refugees and other persons of concern should have a level of access and quality of care similar to that of their place of origin and also equivalent to that of their host populations.

However, if national guidelines are found to be inappropriate, UNHCR and its partners use internationally recognized quality of care guidelines, and work with the national authorities to improve such guidelines and protocols.

Based on complaints received at UNHCR and its partners, urban refugees perceive that there was poor access to health services among their peers in Kampala compared to their counterparts in refugee settlements or among nationals where they live. These issues were routinely mentioned in the UNHCR monthly dialogue meeting with refugees, which were aimed at addressing refugee concerns. Although these reports were received, they were never quantified objectively. Specifically, in these meetings, the refugees reported language barriers, absence of health workers, discrimination toward refugees and difficulty in accessing drugs in the government health facilities. Similar issues were identified in a UNHCR funded socioeconomic survey [6, 7] which found that refugees had challenges accessing services at public health facilities. Cost was a factor, since despite the services being nominally free; there are certain costs that must be made by the refugees for example, costs of transport, investigations, and some drugs. From the refugee meetings, there were reported delays in the delivery of timely health care for life threatening conditions, with the consequence that some refugees independently resort to herbal medicine, self-medication, or seek services for serious medical conditions in small ill-equipped private clinics that are not part of either the integrated or parallel health system. Because of challenges in access, some refugees were bringing critically ill family members to the UNHCR and partner offices while others camped outside agency offices as a sign of protest for the poor access to health services. Community-based health care was not available in the urban areas, unlike in the settlements where refugees benefit from the services of community-based workers for preventive and promotive health services. Researchers in a recent study of urban refugees [6], found that 23% of the study respondents wanted HIV awareness campaigns, while about one-third (32%) were in need of HIV counselling and testing services. Unlike their counterparts in the refugee settlements, there were no established referral arrangements affiliated with the urban health care system to transport patients from home to health facilities. In response to the concerns, Inter-aid set up a dispensary to provide medicines that refugees are unable to access at the public health facilities and also offer basic curative services for the simple ailments. This study sought to identify the factors, barriers as well as perceptions affecting access to healthcare (availability, accessibility, accommodation, affordability and acceptability) for urban refugees in comparison with the host population so as to inform healthcare programming for refugees.

## 2. Materials and Methods

### 2.1. Study Design

The descriptive cross-sectional design was used to carry out

the research among the urban refugee population in Uganda.

## 2.2. Study Area and Setting

The study was carried out amongst urban refugees and host populations living in the same areas of Kampala-the capital city of Uganda between July 2011 and June 2012. The UNHCR database showed high concentrations of urban refugees in the low income neighbourhoods of Kabalagala, Kansanga, Katwe, Kisenyi, Nabulagala, Nateete, Najjanakumbi, Nakulabye, Rubaga, Makindye, Mengo, Old Kampala, Salaama, Kawempe, Kyebando, Kisaasi, and Kamwokya, Makerere.

## 2.3. Study Participants

The study population included refugees and host populations living in the same neighbourhoods in Kampala district. Respondents were members of these households above the age of 18 years. The refugee study participants (1 respondent per household) were drawn from the most populous ethnic groups (i.e., Burundian, Congolese, Ethiopians, Eritreans, Kenyan, Rwandese, Somalis, and Sudanese origin) out of the 34,000 urban refugees that were estimated by UNHCR to be residing in Kampala.

## 2.4. Sample Size and Sampling

Sample size [8] was based on primary outcome variables of accessibility to health facilities. The consideration for this study was the proportion of population above 18 years with a history of illness that accessed services at the government health facilities. This variable was used to calculate the sample because it would be easy to monitor after application of interventions and the respondents were old enough to comprehend the nature of services that are offered at the health facilities.

*For refugee population sample size:*

*Assumptions*

$z$  = Level of uncertainty in the sample mean or prevalence as an estimate of the population mean or prevalence will be kept at 1.96 (95% confidence level)

$d$  = Margin of Error is 0.05

$p$  = Proportion of refugee who utilized health services from public health facilities  $p$  was estimated at 50% because the information could not be obtained.

$$Q = (1 - p)$$

$DEFF$  = Design Effect

$R$  = Response rate

*Formular*

$$n = z^2 p(1-p) / d^2 \times DEFF / R$$

$$n = [(1.96)^2 \times 0.5 (1-0.5)] / (0.05)^2 \times 1 / 80\%$$

$$n = 480 \text{ refugees}$$

Using the WHO and UNICEF EPI-30 cluster sample

method, the sample size of 480 involved 30 clusters with 16 interviews carried out in each of the cluster.

