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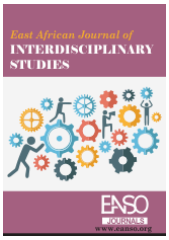

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Original Article

A Systematic Review of the Healthcare Access and Utilization Barriers Faced by Refugees in Uganda

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ABSTRACT

The increasing number of refugees in Uganda is putting a significant strain on the country's already limited resources, particularly those for healthcare. The government has implemented policies in response to the crisis. However, numerous obstacles have hampered these efforts. The aim of this article is to review previously published research by synthesising global evidence on factors that impede refugees' access to healthcare services across the country. Articles published between 2016 and 2022 were searched in the Google Scholar and PubMed central databases. Google Scholar yielded 21,300, PubMed Central 637, and 5 articles from cross-references, however. The PRISMA framework was used to structure the selection, and 21 studies from different fields and settings met the inclusion criteria. The most frequently cited factors that impede access to and utilisation of needed healthcare services were sociocultural considerations such as stigma and discrimination, health system anomalies that led to mistrust of healthcare services and workers by refugee populations, and financial difficulties. In order to overcome these obstacles, the government and humanitarian organisations ought to carry out a comprehensive screening with leaders of refugee communities and local refugee organisations in order to comprehend the conditions of refugees. They ought to pay particular attention to the differences between the various cultures and settings, as well as the flow of the healthcare system, in order to sensitise people and raise awareness about the healthcare system. To make it easier for refugees to access and use the necessary healthcare services, specific health policies should be implemented. When looking for healthcare, equal rights and freedom of movement should be top priorities.

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INTRODUCTION

Refugees have the right to the best possible healthcare. Meeting the healthcare needs of refugees remains difficult, owing to the dramatic increase in the number of migrants and refugees in recent years worldwide. As a result, meeting needs has emerged as a global health priority that is inextricably linked to the universal health coverage (UHC) principle. Precarious legal status, discrimination, social, cultural, linguistic, administrative, and financial barriers; a lack of information about health entitlements; low health literacy; and fear of detention and deportation are all factors that refugees must contend with when attempting to meet their health needs (World Health Organization, 2022). Despite the policy's provision of free primary healthcare, Uganda, with its over 1.5 million refugees, has other advantages, but these people face various challenges in accessing their health needs (Fred, 2021; Unicef, 2022). 15.7 million Ugandans require basic health services (Unicef, 2022).

Access to healthcare is hampered for urban refugees due to proximity to health facilities, the cost of healthcare, long waiting times, low acceptability of services, and a lower perception of the quality of health services compared to nationals, while access to immunisation centres is difficult due to impracticable roads, affecting the effectiveness of the outreach program, support supervision, mentorship, and timely delivery of immunisation program support supplements. Some facilities lack the necessary resources to support the program effectively. The identification, reporting, and management of adverse events following vaccination (AEFI) are poorly understood (Kasozi et al., 2020; Ombeva et al., 2019). Corruption, discrimination, language barriers, and a lack of privacy were also highlighted by these women during their delivery experiences in a qualitative study that was conducted in both urban and rural settings on women. There was limited availability of trained healthcare staff, health facilities, and medication supplies, as well as inadequate referral systems (Nara et al., 2020). Lack of adequate SRH information was cited by adolescent refugee girls in the Nakivale refugee settlement as a major reason they did not seek care, and the refugee context exacerbates the barriers (Id et al., 2020; Ivanova et al., 2019). Distance, cost, unemployment, climate, unsafe disclosure of health status, and stigma were among the barriers to clinic attendance in the same setting (Laughlin et al., 2021).

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HIV and STI testing strategies for urban refugee youth are constrained by intersecting stigmas rooted in fear, misinformation, blame and shame, legal precarity, and healthcare mistreatment (Logie et al., 2021; Logie et al., 2020). Refugees' non-use of healthcare services is also influenced by their lack of access to insurance, high service costs, inability to get to services quickly, long wait times, a lack of transportation, and limited-service hours (Albright et al., 2022). We will attempt to highlight various aspects of obstacles to access and use of healthcare services by refugees in Uganda in this review. It is important to note that this relationship could all benefit from an in-depth analysis.

