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Review

# Vaccination Coverage Among Migrant and Refugee Populations in Uganda: A Narrative Review of Challenges and Recommendations

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## Abstract

Uganda hosts one of Africa's largest refugee populations, yet displaced and migrant communities face persistent barriers to routine immunization. Despite commitments to vaccine equity, many remain unprotected against preventable diseases. This narrative review synthesizes evidence from peer-reviewed studies, national surveys, and institutional reports up to September 2025 to assess immunization coverage, challenges, and potential solutions among refugees and migrants in Uganda. Findings indicate that vaccination rates in refugee communities are generally lower than national averages due to administrative barriers, vaccine shortages, long distances to health facilities, language difficulties, and misinformation, challenges intensified during the COVID-19 pandemic. Economic hardship further limits healthcare access. However, several strategies show promise: integrating refugees into national immunization systems, simplifying registration processes, strengthening mobile outreach, engaging community health workers, and improving cross-border data coordination. Addressing these inequities requires both technical and social commitment, through adequate financing, inclusive policies, and meaningful community engagement. Achieving equitable immunization for refugees in Uganda is essential for public health protection and the realization of universal health coverage.

**Keywords:** refugees; vaccination coverage; vaccination challenges; Uganda

## 1. Introduction

According to the World Health Organization (WHO) Immunisation Agenda 2030, vaccination is essential in advancing progress toward the Sustainable Development Goals (SDGs), serving as a backbone of primary health care and universal health coverage. However, certain vulnerable groups, particularly migrant and refugee populations remain underserved. [1] Globally, immunization among refugees and migrants is hindered by language barriers, vaccine safety concerns, logistical difficulties, inaccessibility, among others, emphasizing the need for improved health information and equitable access. [2–4]

In Uganda, national immunisation coverage remains below the recommended 90% threshold for most vaccines. [5] The 2022 Uganda Demographic and Health Survey (UDHS) reported that among children aged 12–23 months, Coverage was highest for Bacillus Calmette-Guérin (BCG) (97%), Diphtheria, tetanus, pertussis hepatitis B and Haemophilus influenzae type b (DPT-HepB-Hib) first dose (95.6%), and oral polio first dose (96%), while measles coverage was lower at 83%. For pneumococcal conjugate vaccine (PCV), 94% received the first dose, 92% the second, and 83% the third. Rotavirus vaccine coverage improved markedly from 10% and 6% in 2016 to 93% and 87% for the first and second doses, respectively. Despite these improvements, only 63% had received all basic vaccinations while 2% had none. [6]

Uganda's continued dedication to a progressive refugee policy and its open-door approach to refugees and asylum seekers has led to a growing number of refugees and subsequently, immunization gaps among its refugee population. By the end of 2024, Uganda was home to an estimated 1.8 million refugees and asylum-seekers, the largest refugee-hosting nation in Africa [7], placing significant pressure on its health system. Majority of the refugees come from neighbouring countries like South Sudan, Democratic Republic of Congo (DRC), Rwanda, Burundi, Somalia and Ethiopia. South Sudan accounts for the largest of refugees in Uganda approximately 173,650 most of these asylum seekers have settled in districts of Adjumani, Arua in West Nile and Kiryandongo. [8] Recently the high number of influx is from DRC primarily due to the conflict between the government of DRC and the rebel group allegedly backed by Rwanda and Uganda it has led to arrival of over 23,000 new refugees and migrants. [9]

Immunization gaps within these populations are evident. In the Kyangwali refugee settlement, only 33.3% of children aged 12–59 months had received full vaccination. [10] Such gaps contribute to immunity deficits that increase the risk of vaccine-preventable disease outbreaks both within and beyond refugee settlements. [11] Insufficient vaccination coverage among refugee children has been linked to higher morbidity and mortality rates, while also posing public health risks through potential transmission to host communities. [10] Furthermore, refugees and migrants often live in overcrowded conditions, with inadequate sanitation and limited nutrition, further heightening vulnerability to vaccine-preventable diseases. [12]

This literature review consolidates current research on immunisation efforts targeting migrant and refugee populations in Uganda. It identifies key challenges and explores strategies aimed at closing these immunisation gaps for displaced populations in Uganda.