*For the sample size of the host population respondents:*

*Formular*

$$n = z^2 p(1-p) / d^2 \times DEFF / R$$

$$n = [(1.96)^2 \times 0.5 (1-0.5)] / (0.05)^2 \times 1 / 80\%$$

$$n = 480 \text{ Nationals}$$

Using the WHO and UNICEF EPI-30 cluster sample method, the sample size of 480 involved at least 30 clusters with 16 interviews carried out in each of the clusters. 960 households (480 refugee households and 480 host population households) were selected and participated in the study.

A two-stage cluster sampling was used to determine the clusters and households to be visited. Stage one: 30 clusters were selected using Probability Proportion to Size (PPS) from the list of refugee hosting villages in Kampala with their corresponding refugee populations from the UNHCR database. Stage two: 16 households in each cluster were selected using simple random sampling and were interviewed.

## 2.5. Data Collection and Analysis

Quantitative data was collected by in-depth interviews with 944 heads of household aged 18 years and above using a structured questionnaire while qualitative data was collected through 6 key informant interviews using structured guides with women leaders in communities, health workers at the government clinics, health workers at Inter-Aid, health officials at Kampala City Council Authority and 2 focus group discussions with a group of refugee women. All tools were translated to 4 local languages ie Amharic, Somali, Swahili and Kinyarwanda. Quality control and quality assurance was ensured through training of all research assistants, pretesting of the English and translated versions of the questionnaires, observation checklist, key informant and focus group discussion guide.

## 2.6. Study Variables

Demographic information, knowledge of existence of community based health care, reasons for inability to access community base health care, preferred delivery of community based health services, health and illness-nature of illness, sources of treatment, reasons for choosing a source of treatment, and who decided to seek that treatment as well as aspects of accessibility, home treatment, perceptions and accessibility for special services.

*Dependent variable:* Utilization of health services

*Independent variables:* Affordability (Individuals who were able to pay for the costs related to seeking medical services), availability (Presence of health workers and drugs at the health facility), accessibility (Distance to the health facility), accommodation (Average duration for one to access a service), acceptability (accepting attitude to sex, language, handling, diagnosis and treatment provided) and nationality or refugee status

Outcome variables for perceptions towards health services: Perceptions towards the health services and their service providers.

## 2.7. Data Management and Analysis

At the data entry site, the serial numbers of the received questionnaires were recorded. An EpiData data entry screen was used for data entry, editing, and cleaning. The principal investigator, and some hired experienced data entrants did the data entry. Data editing and cleaning included the range data entry checks, structure and internal consistency. The data were exported to Stata for analysis. The data file was kept on at least one computer hard drive and backed up to three separate flash drives. No questionnaire or file including information from the survey were copied or taken out of the data entry office. Data was analysed using univariate analysis, cross-tabulation of selected variables and logistic

regression using SPSS version 20.0 data sheet, upon completion, data was cleaned and then exported to STATA 11.0 software.

## 3. Results

### 3.1. Socio-demographic Characteristics of Respondents

Table 1 shows that 99.7% of participants were above 18 years of age. A higher proportion of respondents were female (56.8%) compared to males (43.2%). The main sources of income were petty trade (38.1%) followed by formal employment (33.6%) while a fifth (18.4%) of the respondents had no source of income. Close to half (45.8%) of the respondents earn less than USD 40 a month, 19.7% between USD40-80 per month while 34.5% were getting more than USD80 per month.

