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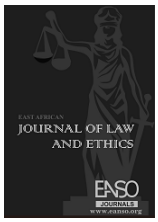

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Original Article

Effect of Refugee Influx on the Right to Health of Refugees in Nakivale Settlement Camp in Uganda

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Refugee Influx, Right to Health, Nakivale Settlement, Uganda, Health Care System, Policy Recommendations.

ABSTRACT

This study investigates the effect of refugee influx on the right to health of refugees in the Nakivale settlement camp in Uganda. Utilizing a cross-sectional case study design, the research surveyed a sample of 158 refugees from a target population of 260. Data was collected through questionnaires, interviews, focus group discussions, and document reviews. The results indicate that while the refugee influx has positively impacted certain aspects of the healthcare system—such as the construction of new health facilities and the provision of hospital beds—significant challenges remain. Specifically, maternal health and access to essential medicines have suffered, highlighting a negative impact on the overall right to health. The correlation analysis revealed a strong relationship ($r = 0.76$, $p < 0.05$) between refugee influx and health outcomes, affirming the hypothesis that refugee influx significantly affects health rights. Furthermore, regression analysis showed that factors related to refugee influx account for 63.5% of the variance in health service delivery. The study underscores the necessity for improved coordination, policy formulation, and resource allocation to enhance refugee health services. Recommendations include integrating health services for refugees and local populations, improving health financing, and promoting continuity of care, particularly for vulnerable groups. Addressing these issues is crucial for ensuring equitable access to health services in the context of growing refugee populations.

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INTRODUCTION

The refugee crisis is a global problem where over 65.6 million people globally have been displaced and forced to flee their country of origin. Notably, about 22.5 million refugees and over half of this figure are below 18 years of age (UNHCR Report, 2015). On the other hand, over 10 million people worldwide have been denied their nationality and do not have access to basic human rights, including rights to work, primary healthcare, right to education and freedom of expression as well as movement.

The sub-Saharan African region hosts over 66% of the world's total refugee population. It is reported that more than 18 million people living in Sub-Saharan Africa are under the responsibility of the UNHCR. That figure has increased in recent years, partly due to the current conflicts in South Sudan, the Central African Republic (CAR), Congo and Nigeria (UNHCR Report, 2015). Also, the Yemen and Burundian conflict have greatly contributed to the growing number of refugees in Africa (Andrew, 2009)

Poor infrastructure, including accommodation mainly in the host communities, has created serious problems in these countries. As a result, a Burden-sharing approach among the countries can produce positive outcomes. In most cases, refugees are detained on trepidation grounds. For instance, in Thailand, most of the asylum seekers were detained and charged with illegal immigration. On the other hand, there has been a growing instance when refugee settlement camps have been attacked by militia groups from countries across the border. Sufficient protection for such camps is a central aspect that needs immediate attention by all governments. For instance, the governments, non-government organizations, and the UNHCR should collaborate to protect the interests and rights of refugees more specifically the vulnerable groups, including women and children (Andrew, 2009)

The statement by the UN Declaration on Human Rights and Training (2011), Human Rights Education, translates this as learning about; through and for Human Rights. Such declarations and scope seek to design and develop skills, attitudes and knowledge-base where Human Rights principles, values and norms and "the mechanisms for their responsibility to "protect people" are crucial components, where human rights to healthcare is a right established by itself (Alfredsson, 2016), and as a critical element to reveal the importance of other human rights (Tomasevski, 2003)

According to the 1951 Geneva Convention, a refugee is any person(s) who fears being persecuted and victimized on grounds of political opinion, nationality, race, ethnicity, religion, belief, member of a particular political party as well as a social group; is not currently living in his/her country of nationality and is unwilling or unable to disclose himself to that country for security purposes.

The AU has expanded this definition. In the present times, a refugee now applies to any person(s) who; owing to foreign domination, external aggression, external employment or phenomenon that severely disrupts public order and natural law, in his nationality or in part, is forced to leave his home to seek for safety at the border or outside his country (Hovil, 2016).

Hovil suggests that a global refugee crisis should be given a global response. However, this is not being practised anywhere than when waiting to see how the world, including the UN and International security agencies, respond to the refugee crisis and mass migration; and to issue that creates virtually no room for the global untouched (Hovil, 2016). It should be noted that more people are seeking humanitarian assistance today than ever before. Almost a quarter of a billion have left their families in the quest for a safer environment, and hopefully for new lives in

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a foreign country. Over 55 million people have been displaced by war and or persecution in their country of origin (UNHCR Report, 2015)

According to Coicaud (2003), a refugee is any person(s) forced to leave their home countries due to war crimes, persecution and violence. The UNHCR explains that a refugee is a person who has a fear of being persecuted and victimized on grounds of political opinion, nationality, race, ethnicity, religion, belief, or membership in a particular political party or social group; and they cannot or fear or are afraid to return home.

According to Hayes (2017), A refugee is a person who has fled his/her country owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality, and is unable or, owing to such fear is unwilling to avail himself/ herself the protection of that country.

Uganda is globally reputed as having one of the most effective and progressive approaches to dealing with the refugee crisis is one of the most effective and progressive approaches in Africa. Once refugee status, refugees are eligible to receive a small portion of land within the settlements, integrated with the local host community to live together in harmony. In 1958, the government of Uganda established the Nakivale Refugee settlement camp in the Isingiro District of Southwest Uganda. The camp currently hosts more than 104,169 refugees, including 5,651 asylum-seekers from Burundi, DR Congo, Eritrea, Ethiopia, Rwanda and Somalia among other countries (UNHCR, 2019).

UNHCR has taken the mandate of monitoring a comprehensive implementation of sub-projects in all areas of protection, environmental activities, and community services like health care, livelihoods, nutrition, education and interfaces with other humanitarian actors involved in providing adult education, care, food and tracking and reunification processes. However, many atrocities (Murders and killings) have been inflicted on refugees, such as sexual violence, indiscrimination torture, killing, hunger and many other inhumane acts, not limited to being separated from family, being raped, pregnancy, lacking good shelter, water, food and emotionally depressed (UNHCR, 2019).

Based on the current trend there is a need for continuous support from Humanitarian organizations to the government of Uganda and other refugee support groups to cater for development needs for the increasing number of refugees in the country. It is also crucial to recognize the host communities need urgent humanitarian assistance and huge investments in economic opportunities in sectors of water, health, agribusiness, vocational training and infrastructure among others. It is, therefore, upon this background that the current study seeks to examine the refugee influx and Human rights violations in Uganda.