## 2. Methods

Searches were performed across PubMed, Web of Science, Google Scholar, African Journals Online, and a general google search to identify grey literature including WHO and United Nations (UN) agency reports, government policy documents. Search terms combined concepts of "vaccination", "immunization", "refugee", "migrant", and "Uganda", with no language restriction; publications and reports up to September 2025 were included. Findings were then synthesized thematically.

### **Immunization Policy Context in Uganda**

#### **Uganda's National Immunization Program (UNEPI)**

The Uganda Ministry of Health (MoH), in partnership with the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the Global Alliance for Vaccines and Immunization (GAVI), implements a structured routine immunization schedule targeting children under two years, 9-year-old girls, and women of reproductive age. At birth, infants receive Bacillus Calmette–Guérin (BCG) for tuberculosis, the zero dose of oral polio vaccine (OPV-0), and Hepatitis B. Subsequent immunizations at 6, 10, and 14 weeks include the pentavalent vaccine (DPT-HepB-Hib), pneumococcal conjugate vaccine (PCV), rotavirus vaccine, and additional OPV and inactivated polio vaccine (IPV). At 6 months, Vitamin A supplementation is introduced, followed by measles-rubella and yellow fever vaccines at 9 months, and booster doses of PCV and measles-rubella at 18 months. Human papillomavirus (HPV) vaccination is administered to 9-year-old girls for cervical cancer prevention, while women of reproductive age (15–49 years) receive tetanus toxoid (TT) or tetanus-diphtheria (Td) vaccines in a five-dose schedule to prevent maternal and neonatal tetanus. [13] In 2025, Uganda rolled out the malaria vaccine, administered at 6, 7, 9, and 24 months [14] (Table 1).

**Table 1.** Routine immunization schedule for children under two years, 10-year-old girls and women of child bearing age.

Number of visits/contacts	Age of administration	Vaccine and dose	Disease against	Mode of administration
1st	At birth	Oral polio vaccine 0	polio	2 drops in the mouth
		BCG	Tuberculosis	Injection on right upper arm
		Hepatitis B	Hepatitis B	Injection on left upper thigh
2 <sup>nd</sup>	At 6 weeks	Oral polio vaccine 1	Polio	2 drops in the mouth
		Injectable polio vaccine (IPV1)	Polio	Injection on right upper thigh
		DPT-Hep B-Hib1	Diphtheria, tetanus, whooping cough, <i>Haemophilus influenzae</i> type B, hepatitis B	Injection on left upper thigh
		Pneumococcal conjugate vaccine 10(PCV1)	Meningitis and pneumonia	Injection on right upper thigh
		Rota vaccine 1	Diarrhoea caused by rotavirus	Slow release into the mouth
3 <sup>rd</sup>	At 10 weeks	Oral polio vaccine 2	Polio	2 drops in the mouth
		DPT-Hep B-Hib 2	Diphtheria, tetanus, <i>Haemophilus influenzae</i> type B, whooping cough, Hepatitis B	Injection on left upper thigh
		Pneumococcal conjugate vaccine 10(PCV 2)	Meningitis and pneumonia	Injection on right upper thigh
		Rota virus vaccine 2	Diarrhoea caused by rotavirus	Slow release into the mouth
4 <sup>th</sup>	At 14 weeks	Oral polio vaccine 3	polio	2 drops in the mouth
		Injectable polio vaccine (IPV2)	Polio	Diphtheria, tetanus, <i>Haemophilus</i>

				influenza type B, Whooping cough, Hepatitis B
		Pneumococcal conjugate vaccine 10(PCV3)	Meningitis and pneumonia	Injection on right upper thigh
		Rota virus 3	Diarrhoea caused by rotavirus	Slow release into the mouth
5 <sup>th</sup>	At 6 months	Malaria vaccine 1	malaria	Injection on right upper arm
6 <sup>th</sup>	At 7 months	Malaria vaccine 2	Malaria	Injection on right upper arm
7 <sup>th</sup>	At 8 months	Malaria vaccine 3	Malaria	Injection on right upper arm
8 <sup>th</sup>	At 9 months	Measles-Rubella vaccine 1	Measles, rubella	Injection on left upper arm
		Yellow fever vaccine	Yellow fever	Injection on right upper arm
9 <sup>th</sup>	At 18 months	Measles rubella vaccine 2	Measles, rubella	Injection on left upper arm
		Malaria vaccine 4	malaria	Injection on right upper arm
Single dose	10-year-old girls	Human Papilloma virus	Cancer of the cervix	Injection on upper arm
1 <sup>st</sup> dose	Women of child bearing age(15-49years)	Tetanus Diphtheria (Td1) vaccine	Tetanus diphtheria	Injection on upper arm
2 <sup>nd</sup> dose	1 month after first dose	Tetanus diphtheria (Td2) vaccine	Tetanus diphtheria	Injection on upper arm
3 <sup>rd</sup> dose	6 months after 2 <sup>nd</sup> dose	Tetanus diphtheria (Td3)	Tetanus diphtheria	Injection on upper arm
4 <sup>th</sup> dose	12 months after 3 <sup>rd</sup> dose	Tetanus diphtheria (Td4) vaccine	Tetanus diphtheria	Injection on upper arm

