ACCESS TO COVID-19 VACCINES FOR REFUGEES IN UGANDA
Oxfam in Uganda recognizes the need for equitable access to vaccines and affordable healthcare services for everyone – including refugees and asylum seekers. Ensuring that COVID-19 vaccines are available and accessible to refugees is critical in the fight against the pandemic in Uganda. It is thus important to identify and address barriers that refugees are facing in accessing vaccines.
INTRODUCTION

The only way out of the COVID-19 pandemic is for everyone, everywhere, to have equitable and swift access to vaccines. As Uganda is host to over 1.5 million refugees, it is critical for the country’s fight against COVID-19 to include refugees in its vaccine campaign.

For many countries, 2021 saw a shortage of vaccine doses, preventing most refugees and host communities alike from being vaccinated. In Uganda, 2022 has begun with the promise of increased vaccine supplies through COVAX. Therefore, it is important to consider how to effectively deliver these vaccines in a way that adequately and equitably reaches all populations.

This paper examines Uganda’s efforts to vaccinate refugees, and identifies a number of major barriers to vaccine access, particularly:

- Administrative barriers (e.g., the need to show ID, exclusion by frontline health workers);
- Physical, financial and social challenges in accessing vaccine centres;
- Logistical barriers, including the lack of existing healthcare infrastructure and cold chain infrastructure for vaccine delivery;
- A lack of information and outreach to refugee communities; and
- Vaccine hesitancy.

The paper concludes with recommendations on how to overcome these barriers, including:

- Introduce more flexible ID requirements for vaccination;
- Provide vaccines where refugees are, through door-to-door or mobile vaccine campaigns, and/or ensuring health centres in close proximity to refugee settlements are able to provide vaccines;
- Run targeted outreach campaigns for refugees, in languages they understand, about how and why to get the vaccine; and
- Work closely with civil society, refugee-led organizations, and community and women leaders to ensure the success of vaccination campaigns.
2 COVID-19 VACCINATION IN UGANDA

Uganda registered its first case of COVID-19 on 21 March 2020. Almost one year later, on 10 March 2021, Uganda launched its vaccination campaign at the Mulago National Referral Hospital, having received its first shipment of vaccines – 864,000 doses of the AstraZeneca vaccine – from the COVAX facility.

The campaign began by targeting:
- healthcare workers and support personnel (150,000 people);
- security personnel (250,000 people); and
- teachers and educational staff (550,000 people).

This was followed by essential service workers, and people aged over 50 (3.3 million people), as well as younger people with certain underlying illnesses.

Vaccination is now available to anyone over the age of 18, but the country is still struggling to vaccinate its population.

As of February 2022, Uganda has received roughly 36 million COVID-19 vaccines, over 33.5 million of these via COVAX. As a result of a range of factors – including short shelf lives of some of the donated doses leading to expiry before delivery, as well as slow vaccine uptake – only around 14.92 million of these doses have been administered. Approximately 27% of people in Uganda have received a first dose of the vaccine, and under 5% are fully vaccinated.

2.1 VACCINATION OF REFUGEES

Uganda has one of the largest refugee populations in the world, hosting over 1.5 million refugees and asylum seekers. This is due to several regional factors, especially war and violence in South Sudan and the Democratic Republic of Congo, and associated economic crisis and political instability in the region.

Uganda has been praised for having one of the most progressive and generous refugee regimes in the world, with policies providing rights to education, work, private property, healthcare and other basic social services. The Ugandan 2006 Refugee Act and 2010 Refugee Regulations allow for the integration of refugees within host communities, with refugees having access to the same public services as nationals. In fact, the 2016 UN Summit for Refugees declared Uganda’s refugee policy a model.

In line with its inclusive refugee policies, refugees are included in Uganda’s national COVID-19 response and vaccination plans, and are permitted to
access vaccines on an equal timeline as citizens.

When Uganda launched its vaccination campaign in March 2021, refugees who fell into the priority groups – such as refugee healthcare workers or those over the age of 50 – were eligible. In May 2021, the government first began extending COVID-19 vaccination campaigns to refugee settlements.9

Now, all refugees aged over 18 are eligible to receive the vaccine, but barriers to access persist, and stronger efforts are needed to ensure that assurances for refugee inclusion in COVID-19 vaccination turn into reality.