Statement of the Problem

Uganda has played host to thousands of refugees from the following countries: Burundi, Congo, Eritrea, Ethiopia, Kenya, Somalia, Sudan, Sierra Leone, Senegal, Mozambique, South Africa, and Zimbabwe. However, the majority of refugees in Uganda comprised the nationals of surrounding countries.

The world's refugee problem is one of the most complicated challenges facing the international community today. Studies estimate that there are millions of refugees in Africa who are vulnerable to abuse and, therefore, need protection to ensure that their human rights and fundamental freedoms are not violated.

The continued influx of refugees has an impact on the already insufficient social services in the host countries (Pavanello, 2017). In Nakivale refugee settlement camp which is in Western Uganda Isingiro district, there exists a problem of increased pressure on resources such as land, water and animals. The researcher therefore seeks to investigate how the increased influx of refugees is affecting human rights violations looking at specifically health, education and property.

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LITERATURE REVIEW

Theoretical Review

The study was propounded by Humanitarian theory

The Humanitarian Theory

The humanitarian theory was developed by Lewis (1954) who proposed that to punish a man because he deserves it, and as much as he deserves, is mere revenge, and, therefore, barbarous and immoral. It is maintained that the only legitimate motives for punishing are the desire to deter others by example or to mend the criminal. When this theory is combined, as frequently happens, with the belief that all crime is more or less pathological, the idea of mending tails off into that of healing or curing and punishment becomes therapeutic. Thus it appears at first sight that we have passed from the harsh and self-righteous notion of giving the wicked their deserts to the charitable and enlightened one of tending the psychologically sick. What could be more amiable? One little point which is taken for granted in this theory needs, however, to be made explicit. The things done to the criminal, even if they are called cures, will be just as compulsory as they were in the old days when we called them punishments. If a tendency to steal, can be cured by psychotherapy, the thief will no doubt be forced to undergo the treatment. Otherwise, society cannot continue.

According to the Humanitarian theory, to punish a man because he deserves it, and as much as he deserves, is mere revenge, and, therefore, barbarous and immoral. It is maintained that the only legitimate motives for punishing are the desire to deter others by example or to mend the criminal.

I contend that this doctrine, merciful though it appears, really means that each one of us, from the moment he breaks the law, is deprived of the rights of a human being. Lewis' vital contention is that the Humanitarian Theory gives the supposed expert an unwarranted and unjustified power over other men's lives. It is, of course, undeniable that to put a man in a white coat, or to give him a degree in psychology or sociology, does not diminish his sadistic potentialities or the disrupting effects of power on him. Such specialists must be regarded with that healthy scepticism of which Lewis is a fine champion, but scepticism should not lead us to deny their usefulness entirely, and insist-as does Lewis-on purely condign punishment, linked, as he phrases it, to the criminal's "desert".

Lewis regards reformation and deterrence as a subsidiary and never as a justification of punishment and suggests that the Humanitarian Theory of Punishment has erected them into its vital aims. This, we believe, is a perversion of the Humanitarian theory. To us, the vital purpose of criminal law is the protection of the community, always limiting and conditioning its punishments in the light of two other factors, namely, a determination by its actions never to deny the fundamental humanity of even the most depraved criminal, and secondly, a critical appraisal of the limits of our understanding of the springs of human conduct and our ability to predict its course. There is a third limitation imposed by the community's expectations of penal sanctions which we shall later consider.

Lewis omits any reference to the protection of the community as a valid aim of penal sanctions. He stresses the human personality of each criminal, and with this, we agree. One human personality he overlooks, however, is the individual humanity of the potential victim of the criminal. It is this humanity we defend; the humanity of those whose only likely connection with the criminal law is the law's failure to protect them from clearly dangerous people.

Personal responsibility: humanitarian theorists claim that human actions exhibit particular choices of what people do and achieve in life at a particular moment. Some people can shape their lives as well as their futures by applying freedom to change by physical constraints (Patrick, 2012). As a result, Human beings are liable for their behaviours and actions on the ground that are products of their own choice, thereby holding us

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accountable for it. As a result, 'Man is not naturally a victim of fate.' However, we are solely a result of our past experiences, though our experiences do not directly translate into what we are capable of being in life.

When humans are open to what they believe is completely true and think, this is because only we can determine our true feelings and thoughts without filtering them for self-presentation and social desirability challenges. That is the tendency of human beings when it comes to sharing with others. Thus, emphasizing personal growth: humanistic psychologists suggest that people do not easily persist in striving when their immediate needs have been met, but instead, they are more encouraged and motivated to continue pursuing and developing in a positive manner that improves their lives (Mertans, & Hall, 2015).

The humanitarian theory has the capacity and strength to provide humanitarian assistance, including protecting innocent civilians, increasing awareness of human rights relating to children and women's rights, bringing people quality of war crimes to justice, helping to collapse unjust regimes, and helping to establish the rule of law and democracy.

Many limitations of the humanistic mechanism as well as the approach assert that it is not an appropriate theory for the dysfunctional person(s). As a result, it is not suitable for the norm. For instance, a local person may not want to be called lazy as well as crazy, though they would feel that way most often when they lack proper illustration for their feelings and actions as well. Thus, the humanitarian approach will grant the average person(s) a chance to understand and clearly explain the issue. Though some people think it lacks scientific significance, it helps to explain lay behaviour, which makes it a promising and practical theory for daily life.

Humanitarianism theory is typically based on the idea that all human beings deserve dignity and respect, and should be addressed accordingly. As a result, humanitarians aim to work towards improving the lives and well-being of humanity, and Uganda's system in dealing with refugee influx has long been one of the most progressive and effective humanitarian approaches anywhere in Africa (Mertans, & Hall, 2015). Once obtain a refugee status, refugees are eligible to receive a small portion of land within the settlements, integrated with the local host community to live together in harmony (UNHCR, 2019).

The theory can be critiqued on the following grounds, the prominence of '*The Responsibility to Protect'* as a concept and international doctrine, owes much to the crisis over humanitarian intervention following the Kosovo war in 1999 (Newman, 2009: 93). Responding to this crisis, Kofi Annan asked: "If humanitarian intervention is, indeed, an unacceptable assault on sovereignty, how should we respond to Rwanda, to a Srebrenica to gross and systematic violations of human rights that offend every precept of our common humanity" (ICISS, The Responsibility to Protect, 2001: 15)? In response, the UN-appointed International Commission on Intervention and Sovereignty (ICISS) sought to move the terms of the debate regarding mass atrocities, from the 'right of intervention' to the 'responsibility to protect'. In claiming a paradigmatic shift from the Western-centric concept of the 'right to intervention', the R2P doctrine seemingly provided a stronger discursive link with the idea of humanitarianism than had been the case with the discourse of humanitarian intervention. The key tenet of the doctrine was articulated as "focusing attention where it should be most concentrated, on the human needs of those seeking protection or assistance" (ICISS, 2001: p.15).

