Transition of Refugee Services in East Africa

A comparative policy analysis of refugee health-service transitions in Kenya, Uganda, and South Sudan

IRC Policy Paper

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Executive summary

Across East Africa, governments and their partners are transitioning the delivery of refugee health services from parallel humanitarian systems toward national health systems. This shift reflects commitments under the Comprehensive Refugee Response Framework (CRRF) and the Global Compact on Refugees (GCR), and is driven by protracted displacement, mounting pressure on humanitarian budgets and ambitions for the socioeconomic inclusion of refugees.

The IRC delivers refugee health services across all three countries and works with governments, U.N. agencies and donors on the transitions underway. This paper draws on that frontline experience to compare how the transition is unfolding in Kenya, Uganda and South Sudan—three countries responding to a common, intensifying financing shock from very different starting points. Integration is broadly endorsed and offers real long-term gains in equity, sustainability and social cohesion, but policy commitment alone does not determine outcomes. Success depends less on the ambition of "integration" than on practical enablers: predictable, multi-year financing; viable workforce absorption; resilient supply chains; functional coordination and referral systems; political will; and explicit strategies to protect specialized services through the handover.

The three cases illustrate the range. Uganda shows what a deliberate, structured model can achieve when backed by coherent planning—even as sharp funding cuts now test its sustainability. Kenya has moved decisively on policy reform and selective operational shifts, but faces unresolved gaps in county capacity, financing flows and service continuity. South Sudan illustrates the limits of integration where state capacity and public financing are severely constrained, and where an accelerated transition has, in some cases, led to service deterioration and renewed reliance on short-term humanitarian support.

The common thread is financing: when humanitarian funding contracts faster than governments can absorb costs, service gaps open quickly, hitting workforce, supplies and specialized care first. Integration is best understood not as a cost-saving exit but as a restructuring investment—adequately financed and deliberately sequenced, it can stabilize systems; rushed or underfunded, it erodes service quality and community trust. The recommendations that follow set out how donors, governments and partners can safeguard predictable financing, workforce continuity and specialized care before responsibility shifts, so that integration strengthens national systems.

Background

In recent years, several East African countries— including Kenya, Uganda and South Sudan— have begun transitioning the delivery of refugee services from humanitarian actors, namely United Nations (U.N.) agencies and nongovernmental organizations (NGOs), toward national systems. This shift aligns with commitments under the Comprehensive Refugee Response Framework (CRRF) and the Global Compact on Refugees (GCR) for host countries and partners to move toward government-led delivery and integration rather than sustaining long-term parallel humanitarian systems. Its practical drivers include the protracted nature of displacement in the region, growing pressure on humanitarian budgets and ambitions for the socioeconomic inclusion of refugees and asylum seekers. The process has varied widely, with different approaches and timelines across contexts.

This paper documents and analyzes how, as of July 2026, these transitions are unfolding in Kenya, Uganda and South Sudan, drawing out comparative insights, lessons learned and recommendations for policy and programming in the region and globally. It focuses on health services, where the strongest evidence and operational experience currently exist, though significant transitions are also underway in education and water, sanitation and hygiene (WASH). What makes the current moment distinctive— and this comparison useful— is that all three countries are now navigating the same sharp contraction in humanitarian financing from very different starting points, offering a real-time view of how integration fares under comparable fiscal pressure.

The methodology was a qualitative, multi-country case study drawing on primary and secondary data collection. Key informant interviews were conducted with government officials, practitioners (including from within the IRC), donors and U.N. agency representatives. Findings were analyzed across countries to identify cross-cutting themes, innovations and divergences in experience.[1]

[1]This analysis should be read with its scope in mind: as a qualitative study drawing on key informant interviews, the findings reflect the perspectives of the stakeholders consulted; the depth of available data varied across the three settings; and, because these transitions are still evolving, the analysis offers a point-in-time picture that later developments may update.

Country-specific situation overview

Kenya: a policy pivot, with heavy operational work underway

Most refugees in Kenya have lived in camps for over three decades, even as new populations continue to arrive. As of June 30, 2026, Kenya hosted 857,065 forcibly displaced people. Even as need has grown, funding for the refugee response has declined steadily since its 2014 peak, and funding for 2026 is projected to be the lowest seen in over a decade— the fiscal backdrop against which the country's transition is now unfolding.