Table 1: COVID-19 statistics for refugees in Uganda, November 2021

<table>
<thead>
<tr>
<th>Refugees tested</th>
<th>Refugees tested positive</th>
<th>Cases recovered</th>
<th>Refugee deaths</th>
<th>Refugees receiving first dose</th>
<th>Refugees receiving second dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>31,196</td>
<td>3,347</td>
<td>3,179</td>
<td>52</td>
<td>12,963</td>
<td>3,149</td>
</tr>
</tbody>
</table>


According to the most recent available statistics broken down by refugee population, shown in Table 1, in November 2021 of the 1.5 million refugees in Uganda, 0.86% had received a first dose, and 0.21% had been fully vaccinated. This is significantly below the national averages at the same time - as of 15 November 2021, 8.2% of the population in Uganda had received a first dose, and just under 1.9% were fully vaccinated.10
3 BARRIERS TO VACCINE ACCESS FOR REFUGEES

There are many formal and informal barriers to healthcare access for refugees that predate the pandemic, as well as a number of specific barriers to vaccine access. These are sometimes invisible at the policy level, although similar issues have been noted for refugees around the world.

There is a need to understand these barriers, adopt measures to overcome them, and establish procedures that facilitate equitable access to vaccination.

3.1 ADMINISTRATIVE BARRIERS

The administrative requirements of registering for and receiving vaccines can present a challenge for many refugees:

- Because of the initial scarcity of doses, eligible people were required to visit health facilities on a few designated days.
- All eligible refugees must bring their refugee ID card with them to vaccination. This excludes those who do not have one. The Ugandan government has attempted to minimize this barrier by allowing refugees without ID to instead obtain a letter from the Office of the Prime Minister (OPM), although this can be a cumbersome administrative process.
- Upon presentation of proof of identification, a refugee is expected to complete a form to be issued a vaccination card that permits immunization. The registration form and vaccination card are written in English, which can cause problems for those refugees who do not understand the language.

It has been reported by a number of refugee representatives that refugees have also faced discriminatory practices by some healthcare workers, counter to in contravention of official policies. Throughout the vaccination drive, there have been stories of refugees being turned away from public health facilities even though they have valid refugee ID cards. For example, when Jean Mwene, a Rwandan refugee, learned that Uganda had started vaccinating against COVID-19 in March 2021, he quickly went to a public health centre in Kampala. ‘When I got there, I was told that they were only vaccinating those with identity cards. When I produced my refugee card, they said the vaccine was only for Ugandan citizens,’ he told freelance journalist Evelyn Lirri.

Whether such practices are deliberate acts of discrimination or a result of healthcare workers’ ignorance of official policy, they must be urgently addressed.

‘Do away with the requirements for documentation – not everyone has an ID.’
- Refugee-led organisation, Adjumani district
3.2 PHYSICAL BARRIERS

COVID-19 vaccinations in Uganda are mostly administered in public health facilities, including national and regional referral hospitals, general hospitals, health centre IVs (county level) and health centre IIIIs (sub-county level). There are approximately 840 vaccination sites across 136 districts. However, information on vaccination sites is not necessarily available to all refugees, especially those in settlements without health centres undertaking COVID-19 vaccination.

There have been efforts to provide vaccines in some refugee settlements, with health facilities established by implementing partners like Yinga Health Centre III and Ocea Health Centre III in Imvepi and Rhino camps, respectively. However, many refugees have had to find their way to the nearest health centre III (at sub-county level) or IV (at district level).

Unfortunately, the health centre IIIIs closest to refugee settlements do not all provide vaccines, so most refugees must travel 5–30km. The majority of refugees walk to these facilities; usually the only other available modes of transport are cycling, or, for the few who can afford it, ‘boda boda’ motorcycle taxis. The cost of transport and/or the time away from work or caring responsibilities is prohibitive for many refugees.

These transport issues can present an even greater barrier for women, who tend to face greater time poverty than men and may not be able to travel safely outside of their home or local area. The distance and accessibility of vaccine delivery sites can be even greater barriers to displaced people with disabilities and the elderly, who are also often particularly vulnerable to COVID-19.

3.3 LOGISTICAL BARRIERS

An Oxfam survey of refugee representatives in Uganda found that most are aware that the vaccine is free of charge to both nationals and refugees.