METHODS

The protocol for this review included data extraction, data checking, screening, and quality assessment (Tawfik et al., 2019). Prior to beginning the search, a gray literature search plan specified the resources, search terms, websites, and limitations to be utilised (Kanu et al., 2020). The methodological plan reduced the risk of bias being introduced into the search methods by providing them with direction, structure, and transparency. This ensured that the search methods were comprehensive and organised. Creating a plan for the search method was also important for time management because it limited the number of search terms and the number of results that needed to be screened. To ensure compliance with systematic review reporting standards like Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021), it was helpful to devise the strategy and record each step of the search process. A gray literature search ought to be subjected to these reporting guidelines.

Search Strategy

To support the literature review, the PRISMA framework was used (Page et al., 2021). The primary databases searched were Google Scholar (http://scholar.google.com/) and PubMed Central (http://www.ncbi.nlm.nih.gov/pmc/) between mid-December and late January. Articles published between January 2016 and December 2022 were identified. We scoured the databases once more for any relevant publications from the previous six years. Manual searches in the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR) databases were also conducted for gray articles and publications that were not indexed in established academic journals. The keywords were combined with different synonyms. Provisions were made for spelling variations. Truncation functions were used to allow the phrase "Barriers to access and use of healthcare service among refugees in Uganda" to include all possible variations of the identified words. For "barriers", we used obstacles, challenges, and difficulties; for "healthcare", we used healthcare, care delivery, Medicare, medical intervention, medicine, and treatment; and for "access and use", we used uptake, use, and receive.

Participants

We included studies conducted among refugees in Uganda on healthcare access and services utilisation.

Eligibility, Inclusion and Exclusion Criteria

Studies published in English and peer-reviewed journals between 2016 (the year the Sustainable Development Goals-SDGs-2030 agenda went into effect (Johnston, 2016) and 2022 were chosen as relevant, with primary research of any design and methodology conducted in Uganda. Papers Excluded from consideration were studies conducted on non-refugee or among refugee populations living outside of Uganda as well as editorials, case reports, systematic reviews, and review articles.

Screening Process

The screening process was broken down into three steps. First, relevant publications were chosen based