Kenya's approach sits within the broader policy shift toward integrating forcibly displaced populations into government-led systems. The Refugee Act of 2021 and the Shirika Plan for Refugees and Host Communities, together with county-level frameworks—the Kalobeyei Integrated Socio-Economic Development Plan (KISEDP) and the Garissa Integrated Socio-Economic Development Plan (GISEDP)—signaled a significant shift away from a camp-centric model toward local integration, government-led service delivery, self-reliance and socioeconomic development.

Within this architecture, the transition of refugee health services in Turkana County is guided by the draft Pilot Health Facilities Transition Plan (2025–2027),[2] which aims to establish a sustainable, government-managed system serving refugees and integrated with national services, reducing reliance on NGO support. Structured around the six health-system building blocks of the World Health Organization (WHO), it is to be implemented in three phases between July 2025 and December 2027—stabilization and systems strengthening; integration and phased handover; and consolidation and sustainability—and is aligned to the Shirika Plan timeline as the government finalizes its implementation matrix.

As one donor put it:

> **"We have been supporting basic services in the camp for 28 years. We need to realign with our mandate, find solutions to build the health system capacity for it to transition to [the Ministry of Health] and different players.**
>
> **—Key informant interview, donor**

OPERATIONAL PROGRESS

Integration of health services has advanced incrementally for over a decade—from UNHCR-supported enrollment of urban refugees in the National Hospital Insurance Fund (NHIF) in 2014 to a Kalobeyei enrollment pilot in 2023. Following the transition to the Social Health Authority (SHA), which administers the Social Health Insurance Fund (SHIF), efforts are focused on refugee enrollment in the new system. Initial technical barriers have been resolved, although as of mid-2026 those without a refugee ID card still cannot register.

At the same time, camp-based facilities have been progressively registered and gazetted by the Kenya Medical Practitioners and Dentists Council (KMPDC) and assigned a Master Facility List (MFL) code. MFL registration makes facilities eligible for Ministry of Health support, including medicines, supplies, and human resources. It also facilitates SHA empanelment—the accreditation process through which facilities are contracted to provide services under the SHIF. The IRC-managed Ammusait Hospital, a Level 4 facility in Kakuma refugee camp, now receives SHA reimbursements for services provided to registered clients. Facilities are also transitioning from parallel information systems to the Kenya Health Information System (KHIS), while Community Health Promoters

[2]KISEDP Pilot Health Facilities Transition Plan (2025–2027).

are being trained, equipped with smartphones and onboarded into the Electronic Community Health Information System (eCHIS).

REMAINING CHALLENGES

Kenya's refugee response was long built around an encampment model in which U.N. agencies and international NGOs financed and delivered a largely parallel service-delivery system, leaving limited room for government leadership and public investment. The Shirika Plan represents a major shift toward government-led refugee services, and its emphasis on self-reliance is timely given declining humanitarian funding. But government ownership must be matched with a realistic assessment of capacity. Current analyses suggest county and sub-county health systems require strengthening before they can fully absorb refugee health services without compromising disease surveillance, outbreak preparedness or supply continuity.

Camp health services have historically offered relatively high accessibility, coverage and quality, and there is a risk that refugees will transition from relatively strong humanitarian systems into county systems that are often overstretched and under-resourced. Key informants reported that funding reductions have already led to fewer consultations, reduced delivery capacity, and declining service quality in some locations—a concern also documented by the NGO Refugee Group.

Acceptance of the Shirika Plan is uneven. County leaderships have broadly expressed support, but some political voices have raised concerns about the potential effects of integration on host communities and the risks of conflict. At community level, reservations are often driven by misinformation, inadequate engagement and local political dynamics. Resource-allocation concerns and upcoming elections further shape public discourse. Communities frequently conflate aid cuts, transition measures and the introduction of differentiated assistance,[3] creating an environment of mistrust. This is compounded by comparisons between services available to refugees and those available to host communities, which are politically sensitive and must be navigated carefully.

Financing remains the most significant barrier to sustainable transition. As Cabinet Secretary for the Ministry of Interior and National Administration, Hon. Kipchumba Murkomen, noted in March 2025, implementing the Shirika Plan will require "substantial investments from all partners, including donors, international financial institutions, and the private sector." Humanitarian funding has fallen sharply—in 2025 only a quarter of UNHCR's needs-based budget for Kenya was funded—while refugees remain largely absent in national and county budget planning. Given Kenya's high unemployment and competing pressure on public services, mobilizing sustained domestic financing for refugee services remains politically challenging—but not unattainable, provided the groundwork is laid. Donors therefore face the urgent task of supporting the government to expand and adapt existing budget mechanisms to reflect refugee populations; without this, sustainability will remain out of reach.