However, government programmes and NGOs are facing challenges delivering and storing COVID-19 vaccines in refugee camps and remote settlements.

For instance, a district official told Oxfam that vaccine delivery faced challenges given the specific conditions needed to keep doses (e.g. cold storage) as well as, with many vaccines, the need to coordinate people to receive two doses. A lack of healthcare infrastructure can also increase the complexity of effectively delivering vaccines in refugee settlements. Significant investment is required in these areas to ensure effective vaccine delivery.
Timely, accurate and reliable information about the efficacy, safety and availability of COVID-19 vaccines is essential for promoting vaccine uptake, acceptance and trust.21 However, there has been a lack of targeted outreach to sensitize refugees in Uganda. As a result, many refugees still do not know how or why to get vaccinated, and misinformation has spread in many communities.

Mass media, public health campaigns and outreach activities have been the primary means to reach communities with COVID-19 information in Uganda. The government and its partners have largely relied on relaying messages through radio, TV and the internet to encourage populations to be vaccinated.

However, the generic public health campaigns used by the government have largely excluded refugees, because:

- The communication channels used are unavailable to many refugees, who do not have access to radio, TV or internet services.
- The messages are delivered in English or local languages of Uganda, which many refugees do not (completely) understand.
- Public outreach campaigns have been themselves disrupted by pandemic restrictions, and have not thus been as intensive as the campaigns conducted around Uganda’s six best-known preventable diseases (i.e. polio, measles, tuberculosis, diphtheria, whooping cough and tetanus).

There have not been any national information campaigns tailored to specifically target refugees with vaccination information.

Some refugee-led organizations, and local and national NGOs have run mini-outreach projects for refugees. These organizations are best placed to assess the needs of these communities, undertaking outreach in local languages and culturally appropriate ways. However, they need government support in terms of up-to-date information, training, finances and technical resources to effectively conduct these projects.

Healthcare workers at the sub-national level working with refugees are also vital actors in disseminating information about COVID-19.22 However, not all healthcare workers have received adequate training from government to provide the necessary information to refugees. Indeed, some government healthcare workers are even unaware that refugees are eligible to be vaccinated [see Section 3.1].

Refugees without adequate information will often rely on information from vaccinated peers. While this seems a logical approach, unfortunately, word-of-mouth has often led to the exaggeration of the [usually minor] side effects experienced as a result of the vaccine - and can provide space for misinformation to spread.
3.5 VACCINE HESITANCY

Inadequate knowledge, as well as misinformation, has contributed to scepticism among Uganda’s refugee communities, leading to vaccine hesitancy.

Vaccine hesitancy encompasses a range of views, from delayed acceptance to outright refusal of a vaccine, and it is thus important to understand the specific forms of vaccine hesitancy and the reasons behind it in any particular context.23

Many refugees do not fully appreciate how effective vaccination is or the benefits it provides. Some refugees Oxfam interviewed were not actively against vaccination, but wished to wait until they felt it to be a greater priority or knew more about its long-term effects, as they felt they were receiving contradictory information. The particular kind of vaccine can also be relevant to feelings of hesitancy – for instance, some refugees expressed that they would not be comfortable taking vaccines that have been ‘refused by other countries’.

Lack of outreach can lead to refugees believe they are not eligible for the vaccine or will experience discrimination if they seek it out. For instance, some refugees expressed a perception that, since Uganda is among the least developed countries in the world, any funds and vaccines that are available would prioritize Ugandan citizens first, and that those involved in delivering the vaccine might be biased in favour of Ugandan citizens at the expense of refugees.

Some refugees have a more negative perception of COVID-19 vaccinations, considering them dangerous to their health. Social media in Uganda is awash with anti-vaccination messages – especially regarding the AstraZeneca vaccine, which is the predominant type available. Opinions about side effects are rife on social media, including allegations that the vaccine causes hospitalization or death. Myths like ‘people die within two years of getting the COVID-19 vaccine’ were reported in interviews Oxfam undertook with refugees. It can be is difficult for refugee populations, especially at settlement level, to filter whether such social media stories are true or fake given the lack of outreach providing official information about the vaccine.