*Table 1. Socio-demographic characteristics of respondents.*

Characteristic of Respondents	Refugee (N=472)	Nationals (N=472)	Total
	N (%)	N (%)	
Number of respondents	472(50)	472(50)	944 (100)
Age			
<18 years	1 (0.4)	2 (0.7)	3 (0.3)
≥18 years	471(99.6)	470 (99.3)	941 (99.7)
Sex			
Male	220 (46.6)	188 (39.8)	408 (43.2)
Female respondent	252 (53.4)	284 (60.2)	536 (56.8)
Residence			
Kampala central	202 (42.8)	213 (45.1)	415 (43.9)
Kawempe	02 (0.4)	0 (0)	02 (0.2)
Nakawa	67 (14.2)	8 (1.7)	75 (7.9)
Makindye	140 (29.7)	146 (30.9)	286 (30.3)
Rubaga	61 (12.9)	105 (22.3)	166 (17.6)
Age of head of household (HoH)			
< 18	1 (0.4)	0 (0)	1 (0.1)
≥ 18	471 (99.6)	472 (100)	943 (99.9)
Sex of HoH			
Male	256 (54.2)	380 (80.5)	636 (67.4)
Female	216 (45.8)	92 (19.5)	308 (32.6)
Number of household members			
0-3 (base)	264 (55.9)	256 (54.2)	520 (55.1)
4-7	156 (33.1)	190 (40.3)	346 (36.7)
>7	52 (11.0)	26 (5.5)	78 (8.2)
Number Slept in household day prior to study			
0-3	257 (54.4)	280 (59.3)	537(57.5)
4-7	160 (33.9)	171 (36.2)	331(35.4)
>7	45 (9.5)	21 (4.5)	66 (7.1)
Number of rooms in household			
1	337 (71.3)	194 (41.1)	531 (56.3)
2-3	92 (19.5)	197 (41.7)	289 (30.6)
>3	43 (9.1)	81 (17.2)	124 (13.1)
Main sources of income			
Formal employment	116 (31.2)	128 (36.1)	244 (33.6)
Petty trade	87 (23.4)	190 (53.5)	277(38.1)
Begging	17 (4.6)	1(0.3)	18 (2.5)
No income	127 (34.1)	7 (1.9)	134 (18.4)
Others	25 (6.7)	29 (8.2)	54 (7.4)
Monthly income (UGX)			
< 50,000	94 (24.5)	9 (2.6)	103(15.1)
50,000-100,000	108 (32.7)	101 (28.8)	209 (30.7)
100,000-200,000	45 (13.6)	89 (25.4)	134 (19.7)
200,000-500,000	23 (6.9)	124 (35.3)	147 (21.6)
>500,000	60 (18.2)	28 (7.9)	88 (12.9)

### 3.2. Factors Affecting Access to Health Care for Urban Refugees and the Host Communities

Table 2. Factors affecting access to health services by refugees and nationals.

Accessibility parameters	National	Refugee	Test of Significance		
	N (%)	N (%)	OR	95% CI	p-value
Availability of health services	220 (97.8)	229 (91.2)	2.61	1.36-5.03	p<0.05
Geographical accessibility	340 (95.5)	291 (75.6)	1.64	1.25-2.16	0.000
Affordability	288 (80.9)	173 (44.9)	4.68	3.33-6.59	p<0.05
Temporal access (spent less than 3 hours to obtaining medical care)	203 (67.4)	53(23.5)	2.61	1.36-5.03	0.05
Acceptability of the services					
<i>Very good</i>	116 (33.0)	69 (18.9)	1.05	0.69-1.60	0.814
<i>Good</i>	122 (34.7)	69 (18.9)			
<i>Fair</i>	89 (25.3)	90 (24.6)	1.79	1.18-2.71	0.006
<i>Poor</i>	25 (7.1)	138 (37.7)	9.76	5.81-6.39	0.000
Perception towards KCC health care services					
<i>Very good</i>	105 (25)	19 (5.3)	0.41	0.23-0.73	0.003
<i>Good</i>	129(30.7)	57 (16.0)	-	-	-
<i>Fair</i>	52 (12.4)	96 (27.0)	4.18	2.64-6.61	0.000
<i>Poor</i>	66 (15.7)	66 (18.5)	2.26	1.43-3.59	0.001
<i>Don't know</i>	68 (16.2)	118 (38.2)	3.93	2.55- 6.05	0.000

Table 2 shows the proportion of Nationals that were able to afford costs (80.9%, 288/356), were close to twice those of Refugees (44.9%, 173/385) OR = 4.68; 95%CI 3.33-6.59; p<0.05). A significantly higher proportion of nationals (67.4%, 203/301) compared to refugees (23.5%, 53/226) (OR = 2.61; 95%CI 1.36-5.03; p=0.05) received services within 3 hours of arriving at the health facility.

#### 3.2.1. Factors That Promote Access to Health Services

Factors that significantly promote access to health services were mainly availability of health facilities for both refugees (91.2%, 229/246) and nationals (97.8%, 220/224) (OR=2.61; 95%CI 1.36-5.03; p<0.005) and geographically accessibility of health facilities for both nationals (95.5%, 340/356) and refugees (75.6%, 291/385) (OR=1.64; 95%CI 1.25-2.16; p=0.000).

For nationals, affordability of medical related costs (80.9%, 288/356), organization of health services which allows two thirds (67.4%, 203/301) of the nationals to receive health care with 3 hours of visiting a health facility and their acceptability of the health services (67.7%, 238/352) were additional promoters for nationals.

Affordability and geographical accessibility of health care during the last illness: Nationals (80.9%, 288/356) were significantly much more likely to afford medical related expenses than refugee households (44.9%, 173/385) (OR = 4.68; p<0.05; 95%CI 3.33-6.59).