Several partners are working to close these gaps. Through the Danish Alliance, UNHCR supports inclusive service delivery, while AMREF Health Africa works with Turkana County on budgeting, human resources, infrastructure, and revenue generation; the Refugee Consortium of Kenya (RCK) supports the underlying policy reforms; and World Bank financing currently aims to address some of these gaps. To build sustainability rather than postpone a funding cliff, these efforts require clear exit and handover plans linked to government co-financing and capacity benchmarks.

The five-year, $2.5 billion bilateral health cooperation Memorandum of Understanding (MoU) between the United States and Kenya is also expected to improve the financing outlook. Under it, the U.S. commits $1.6 billion and Kenya pledges a $850 million increase in domestic health expenditure over five years, and the framework explicitly supports including refugee services in national health systems and digital health databases. In

[3]Under the differentiated-assistance model, the World Food Programme prioritizes the most vulnerable refugees, dividing them into four categories by need. Category 1 (most vulnerable) receives 40% of a full ration; Category 2 (less vulnerable but without reliable income) receives 20%; Categories 3 and 4, assessed as having other income sources, receive no food rations.

December 2025, however, Kenya's High Court suspended its implementation pending two legal challenges concerning data protection, digital health law, and public participation.

Coordination challenges persist alongside financing constraints. County-level coordination among government, UNHCR and health partners has been broadly positive, but donors report remaining somewhat detached from day-to-day processes and note that a clearer, jointly owned transition roadmap would strengthen forward planning. Ensuring each facility has a county-appointed lead and sits within standard health-management structures—including boards representing both host and refugee communities—is an emerging priority.

WAY FORWARD

Looking ahead, access to health services will be shaped by the rollout of the differentiated-assistance framework. First introduced for food assistance in August 2025 and expected to extend to health and WASH, it would direct insurance support primarily to the most vulnerable while requiring others to enroll and contribute financially. In practice, however, it raises unresolved questions—how vulnerability is assessed, who pays premiums for those who cannot afford them, and how to avoid excluding people who fall just above the eligibility threshold. Making it work will depend on clear and transparent vulnerability criteria, safeguards for those unable to pay and monitoring to ensure no one is left without cover.

Overall, Kenya's transition is a meaningful step toward sustainability, but its success will depend on sustained financing, stronger government capacity, clearer donor engagement and continued efforts to build community trust.

Uganda: structured transition under strain from evolving financing realities

Uganda hosts one of the world's largest refugee populations and the largest in Africa—nearly two million refugees and asylum seekers, primarily from South Sudan, the Democratic Republic of the Congo (DRC) and Sudan. More than 92% live in integrated settlements alongside host communities. Uganda's long-standing open-door asylum policy—granting refugees freedom of movement, access to land, and inclusion in public services—has made it a regional leader in refugee protection and integration. Yet its funding environment is deeply strained: the Uganda Country Refugee Response Plan has been dramatically underfunded, with only a fraction of planned resources made available in 2025 and just 30% of the 2026 requirement funded so far.

Uganda's transition is rooted in a durable policy commitment to integration and self-reliance. From the Self-Reliance Strategy (1999) through the Settlement Transformation Agenda (2015) and the adoption of the CRRF (2017), the government has consistently positioned refugee services within national development and sectoral planning. This has been reinforced by sector frameworks—notably the Health Sector Integrated Refugee Response Plan (HSIRRP 2019–2024) and its successor (HSIRRP 2025–2029)—and recently consolidated under a government-led National Transition Strategy (2025–2035) covering health, education and WASH, one of the most comprehensive transition frameworks in the region. While that strategy spans all three sectors, this paper's focus remains on health.

The transition has been shaped by financial pressure as much as policy ambition. Health, education and WASH together account for nearly 80% of UNHCR's operational budget in Uganda, prompting a concerted push toward government-led integration. Donors have encouraged the shift, but its deeper rationale is a nationally anchored model that can endure beyond fluctuating humanitarian funding. In practice, Uganda is undergoing a compressed transition in which funding reductions are outpacing the government's capacity to absorb service-delivery responsibilities.