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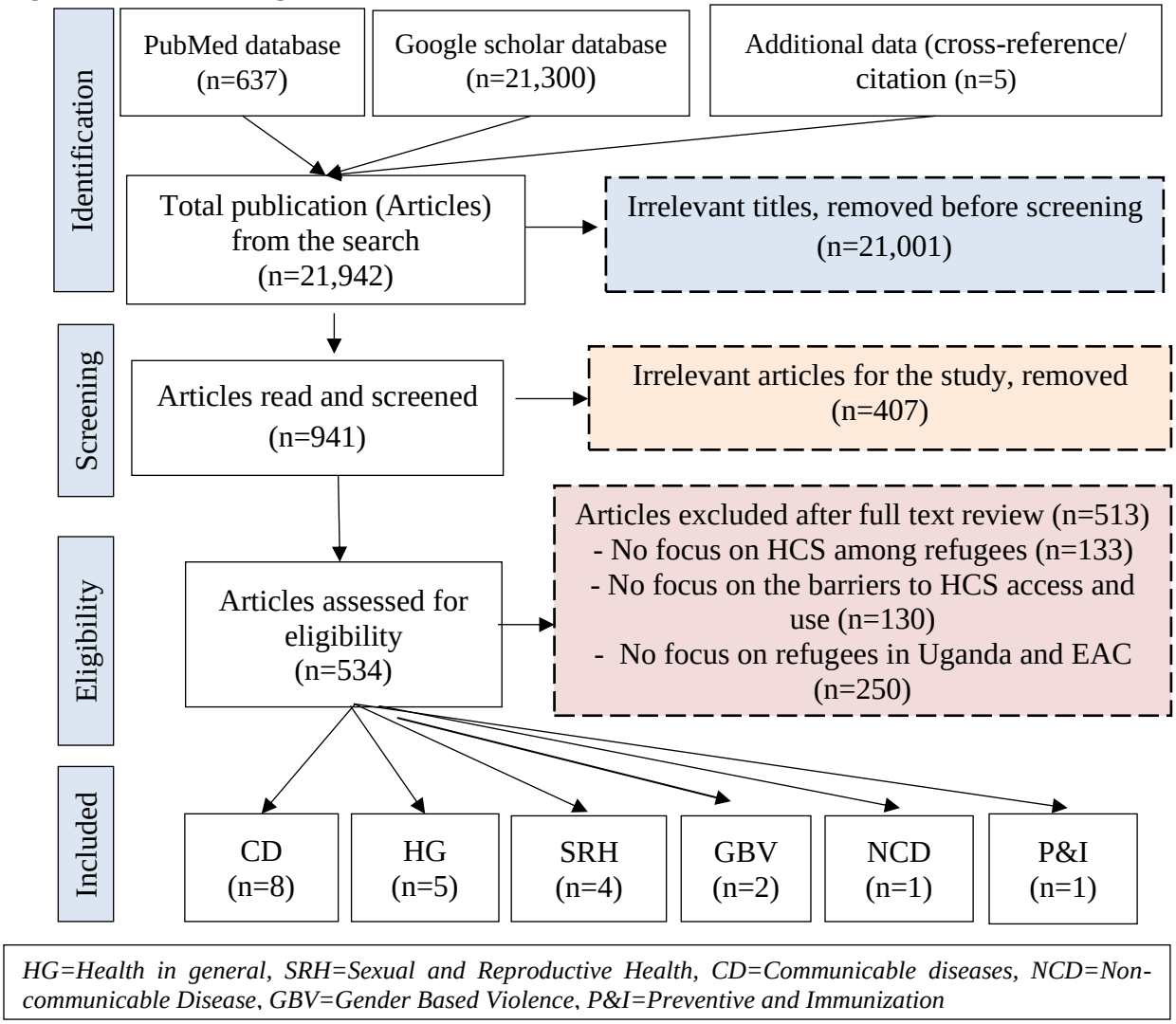
on the title and abstract. Following the first screening step, publications were downloaded and their full text was checked for relevance. Publications that could not be downloaded were excluded. Additional relevant publications were discovered in the reference lists of the publications that survived the second screening step. This was the third and final level of screening. The selection was carried out by a member of the research team. The team's other researchers discussed the intermediate and final results.

Figure 1: PRISMA diagram-flow chart for articles selection



HG=Health in general, SRH=Sexual and Reproductive Health, CD=Communicable diseases, NCD=Non-communicable Disease, GBV=Gender Based Violence, P&I=Preventive and Immunization

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Table 1: Metadata on the barriers to healthcare access and utilisation among refugees in Uganda

Author/country/setting	Study population	Method	Cited factors that hinder access and utilisation of healthcare service				
			Socio-cultural	Personal/ Patient	Healthcare providers and quality of services	Financial conditions/ costs of services	Environmental
(N. S. S. Id et al., 2022), Northern Uganda	Partnered women of reproductive age	Mixed	X		X		
(Carmen H Logie, Okumu, Musoke, Hakiza, Mwima, Kacholia, et al., 2021), Kampala, Uganda	Youths aged 16-24	Qualitative	X	X	X	X	X
(Carmen Helen Logie et al., 2020), Kampala, Uganda	Urban refugees and displaced youths	Quantitative	X	X			
(Carmen H Logie et al., 2019), Kampala, Uganda	Urban refugee and displaced youth	Quantitative	X	X	X		
(Ivanova et al., 2019), Nakivale refugee settlement, Uganda	Adolescent girls aged 13-19	Mixed	X		X		
(Renzaho et al., 2017), slums area, Kampala, Uganda	Participants aged 13-24	Quantitative		X	X		
(Carmen H Logie, Okumu, Musoke, Hakiza, Mwima, Kyambadde, et al., 2021), Kampala, Uganda	Refugee cisgender youth aged 16-24	Qualitative	X	X	X		
(Mwenyango & Palattiyil, 2019), Uganda's settlements	Refugee women and men	Mixed	X	X			
(Kasozi et al., 2020), Kampala, Uganda	Heads of households	Mixed	X.	X	X	X	