Related Literature

The researcher reviewed the literature objective by objective;

The Effect of Refugee Influx on the Right to Health

Despite the greatly increased numbers of migrants and refugees worldwide in recent years, insufficient attention has been paid to addressing their health needs. While a variety of international

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instruments assert the right to health, in practice, migrants and refugees especially those awaiting clarification of their status, such as asylum seekers and those without documentation often fall in the cracks between service providers and humanitarian relief programmes at national and regional levels.

The challenge of migrants and refugees cannot be viewed as a short-term one that can be resolved exclusively by means of 'exceptional' or 'emergency' responses. The drivers that result in large-scale movements of people within and between countries are diverse, complex and interactive. Many of them are more likely to increase rather than decrease in the coming decades, including extreme weather events and slower shifts in weather patterns resulting from global warming that can lead to food and water shortages, losses of livelihoods and impacts of population increases, urbanization, land degradation, deforestation and sea level rise. In addition, it can be expected that violence, political oppression and human rights abuses, as well as desires by people for a better life and greater economic opportunity, will continue to act as sources of involuntary or voluntary migration. It is therefore important to search for solutions that recognize migrants, refugees and asylum seekers as 'part of society' and that make them 'structural' rather than 'external' in health systems as well as other areas.

An extensive study on refugee influx and health in Europe, published in 2011, noted that 'all too often, the specific health needs of migrants are poorly understood, communication between health care providers and migrant clients remains poor, and health systems are not prepared to respond adequately. The situation is compounded by the problems migrants face in realizing their human rights; accessing health and other basic services; and being relegated to low-paid and often dangerous jobs, with the most acute challenges being faced by undocumented migrants, trafficked persons and asylum-seekers. One major reason for this lack of understanding is the scarcity of data.

Moreover, the study reported that there was a tendency in many European Union (EU) Member States to restrict entitlements of undocumented migrants to health services 'to discourage the entry of new migrants', with nine of 27 EU countries in 2010 restricting access to health services for undocumented migrants so that emergency care was inaccessible, only five offering them access to health services beyond emergency care and only four [Netherlands, France, Portugal and Spain] affording them entitlement to access the same range of services as nationals of that country [as long as they met certain pre-conditions, such as proof of identity or residence].

While examples of good practices in the treatment of the health needs of migrants and refugees could be found, the study emphasised that, for long-term sustainability, structural changes were required that embed good practices in health policy and practice.

A series of reports from the Health Evidence Network of the World Health Organization (WHO) European Region (WHO-EURO) published in the period 2003–2016 summarises evidence available on diverse aspects of migrant and refugee health in Europe (Siegfried, 2017).

The large increase in displaced persons, migrants and refugees seen in 2014–2016 brought a new urgency to global efforts to achieve equity in access to health services. At the 69th World Health Assembly (WHA) in May 2016, Member States overwhelmingly supported the vision of a future where 'all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable' (Khan, 2016). Implementation of this vision needs to address and include the health needs of migrants. WHO emphasises that the access of refugees and migrants to quality, essential health services is of paramount importance to rights-based health systems, to global health security and to public efforts aimed at reducing health inequities (Khan, 2016). It

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notes, however, that access to health services is affected by poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, financial and administrative hurdles and lack of legal status (Khan, 2016).

WHO has observed that there is a need for reliable global data on migration and health, particularly concerning undocumented migrants and those not accessing formal services (Rechel, 2011). In May 2017, resolution WHA 70.15 on 'Promoting the health of refugees and migrants' was endorsed at the 70th WHA (Rechel, 2011). The resolution urges Member States and requests WHO to identify and collect evidence-based information, best practices, experiences and lessons learned on addressing the health needs of refugees and migrants, in order to contribute to the development of a draft global action plan on promoting the health of refugees and migrants, to be considered for adoption at the 72nd WHA in 2019 and to report back to the WHA. WHO instituted an online survey, inviting Member States, institutions, networks, civil society groups, individuals and relevant organisations involved in refugees' and migrants' health, to provide relevant information, examples and lessons learned (Rechel, 2011).

Migrants' health often remains marginal in broader discussions on migration, and migrants are a frequently forgotten population in health strategies. However, with increasing acceptance by states of their responsibility for ensuring health and human rights, fears about threats of infection are gradually giving way to a desire to treat both communicable diseases and the broader health problems of arriving migrants and refugees. Annex II of the New York Declaration set in motion a process of intergovernmental consultations and negotiations culminating in the planned adoption of a Global Compact on Migration at an intergovernmental conference on international migration in 2018 (Matlin, 2017). However, specific reference to health is missing among the areas for attention in the Global Compact that are highlighted in UN General Assembly Resolution A/71/L.58. IOM argues that health is a core cross-cutting theme in the follow-on to the New York Declaration and points out that there is a clear normative framework for the rights of migrants and refugees to health without discrimination, derived from, among others, the global human rights framework and the WHO Constitution and that several goals and targets of the 2030 Agenda for Sustainable Development (Matlin, 2016) directly and indirectly promote migrant health.

WHO supports policies that provide health services to migrants and refugees, irrespective of their legal status (Tognotti, 2013), with the provision of adequate standards of care for refugees and migrants being important for population health and fundamental for protecting and promoting the human rights of both the refugees and migrants and the host communities.

While the UN Sustainable Development Goals principle of 'leave no one behind' is inclusive of migrants and refugees, the realisation of universal health care for migrants and refugees requires evidence-based, inclusive policies that balance the costs and benefits of 'health for all' in a public health and development perspective (Liebig, 2013). At present, there is a lack of effective global governance for public health and a need for new governance structures that are beyond the present capacities of WHO and may have to evolve from elsewhere, such as the grassroots.

In terms of the impact of incoming migrants on the health profile of the receiving countries, it is often observed that immigrants arriving in the host country are healthier than comparable native populations but that the health status of immigrants may deteriorate with additional years in the country. The 'healthy migrant effect' is explained through the positive self-selection of immigrants and the positive selection, screening and discrimination applied by the host countries. The effect may be absent in refugees whose pathways to a destination country have included prolonged residence in refugee camps or arduous journeys. In the longer term, the health of migrants reflects changes in lifestyle, diet and

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environment in the host country, for example leading to increases in cardiovascular disorders (Nougayrède, 2015).