A large proportion (95.5%, 340/356) of nationals reported being within 5 km radius from government health facility

compared to 75.6% (291/385) of refugees despite all these communities living side by side.

Availability of health care during the last illness: The availability of care during the last illness is described by the ability of the family to receive both consultation and treatment (whether partial or complete). The table below summarizes the different sources of both consultation and treatment by nationality.

Table 3. Sources of consultations and medicines during the last illness.

Factor	Nationals	Refugees
Health facilities	N (%)	N (%)
Mulago	63 (24.8)	93 (31.7)
Public clinics	81 (31.9)	90 (30.7)
Private Clinic	110 (43.3)	94 (32.1)
InterAid	0 (0.0)	16 (5.6)
Total	254 (100)	293(100)

For Nationals, the main sources of medical care were private clinics (43.3%, 110/254), KCC clinics (31.9%, 81/254), Mulago Hospital (24.8%, 63/254) compared to refugees whose main sources were private clinics (32.1%, 94/293), Mulago hospital (31.7%, 93/293) and KCC clinics (30.7%, 90/293). Another source of health care for refugees unlike nationals was Inter-Aid (5.6%, 16/293). Temporal access while at the health facility during the last illness: A significantly higher proportion of nationals' households (67.4%, 203/301) spend a shorter time on average ( $\leq 3$  hrs) at the health facilities than refugee households (23.5%, 53/226) (OR = 2.61; p<0.05; 95%CI 1.36-5.03).

Table 4. Time spent seeking health services.

Duration of time spent at the health facilities	Health facilities				
	Public		Private		Total
	KCC	Mulago	InterAid (NGO)	Private for profit	
	N (%)	N (%)	N (%)	N (%)	N (%)
Refugees					
( $\leq 3$ hrs)	15 (20.3)	9 (14.5)	2 (16.7)	24 (43.6)	50 (24.6)
3-10 hrs	59 (79.7)	53 (85.5)	10 (83.3)	31 (56.4)	153 (75.4)
Total	74 (100)	62(100)	12(100)	55(100)	203(100)
Nationals					

Duration of time spent at the health facilities	Health facilities				
	Public		Private		Total
	KCC	Mulago	InterAid (NGO)	Private for profit	
≤3 hrs	54 (67.5)	28 (46.7)	0 (0)	116 (78.9)	198 (68.0)
3-10 hrs	26 (32.5)	36 (63.3)	0 (0)	31 (21.1)	93 (32.0)
Total	80(100)	64(100)	0	147(100)	291(100)
Both refugee & Nationals					
≤3 hrs	69 (46.2)	37 (29.4)	2 (16.7)	140 (69.3)	248 (50.2)
3-10 hrs	85 (53.2)	89 (70.6)	10 (83.3)	62 (30.7)	246 (49.8)
Total	154(100)	126(100)	12(100)	202(100)	494(100)

The study shows that at both public and private clinics, refugees (24.6%, 50/203) are less likely to spend less than 3 hours compared to the nationals (68.0%, 198/291). Those who reported being able to pay all medical related costs (57.4%, 198/345) were more likely to spend less than 3 hours

at the health facility seeking services compared to their who were not able to pay all cost (31.9%, 58/182) (OR = 2.88; 95%CI 1.97-4.20; p<0.05).

#### *Acceptability of health care services*

*Table 5. Acceptability of health services during the last illness episode.*

Variables	Nationals	Refugees	OR	95% CI	P-value
	N (%)	N (%)			
Sex of health worker					
Very acceptable	242 (68.8)	167 (48.6)	-	-	-
Acceptable	85 (24.2)	137 (39.6)	2.32	1.66-3.24	0.000
Unacceptable	19 (5.4)	32 (9.3)	2.43	1.33-4.42	0.004
Extremely unacceptable	6 (1.7)	9 (2.6)	2.167	0.75-6.18	0.151
Sub-total	352 (100%)	345 (100%)			
Languages used					
Very acceptable	204(58.0)	111 (30.9)	-	-	-
Acceptable	115 (32.7)	175(48.2)	2.77	1.99- 3.85	0.000
Unacceptable	29(8.2)	59 (16.3)	3.71	2.25-6.11	0.000
Extremely unacceptable	4 (1.1)	17 (4.7)	7.74	2.54-23.57	0.000
Sub-total	352 (100%)	362 (100%)			
Handling at the health facility					
Very acceptable	159 (45.3%)	89 (24.3%)	-	-	-
Acceptable	124 (35.5%)	98 (26.8%)	1.41	0.97-2.05	0.068
Unacceptable	58 (16.5%)	104 (28.4%)	3.20	2.12- 4.84	0.000
Extremely unacceptable	10 (2.9%)	74 (20.5%)	13.40	6.59-27.23	0.000
Sub-total	351 (100)	365 (100)			
Perception of accuracy of diagnosis					
Very good	205 (58.7)	94 (25.8)			
Good	97 (27.8)	147 (40.3)	3.31	2.32- 4.71	0.000
Poor	36 (10.3)	55 (15.1)	3.33	2.05-5.42	0.000
Very poor	11 (3.2)	68 (18.9)	13.68	6.92- 27.04	0.000
Sub-total	349 (100)	364 (100)			
Treatment given at the health facility					
Very good	216 (61.7)	84 (23.3)			
Good	86 (24.6)	104 (28.9)	3.11	2.12- 4.55	0.000
Poor	33 (9.4)	80 (22.2)	6.23	3.87-10.05	0.000
Very poor	15 (4.3)	91(25.6)	15.77	8.65-28.77	0.000
Sub-total	350(100%)	359 (100)			