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Author/country/setting	Study population	Method	Cited factors that hinder access and utilisation of healthcare service				
			Socio-cultural	Personal/ Patient	Healthcare providers and quality of services	Financial conditions/ costs of services	Environmental
(Ombeva et al., 2019), rural district, Uganda	Caretaker/child pairs were included in the study	Mixed		X			
(Laughlin et al., 2021), Nakivale Refugee Settlement in Uganda	Clients in HIV care and clinic staff	Qualitative				X	X
(Andrew, 2016), Nakivale Refugee Settlement in Uganda	Health providers and Congolese refugees	Mixed		X	X		X
(Guruge et al., 2018), Nakivale Refugee Settlement in Uganda	Refugee participants, clinic staff	Qualitative	X	X	X		
(Kawaguchi, 2020), settlements in Uganda	GBV Survivors in South Sudanese Refugees	Qualitative	X	X	X		
(Walnycki et al., 2019), Kampala, Uganda	Household interviews	Mixed			X		
(King et al., 2022), 2 districts in Uganda	Women	Quantitative				X	
(Buregyeya et al., 2022), slums in Kampala, Uganda	Caretakers/family members, healthcare workers, implementing partner representatives, refugees, and local leaders	Qualitative	X	X	X	X	X
(Nara et al., 2019), Camps and urban settings, Uganda	Refugee women and women of reproductive age	Qualitative			X		

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Author/country/setting	Study population	Method	Cited factors that hinder access and utilisation of healthcare service				
			Socio-cultural	Personal/ Patient	Healthcare providers and quality of services	Financial conditions/ costs of services	Environmental
(Adoch et al., 2020), in northern Uganda	Women aged 18–60	Quantitative		X			
(Achola et al., 2022), Adjumani district, Uganda.	Females aged 15 and above	Qualitative	X	X			
(Abrahamsen, 2019), in western Uganda.	National humanitarian health workers	Qualitative	X		X		

X in cell means that the article cited the corresponding factor as a barrier to access and utilisation of Healthcare services.

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Tables 1 show the overall characteristics of the reviewed publications. All publications were empirical and cross-sectional studies published in peer-reviewed journals between 2016 and 2022, conducted in resource-constrained refugee settings, pertaining to various types of care delivery to refugees displaced in their home countries due to war or conflict. Overall, the topics were quite diverse, both within and across categories. Five quantitative, nine qualitative, and seven mixed-methods designs were included among the 21 articles, as well as a variety of fields (Figure 1) and study designs (*Table 1*). The majority of publications mentioned refugee settlements, urban health facilities, and/or camps as the research settings.

RESULTS

This overview includes 21 studies that have been published (*Figure 1*). More than 90% of researchers agreed at each stage. Through discussion, disagreements were easily resolved.

Sample Characteristics, Study Design, and Study Setting

The final sample's 21 academic articles were all published between 2016 and 2022. Table 1 provides information about each article. The majority of articles (eight) focused on communicable diseases, followed by general health (five), SRH (four), and GBV (two), with the fewest articles focusing on non-communicable diseases and vaccination (one) (*Figure 1*). With 12 (57.1%) academic papers focusing solely on refugees living in settlements, 8 (38.0%) on urban refugees in Kampala, and only 1 (4.8%) on both, all used cross-sectional methods, and most studies were qualitative (9, 42.8%), followed by mixed methods (7, 33.3%), and the fewest were quantitative (5, 23.8%) (*Table 1*).

Factors Affecting Healthcare Access and Utilization

The following are the categories of factors that influence refugees' access and use of healthcare services: sociocultural, patient's/personal, treatment/service, healthcare providers, financial, and environmental factors.

Socio-Cultural

Discrimination and stigma were identified as significant obstacles to accessing and utilising healthcare services in the majority of articles across all settings. These were either related to the person's status as a refugee, their health, or their illness. Adolescent SRH-related stigma as a result of testing and use of SRH services, intertwining stigma rooted in fear, blame, and shame, legal precarity, medical mistrust of HIV testing, and inequitable gender norms (Logie et al., 2019; Logie et al., 2021; Logie et al., 2020), are exemples of wide spread TB stigma (Buregyeya et al., 2022).