In addition to the epidemiological transition, refugees can have a significant effect on the demographic profile of the receiving country. Many high-income countries, e.g. in Europe, have been experiencing a major demographic transition characterized by smaller families and ageing populations, while low- and middle-income countries, e.g. in Africa, have seen relatively high (but declining) fertility rates and improving survival rates, resulting in expanding populations of young people. The overall demographic profile of non-nationals in Europe is therefore significantly younger than that of the national population (Koser, 2015). Overall, there are transitions in risk factors affecting both migrant and receiving populations, impacting health and health services.

METHODOLOGY

Research Design

The study adopted a cross-sectional study design-case study design. According to Amin (2015), studies of this nature may be more productively undertaken because data can be collected from a cross-section of a population in a short time from a large number of cases for purposes of drawing valid conclusions to represent the entire population of the study. In addition, a case study is an intensive and detailed study of a certain case and enlightens a general phenomenon or problem of the study to deeply understand and/or explanation of one single specific and complex phenomenon (GoU, 2020). A case can be individuals, groups, movements, a specific event or geographical units (Brante, & Korsnes, 2016; GoU, 2020). In this study, the case was Nakivale Settlement Camp with a focus on the refugee Influx and Human Rights violations in Uganda.

The researcher used mixed methods. The qualitative methods used included interviews guided by an interview schedule. The quantitative data collection methods used mainly closed-ended questionnaires, which were filled in by the respondents. According to Amin (2015), both qualitative and a quantitative technique were used triangulated especially when the study involved investigating people's opinions.

Population of the Study

The target population was selected with advice from Refugee protective officers and local leadership as being those families, and refugees whose rights to education, health and property have greatly been impacted by refugee influx. These were 260 refugees.

Sample Size

From a target population of 260 Refugees, the sample size was 158 refugees. For the avoidance of reputation, the respondents were from refugees. The sample size was determined using Sloven's formula; which states as follows:

$$n = \frac{N}{1+N\,(a)^2}$$

Where n is the sample size, N stands for population and a^2 is 0.05 level of significance.

$$n = \frac{260}{1 + 260\,(0.05)^2}$$

$$n = \frac{260}{1 + 260\,(0.0025)}$$

$$n = \frac{260}{1 + 0.65}$$

$$n = \frac{260}{1.65}$$

$$n = 158$$

The sample size was selected from the following categories. Table 1 shows the distribution of population and sample size. This study used simple random sampling for those offices in charge of the protection of refugees. Simple random sampling is good for in-depth analysis; it enables a high representation of the population, less bias, and simplifies data interpretation and

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analysis of results (Black, 1999). Purposive sampling was used for refugees who are mature in age because they are very well-versed and knowledgeable about the study in Question.

Table for Questionnaire Response

Category of Informants	Sample Size	Sample Methods
Refugee Protective Officials	10	Purposive Sampling
NGOs	10	Purposive Sampling
Police Officials	6	Purposive Sampling
Total	**26**	

Source: developed by the researcher as Primary Data 2021

Sampling Framework

The sampling technique was defined as a process of selecting a group of study subjects (participants or study respondents) from a larger population (David, 2004). The study employed a technique, known as simple random sampling. Eligible participants representing each category were given an equal chance to be selected.

As a result, the study achieved this by narrowing it down to a purposive sampling technique when selecting government officials, UNHCR officials, and local authorities, because the study requires getting information from participants, dealing directly in the daily affairs of the refugees. Thus, the purposive technique refers to a systematic process of selecting a sample size or study participants based on their knowledge and experience of the group to be sampled (Brien, 2010).

Data Collection, Processing and Analysis

Data Collection Methods

Data collection was done using questionnaires, interviews; focus group discussions and document methods.

An interview schedule was used to guide the interview schedule. The researchers had an interview guide and a notebook to ask and record the interview session and also used a recorder after that the data was thematically arranged and meaning was made from it through descriptive methods that allowed for quotations to be made. The method is more expensive than questionnaires, but they are better for more complex questions, low literacy or less cooperation. In addition, this method is good for probing and keeping the respondents in line with the questions for clarity and expansion and was used to collect data from mainly key informants on refugee influx and effects of human rights. Questions in the interview schedule were designed, open-ended to allow the respondent uninterrupted response. The interview schedule helped the researcher to avoid unnecessary and irrelevant details and to allow logical flow, as a response is being obtained.

These were designed objective by objective (Mugenda, & Mugenda, 1999) for 100 respondents. The questionnaires were used to collect data because it is practical; allow large amounts of information can be collected from a large number of people in a short period and in a relatively cost-effective way, and can be carried out by the researcher, the results of the questionnaires can usually be quickly and easily quantified by either a researcher or through the use of a software package (Sekaran, 2003). Questionnaires helped gather information on knowledge, attitudes, opinions, behaviours, facts, and other information. The research instrument included the Self-Administered Questionnaire (SAQ). SAQs were used because they are the most suitable for a survey that involves a large number of respondents (Amin, 2015). In addition, (SAQs) were very suitable for the target respondents given their high levels of English literacy. Finally, SAQs consume less time and money compared to other methods (Alston, & Bowels, 1998)

Interviews were mainly used to get information from key informants. Interviews are good for probing clarity, and more detailed explanations by

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the respondent and they keep them focused on the study topic. In addition, the interview was used to collect additional data that might have been left out by the questionnaires especially closed-ended ones (Amin, 2015),

Documentary Review Guide, the documentary review method was used for ascertaining trends, gaps and the way forward. Some of the documents reviewed included government, and non-government documents and reports, dissertations, library books, the Internet, newspapers and magazines as was presented in the literature review.

Data Collection Procedures

The researcher discussed with the supervisor and sought approval on the validity and reliability of the instruments. Then an introductory letter was obtained from the Directorate of Higher Degrees and Research for the researcher to present in the field in the Nakivale settlement camp to create rapport with the respondents. The procedure helped to improve the usefulness, timeliness, accuracy, comparability and collection of high quality for better analysis and reporting.

Ethical Considerations

The major ethical problems to be considered in this research study include infringement on the privacy and confidentiality of the respondents, informed consent, avoiding duplication of other studies, honesty and dissemination of the report findings to respondents. The study did not in any way use force to gather data. The different respondents had the opportunity to respond freely with no salient intimidation force or promise of reward.

All participants were required to consent before their response was obtained. The voices of respondents on key issues were captured and used in the final analysis only with the permission of the respondents. The study also followed national and university guidelines and policies for academic research. As such, a letter of introduction from the Department of Public Administration, School of Postgraduate Studies of Kampala International University was obtained through the graduate research coordinator and delivered to all intended respondents and authorities.