5 <sup>th</sup> dose	12 months after 4 <sup>th</sup> dose	Tetanus diphtheria (Td4) vaccine	Tetanus diphtheria	Injection on upper arm
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### *Integration with global and regional initiatives*

Uganda's Health Sector Integrated Refugee Response Plan (HSIRRP, 2019–2024) is anchored in global commitments, including the New York Declaration on Refugees and Migrants and the Comprehensive Refugee Response Framework (CRRF). It aligns refugee health services with national systems, ensuring their inclusion in primary healthcare alongside host communities. [15] International and multilateral partnerships have been central in strengthening this approach. In October 2024, the Ministry of Health, in collaboration with WHO, launched the *Refugee and Migrant Health System Review*, which emphasized health workforce capacity, access to essential medical supplies, and improved coordination among government bodies, UN agencies, and implementing partners. [16] The report, jointly produced by MoH, WHO, United Nations High Commission for Refugees (UNHCR), and UNICEF, outlines strategies that integrate refugee health within broader health system strengthening, reflecting a global push for inclusive healthcare. [17]

Under the HSIRRP, an estimated USD 100 million (UGX 2.1 trillion) has been allocated over five years to expand access to medicines, infrastructure, and human resources across refugee-hosting districts [18] Uganda's commitment to equity was further demonstrated during the COVID-19 pandemic, when UNICEF and the ministry of health rolled out an accelerated vaccination campaign through the COVAX Humanitarian Buffer. In districts such as Adjumani, outreach posts achieved 80% coverage, highlighting the effectiveness of integrated service delivery. [19]

#### **Policies on refugee health and vaccination access.**

Uganda has progressively advanced policies that integrate refugees into its national systems, transitioning from restrictive frameworks to inclusive development-oriented approaches. The Control of Alien Refugees Act of 1960 represented an early, control-based policy [20], later superseded by the Refugee Act of 2006 and Refugee Regulations of 2010, which domesticated international obligations and expanded refugee rights [21]. The adoption of the Self-Reliance Strategy (1999) and its successor, the Development Assistance to Refugee-Hosting Areas programme (2004), marked a shift toward harmonizing service delivery and enhancing local government capacity. [22,23] Refugees were further embedded into Uganda's development agenda through the Settlement Transformation Agenda (STA) under the National Development Plan II (2015/16–2019/20), which institutionalized the non-encampment policy and promoted land allocation for cultivation. [24] At the global level, Uganda endorsed the New York Declaration (2016), launched the Comprehensive Refugee Response Framework (CRRF) in 2017, and adopted the Global Compact on Refugees in 2018, reinforcing its international commitments. [25,26] More recently, integration has been operationalized through frameworks such as the ReHoPE strategy (2017), [27] the Uganda Country Refugee Response Plan (2019), [28] and the Health Sector Integrated Refugee Response Plan (2019–2024), [29] which collectively align refugee inclusion with national health, development, and resilience agendas. Health facilities in refugee settlements operate under the Ministry of Health guidelines. On the other hand, there is free access to government and UNHCR-supported health services for refugees. [30] During the COVID-19 pandemic, Uganda's Ministry of Health and UNHCR extended vaccination services to refugees and nationals alike free of charge. [31]