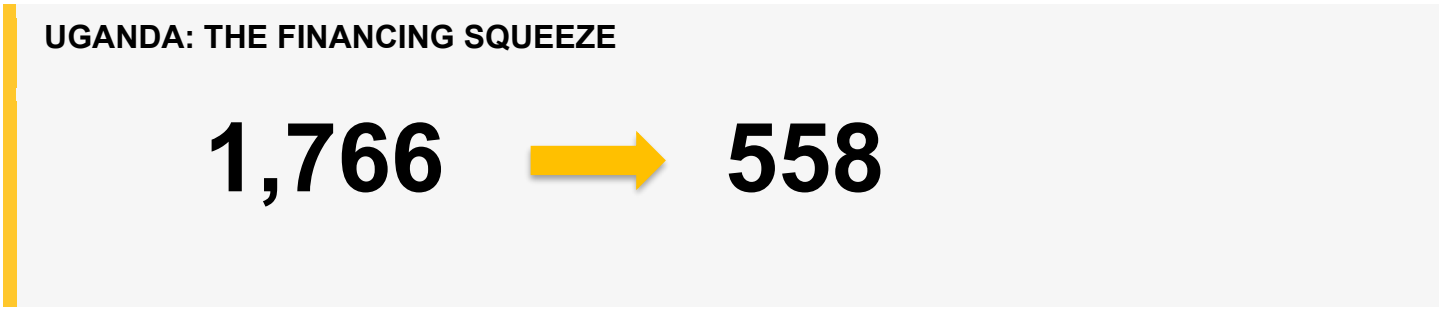
Institutionally, integration is led by the Ministry of Finance, Planning and Economic Development, in coordination with the line ministries for health, education, and WASH and with the Office of the Prime Minister (OPM). A ten-

year National Transition Strategy and sector-specific roadmaps were developed and finalized by technical experts in 2025, budgeted at around $1.8 billion. The strategy sets out phased absorption of facilities, staff and recurrent costs, but its financing mechanisms remain undefined and yet to be approved by Cabinet. Operationally, Uganda has made notable progress on formal integration: of the 89 facilities currently serving refugees, around 95% have been coded—the administrative step that recognizes a facility as part of the national health system and unlocks government resources through district and national channels. Once coded, facilities are assigned government-appointed in-charges and receive limited allocations of health workers, medicines and primary healthcare grants.

REMAINING CHALLENGES

Despite these administrative gains, service delivery in refugee settlements has remained overwhelmingly dependent on humanitarian financing. Government staffing typically covers only 20–25% of required personnel, with the remainder supported by NGOs—historically funded largely by UNHCR and the former U.S. Bureau of Population, Refugees, and Migration (PRM). In 2025, of approximately 2,500 health workers serving refugee settlements, only 623 were government-supported; the vast majority (1,766) were funded through UNHCR and a small number (117) by other partners. For 2026, partners and UNHCR projected support for only 558 health workers, creating a substantial and immediate gap. By early 2026, UNHCR was contributing 275 staff members, covering 89 facilities across 13 districts. Medicines and supplies follow the same pattern: while the government provides small quantities, the bulk is still procured by UNHCR and its partners.

Figure 1. Health workers in Uganda's refugee settlements funded by UNHCR in 2025 (1,766) vs 558 projected for 2026.



In 2025, the financing assumptions underpinning the transition shifted significantly. The original plan envisaged a gradual UNHCR withdrawal as development partners such as USAID and the World Bank stepped in through direct support to the Ministry of Health. That pathway was disrupted by three converging developments: the January 2025 U.S. Stop Work Order, which halted or delayed expected flows; a sharp decline in UNHCR health funding, from roughly $15 million annually to around $1 million in 2026; and—consistent with development financiers' broader caution on financing recurrent costs—the World Bank's decision not to finance salary-related recurrent expenditure, despite having extended its refugee funding window, leaving critical gaps unresolved.

These dynamics have produced interlinked risks. The most immediate is declining service standards: as Uganda aligns refugee services with national norms, coverage and quality are already under pressure. Human resources account for roughly 70% of sector costs, and staffing reductions are causing burnout, slower response times and reduced access to care. Supply chains face parallel strain—facilities are only partially integrated into government systems, and medicines remain heavily donor-dependent, raising stockout risk as funding declines. The impact is already visible: reduced immunization coverage and weak surveillance have raised outbreak risk, and in January 2026, 65 deaths were recorded, including 20 children under five, mostly from malaria and respiratory infections.