A higher proportion of nationals (90.7%, 319/352) compared to refugees (79.1%, 286/362) found the language used during the consultations acceptable. Similarly handling while accessing health services, national (80.8%, 283/351) compared to refugees (51.1%, 187/365) and treatment received for nationals (86.3%, 302/350) compared to refugees (42.2%, 188/359) were considered more acceptable accordingly. During focus group discussion, refugees highlighted the language challenge for those who did not understand Luganda or English languages. If languages known to the refugees (especially Swahili) was used, they were not well articulated by the health workers for the refugees to understand. Some refugees had complaints that

health workers were rude, harsh, too busy for them, and that they were not able to understand instructions given to them at the health facilities. "At Mulago they use Kiganda and English and us Congolese find it a problem to explain our sickness to them. Interpreters will help" [FGD, Congolese women, Katwe]. Because of medicine shortages in public health facilities, some clients don't get medicine and are therefore advised to buy them from drug shops. In some instances, not all conditions are treated while for others, only starter doses are given.

#### **3.2.2. Barriers to Access to Health Services**

A significantly higher proportion of nationals (80.9%,

288/356) were more likely to afford medical-related costs compared to refugees (44.9%, 173/385) (OR=4.68; 95%CI 3.33-6.59; P<0.005). Only 23.5% (53/226) of refugee households compared to 67.4% (203/301) (OR=2.61; 95%CI 1.36-5.03; P=0.005) of national received health services

within 3 hours of visiting a health facility. Over a third (37.8%, 138/365) of refugees was comfortable with the services provided at KCC facilities compared to 67.7% (238/352) of nationals.

### 3.2.3. Perception Towards Health Services Provided

Table 6. Perception towards services provided by category of facilities.

Variables	Nationals	Refugees	OR	95% CI	P-value
	N (%)	N (%)			
<b>KCC Clinics</b>					
Very good/good	234 (55.7)	76 (21.3)	0.41	0.23-0.73	0.003
Fair	52 (12.4)	96 (27.0)	4.18	2.64-6.61	0.000
Poor	66 (15.7)	66 (18.5)	2.26	1.43-3.59	0.001
Don't know	68 (16.2)	118 (38.2)	3.93	2.55- 6.05	0.000
Sub-total	420 (100)	356 (100)			
<b>Inter-Aid</b>					
Very good	9 (2.1)	9 (2.8)	2.03	0.79-5.21	0.139
Good	22 (5.3)	34 (10.7)	3.14	1.79- 5.52	0.000
Fair	4 (1.0)	38 (12.0)	19.31	6.79-4.92	0.000
Poor (base)	3(0.7)	52 (16.4)	-	-	-
Don't know	373 (90.7)	184 (58.0)	35.2	10.86-114.3	0.000
Sub-total	415 (100)	317 (100)			
<b>Private clinics</b>					
Very good	67 (16.0)	83 (26.3)	0.59	0.39-0.89	0.003
Good	114 (34.3)	44 (13.9)	0.15	0.09- 0.22	0.000
Fair	84 (20.0)	14 (4.4)	0.08	0.04- 0.15	0.000
Poor	42 (10.0)	5 (1.6)	0.06	0.02- 0.15	0.000
Don't know (base)	83 (19.7)	170 (53.8)	-	-	-
Sub-total	420 (100)	316 (100)			
<b>Drug shops</b>					
Very good	49 (11.7)	80 (25.6)	1.47	0.96- 2.25	0.074
Good	92 (22.0)	57 (18.3)	0.56	0.37- 0.84	0.005
Fair	66 (15.8)	14 (4.5)	0.19	0.10- 0.36	0.000
Poor	71 (17.0)	9 (2.9)	0.11	0.06- 0.24	0.000
Don't know (base)	140 (32.6)	152 (48.7)	-	-	-
Total	418 (100%)	312 (100%)			

Table 6 above shows that only a fifth (21.3%, 76/356) of refugees considered health services provided by the KCC facilities to be either good or very good compared to more than a half (55.7%, 234/420) of nationals. Smaller proportion of refugees (13.5%, 43/317) perceived the services of Inter-aid as good with majority of refugees (58.0%, 184/317) being unable to rank the services provided by this specialized refugee NGO.