#### **Immunization Coverage among Refugee populations in Uganda**

Publicly available literature regarding immunization coverage among refugee populations remains scarce. Coverage among refugees in Uganda remains uneven, with routine vaccination rates often falling below national targets. For example, a 2024 study in Kyangwali settlement found that only 33.3% of children aged 12–59 months were fully immunized. [32] During outbreaks and mass campaigns, however, coverage can be much higher: measles vaccination rates reached 87% among

refugees in Kiryandongo during a 2023 outbreak response [33] and 98.1% during a national campaign reported by UNHCR. [34]

### 3. Key Challenges in Immunizing Migrant and Refugee Populations

Refugees and migrants often encounter distinct challenges that hinder their access to vaccination services. The studies reveal that obstacles to vaccine access can be categorized into legal, individual, community-level barriers, and structural or system-level barriers. [35]

#### **Administrative and legal barriers**

Refugees are often required to present their refugee ID cards with them to receive vaccination. This excludes those who do not have one, and those without IDs are required to have a letter from the office of the prime minister (OPM), and this could also be a hard administrative process. [36] Frontline staff request unnecessary paperwork because of misunderstanding of policy, fear of extra paperwork, or unconscious bias leading to on-site exclusion even where policy is inclusive. [37] Moreover it is common for cases of fraud and corruption being reported in refugee camps during ongoing vaccination and health campaigns and as such viewed as “suspicious business” being conducted by those in higher authority. [38] This contributes to reduced uptake in this population.

#### **Logistics, supplies and infrastructure challenges**

Despite Uganda’s progressive integration of refugees into its national health system, challenges still persist, such as resource constraints, including limited vaccine stock, insufficient trained healthcare workers, and gaps in logistics and supply chains. [39] During the COVID-19 vaccination campaign, challenges in vaccine supply significantly hindered uptake in refugee settings such as Palabek settlement. Inconsistent availability of vaccines disrupted the continuity of immunization, with many individuals who received a first dose of AstraZeneca or Moderna unable to access the corresponding second dose within the recommended timeframe. When alternative vaccines were later provided, uptake remained low, as recipients expressed reluctance to complete their schedules with different vaccine types, and raising concerns about delayed second doses and mixing vaccines, reflecting both supply chain weaknesses and limited community confidence in heterologous vaccination. [38] Additionally, high population density in refugee settlements like Kiryandongo means that often times, there are shortages and this undermines vaccination coverage which impede effective outreach and record-keeping. [40]

#### **Knowledge, information gaps and health concerns**

A consensus world report by WHO showed that under privileged groups, which typically includes refugees may lack knowledge regarding benefits of immunization. [41]. Another report regarding HPV vaccination showed that many of the immigrants had little or no knowledge about HPV vaccine and didn’t know about its purpose, eligibility and dosing schedule [42].

On the other hand, misinformation about the vaccines [41] which is as a result of open sources such as the internet [43] while others get information from fellow refugees which sometimes is inaccurate [44] causes vaccine mistrust among the refugee populations. This mistrust is further compounded by doubts among health workers themselves, particularly regarding the AstraZeneca vaccine as many expressed concerns rooted in what they perceived as inconsistencies in standard vaccine practices such as short research period, before its rollout. [45]

Refugees often have concerns about vaccine safety and fear of associated side effects [42,46,47]. Widespread myths have significantly hindered vaccine acceptance among some populations. False beliefs, including claims that vaccines were designed to harm Africans, cause infertility, or were linked to satanic practices, create deep mistrust. One persistent rumour suggested that individuals who received the COVID-19 vaccine would die within two years. [47] These myths were reinforced by health concerns such as fears of blood clots and infertility, particularly as AstraZeneca, the vaccine most widely available in refugee camps, had been subject to safety debates in high-income countries. This was compounded by the relatively low severity of COVID-19 in refugee settlements, fuelling perceptions that vaccination campaigns were externally driven, including beliefs that Western actors sought to control population growth. [38] Some people even believed that Ugandans were

unknowingly participating in a clinical trial as one unvaccinated male informant thought that they being used as guinea pigs in the COVID 19 vaccination. [45]

Parents and caregivers of young children frequently express worries about the safety of vaccines and the potential for adverse events following immunization (AEFI). [48] These concerns can be heightened by personal or community experiences of vaccine-related reactions. For instance, most parents whose child experienced an AEFI following the 2010 seasonal trivalent influenza vaccine (STIV) reported lower confidence in the safety of influenza vaccines, which likely contributed to lower uptake of the seasonal influenza vaccination in 2011. [49] A key barrier to immunization in the Kyangwali refugee settlement is parents' reliance on alternative information sources instead of community health workers, which significantly reduces childhood vaccination rates. [32]