In the Dadaab refugee camp in Kenya, stigma from family and community, the fear of additional violence from perpetrators, feelings of helplessness and insecurity, and guards denying entry to service provision premises (Muuo et al., 2020). The majority of refugee communities have maintained their sociocultural practices (Abrahamsen, 2019; Mwenyango & Palattiyil, 2019). Fear of stigma caused by social and cultural norms, gender dynamics, men's negative attitudes, leaders' opposition to women using contraception, and women's retaliation (Achola et al., 2022). Women's access to healthcare services is hampered, for instance, by a lack of information and decision-making authority (Cg et al., 2009; Kawaguchi, 2020), as well as by a lack of choice for women (Id et al., 2022). The settlement's violence and unrest were also cited as a factor in refugees' inability to access healthcare and their lack of use of it (Guruge et al., 2018).

In some Kampala slums, refugees were also reported to be unable to move around due to a lack of mobility, poor living conditions, overcrowding,

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and unemployment (Buregyeya et al., 2022; Laughlin et al., 2021; Logie et al., 2021). Sexual violence and cultural practices such as FGMs also stop refugees from seeking healthcare (Ivanova et al., 2019). Access to and use of healthcare is also hindered by legal restrictions on some services. Take, for instance, the ban on abortion. Refugees are exposed to unsafe abortion methods as a result (Nara et al., 2019). In the Adjumani district, major barriers to Sexual and Reproductive Health (SRH) use included cultural norms and socially constructed myths about the use of contraception (Achola et al., 2022). In western Uganda, there were also reports of disparities between health workers and refugees and their hosts (Abrahamsen, 2019).

Personal/Patient

In the refugee camps in Uganda, individual factors were mentioned (Mwenyango & Palattiyil, 2019). In all settings, care-seeking was slowed down by a lack of information about health conditions, available and required healthcare services and a low perception of need. Time constraints and other commitments also played a role. Low condom self-efficacy and language and literacy barriers, for instance (Andrew, 2016; Logie et al., 2021; Logie et al., 2020; Ombeva et al., 2019). Adherence to HIV testing services was linked to youth awareness (Adoch et al., 2020; Logie et al., 2019). Poor SRH outcomes were reported in Nakivale settlements, and a lack of comprehensive sex education in Kampala's slums was linked to low utilisation of SRH services (Achola et al., 2022; Ivanova et al., 2019; Logie et al., 2021; Renzaho et al., 2017). In comparison to nationals, they have a lower perception of the quality of health services (Kasozi et al., 2020).

Healthcare Provider and Quality of Services

There are reports of treatment non-adherence and a lack of a relationship with healthcare providers. Mistreatment in the healthcare system and mistrust of healthcare workers (Id et al., 2022; Logie et al., 2021), lack of support for health workers, management, and inequalities between health workers can affect refugees' access to and utilisation of healthcare services, despite the fact that healthcare providers will unavoidably face a heavy workload as a result of the demand for healthcare in all refugee settings (Abrahamsen, 2019; Buregyeya et al., 2022).

Reaching a suitable facility is frequently delayed due to service inaccessibility. In Kampala's slums, for instance, it was reported that good facilities were either unavailable or that people could only get to facilities that could not diagnose and treat Tuberculosis (TB) (Buregyeya et al., 2022). In Northern Uganda and in the Nakivale settlement, there were reports of inadequate drugs and drug stockouts, as well as poor service quality, lack of privacy, and stockouts of FP commodities (Andrew, 2016; Guruge et al., 2018; Id et al., 2022). Treatment and service barriers include medical mistrust of HIV testing, lengthy wait times, low acceptability of services, and gaps and difficulties at health facilities (Abrahamsen, 2019; Kasozi et al., 2020; Kawaguchi, 2020; Logie et al., 2021).

Financial

When there are gaps in health insurance or unexpected and costly co-payments, barriers to receiving care at the facility for refugees are more frequently reported in Uganda. This could mean that refugees' perceptions of the cost of treatment, their ability to pay, and access to money play a bigger role in their decision to seek care in Uganda. As a result, many people who would have had financial trouble at the facility never actually go there. In Uganda, however, access to healthcare is restricted by informal payments (Kasozi et al., 2020; Laughlin et al., 2021). According to reports, one of the primary factors were poor living, financial insufficiency as well as the detrimental effects of the high costs of healthcare services (Buregyeya et al., 2022; King et al., 2022).