Perception of respondents towards KCC health facilities

Overall, over a half (234/420, 55.7%) of nationals and a fifth (21.3%, 76/356) of refugees ranked KCC services as

very good or good. During KII interview and focus group discussion, issues of high patient load and absence of medicines and supplies at the health centre were expressed as illustrated in the quotes below;

*"We have a high health worker to patient ratio and as a result the waiting time for all patients regardless of whether they are refugees or not is longer than expected"* [KI, Acting In-charge, Kisenyi health centre]

*"Kisenyi is near but the lines are long and getting drugs is a problem. Some of us don't understand Kiganda"* [FGD, Congolese women, Katwe]

Table 7. Perception towards KCC health centers by both refugees and nationals.

Factors	Perception towards KCC health centre				
	Very good/good	Fair	Poor	Don't know	Total
	N (%)	N (%)	N (%)	N (%)	N (%)
<b>Ability to pay all costs</b>					
Able	178 (47.8)	46 (12.4)	60 (16.1)	88 (23.7)	372 (100)
Unable	61 (26.4)	82 (35.5)	50 (21.6)	38 (16.5)	231 (100)
<b>Sex of head of household</b>					
Male	220 (40.8)	91 (16.9)	96 (17.8)	132 (24.5)	539 (100)
Female	90 (37.9)	57 (24.1)	36 (15.2)	54 (22.9)	237 (100)
<b>First choice of source of medical care</b>					
KCC as first choice of treatment during the last illness	95 (56.2)	45 (26.6)	25 (14.8)	4 (2.4)	169 (100)

Table 7 above, a high proportion of respondents who were able to pay (47.8%, 178/372) perceived the KCC health services as very good or good compared to those who were unable to those who were unable to pay (26.4%, 61/231). Over half (56.2%, 95/169) of the respondents that had visited KCC clinic during the last illness of their family member ranked the services as very good or good. A small proportion of refugee (2.8%, 9/317) perceived the services provided by Inter-Aid to be very good, 10.7% (34/317) felt there were good. For those that have ever sought services from Inter-Aid, the main reasons for ranking positively include free services, accessibility and provision of free drugs. The ranking of 'poor' was attributed to absence of laboratory services, provision of only part of treatment, long queues and inadequate respect for patients.

*"Interaid serves only refugees and they know our problems... sometimes there are no laboratory services and they send us to mulago"* [FGD, Congolese women, Katwe]

The perception of the respondents towards private clinic services was good with 20.4% (150/736) ranking them as very good and 25.5% (188/736) as good. Although the perception towards private clinics is generally good, nationals are more likely to have a positive perception than refugees. More than half (53.8%, 170/316) of refugees did not have any perception towards private clinics compared to a fifth (19.8%) of nationals.

The positive ranking statements for the private clinics were attributed to the private clinics' capacity to provide 24hr services, provision of adequate drugs, good quality care that is efficient and fast with adequate attention to patients. Services were rated as 'poor' where there were reported to be unqualified staff and being too expensive. Because of these shortcomings, many families have not been to any private clinics.

#### 4. Discussion

Results indicate that the factors that promote accessibility to health care services were availability and proximity to the health facilities. Both refugee and national households with recent illnesses who had sought care at the public facilities reported lack of medicines, a similar study indicated only 49.3% of public hospitals and 73.5% of public clinics had free drugs in comparison to 30.3% of public hospitals and 16.1% of public clinics which had patients purchase some drugs; and 20.1% of public hospital and 8.3% of public clinics that had patients purchase all medicines and medical supplies. [9] This underscores the need for the health system to ensure adequate supplies of essential medicines and human resources for health particularly in public health facilities. 36% of the urban refugees access health care from public health facilities and only 29% from public facilities because of unavailability of all health care services at the public facilities [22]

Majority of health facilities were within 5 km radius of the

refugee and national respondents and therefore less challenges relating to geographical access as per the recommended walking distance. The discrepancy in distances to the health facilities between refugees and nationals is related to knowledge of existence of health facilities, which is influenced by language, duration of residence in their current addresses and history of use. The findings of this study are in line with the earlier national study which highlighted the majority (98.6%) of the urban populace being within 3 km walking distance of a health facility and 70% of communities have traditional healers with in the community although 1% consults them [9, 10].