Misinformation around vaccine dangers is often gender-specific. For instance, myths that COVID-19 vaccines cause infertility or miscarriages in women have been reported in the West Nile region. There are also myths that the vaccine will cause impotence in men.

Such myths need to be tackled through targeted information campaigns if vaccine hesitancy is to be addressed.

‘My experience is that whoever got the vaccine is hospitalized, so I cannot put my life at risk being hospitalized because of the vaccine.’
– Refugee, Kikuube district

‘In the West Nile sub-region of Uganda, rumour has it that COVID-19 vaccination can lead to involuntary abortion/loss of pregnancy and loss of fertility among women.’
– District Leader in Arua district
4 RECOMMENDATIONS

For the barriers described in Chapter 3 to be overcome the Government of Uganda should:

Make ID requirements for vaccination more flexible:

- The requirement to bring a refugee ID or obtain a letter from the OPM can be burdensome for some refugees. As far as possible, identity requirements for vaccination should not be imposed or should be limited in nature. If this is not possible, the requirements should be made more achievable for refugees and undocumented people, for example by allowing authorization or identity documents for vaccination to be obtained from local authorities as well as the OPM.24

- Make vaccination more accessible to refugees: The government should establish a system to make interpreters available at certain public facilities close to refugee settlements. These interpreters can explain the administrative requirements, as well as the vaccine and its possible side effects, to refugees.

- The Ministry of Health, should make efforts to undertake door-to-door vaccination for refugees. This would address the logistical barriers of travelling to vaccine sites and spending time queueing. It would also allow refugees to ask healthcare workers questions about the vaccine to alleviate any concerns.

- The Ministry of Health should provide safe and equitable access to COVID-19 vaccination for all refugees without discrimination. It is essential that the government carry out information campaigns to inform Ugandan healthcare workers about the eligibility of refugees to receive vaccines.

Undertake targeted outreach to refugees:

- The government, UNHCR and other development partners need to translate messaging on COVID-19 vaccines into languages that refugee populations in Uganda can understand.

- More diverse means of communication need to be adopted for information campaigns around vaccine availability and safety. These could include door-to-door or mobile outreach campaigns; working with faith-based organizations; and training frontline healthcare/government/NGO staff to better interact with refugees. The government should specifically explore outreach options for older people, who are less likely to get information via social media.

- The government and UNHCR should make efforts to deliver targeted vaccine campaigns at the community level, to build trust and reach refugee populations effectively.25 Governments should work collaboratively with civil society organizations, refugee leaders, refugee-led organizations and village health teams.26 This should include providing them with up-to-date information about the COVID-19 situation, necessary equipment to process and disseminate information.

‘Getting out into the communities is a crucial part of ensuring everyone helps stop the spread of the virus, but also to build up trust and boost demand for vaccines.’

- Dr Annet Kisakye, immunization officer for the World Health Organization in Uganda
(e.g. computers), funding and other support.

- When designing outreach and vaccine roll-out plans, the government should consider targeted action that reaches vulnerable groups within the refugee population that might face additional barriers, including women, the elderly and people with disabilities.

**Include communities of concern in planning and implementation of vaccination strategies:**

- For vaccine roll-out efforts to be successful, community and refugee leaders (including refugee welfare committees), religious leaders, refugee-led and women-led organizations, and local NGOs need to be meaningfully involved at the local and national levels. The government should engage a wide range of stakeholders in identification, outreach and vaccine distribution to enhance willingness to get vaccinated.

- Include women’s voices in vaccine planning and recognize the important role that women in displaced communities play in ensuring successful vaccine campaigns, including as carers and frontline healthcare workers. Women need to be included in COVID-19 taskforces, bodies and committees to strengthen the effectiveness of vaccine responses, and to effectively identify and address barriers to access for women and girls in all their diversity. It is also important to recognize and support the role and safety of semi-formal and informal health workers – an estimated 70% of whom are women – as part of COVID-19 vaccine roll-out strategies, as they are key in serving patients over the last mile of delivery.
NOTES

All links last accessed 12 February 2022 unless otherwise specified.


18. According to a district official interviewed by Oxfam in October 2021.


26 Village Health Teams (VHTs) have been established by the Ugandan Ministry of Health to empower communities to take part in the decisions that affect their health; mobilize communities for health programs, and strengthen the delivery of health services at house-hold level.


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