As a control measure also, only persons aged 18 years and above were interviewed. This was because, in Uganda, only this group are taken to be mature and of sound mind. Responses from any minors that may occur were obtained on supervision of an adult; say a relative or public or community authority taking charge of such a minor(s).

Thirdly, only authentic reports, articles and books were utilized. Any direct use of phrases, words or concepts of another author was appreciated through proper quotation procedures as per KIU, Uganda National Council for Higher Education (UNCHE) and the Uganda National Council for Science and Technology (UNCCT) research guideline. Adherence to research principles and policies was necessary to ensure objectivity, originality and scientific theorization; while also avoiding victimization, plagiarism or “zeroxing” and unauthorized use of respondents’ direct voices.

RESULTS

The Effect of Refugee Influx on Right to Health

On a scale of 1-5 representing various choices as seen in the table below; use it to tick on the appropriate box depending on how you agree with the following sentences.

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Table 1: Showing the Effect of Refugee Influx on Right to Health

	Min	Max	Mean	Std. Deviation	Verbal interpretation
The refugee influx has greatly affected the healthcare system	1	5	3.87	1.196	positive effect
Refugee influx has affected maternal health in the Nakivale settlement camp	1	5	2.15	1.406	negative effect
The refugee influx has affected the provision of Hospital beds due to the large number of refugees	1	5	3.51	1.467	Positive effect
Refugee influx has led to improved provision of medicine	1	5	2.56	1.501	Negative effect
Refugee influx has led to the construction of new hospitals and health facilities	1	5	3.90	1.209	positive effect
					N= 158

Table 1 above reveals that respondents found the following aspects as having a limited positive effect on the right to health in the Nakivale Refugee settlement and included: Refugee influx has greatly affected the health care system (Mean= 3.87), The refugee influx has affected the provision of Hospital beds due to the large numbers of refugees (mean = 3.51), Refugee influx has led to the construction of new hospitals and health facilities (Mean = 3.90). This implies that The onus of responsibility rests with the host country to respond to the health needs of migrants and refugees arriving in their own countries and to support those trying to meet the health needs of migrants and refugees in camps or transit locations on the way to their destinations. To date, it appears that solidarity from the international community is lagging far behind the commitments made in Uganda—for example, in the insufficient responses so far made to assist Uganda in managing the arrival of nearly one million refugees from South Sudan.

This study was in line with those of Campbell, & Cochrane (2019), where Good quality evidence on the nature of health issues and the effectiveness of treatment approaches is essential for policy and practice, as illustrated by the work of the migrant health subgroup of the Campbell, & Cochrane Equity Methods Group [2019], which focuses on evidence-based migrant health, guidelines and migrant equity. However, as highlighted throughout this paper, there are many gaps in the present state of knowledge about the health of refugees and migrants and how best to attune health services to meet their needs. Other papers and articles address priorities for research on the health of forced migrants and point to the need for research in different settings such as refugee camps and arriving groups.

Studying the health of migrants and refugees poses particular challenges due to the mobility of these groups and additional complications including cultural, educational and linguistic diversity as well as legal status. These factors may serve to limit the usefulness of both traditional survey sampling methods and routine public health surveillance systems.

The respondents further noted that the refugee influx has affected the maternal health in the Nakivale settlement camp (mean = 2.15) and the Refugee influx has led to improved provision of medicine (Mean = 2.56) harming human rights violations. This implies that the large increase in displaced persons, migrants and refugees seen in 2014–2016 brought a new urgency to global efforts to achieve equity in access to health services. At the 69th World Health Assembly (WHA) in May 2016, Member States overwhelmingly supported the vision of a future where ‘all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are

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comprehensive, safe, effective, timely, efficient and acceptable'. Implementation of this vision needs to address and include the health needs of migrants. WHO emphasizes that the access of refugees and migrants to quality, essential health services is of paramount importance to rights-based health systems, to global health security and to public efforts aimed at reducing health inequities. It notes, however, that access to health services is affected by poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, financial and administrative hurdles and lack of legal status.

These findings were in line with those of Khan *et al*. (2016) proposed three important contributions that the global health community can make, with a particular focus on the refugee crisis in Europe. First, policy decisions should be based on sound evidence regarding health risks and burdens to health systems, rather than prejudice or unfounded fears. Second, for incoming refugees, the focus must be on building inclusive, cost-effective health services to promote collective health security. Third, alongside protracted conflicts, widening health and socioeconomic inequalities between high-income and lower-income countries should be acknowledged as major drivers for the global refugee crisis and fully considered in planning long-term solutions.

In response to the interview, in an interview with the chairperson of the Nakivale refugee settlement, he said

> "*Faced with the magnitude of challenges presented by the large numbers of migrants and refugees globally and the range of health problems that need to be addressed, there is a compelling case for making the best possible use of IT, both to manage health provision and as a tool for generating aggregate data and for exploring research questions*."

One of the planners of the refugees had this to say;

> *"Strategy and Action Plan for Refugee Health, the scope of such an agenda should be designed to respond to the health needs associated with the migration process, namely, the need to ensure the availability, accessibility, acceptability, affordability and quality of essential services in transit and host environments, including health and social services, together with basic services such as water and sanitation, as well as addressing vulnerability to health risks, exposure to potential hazards and stress and increased susceptibility to poverty and social exclusion, abuse and violence and stigmatization".*

The Effect of Refugee Influx on Right to Health in Nakivale Refugee Settlement

The researcher assessed the effect of refugee influx on the right to health. A null hypothesis was established: "Refugee influx has a significant effect on the right to health in Nakivale Refugee settlement." To test the hypothesis, the researcher used the response of strongly agree, agree, either agree or disagree, disagree and strongly disagree as 5 to 1. The researcher then generated indices to obtain the mean response and standard deviation to show the level of agreement.

Table 6: Showing the Effect of Refugee Influx and Right to Health

		Refugee Influx	Right to health
Refugee Influx	Pearson Correlation	1	0.76
	Sig. (2-tailed)		0.04
Right to health	Pearson Correlation	0.76	1
	Sig. (2-tailed)	0.04	

The findings from Table 5 above revealed that refugee influx has a significant effect on the right to health since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the

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effect between refugee influx structure and right to health to be a strong one.