The study revealed that the main barriers to health service which affected more refugees than national included cost of medical care, organization of health services and acceptability of health services. The costs associated with accessing health services are linked to the purchasing power of the households. The national households tended to have better incomes and fewer female headed household. As such, on average, the national households were more likely to pay for the formal and informal costs related to the medical services received during a recent illness than their refugee counterparts. A large proportion of national households sought services from private clinics and were able to pay for services, unlike the refugee households who were more likely to seek services from government health facilities and were still unable to pay the associated costs for drugs that were not available at the public facilities. A similar study in Uganda, indicated that health expenditure per household for the health services are significantly lower among poor household (and non-employed) than rich households (and employed) and female-headed households spend less than male-headed household. A high stock-out of drugs in public health facilities meant patients were being asked to go and buy medicines which further emphasizes the argument that costs remain the hindrance to health care access even in public health facilities. These costs are related to transport, buying of additional medicines or medical supplies exist in government, private, drug shops as well as the traditional healers which explains lower proportions among refugees [9, 11-12]. Preventive and primary health care are more accessible than advanced services for refugees. [23]

Refugees reported longer waiting times at the facility than nationals mainly because many nationals are able to afford consultations in the private clinics, which generally have a shorter waiting time. A study conducted in Mulago National referral hospital revealed that 39.5% of patients spent at least 4 hours while in Malaysia, only 1.8% of patients waited less than 3 hours were because of challenges related to availability of facilities and equipment, human resources, patients and registration process. [13, 14]

One-third of the refugee community and two-thirds of the host population were comfortable with the health services they had obtained. The sex of the health workers who saw the patients was a concern for particularly the Somali refugee community, but not for the other refugee communities and

nationals. While it was expected that all nationals would understand the languages used during the consultations, this was not the case. Among the refugees, there was a particular challenge for the refugees who did not understand Luganda or English languages; in addition, if languages known to the refugees (especially Swahili) was used, they were not well articulated by the health workers for the refugees to understand. Language barrier was found to influence the perceptions of refugees towards seeking health care because many refugees would not articulate luganda and English which are the commonly used languages by the health workers. These inadequacies in communication influenced refugee perceptions of how their patients were handled at the health facilities. The other factors that influenced the perception of refugees towards health facilities were the cost of services, existence of qualified health workers, quality of services (including diagnosis and treatment), hours of services (8 or 24 hours), waiting time of patients, availability of drugs and perceived discrimination against refugees. These findings are similar to the perceived quality of health care study in Ghana where participants highlighted absence of examinations, information about their illness, inadequate drugs, health workforce, poor attitude, long waiting times, poor attitude of health workers, high cost of services, poor attitude of some health workers [15-20]. Advocacy and awareness raising activities have been proposed at all levels including government bodies and health workers as a way of reducing the discrimination experienced by refugee children. [21]

Despite the negative perceptions, refugees still go to government health facilities and consider them as the most useful and the driving factor has been the existence of free medical services. Inter-aid is visited by a small proportion of refugees, the majority accessing services from the government health system.

## 5. Limitation of the Study

The urban refugee community was characterised with high mobility, denial of refugee status, and high attrition rate of data collectors, recall bias and limited numbers of focus group discussions might have minimally affected the results. Limited work has been done in terms of refugees and health care access and therefore references are limited.

## 6. Conclusions

The findings of this study showed that health services were available within 5 km walking distance for both refugees and host populations. Refugees are generally unable to meet the cost of accessing health services (includes transport, costs of investigations, essential medicines and other informal costs), waited for a longer periods of time, and had a low acceptability of services compared to the nationals. The perception of refugee towards the public health services is poorer compared to nationals mainly because of long waiting times, few hours of service, inadequate essential medicines,

perceived discrimination, and existence of non-formal costs/payments.

There is need for adequate investment in human resource, medical supplies and equipment in public health facilities particularly those located in areas with high concentration of refugees. Key proposed actions include supplementation of the medicines supplied by government to the public facilities serving refugees, recruitment of health workers, establishment of referral focal points at the national referral hospitals, incorporating refugees in the community/village health structures to link the refugees to the care especially addressing the communication challenges, improving refugee self-sufficiency (skills trainings and income generation initiatives), initiation of a buddy-system to curb the language barrier and intensify community sensitization about the availability of the alternative sources of health care that are supported by UNHCR. A further study to investigate refugees status as a factor of access needs to be carried out in Kampala to inform future policy and programmes.

