Mini Review

IT Medical Team
https://www.itmedicalteam.pl/

Health System and Policy Research
2254-9137

2023
Vol.10 No. 3: 177

Public Health Emergencies during Migrant Health Ebola Crisis in Uganda

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Citation: Rai K (2021) Public Health Emergencies during Migrant Health Ebola Crisis in Uganda. Health Sys Policy Res, Vol.10 No. 3: 177.

Abstract

By early November 2022, the Ebola virus disease (EVD), which was first reported in Uganda on September 22, 2022, had spread to seven districts, with a total of 131 confirmed cases and 48 fatalities. Due to Uganda's present demographic makeup, which includes about 1.4 million refugees and asylum seekers, public health emergency response calls for a particular and tailored strategy. In fact, Uganda may serve as an illustration of the significant negative effects on global health caused by forced migration as a result of improved global connectedness. Inclusive policies are even more crucial during public health emergencies given the susceptibility of refugees and migrants due to poor living, housing, and working situations. Lessons on inclusivity from COVID-19 in a variety of contexts, including as universal access to care and vaccination It would be essential to safeguard the wellbeing of immigrants, refugees, and host communities regardless of nationality, place of residence, or legal status.

Keywords: Ebola; Uganda; Migrants

Received: 01-May-2023, Manuscript No.Iphspr-23-13531, **Editor assigned:** 03-May-2023, PreQC No.Iphspr-23-13531; **Reviewed:** 17-May-2023, QC No.Iphspr-23-13531; **Revised:** 22-May-2023, Manuscript No. Iphspr- 23-13531 (R); **Published:** 30-May-2023, **DOI:** 10.36648/2254-9137.23.10.3-177

Introduction

On September 19, 2022, Uganda declared an Ebola outbreak brought on by the Sudan ebolavirus [1]. On January 11, 2023, the outbreak was proclaimed to be over after spreading to nine districts, resulting in 164 cases and 55 confirmed fatalities [2]. In order to contain the outbreak, the Ugandan government turned on the incident management system. On October 1, 2022, the World Health Organization, the Ministry of Health, and other partners in Uganda unveiled the country's Ebola response strategy, outlining planned initiatives, top priorities, and gaps [3]. CEPI, Gavi, and WHO have developed a strategy to speed up research during the outbreak, ensure access to investigational doses, and facilitate scaling up and access in support of the Ministry of Health-led activities [4]. To any vaccination subsequently granted a licence. Due to the current demographic makeup, public health emergency response in Uganda merits a particular and tailored approach. Approximately 1,395,100 refugees and asylum seekers lived in Uganda in 2019, making up 2.7% of the country's overall population [5]. Million refugees lived in Uganda in 2020; the majority came from South Sudan and the Democratic Republic of the Congo [6]. Conflict and poverty, the porousness of international borders, and an imbalance between population growth and resources as well as opportunity all contribute to migration to Uganda [7]. Due mostly to widespread displacement brought on by violence, the migration corridor connecting South Sudan and Uganda is ranked third among the top migratory corridors [8]. An important factor affecting one's health and happiness is their experience of migration. Refugees and migrants continue to be some of society's most disadvantaged individuals, frequently facing discrimination in addition to unfavourable living, housing, and employment conditions [9]. A significant negative element that aggravates the commonly occurring physical and mental health issues is inadequate access to health services [10]. Uganda may serve as an illustration of how improved global connectivity has prompted forced migration that has had a significant negative impact on health around the world [11].

Discussion

According to a One Health perspective, these effects are brought on by increasing stress at the interface between humans, animals, and the environment as a result of exposure to new endemic diseases, lack of access to WASH and health services, as well as the local environment's capacity to cope, including its natural resources like flora and fauna [12]. According to the One Health philosophy, each of these elements contributes to the emergence