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Environmental

In Uganda, geographical and environmental obstacles to healthcare access are more severe. For instance, the climate, including rain (floods) and low temperatures, as well as the long distances required to get to health facilities, Sunshine and higher temperatures, always make it hard to get healthcare, but in High-Income Countries (HICs), it's usually because it's hard to get to specialist services or it costs money to get there; In contrast, patients in Low- and Middle-Income Countries (LMICs) frequently have to travel long distances that are too difficult due to rough terrain and inadequate road infrastructure, particularly in refugee camps (Andrew, 2016; Guruge et al., 2018; Laughlin et al., 2021). Refugees are always demotivated to seek healthcare because of the high cost of transportation to health facilities (Logie et al., 2021).

DISCUSSION

While seeking healthcare, refugees face difficulties in every country. The host community's socio-cultural factors, as well as the refugees' lack of awareness and language barrier, all play a role in the factors that prevent refugees from using healthcare services in Uganda, according to the majority of articles (Adoch et al., 2020; Id et al., 2022; Logie et al., 2021). The poor conditions and refugee status always result in stigma and discrimination in the process of healthcare seeking. Similar obstacles confront refugees in Europe and other developed nations, such as interpersonal and structural discrimination in employment and healthcare utilisation among Somali refugees in the United States (Houston et al., 2021; Satinsky et al., 2019). Another study conducted in Uganda on factors that hinder refugees from practising Ebola preventive measures language barrier was also cited (Rodrigue, 2022).

A Malaysian article revealed that refugees unawareness of their right to healthcare; differences in culture and language; and security concerns brought on by a lack of legal status (Khatoon et al., 2018; Leh et al., 2018). According to a publication in Japan, language was a major obstacle to health access (Matsuoka et al., 2022). In addition, refugee families in Canada complained that they were unable to get care because of a lack of social support (Özkan & Taylan, 2021; Woodgate et al., 2017). Access to healthcare is greatly influenced by sociocultural factors. However, they manifest in different ways depending on the social and cultural context. For instance, despite the fact that the reasons for stigma and the conditions it is associated with vary depending on the context, it restricts access to healthcare across all delays and settings. Gender-related social and cultural issues, such as social roles and expectations for men and women, can vary greatly from country to country, which can exacerbate disparities in health and access to healthcare. Men, for instance, do not permit their female patients to be consulted or treated by men in some societies (Al-hamad et al., 2020; Guruge et al., 2018). As a result, a study on refugees' access to healthcare revealed that in Norway, immigrants prefer to see doctors (Mbanya et al., 2019).

The capacity to provide the necessary healthcare is a recurring theme. In some settings in Uganda, patient experience is more important than the lack of care in health facilities. Even if care is there, it is not always of the necessary quality, complete, or continuous, especially in camps, where barriers to healthcare access are more numerous and severe to the point where patients' privacy and rights are violated. Refugees' mistrust and opposition to the healthcare system resulted from this condition (Abrahamsen, 2019; Id et al., 2022; Logie et al., 2021). This was also shown by articles that were published all over the world and said that healthcare services for refugees were inadequate because of a variety of obstacles (Davidson et al., 2022; Korri et al., 2021; Zhang et al., 2022). The healthcare system particularly marginalises immigrants (Albright et al., 2022). Long waiting lists have been cited as one

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of the factors that discourage refugees from seeking medical care in developed nations like Australia, Canada, and others (Kohlenberger et al., 2019; Oda & Mn, 2017; Robertshaw et al., 2017).