Financing uncertainty is also reshaping perceptions. While the logic of integration is widely accepted, there is growing concern that it transfers responsibility for refugees to national systems without commensurate,

predictable financing. This is most evident at district level, where authorities accept the rationale but fear delivering services on inadequate budgets. Efforts to establish pooled financing have met resistance, especially where funds would be government-managed, and donors remain cautious about recurrent costs such as salaries and medicines. At community level, past reductions in food rations have heightened tensions between refugees and host communities, in some cases escalating into violence; further reductions are likely to force facility closures, lengthen travel distances and erode trust in UNHCR and its partners. Managing expectations will be critical as refugees increasingly access services at parity with nationals rather than higher standards.

The five-year, $2.3 billion bilateral health cooperation MoU between the United States and Uganda is expected to improve the overall financing outlook. Its exact terms are yet to be confirmed, and concerns have been raised in some African countries about the nature of such agreements—including data-sharing requirements and potential conditionalities linked to mineral resources. As part of the agreement, Uganda has pledged to increase domestic health expenditure by more than $500 million over five years, gradually assuming greater financial responsibility. While the MoU is expected to strengthen national health infrastructure broadly, its implications for refugee health services specifically remain indirect and uncertain. Compounding this uncertainty, Uganda enacted the Protection of Sovereignty Act in May 2026, increasing regulatory oversight of foreign-funded organizations. Although the final Act explicitly exempts humanitarian assistance, it creates additional uncertainty for the international partners that continue to play a central role in supporting the health transition.

WAY FORWARD

Uganda's high rate of facility coding, existing fiscal-transfer mechanisms, and long history of integration provide a strong foundation for a sustainable government-led model—ultimately more viable and cost-effective than parallel humanitarian delivery. Success now depends on three things: predictable financing for recurrent costs, especially workforce and commodities; alignment of donor and government budget cycles and instruments; and political endorsement and operationalization of the National Transition Strategy. Without these, funding reductions risk outstripping the government's capacity to absorb responsibility, undermining both service delivery and the broader goals of integration.

South Sudan: fragile transition under severe constraints

South Sudan hosts over 600,000 refugees and asylum seekers, the vast majority from neighboring Sudan. It remains one of the world's most fragile humanitarian contexts, marked by protracted conflict, political instability and a severely constrained economy. As elsewhere in the region, the refugee response is severely underfunded: in 2025, the appeal of nearly $300 million was only 38% funded.

Refugee protection is governed by the Refugee Act of 2012 and associated regulations. Most refugees live in camps alongside host communities and are entitled to work and to access land. South Sudan is part of the CRRF and, in its 2023 pledge to the Global Refugee Forum (GRF), committed to enabling sustainable integration through equitable access to health, education and economic opportunities by 2027. In line with the Global Compact on Refugees (GCR), it also adopted a Durable Solutions Strategy and Plan of Action for Refugees, Internally Displaced Persons, Returnees and Host Communities—a significant step toward integration that includes a government commitment to provide land for refugee settlement and income generation, signaling a shift from camp-based toward more durable settlement models.

Against this backdrop, South Sudan's transition from partner-led humanitarian delivery to a government-led model reflects a broader effort to move from emergency response toward more sustainable, development-oriented systems, even as the national health context remains extremely fragile. For decades, health services—including in refugee-hosting areas such as Maban County—have been almost entirely delivered by humanitarian partners, with UNHCR and NGOs providing primary, secondary and referral-level care for both refugees and host communities. Chronic underfunding accelerated the push toward a nationally coordinated, government-led

model—moving away from parallel humanitarian delivery toward financing and oversight through the Ministry of Health.