and spread of infectious diseases [13]. One of the biggest issues is that migrants frequently go to nations where resources, such as health systems, are scarce, as was noted in the 2021 WHO Global School for Refugee and Migrant Health in Jordan, which featured experiences from nations like Uganda [14]. Where the host population's health care is frequently insufficient and already stretched thin [15]. As resources are always limited during public health emergencies, inclusive policies are even more important. Such measures would guard host communities from an increased risk of infectious disease while assisting refugees and migrants to maintain their health, including mental health and engagement with healthcare providers and host communities. In view of the aforementioned, inclusion must remain at the core of outbreak response strategies like the Uganda Ebola response plan. A good example of this was Jordan's COVID-19 policy, which gave free access to COVID-19 testing, treatment, and vaccinations for migrants and refugees in particular. In addition, in accordance with the 2005 International Health Standards Analysis and specialised interventions at entrance ports, in transit corridors, and in congregation spaces—all places that are crucial for refugees and migrants—must be considered in the response. The goal would be prompt case identification, transmission avoidance, and prompt access to effective pre- and post-treatment measures. Such a strategy would take care of issues like infection prevention and control, for instance by providing access to clean water and hygiene kits, a crucial component of efficient EVD infection prevention. The One Health strategy should also involve the supply of sufficient food, housing, heating supplies, and financial support in order to reduce stress at the human-animal-environmental interface caused by, for example, deforestation, poaching, and overfishing. Such a strategy would guarantee that refugees and migrants, especially those who are One Health-related risks continue to be in good health in order to safeguard host populations as well. If host nations and the international community provided refugees and migrants with comprehensive health services and took into account the One Health concept, the human right to health of both migrants and host populations would be better protected. Under the inclusivity principle learned from COVID-19, the same One Health approach could and should be streamlined within the Emergency Cycle Management, from preparedness to response and recovery, including access to treatment and vaccination for all individuals regardless of nationality, residence, and legal status. To do this, it is essential to guarantee dependable and ongoing technical and financial support from partners, especially international institutions, in accordance with a no-regrets policy.

Conclusion

The Ebola virus disease (EVD), as its name suggests, is brought on by a virus. There are now five known species of the Ebola virus. There are four of them that are known to harm people. Ebola viruses have been linked to past epidemics in a number of Central African nations and were the primary cause of a significant outbreak in West Africa from 2014 to 2016. People to people unprotected contact with the body fluids, tissues, or blood of a patient with EVD. There is no evidence that infected people spread the illness before showing symptoms. After contracting the Ebola virus, unprotected sexual intercourse with a person who is recovering from EVD is prohibited for up to 12 months. In medical facilities, if personnel are taking care of a patient who has the do not routinely and appropriately wear required personal protective equipment such as masks, gowns, and gloves; do not follow recommended infection prevention and control procedures such as hand washing, using needles safely, and keeping patients isolated. Exposure to polluted things. Contact without protection with filthy surfaces, infected objects (like bedding), or objects used in medicine (like needles) that have the Ebola virus. Humans to animals if you or anybody in your household has any of the symptoms described above and have travelled in an EVD-affected area in the previous 21 days, notify your appropriate public health authority right away before going to the doctor or the hospital. Over the phone, describe your symptoms, let them know where you've been travelling or residing, and indicate any potential exposure dangers. The public health authority will set up the proper conditions for your medical evaluation. Follow the guidelines your public health authority has given you, isolate yourself if you haven't already, and avoid making physical contact with humans, dogs, or other animals. Make sure everyone else does by washing your hands often, especially after vomiting or using the restroom. Not to come into contact with your bodily fluids or anything that might have done so. Lab testing is used to validate EVD. Your symptoms and patient information, such as your travel history, may lead your doctor to assume that you have EVD. Since Ebola symptoms often resemble those of other infectious diseases, including malaria, that may be prevalent in the same locations, laboratory testing is required to diagnose EVD. EVD is not currently the subject of any approved treatments. An early diagnosis is crucial. Because the symptoms of EVD can deteriorate rapidly, treating these patients can be exceedingly challenging. Oxygen, intravenous fluids, and other medications can be administered to EVD patients to assist control their symptoms. Patients' chances of survival are improved the earlier they seek medical attention. Up to 90% of EVD patients die if untreated. A patient with the Ebola virus would receive treatment in a hospital in Canada that had the strictest infection prevention and control policies in place, as well as medical staff that had undergone extensive training. For the highest level of care and to prevent the spread of the Ebola virus to others, hospitalisation would be required.

Acknowledgement

None

Conflict of Interest

None

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