Rationing, waiting lists, and systems to manage referrals and prioritise patients according to need are used to manage this. As a result, while patients may not always have immediate access to care for less pressing medical issues, emergency care can be prioritised, resulting in fewer capacity-related obstacles for emergency care in some settings. However, Uganda's severe capacity constraints are the source of many of the obstacles refugees face in obtaining healthcare. Capacity-related obstacles are encountered at all levels, for all conditions, and regardless of the severity of need in this region, where there is a complete absence of healthcare options in some areas. Deficits in other crucial areas, such as finance, education, and transportation, frequently exacerbate capacity limitations in healthcare settings more than others. The majority of Uganda's refugee population is unable to access or use healthcare for a variety of reasons, the most significant of which are financial constraints, frequently resulting in refugees not showing up at all for healthcare providers. Health insurance for refugees is often limited or non-existent in Uganda, which can have an impact on their health-seeking behaviour and encourage auto medication or other illegal healthcare practices (King et al., 2022; Laughlin et al., 2021).

Lack of support for health workers (Buregyeya et al., 2022) contributes to the poor quality of services provided to refugees in all settings and may encourage corruption in the healthcare search process. In HICs, as a result of better support for healthcare financing in some developed nations, refugees are more likely to run into financial difficulties later on if their insurance does not cover all of their medical care or if they are required to pay co-payments (Guruge et al., 2018). This makes it difficult for refugees to afford medical care because of their inadequate incomes (Leh et al., 2018; Oda & Mn, 2017). In Uganda, geographical and environmental obstacles to healthcare access are more severe. This mostly affects refugees who live in camps, where they have to travel far to get to medical facilities due to the rough terrain and poor road infrastructure, then wait in long queues in extreme weather like rain (floods), lower and higher temperatures (Andrew, 2016; Guruge et al., 2018; Laughlin et al., 2021).

Refugees are always demotivated to seek healthcare in any setting because of the high cost of transportation to health facilities. Environmental constraints and transportation issues were also reported to significantly influence care access and preferences in other countries throughout the world (Guruge et al., 2018; Mehta et al., 2018). The majority of refugees live in camps, which prevents them from receiving the specialised care they need. As a result, they must travel long distances, especially to cities, for hours to get to the facilities, which comes at a cost in terms of both transportation and living expenses. The need to improve refugees' access to welfare services such as healthcare is urgent because it has an impact on their individual worth and dignity. In a wider societal sense, ignoring their public health concerns would cause negative consequences to the development of the country (Mwenyango & Palattiyil, 2019). In order to comprehend the factors that influence healthcare access, it is essential to comprehend the socio-cultural environment of each setting. The role of the socio-cultural environment of each setting, which is necessary for healthcare strategies to be successful, should be comprehended.

Limitations

Migrants were also included in some of the reviewed studies; these studies were taken into consideration because refugees are also migrants. As a result, they provide an overall view of the difficulties foreigners in Uganda face in obtaining and using healthcare. There is insufficient documentation of the obstacles that refugees in east

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Africa face in accessing healthcare services. As a result, original research could investigate this unexplored region. Despite the fact that some studies only looked at one nationality, each nationality is linked to a language, culture, or religion that distinguishes its healthcare-seeking behaviour from that of others. This is an area that future research should carefully investigate by taking into account each culture separately.

CONCLUSION

Refugees in Uganda face a variety of challenges in accessing and utilising healthcare services. Those living in camps, where resources for healthcare are frequently scarce on a patient and health system level, are particularly susceptible to these challenges. For efforts to comprehend and overcome these obstacles, it is necessary to comprehend the requirements of the healthcare system, the social and cultural environment, and the requirements of the healthcare system. The evaluation requires methods that take into account the healthcare finance systems, the socio-cultural environment of the setting, and the health system and wider cultural factors that influence the capacity to provide care. As a result, refugees should have easier access to and use healthcare services if health policies that favour them are implemented.

Abbreviations

AEFI: Adverse Events Following Immunisation; FGM: Female genital Mutilation; FP: Family Planning; HCSs: Healthcare Services; HICs: High-Income Countries; LMICs: Low- and Middle-Income Countries; SDGs: Sustainable Development Goals; STI: Sexually Transmitted Infections; SRH: Sexual and Reproductive Health; UHC: Universal Health Coverage.

Authors' Contributions

Rodrigue MB (the corresponding author) conceived the review, coordinated contributors, and revised manuscript drafts. Rodrigue MB, Alex NM, and Pascal K contributed to the analysis design, study selection, data extraction, and data analysis, as well as interpreting the findings and integrating results into the draft. Joyeux MM and Marie ZM revised and prepared the manuscript.

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