#### **Cultural, religious and social barriers**

Religious and spiritual beliefs among cultural groups shape perceptions of illness and healing, often attributing misfortune and disease to spiritual imbalance rather than biomedical causes, and this was evident among South Sudanese refugees in Acholi. Such views can create suspicion toward external interventions like vaccines, which may be seen as conflicting with established spiritual practices. As a result, vaccine uptake is sometimes hindered by the need to reconcile biomedical approaches with local religious understandings. [38]

Studies have highlighted difficulties in communication, particularly those stemming from language barriers [50] and the shortage of interpreters [51], as a significant obstacle to healthcare access for refugees. These challenges are largely due to refugees having poor literacy in the host community languages and absence of tailored language support services. [46] Julius Kasozi in his article about refugees in Kampala highlighted that refugees who did not understand Luganda or English languages had issues with communication and if languages known to the refugees especially Swahili was used, they were not well articulated by the health workers for the refugees to understand. [52]

#### **Financial constraints**

Low socioeconomic status among refugee and migrant populations also hinder vaccine uptake [53]. Social economic status in this case varies from formal education level, family income to housing conditions [54]. On some occasions migrants are required to pay the direct costs of vaccination, [46] especially for undocumented refugees and refugees who seek vaccinations at private facilities which they may not be able to afford [55]. Indirect costs, such as travel costs and loss of wages from taking time off work. [46]

### **1. Strategies and Recommendations for Improved Vaccination Coverage among Refugees in Uganda**

#### **Policy and System-Level Approaches**

Uganda's historically inclusive refugee policy, refugees have the same access to public services as hosts, provides a strong foundation for equitable immunization. [56] Nonetheless, gaps remain in implementation. To bridge these, national policy should explicitly guarantee non-discriminatory, free and accessible vaccination for all refugees and migrants. Guidance urges governments to "make routine immunizations free at the point of delivery" and to remove administrative barriers [57,58] and in practice, this means formally integrating refugees into the Uganda National Expanded Programme on Immunization (UNEPI) and related health strategies, a strategy that has worked well for the country. [59]

#### **Community Engagement and Communication**

Effective outreach hinges on trusted, culturally sensitive communication. WHO emphasizes developing a risk communication and community engagement strategy for refugees: providing vaccine information in refugees' own languages, via trusted channels and messengers [58]. In Uganda, language barriers have been a major issue [60], with most official health messages are in English or Luganda, while many refugees speak only regional dialects. Partnering with refugee community leaders, translators, and locally recruited health promoters can overcome this. For example, refugee health workers and volunteers can hold small public discussions in refugee

settlements to explain vaccine benefits and counter myths [59]. Stakeholder forums, religious leaders, women's groups and youth networks should be involved in planning and disseminating vaccine information, to build trust and dispel disinformation. Engaging refugee youth as was done in Uganda's recent polio campaign or respected elders in settlement councils can personalize messages and encourage uptake [61].

### **Service Delivery Innovations**

To reach transient and hard-to-access populations, Uganda should diversify delivery modes beyond static clinics. WHO notes that mobile vaccination clinics, pop-up sites in community venues, and door-to-door outreach are highly effective for refugees. [58] During COVID-19 in Uganda, aid organizations deployed mobile teams to vaccinate refugees in camps and settlements, often offering a single vaccine type per visit to simplify delivery. [62] Such mobile clinics whether on trucks, boats, or tents can visit remote settlements on a regular schedule. Similarly, targeted mass campaigns or vaccination days in camps can rapidly boost coverage, especially following new arrivals. Integrating immunization into other services can also improve uptake: for instance, offering catch-up vaccines alongside antenatal care, nutrition programs or child health days reduces the need for separate visits [58]. Using local community health workers (CHWs), both refugees and host nationals, to deliver vaccines and track defaulters has proven crucial; in Kakuma camp (Kenya), for example, recruiting multilingual refugee CHWs greatly expanded routine immunization uptake. [63]