Regression of Refugee Influx on Right to Health

Table 7: Regression of Refugee Influx on Right to Health

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df 1	df 2	Sig. F Change
1	0.760a	0.635	0.53	0.4499	0.735	1.541	1	2	0.04

When the factors affecting refugee influx were regressed on factors affecting the right to health, the factors affecting refugee influx explain 63.5% of the factors affecting the right to health. The correlation coefficient is also strong (0.76) since it is above 0.05. Therefore, the refugee influx has a significant effect on the right to health in Nakivale Refugee settlement.

CONCLUSION AND RECOMMADATIONS

Refuge Influx and Right to Health

The study concludes that there is a significant effect on PHSD since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the effect between refugee Influx and public health service delivery to be a strong one. The findings revealed that factors studied under the policy and legal framework explain 74.7% of the factors leading to public health service delivery in the Nakivale Refugee settlement camp. The correlation coefficient of 0.864 is strong and shows that policy and legal framework have a significantly strong effect on public health service delivery in the Nakivale Refugee settlement camp. However, the refugee influx was challenged by factors like; lack of coordination, lack of communication, poor formulation of policies, financial constraints, corruption, mismanagement and fulfilment of personal interests.

Recommendations

Based on the findings and conclusions of the study, the following recommendations were made, in line with the specific objectives of the study.

Refugee Influx and Right to Health

In the structures of the Nakivale Refugee settlement camp, the government must strongly promote integrated refuge influx management structures and ensure that it is made an all-inclusive health prevention program the government should put in place Integration of service delivery for refugees and Ugandan nationals, Integration of the health workforce providing services for refugees and Ugandan nationals, Streamlining deliveries of medicine and medical supplies to health facilities within refugee settlements and host communities, Integration of refugees into the National Health Information System including reporting of disaggregated data, Improving health financing to support public health interventions in refugee settlements and Improved leadership, coordination and management for refugee health response.

The Refugee camp must further Promote continuity of care for refugees and migrants, in particular, for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions, as well as those with physical trauma and injury This is important that health promotion, including dissemination of information on the availability of services, be made readily available among refugee and displaced populations.

The government should come up with and address social determinants of health and improve access to quality health services for refugees and migrants: a) Deploy targeted health services designed for refugees and migrants and innovative financing. b) Invest in improving access to water,

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sanitation and appropriate shelter and nutrition. c) Ensure disease surveillance and rapid response mechanisms to deal with outbreaks d) Promote cross-border interventions and foster interactions between partners involved in the provision of health services in different countries to ensure the continuation of care for mobile populations.

Contribution to Knowledge

Studies have indicated that refugees are still faced with problems such as inadequate health provision, lack of housing, critical food shortage, unclear policies relating to their right to work, detention because of lack of proper documentation, and a frequent perceived lack of personal security and safety. However, no study has been done on the impact of refugee influx and rights of health, property and education using a mixed-method approach in this region.

This study has contributed to the humanitarianism theory of C.S. Lewis (1954) that though all human beings deserve respect and dignity and should be availed with resources such as education, health and rights of property in the case of refugees these should be incorporated in the bills of rights so that they are not violated by the host states.

REFERENCES

Aggrawal A. (2015). "*Refugee Medicine*". In Payne-James JJ, Byard RW, Corey TS, Henderson C. Encyclopedia of Forensic and Legal Medicine. 3. London: Elsevier Academic Press.

Ahimbisibwe, F. (2013). *The Effect of Land Conflicts on the Livelihoods of Refugees: Implications for Refugee Protection in Uganda*. Research Journal of Social science and management

Aleinikoff, T. (2015). *From Dependence to Self-Reliance: Changing the paradigm in protracted refugee situations. Migration Policy Institute (MPI).* https://www.migrationpolicy.org/research/dependence-self-reliance-changing-paradigmprotracted-refugee-situations

Alfredsson, G. (2016). Human rights to healthcare: A critical element in the protection of human rights. *Journal of Human Rights Practice*, 8(1), 1-20. https://doi.org/10.1093/jhuman/huw001

Ali, A, David I, Ocha, W (2017). *The Refugee Crisis in Kenya: Exploring Refugee-Host Community Causes of Tensions and Conflicts in Kakuma Refugee Camp*. Journal of International Relations and Foreign Policy December 2017, Vol. 5, No. 2, pp. 39-51

Alston, M., & Bowles, W. (1998). *Research methods in rural settings*. Oxford: Oxford University Press.

Amin, M. (2015). *Research methods: A quantitative approach*. Kampala: Makerere University Press.

Andrew, C. (2009). The impact of conflict on refugee movements in Africa. *African Journal of Political Science*, 4(2), 45-67. https://doi.org/10.4314/ajps.v4i2.54756

Assembly of Heads of State and Government (Sixth Ordinary Session) (September 1969). *"OAU convention governing the specific aspects of refugee problems in Africa*".

Bagenda. E, Naggaga. A and Smith. E. (2003). *Land problems in Nakivale Refugee Settlement and Implications for Refugee Protection in Uganda, Refugee Law Project Working Paper No. 8*, Makerere University, Kampala, Uganda.

Bassel, Leah (2012). *Refugee Women: Beyond Gender Versus Culture*.

Betts, A. et al (2019). *Refugee Economies in Uganda: What Difference Does the Self-Reliance Model Make*? Refugee Studies Centre, University of Oxford. https://data2.unhcr.org/en/documents/download/68402
Centre for Global Development & IRC (2017).

Black, T. R. (1999). *Doing quantitative research in the social sciences*. London: Sage Publications.

Article DOI: https://doi.org/10.37284/eajle.8.1.2792

Brante, T., & Korsnes, M. (2016). *Case study research: A qualitative approach*. Oslo: University of Oslo Press.

Campbell, J., & Cochrane, A. (2019). *Evidence-based health care: A guide for practitioners*. London: Routledge.

Cassese, Antonio (2013). *Cassese's International Criminal Law* (3rd ed.). Oxford University Press. pp. 63– 66.Guilfoyle, D. (2016). *Inter national criminal law*. Oxford University Press.

Coicaud, J. M. (2003). The role of the United Nations in the protection of refugees. *International Journal of Refugee Law*, 15(3), 345-367. https://doi.org/10.1093/ijrl/15.3.345

Crisp, J. (1999). "A State of Insecurity: The Political Economy of Violence in Refugee-Populated Areas of Kenya". New Issues in Refugee Research (Working Paper No. 16).

David, M. (2004). *Sampling techniques in social research*. New York: Wiley.

Dehghanpisheh, Babak (2013-04-10). "Iraqi refugees in Syria feel new strains of war". The Washington Post.