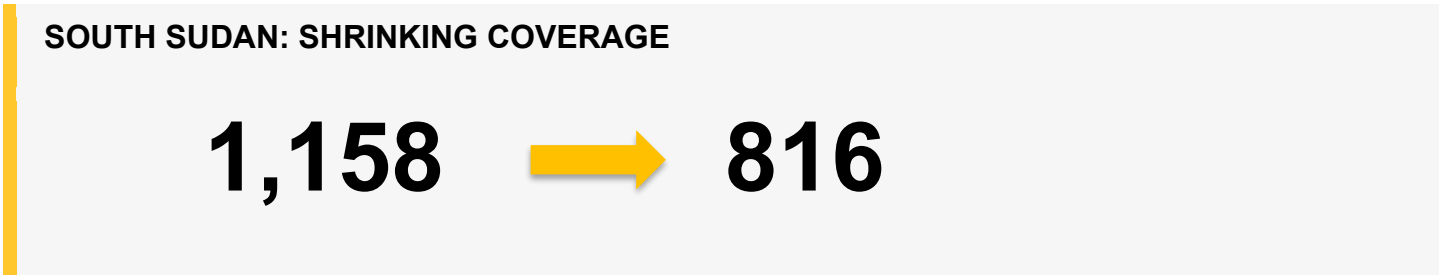
Launched in July 2024, the Health System Transformation Project (HSTP) became the primary framework for this shift. A multi-donor fund led by the World Bank and implemented through WHO, UNICEF and partners in partnership with the Ministry of Health, HSTP aims to strengthen national systems by channeling resources through government structures, standardizing a basic package of health and nutrition services and expanding coverage through incentive-based staffing and quarterly commodity supply. It is explicitly aligned with South Sudan's Health Sector Strategic Plan (HSSP) 2023–2027, which frames health as a human right and commits the government to equitable access with particular attention to vulnerable and crisis-affected populations. While not designed specifically for refugee settings, HSTP became the de facto vehicle for transitioning refugee health facilities into the national system from mid-2024. It was originally intended to support 1,158 facilities across ten states and two administrative areas over three years. In Maban County, this has played out on the ground: facilities serving refugees—including Bunj Hospital and camp primary health centers—have been mapped under government ownership, with County Health Departments (CHDs) assuming responsibility for service delivery, staffing oversight and coordination, and UNICEF and partners supporting implementation under HSTP. UNHCR and partners played a critical intermediary role during the handover—engaging communities accustomed to NGO-led services, reinforcing the rationale for government leadership and facilitating dialogue among refugees, host communities and authorities.

REMAINING CHALLENGES

Implementation has been uneven, with workforce gaps the most immediate constraint. Refugee health programming was due to shift to HSTP from June 2024, but UNHCR sustained it through quarterly extensions to avoid interruptions. Recruitment proved difficult: government incentive payments are lower and less predictable than NGO salaries and have also been severely delayed, with payments for October–December 2025 made only in May 2026 and no payments made for any period since January 2026. Many skilled clinicians, including doctors and midwives, declined government posts or left, and by mid-2025 staffing gaps were acute, referral systems had broken down, and maternal, newborn, nutrition and emergency care were severely disrupted.

Commodity supply has been the other major weakness. HSTP's centralized "push" system allocates standardized quantities by facility type rather than population, mobility or refugee-specific need. In camps whose catchment can exceed 100,000, supplies run out within weeks rather than a quarter, and hospitals receive primary-care volumes that leave them unable to deliver secondary care, diagnostics and referrals. Services once run by humanitarian partners—nutrition, mental health and psychosocial support, outreach, and specialized care such as trauma—are now inadequately covered or excluded. Delivery is also slow: MSF documented that HSTP drug and commodity supplies for July-October 2025 were ordered only in September 2025 and were not expected until late 2025 or early 2026. MSF further warned that, even at full implementation, HSTP would leave significant gaps in specialist and referral care.

Figure 2. HSTP facility coverage in South Sudan: original target (1,158) vs funded reach through 2027 (816).



Funding cuts have steadily narrowed HSTP's reach: intended coverage fell from 1,158 facilities to 816 through 2027 and in January 2026 further cuts removed support from 102 facilities. These compounded a sharp drop in

U.S. Government (USG) funding—$27.2 million in 2024—whose abrupt 2025 reduction closed several facilities. UNHCR and partners mobilized limited stopgap funding for critical services such as sexual and reproductive health, ambulance referrals, and midwife recruitment, while refugee and host communities increasingly took on facility security and oversight—a sign of local ownership as much as of absent formal support. Even so, service quality has deteriorated markedly, with key informants reporting rising mortality, lower facility use and, in some camps, large-scale spontaneous returns as refugees weigh dwindling assistance against conflict at home.

WAY FORWARD

South Sudan's health transition cannot be separated from the broader context of state fragility, ongoing conflict, and severe economic strain, which constrain government capacity across every sector. The most immediate concern is the sharp decline in the quality and continuity of care: facilities are operating below minimum standards, with community health workers performing clinical roles beyond their training, diagnostic equipment idle for lack of qualified staff and infection prevention compromised by under-staffing. These systemic risks are compounded by HSTP's design—a standardized national package that overlooks refugee population density, cross-border service use, and higher vulnerability, and a quarterly push-supply model ill-suited to dynamic, high-demand settings—and by coordination challenges linked to leadership transitions at the Ministry of Health and county-level politics. The consequences fall on refugees and host communities alike but hit refugee settings hardest.