## Ethical Approval

This study was approved by the Makerere University School of Public Health Institutional Review Board, OPM and UNHCR representation in Uganda.

## Informed Consent

Written informed consent was sought from all respondent who participated in this study and all information was protected and kept confidential. No videos and photographs of the respondents were taken and there was no risk to the human subjects participating in the study.

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## Availability of Data and Material

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

## Conflict of Interests

The authors declare that they have no conflict of interests.

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## References

- [1] Spiegel, P. B., 2004; HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action as appeared in *Disasters* 2004, 28(3) 322-339.
- [2] Mwekesege, C., 1995; Impact of Refugees on Host Communities – a Case study of Kasulu, Ngara, and Karagwe Districts in Tanzania.
- [3] Spiegel, P., 2010; Conflict-affected displaced persons need to benefit more from HIV and malaria national strategic plans and Global Fund grants as appeared in *Conflict and Health* 2010, 4:2.
- [4] Ginyera-Pinyawa, A. G. G., 1998; Uganda and the problem of refugees, Makerere University Press, Kampala Uganda.
- [5] Annual Health report 2010. United Nations High Commissioner for Refugees.
- [6] Inter-Aid, 2010; Socio-Economic Baseline Survey for Urban Refugees in and around Kampala.
- [7] Inter-Aid Uganda, 2010; Urban Refugee Project Annual Reports 2006-2009.
- [8] Kish and Leslie. 1965; Survey Sampling, John Wiley and Sons; New York 1965.
- [9] Kasirye. I.; Lawson. D; Sewanyana. L et al, 2004; Demand for health care services in Uganda: Implications for poverty reduction as appeared in Munich Personal RePec Achieve, MPRA Paper No. 8558.
- [10] Ministry of Health, 2010; Health Sector Strategic and Investment Plan 2010/11-2014/15.
- [11] Penchansky, R.; and Thomas, J. W., 1981; “The concept of access,” *Medical Care* 19, 127–40, 1981.
- [12] Acuna, D. L.; Gattini, C., Pinto, M., Andersson, B., 2008; Access to and Financing of Health Care: Ways to Measure Inequities and Mechanisms to Reduce Them, Pan American Health Organization (PAHO).
- [13] Nabbuye-Sekandi. J; Makumbi. F; Kasangaki. A et al, 2011; Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda as appeared in *International Journal for Quality in Health Care* 2011; pp. 1–8).
- [14] Abdullah, MH, 2005; Study on Outpatients’ Waiting Time in Hospital University Kebangsaan Malaysia (HUKM) Through the Six Sigma Approach.
- [15] Andaleeb, S. S., 2001; Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social Science and Medicine* 52: 1359–70.
- [16] Singh, R 2010; Patients’ Perception towards Government Hospitals in Haryana as appeared in *VSRD-TNTJ*, 1(4), 2010: 198-206.
- [17] Turkson, P. K, 2009; Perceived quality of health care study in Ghana as appeared in *Ghana Medical Journal* June 2009, volume 43, Number 2.
- [18] Lawrie, N., Van Damme, W., 2003;. The importance of refugee-host relations: Guinea 1990–2003 as appeared in *Lancet*. 2003 Aug 16; 362(9383):575.
- [19] World Bank, 2010; The Impacts of Refugees on Neighboring Countries: A Development Challenge as appeared in *World Development Report*, 2011
- [20] Orach, G. C.; Brouwere, V., 2005; Integrating refugee and host health services in West Nile districts, Uganda as appeared in *Oxford Health and Planning Journal* Volume 21 Issue 1 Pg 53-64
- [21] Horn Rebecca, David Bizimana, Scholastica Nasinyama, Lilia Aporo, Emmanuel Kironde, Mark Canavera and Lindsay Stark, 2013; Community based child protection mechanisms among urban refugees in Kampala, Uganda. An ethnographic study. *Child Protection in Crisis*.
- [22] Francis Anyanzu, 2016. Livelihood and Informality: The case of Urban Refugees and Internally Displaced Persons in Kampala. University of Sussex. <http://sro.sussex.ac.uk/>
- [23] Merve Ay, Pedro Arcos Gonzalez and Rafael Castro Delgado, 2016. The perceived Barriers of access to health care among a group of non-camp syrian refugees in Jordan. *International Journal of Health Services*. Vol 46, Issue 3, 2016. <http://journals.sagepub.com/doi/abs/10.1177/0020731416636831>