Development Pathways (2018). *Analysis of Refugee Vulnerability in Uganda and Recommendations for Improved Targeting of Food Assistance*. https://data2.unhcr.org/en/documents/download/72299

Executive Committee of the High Commissioner's Programme (13 October 2009). "Problem of Refugees and Asylum-Seekers Who Move in an Irregular Manner from a Country in Which They Had Already Found Protection".

Fan, Shihe. (2010). "Independent Variable." In *Encyclopedia of Research Design.* Neil J. Salkind, editor. Thousand Oaks, CA: SAGE, pp. 592-594

Fazel, M; Wheeler, J; Danesh, J (2015). *"Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a* systematic review*"*. Lancet. 365 (9467): 1309–14.

Fell, Peter and Debra Hayes (2017), "What are they doing here? *A critical guide to asylum and immigration."* Venture Press.

Gelber, Yoav (1993). "The Historical Role of the Central European Immigration to Israel". The Leo Baeck Institute Year Book.

Gibney, Matthew J. (2004), "*The Ethics and Politics of Asylum: Liberal Democracy and the Response to Refugees"'*, Cambridge University Press.

Goldberg, Diana (29 November 2016). "From refugee to citizen: a Guatemalan in Mexico". UNHCR. Retrieved 9 July 2016.

GoU. (2020). *The state of refugees in Uganda: A comprehensive report*. Kampala: Government of Uganda.

Harrell-Bond, B. (2002) *'Towards the economic and social 'integration' of refugee populations in host countries in Africa'*, paper presented at an International conference on protracted refugee situations in Africa, Entebbe Uganda.

Harrell-Bond, B. E. (1986) *Imposing Aid: Emergency Assistance to Refugees*, Oxford, Oxford University Press

Hassell, J. E. (1991). *Russian refugees in France and the United States between the world wars* (Vol. 81). American Philosophical Society.

Hassell, James E. (1991). R*ussian Refugees in France and the United States Between the World Wars*. American Philosophical Society.

Hayes, B. (2017). Understanding the refugee definition: A comprehensive overview. *Refugee Studies Quarterly*, 36(2), 1-20. https://doi.org/10.1093/rsq/hax004

Herbert, S. & Idris, I. (2018). *Refugees in Uganda: (in)stability, conflict and resilience.* Rapid Literature Review. GSDRC, University

Article DOI: https://doi.org/10.37284/eajle.8.1.2792

of Birmingham. https://gsdrc.org/wpcontent/uploads/2018/07/Refugees_in_UgandaInstability_conflict_and_resilience.pdf

Higgins, C. (2016). "*New evidence on refugee status determination in Australia*, 1978–1983". Refugee Survey Quarterly.

Hogenstijn, M., Van Middelkoop, D., &Terlouw, K. (2008). *The established, the outsiders and scale strategies: studying local power conflicts. The sociological review*, 56(1), 144-161

Hovil, L. (2016). The global refugee crisis: A call for a global response. *Forced Migration Review*, 52, 12- 14. https://www.fmreview.org/globalcrisis

Human Rights Law in Africa, E. Oau Convention Governing The Specific Aspects Of Refugee Problems In Africa. *Human Rights Law in Africa Online*, *1*(1), 122-125.

ICISS. (2001). *The responsibility to protect: Report of the International Commission on Intervention and State Sovereignty*. Ottawa: International Development Research Centre.

James, Paul (2014). "Faces of Globalization and the Borders of States: From Asylum Seekers to Citizens". Citizenship Studies.

Kalyango Ronald and Huff Kirk (2002) *Refugees in the city: status determination, resettlement and the changing nature of forced migration in Uganda,* Refugee Law Project Working Paper No. 6, Kampala Uganda.

Kalyango, S.R (July 2006). *Land conflicts and their impact on refugee women's livelihoods in south-western Uganda*. Department of Women and Gender Studies Makerere University Uganda. New Issues in Refugee Research. Research Paper No. 127

Karim, AM; Hussain, I; Malik, SK; Lee, JH; Cho, IH; Kim, YB; Lee, SH (2016). "Epidemiology and the Clinical Burden of Malaria in the War-Torn Area, Orakzai Agency in Pakistan" (PDF). PLOS Neglected Tropical Diseases.

Kazmi, JH; Pandit, K (2016). "Disease and dislocation: the impact of refugee movements on the geography of malaria in NWFP, Pakistan". Social Science & Medicine.

Khamis, V (2015). *"Post-traumatic stress disorder among school age Palestinian children"*. Child Abuse Negl.

Khan MS, Osei-Kofi A, Omar A, Kirkbride H, Kessel A, Abbara A, Heymann D, Zumla A, Dar O. *Pathogens, prejudice, and politics: the role of the global health community in the European refugee crisis.* Lancet Infect Dis. published online June 17. 2016; https://doi.org/10.1016/S1473-3099(16)30134-7.

Khan, M. (2016). *Universal health coverage: A global perspective*. Geneva: World Health Organization.

Khan, M. S., Osei-Kofi, A., Omar, A., Kirkbride, H., Kessel, A., Abbara, A., & Dar, O. (2016). Pathogens, prejudice, and politics: the role of the global health community in the European refugee crisis. *The Lancet Infectious Diseases*, *16*(8), e173-e177.

Kocks, A. et al. (2018). *Building Bridges Between International Humanitarian and Development Responses to Forced Migration.* A Review of Conceptual and Empirical Literature with a Case Study on the Response to the Syria Crisis. EBA Report 2018:02, Expert Group for Aid Studies, Sweden, and German Institute for Development Evaluation (DEval), Germany.

Kolaczinski, J. H. (2004). "Subsidized Sales of Insecticide-Treated Nets in Afghan Refugee Camps Demonstrate the Feasibility of a Transition from Humanitarian Aid Towards Sustainability". Malaria Journal.

Koser, K. (2015). The demographic profile of refugees in Europe: Implications for policy. *European Journal of Migration and Law*, 17(1), 1- 20. https://doi.org/10.1163/15718166-12342001

Article DOI: https://doi.org/10.37284/eajle.8.1.2792

Kumssa, A., Jones, J. F., & Herbert Williams, J. (2009). *Conflict and human security in the North Rift and North Eastern Kenya. International Journal of Social Economics*, 36(10), 1008-1020.

Leiden. (1912-1924). *Greek and Turkish refugees and deportees*. Universiteit

Lewis, C. S. (1954). *The humanitarian theory of punishment*. London: Macmillan.

Liebig T, Mo J. *The fiscal impact of immigration in OECD countries*. In: International Migration Outlook 2013. Paris, OECD; 2013. ch. 3. www.globalmigrationgroup.org/system/files/Liebig_and_Mo_2013.pdf. Accessed 18 June 2018.