At the same time, the transition holds longer-term promise: integrating refugee services into the national system can strengthen peaceful coexistence, reduce parallel structures and sustain access as humanitarian actors scale down, while localized recruitment paired with adequate training and pay could build a more durable workforce rooted in host communities. Government, UNICEF and partners increasingly recognize that the first 12–18 months of implementation warrant a structured review to capture lessons, recalibrate HSTP for refugee contexts and set realistic financing and capacity requirements. Ultimately, South Sudan shows that transition without sufficient time, resources and contextual adaptation risks undermining both health outcomes and confidence in national systems; a more deliberate, evidence-informed approach—phased implementation, flexible financing, and targeted humanitarian top-ups—will be essential to stabilizing services and protecting hard-won gains.

The IRC on the ground across the three countries

This paper draws on the IRC's direct experience delivering services in the refugee camps and settlements at the center of each transition:

- In **Kenya**, the IRC has worked since 1992 and reached more than 650,000 people in 2025 across five counties, including in Kakuma and Dadaab. It partners with the Ministry of Health and UNHCR to strengthen government-led services.
- In **Uganda**, the IRC has worked since 1998 and reached over 850,000 people in 2025 across 12 districts and seven settlements. Through 29 partnerships, it supports the transition of health facilities to district governments.
- In **South Sudan**, the IRC has worked since 1989 and served more than 1.8 million people in 2025 through 56 health facilities. These include the IRC's facility in Maban, now being folded into the Health System Transformation Project (HSTP).

In each country, the IRC is using its frontline presence to strengthen government capacity and protect continuity of care as national systems take the lead.

Policy implications and recommendations

Integration is a restructuring investment requiring upfront financing, careful sequencing and sustained political and technical support. Where these conditions are met, integration can stabilize systems. Where they are rushed or underfunded, integration risks eroding service quality and community trust.

1. **Anchor integration in predictable, multi-year financing**: Unpredictable funding is the single biggest threat to transition: it leaves Uganda's settlements chronically underfunded, Kenya piloting without clarity on post-pilot or county financing and South Sudan facing stockouts, staff attrition and mortality risk. Donors should commit to multi-year frameworks that bridge humanitarian and development funding; governments and partners should cost transitions in advance and embed refugee-hosting areas in national and sub-national budgets. Where funding is not yet secured, match the pace of transition to the pace of funding, not to a fixed calendar.

2. **Protect and professionalize the health workforce during transition:** Across all three contexts, workforce collapse—not policy failure—has been the most immediate cause of service decline. Protecting the workforce requires deliberate planning before transition begins: mapping the humanitarian health workforce, building pathways into government payrolls, aligning pay to avoid sudden salary shocks and ensuring reliable payment systems—all backed by sustainable funding. Where full absorption is unaffordable, use pooled financing or transitional contracting as bridges toward public financing—not permanent parallel structures.

3. **Protect specialized and referral services**: Nutrition, maternal and child health, mental health, gender-based violence (GBV) care and referrals are the first to fall when they are assumed to fold automatically into primary care. These services should instead be treated as protected components of the transition: identify high-risk service areas early, maintain dedicated funding lines through the transition and strengthen referral pathways between settlement-level facilities and higher-level hospitals.

4. **Sequence transition deliberately and anchor it in readiness assessments**: Predictable financing is a precondition, but sequencing determines whether transition succeeds in practice. Where sequencing outran capacity or adequate financing, services broke down. Effective implementation requires structured readiness assessments across financing, workforce, supply chains, infrastructure and governance. Timelines should be phased and conditional on jointly agreed benchmarks—set by governments, donors and implementing partners—rather than fixed deadlines, with monitoring mechanisms and contingency triggers that allow adjustment, or a temporary slowing of handover, if capacity gaps emerge.

5. **Invest in community engagement to build acceptance and counter misinformation**: Where communication faltered—as in Kenya and South Sudan—mistrust drove service avoidance and even returns to conflict areas, whereas Uganda's longer-standing compacts around inclusion have held up better. Treat engagement as a core pillar, not an afterthought: explain what is changing, what services will remain and how to access them, working through trusted community health workers, refugee leaders and civil society to sustain trust during uncertain periods.