### **Monitoring, Data, and Cross-Border Collaboration**

Uganda's porous borders mean refugees frequently travel or return home, so cross-border coordination is important. Robust data systems are needed to track coverage among migrant groups. WHO/UNICEF guidance emphasizes enhancing immunization information systems to capture refugee status and migration history. In practice, health facilities serving refugee areas should record country of origin and arrival date in patient files and electronic registers. Giving every refugee family a vaccination card (and educating them to retain it) helps maintain continuity if they move. Health officials should collaborate with neighbouring countries (South Sudan, DRC, Rwanda, etc.) to share immunization records and synchronize catch-up campaigns for mobile populations. [57,58]

## **2. Lessons from Other Countries or Contexts**

Global experience offers valuable models for Uganda. In Bangladesh's Rohingya camps, WHO and partners used community theatre to raise vaccine awareness among illiterate or hesitant populations. Rohingya and Bangladeshi youth jointly performed plays that dramatized vaccine benefits and risks of non-vaccination, incorporating messages about locating vaccination sites and keeping immunization cards. This creative, participatory approach helped bridge cultural divides and gave refugees ownership of the message: actors learned key facts themselves and then taught family and neighbours through entertainment. Community leaders and the camp-in-charge supported the initiative, amplifying its reach. [64] Such strategies underscore the importance of engaging beneficiaries as active participants.

In Kenya's Kakuma camp, the challenge was linguistic fragmentation. Refugees from South Sudan, Somalia, DRC and Burundi lived in the same settlement but spoke different languages. The International Rescue Committee built a "vast and efficient network of community health workers" drawn from each nationality. One veteran South Sudanese community health practitioner explained that speaking parents' mother tongue (plus Kiswahili/English) was key: "The importance of using mother tongue is for them to understand," he said. This multilingual outreach has led to noticeable improvements in coverage and defaulter follow-up. Kenya also leveraged mass campaigns (e.g. measles and cholera vaccination rounds) in the camps during disease outbreaks. The Kakuma experience highlights how recruiting and training refugee volunteers can build trust and overcome information gaps. [63] Also in Kenya, during the COVID-19 pandemic, Koiboi's "Corona Guy" radio show in Dadaab refugee camp became a trusted voice that debunked rumours and engaged residents directly, effectively reducing misinformation and vaccine hesitancy [65]

Modelling within Turkey's large Syrian refugee population found that promoting social integration between refugees and host communities can significantly reduce measles transmission by

nearly 50% leveraging herd immunity from high vaccination rates among Turkish nationals. This underscores the epidemiological benefit of inclusive social policy, not only for refugees but for broader public health protection [66].

More to the above, digital tools for tracking vaccination coverage, as in Jordan. In Zaatarı Refugee Camp, the CImA (Children's Immunisation App) provided parents with digital immunization records and trusted vaccine information. This low-cost solution enhanced vaccine tracking and caregiver awareness, showcasing the value of digital innovation in humanitarian settings. [67]

Another lesson is to be drawn from Belgium. In Flanders, Belgium, mobile vaccination teams provided services to asylum seekers, homeless individuals, and other marginalized groups. All vaccinations were recorded centrally, ensuring continuity and preventing duplication an approach that boosted both accessibility and monitoring. [68]

#### 4. Conclusion

Uganda's progressive refugee policies and strong partnerships have created a solid foundation for inclusive immunization, but there's still a clear gap between policy and practice. Refugee communities face unique and overlapping barriers that make it hard to access vaccines. Some refugees are held back by documentation requirements and administrative rules, while others struggle with irregular vaccine supplies that disrupt schedules. Misinformation and cultural concerns can lead to mistrust, and language differences often make it difficult to understand health messages. On top of that, transport costs or the time required to visit clinics can discourage families from seeking immunization.

These challenges don't just affect individuals; they leave entire communities vulnerable to outbreaks of preventable diseases. Experience on the ground shows that closing these gaps requires more than good policies. It involves fully integrating refugees into national immunization systems, removing unnecessary bureaucratic barriers, and ensuring reliable funding for cold chains, outreach, and staff. Practical steps like training multilingual refugee health workers, running regular mobile clinics, holding catch-up days for new arrivals, keeping standardized records, and coordinating across borders can make a real difference. To turn Uganda's strong policy commitments into lasting health equity, national and international partners need to provide predictable funding, track coverage among refugees closely, and invest in culturally sensitive community engagement that builds trust. Aligning policy, financing, and community action is essential to protect both refugees and host communities.

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