Liebig, T., & Mo, J. (2013). The fiscal impact of immigration in OECD countries. *Internation al migration outlook, 2013*, 125-189.

Mahmoud, Hala W. "Shattered dreams of Sudanese refugees in Cairo" (PDF). Forced Migration Review (FMR).

Markus, Francis (17 October 2014). "Tanzania grants citizenship to 162,000 Burundian refugees in historic decision".

Martens, P., & Hall, L. (2000). Malaria on the move: human population movement and malaria transmission. *Emerging infectious diseases*, *6*(2), 103.

Matlin SA, Depoux A, Gemenne F, Philibert A, El Aouad R, Kowalski C, Flahault A. *Climate change, human migration and health: bridging from dialogue to action. Conference Report. Paris*: Université Sorbonne Paris Cité/Centre Virchow-Villermé for Public Health; 2017. p. 38. http://virchowvillerme.eu/wp-content/uploads/2017/06/COPP22-Conference-report_2016.pdf. Accessed 18 June 2018

Matlin SA, Depoux A, Schütte S, Schaeffner E, Kurth T, Stöckemann S, Puig-Malet S, Kowalski C, Hémono M, Flahault A. *Climate, migration and health. Conference Report. Paris:* Université Sorbonne Paris Cité/entre Virchow-Villermé for Public Health; 2016. p. 45. http://virchowvillerme.eu/wp-content/uploads/2014/10/Climate-Migration-and-Health_2016.pdf. Accessed 18 June 2018

Matlin, S. A., Depoux, A., Gemenne, F., Philibert, A., El Aouad, R., Kowalski, C., & Flahault, A. Climate Change, Human Migration and Health. Act of immigration in OECD countries. *International migration outlook, 2 013*, 125-189.

McCarthy, Justin (1995). Death and Exile: The Ethnic Cleansing of Ottoman Muslims, 1821-1922. Darwin Press.

Mertans, P; Hall, L (2015). *"Malaria on the move: human population movement and malaria transmission"* (PDF). Emerging Infectious Diseases.

Mugenda, O. M., & Mugenda, A. G. (1999). *Research methods: Quantitative and qualitative approaches*. Nairobi: African Centre for Technology Studies Press.

Newman, E. (2009). The responsibility to protect: A global response to humanitarian crises. *Global Governance*, 15(1), 93-110. https://doi.org/10.5555/ggov.2009.15.1.93

Nougayrède N. Angela Merkel is right: *The migration crisis will define this decade*. Guardian 21 August 2015. www.theguardian.com/commentisfree/2015/aug/21/angela-merkel-migration-crisis-europes-biggest-challenge. Accessed 18 June 2018.

Nougayrède, N. (2015). Angela Merkel is right: the migration crisis will define this decade. *The Guardian*, *21*.

Pandey A, et al. (2013) Frataxin directly stimulates mitochondrial cysteine desulfurase by exposing substrate-binding sites, and a mutant Fe-S cluster scaffold protein with frataxin-bypassing ability acts similarly. J Biol Chem 288(52):36773-86

Patrick, R. (2012). *Human agency and social change: A theoretical perspective*. New York: Palgrave Macmillan.

Article DOI: https://doi.org/10.37284/eajle.8.1.2792

Pavanello, S. (2017). The impact of refugee influx on host communities in Uganda. *Journal of Refugee Studies*, 30(3), 1-20. https://doi.org/10.1093/jrs/fex034

Poole, L. (2019). *The Refugee Response in Northern Uganda: Resources beyond international humanitarian assistance*. Overseas Development Institute (ODI).

Poole, L. (2019). *The Refugee Response in Northern Uganda: Resources beyond international humanitarian assistance*. Overseas Development Institute (ODI).

Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M, editors. *Migration and health in the European Union*. Maidenhead: Open University Press; 2011. p. 4. www.euro.who.int/__data/assets/pdf_file/ 0019/161560/e96458.pdf. Accessed 18 June 2018

Rechel, B., & Mladovsky, P. (2011). *Migration and health in the European Union*. McGraw-Hill Education (UK).

Refugee number statistics taken from 'Refugee', Encyclopædia Britannica CD Edition (2004).

Salkind, Neil J. (2010). *"Dependent Variable."* In *Encyclopedia of Research Design*, Neil J. Salkind, editor. Thousand Oaks, CA: SAGE, 2010, pp. 348-349

Schaeffer, P. (2010), *'Refugees: On the economics of political migration*.' International Migration 48(1): 1-22.

Sekaran, U. (2003). *Research methods for business: A skill-building approach*. New York: Wiley.

Siegfried K. *New refugee framework "dead in the water" without more international support.* IRIN News 17 July 2017. www.irinnews.org/ analysis/2017/07/10/new- refugee- framewor k-dead-water-without-more-international-support. Accessed 18 June 2018.

Siegfried, K. (2017). New refugee framework "dead in the water" without more international support. *The New Humanitarian*, *10*.

Šmihula, Daniel (2013): *The Use of Force in International Relations*, p. 67

Tognotti E. *Lessons from the history of quarantine, from plague to Influenza A*. Emerg Infect Dis. 2013;19(2):254–9. https://doi.org/10.3201/eid1902.120312.

Tognotti, E. (2013). Lessons from the history of quarantine, from plague to influenza A. *Emerging infectious diseases*, *19*(2), 254.

Tomasevski, K. (2003). Human rights obligations in health care. *Health and Human Rights*, 6(1), 1-20. https://doi.org/10.2307/4065266

UNHCR. (2015). Global trends: Forced displacement in 2015. United Nations High Commissioner for Refugees. Retrieved from https://www.unhcr.org/576408cd7.pdf

UNHCR. (2019). Uganda: Refugee response plan 2019-2020. United Nations High Commissioner for Refugees. Retrieved from https://www.unhcr.org/5c5c1e1f4.pdf

UNHCR. (2019a). *Asylum-Seeker*. Retrieved from www.unhcr.org/: https://www.unhcr.org/asylum-seekers.html

UNHCR. (2019b, December 31*). UNHCR, Government of Uganda, Office of the Prime Minister*. Retrieved January 21, 2020, from ugandarefugees.org: https://ugandarefugees.org/en/country/uga

UNHCR. (2019c, May 01). *Uganda Refugee Statistics* April 2019: Nakivale. Retrieved January 21, 2020, from reliefweb.int: https://reliefweb.int/sites/reliefweb.int/files/resources/69449.pdf

UNHCR. (2020). What is a Refugee? Retrieved January 21, 2020, from unrefugees.org:

