



# THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

**Health Needs and Services for Refugee Women and  
Children in Uganda's Settlements: Articulating a Role for  
Social Work**

**Hadijah Mwenyango  
S1608414**

**Final Thesis Submitted to The University of Edinburgh, College of Arts, Humanities  
and Social Sciences as Part of the Requirement for the Award of a Doctor of Philosophy  
in Social Work**

**December 2019**

**Supervised by:**

**Dr. George Palattiyil**

**Prof. Harish Nair**

## DECLARATION

I declare that this thesis was composed by myself, that the work contained herein is my own except where explicitly stated otherwise in the text, and that this work has not been submitted for any other degree or professional qualification except as specified. Some literature review sections appear in the publication which was released at about the same time as this thesis [Mwenyango and Palattiyil, 2019] and other incomplete manuscripts.



## ACKNOWLEDGEMENTS

When I started my Ph.D. studies in 2016, my life fell apart! My health deteriorated because of the several shocks I suffered one after another. For some months, I felt I was not living anymore. This is the focal point of my gratitude because I'm alive and have been able to complete my thesis in time. First and foremost, I'm grateful to the Almighty God for the gifts of life, protection and wisdom through this tough journey.

Secondly, I'm so grateful to my wonderful supervisors; Dr. Palattiyil George and Prof. Nair Harish. This project would have been impossible without their insightful comments, constructive critiques, and depth of knowledge which inspired me to reason beyond conventional sense. Dr. Palattiyil, thank you for keeping your office door 'widely open' without prior appointments— this gave me the courage to keep going especially during my first year.

I am grateful for the Commonwealth Scholarship, funded by the United Kingdom (UK) Government that made this study possible. This financial support helped me to remain focused and complete my studies on time.

I'm eternally grateful to my husband Elisha Lugoloobi who has been my rock at every stage of this academic journey. Thanks for the advice, love, patience and encouragement and most importantly for caring for our children in my absence. Moreover, I'm highly grateful to our lovely children; Shauna Lisa N. Lugoloobi, Sheba N. Lugoloobi, Seth N. Lugoloobi and Serah N. Lugoloobi for enduring without motherly care for some periods during the course of my studies. Thank you, Shauna, for being a virtuous big sister to Serah during the write-up phase. I'm also thankful to my sister-in-law Oliver Ndagire and Diana Wanyana for support with childcare.

My highest respects and gratitude go to my parents Mr. Hassan Kizito and the late Mrs. Zaitun Kizito for having carefully performed their parental role in nurturing me into a decent adult. Thank you, Mum, for always stressing that I should study hard to be happy. It was so unfortunate that you passed away just before I submitted this final thesis. You will be remembered forever for your love and hard work. Thank you, Dad, for believing in me and for raising my confidence. I still remember your gifts and the Newspaper (celebrating the Advanced Learner's stars) that you intentionally bought for me when I was in S.6 as inspiration to strive to excel at school. Thank you to my siblings for your encouragement.

My gratitude goes to my current employer, Makerere University for granting me a study leave for my academic pursuits in The United Kingdom. I will forever be grateful to the invaluable support from my mentors and colleagues from the Department of Social Work and Social Administration (SWSA), Makerere University. Each of you, has ‘planted a seed of hard work’ in my life, thank you for inspiring me to go for further studies. Prof. Walakira and my ‘dad’ Prof. Asingwire thank you for answering my family’s and my calls when we needed you most.

I thank the School of Social and Political Science at The University of Edinburgh, for giving me the opportunity to tutor on a postgraduate course (Research Design) and two undergraduate courses (Social Work Policy and Legal Frameworks and Working and Relating: Developing your people skills). These were great opportunities to share my knowledge but more importantly to learn from fellow students. I’m grateful to specific lecturers who invited me to contribute lectures on their courses; Dr. Clapton Gary and Dr. Gulland Jackie and my supervisor. All these generousities were also accompanied by other forms of support and encouragement from the entire staff in the Department of Social Work at the University of Edinburgh, for which I will forever be grateful.

Similarly, I thank my previous lecturers at the University of Gothenburg, Sweden for mentoring me into a researcher. Special thanks go to Dr. Jansson Birgitta and Prof. Höjer Staffan for believing in me and writing reference letters at short notice when I had plans to start my Ph.D. studies.

I am thankful to my colleagues with whom we started this academic journey; Sarah Henning, Sarah Golightley and Pascal Rudin. Thank you for your time and for welcoming me even though I was distressed. My gratitude also goes to other Ph.D. candidates but at other levels; Nakyeyune Annet, Lamba Yukti, Carol Duncan and Patrick Kwasi Brobbey. I also thank the diverse group of Ph.D. students with whom we shared the West Wing reading spaces from 2016 to 2017. Thank you for your friendships and social times.

I will remain ever grateful to my friends Dr. Sidhva Dina at the University of West of Scotland for your compassion and sisterly counsel. I also express my thanks to all my friends from The Edinburgh International Church of Christ and my warmest thanks go to Anastasia Morrell and Tina Poole for your prayers and for caring about my welfare particularly during my initial days in Edinburgh and thank you Amy and Marcus Overstreet for your spiritual messages. Thank you, Brenda and Sane Zuka and Isobel Booth-Clibborn for your friendships during my stay in Edinburgh.

My highest appreciation is reserved for the refugee women who shared their painful histories and prospects with me in Nakivale. You are my experts through your experiences and as promised, I have done my best to represent your views with sincerity. I have learned a lot from you and my hope is to be able to push forward your ideas into policy and action to improve your welfare. I also express gratitude to all my key informants at the Office of the Prime Minister (OPM) Department of Refugees (at Old Kampala and Nakivale offices), district staff and the different partners supporting refugee work.

I'm eternally grateful to my research assistants; Grace Cherotich Ruto and Centenary Gloria for your commitment and brilliant work during the survey. Thank you Ms. Mugumbu Fatuma and Mr. Lutalo Ibrahim for your expert advice in quantitative data management. Warmest thanks to Mr. Carl F. Denig for your advice during the write-up stage. And finally, thank you, my translators, for your exceptional service.

## DEDICATION

*This work is dedicated to my beloved parents Mr. Hassan Kizito and the late Mrs. Zaitun Kizito, my husband Elisha Lugoloobi and our children: Shauna Lisa Ndagire L., Sheba Nakasi L., Seth Nsibirwa L., and Serah Nanozi L.*

## ABSTRACT

Approximately 70.8 million individuals are displaced worldwide and of these 25.9 million are refugees (UNHCR, 2019). According to UNHCR (2018), 85% of the world's refugees are hosted by low-income nations such as Uganda. Presently, the country faces Africa's highest refugee crisis in years (ibid). The scale of the problem is growing rapidly, with refugee numbers increasing from half a million in 2016 to 1.36 million in 2019 making it the third-highest refugee-hosting country in the world (ibid). Most of the refugees in the country are women and children (IRC, 2014). While the country recently shot to prominence with regards to refugee settlement and management, it is confronted with the subsequent protection and assistance demands (Mwenyango and Palattiyil, 2019).

Refugees have the right to the highest attainable standard of health. Health, however, is influenced by individual behaviour, social-cultural factors and other social determinants including the migration process and status (WHO, 2018). The conditions experienced before, during transit and in host destinations create and increase vulnerability for poor health outcomes (ibid). Women and children on the move are exceptionally vulnerable to inequities that operate through exploitation and abuse (Freedman, 2019; Alsaba and Kapilashrami, 2016; IOM, 2014; Papadopoulos; 2008; Berends, 2017).

Social work is a distinct profession that alleviates suffering and deprivation of individuals and groups, due to its professional values of respect for human rights, social justice and care (IFSW, 2012). This study sought to examine the health needs and services for refugee women and children in the Nakivale refugee settlement (NRS) Uganda and enunciated the role of social work in responding to such needs. I specifically examined: (a) the public health needs, vulnerabilities and experiences of refugee women and children (b) accessible health services and (c) barriers to accessing and utilising health services for this group. All three were united by the overarching goal of interrogating social work's role in health promotion. The study used mixed methods (quantitative and qualitative). I administered a survey of 377 refugee women and 69 in-depth interviews (refugee women and men and key informants). The findings indicate that the Government of Uganda and its partners in refugee work are trying to support refugees to overcome the devastating conditions. However, there are outstanding gaps/ barriers (individual, socio-cultural and structural) to access and utilisation of health services. Women and children continue to live in vulnerable conditions. The study reveals a necessity for social work in settlements and provides recommendations for improving health services. The need to



improve refugees' access to health care is urgent because it impacts their worth and dignity and is essential for the country's development (UNDP, 2016).

## LAY SUMMARY

Although the Government of Uganda and its partners in refugee work have made efforts to support refugees to overcome the devastating conditions, evidence reveals outstanding gaps in health care particularly for the most vulnerable. The circumstances in which migration takes place, compounded by individual factors have a significant impact on health-related vulnerabilities and access to services. Women and children on the move are exceptionally vulnerable to inequities that operate through exploitation and abuse. Although the conditions at the settlement are meant to be part of the goal of migration, these actually independently contribute risk to the health of refugee women and children. In line with Sustainable Development Goal (SGD) 3, this study adopted a holistic approach of health and explored the health needs and services for refugee women and children in NRS. The study draws on a survey of 377 refugee women and 69 in-depth interviews (refugee women and men and key informants) and observations conducted in 2017. Through face-to-face interviews, the study captures (a) the public health needs, vulnerabilities and experiences of refugee women and children (b) accessible health services and (c) barriers to accessing and utilising health services. All three were united by the overarching goal of interrogating social work's role in health promotion for refugee women and children. Quantitative and qualitative findings indicate that women and children have multiple and multifaceted health concerns arising from factors such as exposure to risks earlier in the migratory process and in the settlement environment. These intersect with social factors (language skills, gender, level of literacy, discrimination and social inequalities), economic factors (poverty) and rights-related factors (inaccessible services) and exacerbate their vulnerability. I argue that social work needs to be streamlined to promote refugee health because of its attention to the social determinants of health. This research argues for a rights-based approach to health care that considers respect, protection and fulfilment of human rights an obligation. This obliges a proper analysis of refugee women's and children's situation, application of both international and national law to identify needs arising from the migration experience and the settlement environment. This also necessitates adoption of durable solutions such as integration to replace the present method of settlement. Further, UNHCR and the global community have a duty to fulfil their promise of mutual responsibility for refugee support. This study is significant for informing measures intended to improve health service delivery to ensure healthy lives and well-being for refugee women and children and I propose a Comprehensive Model for Improved Refugee Women and Children's Health.

## TABLE OF CONTENTS

DECLARATION .....	2
ACKNOWLEDGEMENTS .....	3
DEDICATION .....	6
ABSTRACT .....	7
LAY SUMMARY .....	9
TABLE OF CONTENTS .....	10
LIST OF TABLES .....	17
LIST OF FIGURES .....	18
KEY CONCEPTS .....	19
ACRONYMS AND ABBREVIATIONS .....	22
CHAPTER ONE: LANDSCAPES OF REFUGEE PREDICAMENTS .....	24
1.0 Introduction .....	24
1.1 Main Aim and Objectives .....	28
1.2 Significance of the Study .....	28
1.3 Scope of the Study .....	30
1.4 Values and Reflexivity .....	31
1.5 Main Contribution .....	35
1.6 Synopsis .....	36
1.7 Conclusion .....	37
CHAPTER TWO: CONCEPTUAL AND THEORETICAL FOUNDATIONS .....	39
2.0 Introduction .....	39
2.1 The Right to Life .....	39
2.2 The Right to Health .....	40
2.3.0 Defining Health .....	41
2.3.1 <i>Physical functioning</i> .....	41
2.3.2 <i>Mental health</i> .....	41
2.3.3 <i>Social well-being</i> .....	41
2.3.4 <i>Role functioning</i> .....	41
2.3.5 <i>General health perceptions</i> .....	42
2.4 The Biomedical Model of Health .....	42
2.5 The Sociological Model of Health .....	43
2.6 World Health Organisation (WHO) Definition of Health .....	43
2.7.0 Health Behaviour .....	44

2.7.1 Prevention.....	44
2.7.2 Detection.....	44
2.7.3 Promotion .....	45
2.7.4 Protection .....	45
2.8.0 Theoretical Foundations for Health Behaviour .....	46
2.8.1 The Macro Approach .....	46
2.8.2 The Structural Model of Health Behaviour .....	47
2.8.3 The Micro Approach.....	49
2.8.4 The Health Belief Model (HBM) .....	50
2.9.0 Health Needs Assessment .....	52
2.9.1 Felt needs.....	52
2.9.2 Normative needs .....	53
2.9.3 Expressed needs .....	53
2.9.4 Comparative needs .....	53
2.10 The Global Strategy for Women’s and Children’s Health (2010–2015) .....	54
2.11 The Global Strategy for Women, Children and Adolescents’ Health (2016–2030).....	54
2.12 Public Policies .....	57
2.13 Health in All Policies (HiAP).....	58
2.14.0 General Public Health Issues in Refugee Settings.....	59
2.14.1 Communicable Diseases.....	60
2.14.2 Nutritional Health Problems .....	60
2.14.3 Reproductive Health Problems .....	61
2.14.4 Sexual and Gender-Based Violence.....	62
2.14.5 Mental Health Problems.....	63
2.15.0 Health Services Challenges in Refugee Settings .....	64
2.15.1 Language barriers .....	64
2.15.2 Limited/ shortage of health care services or unavailability of health care services. 64	
2.15.3 Low trust of health service providers .....	65
2.16.0 Migration, Vulnerability and Resilience .....	66
2.17 Social Work and Migration .....	69
2.18 Gender, Health and Power .....	75
CHAPTER THREE: GEOGRAPHICAL AND CONTEXTUAL SCOPE.....	77
3.0 Introduction.....	77
3.1 Social Demographics .....	77
3.2 Political and Administrative Factors.....	80

3.3 Population Health Issues in Uganda .....	80
3.4 The Structure of the Health System .....	82
3.5 Refugees in Uganda.....	85
3.6 The Policy Context .....	87
3.7 The Process of Becoming a Refugee .....	87
3.8 Why Refugees are Streaming to Uganda .....	88
3.9 Refugee Settlement and Access to Health Services in Uganda.....	91
3.10 The Social and Theoretical Context of Social Work .....	93
3.11 The Philosophy of Social Work.....	94
3.12 The Western Model of Social Work .....	95
3.13 Professional Social Work in Africa .....	95
3.14 The Evolution of Social Work in Uganda.....	96
3.15 Social Work with Refugee Populations .....	100
3.16 The Need for Social Work Practice in Refugee Settlements.....	100
CHAPTER FOUR: RESEARCH DESIGN AND METHODS.....	104
4.0 Introduction.....	104
4.1.0 Research Design .....	104
4.1.1 <i>Mixed methods</i> .....	105
4.1.2 <i>Phenomenology</i> .....	106
4.1.3 <i>The Descriptive and Exploratory Designs</i> .....	106
4.1.4 <i>The Cross-Sectional Design</i> .....	107
4.1.6 <i>The Quantitative Research Approach</i> .....	109
4.1.7 <i>The Qualitative Research Approach</i> .....	109
4.2 The Setting .....	110
4.3 Study Population .....	113
4.4 Sample Selection .....	113
4.5 The Research Process .....	116
4.6 The Pilot Study.....	117
4.7 Recruiting Research Assistants .....	117
4.8 The Main Survey .....	118
4.9 Data Collection Tools .....	119
4.9.2 <i>Qualitative Interviews</i> .....	120
4.9.3 <i>Participant Observation</i> .....	122
4.10 Data Management and Analysis .....	123

4.11 Validity, Reliability and Trustworthiness .....	126
4.12 Ethical Considerations .....	128
4.13 Positionality and Reflexivity .....	132
4.14 Challenges .....	134
4.15 Limitations of the Study .....	137
4.16 Conclusion.....	138
CHAPTER FIVE: SOCIO-DEMOGRAPHIC PROFILE OF THE RESPONDENTS .....	139
5.0 Introduction.....	139
5.1 Age of the Respondents .....	139
5.2 Nationality and Language .....	140
5.3 Marital Status .....	141
5.4 Reproductive Health/ Family Planning.....	143
5.5 Main Occupation of the Respondents .....	145
5.6 Level of Education.....	147
5.7 Religion.....	148
5.8 Duration of Stay in the Settlement.....	149
5.9 Description Refugee Respondents (In-depth Interviews) .....	150
5.10 Key informants and their organisations .....	151
5.11 Conclusion.....	152
CHAPTER SIX: WOMEN, CHILDREN AND ADOLESCENT HEALTH .....	153
6.0 Introduction.....	153
6.1.0 Women’s Health.....	153
6.1.1 <i>Management of communicable and non-communicable diseases</i> .....	153
6.1.2 <i>Sexual and reproductive health</i> .....	159
6.1.3 <i>Pregnancy, childbirth and postnatal care</i> .....	171
6.1.4 <i>Nutritional health</i> .....	184
6.2.0 Adolescent and Youth Health and Well-Being .....	186
6.2.1 <i>Parenting</i> .....	186
6.2.2 <i>Child sexual abuse</i> .....	188
6.2.3 <i>Early marriage and other harmful practices</i> .....	189
6.3.0 Child Health and Development .....	192
6.3.1 <i>Immunisation</i> .....	192
6.3.2 <i>Treatment and management of childhood illness</i> .....	194
6.3.3 <i>Responsive caregiving and stimulation</i> .....	195

6.3.4 <i>Unaccompanied and separated children</i> .....	197
6.4.0 Gender-Based Violence, Abuse and Torture Among Women and Children.....	198
6.4.1 <i>Types of gender-based violence and abuse in the settlement</i> .....	199
6.5.0 Mental Health Problems Among Women and Children .....	206
6.6 Conclusion .....	209
CHAPTER SEVEN: MAJOR BARRIERS TO ACCESS AND UTILISATION OF HEALTH SERVICES AMONG REFUGEE WOMEN AND CHILDREN .....	210
7.0 Introduction .....	210
7.1.0 Communication Problems .....	210
7.1.1 <i>Language barriers</i> .....	210
7.2.0 Institutional and Structural Barriers.....	213
7.2.1 <i>Lack of health care services</i> .....	213
7.2.2 <i>Medicine and diagnostic equipment shortages and long queues in health facilities</i> .	214
7.2.3 <i>Inconsiderate attitude of health care providers</i> .....	218
7.2.4 <i>Low trust between health service providers and refugees</i> .....	219
7.2.5 <i>Lack of coordination</i> .....	220
7.2.6 <i>Inadequate funding</i> .....	221
7.3.0 Structural Barriers.....	222
7.3.1 <i>Poverty</i> .....	222
7.3.2 <i>Lack of food</i> .....	223
7.3.3 <i>Lack of transport</i> .....	224
7.4.0 Socio-Cultural and Religious Barriers .....	225
7.4.1 <i>Gender dynamics</i> .....	225
7.4.2 <i>Cultural and religious limitations</i> .....	227
7.4.3 <i>Lifestyle</i> .....	228
7.4.4 <i>Stigma</i> .....	229
7.5 Conclusion .....	230
CHAPTER EIGHT: SOCIAL WORK AND HEALTH IN THE SETTLEMENT.....	231
8.0 Introduction.....	231
8.1 Psychosocial Support.....	233
8.2 Group Work .....	234
8.3 Community Work.....	235
8.4 Mediation .....	236
8.5 Casework.....	237
8.6 Administration.....	239

8.7 Health Education .....	240
8.8 Legal Support .....	240
8.9 Basic Needs Support.....	241
8.10 Public Awareness .....	242
8.11 Community Capacity Building.....	243
8.12 Conclusion.....	244
CHAPTER NINE: ANALYSIS AND DISCUSSION .....	245
9.0 Introduction.....	245
9.1 Life in Exile.....	245
9.2 Gendered Dimensions of Health in Exile.....	251
9.3 Vulnerability in Exile.....	259
9.4 The Imagined Homeland Traumatized by Violentisation .....	270
9.5 Articulation of the Social Work Role .....	275
9. 6 Conclusion .....	279
CHAPTER TEN: CONCLUSION AND RECOMMENDATIONS .....	281
10.0 Introduction.....	281
10.1 A Comprehensive Model for Improved Refugee Women and Children’s Health.....	281
10.2.0 Implications of the Findings for Social Work Practice .....	286
10.2.1 Psychosocial support .....	288
10.2.2 Empowerment.....	290
10.2.3 Co-production of services.....	295
10.2.4 Advocacy for rights and resources.....	296
10.2.5 Social work education.....	298
10.3.0 Policy Recommendations for the Government, UNHCR and Partners.....	299
10.3.1 Developing a rights-based approach.....	299
10.3.2 Durable solutions .....	302
10.3.3 Social protection.....	303
10.3.4 Comprehensive and coordinated assistance.....	305
10.3.5 Gender mainstreaming in health care and humanitarian assistance .....	307
10.3.6 Clarifying processes and procedures .....	308
10.3.7 Research .....	309
BIBLIOGRAPHY .....	310
Appendix 1: Interview Guide for Key Informants .....	333
Appendix 2: Interview Guide (Refugee Women and Men) .....	334
Appendix 3: Survey Tool for Refugee women .....	335



Appendix 4. General Observation Checklist.....	355
Appendix 5: Participant Information Sheet- Key Informants .....	356
Appendix 6: Participant Information Sheet (Refugee Women and Men).....	359
Appendix 7: Informed Consent Form (Refugee Women and Men).....	361
Appendix 8: Informed Consent Form- Key Informants .....	364
Appendix 9: The University of Edinburgh School of Social and Political Science Ethical Approval Letter .....	367
Appendix 10: Office of the Prime Minister Research Approval Letter .....	369

## LIST OF TABLES

Table 2. 1 Public Health Approach for Migrants—Basic Principles.....	40
Table 3. 1 Top refugee sending countries in 2018.....	86
Table 3. 2 Districts and settlement populations as of March 2015.....	88
Table 3. 3 Social demographic aspects of refugees and their settlement in Uganda.....	91
Table 4. 1 Summary of the Methods.....	123
Table 5. 1 Age distribution among respondents.....	140
Table 5. 2 Respondents' nationality and language.....	140
Table 5. 3 Respondents' marital positions.....	142
Table 5. 4 Respondent's birth history.....	143
Table 5. 5 Main occupation of the respondents .....	145
Table 5. 6 Religion of the respondents .....	148
Table 6. 1 General living conditions in the settlement .....	154
Table 6. 2 The status of environmental safety for refugee women and children .....	158
Table 6. 3 Period (in months) elapsed since the most recent HIV test .....	163
Table 6. 4 Level of the utilisation of modern family planning methods by different characteristics .	167
Table 6. 4 Logistic Regression analysis results for the dependent variable: Modern family planning utilisation .....	170
Table 6. 6 Differentials in the rates of unintended pregnancies among the participants .....	173
Table 6. 7 Access to and utilisation of antenatal health care among the refugee women.....	176
Table 6. 8 Differentials in access to childbirth services. ....	179
Table 6. 9 Levels of utilisation for postnatal health care services.....	183
Table 8. 1 A Summary of the professional social workers' titles in various organisations. ....	232

## LIST OF FIGURES

Figure 2. 1 The Health Belief Model .....	51
Figure 4. 1 Distribution of refugee women per zone of residence .....	115
Figure 5. 1 Highest level of school attended.....	147
Figure 5. 2 Respondent's length of stay in NRS .....	149
Figure 6. 1 Access to and utilisation of modern family planning methods.....	165
Figure 6. 2 Conception and reasons for conception among the participants.....	171
Figure 6. 3 The common complications during birth .....	180
Figure 6. 4 Vaccination of children against diseases in the last 12 months.....	193
Figure 6. 5 Participants' experiences of abuse and torture in the countries of origin and while in Uganda.....	199
Figure 10.1 A Comprehensive Refugee Health Model.....	283

## KEY CONCEPTS

**Children:** According to the Convention on the rights of the Right Article (1) a child means every human being below the age of eighteen years unless, under the law applicable to the child, the majority is attained earlier. In accordance with the Constitution of the Republic of Uganda (1995) Children, this in this study refers to any person below the age of eighteen.

**Health needs:** Health needs in this study refer to needs which can be addressed by health care services as well as social and environmental changes (Wright, 2008).

**Health promotion** refers to the process of enabling people to gain more control over, and improve their own health and well-being, and that of their families and communities (WHO, 2018, p. vi)

**Health system:** This refers to the ensemble of all public and private organisations, institutions and resources mandated to improve, maintain or restore health (WHO, 2010, p.3).

**Health:** World Health Organisation (WHO) (1946) combines both the medical and socio-cultural aspects and defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The study shall adopt this inclusive and holistic definition of health and well-being.

**Needs:** Unlike wants, needs refer things which are necessary for an organism/human being to live a healthy life.

**Policy:** Rein (1976) argues that policy paradigms are based on particular views of essential problems to be solved thus, he defines policies as “models showing why things are as they are; problem- solving frameworks which supply values and benefits; procedures; habits of thought and views of society functions. There are curious mixtures of psychological assumptions, scientific concepts, value commitments, social aspirations, personal beliefs and administrative constraints” (Cited in Allsop 1995, p.4-5). Allsop (1995) adds that in order to shift these (policies) they must be challenged by alternative views of the world which may particularly appear to fit well with the current problems. The study adopts this broad conceptualisation of the concept policy to study public health policies.

**Refugee settlement:** A refugee camp refers to a temporary settlement reserved to host refugees and people in refugee-like situations. In the Ugandan context, the concept ‘refugee

settlement' is popularly used and actually preferred instead of 'refugee camp'. But basically, a refugee settlement is a locality/portion of land gazetted by the government for settling refugees.

**Refugees:** The United Nations (1951) Geneva Convention Article 1(2) defines a refugee, 'as any person who as a result of events occurring before 1st January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality membership of a particular social group or political opinion, is outside of country of his nationality and is unable to or owing to such fear, is unwilling to avail himself of the protection of that country; or who does not have a nationality and being outside of his country of his former habitual residence as a result of such event is unable or owing to such fear, is unwilling to return to it. The Organization of African Unity (OAU) Convention extended the meaning of refugee to include; 'any person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to seek refuge of another place outside his country of origin or nationality'. Both definitions are relevant when referring to the refugees in the study.

**Services:** Services refer to actions that are intended to meet specific individual or public needs. The study mainly refers to health services- aimed at improving social welfare through public health policies

**Social determinants of health:** These refer to the conditions in which people are born, grow, live, work and age, including the health system (WHO, 2010, p.3)

**Social Work:** The International Federation of Social Work (IFSW) and the International Association of the Schools of Social Work (IASSW) General Assembly (2014) approved and provided the global definition of social work profession stating that, "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance well-being." This definition can be transformed and developed to suit the national development interests. This has not been made for Uganda's case. However, the National Association of Social Workers of Uganda (NASWU) which is the professional body for Social Workers visualises promoting professional practice, national development, and transformation. This is

in line with social development effects. Thus social work in Uganda is broad and the study puts that reality into consideration when referring to social work.

**Women:** This concept refers to adult human females that, is from eighteen years and above (Ugandan context).

## ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARC	American Refugee Council
DRC	Democratic Republic of Congo
CSDH	Commission on Social Determinants of Health
FRC	Finnish Refugee Council
GoU	Government of Uganda
HDR	Human Development Report
HIJRA	Humanitarian Initiative Just Relief Aid
HIV	Human Immune Deficiency Virus
IOM	International Organisation for Migration
LG	Local Government
MDGs	Millennium Development Goals
MGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MTI	Medical Teams International
NPC	National Population Council
NRS	Nakivale Refugee Settlement
NGO	Non-Governmental Organisation
OPM	Office of the Prime Minister
REC	Refugee Eligibility Committee
RMF	Real Medicine Foundation
SDGs	Sustainable Development Goals
SP	Samaritan Purse
STD	Sexually Transmitted Disease
SWSA	Social Work and Social Administration
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey

UNDP United Nations Development Programme

UNHCR United Nations High Commission for Refugees

WHO World Health Organization



## CHAPTER ONE: LANDSCAPES OF REFUGEE PREDICAMENTS

### 1.0 Introduction

*You become so emotional that your emotions supersede the ability and desire to serve these people. For example, you hear five stories—a person telling you how she was raped, how they tied maybe a jerry can of water on his private parts, how somebody was sexually assaulted, then how they raped his children and wife when he was witnessing then afterward they sexually assaulted him. Then the other one comes with a different story of how somebody was abducted, taken to the forest, the rebels now begin killing people- they bring her human flesh to cook, like five of them sleep [on her]. All those, by the time you go back home, you feel you are terminally ill with yourself that sometimes [you] feel 'I should stop working here,' not because 'you' are not paid well, but you become so emotional [and] you feel the best thing to do is actually to abandon this work. (Protection/Counsellor, ARC)*



**A typical shelter design in Nakivale Refugee Settlement (NRS)**

The narrative above indicates a portion of the stories I heard during the months I spent collecting data in the Nakivale refugee settlement (NRS). The protection officer reflects on the refugees' experiences of vulnerability, exploitation and abuse. Painful experiences associated with complex and distinct health needs (in terms of physical, emotional and social well-being) (Mwenyango and Palattiyil, 2019). The words of the service provider mirror a necessity for not only medical care but also comprehensive and sensitive assistance to address the social determinants of health.<sup>1</sup> In many cases, these are aggravated by exposure to difficult socio-economic, cultural, environmental and lifestyle factors in the migratory process (pre-departure, during transit and in destinations) (WHO, 2018; Fleischman et al., 2015).

2016 was pronounced as the deadliest year for refugees to date as an enormous number of people (totalling 3,800) died while attempting to cross the Mediterranean to seek refuge in Europe, and this same process caused a substantial number of fatalities (3,771) the year prior<sup>2</sup>. Refugees within Africa frequently embark on equally perilous journeys in search of sanctuary. Given the causes of involuntary displacement on the continent—wars, violence, persecution and human rights violations (UNHCR, 2019), refugees often resort to unsafe modes of transportation during their flight. These precarious journeys expose them to hostile conditions such as violence, injury, insufficient food and water and shelter, disrupted access to health care. There are many causes of mortality, such as wounds, disease, malnutrition, dehydration, extreme temperatures (UNHCR, 2018). As such, Brian and Laczko (2014) assert that greater numbers of sub-Saharan Africans are dying during migration within Africa than the world is aware of—because there is limited data in some regions. Certainly, one crisis which will never be forgotten occurred on Lake Albert in Uganda, claiming over 251 refugees from the Democratic Republic of Congo. Migration is both a process and a goal (IOM, 2010). Such a dual approach improves our understanding of migrants' health, by examining mobility as both a risk factor and a determinant of health. The circumstances in which migration takes place, compounded by individual factors (such as gender, language, immigration status, and culture), have a significant impact on health-related vulnerabilities and access to services (IOM, 2010)

---

<sup>1</sup> These refer to the conditions in which people grow, live, work, and age, and the systems put in place to deal with illness (Commission on Social Determinants of Health (CSDH), 2008).

<sup>2</sup> See more at UNHCR, 2016

[http://www.refugeecouncil.org.uk/latest/news/4786\\_2016\\_deadliest\\_year\\_for\\_refugees\\_crossing\\_mediterranean](http://www.refugeecouncil.org.uk/latest/news/4786_2016_deadliest_year_for_refugees_crossing_mediterranean)

although for some migrants, movement or relocation denotes prospects for superior and decent lives for themselves and their families (Brian and Laczko, 2014). However, there are also various health risks and vulnerabilities which are associated with mobility. There is ample evidence of refugees ending up in relatively deprived conditions or even in further vulnerable states (e.g., Palattiyil and Sidhva 2011; Allan, 2014). Divergent studies have underscored the role of mobility in spreading diseases, for instance, high incidence cases of tuberculosis among immigrants in the United States, Canada and among migrants in Western Europe (Dasgupta & Menzies 2005 cited in Boyle and Norman 2010, p.354). Similar research conducted by IOM (2011) revealed major migration health concerns among refugees in Kenya including high prevalence of tuberculosis; HIV/AIDS; risky sexual behaviour; reproductive health problems; malaria; measles; occupational health; as well as psychosocial stressors. Another IOM study (2009, p. 12) focussed specifically on analysing HIV/AIDS programming along transport corridors in Uganda suggests that:

Mobility is a potentially significant driver of new infections in East Africa—partly due to the social implications of mobility on HIV risk behaviour, but also because of the relationship between population mobility and risky environments associated with transport corridors that facilitate people to have multiple sexual partners.

These studies confirm that such circumstances notwithstanding biased media broadcasts, have amplified the public health threat of migration and have prompted the emergence of increased surveillance, racialisation, criminalisation, and securitisation of international borders particularly in the Western world (Tsfahuney 1998 cited in Boyle and Norman 2010, p.347). At a time when one in seven people around the world is living as a migrant in one form or another, it makes good sense to concentrate on migrant health as an integral part of human well-being. Boyle and Norman (2010) contend that the appalling conditions of refugees, which contribute to low social-economic status, are major health risk factors and should actually be given more attention; than the immigrant status. The conditions at the camp/settlement are meant to be part of the goal of migration, but these actually independently contribute risk to the health of migrants (in terms of housing, low access to health services and continued violence).

Presently, about 70.8 million individuals are displaced worldwide and of these 25.9 million are refugees (UNHCR, 2019). According to UNHCR (2018), 85% of the world's refugees (16.9 million people) are hosted by low-income nations. Uganda is presently facing Africa's worst refugee crisis in years (Mwenyango and Palattiyil, 2019; UNHCR, 2019). In 2016, Uganda

hosted over half a million refugees, most of whom were women and children (IRC, 2014). The scale of the problem is growing rapidly, with refugee numbers increasing from half a million in 2016 to 1.36 million in 2019 making the country the third refugee-host in the world after Turkey (3.7million) and Pakistan (1.4 million) (UNHCR, 2019). Although the country has shot to prominence in the recent past with regards to refugee settlement and management (OPM, 2017), the government is confronted with the subsequent protection and assistance demands. Migration is an intricate social phenomenon in relation to relocation, integration and in some cases, deportation as these all involve varying degrees of stress, disruption, loss or disorientation (Palattiyil and Sidhva 2011; Papadopoulos, 2010). Forced displacement presents complex challenges such as loss of family, friends, land and other possessions, disruption of education and/or employment, and erosion of community structures and traditions (Thomas et al., 2010; UN, 2016; Berends, 2017). All these processes have implications for the mental, social and physical health and family dynamics of migrants (Potocky-Tripodi, 2002; cited in Hall, 2006). Moreover, it is also not uncommon that many refugees and asylum seekers experience physical and psychological trauma as a result of human rights abuses and protracted conflict in transit and while in exile (Svenberg et al, 2009).

Women and children on the move are exceptionally vulnerable to inequities which operate through exploitation and abuse (Freedman, 2019; Alsaba and Kapilashrami, 2016; IOM, 2014; Papadopoulos; 2008; Berends, 2017 ) which lead to stigma, guilt, and avoidance of social support networks(Ssenyonga et al., 2012). Moreover, refugee women have needs and experiences which are distinctive from those of men because of their reproductive role and social status in society (Mwenyango and Palattiyil, 2019). Given that half of the world's refugee population and Uganda in particular, are children below 18 years (UNHCR, 2019), their health is even much more at risk. Refugee children are vulnerable to a number of health risks such as vitamin deficiency, anaemia, parasitic diseases, malaria, poor oral health and chronic conditions including injuries from war and torture, psychological disorders and delayed growth and development (Thomas et al., 2010). Like adults, many children are separated from families and witness traumatising events such as the killing of their parents (UNHCR, 2019; Berends, 2017). These experiences combined with anxiety, uncertainty and delayed settlement or resettlement process have long-lasting detrimental effects on their physical, emotional and mental health (Thomas et al., 2010). Social work is one of the distinct professions which primarily aims at alleviating the suffering and deprivation of individuals and groups, due to its

professional values being specifically rooted in human rights, justice, health, social care, and welfare (IFSW, 2012). This background conveys the aim of this research as outlined below.

### 1.1 Main Aim and Objectives

This study sought to examine the health needs and services for refugee women and children in the Nakivale refugee settlement (NRS), Uganda and enunciated the role of social work in responding to such needs. The specific objectives of the study were:

1. To examine the public health needs, vulnerabilities and experiences of refugee women and children in NRS.
2. To identify accessible health services for refugee women and children in NRS.
3. To explore barriers to access and utilisation of health services among refugee women and children.
4. To interrogate social work's role in health promotion for refugee women and children.

We turn now to the significance of my research.

### 1.2 Significance of the Study

In line with Sustainable Development Goal (SGD) 3<sup>3</sup>, this research aims to improve health service delivery to ensure healthy lives and well-being for refugee women and children. Refugee health is quite a well-studied subject (UNHCR, 2014; IOM, 2009; Kimbrough et al., 2012; WHO, 2015; Hall, 2006; Anleu and García-Moreno, 2014; Cuadra, 2009; Rachuonyo, 2016; Loparimoi, 2011; IRC, 2014; Orach & De Brouwere, 2005; OPM, 2015). Despite that, a lot of the studies have focused on distinct and narrow aspects of health such as, psychological and mental health (Papadopoulos, 2008; Ssenyonga et al., 2012; Thomas et al., 2010; Refugee Law Project, 2015; Ewles & Simnett, 2003; Hiegel, 1991; Smyke, 1991; Karunakara et al. 2004; UNHCR, 2014); HIV/AIDS (IOM, 2009; Nyanzi, 2013; O'Laughlin, et al., 2015; Wakabi, 2008) and reproductive health (Mulumba 2011; Mulumba and Wendo, 2009; Crawley, 2001; WHO, 2015; Carey-Wood et al., 1995; Orach et al., 2007). While a focus on explicit facets of health simplifies data collection, it also overlooks the multiple problems of vulnerable groups. Action research necessitates composite, all-inclusive and comprehensive approaches

---

<sup>3</sup> Ensure healthy lives and promote well-being for all at all ages

(UNHCR, 2018; 2019). None of these studies takes a holistic approach to investigate the health needs of and services available to this vulnerable population for example by lumping all migrants together, without regard for the specific risks faced by women and children in these scenarios

Gender as an element of migration and health is another critical issue arising from the literature. Despite recommendations from a few studies signifying the urgency for adopting gendered approaches in work with refugees (Alsaba and Kapilashrami, 2016; Deacon and Sullivan, 2009; Paoliso et al., 1995; Comas- Diaz and Jansen, 1995; Dyke, 1991; WHO 2016; WHO, 2015; Wakabi, 2008; Ewles and Simnett 2003; WHO 2009; Merry et al., 2011), these studies have not precisely described the gendered needs and how to really contain these in humanitarian assistance programmes. Beyond that, other studies have concentrated on the self-reliance of refugees and their impact on the environment and host populations (Mulumba, 2011; Orach & De Brouwere, 2005; Omata & Kaplan, 2013) but not explicitly focusing on women and children's health. This study adopts a holistic approach and uncovers such knowledge gaps to contribute to a fuller understanding of refugee health needs (Cohen et.al, 2000; Chen and Land, 1986; Weiss and Lonquist, 2003; WHO, 1986; WHO 2009, Vingilis & Sarkella, 1997) and services for refugee women and children.

Drawing on better-rounded empirical evidence, the World Health Organisation (WHO) model of health, and the Global Strategy for Women, Children and Adolescents' Health (2016–2030); the study suggests practical recommendations for social work, policy, and further research. Moreover, unlike previous studies that have approached refugee health from other disciplines, this study offers a purely social work analytical frame. As I will discuss further in Chapter Three, social work is a human-rights-based profession with a zeal for facilitating people's harmonious existence within themselves and the social and cultural contexts in which they dwell. This is not only key for individual functioning and welfare, but also significant for co-existence/solidarity, structural and social functioning; as well as significant for realising inclusive growth and sustainable development (UN, 2016)

The study focused on refugee women and children because these are a vulnerable group during emergencies and relocations (Berends, 2017). Specifically, from a rights-based perspective, the study emphasised the state of health for refugee women and children (vulnerability and their

strengths); identified the different entitlements of refugee women and children to health care; investigated access to and utilisation of health services (prevention, health promotion and care); investigated gaps in coverage of health services and suggests recommendations for social work, the government and partners to expand their actions.

The need to reduce marginalisation of refugees in access to health care is crucial because it impacts their worth and dignity and affects the country's development (which is still low in human development index rankings) (UNDP, 2016). Addressing health inequity and making health systems migrant-friendly, requires collective responsibility amongst government, partners and professionals. Realising that healthier migrants are able to support social progress and economic development (IOM, 2017) this study is significant for informing measures intended for better access to and utilisation of health services to improve population health. This is because of the shared ecosystem<sup>4</sup> and resources such as health facilities, markets, churches and schools. The next section provides the scope of the study, my positionality in terms of values and motivation for researching refugee health, women and children in particular.

### 1.3 Scope of the Study

World Health Organisation (WHO) (1946) defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". WHO's definition combines both the medical and sociocultural models of health behaviour to coin an inclusive and holistic definition of health and well-being. Many authors on health have criticised this definition of health as being naive, unrealistic and utopian, however, this definition is useful in the way it demonstrates health as being multidimensional and holistic—embracing all aspects of the individual and collective existence (Hunter, 2003). This understanding of health is key for social work practice in health particularly relating to the assessment of health needs for individuals, groups, and communities. This is because one of the core functions of social work is to support people to enjoy harmonious existence within themselves and within their social context. This combines both the biomedical and social-cultural understanding of health. Apparently, all the aspects of health including the physical,

---

<sup>4</sup>For example, in terms of outbreaks such as cholera, polio or measles these will not segregate between a national and a refugee

emotional, psychological, social and intellectual factors are all relevant for achieving total functioning and health and well-being of individuals and that of communities. The problem is that all these determinants of health are relative due to various forms of inequalities, life chances, and life choices. This makes some groups of people like refugee women and children to be much more at risk than others.

Therefore, in order for social workers to do meaningful assessment of these group's health needs, or to make meaningful contribution to proper health service delivery; it is important that they take into consideration all the determinants of health and the various laws, regulations, procedures, administrative actions, incentives, or voluntary practice of governments and any other institutions (policies). Health policies may focus on individual ill-health or on the health of populations (Alsop, 1995). The World Health Organisation's Global Strategy for Women, Children and Adolescents' Health (2016–2030) (as I will expand in Chapter Two) provides a guide to ending preventable deaths of women, children, and adolescents and prescribes recommendations on how to help this group to accomplish their potential and rights to well-being irrespective of the setting (Kuruvilla et al., 2016). This strategy's three goals including, survive (end preventable deaths); thrive (ensure the health and well-being); and transform (expand enabling environments) (WHO, 2016) which are also aligned with several Sustainable Development Goals (especially Goal 3—ensuring healthy lives and promoting of well-being for all at all ages) provides a model of practice for social work.

This research draws on the WHO's model of health/well-being and perspective on public health policy. Because the model adopts a broader and positive view of health, this has informed my approach to studying the comprehensive health needs and services for refugee women and children. The study is not intended to focus on a particular element of health but takes into consideration the fact that health is influenced by various social determinants (including forced migration) which intersect and exacerbate vulnerability for poor health outcomes. However, it is important to explain my values and impetus to conduct this research.

#### 1.4 Values and Reflexivity

Values refer to arbiters of preference or choice, that is—the criteria, perspectives, assumptions, theories or hypotheses, norms that one brings into play, implicitly or explicitly in making



choices (Lincoln and Guba 1985, p.161). These are either personal beliefs or feelings of the researcher (Bryman, 2001). Doing social research requires full engagement and commitment of effort, knowledge, time and financial resources and hence a great deal of choice confronts the researcher. Taking these into consideration, the important question to ask is: what happens to the values of the researcher as the research takes place (Ransome 2013, p.7)?

Social research cannot be value-free, and denial is not the solution either; rather, it is rational for researchers to guarantee that there is no untrammelled incursion of such values into the research process in order to protect the integrity or objectivity of research (Bryman, 2001). These values may be in resonance (affirm, reinforce) or dissonance (reject, conflict) with each other or with the investigation (Lincoln and Guba 1985, p.161). Finlay (2002) affirms that what is perceived as subjectivity can be transformed from being a problem into an opportunity, but this cannot be achieved unless the investigator is aware of his or her value positions. Hence, it is vital for researchers to conduct a thoughtful/conscious self-evaluation. Here, the researcher engages in an explicit, self-aware meta-analysis of the research process— known as reflexivity (Finlay 2002, p.531).

Reflexivity expresses a researcher's awareness of their connection to the research situation and, it makes us more likely to discern our effects upon it (Davies 2008, cited in Ransome 2013, p. 139). Although experiential knowledge in the correct sense is a useful source of insights, Maxwell (1998) recommends a need for critical subjectivity in research. This refers to the quality of awareness in which we do not suppress our primary experience or do not allow ourselves to be swept away and overwhelmed by it, but instead raise it to consciousness and use it as part of the inquiry process (Cited in Bickman and Rog, 1998, p. 78). Reflexivity, however, can be approached differently depending on the research design applied. Finlay (2002, p. 536) proposes that:

As the idea for a project is forming, researchers need to reflect on both the topic of study and their own relationship to that topic. This might involve the researchers' examining both the existing literature and the lived world itself as a means of clarifying the research questions. At this point, researchers could fruitfully examine their motivations, assumptions, and interests in the research as a precursor to identifying forces that might skew the research in particular directions.

Nonetheless, to reflect does not mean that the researcher should do away with trustworthiness, instead, the self is exploited only while to do so remains purposeful (Finlay 2002, p. 541).

My perceptions about the plight of refugee women have been shaped by personal experiences not as a refugee, but as a migrant. From 2010 to 2012, I went to pursue a graduate degree in Sweden. Although I was covered by health insurance, it was not easy to get access to health care. This was for both information and the actual services. On one occasion I was unwell and decided to seek health care in a clinic near my college grounds— only to be bounced at the reception. The reason was that I was not registered to use services in that particular clinic. Before this, I had no knowledge that I should register with a clinic near my residence in advance to access health services. This was my first experience. After this incident, I continued in a series of challenges regarding access to and utilisation of health care every time there was a need. I had no privacy in every single aspect of my life since I needed to consult friends to read and translate letters for me ranging from notifications to communication concerning health examinations. The fact that I was not acquainted with the Swedish system intersected with my negligible language skills which made me vulnerable as a migrant. Further, I also missed out on great opportunities and social life and became isolated. This matters because it allows me to empathise with migrants and the complex challenges they encounter in the process of relocation and integration. I'm also mindful that in worst scenarios, people may forfeit full access to their rights.

In addition, my first days as a fresh Ph.D. student with a young family in Edinburgh were not stress-free. Although this was not my first time living in a foreign country, it was not easy for me to find accommodations that would welcome my children. I had not experienced difficulties in finding housing in Sweden. Even though I had made prior arrangements for meeting our basic needs (in Edinburgh) such as paying for temporary accommodation and secured money for subsistence these provisions did not eliminate the adversities I experienced settling. Because of this discrepancy, I had to take my children (including a six-month-old baby) back to Uganda after working so hard to bring them. I had prospects of living with them during the course of my studies but these were not realised in the beginning. All these events had a great effect on my physical, social and emotional health during the initial phase of my doctoral studies. Although I managed to stay and to carry on with studies and brought back two (out of four) children to stay with me afterward, it has been so challenging for my family. This experience might not be equivalent to what many refugees go through but with it, I was conscious of the adversities of coping and adjusting to a life away from home, specifically in trying to access vital services. Moreover, this past history of suffering was a vital protective

factor that enhanced my emotional strength to objectively pay attention to the experiences of refugee women (Palmer, 2017).

In addition, during my career as an assistant lecturer at Makerere University<sup>5</sup>, I was engaged in meetings with the International Organisation for Migration (IOM) where we often discussed the health of migrants. These meetings were purposed to introduce a short course in Migration Studies in the School of Social Sciences. These meetings developed my interest in the subject of migration. When I composed my initial proposal I did not have a specific interest in refugees or women and children. However, linking my knowledge with my migration experience was a precursor for me to reflect on the dilemmas of vulnerable migrants. After reviewing the literature on migrant health, it was clear to me that refugees are more vulnerable (in terms of accessing services) than other groups of migrants (UNHCR, 2018). Intellectual and personal reflection dovetailed to pique my interest in women's and children's health needs.

Before I started my research, I had not visited any refugee settlement but from the literature, it was clear that the living conditions in such settings are not favourable (e.g., Palattiyil and Sidhva 2011; Allan 2014; Wachter et al., 2016). In a low-income country, in which even nationals struggle to access health care (UNHCR, 2019; OPM, 2017), it was conceivable that refugees could be facing severe hurdles, most particularly, the women who need to manage between understanding systems as well as taking care of children and families. Moreover, during the inception stages of my doctoral studies, I also visited the Office of the Prime Minister—Department for refugees in Kampala, where- I witnessed some of the struggles of asylum seekers to secure refuge. They go to this office to obtain legal status to gain access to assistance and protection.

My former training in social work and human rights also helped me to appreciate the importance of human rights (IFSW, 2012). I have always maintained the right of all people to liveable space regardless of class and status. As a result, I'm committed to making a meaningful contribution in the fight against discrimination towards and marginalisation of vulnerable groups (such as refugees) who may not have a voice.

---

<sup>5</sup> This is my current employer although I'm currently on study leave.

Although this prior knowledge and experience influenced my decision to investigate health needs and services for refugee women and children, it did not, however, bring any (conscious) bias to the way I collected, perceived, analysed and presented data. Ransome (2013, p.111) considers personal interest in the topic as a basic requirement for being able to carry out systematic research. This is vital to solve social problems and to bring about actual social change. I attempted to counter any residual (i.e. un-or sub-conscious) bias throughout the research by sharing with supervisors and peers. Consistent with phenomenological requirements, I ensured objectivity by letting my respondents speak for themselves (Patton 2002; Bryman 2001). Such procedures as peer and supervisor review helped to increase generalisability by backgrounding negative aspects of personal subjectivity. We now turn our focus to the ways in which this research will contribute to theory and practice

### 1.5 Main Contribution

In line with SDG 3, this research aims to improve health service delivery to ensure healthy lives and well-being for refugee women and children. The study was informed by the Global Strategy for Women, Children and Adolescents' Health (2016–2030) vision statement that “by 2030, there will be a world in which every woman, child, and adolescent in every setting realise their rights to physical and mental health and well-being, has social and economic opportunities, and able to participate fully in shaping prosperous and sustainable societies” (WHO 2016, p.6). Cognisant of a holistic understanding of health and well-being, WHO, 1986; Delavega, et al., 2019) this study offers a purely social work analytical frame to the phenomenon of refugee women and children's health that is: health status, health determinants and access to health services.

The use of both quantitative and qualitative methods develops a better understanding of the public health needs and vulnerabilities of refugee women and children, accessible health services and the challenges faced in accessing and utilising health services. The quantitative aspect expediently captured information from a broad sample of women which provides insights into relationships between variables and therefore could be generalisable to other refugee women in settlements. Qualitative data provides experiences and what processes refugee women encountered in trying to meet their health needs and those of their children. Together, the data provide knowledge which will influence policy development and

implementation to the authorities (such as OPM, UNHCR, IPs and OPs) and essentially inform further research in refugees.

Given that improved access to and greater utilisation of health services enhance population health (IOM, 2017), this research uncovers the unmet need for health care among refugee women and children, abuse and violence suffered by this group in remote settlements and reaffirms the need to develop and implement immediate and long-term solutions, protection of human rights and gender mainstreaming in programmes to reduce vulnerability. These are important because of my assumptions: a) that protecting refugees- equals protecting nationals (due to a shared eco-system); b) refugees might contribute to their health and development of Uganda if they are healthy, thriving and fully integrated; and c) due to an end goal to improve health care to average Ugandans especially those in rural settings where settlements are located. It is against this background that I propose a Comprehensive Model for Improved Refugee Women and Children's Health (See: Chapter Ten).

Finally, the study intends to make a contribution to social work knowledge and practice by interrogating social work's role in health promotion for refugee women and children (See: Chapters Eight, Nine and Ten). Recognising the central goal of social work as effecting change, empowerment and liberation of the vulnerable groups and individuals in society, I examine the prevailing social work practice and challenges and conceptualise how it would broaden its remit. The data suggest a need for expanding the social work curriculum and practice methods to cover knowledge relating to human rights, social justice, advocacy, cultural competency, community development, problem-solving abilities and the relevant domestic and international law. These are important for providing sensitive support which adequately responds to the health needs of the most vulnerable. The following section describes the structure of this thesis.

## 1.6 Synopsis

This study sought to examine the health needs and services for refugee women and children in NRS and articulated social work's role in health promotion for this group. It is organised under ten chapters. Chapter One sets the stage by outlining the background, objectives, scope and rationale for the study. Chapter Two presents the theoretical and conceptual background of the study. It explores the rights to life and health particularly highlighting the holistic aspects of

health and the broad public health concerns and service challenges in refugee settings. Chapter Three describes the geographical and contextual scope of the study and explores the aspects of refugee management and response in Uganda. Further, it introduces the philosophy of social work and its outstanding role in health promotion activities. Chapter Four examines the methodological considerations and points out the ethical issues and challenges of this research.

Chapter Five introduces the socio-demographic characteristics of the respondents, providing a foundation for understanding the health needs, vulnerabilities, accessible services and the barriers to access and utilisation of health services among refugee women and children in NRS. It opens up some of the key findings which are examined in the ensuing chapters.

Chapter Six specifies the key health themes derived from both qualitative and quantitative data that are: women's health, adolescent health, children's health, gender-based violence and abuse and mental health concerns. By developing an understanding of these realities, it provides a deep understanding of the public health needs, vulnerabilities and experiences of refugee women and children in NRS. Chapter Seven develops a clear picture of the vulnerability by exploring obstacles which impede access to and utilisation of health services. These are discussed under five key themes including communication, institutional, structural, infrastructural and societal challenges. Given these gaps, Chapter Eight examines the practise of social work in NRS which provides insights into how to broaden their remit. Chapter Nine reflects further on the main themes which emerged from both qualitative and quantitative findings and provides a synthesis of these in relation to the existing body of literature. These are summarised around five themes: the life of women and children in exile, gendered dimensions of health in exile, vulnerability, reflections of the imagined homeland and the articulation social work's role.

Finally, Chapter Ten presents conclusions derived out of the data and highlights implications for the social work profession, policymakers and future research. The study concludes with a model for improved refugee health.

## 1.7 Conclusion

The purpose of the first chapter has been to introduce my study, positioning it in the wider body of literature. It presents forced displacement as both a risk factor and determinant of refugee health. This familiarises the reader to the refugee crisis with the associated complex health

needs requiring comprehensive and empathetic care. Further, the central aims of the study, significance, scope, my personal attachments to this research and its potential contributions were highlighted. The chapter concludes with an outline of the thesis. We now turn our focus to the conceptual background of the study addressing the ways in which they both facilitated and informed the study.

## CHAPTER TWO: CONCEPTUAL AND THEORETICAL FOUNDATIONS

### 2.0 Introduction

The first chapter provided a situational analysis of the refugee crisis, aims and the impetus for undertaking this research. This chapter presents the conceptual and theoretical basis of the study. I will start by examining the right to life, followed by the right to health which will lead to a comprehensive exploration of the meaning and aspects of health.

### 2.1 The Right to Life

The right to life and safety is well spelled out in Article three of the Universal Declaration of Human rights (United Nations (UN), 1949). Further, any individual has a right to seek safety and refuge in country which they deem to be secure (UN, 2016). In the last decade, the protection of the human rights of migrants, including the right to health, has been increasingly recognised and has risen upon the international agenda; and in order to fulfil their legal obligations at both the international and national levels, governments in many regions have acknowledged the need to integrate the health needs and vulnerabilities of migrants into their national plans, policies, and strategies (WHO, 2013). Regional communities like Intergovernmental Authority on Development (IGAD) comprising of countries like Uganda, Djibouti, Ethiopia, Kenya, Somalia, and Sudan have developed initiatives aimed at fostering regional integration and management of mobility between participating countries, as well as increased awareness of the correlation between migration and development and IGAD's Health and Social Development Programme explicitly includes a migration policy dialogue component (IOM 2010, p.134). Health can be perceived as a consumption good for the beneficiaries, an investment on the part of those who want to profit from healthy populations but most importantly, health is a fundamental human right. As such, the enjoyment of the highest attainable standard of physical and mental health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and or social condition (WHO, 2013). WHO (2007) put forward the basic principles which any public health approach must address in order to address the health needs of migrants. I have indicated these in Table 2.1.



Table 2. 1 Public Health Approach for Migrants—Basic Principles

- The main public health goal should be to avoid disparities in health status and access to health services between migrants and the host population.
- The second, closely associated principle is to ensure migrants' health rights which entail limiting discrimination or stigmatisation and removing impediments to migrants' access to preventive and curative interventions which are basic health entitlements of the host population.
- The third principle associated with migrations resulting from disaster or conflict is to put in place life-saving interventions so as to reduce excess mortality and morbidity
- The fourth principle is to minimise the negative impact of the migration process on the migrant's health outcomes.

Source: WHO (2007) Report by the Secretariat.

## 2.2 The Right to Health

The right to health is addressed in Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN, 1976). WHO (2010, p.12) states that the right to health embraces social factors that promote conditions in which people live and the underlying determinants of health such as food and nutrition, housing, access to safe water and adequate sanitation and a healthy environment. The right to health can be realised when the following four conditions are met:

- a) Functioning public health and health facilities, goods, services and programmes have to be available in sufficient quantity.
- b) Health facilities, goods and services have to be accessible to everyone without discrimination (physical accessibility, economic accessibility (affordability) and information accessibility)
- c) All health facilities, goods and services must be acceptable to users in terms of being respectful of medical ethics, culturally appropriate and sensitive to gender and life-cycle requirements, and be confidential and improve the health status of those concerned.
- d) Health facilities, goods and services must be scientifically and medically appropriate and of good quality (WHO 2010, p.12)

These are important when seeking to understand the extent to which refugees are able to access and utilise health services in their destinations. This is because refugees tend to live

in isolated communities with limited access to health services and end up forfeiting these rights (Dunn, 2016). The next section examines the comprehensive definition of health.

### 2.3.0 Defining Health

There is no concise definition of the concept of health. Despite that, John Ware (1986 in Weiss and Lonnquist 2003, p.107) recognised some essential introductions to or measurements of health. These include:

#### 2.3.1 *Physical functioning*

This emphasises physical restraints concerning the capacity for self-care, mobility, and engagement in physical tasks; capacity to deal with daily tasks as well as a number of days confined to bed.

#### 2.3.2 *Mental health*

This centres on feelings of anxiety and depression; psychological well-being; and control of emotions and behaviours. Examples of mental health disorders include: Anxiety disorders such as phobias, panic, and obsessive-compulsive disorders; depression- a mental disorder specified with lasting altered mood for no obvious external cause; abuse or dependence on alcohol or drugs; schizophrenia-a mental disorder characterised by delusions, hallucinations thought disturbances and possible withdrawal from social relationships; and anti-social personality disorder manifested in superficial charm, refusal to accept guilt, substance abuse, and inability to accept responsibility (Weiss and Lonnquist 2003, p.79).

#### 2.3.3 *Social well-being*

This considers socialising and networking elements or interactions with friends, family or acquaintances for example, through paying them visits or by communicating with them via telephone or social media.

#### 2.3.4 *Role functioning*

This considers the social functionality of people and thus looks at the ability to discharge normal duties such as schooling or working without facing any difficulties.

### 2.3.5 *General health perceptions*

This focuses on self-reported health and well-being as well as the experience of painful emotions.

## 2.4 The Biomedical Model of Health

The biomedical definition of health is centred on the individual's physiological state and absence of side effects of affliction and health- basically characterised as the non-appearance of illness or physical dysfunctions; it is not a positive state but rather the absence of a negative state- hence, if are not sick, you are well (Weiss and Lonquist, 2003). The model situates health and illness in physiological malfunctions and considers health as the absence of disease. It is assumed that the presence of disease, its diagnosis, and its treatment are all completely objective phenomena and that symptoms and signs provide accurate and unbiased information from which valid diagnosis can reliably be made merely by medical professionals (Weiss and Lonquist 2003, p.107). The medical model designates the physician as the director of care instead of the patient and centres on impairments, diseases, and symptoms rather than the individual (Allen and Spitzer, 2016, p.12). The model is helpful in delineating the physical features of disease and general symptoms. It also signifies how these can be addressed from a medical perspective. This mirrors Parsons' universal conception of health, affirming that well-being and disease apply to every single individual in all social orders (Parsons cited in Jaco,1972).

However, the model is narrow in its ability to recognise the significance of the social-cultural influences on health such as the several aspects which influence the reaction to and reporting of illnesses. For example, people respond to pain or sickness differently, while some cry others may possibly stay firm. This can influence people's behaviour before a specialist. Furthermore, the process of defining health and illness is broad and actually start before visiting the health facility to seek out remedy. All these aspects normally affect people's health because humans are not simply biological beings but they are also psychological and social creatures (Weiss and Lonquist 2003, p.107). Therefore, while one must not discount the power that society has granted to physicians for defining health and illness, a great deal of diagnosing and treatment occurs outside of the physician's office by both the patient and his/her significant others (Weiss

and Lonnquist, 2003). Besides the model gives a lot of consideration on the deteriorating portion of the life which restricts appreciation of whatever is left of the emphatically working being. As a result, much might be found out about ill health, however, less about well-being.

## 2.5 The Sociological Model of Health

The sociological model of health gives attention to the social and cultural factors which determine health. According to Parsons (1972) health refers to a state of the optimum capacity of an individual to effectively perform roles and tasks for which he/she has been socialised hence it is—the ability to comply with social norms (Parsons, 1972 in Weiss and Lonnquist 2003, p.108). Thus, it characterises the well-being by situating individuals in their context viewing them as part of the whole which infers that personal health is determined by the collective and is relative. In addition, the model gives great value to the social than the physical understanding of health; stating that health is relative to one's cultural perceptions (for example, what is considered a healthy state for one person might be considered unhealthy by another); and one's position in the social structure (Twaddle 1974, in Weiss and Lonnquist 2003, p.108).

This model does not nullify the fact that disease can be objectified, rather it's concentration is considerably more extensive and socially applicable than simple physiological breakdown. Additionally, the person's own sense of his well-being is given centrality (instead of the professional's). Moreover, the sociological definition is expressed in positive terms—health is not the absence of something, it is a positive ability to satisfy one's roles and it is not only a physiological condition- but that it also incorporates the dimensions of person's that effect on social participation (Weiss and Lonnquist, 2003).

## 2.6 World Health Organisation (WHO) Definition of Health

WHO combines both the medical and socio-cultural aspects and provide a more inclusive and holistic definition of health and well-being. WHO (1946) defines health as, "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". Although this definition incorporates physiological aspects of health, it is broader and positive. As a result, health is defined in entirety as compared with the objective medical model. However, this subjective classification of health is similarly ambiguous and problematic to

assess. This may pose a challenge in outlining or designing health interventions because it might be difficult to perceive the level of intervention.

WHO has so far broadened the definition of health beyond the individual level of functioning to further consideration of dynamic social processes that influence health. Thus, WHO (1986) describes “health as the extent to which an individual or group is able to realise aspirations and satisfy needs and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasising social and personal resources, as well as physical capacities (WHO, 1986). The necessary conditions and resources for health include peace, shelter, education, food, income, a stable Eco-sustainable resource and social justice (WHO, 1986). It is impossible to discuss well-being without reference to actions which determine health.

#### 2.7.0 Health Behaviour

Alonzo (1993 cited in Weiss and Lonquist 2003, p.109) identified four distinct activities as constituting health behaviour: prevention, detection, promotion, and protection.

##### *2.7.1 Prevention*

The objective of preventive health conduct is to limit the danger of illness, damage, and incapacity. These health defensive practices incorporate taking an interest in activities such as normal workout, keeping up a positive weight, not drinking alcohol or smoking, and getting immunisations against communicable diseases. Fernandes and Miguel (2009, p.20) state that “disease prevention provides health assessment and specific screenings for the target population either in the country of origin or at the destination and necessary psychological support.

##### *2.7.2 Detection*

This includes activities which are intended to screen diseases or infections, injuries or disabilities before signs show up and incorporate therapeutic examinations such as blood pressure tests, pap spread or mammogram.

### *2.7.3 Promotion*

Health-promoting activities comprise of endeavours to urge and influence people to take part in well-being elevating practices and to avoid or withdraw from health hurting practices. According to the 1986 Ottawa Charter for Health Promotion, health promotion is defined as the process of enabling people to increase control over, their health and improve their own health and well-being, and that of their families and communities (WHO, 2018, p.vi). It is also important for targeted interventions, including health education (Fernandes and Miguel, 2009).

### *2.7.4 Protection*

Health protective activities incorporate endeavours to make the environment in which individuals live as sound as would be practical. A lot of these activities happen at the societal level instead of the individual level and include actions such as, monitoring the physical and social conditions in which individuals live; physical structures and infrastructures; systems of transportation; accessible sustenance (food), air and water; work environments; and creating social and financial policies that allow and encourage good health. Protective factors such as income and social support directly impact an individual's and a community's versatility which in turn leads to an improvement in health and well-being (Vingilis & Sarkella, 1997). Researchers have underscored the interrelationship between such protective activities, resilience, and health. For example, Mangham et al. (1995) consider that "resilience is the capability of individuals, families, groups, and communities to cope successfully in the face of significant adversity or risk. This capacity changes over time and is enhanced by protective factors in the individual/system and the and these contribute to the maintenance and enhancement of health" (Mangham et al. 1995, cited in Vingilis & Sarkella, 1997 p.167).

Mangham et al., (1995) further categorised the protective factors which contribute to resiliency into, individual factors (such as a sense of personal responsibility and competency, reading and cognitive skills, a sense of meaning, problem-solving ability, skills in coping with stress and resourcefulness in seeking support); familial factors (for instance, effective parenting and strong family support and cohesion); and support factors (including the presence of caring and supportive individuals) (Mangham et al. 1995, cited in Vingilis & Sarkella 1997, p.167).

In society, however, there are some groups or individuals who may have fewer preventive, detective, promotion and protective factors to maintain and enhance their health. For example, poverty has been identified as a major psychological stressor leading to elevated levels of

anxiety and depression among individuals exposed to various economic stresses (Avison et al., 1994 cited in Vingilis & Sarkella 1997, p.168). In addition, deprived individuals are less disposed to have constructive self-regard; they lack opportunity to organise diverse sponsorships inside and outside the family; have less choices and decisions in their residential, social and work-related situations; make poor personal life choices; are compelled to pick among less choices for adapting/coping; and thus swing to what is economically accessible or generally available (Vingilis & Sarkella, 1997). This intensifies stress and the effect of particular stressors on health problems is exacerbated when other upsetting conditions are experienced (Avison et al., 1994 cited in Vingilis & Sarkella 1997, p.168). I now turn to the fundamentals of health behaviour.

### 2.8.0 Theoretical Foundations for Health Behaviour

There are diverse influences on the health behaviour of individuals and communities. These can be categorised into macro and micro factors. Macro factors can also be termed as ‘life chances’ while micro factors can be termed as ‘life conduct,’ and there are interrelated (Weiss and Lonnquist 2003, p116).

#### 2.8.1 *The Macro Approach*

Macro factors refer to aspects which are beyond individuals but impact their health. The metaphor of Zola provides a practical illustration of the full-scale factors that impact health:

“You know, sometimes it feels like this. There I am standing on the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and another yell. Again and again, without end, and goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in” (Zola in Mckinlay,1974 cited in Weiss and Lonnquist 2003, p.117).

This analogy of the victims drowning in the river and being rescued demonstrates the significance of the social structural processes and procedures and the influence of environmental factors on health and well-being. It suggests that there are broader intricacies which influence health and these restrain the utility of individual measures in addressing health needs. Thus, tending to public health needs would require focusing on addressing the actual causes of health problems as contrasted to the handling of symptoms of health matters. Interventions that change the social and physical environment are structural interventions and this target, for instance, the workplace or community (Cohen et.al 2000, p.147). Such programmes include interventions that increase the availability and accessibility of health elevating products such as, free health screenings, care or subsidised food. The structural model of health behaviour is one of the theories that underlines the significance of inclusive macro interventions to health needs of people as opposed to individualised interventions.

### *2.8.2 The Structural Model of Health Behaviour*

The structural model of health behaviour concentrates on macro factors and pays limited attention to individual factors in responding to health needs. The model was derived from the ecological theory which supposes that environmental (structural) elements are basic determinants of individual conduct. It advocates for structural policies and environmental interventions to improve the health of populations. The ecological theory underlies the fundamental paradigm for the practice of public health. Public health interventions customarily focus on the conditions under which individuals live and often passively involve populations in prevention efforts (Cohen et.al, 2000). The ecological theory proposes that by adjusting and manipulating the environment in which individuals live, it is possible to impact their health hence, better health results are made by changing physical conditions such as providing clean water and secure communities.

The structural model of health targets entire populations and aims to transform conditions for every person, irrespective of whether they are individually at risk (Cohen et al 2000, p.147). Cohen et al. (2000, p.148) coined four factors which constitute a structural model of population-level health behaviour:



### Availability/accessibility of consumer products

This refers to the accessibility of consumer products that are associated with health outcomes (Cohen et al., 2000). These can be both health-enhancing products (such as condoms, sterile needles, mosquito nets, food); or life-threatening products (like tobacco or alcohol). It is expected that greater accessibility to products is associated with greater consumption or utilisation of such products, while lower accessibility is associated with lower consumption of products (Cohen et al. 2000, p.148). The more the population is exposed to products or items that are destructive to health, the more they would consume such products hence leading to poor health and mortality; however, health would improve if such a setting is altered by making safe and healthy products available and accessible.

### Physical structures

These refer to physical characteristics of structures or products that either reduce or increase opportunities for health behaviours and health outcomes, that is, the condition of the physical environments contributes to the establishment of social relationships and risk behaviour which impact health (Cohen et al., 2000). Physical structures are actual tangible objects (like consumer products, structures and physical layout of communities) whose nature and physical qualities would make it either safe or harmful for people. For example, the structure of houses can influence people's welfare; the security of the communities can determine whether there will be cases of assault and rape. These can be altered by putting in place regulations and laws such as secure communities that reduce the opportunities for injuries or assault.

### Social structures and policies

These refer to laws or policies that oblige or prohibit behaviour (Cohen et al, 2000) depending on the value or risk attached to such behaviours. Social structures set guidelines to limit high-risk behaviour and can provide a framework for encouraging low-risk behaviour mainly because of the ideology that, high-risk behaviours are situational and occur spontaneously from a lack of forethought (Cohen et al., 2000). Enforcement is one case of a social structure that helps people in complying with rules and regulations. Consequently, enforcement can either be formal (such as a levied fine or disciplinary action) when implemented by governmental agents or non-governmental bodies; or it can be informal when implemented through family, friends or neighbours (Cohen et al., 2000).

## The media and cultural messages

These also constitute the social-cultural model of health behaviour. These refer to messages that people see and hear frequently through the media and cultural practices (Cohen et al., 2000, p.149). The sort of messages used to get attention and the association of images and products with fundamental human desires and needs regularly bestows more significance to products than these would otherwise have (Cohen et al., 2000). Media can have an influence on individual convictions and knowledge as well as on the structural standards. Nonetheless, media can be viewed as a structural intervention when it impacts norms mainly because the recurrence and force of media messages can make it appear that the utilisation of an item is a standard and that the practices related to the item are normative (Cohen et al, 2000).

The structural model of health behaviour justifies a vast divergence in health outcomes among diverse populations, ethnicities, and income levels. The principal assumption is that exposure to these factors varies across populations, demonstrating that lower-income and minority groups are extremely exposed to factors that promote the use of dangerous products; their physical and social structures are less conducive to health; there are fewer police enforcements and more crowding in such areas; and that safer alternative activities and products are more difficult to find in low-income communities than in high-income regions (Cohen et al. 2000). The challenge with the structural model is its approach, for instance, the emphasis on social policies, rules, and laws to control people's health behaviour. This may be observed as contradicting the independence and freedom of people in their health matters. Equally, contextual, logistical and political factors may render the structural approach less fruitful in bringing on better results in health.

### *2.8.3 The Micro Approach*

Apart from structural factors, there are also some individual factors/characteristics that determine the health needs of populations. This suggests that some interventions should target individuals to change their behaviour in order to influence health outcomes. Examples of such interventions consist of counselling, advice, and education (formal or informal). The purpose of such interventions is the attempt to influence knowledge/information, attitudes, skills/abilities, beliefs and cognitions of people (Cohen et al, 2000). The Health Belief Model is one of the theories which speculates health actions in light of individual attributes.

#### *2.8.4 The Health Belief Model (HBM)*

Health Belief Model was developed by a group of social psychologists (such as Hochbaum, Rosenstock, Mainman and Becker) as an approach to explaining individual's preventive health behaviour in terms of the person's current psychological dynamics and his interaction with situational factors (Chen and Land 1986, p.45). The theory postulates that the emergence and direction of preventive health behaviour depend on the existence of certain beliefs toward a given condition rather than on objective facts (Chen and Land 1986, p.45). The model recognises that in making healthy choices, individuals consider both health-related and non-health related consequences of such actions. This provides a paradigm for understanding why some individuals engage in health-protective behaviours while others behave in knowingly unhealthy ways (Weiss and Lonnquist 2003, p.118). The theory presupposes that individuals will take preventive action at the point when the following four conditions exist: 1) the individual feels susceptible or vulnerable to a certain disease or condition; 2) the individual feels that contracting the diseases would have serious consequences; 3) the individual believes that taking preventive action effectively reduces susceptibility to the diseases or at least reduce its seriousness if contracted and that the action would not involve serious barriers (like cost, embarrassment, inconvenience, expense and trauma) and; 4) when one or more cues or triggers for action occurs (like advice from others, physician reminder or an illness of a family member or friend) (Chen and Land 1986, p.45). Weiss and Lonnquist (2003, p.120) add that all these opinions might be influenced by several non-health factors including demographics (age, gender, social class, race/ ethnicity); socio-psychological (personality, peer, and reference group pressure); and structural (knowledge about the disease). Figure 2.1 presents the Health Belief Model.

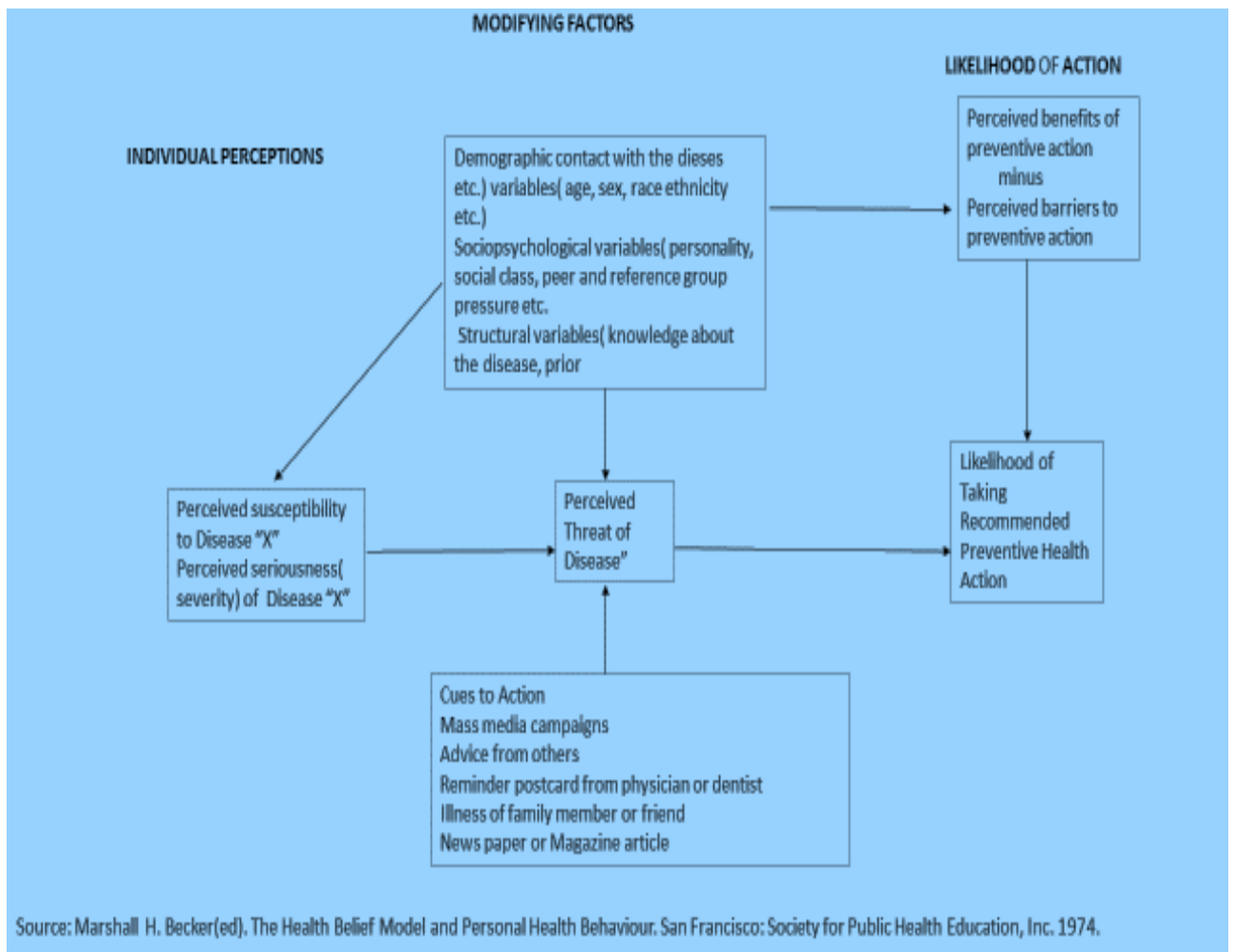


Figure 2. 1 The Health Belief Model

The HBM is limited because of too much focus on preventive health activity with respect to specific illnesses or sickness. To use this model, therefore, one must examine the perception of the practicability of making a move to prevent disease. It is useful in analysing disease-specific practices and less pertinent to understanding preventive health actions in general or in anticipating the probability of taking part in overall well-being elevating conduct insignificant to fear of specific sicknesses (Weiss and Lonquist, 2003).

In summary, both the structural model and the HBM explain the factors which determine people's choices and decisions in terms of seeking health services or support. We can understand the origin of health actions in terms of how people's choices to seek and utilise health services develop. These also determine people's attitudes towards improving their

health. They also shed light on how health services might be informed, designed and implemented. The next section examines the process of determining health needs.

### 2.9.0 Health Needs Assessment

Health needs assessment refers to a process of determining the health and health care needs of any given population (Bani 2008, p.13). This process goes beyond listening to individual health experiences to delineating gaps in health service coverage so as to meet the unmet needs (Bani, 2008). It is a vigorous and complex process and necessitates systematic methods and skills in needs identification mainly because some causes of ill health may be deeply engrained within the wider structures of society. It thus involves going beyond the medical model to identifying wider influences on health such as the changing social and environmental determinants of health including poverty, housing, nutrition, education and employment (Wright, 2008).

Health needs refer to needs that can be addressed by health care services as well as social and environmental changes (Wright, 2008). Depending on different factors and the context, needs may be defined and approached differently. As I will indicate in the next chapter (Three), the identification of health needs and provision of health care services to refugees in Uganda is carried out by various groups at different levels including the Government (Department for refugees, Local government structures); international organisations (UNHCR) and organisations at the national level. It is unclear these fundamentally look at the needs of refugees before any courses of action for arrangements are made. This is on grounds that in crises or emergencies agents have to balance between the existing resources as well as the existing need which implies that need may cease to be a basis for service provision. This does not mean however that it is unessential or unimportant, but decisions must be made to save lives. In trying to assess the health needs of refugees and how the response is organised, we can employ Bradshaw's typology of classifying human needs. According to Bradshaw, there are four hierarchies of understanding human needs including the felt need, expressed need, comparative need, and normative needs.

#### 2.9.1 *Felt needs*

These are needs that people feel that they need. Felt needs can also be called wants and depend on age, gender or someone's biology (Bradshaw, 1972). They also tend to be sensitive needs.

In considering the needs of refugee women and children providers must take into account the existence of such personal needs. These cannot be known except if individual women are approached and asked to voice their experiences. Many women may not have the chance to communicate their felt needs due to a lack language skills or assertiveness. And because some women may not be aware of the existing services, sometimes their felt needs may go unmet.

### *2.9.2 Normative needs*

These are needs that may be defined and determined by the health service providers or any officials in decision making. To determine the needs, experts compare their standards and value judgments of what they consider to be desirable with what they actually find on the ground (Bradshaw, 1972). In refugee situations it very likely that service providers use their own normative measures of adequacy in health and well-being to determine needs. This is necessary to respond to emergencies and to respond to needs of the most vulnerable like children. However, this standardisation may not adequately respond to need because it focuses on what is in stock or prioritised. This approach disregards other personal, social, cultural, economic, and environmental factors that influence health. This scenario may create unmet needs in health care for vulnerable refugees.

### *2.9.3 Expressed needs*

These are needs that can be recognised by considering people's actions or demands. In other words, there are felt needs that are turned into demands or requests (Bradshaw,1972). Refugees normally demand health services for themselves and their children but some services which require specialised care sometimes are not given to them. Besides the demands sometimes go beyond the available services which lead to rationing of services. For some groups like women, cultural norms may deter them from expressing their needs (Fernandes and Miguel, 2009).

### *2.9.4 Comparative needs*

These are needs that are defined by comparing different groups with similar characteristics and if one group is not receiving the service, then there is a need to provide the service to such a group. This is important because refugees settle within communities and universally, they are all human beings. Upon that similarity, refugees deserve to get health services like the locals.

Comparative needs usually represent gaps in service provision and thus are important for those in policy formulation. I now turn to the global commitment to protect the right to health.

#### 2.10 The Global Strategy for Women's and Children's Health (2010–2015)

The Global Strategy for Women and Children's Health was launched in September 2010. It was driven by a global commitment to save lives and improve the well-being of women and children. This was consistent with the eight MDGs: 1) eradicate extreme poverty and hunger; 2) achieve universal primary education; 3) promote gender equality and empower women; 4) reduce child mortality; 5) improve maternal health; 6) combat HIV/AIDS, malaria and other diseases; 7) ensure environmental sustainability and; 8) develop a global partnership for development. Three out of these (MDGs 4, 5 and 6), were focused on health. The principal areas of activity for the Global strategy were: health financing; the health system and workforce; access to essential interventions and life-saving commodities; national leadership; and accountability (Kuruville et al., 2016). The MGDs delivered some advances in poverty reduction, education and access to safe drinking water. However, by the end of the MDGs period in 2015, there were many women, children, and adolescents worldwide who still suffered violence and discrimination, with little or no access to essential, good-quality health services, education, clean water, adequate sanitation and good nutrition; and faced other barriers to realising their human rights (WHO, 2015). This prompted further commitment from WHO and partners to revisit the strategy as the Sustainable Development Goals era set in as I expound in the next section.

#### 2.11 The Global Strategy for Women, Children and Adolescents' Health (2016–2030)

After MDGs (2000 to 2015), a new era of the Sustainable Development Goals (SDGs) evolved. Hence, 17 SDGs with 169 targets were developed. These include: SDG(1) End poverty in all its forms everywhere; SDG(2) End hunger, achieve food security and improved nutrition and promote sustainable agriculture; SDG(3) Ensure healthy lives and promote well-being for all at all ages; SDG(4) Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; SDG(5) Achieve gender equality and empower all women and girls; SDG(6) Ensure availability and sustainable management of water and sanitation for all; SDG(7) Ensure access to affordable, reliable, sustainable and modern energy for all; SDG(8)

Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all; SDG(9) Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation; SDG(10) Reduce inequality within and among countries; SDG(11) Make cities and human settlements inclusive, safe, resilient and sustainable; SDG(12) Ensure sustainable consumption and production patterns; SDG(13) Take urgent action to combat climate change and its impacts; SDG(14) Conserve and sustainably use the oceans, seas and marine resources for sustainable development; SDG(15) Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss; SDG(16) Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels; and SDG(17) Strengthen the means of implementation and revitalise the global partnership for sustainable development (WHO 2015, p.25). Unlike MDGs which might not have represented every individual, SDGs were formulated to account for all humanity in development as the motto goes that, “every action counts and every life counts” (WHO, 2016).

Consistent with SGDs, The Global Strategy for Women, Children and Adolescents’ Health (2016–2030) was launched in 2016 with a vision that, “by 2030, there will be a world in which every woman, child, and adolescent in every setting realise their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies” (WHO 2016, p.6). This strategy gives a guide to ending preventable deaths of women, children, and adolescents by 2030 and helping them accomplish their potential for and rights to well-being and prosperity in all settings (Kuruvilla et al., 2016). The strategy has three goals: 1) survive (end preventable deaths); 2) thrive (ensure the health and well-being) and; 3) transform (expand enabling environments) (WHO, 2016). These objectives were aligned with several SDGs primarily Goal 3 (about health) and several others (such as, 2, 4, 6, 8, 10, 11 and 16) (WHO, 2015). It aims at change across the various elements of health (physical, mental and social) and sustainable development WHO, 2016).

In light of new evidence, socio-political and environmental changes and the SDGs, it incorporates fresh strategic areas: adolescent health; humanitarian and fragile settings; an integrated life-course approach; multisector approaches and principles of universality, human rights, equity and development effectiveness (Kuruvilla et al., 2016). WHO (2016, p.5) asserts that:



With its full implementation, no woman, child or adolescent (even in the most difficult circumstances) should face a greater risk of preventable death because of where they live (including crisis situations) or who they are (including refugees). By creating an enabling environment for health, it aims at transforming societies so that women, children, and adolescents everywhere can realise their rights to the highest attainable standards of health and well-being.

Although health interventions could be contextualised according to the country (depending on health needs, the supply of related products and commodities and legal considerations), all member states have the obligation to move with this campaign of 2030 agenda for sustainable development (WHO, 2016). An outline of the essential intervention packages for this framework is presented in Table 2.2. The next section securitises the concept of public health policy.

Table 2. 2 List of Essential Evidence-Based Interventions for Women, Children and Adolescents' Health

<b>Life Course</b>	<b>Intervention Packages</b>	<b>Enabling Environment</b>
Women's health	Sexual and reproductive health information and services; <ul style="list-style-type: none"> <li>• nutrition;</li> <li>• management of communicable and non-communicable diseases;</li> <li>• screening and management of cervical and breast cancer;</li> <li>• gender-based violence prevention and response;</li> <li>• pre-pregnancy risk detection and Management</li> </ul>	Health System Enablers <ul style="list-style-type: none"> <li>• policies for universal health coverage;</li> <li>sufficient and sustainable financing;</li> <li>• health workforce supported to provide good-quality care everywhere;</li> <li>• commodity supply;</li> <li>• health facility infrastructure;</li> <li>community engagement;</li> <li>• mainstreaming emergency preparedness;</li> <li>• human rights, equity and gender-based approaches in programming;</li> <li>• accountability at all levels</li> </ul>
Pregnancy, childbirth and postnatal care	Antenatal care, <ul style="list-style-type: none"> <li>• childbirth care;</li> <li>• safe abortion and post-abortion care;</li> <li>• prevention of mother-to-child transmission of HIV;</li> <li>• management of maternal and new-born complications;</li> <li>• postnatal care for mother and baby;</li> <li>• extra care for small and sick babies</li> </ul>	

		Multisector Enablers
Child health and Development	Breastfeeding; <ul style="list-style-type: none"> <li>• infant and young child feeding;</li> <li>• responsive caregiving and stimulation;</li> <li>• immunisation;</li> <li>• prevention and management of childhood illness and malnutrition;</li> <li>• treatment and rehabilitation of congenital abnormalities and disabilities</li> </ul>	policies and interventions in key sectors: finance and social protection; education; gender; <ul style="list-style-type: none"> <li>• protection— registration, law and justice; water and sanitation;</li> <li>• agriculture and nutrition;</li> <li>• environment and energy;</li> <li>• labour and trade;</li> <li>• infrastructure, including facilities and roads;</li> <li>• information and communication technologies; and transport</li> </ul>
Adolescent health and development	health education; <ul style="list-style-type: none"> <li>• supportive parenting;</li> <li>• nutrition;</li> <li>• immunisation;</li> <li>• psychosocial support;</li> <li>• prevention of injuries, violence, harmful practices and substance abuse;</li> <li>• sexual and reproductive health information and services;</li> <li>• management of communicable and non-communicable diseases</li> </ul>	

Source: WHO (2016, p. 17)

## 2.12 Public Policies

Policy formulation is a process and procedural activity. Firstly, an issue should be perceived as a problem by legislators, policymakers and the overall community after which proposals for solutions to the problems (policies) are recommended by policy communities (Leppo et al., 2013). There are three key policies in health— promotion, prevention, and protection. WHO (2008, p.64) categorised these policies into:

- a) systems policies (arrangements that are needed across health systems’ building blocks to support universal coverage and effective service delivery),
- b) public-health policies (specific actions needed to address priority health problems through cross-cutting prevention and health promotion and,
- c) policies in other sectors (contributions to health that can be made through inter-sectoral collaboration).

Health systems policies deal with essential drugs, technology, quality control, human resources, and accreditation. These policies are crucial for primary health care and universal

coverage of health services to any population. These usually depend on the demand and supply of such logistics. These policies are crucial for health because without functional supply and logistics systems, for example, a primary-care network cannot function properly (WHO, 2008). Yet this is important for emergencies and saving lives.

Public health policies are measures targeted at addressing public health problems beyond the local level. These measures usually aim at removing major risk factors of diseases and addressing the social determinants of health in order to make communities secure for healthy living. Public health interventions can be very useful in altering individual behaviours and lifestyles; controlling and preventing disease, tackling hygiene and the broader determinants of health; and secondary prevention, including screening for disease (WHO, 2008). Public policies are very important as they can mobilise and prepare communities around health issues, provide a legal and social environment that is favourable to health outcomes and anticipate future health problems before they impact health (WHO, 2008).

### 2.13 Health in All Policies (HiAP)

Health is a fundamental component of individuals' prosperity and development. It is considered to be an empowering and essential component for peoples' capacity to achieve their objectives and happiness and a foundation for society to achieve societal goals (Leppo et al., 2013). Despite this, there are various, social, physical and economic environmental factors as well as individual characteristics and behaviour which affect people's health (Fernandes and Miguel (2009). The determinants of health are different for all populations. This accounts for health inequities within and between countries or groups of people (Leppo et al., 2013). These are further exacerbated by the sometimes insensitive systems put in place to deal with illness.

Health in All Policies (HiAP) refers to “an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasises the consequences of public policies on health determinants and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making” (*ibid*, p.6). The approach highlights the possibility that the health sector cannot function in the disconnection of alternate sectors. The health sector impacts and is additionally affected by different sectors. Hence,

decisions outside the direct remit of the health sector –and often outside the national boundaries – also influence the mandate, regulatory scope and resources for health protection (Leppo et al., 2013, p.7).

The approach is centred on a solid establishment of human rights, values of social justice and equity as well as strong attention to policymaking. HiAP is consequently concerned with the advancement and execution of legislation, standards, models, real procedures, programmes and choices on resource collection and allocation (Leppo et al, 2013). The HiAP approach can essentially be incorporated in project work with refugees whereby all interventions can be connected and cohesively combined towards the goal of health promotion and well-being in refugee settlements. For example, public policies dealing with water and sanitation, education, social services, built and natural environments, agricultural production, trade, regulation, revenue collection and allocation of public resources have important consequences for population health and health equity (Leppo et al., 2013).

The challenge for applying this approach in low-income nations is related to constrained resources. In any case, HiAP does not mean doing everything at all times; it is about doing the most ideal within the context of political will and resources and ideally. HiAP efforts ought to be carefully prioritised, based on information on the extent and significance of the current health situation, its distribution across population groups and, specifically, knowledge on the underlying determinants of health and causes of inequity (Leppo et al., 2013, p.7).

#### 2.14.0 General Public Health Issues in Refugee Settings

Refugees in settlements experience various difficulties including disrupted social networks, limited livelihood opportunities and frequent threats to their security (O’Laughlin et al., 2015). The main causes of ill-health among women and children in settlements are communicable and non-communicable diseases, injuries that they sustain during flight and reproductive causes.

Although experiences of war such as violence, fear, and loss may be significant for all refugees, the gendered experience of war, flight and stressors in exile may impact roughly on women than men leading to differences in the health needs (Deacon and Sullivan, 2009). These are vital in determining their health status. In the study of the gendered politics of firewood in Kiryandongo refugee settlement in Uganda, Mulumba discusses how women consequently faced negative changes in their gender relations, suffered domestic violence for being away

from home for long periods of time, and were unable to invest in their personal development and health needs (Mulumba 2011, p.39). This means that women's health goes beyond reproduction. Thus it is important health interventions take into account the characteristics of women that affect their health and how they seek health services for themselves and their children (Paoliso et al., 1995).

#### *2.14.1 Communicable Diseases*

Communicable diseases such as malaria, diarrhoea, cholera, shigellosis, acute respiratory infections, measles, meningococcal meningitis, dengue haemorrhagic fever, influenza, hepatitis A, and E are the main causes of mortality and morbidity among refugees (UNHCR, 2014). In 2008, malaria was the top cause of mortality among refugees and cases rose in 2011 in countries such as Uganda, Tanzania, and Zambia where malaria is endemic (UNHCR, 2014). Acute upper and lower respiratory infections have increasingly been the leading causes of mortality among refugee populations worldwide (UNHCR, 2014). This is mainly because refugees often end up in crowded and harsh conditions with poor shelter. In addition, they often do not have access to services and assistance to enable them detect and treat health issues that develop from those challenges (UNHCR, 2014).

Tuberculosis is also believed to be a serious health burden to refugees especially those in camps (Kimbrough et al., 2012; Fernandes and Miguel, 2009). Most of Uganda's settlements are located in rural areas with poor sanitation and poor waste management, inadequate water supply and low socioeconomic status as compared to the rest of the population (Refugee Law Project, 2015). The poor sanitation, especially at water sources, exposes the residents to water-borne and water-associated diseases such as malaria, hepatitis, and typhoid (*ibid*).

#### *2.14.2 Nutritional Health Problems*

Refugee women and children face nutritional conditions that make them susceptible to micronutrient deficiencies, such as anaemia and iodine deficiency disorders. Iron deficiency anaemia comes mainly as result of menstruation and pregnancy and iron demands of lactation. Iodine deficiency disorders can lead to goitre and other health problems and in pregnant women, it affects their unborn babies. These conditions are severe where women have no access to essential food supplements especially pregnant and lactating (WHO, 2015). Besides,

the ‘male-centred paradigm’ which usually governs response to survivors of warfare (Comas-Diaz and Jansen, 1995) necessitates that food rations are often distributed to male heads of households who also usually eat first before women and girls (Deacon and Sullivan, 2009). This exacerbates malnutrition levels in women and children as they miss out on their share of the limited resources. A nutrition survey in camps and settlements done by UNHCR in 2012, revealed that two-thirds (63%) of the surveyed camps and settlements showed global acute malnutrition (GAM) levels of 10% or more among infants and children aged 6-59 months (UNHCR 2014, p.48).

### *2.14.3 Reproductive Health Problems*

The UN Platform for Action (1995) defines reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes (Crawley 2001, p.147). Reproductive health problems may include maternal health complications, poorly-managed pregnancy, abortion, anaemia, sexually transmitted diseases and (STDs) female cancers such as cervical and breast cancer, unmet need for family planning services and maternal mortality due to haemorrhage during birth. Biological factors, lack of access to information about available health services, economic vulnerability and unequal power in sexual relations put women in vulnerable states for example; these expose women to HIV infection; as women always have weaker bargaining positions. Refugee women in settlements do not give birth in health facilities not because they do not want but because there are different challenges for them (Deacon and Sullivan, 2009). In Deacon’s investigation of refugee women’s needs in the United States, he revealed that although women were happy with health care, they (mainly Arab and Afghan women) expressed a significant desire of being seen by female specialists (*ibid*, p.278).

Cervical cancer is a common type of illness among women of reproductive age yet access to screenings and immunisation from such diseases may not be accessible to women in camps (Deacon and Sullivan 2009). Women’s responsibilities such as, collecting firewood from bushes put them at a high risk of getting tetanus (WHO, 2015). Immunising potential mothers against tetanus and giving them prophylactic antimalarial protects them and their unborn children (Dyke, 1991).

#### *2.14.4 Sexual and Gender-Based Violence*

Violence is one of the most ignored determinants of health yet women and children worldwide bear the brunt of non-fatal physical, sexual, and psychological abuse (WHO, 2015). Evidence indicates that: 1 in 5 women reports having been sexually abused as a child; 1 in 3 women has been a victim of physical and/or sexual violence by an intimate partner at some point in her lifetime; an estimated 11.4 million women and girls are trafficked worldwide; 125 million women and girls in 29 countries have undergone female genital mutilation; over 60 million women aged 20-24 years worldwide have been married before the age of 18; and women are killed due to a perpetrator's conviction that the victim has brought dishonour on a family or community (WHO 2015, p.81).

This gross violation of women's rights leads to other problems such as trauma, fistula, and sexually transmitted infections (STIs). Acts of sexual violence and gender-based-violence including gang rapes, sexual slavery, purposeful mutilation of women's genitalia, and killing of rape victims are usually common in conflicts (Wakabi, 2008). Wakabi investigated sexual violence among refugee women from Eastern DRC in 2010, and found that rates of reported sexual violence were high over (40%) among women, leading to unprecedented rates of trauma, physical injury including fistula, unwanted pregnancy, infertility, genital mutilation, and HIV/AIDS (Wakabi, 2008). Sexual violence is a very serious issue in the refugee settlements where women must travel long distances in search of water and firewood (WHO, 2015). Some women also end up in survival sex relationships in order to get basic requirements, like a shelter. Studies elsewhere have also indicated that refugee women not in the company of men are sometimes exploited by border guards, soldiers and local officials who demand sexual favours to allow them entry or get the necessary documents (Ewles and Simnett 2003). Mulumba's study shows how refugee women in Kiryandongo refugee settlement in Uganda were required to carry out chores such as farm work for the locals before they were given access to forests to collect firewood (Mulumba 2011, p.41). Domestic violence also manifests as a health problem for refugee women as they have to negotiate new gender roles (Comas- Diaz and Jansen, 1995). These violations aggravate into psychological and social effects for women and children often leading to mental health problems such as depression and suicide (Wakabi, 2008). Gender inequality is a major contributor to the poor health status of women and children. Some female refugees are deterred from movement outside the settlements because they have

to attend to their families which limits their access to opportunities that are unavailable within the settlements such as, specialised health care (Mulumba, 2011).

#### *2.14.5 Mental Health Problems*

Mental health relates to an individual's ability to think clearly and coherently (Ewles and Simnett, 2003) at any given time regardless of the conditions he or she is facing. People who experience conflict and induced movements usually suffer an increased incidence of psychiatric illnesses especially post-traumatic stress disorder which has symptoms like '*intrusive recollections of traumatic events, avoidance behaviour, general hyper arousal and reduced functioning*' (Karunakara et al. 2004, p.84, Fernandes and Miguel, 2009). Contemporary fighting mainly occurs in the developing countries and yet problems brought by deprivation, insecurity, and brutality exacerbate the occurrence of post-traumatic stress disorders. Refugee populations are more likely to experience mental health problems because they witness violence and torture before, during and sometimes even after migration. Others experience trauma due to hopelessness, the absence of employment opportunities and perceived social dysfunction (UNHCR, 2014). In tight circumstances, focus is put on meeting the immediate needs and elementary health care needs and the mental and psychological needs of refugees are neglected (Hiegel, 1991). PTSD, depression and anxiety are serious mental disorders among refugee women worldwide (Smyke, 1991; Karunakara et al., 2004). The causes of such range from infertility, marital conflict, physical and sexual abuse, poverty and lack of social support. Women are also susceptible due to the stress of taking care of homes amidst alien conditions. Further, refugees are usually socially and culturally isolated (Carey-Wood et al., 1995) in their new settlements. Carey-Wood investigated the settlement of refugees in Britain and found that in addition to the stress of involuntary migration, some refugees had traumatic experiences as a result of persecution, torture or imprisonment which aggravated their mental health problems (*ibid*, p.77). One of the challenges of dealing with mental health problems among refugees relates to social contrasts in the perceptions of mental health. Quinn and Knifton (2014, p.554) state that social factors are the origins of both mental health problems and the related stigma. Research shows that refugees usually display their ideas of health and healing and that these more often than not vary from those host communities (Hiegel, 1991; Carey-Wood et al. 1995; Ewles and Simnett, 2003). Hence, it is easy for them to seek assistance from familiar religious leaders, customary healers, their groups or other



individuals who have a 'therapeutic personality' (Hiegel, 1991). Ewles and Simnett's study of refugee women from southeast Asian societies who could not distinguish between physical, mental and spiritual well-being and thus perceived that a whole person ought to be treated from all these illnesses at once by traditional healers (Elwes and Simnett, 2003).

#### 2.15.0 Health Services Challenges in Refugee Settings

Refugees endure a twofold trauma; first, the circumstance that drove them out of their nations and second, the fact that their families are separated during the process of migration (Rachuonyo, 2016). Refugee women and children like other refugees are considered the most vulnerable groups in contemporary society (Berends, 2017; Freedman, 2019; UNHCR, 2019). They have specific health care needs normally arising from the adverse effects of war and forced migration, combined with experiences of persecution, psychological trauma, deprivation, unhealthy environmental conditions, and disrupted access to health care (Tomas et al., 2010). In addition, social factors arising from unequal access to opportunities, information care, and basic health practices, further increase the health risks for women and children (WHO 2009, p.1). These factors are also exacerbated by the fact that most of these refugees usually come from poor resource countries with disorganised health systems (WHO, 2018). Thus depending on where refugees seek refuge, they are usually faced with different health care challenges.

##### *2.15.1 Language barriers*

This is a very important aspect of the provision of health care services. This is on grounds that individuals need to clarify their problems well and be comprehended by the provider. Language difficulties force women who are usually illiterate not to seek health care. In an investigation of the barriers to health and social services among refugee women in Montreal and Toronto, language barrier or communication problems and absence of translators came up as central barriers for seeking services (Merry et al., 2011).

##### *2.15.2 Limited/ shortage of health care services or unavailability of health care services*

This has also been studied to be one of the health care problems for refugees. This is a problem for women because of tight schedules of having to take care of children and families. Deacon and

Sullivan (2009) suggest that in refugee camps women lack access to health resources, and encounter long waiting for queues at the understaffed and understocked health centres to get basic medicines. Loparimoi argues that one of the major health challenges for people in refugee settlements is a lack of education on health problems and how to prevent and control them (Loparimoi, 2011.). His study of refugee women in Kyangwali settlement (Uganda) reports that these would wash utensils and clothing in water holes; and further, spit and wash their legs in the same sources (Loparimoi 2011, p.4).

### *2.15.3 Low trust of health service providers*

This frustrates refugee women from accessing and using available health care. Sexual and gynaecological care are some of the health issues where women are uncomfortable to share with health service providers (Deacon and Sullivan, 2009). Women victims of sexual and gender-based brutality take these personal and might be unwilling to share such experiences with the health care providers. Besides, cultural inappropriateness of services for some conditions like depression or abuse may also arouse mistrustful relations which all affect the way services are sought (Merry et al., 2011). In addition, mistrust arises from bad experiences with trusted officials.

### *2.15.4 Limited immunisation coverage*

Immunisation is very crucial in protecting women and children against major infectious diseases. However, refugee children are not only susceptible to various immunity problems but are also likely to miss out on their vaccination schedules due to the disruption of services usually encountered in conflicts (WHO, 2018). Host states are obliged to administer vaccines in line with the WHO Expanded Programme on Immunisation but the situation may become dire for refugee women and children when this expanded programme takes a long time to be administered; which often leaves them unprotected for long periods (UNHCR, 2014). Women need immunisation against breast cancer and cervical cancer as well as their essential immunisation during pregnancy. This might be difficult to fulfil in refugee settings since many service providers may be preoccupied with other basic health care requirements.

## 2.16.0 Migration, Vulnerability and Resilience

This section explores the concept of migration and how this links with vulnerability and resilience. I will begin with a description of migration and then move on to examine vulnerability and resilience.

### *2.16.1 Migration*

Migration has been a constant and influential feature of human history (Koser,2007, p.10). It refers to the movement of people from one settlement place to another leading to temporary or permanent resettlement (Bartram et al, 2014). This situation could be both internal or transnational. As a social phenomenon, “it connects with a comprehensive range of life domains—politics, economics, culture and identity” (ibid, p.4). My thesis focuses on international migrants describing individuals or groups who cross national borders to settle in other countries (Valtonen, 2008). There are currently a variety of theoretical models that explain international migration. Massey (1999, p.-35-45) suggests six theories of migration including: 1) neoclassical economics (posits that international migration is caused by geographic differences in the supply of and demand for labour); 2) the new economics of migration (suggests that migration decisions are made not by isolated individual actors but within larger units of interrelated people in which people act collectively to maximize not only expected income but also minimize risks to income and maximize status within an embedded hierarchy and to overcome a variety of local market failures); 3) segmented labour market theory (argues that international migration stems from the intrinsic labour demands of modern industrial societies); 4) world-systems theory (posits that international migration emerges in response to the disruptions and dislocations that inevitably occur in the process of capitalist development— penetration of capitalist economic relations into non-capitalist or pre-capitalist societies creates a mobile population that is prone to migrate.); 5) social capital theory (considers that migrant networks connect migrants, former migrants, and non- migrants in origin and destination areas through interpersonal ties that increase the likelihood of international movement due to lesser costs and risks of movement and increased expected net returns to migration; 6) cumulative causation (argues that over time international migration tends to sustain itself in ways that make additional movement progressively more likely).

Although there are various models of migration, the push and pull model better conveys the theme of this research. According to this model, the “individual’s decisions to leave are influenced by push factors (such as political and economic insecurity—persecution or deprivation) in the country of origin (Valtonen 2008, p.8). On the other hand, “the pull factors in the destination country offer perceived options or solutions such as economic benefits, family reunion or political asylum, that also help to shape migration decisions” (Richmond 1994 cited in Valtonen, 2008, p.8). Migrants are generally categorised into voluntary and forced migrants (Koser, 2007). This thesis focuses on the latter. Koser (2007, p16) defines forced migrants as people who leave their countries due to conflict, persecution or for environmental reasons. This migration is often a consequence of compulsion or threat to well-being or survival (Bartram et al, 2014). Migration has consequences for both migrants and host societies (Valtonen, 2008). The next section presents the concept of vulnerability as a cause and effect of relocation.

### *2.16.2 Vulnerability*

The concept has diverse meanings, however, several scholars have managed to propose general epistemology relating to vulnerability. Papadopoulos (2010, p.25) defines vulnerability as: “the propensity to suffer damage or loss and to find it difficult to recover from it, or the tendency of an individual to get hurt, harmed or attacked easily due to a lack of supportive and/or protective factors.” Precisely, it encompasses a diminished capacity of an individual or group of people to anticipate, cope with, resist and recover from the impact of a life-threatening event (Nugent et al., 2014). Gallopín (2006) states that vulnerability constitutes exposure (defined as the external side of vulnerability) and coping (the internal side) or what Nugent et al. (2014) refer to as resilience. Nugent et al. (2014, p.680) assert that the definition of vulnerability must take into consideration a number of factors:

- (1) the “pre-risk” (ex-ante) characteristics—that is, the underlying conditions—of a system (e.g. individual, household, country);
- (2) the wider structural conditions in which the system exists;
- (3) the type of perturbation or risky event that the system experiences; and
- (4) the various complex interactions between these dimensions.

Displaced people especially those who move across borders face situations of distress that might contribute to vulnerability. Stressful and traumatic effects of dislocation center on the loss of the original bonds and property and distressing circumstances prior to flight in terms of the societal turmoil, repression and interruption of formal services (Valtonen, 2008). Sometimes, relocation exposes immigrants to human rights abuses and exploitation (Koser, 2007). Some groups such as women and children become extremely vulnerable. While migration sometimes empowers women (specifically due to change in roles), they are more likely to be vulnerable and to experience further problems such as discrimination and violence from their spouses (ibid). Unlike men, they always stay at home which restricts their ability to develop language skills and essential social networks (ibid). The children, on the other hand, are often more traumatised than adults due to loss of familiar lifestyles. Sometimes gender and generational tensions as a result of migration also affect children such as increase in violence and abusive treatment against girls (ibid). All these processes exacerbate their plight in exile. Migratory processes (relocation, settlement and integration) have been described as difficult periods of transition, adaptation and cultural metamorphosis that necessitate inordinate personal and social resources (families, communities, statutory provisions, specific services and relevant laws (Valtonen, 2008). The success of these depends on and impacts the resilience of migrants which I now turn to.

### *2.16.3 Resilience*

Migration as a process and goal exposes migrants to experiences that threaten personal, family and community coping. Such processes also destroy social and cultural institutions and distort social norms and values (De Vries, 1996 cited in Boyden and Mann, 2005). The destruction of such protective factors undermines their health and wellbeing. For instance, it is stated that such experiences psychologically affect children, undermine their development, coping, and future adaptation in adulthood. Despite that, some immigrants survive and respond positively to challenging conditions. This is conceptualised as resilience. It is further considered as a fundamental resource for responding to the different levels of vulnerability among refugee populations (UNHCR, 2019). Gallopín (2006) considers resilience in terms of both the capacity to cope or respond after adversity. It encompasses coping ability and adaptive capacity. Coping ability refers to shorter-term capacity or the ability of the system (individual) to survive while adaptive capacity denotes longer-term or more sustainable responses (Gallopín, 2006). Boyden

and Mann (2005, p.4) define resilience as the individual's capacity to recover from, adapt, and remain strong in the face of adversity. It denotes the “observable, often measurable, processes that are identified as helpful to individuals, families and communities to overcome adversity (Ungar 2012, p.387). Whether or not migrants exhibit resilience is dependent on personal and collective strengths and is inclined on protective processes from the broader milieu. Some individual attributes among immigrants that contribute to resilience include age, personality, sense of purpose, optimism about the future, and spirituality. In addition to individual competencies, there are external resources such as the presence of supportive family members, friends or neighbours and other interpersonal connections (like institutions) that can help them to overcome challenging life experiences. For instance, institutions aid immigrants through a variety of interventions, such as food and housing. These protective factors nature the strategies that immigrants use to manage trauma and pain amidst adversity. Hope, flexibility and possession of problem-solving skills and networks help immigrants to cope by finding options to their current situations and devising creative solutions (Ungar, 2012). This is important for them to assume control over their lives and reduce vulnerability. Therefore, it is important to acknowledge the resilience of immigrants in settlement interventions. However, immigrant resilience doesn't necessarily remove their vulnerability and should not be a basis for retracting assistance. In fact, researchers caution that the concepts of resilience and coping must be applied with care and should not be considered as permanent conditions (Boyden and Mann, 2005). Essentially, immigrant resilience must be one of the touchstones for supporting them. Immigrants must not be regarded as mere ‘victims’ or ‘vulnerable’ people or ‘beneficiaries’ but as people with power and agency— who can contribute to their welfare. Boyden and Mann (2005) state that although the victim label emphasises pain, it depicts them as passive and defenceless in the face of adversity and discounts their own efforts to cope. This lack of acknowledgment of the validity of their own strategies can undermine their ability to act on their situation (ibid, p.16). Therefore, there is a need to work with immigrants (through actual consultation and partnership) in the design and implementation of interventions or services for their well-being.

## 2.17 Social Work and Migration

Migrants need support to settle into their new destinations. Social workers in human and social service provisioning are among the front line professionals who offer immediate and

continuing support to migrants to enable them to settle and integrate<sup>6</sup> into the new social order. Social work with immigrants has been construed as ‘settlement practice’, ‘settlement work’ or ‘settlement social work’ (Valtonen 2008, p.14). Settlement practice is important for the well-being of immigrants by assisting them to meet their settlement needs. There are particular approaches and areas of expertise that are necessary to effectively address immigrant needs. Firstly, is the rights-based approach. At the outset, refugee protection is a human rights issue. This is vital because human rights and social work are inseparable (Herrero and Nicholls, 2017). Ife (2001, p.76) advises that “instead of seeing social work practice as about the assessment and meeting of human needs, we can see it as about the defining, realising and guaranteeing of human rights”. The human rights approach creates a universal frame for practice with immigrants because it enunciates the basic safeguards and ethics of treatment on the basis of humanity (Valtonen, 2008). This is important especially in situations when people flee from hostile situations to claim protection from violation of their basic human rights. Refugee protection is extended by the international regime<sup>7</sup> through arrangements for refugees’ resettlement in safe countries. Valtonen (2008, p.21) states that social work with refugee clients and groups is one phase of the process of international protection. Human rights offer a moral basis to social work practice, both at the level of day-to-day work with clients, and in policy advocacy and activism (Ife, 2001). Human rights instruments are underpinned by the basic principles of non-discrimination, equality, self-determination, and the right to political participation (Valtonen, 2008; Ife, 2001).

To protect the human rights of immigrants, practitioners must identify problems that are related to transition and settlement. Preventive approaches in social work offer protection by preventing problems from occurring; preventing these from becoming worse or escalating; and preventing such situations from recurring (Valtonen 2008, p.34). Immigrants are sometimes reluctant to seek formal services due to language barriers and lack of strong support networks. Valtonen (2008) argues that a strong outreach programme and the involvement of staff of

---

<sup>6</sup> This refers to a process by which immigrants become accepted into society both as individuals and groups (Koser 2007, p.25)

<sup>7</sup> IRR refers to the international organisations, cooperating states and supranational legal instruments which in concert frame the responses to refugee situations and flows. Immediate responses include different forms of aid and protection in the neighbouring regions, while long term mechanisms refer for example to the placement in Third countries of settlement-21

immigrant background would foster timely recognition of potential problem areas and bridge the distance between communities and the formal services (Ibid p.34).

Critical social work is another significant approach to working with immigrants. This is mainly informed by critical social theory. It focuses on the elimination of structural oppression to improve social relations and bring about change in society. The critical social theory offers a frame for analysing conditions of systemic –level and institutional level exclusionary patterns (such as power discrepancies and differential control of resources) which adversely affect integration processes (Valtonen 2008, p.35). Critical social work practice approaches include Marxist social work, feminist social work, radical social work, structural social work, anti-racist social work, anti-oppressive social work and anti-discriminatory social work (Healy, 2005 cited in Valtonen 2008, p.35). Using this approach, practitioners try to find the root causes of oppression and address barriers in the settlement setting, social structures and institutions to improve the situation of immigrants (Valtonen, 2008).

#### Ecological, strengths and empowerment approaches

Social workers have a duty to assist individuals and groups of immigrants through their transition. Linked to the “person in environment context, the ecological approach adopts systems and a holistic perspective in assessment and intervention by focusing on transactions between immigrants and their environment and on the ‘goodness of fit.” (Valtonen, 2008 p. 114). On the other hand, strengths and empowerment practices allow for settlers to build power by altering past experience into self-reliance and resilience (Moser, 2003). This is important both in the short-and long-term settlement agenda. People are assumed to be empowered when “their personal, interpersonal or political power is increased as a consequence of which they are able to take action to improve their life situations” (Ibid, p.113). People naturally have inner strengths however the powerlessness of immigrants arises from their status of recent arrival into society. Therefore, through empowerment they gain more power and control over their circumstances and shape solutions to problem situations (Valtonen, 2008). Moser (2003) argues that women's empowerment must not be concentrated on increasing their dominance over men but must accentuate increasing women’s self-reliance and internal strengths. It is known as “the right to determine choices in life and to influence the direction of change, through the ability to gain control over crucial material and non-material resources” (ibid, p.75). The strengths approach is based on the principle that resources are to be found in all



environments (Saleebey 1997 cited in Valtonen 2008, p.114) while that trauma and difficulties can strengthen the immigrant. The emphasis is thus placed on the effective identification of strengths so that people can achieve their potential.

#### Macro, meso and micro practice

Social work intervenes in the lives of immigrants at different levels that are, macro, meso and micro. This section examines social work practice through these stages.

Macro interventions are those that involve wider engagement with the political actors and decision-makers (Valtonen, 2008). As such they can engage in policy development and advocacy. Advocacy refers to activities of representing, defending, intervening, supporting or recommending a course of action on behalf of one or more individuals, groups or communities with the goal of securing retaining social justice (Haynes and Mikelson 1991 cited in Valtonen 2008, p.98). Advocacy is equated to empowerment because it intends to meet the rights and needs of vulnerable people. The ecological approaches described above, also accentuate the role of practitioners in working for and with resources in order to promote the goodness of the fit between people and their social environment (Valtonen, 2008).

Meso-level settlement work affords greater significance to the community in meeting peoples' needs. Interventions at this level consider that the community is the "arena with an infrastructural fabric of human relations and a field of affective and productive action" (Ibid, 97). This assumes that practitioners base their interventions on the experiences of migrants. Given that immigrants are likely to be unfamiliar with formal services they rely on communal support (such as interpretation, financial and emotional). It is crucial that their social circles are prioritised (in terms of resource allocation) to maximize outcomes of interventions. Valtonen, (2008) advises that community outreach and alliance with the community helping networks is needed for identification and prevention of settlement and integration problems and aids the development of culturally competent interventions among professionals.

Micro-level measures focus on the psychosocial aspects of integration and personal processes of adaptation. Social workers are among the primary agents of formal social services to engage with individual migrants and their families. It is therefore vital for practitioners to listen, learn and to be conversant with their clients' circumstances of migration and the social conditions in the country of origin for them to have a holistic understanding of their needs. This is based on

the notion that clients possess expertise in their situations. The social worker must support immigrants to attain intermediate and long term integration settlement needs. Valtonen (2008, p.109) states that “the field of integration spans across sectors and spheres of society, crossing disciplinary, professional, occupational boundaries and the practice should center on the active promotion of immigrants’ participation in society, the negotiation of barriers to access, and support of increased recognition of immigrants’ potential roles and inputs”. Within this mix, it is important to delineate the practice mandate of social work to facilitate more collaborative work with colleagues. For instance, social workers disseminate information on the range of available services, rights and obligations related to the immigrant’s formal status in the new environment. Valtonen (2008, p.16) argues that the “positioning of social work in settlement gives the profession a tactical advantage for generating, accessing and mediation of critical information to newer citizens”. While this is significant for immigrants to make informed decisions about their welfare, this interaction is also vital for practitioners to identify client strengths. Exploiting such strengths culminates in the design and implementation of services that adequately respond to the needs of immigrants. This may not necessarily require creation of new services or replacement of mainstream offerings but it’s a process of shaping the modes and conditions of delivery to be more relevant to the specialised situations immigrants (Valtonen 2008, p.19).

Social workers perform case management, connect clients to vital resources and empower them to secure needed resources so that they function autonomously (Valtonen, 2008). This means that practitioners must possess problem-solving abilities, have knowledge of accessible resources and networking skills to link clients with resources and follow up to confirm that people obtain services in a timely manner. This is not devoid of challenges. One is the profession’s position in a bureaucracy of institutions that reduces its autonomy in assisting immigrants to realise their rights. This adversely impacts the image of social work. Derber (1982 cited in Valtonen 2008, p.165) proposes the distinction between two types of autonomy: ideological autonomy and technical autonomy. The former refers to “the degree of independence for an occupation to shape its own objectives, not only at the operational level but also strategically and in the wider society while the latter refers to the degree of independence that is exercised by an occupation in selecting the practices or means through which it seeks to achieve its objectives” (ibid). Second is that people who are not skilled in social work (yet dispensing social work services) might lack knowledge and ethics to

strategically address the needs of immigrants. Professional and field knowledge provides a basis for authority on settlement issues and policy practice.

### Ethical principles

Response to social problems does not only depend on the appropriate problem analysis and policy designs, but also on suitable implementation procedures (Moser, 2003). This section examines social work professional ethics in working with immigrant populations. Clark (2000 cited in Valtonen 2008, p.175) distinguishes between prescriptive and critical ethics. Prescriptive ethics are intended to instruct how professionals ought to deal with morally problematic situations whereas the critical aspects examine the premises and arguments on which prescriptions are based (175). Valtonen (2008) identifies four principles that are important in working with immigrants including respect, self-determination, social justice and professional integrity. Respect is important for interpersonal relations. Immigrants must be respected on the basis of their inherent human dignity. This is also related to being non-judgmental or the precept that people are intelligent about their needs. Linking these two principles, she introduces the value of individualisation—which requires the social worker to be attentive to each client’s unique history, characteristics and situation such as the traumatic events that led to flight, their experiences during transit and in destinations (Ibid, p.176). On the other hand, self-determination recognises the rights of service users to make own choices and decisions. Though immigrants might have limited knowledge of accessible services and options, the role of the practitioner is to provide information about the choices and their likely consequences.

Human rights and social justice are inextricably linked. Social justice depicts the intrinsic value of individuals. It is about providing equal chances for immigrants to thrive in their destinations. Social workers must challenge any injustice and discrimination (at the individual, group and structural levels) specifically arising from the immigrant status. Lastly, professional integrity relates to the need for building specific knowledge in the settlement and integration field, the significance of immigrant participation in decision making and accountability (Valtonen, 2008). Social work approaches may be dependent upon contexts (Ife, 2001). However, the symbiosis with theory helps us to focus on generic facets in approaches, while the centrality of the body of values and ethics promotes distinct standards (Valtonen 2008, p.182).

## 2.18 Gender, Health and Power

It is necessary to reveal the gendered realities of refugee women in relation to their context in order to get an in-depth understanding of their health and that of their children. The concept of gender does not have a definitive description. However, attempts to define it refer to this as “the social attributes and opportunities associated with being male and female” (UNHCR, 2008). Manandhar et al. (2018) state that gender reflects societal roles, behaviours, activities, attributes and opportunities which are considered to be appropriate for boys and girls, and men and women. The differences in gender roles are formed by ideological, historical, religious, ethnic, economic and cultural influences (Moser 2003, p.3). Gender roles determine the needs of women and men and should be the target of responses to alter the situation of women. Moser (2003) identifies two broad definitions of women’s gender needs, a) strategic gender needs and b) practical gender needs. The strategic gender needs are those which originate from the subordinate position of women in society and reflect gender divisions of labour, power and control (that is, issues concerning legal rights, domestic violence, equal wages and women’s control over their bodies) whereas practical gender needs are those that originate from the immediate perceived necessity depending on the context (Moser 2003, p.39-40). The strategic needs must be addressed by arrangements that lead to equality and enhancement of women’s subordinate position while practical needs necessitate responses that modify inadequacies in the living conditions (such health care, water provision and employment) (ibid).

Like gender, power is a relational concept that occurs between two or more persons (Bundy-Fazioli, et al, 2013). Although gender essentially represents existing relations among people, it also reflects the distribution of power within those relationships” (Manandhar et al. 2018, p.644). This suggests the importance of appreciating the power in the assessments of need and in the design of interventions. For example, although women and men might migrate for similar reasons, their experiences tend to differ. It is stated that social and cultural constructions of gender roles and characteristics fundamentally shape people’s opportunities and expectations, put simply, migration changes gender relations (Bartram et al. 2014, p.73). Migration lead to women to gain more power whereas men lose out (Koser, 2007; Bartram et al, 2014). Mayer (2000 cited in Valtonen 2008, p.115) identifies two general categories of power: structural and personal. Structural power is “lodged in the situation and peoples’ objective resources such as the formal authority they hold, or the real choices which exist whereas personal power denotes to individual characteristics, such as determination, knowledge and communication skills”

(Valtonen 2008, p.115). Social work largely works with powerless individuals and groups. It must be stated that not every immigrant is powerless. However, as mentioned earlier, the powerless state of immigrants' derives from their new arrival position, cultural differences, and minority status. All these processes and changes render their needs invisible (ibid).

Hawkes et al., (2017) state that gender is an essential determinant of health because it influences exposure to common drivers of ill-health, health-care seeking patterns, and the response of the health systems to illness. According to Manandhar et al (2018), gender influences health and well-being across three domains: 1) through its interaction with the social and economic determinants of health; 2) via health behaviours that are detrimental to health outcomes, and 3) in terms of how the health system responds to gender. Keeping these in mind, gender determines exposure to a range of illnesses and influences responses to symptoms and signs of illness. However, Manandhar et al., (2018) state that current conceptualisations of gender are narrow and only focus on limited roles of women as mothers, caregivers and as victims of violence while the men are perceived as perpetrators. These narratives are limited in addressing power and hierarchy relations between men and women that shape their health. It is thus essential to recognise the position of women in making informed choices about their health and to seek and receive services they need (WHO, 2015). It about ensuring awareness and access to rights. WHO (2015, p.41) maintains that “gender-responsive health policies and interventions require a thorough analysis of barriers to the achievement of women’s health, including other inequalities based on ethnicity, class, geographic location and gender identity.”

This chapter has presented the theoretical and conceptual background of the study. It has provided a baseline foundation of the rights to life and health particularly pointing out the holistic aspects of health. This led to the examination of the broad public health concerns and service challenges in refugee settings. Further, I have deliberated on migration theories relating them to vulnerability and resilience and finally introduced the linkage between social work and migration. The next chapter discusses the geographical and contextual scope of the study and explores the aspects of refugee management and response in Uganda. The chapter also provides a social and contextual scope of social work and its role in health.

## CHAPTER THREE: GEOGRAPHICAL AND CONTEXTUAL SCOPE

### 3.0 Introduction

This chapter gives an in-depth review of the literature concerning the study and host environment. I explore the social and political characteristics of Uganda, explain its present state of affairs in relation to health and health care indicators and basically introduce the philosophy of social work and its outstanding role towards health promotion activities. First I present the socio-demographic profile of Uganda, followed by its approach to refugees and the final section will provide the social and contextual scope of social work.

### 3.1 Social Demographics

Uganda is located in East Africa and lies across the equator, about 800 kilometres inland from the Indian Ocean. The country lies between 10 29' South and 40 12' North latitude, 290 34 East and 350 0' East longitude. It is a landlocked country, bordered by Kenya in the East; South Sudan in the North; Democratic Republic of Congo in the West; Tanzania in the South; and Rwanda in South West. It has a total area of 240,038 km<sup>2</sup> square kilometres, of which 200,523 Square kilometres are covered by land (Uganda Bureau of Statistics, 2015). Uganda's population has been growing over time, which is from 9.5 million in 1969 to 37.9 million in 2014 (Uganda Bureau of Statistics (UBOS), 2014). It is estimated that 48.5% of the population is male and 51.5% female. The population growth rate is valued at 3.2% per annum.

Like other African countries, it has a high young population below 18 years (55% of the entire population) (UBOS 2014). The total fertility rate is 5.8 children per woman of reproductive age which is very high especially in the rural areas. This is also attributed to persistent gender inequality in the country, including problems related to preventing gender-based-violence, unmet need for family planning, reduced women's decision making, and limited access to social services and economic opportunities (ibid). This also has significant implications for the national development of the country. The average life expectancy at birth is 50 years with males having a lower life expectancy of 49 years at birth compared to females (52 years) at birth (UBOS, 2015). The mean household size for the majority of families is at 4.7 members which also contributes to the high dependency ratio.

Given the tropical climate and fertile soils, the majority of the households in Uganda (80%) depend on agriculture as a source of survival and income. Tourism is another important sector of Uganda's economy. It is estimated that 19.7 percent of Ugandans are poor, corresponding to nearly 6.7 million persons although the incidence of poverty remains higher in rural areas than in urban areas (UBOS, 2015). A number of factors contribute to this vulnerability such as climatic shocks (drought, irregular rains or floods), ill health, crop or livestock diseases and pests and insecurity, conflict, violence which exacerbate the poverty situation. Rural dwellers (94% of households) use firewood or charcoal for cooking. Some regions and some social classes are more disadvantaged than others. The total national poverty by region reveals that the incidence of income poverty varies significantly, showing that poverty remains highest in the Northern region (43.7%) and least in the Central region (4.7%) an average which is much higher than the national average of 19.7 percent (*ibid*, 2015). High poverty indicators in the Northern region can be attributed to a long history of war, although the region is now starting to recover. Map 3.1 presents the administrative districts of Uganda.





### 3.2 Political and Administrative Factors

Uganda was a British protectorate but got independence in 1962. After independence, the country experienced a period of political upheavals and violence. The first Prime Minister was Muteesa who later went into exile, followed by President Milton Obote who was later overthrown by a coup in 1971 by Idi Amin. President Amin's rule was one of those that led to large numbers of forced migration for Asian nationals from the country which was not only a landmark in the country's economy but also in the migration history in Uganda. There were numerous upheavals which led to the current president Yoweri Museveni to come into power in 1986. Since then, there was a brutal 20-year insurgency in the North, led by the Lord's Resistance Army a group that massacred and violated the human rights of many Ugandans. This led to an increased number of internally displaced people (IDPs) in the country and also created refugees for the neighbouring countries.

The Constitution of the Republic of Uganda (1995) and the Local Government Act (1997) have streamlined the decentralisation of service delivery to districts (GoU, 2015). Since 1997, the political, administrative and fiscal responsibilities of government operations are carried out under a decentralised governance framework (Okwero et al., 2010). Districts are further subdivided into lower units of administration, that is, counties, sub-counties, and parishes. To push services closer to the people, the government has been increasing districts and lower-level administrative units. Currently, there are 112 districts and more are still being created. The purpose is to increase legislators and improve services.

### 3.3 Population Health Issues in Uganda

Uganda is a low-income country with a low Human Development Index<sup>8</sup>. However, the country has over the years registered some upgrades in population health. Despite this, various shortcomings such as gender discrimination and high fertility rates have sustained poor health indicators; such as high prevalence of maternal mortality; infant and child mortality rates as

---

<sup>8</sup> Human Development Index (HDI) refers to a composite index measuring average achievement in three basic dimensions of human development- a long and healthy life, knowledge as well as decent standard of living (UNDP 2016, p.203).

well as high under-nutrition among children below five years and women of reproductive age (GoU, 2015). The country's current development agenda is driven by the Second National Development Plan (NDP II) 2015/16 – 2019/20<sup>9</sup> which is also in line with the Uganda Vision 2040<sup>10</sup>. The NDPII 2015/16 – 2019/20 is a five-year plan aimed at (i) increasing sustainable production, productivity and value addition in key growth opportunities; (ii) increasing the stock and quality of strategic infrastructure to accelerate the country's competitiveness; (iii) enhancing human capital development; and (iv) strengthening mechanisms for quality, effective and efficient service delivery (GoU, 2015). Health services are classified within the fourth objective of the NDP11.

Uganda is burdened with different health issues which have impacted on the population's welfare and economy. The major public health issues in Uganda include a shortage of health care providers, increased prevalence of communicable and non-communicable diseases and poor environmental health (Ministry of Health (MOH), 2010). HIV/AIDS, malaria, tuberculosis and environmental risk factors are the highest cause of maternal and child health problems in the country (UBOS, 2014). The effect of HIV/AIDs has increased the burden on the existing health resources and services and a great amount of public health funding which would meet health care is drained by the epidemic. Families experience the burden of care and dispose of their assets, which compound the incidence of poverty in the country (Kyadondo and Mugisha, 2014). The last census found that 8% of the country's children are orphans. The infant mortality rate is 53 infant deaths per 1000 live births mainly arising from communicable and non-communicable diseases (Uganda Bureau of Statistics (UBOS), 2014). Environmental health is a problem due to poor hygienic conditions in the country. According to (UBOS, 2014), 8% of the households in the country have no access to toilet facilities which puts their health in jeopardy. The other major causes of deaths in Uganda include self-inflicted injuries and road traffic accidents.

With a low level of life expectancy, and a high level of mortality in the population resulting from communicable and non-communicable diseases, the overall health of the Ugandan population is still very low (MOH, 2010). There are also differences in the health indicators

---

<sup>9</sup> Its theme is to strengthen Uganda's competitiveness for sustainable wealth creation, employment and inclusive growth

<sup>10</sup> The government visualises "A transformed Ugandan Society from a peasant to a modern and prosperous country within thirty years".

for men and women such as a better life expectancy for females (UBOS, 2015). However, this does not directly translate into better quality of life for women due to a number of health and social factors.

### 3.4 The Structure of the Health System

The health sector in Uganda is led by the Government of Uganda (GoU) through the Ministry of Health and other partners in health. As mentioned in the preceding section, the health sector faces difficult challenges. With these, the government accounts that there is a need to scale up efforts in this sector through specific interventions including:

- a) mass management of malaria (treatment and prevention),
- b) developing a national health insurance scheme,
- c) ensuring universal access to family planning services
- d) health infrastructure development
- e) reducing maternal, neonatal and child morbidity and mortality
- f) scaling up HIV prevention and treatment and developing a centre of excellence in cancer treatment and related services (GoU, 2015).

The government has tabled diverse strategies to realise these objectives including but not limited to strengthening governance mechanisms and structures (GoU, 2015). Using funding from both public and private sources, the government during the five-year period (2015/16—2019/20) planned to achieve the following targets:

- (i) Increase per capita income from USD788 to USD1,039, and GDP growth rate from 5.2 to 6.3 percent,
- (ii) Reduce the poverty rate from 19.7 percent to 14.2 percent and inequality coefficient from 0.443 to 0.452,
- (iii) Reduce the number of young people not in education, employment or training by at least 20 percent
- (iv) Increase manufactured exports as a percentage of total exports from 5.8 percent to 19 percent,
- (v) Increase the percentage of the population with access to electricity from 14% to 30%,

- (vi) Increase access to safe water from 65% to 79% in rural areas and from 77% to 100% in urban areas,
- (vii) Increase the quantity of total national paved road network from 3,795 kilometres to 6000 kilometres,
- (viii) Reduce the Infant Mortality Rate per 1,000 live births from 54 to 44 reducing the under-five mortality rate per 1,000 live births from 90 to 51 and the maternal mortality ratio per 100,000 live births from 438 to 320/100,000,
- (ix) Reduce fertility from 6.2 to 4.5 children per woman,
- (x) Reduce child stunting as a percent of under-fives from 31% to 25% and
- (xi) Increase primary to secondary school transition rate from 73% to 80% and Net Secondary Completion from 36% to 50% (GoU, 2015).

These influence and are impacted by the health and well-being of the population irrespective of national status. Strengthening governance mechanisms and structures are vital for achieving quality, effective, and efficient service delivery for inclusive human development. In line with the SDGs-2030 agenda endorsed by 193 UN member states, Uganda inclusive, it is observed that pursuing and committing to universalism in all policy formulations and programme development is key to achieving human development for everyone (United Nations Development Programme (UNDP), 2016).

Health services in Uganda are decentralised at district, sub-county and parish levels (Basaza et al., 2007). The health system consists of public, private health care service providers who also work with the traditional healers. Although the public sector (line ministries, health service managers, district leaders) leads the larger share of health services, other partners also support the distribution and management of health services. These include private health practitioners, private not for profit sector, civil society organizations (CSOs) and some development partners. These practitioners set their health investment priorities and work according to guidelines set by national health policies and strategic plans which are usually formulated and implemented through a period of ten years. In the recent past, the overall development agenda for Uganda was guided by the Poverty Eradication Action Plan (PEAP), MDGs and other international and regional health commitments (MOH 2010, p.3). The distribution of health services operates through national referral hospitals (NRHs) and regional referral hospitals (RRHs), general hospitals (GHs), health centre (HC) IVs, HC IIIs, HC IIs and village health teams (HC Is). The functions for these are prescribed in the National Hospital Policy (2005). National and regional

referral hospitals are managed by the MOH while public health facilities (HCs and GHs) are run by local governments (LGs). MOH also takes the oversight role of formulating health policies, ensuring quality assurance and funding the delivery of drugs in all parts of the country (Okwero et al. 2010, p.3).

In the 1990s, the GoU introduced user fees in all public health units in an effort to meet the huge public sector deficit from the structural adjustment programmes (Basaza et al., 2007). This led to a high exclusion of over 50% of the population from receiving health care from the public facilities (Bukuluki and Mubiru, 2014). These were again abolished in 2001. Despite this, many Ugandans still lack access to health care (MOH, 2010). There are significant disparities between regions and individuals in the distribution of accessible health stock with some regions of the country (particularly in the northern) having significantly lower levels of health as compared to other regions (MOH, 2010 p. 61). Most Ugandans foot their health bills out of the pocket from the private sector despite their high user charges. Studies in the Ugandan health system estimate that 54% of health expenditure is made out of pocket (Basaza et al 2007).

Apart from high health care costs, the health sector is also partially financed by donors. This is unpredictable and unsustainable and creates uncertainties in budgeting for health care. Uganda is one of the countries in East Africa, without a national health insurance scheme. Other countries such as Rwanda, Kenya, Tanzania, and Burundi have fully developed these (Kagolo, 2014). This leaves out a large proportion of the poor people who cannot pay for health care. Although the GoU through the MOH is in the process of developing a national health insurance scheme, the scheme is still being delayed by critics who consider that it will intensify the burden on taxpayers (Mugerwa, 2013). Studies of social protection in Uganda report that public services including health care, are too commercialised to the extent that residents borrow money for health care (Kyadondo and Mugisha, 2014; Bukuluki and Mubiru, 2014). Other challenges to quality health care include:

- a) inadequate support and supervision from the central government to districts levels, which also extends from districts to lower levels,
- b) insufficient funding of the health services,
- c) poor infrastructure,
- d) low remuneration and retention of health workers,

- e) unavailability of medicines in the health facilities,
- f) poor planning, management and leadership (MOH, 2010)

Moreover, the creation of different bureaucratic layers of management and administrative units has also placed an inordinate burden on the already strained health services. The scope of coverage of the health services in these newly created units is also limited especially in the rural areas.

This section has presented the context and provided an overview of the overall structure of health services in Uganda. I have argued that health sector is generally facing serious challenges from low financing, understaffing, lack of stock and limited coverage, especially in the rural areas. The country does not yet have a national health insurance scheme that jeopardise the health of those who cannot pay for themselves. The important question is: Can the state adequately respond to the health needs of migrants with an already constrained health system? The next section provides an overview of the refugee situation in Uganda.

### 3.5 Refugees in Uganda

There are various definitions of refugees, but this research will adopt the definitions of the United Nations and the Organisation of African Unity as these are broad. The United Nations (1951) Geneva Convention Article 1(2) relating to the status of refugees, which came into force in April 1954, defines a refugee as:

Any person who as a result of events occurring before 1st January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality membership of a particular social group or political opinion, is outside of country of his nationality and is unable to or owing to such fear, is unwilling to avail himself of the protection of that country; or who does not have a nationality and being outside of his country of his former habitual residence as a result of such event is unable or owing to such fear, is unwilling to return to it (Handmarker et al. 2008, p.219).

However, the 1951 Convention definition was thought to be restricted as it did not take into the respect of the issues surrounding the development of African states. The battles for freedom and the patriot battles against imperialism and politically-sanctioned racial segregation to acquire independence which prompted massive forced displacement were overlooked. In this respect, the Organization of African Unity (OAU) Convention expanded the refugee definition:

Any person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of

origin or nationality, is compelled to seek the refuge of another place outside his country of origin or nationality (Handmarker et al., 2008).

With over 25.9 million refugees globally the world is experiencing the highest refugee crisis (UNHCR, 2019). Table 3.1 shows the highest refugee sending countries in the world in 2018.

Table 3. 1 Top refugee sending countries in 2018

Country	Number of refugees(in millions)
The Syrian Arab Republic	6.7
Afghanistan	2.7
South Sudan	2.3
Myanmar	1.1
Somalia	0.9

Adapted from UNCHR (2019, p.3)

During the last few years, three of the top refugee sending countries were on the African continent (i.e. Somalia, Sudan, and the Democratic Republic of the Congo (UNHCR, 2012). Evidence shows that approximately four-fifths of forced migrants settle in nearby countries (UNHCR, 2012). This explains presence of high sums of refugees in the countries which border nations in conflict. Although the refugee crisis has been a global phenomenon in the recent past, it is stated that Africa put up with the highest burden of these in 2015 (UNHCR, 2015). According to IOM (2014), it was estimated that by March 2013, there were over nine million refugees and internally displaced persons in East Africa and the Horn of Africa mainly as a result of armed conflict; climate changes and environmental degradation; as well as due to political, economic and food crises. Uganda started accommodating refugees after the Second World War when Polish refugees settled in Nyabyeya, Masindi District (OPM, 2017). Most recent research indicates that Uganda hosts most of Africa's refugees (1.36 million) (UNHCR, 2019). Unlike other countries within the region, with the capacity to execute strict border controls, Uganda is landlocked which makes migration persistent in the country. It hosts different types of migrants: economic, trafficked people, internally displaced persons, asylum seekers and refugees. Internally displaced people (IDPs) have been from the civil conflicts which happened in a few regions particularly in the Northern and Western parts of the country (Mulumba, 2011). Internal migration is also due to natural disasters, for example, occurrences of landslides in the Eastern region prompt large numbers of residents to relocate to nearby

districts. Notwithstanding, the current study focuses on refugees in the country particularly women and children.

### 3.6 The Policy Context

Uganda has an open-door policy to refugees which also allows refugees to enjoy rights of citizens (OPM, 2017). In this model refugees share resources with the local community. The GoU has set aside 1, 000 square miles of land in the rural communities for refugee settlement (OPM 2017, p. 23). In addition, the government appeals local communities to donate land for hosting refugees in exchange for better infrastructure (OPM, 2017). Refugees in Uganda are allocated a plot of land to settle and cultivate, allowed the freedom of movement, work, have access to public services such as health and education and protection from the state (OPM, 2017). The Office of the Prime Minister (OPM) coordinates refugee response and management activities. This operates under Schedule 3 of the Constitution of the Republic of Uganda. The government is also supported by Implementing Partners (IPs) under a tripartite agreement. Under this, OPM, UHCHR and IPs (contracted annually) provide services (including health) to refugees and host communities. Most of the funding to IPs come from UNHCR. There are also operating partners (OPs) who are not directly funded by UNHCR such as Finnish Refugee Council. The operation of refugee work is fully covered by the Refugee Act 2006 and the Refugee Regulations Act 2010. An immigrant to Uganda qualifies for refugee status if she or he proves that they are under fear of being persecuted for reasons as set out in the Refugee Act of 2006 such as race, sex, religion, nationality (GoU, 2006). Uganda is also a signatory to other international legal instruments including the 1951 Refugee Convention, the 1976 Protocol and the 1969 OAU (Organization of African Unity) Convention which spell out the rights and entitlements of refugees.

### 3.7 The Process of Becoming a Refugee

The Refugee Eligibility Committee (REC) decides the status of refugees in Uganda. This is an inter-ministerial committee formed by ministries of Internal Affairs, Foreign Affairs, External Security Organisation, Internal Security Organisation, Local government, and the Ugandan Police. This board investigates their personality, reasons for flight, social identity, and adjudicates on applications for asylum based on factors such as familiarity with the political situation in the claimed country of origin (Mulumba, 2011). In addition, a functional Refugee



Appeals Board also reviews appeals for those who are not satisfied with the decisions of the REC (OPM, 2017). This committee may request the REC to review its decisions based on the petition. Upon receiving refugee status, individuals get identity cards and are permitted to get indistinguishable treatment and privileges as are generally accorded to aliens under the Constitution. Furthermore, they are likewise entitled to basic rights as set out in the Refugee Act 2006. For instance, they have rights to education, health care; gainful employment; right to engage in agriculture, industry and commerce; right to practice if they are professionals; right to profess their religion and a right of association (GoU, 2006). Within Uganda’s legal framework, health services for refugees are part of the wider public social services. Therefore, when refugees have secured legal status, they should be eligible to access health services that are provided by the mainstream health care systems (OPM, 2017). Table 3.2 presents refugee settlement in the different districts in 2015.

Table 3. 2 Districts and settlement populations as of March 2015

<b>District</b>	<b>Refugee settlements and villages</b>	<b>Refugee population (UNHCR)</b>	<b>Host Population(census)</b>	<b>Refugees as % of all district</b>
Adjumani	Adjumani	101,468	232,813	29%
Arua	Rhino Camp	19,387	785,189	2%
Kampala	Kampala	71,949	1,516,210	5%
Koboko	Lobule	4,745	208,163	2%
Hoima	Kyangwali	4,1642	573,903	7%
Kiryandongo	Kiryandongo	38,529	268,188	11%
Isingiro	Nakivale Oruchinga	73,118 529,3	492,116	14%
Kyegegwa	Kyaka 11	23,009	277,379	8%
Kamwenge	Rwamwanja	52,816	421,470	11%

Source: OPM (2015 p.5) District and settlement populations

### 3.8 Why Refugees are Streaming to Uganda

A number of pull and push factors determine the refugee influx to specific places<sup>11</sup>. Uganda might not be well prepared to control extensive numbers of refugees because they don’t have adequate resources (Baragaber, 2006). Despite that, it has been hosting refugees as far back as

---

<sup>11</sup> See: Guardian Africa Network Uganda: Is Uganda the world's best place for refugees? Available at: <https://www.theguardian.com/world/2017/apr/01/is-uganda-worlds-best-place-for-refugees-south-sudan>

1959 and settled them in village style settlements. There are different explanations for this scenario. The presence of huge chunks of land which are sparsely populated in some regions of the country, proximity to refugee sending countries, as well as existing ethnic relations have not only influenced the establishment of settlements (Orach and De Brouwere, 2005) but have also led to enormous inflows of refugees in Uganda. These are complemented by a favourable government refugee policy, as well as the support from UNHCR

Historically, refugees have been streaming to Uganda for better opportunities such as training, health services, and employment. Bascom (1998) discusses the role of long-standing patterns of cross-border labour migration in Uganda. He states that people from Southern Sudan moved to the cotton region of Uganda which developed into a network of dependable relatives and kin especially among the Madi and Kakwa ethnic groups from both sides of the border (*ibid*, p.20).

Further, ethnic relations between refugee and host populations in Uganda (Orach and De Brouwere, 2005) also account for the settlement of refugees in the country. Refugees move to Uganda because they have ancestries or networks from where to start. The presence of such likeness has additionally influenced government settlement procedures. For example, South Sudanese nationals are largely settled in West Nile districts where they have similarities with the Lugbara, Kakwa and Madi ethnic groups; whereas refugees from DRC and Rwanda are mainly settled in the Western districts like Kisoro, Kabarole, Mbarara and Hoima with fellow Bantu-speaking kinship groups (*ibid*, 2005).

Uganda also attracts refugees due to its favourable policy environment. The main approach of hosting refugees is by integrating them into the local communities, where they are allocated small plots of land to construct small houses and cultivate (OPM, 2017). Omata & Kaplan (2013) adduce that Uganda is a safe haven for refugees due to its peacefulness in recent years, and a friendly policy which allows refugees to live in settlements. In line with this policy, the Government of Uganda gazetted land to cater to the refugee influx whether or not refugees reside on it (UNHCR, 2016). In areas with no gazetted land, the OPM refugee department negotiates with local communities to offer land for refugee settlement. This approach is definitely better than the refugee encampment policy whereby refugees should first secure consent before leaving the refugee settlement (Mulumba & Wendo, 2009). In that capacity, many refugees in Uganda have been settled by the Office of the Prime Minister (OPM) in various refugee settlements- particularly in the Northern and Western regions of the country

specifically in Mbarara, Kabarole, Hoima, Nebbi, Masindi and Arua, Adjumani and Moyo districts. Today, active settlements include - Kyaka II, Nakivale, Oruchinga, Kyangwali, Kiryandongo, Paralonya, Rhino Camp, Imvepi, Madi Okollo, Maaji settlement and the integrated camps of Adjumani (OPM, 2015). Many governments in Uganda have consistently maintained this policy through the years despite the challenges which the policy is facing such as, the increased flow of refugees (OPM, 2015). However, it is unknown if this ‘friendly refugee settlement policy’ stands valid in its own right or a coincidence since the state does not have enough resources and capacities to monitor its borders.

The norms of reciprocity have also influenced the coming of refugees in the country. This is especially for South Sudanese and Congolese refugees. It is said that Ugandans, especially from West Nile, sought refuge in Congo and Sudan around the 1980s (Orach and De Brouwere, 2005) which have made them obliged to reciprocate the hospitality they received by allocating free land to their long-time companions. Table 3.3 presents the diversity of refugees in Uganda and settlement areas.

Table 3. 3 Social demographic aspects of refugees and their settlement in Uganda

Refugee location	Country of Origin						Total	percentage
	DRC	South Sudan	Somalia	Rwanda	Burundi	Others		
Adjumani	7	101375	-	-	-	86	101468	23%
Nakivale	37500	31	12168	10612	11441	1366	73118	17%
Kampala	32322	7245	15971	2459	1147	12805	71949	17%
Rwamwanja	53827	-	-	62	-	-	53889	12%
Kyangwali	38377	2909	7	295	18	36	41642	10%
Kiryandongo	208	36678	1	26	17	1599	38529	9%
Kyaka11	20840	3	2	1594	538	32	23009	5%
Rhino Camp	538	18353	-	25	8	463	19387	4%
Oruchinga	2154	-	-	1623	1515	1	5293	1%
Koboko	4745	-	-	-	-	-	4745	1%
Kiryandongo transit centre	-	362	-	-	-	-	362	0.1%
Nyakabende Transit centre	168	-	-	-	-	-	168	0.04%
Ocea reception centre	-	36	-	-	-	-	36	0.01%
Total	190686	166992	28149	16696	14684	16388	433595	
Percentage	44%	39%	6%	4%	3%	4%		

Source: OPM (2015) Refugee locations and countries of origin.

This table shows that refugees from bordering countries to Uganda occupy settlements that are near to their borders. It is also clear that Nakivale settlement has a good illustration of refugees from diverse countries.

### 3.9 Refugee Settlement and Access to Health Services in Uganda

As stated earlier (See: structure of the health system) of health services in Uganda are problematic, which means that nationals meet their health care costs with negligible subsidisation from the state. Uganda's Refugee Act 2006 sets out the context of regulating and managing refugees' issues concerning rights and access to social services. Internationally, Uganda signed and ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Bearing in mind the role of both parents in the family and in the upbringing of children, and aware of the significance of maternity and the role of women in procreation, the great contribution of women to the welfare of the family and to the development of society (UN General Assembly, 1979) put forward principles to be followed by member states in handling all issues regarding women's affairs. For example, Article (2) of CEDAW condemns all forms of discrimination

against women, while Article (12) specifically prohibits discrimination against women in health care.

Likewise, the CRC requires governments to desist from any form of discrimination (Article 2) against children regardless of nationality. Article 22 prescribes the entitlements and rights of refugee children; while Articles (6, 19, 24 and 27) specifically refer to health care and well-being for children (UN General Assembly, 1989).

The recurring health concerns in Uganda's refugee settlements include limited immunisation coverage for all antigens, high prevalence of controllable diseases such as malaria, and lack of latrine coverage and other sanitation facilities (Refugee Law Project, 2015). Tuberculosis, HIV/AIDS, and cancer are highly endemic in refugee settlements in Uganda leading to high rates of morbidity, mortality (Loparimoi, 2011). Additionally, refugee women and children living in the settlements experience difficult circumstances such as: lack of access to minimum essential food; lack of access to basic shelter or housing; lack of safe drinking water; and adequate sanitation facilities, lack of access to health facilities and basic drugs; as well as lack of access to preventive and curative information concerning reproductive health problems (IRC, 2014; Loparimoi, 2011). With increasing numbers of refugees, the health needs of vulnerable refugee women and children may be poorly defined and perhaps largely going unmet. These conditions also contribute to poverty, discrimination and social exclusion which negatively impact health (IOM, 2015).

As a low-income state, dealing with refugee's health needs applies additional weight to the existing arrangements. Refugee settlements are located out of the main command centre of resources hence it is difficult for refugee women and children to access proper health services. Currently, health services for refugees in Uganda are integrated with those of the host communities. This however just occurred in the year 2000; but before then, there were two parallel health systems (Orach, 1998). Despite this integration, the organisation and implementation of health services for refugees are mainly carried out by international, regional and indigenous NGOs under coordination of UNHCR, while host services are mainly provided by the MOH and district local government (Orach et al., 2007). The structure for health services provided for refugees mainly consists of first-line facilities or health centres set up in the refugee settlements hence, there are no specialised hospitals for refugees that handle serious medical or surgical complications (Orach and De Brouwere, 2005). Refugees with serious

health complications are referred to designated public or NGO facilities to receive specialist treatment and care (Orach and De Brouwere, 2005).

In response to the New York Declaration -2016, the government recently incorporated refugee response activities into the current National Development Plan (NDP II, 2015/ 2016- 2019/ 2020). With support from the Joint United Nations- World Bank Refugee and Host Population Empowerment (UN-WB ReHoPE) the formulation of the Settlement Transformative Agenda (STA) which is to be led by the OPM, Department for Refugees. The STA intends to nurture sustainable livelihoods for refugees and host communities and to create an enabling environment for safety, dignity and harmonious living (OPM 2017, p.26). If this is successful, it is likely to improve the health and well-being of refugees in settlements, however, with over-emphasis on self-reliance or economic factors, this might neglect other social determinants of health.

This section has given an overview of the research context (Uganda), discussed the present state of affairs regarding population health and health care. Health services in Uganda are facing serious constraints. The surging numbers of refugees and the open-door policy exert extra burden on an already constrained system. This is central in the analysis of health and well-being for refugees who expect to obtain protection and access to welfare. The next section examines the development of social work as a profession and practice. This is important to understand the positive contribution of the profession to the well-being of vulnerable populations.

### 3.10 The Social and Theoretical Context of Social Work

This section presents the philosophy of the social work profession, the diverse paradigms of social work, and provides a contextual analysis of its evolution both as a global profession and in Uganda. The unit reflects on the need for social work in rural Uganda—which is the main domain of refugee settlements. First I will present the philosophy of the profession.

### 3.11 The Philosophy of Social Work

The evolution of the social work can be adduced to three major strands: 1) to the focus on individual casework which originated from the work of the Charity Organisation Society (COS) in Britain; 2) to the role of social work in the social administration of relief from poverty which emerged from the Poor Laws and; 3), to the focus on social action—which can be identified with the growth of the settlement movement in Britain and United States (Seed, 1973; Woodroffe, 1962; Lewis, 1995; Rose, 2001; cited in Lymbery 2005, p.2).

These perspectives designate starting points and main roles of social work in society. Mullaly (1997) asserts that social work as a profession can be classified as either ‘conventional’ or ‘progressive.’ The conventional view of social work (also known as the popular view) postulates the structure of society to be fundamentally sound. This view posits the role of social work is either to help people adjust to existing social structures or to amend those structures in a limited way in order to meet people’s needs. For example, this may possibly be through efficient administration of relief/emergency services or through casework (working with a person's family, history, and personal circumstances).

In contrast, the ‘progressive view,’ accentuates the purpose of social work as involving the creation of fundamental social transformation, on the basis that the problems of individuals are caused by inequitable social structures rather than individual inadequacy or weakness” (Mullaly 1997, p.13). Lymbery (2005) contrasts that although these are convincing ways of scrutinising the philosophy of social work, they overgeneralise the inherent paradoxes that characterise daily practice. He divulges that it is important to act in ways that support the framework of society as streamlined by legislative and statutory requirements for the profession (Lymbery 2005, p.14). Lymbery contends with Payne’s generalist view of social work as feasible for practice statutory and policy requirements of agencies within which most social workers operate, subscribe to this orientation (Lymbery 2005, p.14).

Payne (1996) introduces three mutually exclusive concepts to express the concern of social work in society. According to Payne (1996, p.2), social work can be construed as either, ‘individualist-reformist’; ‘socialist-collectivist’; and ‘reflexive-therapeutic.’ For instance; an ‘individual reformist approach intended at supporting a refugee population would involve carrying out community care assessments, arranging for safe and fast settlement of newly arrived refugees or even speedy delivery of material support to individual refugees. In addition

to such therapeutic interventions, a more established individual (for instance, a refugee) would need extra support to deal with adversity and deprivation.

Social practitioners have to reflect on other perspectives such as the utility of collective action in their work (Lymbery, 2005). For example, working with refugee populations, it is important for social workers to engage in activities such as supporting and empowering groups of refugees to meet, interact and discuss their challenges to improve their welfare. This is also a better way of creating awareness of accessible services for their respective needs. I now turn to the schools of social work.

### 3.12 The Western Model of Social Work

Social work in Europe and America emerged as a response to social problems (Midgley, 1981). Research shows that it evolved out of the need to help the poor and underprivileged to survive and also to empower them to enter the mainstream of development rather than remaining as vulnerable, oppressed, and marginalized populations (Ambrosino, Heffernan, Shuttleworth, & Ambrosino, 2005; Neukrug, 2008 cited in Mwansa 2011, p. 2). As result of the process of social development and growing momentum in the delivery of welfare services, social work begun alongside the welfare administrations pioneered by the church, governments, and individuals and philanthropists (Mwansa, 2011). The schools of social work and the different social work methods developed out of the voluntary system of helping the poor. The main method was that of helping individuals to live better lives. It's upon this argument that the difference between African Social Work and Western models are derived. On this Mwansa (2011, p.2) states that the Western approach of social work steers the capitalist ideology which accentuates values of individualism, competition, and accumulation compared to the African indigenous social welfare service ideology (which I turn to in the next section) founded on communalism, kinship systems, and mutual aid.

### 3.13 Professional Social Work in Africa

The introduction of professional social work in Africa is mainly linked to the occupation of evangelical missionaries because they were the pioneers of modern social welfare services such as schools and hospitals (Midgley, 1981). Social work in some parts of Africa such as South Africa was developed as a tool for colonialism and social control of the African population who were perceived as agitators and enemies of the state (Sewpaul, 2005 cited in Mwansa



2011, p.5). In some instances, social work was presented in Africa because of the negative impacts of a market economy and urbanisation. It is argued that the replacement of the subsistence economy with a liberal market economy and the process of urbanisation led to a rural-to-urban migration and emergence of urban communities which weakened the traditional structures and led to new human needs or social issues such as unemployment, accommodation, juvenile delinquency, alcoholism and violence which needs organised social services (Mwansa, 2011). Due to urbanisation and industrialisation, social welfare was important for the well-being of the white population and to ensure the well-being of employees. This led to the development of Ministries of Social Welfare in different parts of the continent such as Zambia, Sierra Leone and Togo, Ethiopia, Kenya, Cameroon, Ivory Coast, Nigeria, Senegal, Tanzania, and Madagascar (ASWEA Documents, 1973, 1974 cited in Mwansa 2011, p.5). In other parts like Uganda, Ghana and Botswana the British also established social services to integrate World War II veterans into society (Mwansa, 2011). All these developments led to the institution of several schools of social work starting with South Africa in 1924, Egypt in 1936, Algeria in 1942, Ghana in 1945, Uganda in 1954, Tanzania in 1958, Ethiopia in 1959, Burkina Faso in 1960, Tunisia in 1964, and Zimbabwe in 1964 (ibid). Upon this background, social work training and practice was designed to fit the prevailing needs and the subsequent service requirements. The newly trained graduates worked as rural animation workers, rural development workers, social workers, community development workers and social development workers. Response and practice were not aligned to the African context but rather to value base and philosophy of colonising countries (ibid). The Western perspective of social work which is mainly based on individual principles and informed by psychology, psychoanalysis, and group dynamics has largely overshadowed the African community-oriented perspective (ibid). A lack of research by the local staff to motivate indigenous curriculum development has further continued dependence on Western literature. These factors account for the prevailing limitations to social work practice such as the low remuneration and status, bad working conditions and lack of authority in their practice (ibid).

### 3.14 The Evolution of Social Work in Uganda

There is scant literature regarding the development of the social work profession in Uganda. Like in many parts of Africa, the extended family and kinship systems were very strong in Uganda during the pre-colonial period, and therefore, most of the social work functions (such

as response to individual needs) were performed by family and kinship systems (Kabadaki, 1995). Twikirize states that “problems such as family conflicts, orphanhood, and child protection were handled within the extended family and the community (Twikirize 2014).

Professional social work in Uganda was instigated by the British colonial administration around the 1950s (Twikirize, 2014). As a result, the training and practice basically served the necessities of the pioneer government thus, social work instruction, educational programmes and practice roles concentrated on individual welfare and correction services. For example, some of the tasks included managing juvenile delinquents and addressing the needs of orphans and homeless people (Twikirize, 2014). In addition, after the Second World War (1939-1945)- Uganda experienced various social problems such as an increased number of orphans, widows and sick veterans. There were also other issues such as expanding urbanisation which led to increased migration of people from rural areas leading to overcrowding in the city and its associated effects. These prompted the development of social policies to meet the social welfare needs of the vulnerable groups as well as to maintain and sustain the standards of the middle-class city dwellers. The Ministry of Planning and Community Development (MPCD) (1965, P.4) states that;

The changing pattern of society with the rural areas ceasing to be isolated and the consequential rapid expansion of urban areas of which the most basic elements were the institutionalisation of society and individualisation of man, all these combined problems necessitated a planned social policy involving professional specialists, administrators as well as people (cited in Twikirize 2014, p.137).

European Christian evangelists and the colonial heads presented services, for example, education, health, and social welfare. The foundation of probation services, children’s homes, and adoption services marked the start of formal social administrations. With this, came the idea of individual welfare. On that account, it was uncovered in the government’s Sessional Paper No.2 (1957/58) that the fundamental preparation that was needed for social welfare service administration and to address the various needs of the urban and rural inhabitants was in social work (*ibid*).

Social work in Uganda to a great extent embraced a remedial approach in its initiation. Social workers were mostly prepared in therapeutic administration. Such services were for the most part urban-based and went for managing social problems of children living on the streets, delinquents, and rehabilitation of drug addicts- keeping in mind the end goal to limit

interruptions to the smooth running of the colonial government's programmes. In alluding to social welfare needs of the urban occupants, sessional paper No.4 (1958/59) stated that: "*the social welfare needs of urban areas seem, by all accounts, to be of two sorts: group social work and remedial welfare*" (Ministry of Social Development 1959, cited in Twikirize 2014, p.138).

Through the community development department, there was some limited engagement of social workers in development-oriented programmes to enhance the general standard of living of the individuals, households and the community, especially in the rural areas (Ssenkoloto, n.d cited in Twikirize 2014, p.138). As such, Twikirize (2014) affirms that while the residual services prevailed in urban areas, including work with juvenile offenders; community development was dominant in rural areas.

Social workers were additionally involved in arranging voluntary services across the country and thus were engaged with voluntary organisations that dealt with childcare, the physically and mentally disturbed, youth study groups, education and culture, women's organisations and services for the aged (MPCD, 1965; Yiman, 1976 cited in Twikirize, 2014, p.138).

After Independence, the Post-Colonial Government continued rendering formal social services which services required experts. The primary degree programme in social work began at Makerere University in 1969 (Makerere University Department of Social Work and Social Administration, 2011). Social work in Uganda is practiced in the form of the informal social welfare system organised around families, clans and voluntary organisations and in the way of the formal social welfare system. Unfortunately, the informal system has been overstretched by emerging challenges of poverty and multiple deprivations, urbanisation, widespread social problems, armed conflicts and civil wars; the monetised economy, HIV/AIDS epidemic and its concomitant issues; and in addition to the worldwide culture of individualism (Twikirize, 2014). These developments and subsequent changes over the years have called for the renewed need for professional social workers in the country. Twikirize (2014) adds that "the original concentration to remedial services has additionally been overtaken by changes within wider socio-economic environment and by the realisation that the vast majority of problems experienced by individuals have their foundations in the socio-economic and political environment within which they live; hence, there have been efforts to make social work broader and proactive in its approach along these lines underlining need for a social development perspective" (p.139).

Ministry of Gender Labour and Social Development (MGLSD) is mandated with social development and social protection issues in the country and within its portfolio, professional social workers should be employed at every district and sub-county level as probation and welfare officers and community development officers (Twikirize 2014, p.139). But due to the eclectic nature of social work; social workers have been absorbed in almost all ministries, departments and agencies within public service (for example in health as medical social workers and counsellors) and majority are mostly working in the NGO sector/civil society organisations (as social workers -casework and group work, counsellors, programme officers, community mobilisers and educators, monitoring and evaluation specialists), on grounds that the NGO sector is more pronounced than government departments and agencies in dealing with issues of social protection.

In terms of space, most social work graduates have generally looked for work in urban territories but due to limited social work positions, many have taken up positions random to their professional training. A significant number of them take up positions in banks and others in financially related establishments and any organisation that can offer them employment and better working conditions (Twikirize, 2014). Speaking of locality, Kabadaki (1995, p.81) noted that the social service agencies are virtually non-existent in rural areas and due to poor living conditions in rural areas, the majority of social workers prefer not to live or work in these areas.

The profession faces challenges especially those that emanate from its historical links with residual services (Twikirize, 2014). One indication of hope is that the profession has recently secured formal regulation in 2019. Despite this, it remains invisible in the public and political arena. Further challenges include lack of good remuneration which discourages graduates from working with rural communities. Besides, both government and NGOs continue contracting non-social work professionals to perform social work roles (Twikirize, 2014). This is due to a partial comprehension of the skills and competencies of different social science disciplines. Moreover, social work training at the graduate level at Makerere University has just been introduced in 2019. A lack of such has in the past limited context-based social work research and literature. Twikirize (2014) asserts that the application of traditional methods of instruction coupled with the ever-increasing number of students has also compromised standards in terms of skills acquisition and mentorship.

### 3.15 Social Work with Refugee Populations

Social work with refugees refers to the delivery of various social services to groups of people who have been forced to flee their homes to other countries due to internal and external threats (Okitikpi and Aymer, 2000). Social workers must be ready and committed to understanding the relevant vulnerabilities of individual refugees and their families, and certainly, be able to address the international and national policy contexts which shape the structure for social service provision. Hall (2006) alludes that for social professions, migration provides a focus for professional practice in terms of working with and supporting people with issues of relocation, integration or repatriation. Social workers must also have the capacity and morale to work on the oppressive attitudes and practices against refugees. Okitikpi and Aymer (2000, p.285) give a precis of the key competency areas necessary for social work with refugees:

- (i) An understanding of how the experience of being a refugee manifests itself, including an appreciation of the political, social and cultural contexts that created geographical dislocation.
- (ii) Acquisition of enhanced skills of working with people who may be both physically and emotionally vulnerable.
- (iii) The adoption of models of social work intervention sensitive to the cultural needs of refugees.
- (iv) Use of an integrated approach to service provision that can offer swift, practical solutions to daily living problems, give appropriate help for psychological distress and promote the educational development of refugee children.

With such knowledge and skills, social workers may be involved with refugees in a variety of situations and settings including, refugee camps/settlements; in locations close to sites of conflict or disputed borders or refugee centers; and in countries where refugees have formally sought asylum (Hall, 2006). They can work at the individual or group levels with refugees but there is also an underlying expectation that they will exercise leadership in planning and delivery of the needed services.

### 3.16 The Need for Social Work Practice in Refugee Settlements

Refugee settlements in Uganda are gazetted in rural areas and NRS is not an exception. During President Idi Amin's ruthless and destructive regime in the 1980s, Uganda experienced a decline in the economy due to recurrent wars, and political instability (Kabadaki 1995, p.78).

These events specifically impacted negatively on the rural population. This created a number of social problems and resulted in a lower standard of living in rural areas. Rural peasants often experience a number of problems ranging from substandard housing, inadequate clothing, limited education opportunities, diseases, inaccessibility to health services, lack of transportation, lack of safe water, high infant mortality rate, poor nutrition, illiteracy, alcoholism and high fertility rates (*ibid*).

These are exacerbated by contemporary developments such as rural-urban migration, death of able-bodied men as a result of political persecution, wars and epidemics like HIV/AIDS; and economic hardships which have contributed to an increase in the number of widows and female-headed households, and enlarged the number of orphans and vulnerable children in rural districts. Consequently, individuals are struggling to meet their own basic needs and those of their immediate families yet the traditional kinship systems which originally provided social security or arranged social protection are utterly drained (Kabadaki, 1995). As individuals, groups, and communities are no longer able to aid, assist, support, guide or counsel relatives, friends and neighbours, the urgency for social work solutions is incontestable. Al-Qdah & Lacroix (2011) state that although social work has begun to develop interventions among refugees in host countries, it still remains underdeveloped. In refugee settlements, social workers designated as community development officers (CDOs) could assist in assessing health needs and problems so that health care programmes respond to need (Mwenyango and Palattiyil, 2019).

Further, it is important to conduct research on issues like health, culture, and illiteracy and highlight challenges and obstacles to access and use of health services. For instance, some cultural norms prohibit women and children from accessing the public domain (Kabadaki, 1995; Nalukwago et al., 2019). The situation is more challenging for refugee women because are they are also trapped by the refugee status. While the GoU gives plots to refugees (which is praised as the best refugee policy in the world)<sup>12</sup> to construct and cultivate, such land is mostly owned by the household heads who are usually male refugees. This is a problem because agriculture is the main source of survival in rural settlements. The country has through formulation of a gender-responsive regulatory framework made advances in strengthening

---

<sup>12</sup> See: <https://www.theguardian.com/world/2017/apr/01/is-uganda-worlds-best-place-for-refugees-south-sudan>

gender equality and women 's empowerment such as an increase of women in political leadership and gender parity in enrolment of girls at primary level (including in rural areas) (GoU, 2015).

Despite this, unhealthy gender disparities still exist; for example, young girls especially (from rural areas) are poorly represented at higher levels of education, only 27 percent of registered land is owned by women (although 70 percent of the women are engaged in agriculture,) and less than 20 percent of women control the outputs and proceeds from their efforts (ibid). These lead to high levels of poverty, vulnerability and poor health indicators in women and children regardless of age, class, or status.

Social workers can mobilise and motivate refugee populations to participate in planned programmes intended to improve their welfare such as community health programmes, literacy programmes, and life skills educational or economic programmes. This can also help refugees to network and be able to meet their psychosocial and emotional needs which are sometimes ignored by the other groups working with refugees. For example, research indicates that whereas many refugees experience trauma due to hopelessness, absence of employment opportunities and perceived social dysfunction (UNHCR, 2014) especially after settlement; in tight circumstances, there is a very high likelihood that focus is put on meeting the immediate needs of food, water, and shelter as well as elementary health care needs and the mental and psychological needs of refugees are neglected (Hiegel, 1991).

They would also communicate and disseminate information through educational programmes (Kabadaki, 1995) partly to address communal concerns and raise consciousness about cultures that are unfair to some members of the community. Others carry their cultural norms and practices such female genital mutilation, gender-based violence, which might be dangerous. Social workers can better address these tensions from a culturally sensitive practice and improve the well-being of the victims and/or potential victims.

Social workers are able to set up and coordinate other social services that contribute to better health and contribute to policymaking processes regarding the design, formulation, and delivery of health and other social services. For example, Kabadaki (1995) articulates that a well-organised foster care system in rural areas (settlements) could be cost-effective and would address the problem of a growing number of orphans; introduction of social work in settlement

schools may enable extremely poor children, especially girls, to attain more years of formal education by dealing with problems pertaining to lack of school fees and uniforms due to their refugee status.

This section has examined the social and contextual boundaries of social work. I have argued that social work has a crucial role to play in improving the health and well-being of refugees. This is because they are trained in human rights and also have the obligation to abide by the principles and values of the profession such as being just, fair, and being non-judgmental. This preparation puts them in a better position to balance between the humanistic values, social care, and welfare. Despite this, social work is still limited in its remit due to private, pedagogical, and remuneration complications.

The next chapter examines the methodology and research methods that were used to execute the study. The chapter also points out the ethical issues and challenges of doing this research.



## CHAPTER FOUR: RESEARCH DESIGN AND METHODS

### 4.0 Introduction

The previous chapter presented the conceptual and contextual background of this research to provide an understanding of the social realities of refugees in Uganda. This chapter examines the methodology and research methods that were used to execute the study. In this chapter, I will also address some ethical issues and challenges that arose during data collection and analysis. Crotty draws a distinction between methods and methodology; referring to ‘methods as techniques, procedures or activities which are applied to collect and analyse data whereas methodology is a strategy, plan of action, process or design lying behind the choice of particular methods. I feel this distinction is important because it tells the reader decisions and choices about my research, allowing them to better assess my findings. I will first discuss methodology, then methods, and finally ethics.

#### 4.1.0 Research Design

In order to find answers to the research questions, it was necessary to plan and design a research strategy. The research design refers to the overall structure, strategy, plan, and framework for integrating the various aspects of the study into a coherent and logical procedure that can be followed throughout the research process (Blaikie 2010).

Research strategies differ depending on their ontological assumptions, starting points, steps or logic, use of concepts and theory, styles of explanation and understanding and the status of their products. A research strategy can be inductive, deductive, retroductive and abductive<sup>13</sup> (Blaikie 2010, p.81-82).

Early on, I adopted an inductive strategy to formulate relevant concepts about the topic. An inductive research strategy utilises data to generate ideas (Thorne, 2000; 6 and Bellamy, 2012). It was thus important to carry out a thorough literature review to sensitise myself to the concepts of health and social work. A detailed conceptualisation of the topic influenced the choice of adopting mixed methods to benefit from their relative strengths (Bryman, 2006).

---

<sup>13</sup> A deductive strategy sets out to test theories by developing hypotheses; the retroductive seeks to discover mechanisms to explain observed regularities, whereas the abductive involves developing descriptions of and construction of theory grounded in people’s daily activities (Blaikie, 2010).

#### *4.1.1 Mixed methods*

A mixed-method study is one in which the researcher uses multiple methods of data collection and analysis; where the methods might be drawn from within a single-family (say qualitative or quantitative) or between methods drawing on both qualitative and quantitative data collection procedures (Creswell 1994, p.174). To better answer the research questions and overcome limitations of each method, this study combined both qualitative and quantitative methods. This was done at different stages of the research process that is, at sampling, data collection and data analysis (Bryman, 2006). Mixed methods were preferred to achieve triangulation<sup>14</sup> of data, greater validity and complementarity (Bryman 2006; Blaikie, 1991; Moran-Ellis et.al, 2006). While quantitative data helped to identify the actual public health concerns, exacerbating factors and draw comparisons among the different characteristics of refugee women and various variables, qualitative methods provided deeper insights into these public health issues and health service provision.

Combining methods is, however, connected with the risk of creating ontological and epistemological contradictions when methods based on different assumptions are used (Blaikie 1991, p.115). Thus, while it was helpful to apply multiple methods, these were used consistently and sequentially such that each, in turn, provided a basis for the development of the subsequent stages of the research (Zelditch, 1962; Sieber, 1973; Ianni and Orr, 1979; Madey, 1982; Burgess, 1984 cited in Blaikie, 1991, p.131). The quantitative methods provided numerical data for understanding the magnitude of the health concerns and for generating correlations of health services and gaps. This data provided a developmental basis and was used to inform qualitative data collection in terms of sampling and implementation (Creswell 1994, p.175). Basically, the survey preceded the other methods of data collection, with in-depth interviews delving further into issues raised by the survey. Moreover, combining qualitative and quantitative methods was essential for capturing the views of various participants involved in supporting refugees. In addition, I carried out observations (I expand this later in the chapter). This technique allowed me to gather data on difficult to discuss or taken-for-granted social, cultural and economic circumstances in the settlement. Further, a phenomenological

---

<sup>14</sup> Bryman 2001, p.274 defines triangulation as an approach to research that entails using more than one method or source of data in the study of social phenomenon

perspective was considered appropriate to provide a theoretical ground for studying experiences, perceptions and subjective interests (in matters of health) of refugee women and children (Patton, 2002).

#### *4.1.2 Phenomenology*

Phenomenology in social science is attributed to the work of Alfred Schutz (1899-1959) and is associated with the epistemological position that social reality has meaning for human beings (Bryman 2001). A phenomenological perspective was ideal especially for the qualitative component to gain access to respondents' social world and interpret it from their point of view (Bryman 2001, p.14). The approach is less interested in reality status of particular instances, and more concerned with 'essences' or 'meanings' (Patton 2002, p.106). It involves studying people's subjective and everyday experience, and so aims toward collecting and analysing data in ways that do not violate their subjective character (Crotty 1998, p.83). The approach is also commendable for investigating experiences in health research because it allows the researcher to delve into the perceptions, understandings, and feelings of the people who have experienced or lived the research phenomenon (Pringle et al, 2011; Thorne, 2000). Such an epistemological commitment led me to a mutually descriptive and exploratory research design.

#### *4.1.3 The Descriptive and Exploratory Designs*

The study was both descriptive and explorative in design. The descriptive design was viewed as appropriate to observe, describe, document and to provide a picture of the phenomenon as it naturally occurs, as opposed to studying the impacts of the phenomenon (Bickman et al., 1998). This design is also commendable for gathering the characteristics of the phenomenon under study, hence suitable for quantitative research (Nassaji, 2015). On the other hand, the explorative design seeks to examine or explore the phenomenon in order to provide deeper meanings of it (Miller et al., 2014). The study examined health and health services for refugee women and children and the role of social work in health promotion in refugee settlements in Uganda. The explorative design thus helped to identify the major structures or institutions and stakeholders in health promotion activities in the settlement. I turn now to my choice to gather data cross-sectionally, that is, in a single burst of research.

#### *4.1.4 The Cross-Sectional Design*

A cross-sectional study involves studying aspects of social life such as demographic characteristics, individual qualities, values, beliefs and behaviour, social interactions and aspects of social groups, organisations, institutions, and structures at a single point in time (Blaikie 2010, p.200). For practical and economic reasons, a cross-sectional design was both expedient and theoretically justified. In contrast with longitudinal studies where data is collected over a period of time to track changes or historical studies which deal with social events that took place in the past, this study was interested in and sought to investigate the contemporary health conditions of women and children living in the settlement at the time of the study. The cross-sectional design was more flexible to study different categories of refugee communities and simultaneously interact with key informants. And unlike longitudinal studies which are generally costly in terms of maintaining respondent contact, motivation and commitment over a period of years (Payne and Payne, 2004), cross-sectional studies are time and cost-effective. I will now detail the stages of the research: documentary review, quantitative survey, interviews, and finally, participant observation.

#### *4.1.5 Documentary Review*

A 'document is an artefact which has an inscribed text (script) as its central feature or written expression of a spoken language' (Scott, 1990, p.5). According to Payne and Payne (2004, p.61), the documentary review is a technique used to categorise, investigate, interpret and identify the limitations of physical sources and most commonly written documents—whether in the private or public domain. Documents can be classified according to their main source, purpose, or intended audience. Types include:

- a) Personal/individual (e.g. individual letters, diaries),
- b) Private documents from civil society organisations and NGOs (e.g. training manuals, annual reports and media statements)
- c) Public, meant largely for planning or accountability or regulatory purposes (e.g. policy statements, census reports, ministerial or departmental annual reports) (Payne and Payne 2004; Mogalakwe 2006; Bryman 2001; Scott, 1990).

Often, these documents are not deliberately produced for social researchers but are usually natural objects with a concrete and semi-permanent existence that provides indirect information about the social world of their authors (Payne and Payne, 2004). Hence, it is always upon researchers to make meaning out of these texts so that these can accurately feed into their own investigations. I started by reviewing the relevant documents and studying some background information regarding the situation of refugees in general and as well as refugees in Uganda. The selection of documents was based on availability, personal knowledge and brainstorming with experts. Having located the documents then led to the key step of assessing them for inclusion.

Scott (1990, p.6) provides a four-step approach for examining the quality of documentary material including authenticity, credibility, representativeness, and meaning. Authenticity fundamentally questions the genuineness and originality of the document; credibility relates to the extent to which the material is profound, free from delusion, evasion, and distortion; representativeness refers to the typicality of the material; whereas meaning depicts the extent to which the material is clear and comprehensible to the researcher (Scott 1990, pp.7-8). This suggests that before making use of any document, a researcher should assess its quality. Thus, any document that is not authentic, credible, representative or deemed lacking in the least one of those elements should not be included in the literature. I embarked on an intense literature search and review of documents in line with Scott's criteria. Hence, solely documents that meet the criteria were selected for inclusion.

Most of the documents accessed came from University libraries, others from official government websites and others from reliable databases such as (Applied Social Science Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus), International Bibliography of Social Science (IBSS) Online, ProQuest Social Science Journals, ProQuest Sociology, PsycINFO, SAGE, SCOPUS, Scholar Google, Social Services Abstracts and Web of Science Core Collection). Further official and public documents were obtained from the Office of the Prime Minister (Department for Refugees) and UNHCR official publication sites. I specifically reviewed official government documents on refugees, national health policy documents, archival materials on refugees, UNHCR policies and guidelines for health service provision, World Health Organisation (WHO) publications and reports, journal articles covering refugee health and social work; newspapers; books and publications on

refugees and methods. This laid the ground for conceptualisation and detailed formulation of the research design. Hence, all the decisions regarding research questions; methods for data collection; data management and analysis; ethics and time schedules were completely informed by intense background research. I now turn to the quantitative research approach.

#### *4.1.6 The Quantitative Research Approach*

Quantitative research is a research strategy that emphasises quantification in data collection and analysis (Bryman 2001, p.20). Such an approach rests on precise measurement to collect numerical data and the use of validated data-collection instruments. It is additionally used to test hypotheses, analyse relationships, and decide cause-and-effect relationships between variables (Bryman, 2001). The quantitative approach in this study involved administering a survey to 377 refugee women living in Nakivale Refugee Settlement. Since data were collected during the rainy (and thus crop-planting) season, many refugee women did not have time for qualitative interviews. The survey allowed me to expediently capture information from a broader sample of women than interviews would have allowed. Quantitative data were then aggregated and analysed using SPSS Version 17.0.

#### *4.1.7 The Qualitative Research Approach*

In addition to quantitative research, a qualitative approach was conducive to achieving the purpose of this study. Qualitative research refers to a strategy emphasising words rather than quantification in the collection and analysis of data (Bryman 2001, p.264); it is inductivist, constructionist, and interpretivist (Creswell, 1994; 6 and Bellamy, 2012) although this varies across researchers. An inductive approach begins with a question and generates theory out of research, instead of seeking to find out whether a hypothesis is true or false which is more general in quantitative research (6 and Bellamy, 2012). An interpretive epistemology calls for an understanding of the social world through interpretations from participants instead of through natural scientific models that utilise quantitative strategies; whereas the constructionist ontology portrays social properties as outcomes of interactions between individuals (Bryman 2001, p264). Qualitative researchers are more interested in understanding how others experience life, in interpreting the social phenomena as well as exploring new concepts and developing new theories (Alston and Bowles 2003, p.10). Instead of aiming for discoveries and testing of theories as in quantitative research, qualitative research considers experiences rather than preconceived ideas (Thorne, 2000). There were various benefits of applying qualitative

methods, such as the flexibility which was vital for getting the overall picture of the researched in their everyday world (Kvale and Brinkmann, 2009). Bryman states that qualitative researchers aim at seeing social worlds through the perspectives of their respondents, providing descriptions of and emphasising the research context, and considering social life in terms of processes (Bryman 2001, p 276-279). The main aim of the study was to examine the health services for refugee women and children and the role of social workers in health promotion in refugee settlements. The study intrinsically sought to investigate and understand refugees' and key informants' perceptions, beliefs, ideas and opinions about the topic, which aspects would be difficult to measure by solely quantitative procedures. In order to obtain information on women's experiences and what processes women encounter in trying to meet their health needs and those of their children, there was a need for close interaction and sharing in natural settings, as well as paying attention to the meanings which refugees attach to life in exile. This also required a flexible qualitative method. I opted for a conversational approach which deemphasised the power differential between the researcher and subject (Beresford and Evans, 1999). I now turn to the location of the research.

#### 4.2 The Setting

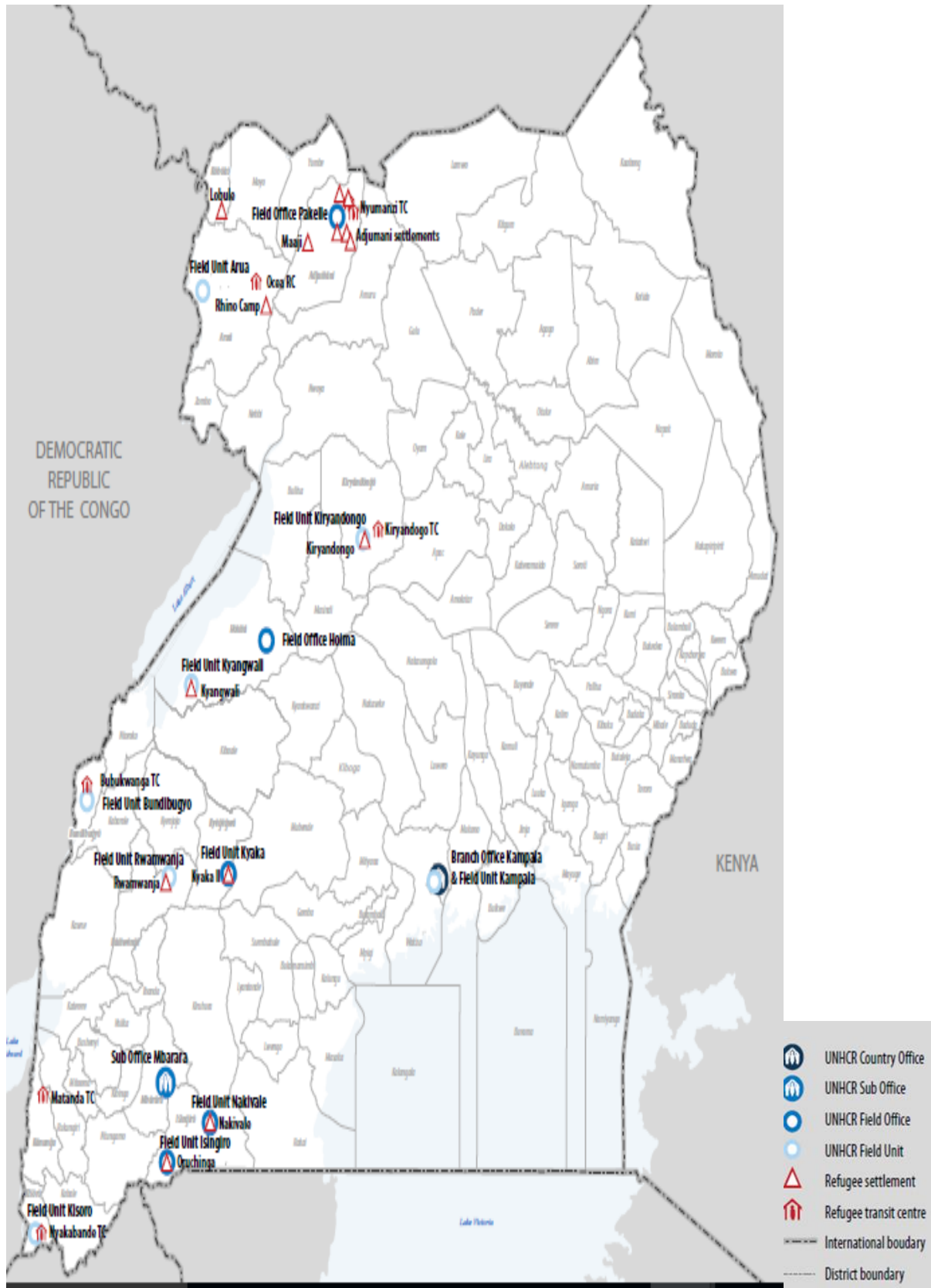
The choice of the research setting is one of the basic decisions that must be made early in designing a study and should be dictated by rational procedures. As mentioned earlier in Chapter Three, Uganda currently has several active refugee settlements including Nakivale, Kyaka II, Oruchinga, Kyangwali, Kiryandongo, Paralonya, Rhino Camp, Imvepi, Madi Okollo, Maaji settlement and the integrated camps of Adjumani (OPM, 2015). Map 4.1 shows the refugee settlements and UNHCR presence in Uganda as of April 2015

According to Marshall and Rossman (2006, p.62), the ideal research site is one where entry is possible; where there is a high probability that a rich mix of the processes, people, programmes, interactions, and structures of interest are present; where the researcher is likely to be able to build trusting relations with the participants in the study; and where data quality and credibility are reasonably assured. The study was carried out at the Nakivale refugee settlement (NRS). The settlement is located in Isingiro district, which is bordered by Kiruhura district to the north, Rakai District to the east, Tanzania to the south, Ntungamo district to the west and Mbarara district to the north-west. NRS was established in 1958 and officially recognized in 1960. Nakivale refugee settlement was chosen purposely because of its historical profile, size, and

richness in diversity of the residents. NRS is the 8<sup>th</sup> largest in the world and is one of the oldest refugee settlements in Uganda. It has 185 square kilometres with three main zones including Juru, Base and Rubondo camps. The settlement is located in an underdeveloped area with limited infrastructure and minimal access to formal services. Juru camp is in proximity to the local government offices of Isingiro. Base camp is the central zone near the offices of the OPM, UNHCR and most humanitarian organisations— which also qualifies it as the urban zone with busy life and lots of commercial activities. On the other hand, Rubondo is considered as the remotest zone. Most people in this zone are peasants and there were not many commercial activities. Compared with other refugee settlements in the country, the site has a good representation of the refugees (in terms of ethnicity) in the country which was important because this ensured participation from a diversity of respondents.



Map 4.1 Refugee Settlements and UNHCR presence in Uganda as of April 2015



Source: UNHCR Maps Uganda (2015)

Nakivale hosts a number of refugees from different nationalities with recent statistics showing; Congolese (49.4%), Somalis (20.5%), Burundians (14.8%), Rwandese (13.1%), as well as others from South Sudan, Kenya, Ethiopia, and Eritrea (Refugee Law Project, 2015). We turn now to how participants were selected from this diverse mix.

### 4.3 Study Population

A study population comprises individuals, objects or events which have some attributes of interest for a researcher (Marshall and Rossman, 2006). This study population comprised of both primary and secondary individuals. The primary population was the refugee women who were living in NRS in 2017. This was conceived based on the official statistics of 1.5 million refugees in Uganda (OPM, 2015). By the year 2017 NRS hosted over 73,118 refugees (OPM, 2015) out of that 40,320 were females of which 18,258 were adults of reproductive age (18-59); 9,015 school going children (5-11); 6,266 adolescents (12 -17); 5913 pre-school children (0-4) while 868 were elderly women above 60 years (OPM, 2015). Given that the age of consent in Uganda is eighteen, the study population comprised all refugee women aged 18 years and above living in the settlement at the time of the research. Moreover, only adults were considered because they were believed to have sufficient maturity to contribute to the subject matter and were expected to have experienced a host of challenges in the search for health services for themselves and any children they might have. On the other hand, the secondary population was the refugee men who were in NRS at the time of the survey and experts in the theme of the study such as the staff of OPM, NGOs supporting refugees and academicians.

### 4.4 Sample Selection

Sampling can be described as a procedure that is used to extract a small proportion (sample) of units from the larger population. The process involves a proper and critical definition of the entire universe from which the subset will be drawn (Bryman, 2001). The sampling criteria may utilise probability or non-probability techniques. This study utilised both probability and non-probability sampling techniques to determine sample sizes for the survey and qualitative interviews, respectively. A probability sample is a randomly selected set of units from an entire population and it is usually meant to be representative and generalisable to the whole whereas a non-probability sample refers to a non-random selection of units (Bryman, 2001).

To draw a representative and generalisable sample for the survey, the study utilised stratified and systematic random sampling techniques. Based on Krejcie and Morgan (1970), table for determining sample size from a given population, 377 women was determined as the optimal number to survey from a population of 19,126 adult refugee women. This number was then divided into three zones to determine the stratum of at least (126 women) to be surveyed from each zone. These strata were not based on the proportionate number of women in each zone because there were no readily available lists to indicate the number of women per zone of residence.

The sample for the survey consisted of 377 women aged between 18 and 80 years (mean age= 33.9, standard deviation=11.6 years) who had sought refuge in Uganda between 1992 to 2017. The survey provided data on the socio-demographic and economic characteristics of refugee women in the settlement such as age, gender, country of origin, education, religion, marital status, household information, duration of stay, data on health status of the people in the settlement for example the common diseases, data on health service provision, access, and utilisation.

Since the study area was divided into three zones, the sample consisted of nearly the same number of residents from each zone, to ensure representativeness of refugees from all residences. Almost more than half of the participants comprised of refugee women from Congo (55.2%) whereas (41.4%) were Rwandese and Burundians. This was inevitable because the camp is bordered by Congo, Rwanda, and Burundi which makes it easy for refugees from these countries to seek refuge in this camp. Thus, refugee women of other nationalities (Somalis, Tanzanians, and Eritreans) only formed a small portion (3.5%) of the entire sample. Figure 4.1 presents the percentages of refugee women who were selected from each zone of residence.

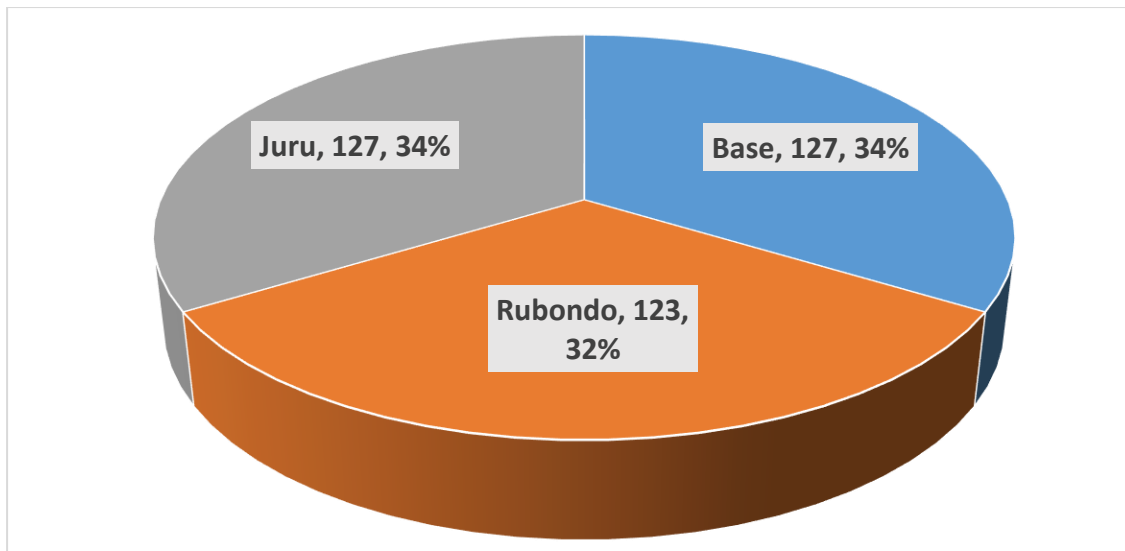


Figure 4. 1 Distribution of refugee women per zone of residence (N=377)

Having determined the required stratum for each zone, a sampling interval was calculated using the formula:  $[k = N/n]$  where  $N = 377$  and  $n = 126$  hence  $k = 2.992$ . Since this was not evenly divisible, this figure was rounded off to  $k=3$ . With a random starting point of 1, every woman living in the 3<sup>rd</sup> household was selected for the survey. However, if any woman in the 3<sup>rd</sup> household was not found at home or was not willing to participate, another woman from the next household was selected. The sampling procedure sometimes had to be adjusted. In Rubondo and Juru, women were frequently out of the house, and so were located at health centres. Here too every third woman was selected for participation.

In addition, 69 in-depth qualitative interviews were conducted with refugee women, refugee men and key informants. Given the main objective of the study, the samples for qualitative interviews were determined using non-probability sampling techniques. The samples were reached by a process of theoretical saturation, that is, when no new qualitative data were emerging from interviews with women, men and key informants (Cobin and Strauss 2008, p.2).

Informed by the phenomenological approach, the sample of refugee women (N=31) was purposively determined based on their descriptive characteristics (derived from the survey) to give more meaning to their experiences (Patton, 2002). The in-depth interviews with refugee women provided specific information on the public health concerns and interventions in the

settlement, coping mechanisms; as well as issues related to access and utilisation of health services.

Individual male participants were located using convenience sampling. A convenience sample is preferable when there is a particular interest in generating an in-depth analysis of the issues under investigation rather than focusing on the representativeness of the sample (Bryman, 2001). As men tend to dominate family decision making in Africa, including health care for their wives and children, their opinions were perceived to be useful in exploring the phenomena. Moreover, it would have been impossible to fully appreciate refugee women and children's health without directly exploring the ways in which men influenced it.

Purposive sampling was also used to select key informants which allowed for a rich collection of cases that provided in-depth information and knowledge about the topic (Bryman, 2001). This selection was based on their knowledge about the topic of refugees or their involvement in supporting refugees. Key informants included staff from the Office of the Prime Minister (OPM), local district, UNHCR and relevant agency field staff (including clinical officers, nurses social workers, counsellors, community workers, community development officers, health promoters, village health team leaders); operating partner staff, private health care providers within the settlement; refugee leaders and Ugandan police. Since the focus of this research was on health services, it was important to get deep insights from these individuals into their work with refugee women and children and detailed information about public health issues in NRS. The next section explores how this valued information was collected.

#### 4.5 The Research Process

Social research can utilise primary, secondary and tertiary data. Primary data refer to data that are new and generally collected by the current researcher to answer specific research questions which also implies that they do have control over their production and analysis; while secondary data refer to raw data collected by someone other than the current researcher (Blaikie, 2010, p.160). Keeping in mind the end goal to have the capacity to determine a more profound comprehension of health needs and services for women and refugee children, there was a need to gather as much significant information as possible from the selected respondents. As mentioned at the beginning of the chapter, data was collected by using both quantitative

methods (survey) and qualitative techniques (qualitative interviews and participant observation). After several approvals (See section on ethics), the process of collecting data involved conducting a pilot study, recruiting and training research assistants, the main survey and conducting qualitative interviews.

#### 4.6 The Pilot Study

In order to refine the readability of the research instruments, clarity and relevance to the issues under investigation, it was important, to conduct a pilot survey. This took place at an organisation (InterAid, Uganda) found at Kabaka Anjangala Road, Kampala. It is an implementing partner to UNHCR and implements a multisectoral programme of which health is key. InterAid was chosen because it supports refugees who are referred from all the settlements country-wide to seek health services in Kampala. Refugees from settlements are received at this organisation and assisted to access services at Mulago National Referral Hospital, Kiruddu Hospital and other specialised service providers. Hence their clients were considered to have similarities with those in NRS. At first, I visited this organisation in July 2017 and found out about their work with refugees. This was followed by additional correspondence (email) requesting approval to conduct a pilot study at this organisation. Thus the pilot survey took place in August 2017 before setting out to the field. Ten refugee women were conveniently selected to participate in the study. This helped to identify ambiguity and inconsistencies in the flow of questions, hence all misconceptions were ironed out before applying these tools in NRS.

#### 4.7 Recruiting Research Assistants

Given the magnitude of the study as indicated by the large sample size, two graduate research assistants were recruited to conduct face-to-face interviews during the main survey. Although these were not recruited directly from the refugee community, the researcher selected individuals based on their knowledge of local dialects in NRS. Since the study was specifically about women and children and given the prevailing gender norms in some communities, I specifically recruited two women. These were informed about the objectives of the study; trained in questionnaire administration; and prepared before setting out for the research. Although there were specifically marked pointers in the questionnaire about ensuring

confidentiality, I also trained them about the importance of observing confidentiality. Moreover, I observed the first interviews they administered and supervised them throughout the whole research process for purposes of quality assurance (Sapsford, 2007). Spot checks were also conducted to ensure consistency and standardisation in the survey process. Besides I was in control of all the filled questionnaires. And since we were living at a shared accommodation, it was easier to discuss any challenges encountered in the field during the morning and evening debriefs.

#### 4.8 The Main Survey

A 'survey refers to a research method that involves systematic observation or systematic interviewing in order to describe a natural population and, generally, be able to draw inferences about causation or patterns of influence from systematic covariation in the resulting data' (Sapsford 2007, p.12). Surveys primarily serve to count and describe populations. The survey technique is usually taken to be purely quantitative and positivistic and generally seen as sterile and unimaginative (De Vaus, 2002) as compared to other qualitative research methods. However, De Vaus (2014) challenges this way of qualifying quantitative and qualitative research, classifying it as misleading. He indicates that it is rather helpful to focus on the process of data collection and data analysis and instead distinguish between research methods that produce structured and unstructured data sets (De Vaus 2014, p.6). Thus, what distinguishes a survey from other techniques of data collection is the level of standardisation and constancy in its approach to research (Sapsford, 2007). Hence, although social surveys tend to collect quantitative data, these can also gather qualitative data (Payne and Payne, 2004). Social surveys can be categorised by how data are collected: face-to-face interviews, telephone and internet, or self-completion (Payne and Payne, 2004). Survey data can be gathered by using questionnaires, or by applying other means such as interviewing; observing each case, or by use of secondary data (De Vaus, 2014). The survey method is, however, associated with the risk of neglecting the role of human consciousness (De Vaus 1996). This suggests that research participants are dealt with as subjects who ought to simply react to the inquiries of the interviewer as they are asked.

I utilised the survey method not to test the theory but rather to collect descriptive characteristics of the study participants. Rubin and Babbie (1989) encourage the use of surveys to collect

evidence for describing a population too huge to be observed one-by-one. NRS is very large, and refugees are widely scattered out in the three zones. By providing a systematic overview, the survey enabled me to delimit the study's boundaries and better structure the qualitative components. Specifically, the survey yielded information on the demographic characteristics of refugee women and children in the settlement against which generalisations were made about the situation in NRS.

#### 4.9 Data Collection Tools

##### *4.9.1 Structured interviews*

The survey was administered using a structured tool (see Appendix 3). A structured interview is typically used in survey research as a tool for eliciting precise responses. During this interview, a researcher reads out closed-ended questions in a logical flow to every respondent so as to elicit standardised replies which can be aggregated to find variations across interviews (Bryman, 2001). This tool was preferred over a self-administered questionnaire because the context for this study was a refugee settlement, with different challenges for data collection (such as language barriers) as I will later explain. The questionnaire was developed in line with the demographic and health survey model for collecting and analysing data for planning, monitoring, and evaluation of population health, and nutrition programs (ICF, 2011).

A structured questionnaire was administered face-to-face to 377 randomly selected refugee women in NRS. The questionnaire collected statistical data on aspects such as age, sex, country of origin, education, religion, marital status, household information; data on health status, for example, the common diseases; as well as data on health services such as need for health care, access, and use. The amount of data generated from questionnaires would not have been captured with only qualitative interviews. Moreover, face-to-face structured interviews were valuable since they decreased the rate of misunderstandings (which could be as a result of poor wording in the questions) and ensured a high-response rate (Bryman, 2001).

Nonetheless, using standard questionnaires was not without costs. First, in addition to the costs of printing information and consent forms, there were substantial costs for printing questionnaires. Since these often require more than one interviewer (Rubin and Babbie, 1989) especially given time constraints, I was compelled to use two research assistants to administer



the survey. Further, most refugee women could neither read nor write thus the questionnaires were completed by the research assistants on behalf of women. As mentioned earlier, this research intended to get a profound contextual understanding of the subject and this necessitated a triangulation of methods. I turn now to examine the qualitative methods.

#### *4.9.2 Qualitative Interviews*

Qualitative interviews were also used to collect primary data. Qualitative interviewing is quite different in various aspects in contrast to interviewing in quantitative research, for example, it tends to be much less structured and more flexible (Bryman, 2001). The interviewer focusses on and adjusts to the interviewee, there is much interest in the respondent's perspective and rich, detailed answers. The interviewer is also free to depart from any schedule that was previously set, new concepts may also come up due to probing and the flow of the interview may be revised or changed depending on need (ibid).

Qualitative interviewing mainly takes two approaches, namely, unstructured and semi-structured interviewing. The unstructured interview takes the form of a conversation where the researcher starts with a question and then actively listens to the respondent who is allowed to respond freely, while the researcher only intervenes when there is a need for clarification (ibid). Alternatively, the semi-structured interview process follows an interview guide or checklist of issues and questions which are suggested by the phenomena under investigation and these guide the researcher during the session, and from one interview to another (ibid). Informed by this understanding, semi-structured interviews (See: Appendix 2 for Interview guide consisting of open-ended questions) were used in this study so as to elicit specific information on the health concerns of refugee women and children, coping mechanisms, as well as issues related to access and utilisation of health services.

Refugee women were visited to explain the purpose of the study and its relevance, and their informed consent sought. Those who agreed were interviewed in their homes. This was useful because interviews did not overly interfere with their daily activities. Some women were interviewed at the health facilities because they were not found in their homes.

The interviews were conducted in English and were recorded (with the permission of respondents) to allow for easy transcription and guard against loss of data. However, since the

language barrier was a major issue particularly during interviews with refugee women and men, I recruited four translators conversant in the local dialects from the community. These were rigorously trained and taken through the points of interest of the study before commencing research. Interviews generally provided valuable context on the current arrangements for health services in the settlement. Compared with other methods, interviews are more confidential, less harmful and also give an opportunity to the less privileged participants who may not have a chance to speak in other research settings (Greener, 2011). Hence, they were empowering to the refugee women in the study to speak freely and to express their opinions regarding the topic.

Unlike, the interviews for the refugee women and men which strictly followed a checklist, key informant interviews (see Appendix 1 for interview guide) were more flexible and combined aspects of semi-structured and unstructured approaches. This flexibility gave them the opportunity to expand their ideas and speak in great detail about the subject rather than relying only on concepts and questions defined in advance of the interview. Key informant interviews were held with the staff of OPM, local Government, and the staff of humanitarian organisations. This is because these employ a large number of social workers and these are so visible in terms of migrant safety and support. Hence, these subjects gave insights into their work with refugee women and children. The researcher visited the offices of all these agencies to seek consent for participation in the study after showing proof of approval from the OPM. Given their busy schedules, the interviews took place in the offices of the key informants because this was the only place I could find them. Interviews mainly lasted between 45 minutes and one hour. There were only two interviews that took place in the homes of key informants. For one of them, it was the first interview in the field before we started the survey. This was important too because it provided initial information about the setting and the key providers whom I was to contact afterward. The other key informant was staying at the office premises and was interviewed on a weekend because that was when she would be free to talk to me.

Although I had two identifications (Makerere University staff and the University of Edinburgh student identifications) which were advantageous in terms of securing fast approval from key informants to participate in the study, it was not without much effort. Some key informants needed to secure approval from their head-offices before they could agree to participate in interviews. There was a particular organisation in which a key staff kept me waiting until he told me that he had failed to secure permission from his supervisors. However, I later found

from the key informants and observations that organisations may be hesitant to share their programme information because of existing competition for project funds from UNHCR.

#### *4.9.3 Participant Observation*

Marshall and Rossman (2006, p.98) define observation as the systematic noting and recording of events, behaviours and artefacts (objects) in the social setting chosen for study with a goal of developing an observational record also referred to as field notes. Participant observation is a research approach that requires spending a substantial amount of time with the people or communities under investigation with the goal of obtaining their perspective in relation to a given phenomenon. The method involves participation in the lives of people but without going native, so as to allow enough space for observation and recording of data (Fetterman in Bickman and Rog, 1998). Fetterman suggests that “the simple, ritualistic behaviour of going to the market or to the well for water can teach how people use their time and space, how they determine what is precious, sacred and profane... and that although the process may seem unsystematic in the beginning, it does help the researcher to internalise the basic beliefs, fears, hopes and the expectations of the people under study” (Fetterman in Bickman and Rog, 1998 p. 480).

Qualitative researchers can apply this method depending on the level at which they want to engage with the participants or be involved in the community’s activities. Thus, they can assume roles such as complete participant; complete observer, participant-as-observer and observer- as a -participant. According to Gold, a ‘complete participant’ is one whose identity is hidden (covert) but actively participates and observes; a ‘complete observer’ does not interact directly with the participants but systematically observes; the ‘participant –as- observer’ is one whose identity is not hidden (overt) and is a very active participant and observer; whereas the ‘observer-as-participant’ is overt but takes on a limited participatory role yet actively observing (Gold, 1958 cited in Bryman 2001, p.299).

The approach uses various methods of data collection (for instance, taking objective field notes about observations or any informal conversations; drawing sketches; taking photographs or making videos) and can be applied at different intervals (that is, prior to other data collection, simultaneously with other methods, or after other data collection) (Laurier, in Clifford and

Valentine, 2010). I mainly embraced the ‘observer–as- participant’ role and observations were conducted simultaneously with the other forms of data collection (survey and interviews).

I applied participant observation to set the scene for the study. At first, I obtained prior insights about the study area and the population. On the first day, I moved around the settlement and observed behaviour and the different activities of people. This process was crucial because it informed other preparations and methods. During my fieldwork, I wrote detailed notes from informal interviewing about the economic, social and cultural circumstances of respondents, people’s behaviour, the existing relations, ideas, norms and events (see Appendix 4 for observation checklist). I also took photographs of events and activities and I was vigilant to undisclosed detail. The notes were later typed and expanded for analysis. Moreover, I participated in informal and formal events such as the settlement mission of new refugees (see photographs of this event in Chapter Six). This method produced invaluable information for clarifying the results from the other techniques of data collection, thus, giving a finer grasp of the public health concerns and participants’ experiences (Fetterman in Bickman and Rog,1998). This led to new insights and triangulation of data from the other methods. A summary of the methods is presented in Table 4.1.

Table 4. 1 A summary of the methods

<b>Research Methods</b>		
<b>Approach</b>	<b>Tools</b>	<b>Sample</b>
<b>Quantitative (Survey)</b>	Structured questionarre	377 Refugee Women
<b>Qualitative</b>	Qualitative interviews (Interview guide)	31Refugee Women 6 Refugee Men 32 Key Informants
	Observation checklist	All

The next section presents the choices and decisions which were made to accurately present the lived realities of my participants and to realise the research aim.

#### 4.10 Data Management and Analysis

After fieldwork, data from the survey was sorted, edited and coded. A coding frame was developed using numerical codes and the data was entered for analysis. As stated previously, these quantitative results were analysed using the Statistical Package for the Social Sciences

(SPSS Version 17.0) to generate descriptive statistics and test associations between variables. This was preferred because of its advanced statistical modules compared to other packages such as EPI- INFO Version 7 and it was provided free from the School of Social and Political Science. The data was then checked for any errors and cleaned. Quantitative data analysis involved generating descriptive statistics, including generating frequency distribution tables, cross-tabulations, univariate and bivariate analyses (chi-square statistics). These were important for establishing associations between different variables. To control confounding effects, a binary logistic regression model was used to determine the net effects of selected independent variables (zone of residence and marital status) on the dependent variable (modern family planning utilisation).

On the other hand, qualitative data from interviews and observations were analysed through induction following a phenomenological approach. Analytic induction starts by roughly defining the research problem and then continuing to data collection, after which conclusions are drawn by looking at that data; while the phenomenological analytical approach requires setting aside all the presuppositions and working inductively with the data so as to derive the depth and detail of experiences as they are lived (Thorne, 2000). The analysis borrowed features from the grounded theory approach advanced by Strauss and Corbin (2008) and Miller et al., (2014). This approach allows for continuous and repetitive working with the findings in order to develop themes that can be built into models arising from the data. It was here used to draw comparisons or establish connections (Thorne, 2000) between the various women from different backgrounds, and to discern whether some women manage better than others and how they achieve these results. Nonetheless, although elements of the grounded theory were within the analytical approach, the research took a more phenomenological approach.

All interview data and field notes were analysed using a phenomenological approach and done in stages as proposed by Hycner (1985, p.280-293).

First, I transcribed interview data verbatim. However, in the report, I changed a few things to ensure clarity of the findings. For instance, the translator's third-person depiction was changed to first person and I corrected grammatical errors. Secondly, I engaged in bracketing and phenomenological reduction (Hycner, 1985). This involves letting off all the biases and entering into the unique world of the individual who was interviewed (Hycner 1985). This is done while listening to the recordings and reading the developed transcripts. To this end, Keen (1975, in Hycner 1985, p.280) alludes that:

The phenomenological reduction is a conscious, effortful, opening of self to the phenomenon as a phenomenon. We want not to see this event as an example of this or that theory that we have, we want to see it as a phenomenon in its own right, with its own meaning and structure. Anybody can hear words that were spoken; to listen for the meaning as they eventually emerged from the event as a whole is to have adopted an attitude of openness to the phenomenon in its inherent meaningfulness. It is to have 'bracketed' our response to separate parts of the conversation and to have let the event emerge as a meaningful whole.

I listened to the interviews and read the transcripts several times to get a sense of the whole. Hycner (1985) states that as one listens, it is important to make memos, and these are important to delineate the units of general meaning. I then engaged in a process of crystallisation and condensation of data to get units of general meaning<sup>15</sup> (p.282) which were then critically delineated into units of meaning in relation to the research questions. This involves paying attention to the actual content while referring to the initial research question to see if the collected data is relevant and at this point, unrelated data are excluded from the analysis. Then I clustered related units of meaning. This is an iterative process of working through the units of meaning through examining their essence. This also depends on the context under which a unit was mentioned. The essence is not just to get what was said but also to dwell on the way it was said (Bryman, 2001). I then determined central themes from these clusters of meaning while working through the segments of the transcripts. After this, a summary of individual interviews was written while trying to incorporate the themes; this also gives a sense of the whole. This led to the identification of general and unique themes for all the interviews. This step looks for common themes in all the interviews as well as individual variations or uniqueness and these are clustered under general themes. The final stage, according to Hycner, is the contextualisation of themes. This step requires that all the general and unique themes from the rigorous process are placed back into the initial contexts from which they developed so as to get a deeper understanding of the phenomenon under investigation. As such, the analysis is presented with evidence from the actual words of the interviewees. Hycner (1985) alludes that the process takes fourteen steps but here some of these were merged and done simultaneously as the research progressed. For instance, Hycner recommends doing validity

---

<sup>15</sup> Hycner (1985, p. 282) defines a unit of general meaning as those words, phrases, nonverbal or paralinguistic communications which express a unique and coherent meaning (irrespective of the research question) clearly differentiated from that which precedes and follows.

check with the interviewees to see if what one has come up with, actually represents what the respondents tried to bring forward. Given the population being studied, time and resource constraints, this process was combined with data collection. Individual respondents were asked immediately after the interview whether they had anything else they wanted to say and if they felt they had accurately conveyed their views.

#### 4.11 Validity, Reliability and Trustworthiness

Validity refers to the capacity of research techniques to summarise the characteristics of the concepts being studied, and so, to properly measure what the methods were intended to measure (Payne and Payne, 2004, p.233). The concept generally deals with the integrity of the conclusions that are generated from a certain piece of research (Bryman, 2001 p.30). On the other hand, reliability mainly refers to the consistency and the extent to which the results of the study can be replicated or are repeatable (Bryman, 2001 p.29). Validity and reliability are concerned with both the process as well as the outcome of the research process. The two concepts are very popular in quantitative research as measurements of quality. However, this does not mean that qualitative studies do not accurately portray the real-world or that qualitative researchers should not justify their actions and decisions. In fact, Payne and Payne (2004) argue that the integrity of qualitative research has to be both executed and displayed. The purpose thereof is to show conscientiousness (of the researcher) about the limitations of applying certain techniques as well as the potency of utilising such methods. This knowledge helps the researcher to mitigate the weaknesses of qualitative methods and ensure that instead, they have fully capitalised on all the strengths of given methods (Payne and Payne, 2004). However, unlike in quantitative research where there is a need to construct and administer instruments in a standardised way so as to ensure validity and reliability, in qualitative research, the researcher is the instrument (Marshall and Rossman, 1995), who should have the skills and competence to produce authentic results (Golafshani, 2003). Golafshani (2003) adds that whereas quantitative research utilises the concepts of validity and reliability separately—yet referring to credible research, qualitative research does not view them as separate, it treats them as one, but instead adopts terminologies such as credibility, transferability, and trustworthiness which combine the two concepts.

Accordingly, Lincoln and Guba (1985) put forward trustworthiness as an alternative term for assessing the quality of qualitative research. Their criteria for implementing trustworthiness in

qualitative research involves ensuring credibility, transferability, confirmability and dependability for both the process and product. Credibility deals with the extent to which the findings from a study are believable; transferability is whether the findings apply to other contexts; dependability questions whether the findings are likely to apply at other times and confirmability considers the extent to which researcher's values are reproduced within the findings in the form of bias (Bryman 2001, p.32). The findings can be considered credible if the researcher adopts and utilises: 'canons of good research practice and by submitting the research findings to the participants for confirmation (respondent validation or member validation); transferability can be realised by providing thick description (rich accounts of details of culture) of the data which can help others to make informed judgments about transferring the findings to other contexts; confirmability can be gauged by other people especially experts and dependability can be achieved by adopting an audit approach which necessitates the researcher to keep records of phases throughout the research process' (Bryman, 2001. p.274).

Informed by these values, this study adopted a phenomenological strategy, a mixed-methods approach to data collection and analysis and adopted proper research practice and procedures to enhance the findings' trustworthiness and authenticity.

Firstly, (as mentioned earlier) the design and formulation of the study were informed through reading and an audit of literature about the concepts under investigation. Before undertaking the main study, the structured interview questions and the semi-structured guide were pretested in a pilot study before applying these tools in on the real participants.

The adoption of the phenomenological qualitative approach (interviews) required lengthy engagement and immersion in the refugee settlement (Greener, 2011). This was useful for the validation of the data. Lincoln and Guba (1985, p. 301) assert that prolonged engagement can assist the researcher to learn the culture, test for misinformation introduced by distortions either of the self or of the respondents, building trust, and help with the understanding of the phenomenon under study. In addition, the use of open-ended questions in the individual interviews made provisions for respondents to raise issues that they deemed influential on their health and provided data that was more detailed than that from the closed-ended questions in the survey.



To ensure honesty and transparency (Greener, 2011) in the whole research process, I kept a research notebook where all research procedures and any events that took place in the field were noted for further follow-ups. Lincoln and Guba (1985, p.327) maintain that the use of the reflexive journal/diary for noting information about self (human instrument) as well as methods is a good practice and helps to reduce the researcher's biases. Furthermore, participant responses were checked and verified thoroughly by probing and use of key informant interviews (open-ended questions). This iterative process of working throughout the research journey controlled trustworthiness and authenticity for both the process as well as the final outcomes of the study. I now discuss in more detail the ethical dilemmas I faced while conducting this research.

#### 4.12 Ethical Considerations

Ethics can be understood as 'a branch of philosophy that deals with thinking about morality, moral problems and judgments of proper conduct (Frankena 1973 in Kimmel, 2011, p.2). In general, research ethics are conceived as a system of moral values referring to the degree to which the research procedures adhere to individual, social, and professional obligations. Consequently, ethical challenges can be classified according to the level the research impacts, for example, the individual research participants, the society upon which research is conducted, or the scientific body to which the findings and discussions are reported (Kimmel, 2011). According to Sieber (1998), 'ethics of social research is about creating a mutually respectful, win-win relationship in which participants are pleased to respond candidly, valid results are obtained, and one in which the community considers the conclusions constructive' (cited in Bickman and Rog 1998, p.128). This requires social researchers to constantly engage in a process of moral reflection, making choices and being accountable all through the research process (Edwards and Mauthner in Miller et al.,2014).

There are two main approaches/ schools of thought which provide an explanation for the role of ethics in social research. These are: 1) the normative ethicists who maintain that ethics must stipulate a set of guiding principles for human behaviour and 2) the meta-ethicists with an assumption that research ethics should analyse statements from people's expression of moral beliefs or actions (Kimmel, 2011). These have evolved into two main theories of research ethics.

The first is the teleological theory, which holds that a research choice or act is judged as right or wrong depending on its consequences (Beauchamp et al., 1982). In line with this perspective, a researcher can move on to carry out a study if the anticipated benefits from the study outweigh its costs to human welfare. However, the theory has differing notions about moral judgments for research actions when it comes to welfare. There is a strand of 'ethical egoism' which accentuates the 'well-being' of the agent with the reasoning that an ethical decision would be one that 'promotes at least as great balance of good over evil for the researcher in the long run more than any other alternative' (Kimmel 2011. p.4). The utilitarian position is the other strand of teleological theory. The utilitarian theory gives prominence to the well-being of the majority or public good. Hence, a moral rule or conduct would be right if it can 'produce a greater balance of values -over disvalues for all the affected people' (Beauchamp et al, 1982). This implies that research is ethical if it would eventually turn out for the common good (Kimmel 2011) even if the majority benefits would be achieved at the expense of the individual or minority others. This position is controversial because the welfare of minorities may be neglected.

Deontological theories give a differing account of the morality or ethicality of research actions. Deontologists view moral choices as those that supersede the assessment of mere consequences of research actions, in other words, these shift their attention beyond research effects. Thus, by contrast with the teleologists, deontologists affirm that additional features of action other than only its consequences should also be taken into consideration when morally assessing an action. On that account, one deontological position maintains that moral/ethical actions are those that meet the formal conditions of universality; while the other stance contends that morals/ethics are those which are grounded in natural law or derived from a hypothetical, situational social contract' (Beauchamp et al, 1982, p.20). In sum, teleological theories are principally concerned with the 'ethics of consequence' leading to principles that assess the outcomes of research, while deontological theories can be conceived as 'duty ethics' with principles that assess the intentions of research.

Teleological and deontological theories form the basis upon which the principles of social research are formulated. The central principles of social research include autonomy/self-determination, non-maleficence, beneficence, and justice (Alston and Bowles, 2003; Beauchamp et al, 1982). The principle of autonomy compels that any research endeavour

should respect the values and decisions of the participants necessitating that the reasons for the actions and the actions themselves should not be interfered with (Beauchamp et al., 1982 p.18). In accordance with this principle, it was vital that any information about the research undertaking was fully disclosed to the participants, where after their informed consent to participate in the project was sought. As such, participants were seen as ends and not means to ends (Beauchamp et al., 1982).

Another ethical principle that is important to social researchers is non-maleficence. This general rule checks against the infliction of harm to research participants or any others involved (Beauchamp et al., 1982). According to Peled and Leichtentritt (2002), it is ethically wrong for the participants to be harmed as a result of taking part in the research. This harm can be physical or nonphysical, like embarrassment or loss of self-esteem or stress.

This principle is related to the principle of beneficence in research, which principle precisely requires research to remove any existing harm and to confer benefits such as contribution to scientific knowledge or improvement in people's welfare. According to Beauchamp et al. (1982), harms and benefits 'basically depict certain effects of a piece of research on the well-being (in terms of attainment of goals or values states like health, security or social cohesion) of individuals and society' (p.47). Consequently, researchers are under the obligation to prevent any harm from occurring to their participants as a consequence of their actions, and also to be able to intervene appropriately in case of any harm occurring during the research process or afterward. Furthermore, researchers are also obliged to follow up on any information which indicates that there might be a potential risk or harm to the participants.

The potential challenges associated with these principles are varied, including subjectivity in the definition and interpretation of harm or benefit to participants. Moreover, some scholars have drawn attention to the labelling effect of such potentially disempowering concepts as 'vulnerable' or at 'risk' to participants (Peled and Leichtentritt, 2002). The other downside of the principle concerns the amount of time that can be invested in the process of assessing the likely harms from the project (Edwards and Mauthner in Miller et al., 2014). Such questions are open to interpretation, but nevertheless necessitate that researchers to apply expertise, skill and technical competence from inception to completion of a project.

Finally, the principle of justice relates to treating people fairly during and after the research process. Beauchamp et al., (1982, p.19) describe the principle in its entirety stating that, 'justice

stipulates that people who are equal in relevant respects should be treated equally, while those who differ in such respects should be treated differently. It is important to do justice to the participants as well as to data which is generated from research.’ Kimmel (2011, p.13) asserts that whereas it is a usual expectation that social research would exhibit intellectual honesty and integrity, sometimes researchers tend to ‘cook, trim and forge’<sup>16</sup> data. Researchers, like all other humans, face a complicated set of competing motivations—here it is prestige, the desire for a certain theory (usually one’s own) to be correct, and the well-being of the participants that are at odds. This practice corrupts and violates the good intentions of scientific inquiry. Reflecting on the principle of justice also points to the manner in which research findings should be utilised considering the serious ethical challenges which can arise when data are misused, mismanaged, or inappropriately utilised beyond their stated bounds (Kimmel, 2011).

Given the end goal to improve health and well-being for the participants, this research adopted a non-utilitarian deontological rights-based approach and observed the following ethical procedures. Firstly, I obtained research approval from the Office of the Prime Minister (OPM) Department for refugees (see Appendix 10), to access premises, read about the subject matter and to know more about their work with refugees. This clearance was obtained during the proposal writing stage of my Ph.D. study (specifically 21<sup>st</sup> December 2016). This gave me access to their resource centre/library at Sir Apollo Kagga Road, and also enabled me to interact with officers in the Department of Refugees. During fieldwork, this clearance also gave me access to the office of the settlement commandant in NRS and enabled me to access all other implementing and operating partners dealing with refugees.

Also before setting out to the field, I completed a research ethics application for the School of Social and Political Science, as a requirement by the University of Edinburgh. This was assessed and approved by the University Research Ethics Committee (see Appendix 9).

Additionally, I obtained clearance from the Research Ethics Committee (REC) at Makerere University, School of Social Sciences. After their approval, I applied to the Uganda National Council for Science and Technology (UNCST)—which was then the highest research clearing

---

<sup>16</sup> He (ibid) discusses these in relation to Babbage (1969). Cooking means the selection of only those data that fit the research process; trimming means the manipulation of data to make them look better and forging refers to the complete fabrication of data.

institution in Uganda then. These two ethics approvals are essential to completing social research in the context of Uganda.

To secure informed consent in the field, the purpose of the study and risks associated with participation were verbally communicated to all the respondents, thus participation in this study was voluntary. Permission was also sought from the participants to tape-record their responses (the participant information and consent sheets are attached). And once consent was given, recorders were used to capture their responses. This was useful to ensure that any valuable information was not lost.

As a matter of justice and not doing harm to participants, I ensured the confidentiality of the information given to me. As mentioned earlier, research assistants (RAs) and my translators were trained about the importance of maintaining confidentiality, RAs were supervised and most importantly I was in charge of all the completed questionnaires. In addition, no data has been divulged to other parties outside the research context, except for research reporting, and data has not been used for any purpose other than research. Greener (2011) argues that it is the role of the researcher to organise and safely store the information they receive from respondents. Information given by my participants has been anonymised in a way that sensitive quotes and incidents (*ibid*) cannot be traceable to them. After transcription, the audio files were erased from the recorders. The following section presents positionality and how this shaped research design and methods.

#### 4.13 Positionality and Reflexivity

Positionality refers to how self-identity (ethnicity, gender and social status) impacts our view of social reality. As a Ugandan, I have developed a particular interest in the phenomenon of migration which poses a challenge to my country—which currently hosts most of Africa's refugees. Finlay et al. (2003, p.1) state that reflexivity facilitates insights into personal and social experiences and produces data about the emotional world of the participants. My study aims at deepening our knowledge of the experiences, vulnerabilities and resilience of refugees by examining the health needs and services for women and children in a refugee settlement environment.

I have been involved in the field of social work as both a social work student and academician. These roles essentially influenced and shaped my choice of research design and methods. Through my previous education and extensive literature review, I found out that migration poses a great challenge to my profession in terms of support for vulnerable migrants. In my academic position, I participated in meetings between the School of Social Sciences at Makerere University and the International Organisation for Migration (IOM) Uganda about introducing a short course in migration. These meetings increased my awareness of the concept of migration health and challenges which migrants experience in accessing services such as health. This awareness led me to explore the phenomenon of health needs and services for refugee women and children to further understand their situation. Further, in the Department of Social Work and Social Administration (SWSA), we train students aspiring to become social workers. Twikirize (2014) states that social work training in Uganda aims at imparting knowledge for direct social work practice (with individuals, groups and communities) as well as the administration (macro levels). The social work curriculum entails issues in disaster and forced migration both at the undergraduate and postgraduate levels. However, this training is generic and rarely provides specialist practice skills (Twikirize, 2014). Considering the coverage of these, students are not adequately prepared with the skills to respond to vulnerable migrants (such as in the area of cultural competency). Reflecting on these, my research is timely to provide evidence of health needs and challenges to access and utilisation of health services among refugee women and children. This is significant for social work practice and training. Moreover, a combination of both qualitative and quantitative methods produces valuable data and knowledge which will potentially influence policy development and implementation and inform further research.

As a Ph.D. student, I have been living in Scotland since 2016 when I started my studies at the University of Edinburgh. Twikirize (2014) argues that social work academics trained in the Western context might be detached from the local communities and local situations. Hence it was important for me to move into the deep areas of NRS to circumvent and understand the lived reality of my respondents. Being a Ugandan was also important in the design and execution of the study because I'm conversant with the local context with its attendant problems and needs (Twikirize, 2014).

Despite the fact that I was operating in an unfamiliar social and cultural setting, my personal experience as a migrant (International student) helped me to make sense of the circumstances and the position of women and children in NRS. My own experiences as a migrant woman with

a young family have pointed to the diversities of experiences for different migrants. Hence the importance of highlighting gender and other intersectional factors that exacerbate vulnerability for the powerless groups of migrants.

I also wanted to take a particular focus on women's own perceptions of their health needs and services because they possess expertise in their situations (Valtonen, 2008). Rather than bias, this approach generated insights which formed the basis of a more comprehensive understanding and interpretation of the phenomenon (Finlay et al., 2003).

Being an African woman was important for this research. Valtonen (2008, p.16) states that “in the process of identifying information and assessing problem situations, knowledge of the culture and social history of groups can help us to sharpen our ability to recognise and appreciate otherwise impacting factors.” Although my circumstances (such as ethnicity, level of education and social status) differed from those of my refugee respondents, the women were eager to share their painful stories with me through interviews. This was due to the good rapport I developed while in the community such as through active listening (in spite of language barriers) and wearing simple and socially accepted attires. This created a connection and bridged our differences (Finlay et al., 2003). This increased the response rate and fully eliminated participation refusals. I now turn to discuss the challenges which were encountered throughout the research process.

#### 4.14 Challenges

There are multiple realities and constraints in the field which must be considered by an individual researcher occupied in the process of developing a research design. This is as Lincoln and Guba (1985, p.210) argues that “what will be learned in the field is always dependent on the interaction between the investigator and the context—which are both unpredictable until the mutual shapings are witnessed. With this indeterminacy, the design must be ‘played by ear,’ it must unfold, cascade, roll and emerge” (*ibid*).

Likewise, this research was not without difficulties, though these ultimately did not deter completion of the study. Owing to the nature of the study which required studying the selected refugee women and some refugee men, regardless of ethnic background and nationality, the language barrier was definitely an enormous challenge. Very few women could understand English or my first language. This means that I had to rely on translators who were familiar with the local dialects. These were recruited from inside the refugee community and trained.

These commonly have problems with misinterpreting responses in the process of translation. However, I was observant and paid attention to the non-verbal cues to make sure that their translations were authentic.

As anticipated, the other problem concerned financial limitations. I needed money for printing services, RAs and translators. However, to minimise expenditure I did the greater part of the work for instance, I administered some questionnaires and conducted all the qualitative interviews without any assistance from RAs. Further, owing to the nature of deprivation in the settlement many interviewees expected an incentive after interviews although I specifically mentioned that their participation was voluntary and must not expect payment. Nonetheless, this issue had been raised during the ethical review and prompted me to be in contact with the authorities in NRS. Hence by the time of fieldwork I was adequately prepared. They recommended me to take small gifts (handkerchiefs) instead of money. So, I bought these in bulk and brought them into the settlement. Although these were welcomed by the refugees, I realised that I should have taken something more essential like soap or salt. Nevertheless, there were more vulnerable people who explicitly asked me to give them money, at least enough to meet these needs. For these, I gave them whatever little amount I had with me (on average, less than the local equivalent of a pound).

Furthermore, the settlement is located in a rural part of Uganda where transport and accommodation are significant issues. Therefore, there were delays in attempting to deal with these logistical difficulties in the field. I built rapport with the knowledgeable people in the community to learn how to survive in the settlement. For example, when I first entered the field (with my RAs), it was difficult to secure accommodation. Before we set foot in the settlement, I was in contact with the commandant who advised that it was better to commute from Isingiro District Town, which is approximately 28.7km away from the settlement. This initial plan was dropped after I realised that it was going to be tough to commute and at the same time keep up with appointments in the settlements. I decided to stay at the camp with my RAs. Thus, on the first day, I was welcomed at the office of the settlement commandant by one of the staff who had been delegated by the commandant. She initiated me to the settlement and assigned me a contact person to take me around the settlement to search for lodging. We moved throughout the settlement trying to look for accommodation however, all the small lodgings looked insecure on first examination. Most lodges were used as social spaces for refugees and



were occupied with clusters of people drinking alcohol, smoking, gambling, and being noisy. It was obvious these were unsafe. Finally, the contact person brought me to the offices of an organisation (name withheld for confidentiality) which had uninhabited staff quarters. On arrival, we learnt that the country director had issued an order prohibiting caretakers to take in any guests. Though accommodation rooms were empty, they could not host us. I almost gave up the thought of staying in the settlement when I told the contact person to take me back to the OPM office. There we found a staff-member of this anonymous organisation, who offered space at her apartment because her housemate had gone on maternity leave. This is where we stayed the entire time we spent in the field.

Furthermore, there were delays in securing the applicable authorisation from the Uganda National Council for Science and Technology (UNCST) although efforts were made to reach them before fieldwork began.

Finally, the respondents' stories were difficult for them to relate, because it meant retelling their painful experiences. Although I had informed the participants that they were not obliged to answer anything they felt uncomfortable or that they would discontinue the interview at any point without any consequences, there were a few occasions where refugee women felt completely overtaken by their emotions and instead cried. I frequently had to pause interviews and supported them to calm down. Thus, I found myself in the role of a guidance counsellor at many interviews, as well as having to manage my own emotional reactions to their tales. For the vast majority, I had to refer them to appropriate agencies for assistance at the end of the interviews. In agreement with Palmer (2017), it was important to adapt the ABC principle of preventing vicarious trauma<sup>17</sup> prior to, during and after fieldwork for my personal care. This involves awareness (A) of personal needs, limits, emotions, and my resources; balance (B) between work, play, and rest and connection (C) with significant others (Palmer 2017, p.5). Specifically, scheduled supervisory support, debrief with RAs during fieldwork, having research notebook, family support and connection with spiritual sense have built my emotional strength through this research project. I now turn to the limitations of the study.

---

<sup>17</sup> Aparicio, et al. (2013) define vicarious trauma as affective distress and shifts in cognitive schemas following secondary exposure to traumatic material.

#### 4.15 Limitations of the Study

Data was collected using both quantitative tools (survey) and qualitative techniques (qualitative interviews and participant observation).

The risk associated with quantitative research majorly arises from its reliance on instruments and procedures (such as structured interviews) which greatly hinders personal connection and the linkage of research with everyday life situations (Bryman, 2001). This difficulty partially justifies why the study complemented the survey with qualitative methods to cover this gap.

Qualitative research is sometimes associated with limitations such as being too subjective (because it relies on the researcher's value judgments about what counts as relevant and irrelevant); lacking transparency (in terms of the way respondents are selected); difficulty in replication (as it depends on researcher's personality) and laden with problems of generalisability (as the findings are never representative of the entire population) (Bryman, 2001p.282). However, the study adopted a clear phenomenological qualitative approach which emphasises bracketing personal values. In addition, Greener (2011) warns about the possibility for interviews to produce artificial data as a result of respondent confabulation and/or psychological defensiveness. In this case, open-ended questions allowed me to adjust questions depending on the attributes of individual refugee women. Semi-structured interviews provided the opportunity to regulate the order of the questions which guarded against any defensive attitudes or in the case of respondents diverting from the subject or wanting to please the interviewer (see Appendix 3 for the guide). Additionally, it was useful to triangulate research methods and not solely depending on interviews.

Participant observation risks violating the participants' privacy, especially in cases when the researcher does not disclose her role. Moreover, systematic observations are time-consuming to carry out. The current study employed observation in combination with other data collection methods. I also exercised great caution, for instance, I did not take any identifiable images of respondents.

The phenomenological approach is not without limitations. For example, the phenomenological analysis can be exhausting with large amounts of data. This shortcoming was dealt with by combining different methods of analyses, for example, the data analysis

process was also aided by the use of a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) programme, NVivo (Version 11). Software packages can be categorised into, text retrievers, code and retrieve packages as well as theory building software. The text retrievers find texts in large databases and documents. On the other hand, code and retrieve packages aid in sorting of textual data into categories and codes which are later retrieved for analysis (Gibbs and Mungabeira, 2002). The theory-building packages combine the aspects of coding and retrieval. NVivo 11 is a theory building software not because it can build a theory on its own but because it aids the process (Gibbs and Mungabeira, 2002) of generating ideas. NVivo helps the researchers to make mind maps and visual representations of their analysis. Thus, after transcription, the interviews were also uploaded into the software. This helped me to work efficiently through my data and also to improve the quality of data analysis (Fielding and Lee, 1991) thereby also dealing with the issue of the subjective influence of the researcher (Hycner, 1985) which is a usual criticism for phenomenological analysis.

In terms of generalisability, the findings of this study might be less generalisable to the entire refugee population or the refugees in other settlements across the country and therefore less conclusive, but these are suggestive, plausible and convincing enough (Crotty, 1998) to bring about change in the lives of refugee women and children, and refugees in general.

#### 4.16 Conclusion

This chapter has presented the methodology and methods for this study. Given that the aim to develop a theoretical ground for studying the experiences, perceptions and subjective interests (in matters of health) of refugee women and children, this study adopted an inductive and phenomenological strategy; and mixed methods approach data collection and analysis. The study primarily employed a mixed-method approach aimed at achieving triangulation, development and complementarity. The quantitative component helped me to identify the actual public health concerns while the qualitative methods provided deeper insights into these public health issues and health service provision in the settlement.

The next chapter presents the socio-demographic characteristics of the respondents. It provides a foundation for understanding the health needs, vulnerabilities, accessible services and the barriers to access and utilisation of health services among refugee women and children in NRS.

## CHAPTER FIVE: SOCIO-DEMOGRAPHIC PROFILE OF THE RESPONDENTS

### 5.0 Introduction

The previous chapter presented the research methods and methodology which were utilised to execute the study and provided insight into the research questions and motivations. This chapter gives an account of the socio-demographic profile of the respondents in order to convey the baseline conditions of women and children living in NRS. It is against this baseline that public health concerns will be measured in subsequent chapters. The socio-demographic data will also indicate ways in which women's and children's health is impacted by exile.

As mentioned in the preceding chapter, the sample size of the survey was 377 refugee women who came from different countries. These were clustered in the three zones (Base, Rubondo and Juru) of the settlement. However, in order to optimise space, only selected demographic aspects (age distribution, nationality, marital positions, fertility, main occupation, formal education, religion and length of stay in the settlement) of the sample have been highlighted using statistical tables and charts. The qualitative aspects are presented using direct quotes from the respondents to provide a triangulation of findings. Moreover, data from observations has been presented using graphic<sup>18</sup> material. The first section provides the demographic data of the surveyed refugee women after which I provide the profiles of the respondents who were purposively selected for qualitative interviews, profiles of the refugee men and the key informants. Table 5.1 presents the age distribution of the respondents.

### 5.1 Age of the Respondents

Given that the age of consent in Uganda is 18, this study only included women who were 18 years and above at the time of the research. Table 5.1 shows the age distribution of the respondents.

---

<sup>18</sup> All identifying details have been removed from the photos in compliance with the ethical principles of confidentiality and anonymity.

Table 5. 1 Age distribution among respondents

Age in complete years	Number of women (N=371)	Percentage (%)
18-24	80	21.6
25-29	65	17.5
30-34	76	20.5
35-39	60	16.2
40-44	33	8.9
45+	57	15.4

It is clear from the table that a majority of women were below 45 years which is the recognised reproductive age, with the largest group (21.6%) falling in the age range of 18 to 24. The second-largest category (20.5%) was between the ages of 30 and 34. The least represented category (8.9%) were those aged 40 and 44. This could be that these are strong enough to migrate compared to other age groups as roughly one-sixth of women (15.4%) were aged above 45 years.

## 5.2 Nationality and Language

The respondents came from various countries and spoke diverse languages and Table 5.2 represents the respondents' nationality and language options.

Table 5. 2 Respondents' nationality and language

The nationality of refugees	Number of women(N=377)	Percentage (%)
Congolese	208	55.2
Rwandese	58	15.4
Burundian	98	26.0
Somalis	9	2.4
Others	4	1.1
Main Language	Number of women(N=377)	Percentage (%)
Kinyabwisha	120	31.8
Kirundi	100	26.5
Kinyarwanda	76	20.2
Swahili	41	10.9
Others	40	10.6

The findings revealed that more than half of refugee women (55.2%) were originally from the Democratic Republic of Congo, followed by those from Burundi (26.0%), Rwanda (15.4%), and Somalia (2.4%). This could be due to proximity reasons to countries of origin and presence of continuous conflict and abuse of human rights in these countries (UNHCR, 2019). Refugee women from other nationalities (Tanzanians, Ethiopians and Eritreans) formed only a small fraction (1.1%) of the entire sample primarily because these countries were not facing severe conflict at the time of the survey.

The respondents spoke diverse (15) languages including, Kinyabwisha, Kirundi, Kinyarwanda, Swahili, Somali, Kirega, Kifulero, Ubembe, Kinande, Lingala, French, Kiviira, Mashi, English and Oromo. This was also confirmed by a key informant who said that:

*Refugees are many with different tribes, different clans, different nationalities (Ethiopian Refugee Leader, Male)*

However, the most predominant languages used by women were Kinyabwisha (31.8%), Kirundi (26.5%), Kinyarwanda (20.2%) and Swahili (10.9%). It is important to note that most of these languages are not publicly used by the service providers. This was revealed by a key informant when he was describing his job:

*I help those technical staff to translate the local languages of the sick people from different countries, Burundi, Rwanda, Congo. It is difficult for them to discuss in the local language[s] with the medical people so I mediate them. (Translator)*

This is also a problem for them to integrate in the Ugandan local communities where refugees live or where they are referred to receive services. This was also revealed by a key informant:

*We have refugees from the settlements, they've come for services. In the central here basically we use Luganda, we use English and a little Swahili— not so common remember, Swahili in the central isn't a thing. Then in the settlements where they use Swahili, they use those local dialects which do not apply here (Senior Official InterAid)*

Language is a vital aspect of the study because communication is central to access and utilising health (WHO, 2015) services and thus determines the quality of health care. Marital status can also influence health care decisions, and so was also explored.

### 5.3 Marital Status

The respondents were asked about their personal relationships and choices. Table 5.3 shows the marital positions of the respondents.

Table 5. 3 Respondents’ marital positions

Marital status	Number of women (N=374)	Percentage (%)
Married	229	61.2
Never married	75	20.1
Ever married (separated & widowed)	70	18.7
Does your husband live with you?	Number of women (N=341)	Percentage (%)
Yes	191	56.0
No	150	44.0
Does your partner have other wives?	Number of women (N=282)	Percentage (%)
Yes	86	30.5
No	196	69

Most (61.2%) of the women stated that they were married (n=229). These were followed by those who were single (20.1%), while the least represented (18.7%) were either separated or widowed. However, a significant percentage (44.0%) of women (N=341) stated that they were not living with their spouses. A substantial percentage (30.5) of refugee women (N= 282) expressed their grief and communicated that their spouses had deserted them and married other women in the camp. One of the refugee women narrated her ordeal:

*He is here in Rubondo, in this Nakivale settlement, but he left me with children and he went. He married another woman, then after giving birth without even finishing one day he left me and went somewhere to that woman... With my children we don't have any help, I'm the father and I'm the mother. If bad times come, I'm the one who suffers (Congolese woman, Rubondo).*

This indicates separation or social divorce and short-term relationships occur among officially married couples. Although some women complained that their marriages broke after moving into the settlement, for others, it was another landing—finding new partners. However, most of these relationships also failed to endure. A key informant was explicit about the cause of easy separation in the settlement:

*We did have a dialogue, I think last year sometime, with a [refugee]community where we were asking why this? Why there were more women-headed families than you know men heading entire families-like they were more single mothers and the men openly told us that, ' you know some us of come in this settlement with our issues, with our*

*trauma, with our you-know-all that, we meet these women, you don't really have to love them but you know they are around, things happen, they have our children, but there is no bond enough for me to stick around and take care of these children, so I walk away—I walk away [and] I find another one' (Assistant Counsellor, OPM).*

This shows that sexual relationships are for convenience and not commitment. This desertion also has consequences for relationships resulting in children.

#### 5.4 Reproductive Health/ Family Planning

Given the purpose of this research to examine health needs and services for refugee women and children, it was important to inquire about their fertility particularly whether they had children, numbers, whether they stayed with them and if they were pregnant. Table 5.4 presents the birth history of the respondents.

Table 5. 4 Respondent's birth history

Ever given birth	Number of women (N=377)	Percentage (%)
Yes	351	93.1
No	26	6.1
Number of children	Number of women (N=349)	(%)
1	42	12.0
2	46	13.2
3	50	14.3
4	53	15.2
5	53	15.2
6 or more	105	30.0
Currently residing with children	Number of women (N=349)	(%)
Yes	271	77.7
No	78	22.3
Pregnant now	Number of women (N=354)	(%)
Yes	46	13.0
No	308	87.0

The findings further indicated that out of the sampled 377 women, only (6.1%) indicated not having ever given birth. A few women (n=46, N=354) said that they were pregnant (13. 0%). A larger proportion (30.0%) of the women with children (N=349) had 6 or more children at the time of the survey. This is indicative of high fertility rates in the settlement. This is not surprising given the existing high total fertility rate reported at 5.4 children per every Ugandan



woman (UDHS, 2016). About above half (77.7%) of them (N=349) lived with their children in the settlement. Almost one quarter (22.3%) of women indicated that they were not living with their children. This is important because many women said that they had left some of their children behind when they fled. This was perceived as loss which could be one of the reasons for high fertility after settling in NRS. This was revealed in an interview with one woman:

*I have eight [children] but now I have six with me here. Others were left in Congo. I had three children with the first man. Left them in Congo then came and married another man so by now I have five...[and] I'm pregnant (Congolese woman, Rubondo).*

Another woman reiterated:

*"These one[s] have their own father [points to children]; other children they have their father— their father died in Somalia- then [the]second husband [owns] the first boy. Five children their father died. Two of these children their father is in Kampala he is working- he is [a] waiter... sometimes he helps me with milk and food for the children. (Somalian woman, Base camp)*

While this shows reference to the loss of a husband, it also shows that high fertility is inevitable due to new and multiple relationships. This was revealed by a key informant that:

*An average single mother will have at least four or five children, [and] probably have multiple fathers within them. (Assistant counsellor, OPM)*

Although this increases the childcare burden and the number of dependents in the family, it is another way to cope amidst deprivation (securing basic needs from new partners). For some women, however, entering new relationships with children was problematic for themselves and their children. This was revealed by one of the refugee women:

*When I got married to this man, I had two children and then when I produced the third, and then this husband tried to kill one of them and gave him poison so when I realised that, I reported this case to Tutapona [organisation] and they tried to help but then after that, he persecuted me and wants to have me killed. So, we fought, we went into a lot of things with this husband and then till now still things are still worse (Congolese woman, Juru).*

This reflects violence against women and children in the settlement. It also reflects a need for strong protection mechanisms for the victims and survivors of violence. Violence against women and children were captured in the survey and further in-depth interviews. This will be reviewed in more detail in the next chapter. Violence is partly caused by a lack of appropriate means of support for women and children.

## 5.5 Main Occupation of the Respondents

The respondents were probed about the kind of work they do. This was essential because the nature of occupation greatly determines health and well-being in terms of access to income and resources to meet basic needs and health care. Table 5.5 represents the main occupation of women in NRS

Table 5. 5 Main occupations of the respondents

Main occupation	Number of women (N=338)	Percentage (%)
Farmer	196	58.0
Self-employed/Business	67	19.8
Housewife	35	10.4
Casual labour	38	11.3
Salaried worker	2	0.6

Most of the women (58%) in this study worked as peasants. However, the food they cultivate is not theirs. They mainly worked on the nationals' (local Ugandans') farms and were often paid either food (to supplement food rations from UNHCR) or little amounts of money, barely enough to meet their needs. They walked long distances out of the camp and more often through forests to go to these farms where they also worked for long hours. The second-largest group (19.8%) were self-employed, mainly having small kiosks selling foodstuff or merchandise. These were followed by women who worked as casual labourers (11.3%) such as bricklayers, housemaids or clothes-washers (for fellow refugees and professional staff of agencies) and commercial sex work. The other women reported that they had no means of income, they only concentrated on housework (10.4%). Only 0.6% of the respondents reported waged work as translators (at the health centre or an NGO).



**Women with hoes and logs**

The nature of work women did is not unexpected when compared with their level of educational attainment which we now turn to.

### 5.6 Level of Education

The women were asked about their level of education. This was central to the study since it impacts on health behaviour in terms of choices for maintaining health, preventing diseases and seeking care.

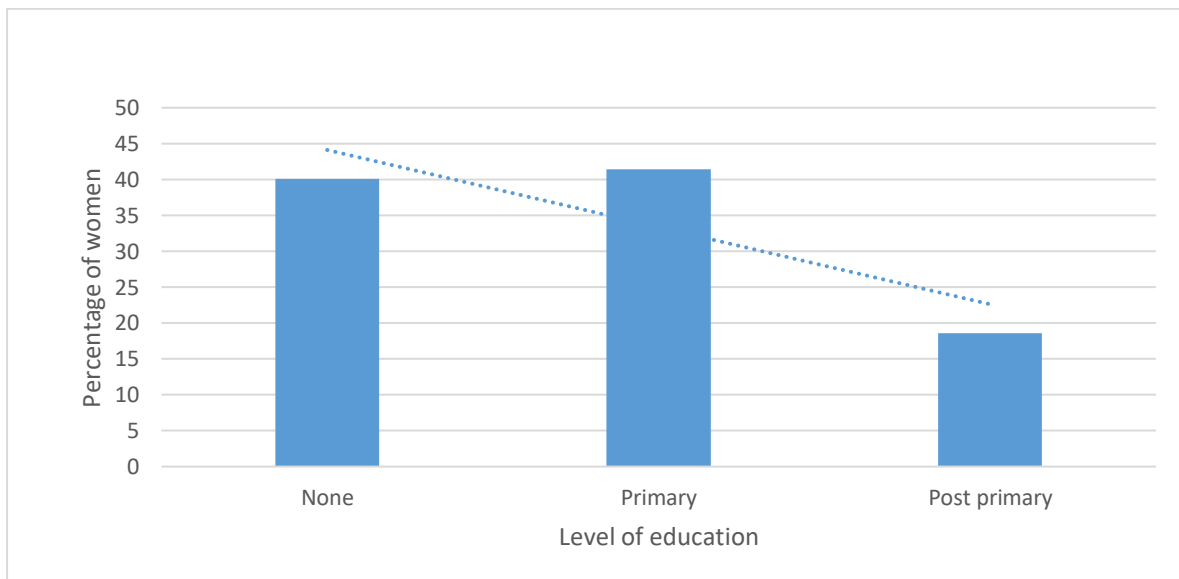


Figure 5. 1 Highest level of the school attended

Less than 20% of the study participants attained more than primary education. This includes Secondary, Vocational and University education. Most of the respondents had attained primary education (41.4%) of seven or fewer years, while a comparable proportion (40.1%) had no formal education whatsoever. This was also revealed in a key informant interview:

*They never studied, they never went school, so these people— I think because of that, their knowledge is kind [of] low. (Enrolled nurse, MTI)*

This statement equates low education with a lower cognition ability. Kikulwe et al, (2017) assert that women’s low level of education is engrained in gender-based inequalities and social structural and cultural barriers produced by patriarchy such as teenage pregnancy, sexual

violence and early marriage. This is also reflected in the failure of the educational institutions to adapt interventions that meet the critical needs of girls in the education system (Ibid, p. 308).

Another key informant echoed the vulnerabilities associated with lack of education:

*Our biggest percentage we are supporting is women because I think from the research and findings, [it] is [indicated] that from back their own countries, the majority who did not get a chance to go to school are women. So you find in most aspects of life, they are the most affected and so health is inclusive. (Community development officer, FRC)*

Education is an important determinant of health and health behaviour in NRS for instance in terms of prevention of hygiene-related diseases such as diarrhoea. The level of education was not the only influence on women's and children's health, the religious beliefs of the respondents were of similar significance.

## 5.7 Religion

The survey also revealed the religious choices of the respondents. Table 5.6 presents these variations.

Table 5. 6 Religion of the respondents

Religious affiliation	Number of women (N=377)	Percentage (%)
Pentecostal	126	33.4
Catholic	87	23.1
Protestant	78	20.7
Muslim	37	9.8
Others	49	13.0

Pentecostal Christianity had the most adherents (33.4%), followed by Catholics (23.1%) and Protestants (20.7%) and only 9.8% were Muslims. Other women (13.0%) belonged to denominations such as Seventh-day Adventism, Jehovah's witness and Rehoboth. The respondents had strong beliefs in God as a great source of help, peace and provision. This was also reiterated by a key informant:

*I will talk of the religious part of it, some deny drugs that for them they are going to pray, for example, HIV, 'aah, me, I will pray', God will cure me everything (Enrolled nurse, MTI)*

The religion of the respondents was important because of the prevailing spiritual and religious influences on health and the decisions for seeking health care, as shown above. In the next section, I will present the respondents' length of stay in the settlement.

### 5.8 Duration of Stay in the Settlement

The respondents were also asked about their period of stay in the settlement and this is presented in Figure 5.8.

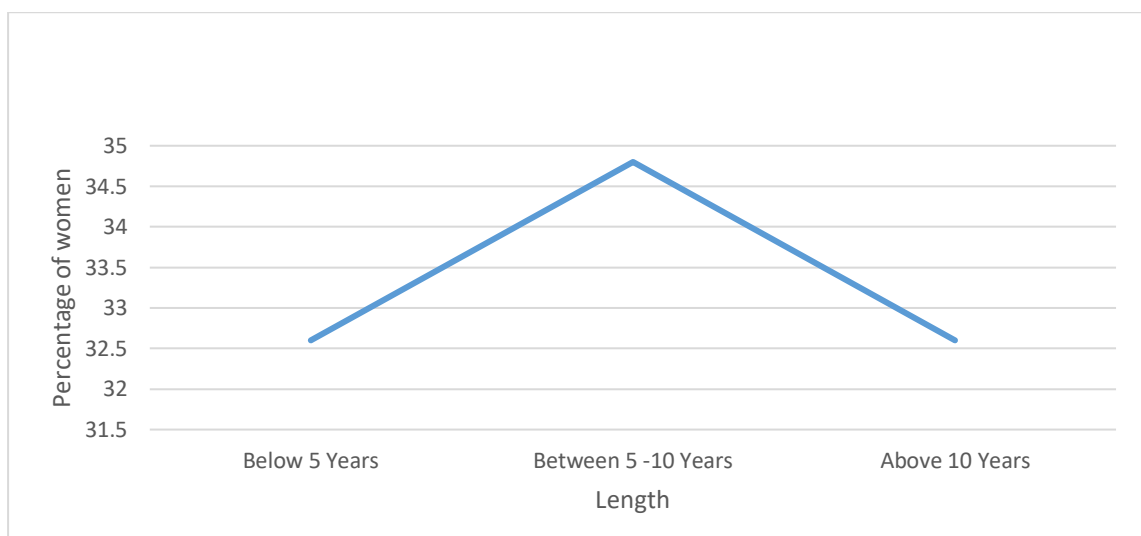


Figure 5. 2 Respondent's length of stay in NRS

The findings show that only (32.6%) of the respondents had lived in the settlement for less than five years. More than half (69 %) had lived in the settlement for over five years. The duration of stay ranged from less than one to twenty-five years, with entry dates from 1992 to 2017. The period of stay in exile is an important determinant of access to basic rights and essential social and economic resources. Refugees who find themselves in extended exiles are more likely to forfeit their rights and also become chronically dependent on humanitarian assistance (UNHCR, 2018). This will be examined in more detail in the ensuing chapters of this thesis. The next section provides details of respondents who took part in qualitative interviews.

## 5.9 Description Refugee Respondents (In-depth Interviews)

The refugee women who participated in qualitative interviews were purposively selected based on the information they provided in the survey. Most of these women were single mothers with several dependants. Some had been sexually abused with quite a lot of health issues in relation to supporting their families. In addition, they faced serious challenges with accessing services. The next section provides a description of the refugee men who participated in this study. As mentioned in Chapter Four, it was crucial to engage men because they influence decision making about seeking health care and health behaviour. Table 5.7 provides a profile of the male respondents.

Table 5.7 Male refugee participants

<b>SN</b>	<b>Nationality</b>	<b>Zone</b>	<b>Marital status</b>	<b>Number of children</b>	<b>Year of seeking refugee</b>
1	Congolese	Juru	Married	1+others in Congo	-
2	Congolese	Rubondo	-	11	2006
3	Congolese	Base camp	Married	5	2000
4	Congolese	Base camp	Separated	1	2017
5	Congolese	Rubondo	Married	2	-
6	Congolese	Rubondo	Married	6	2006

From the table, it is can be seen that male refugee respondents were Congolese. This is because men from other nationalities were not easily traceable. An attempt to interview a Somali man resulted in a group discussion because others, including their chairman joined us during the interview. Although the contents of this discussion have not been cited in this thesis, their health concerns were similar to those raised by other men. The discussion was also important to validate the responses from other respondents. Three out of the six male respondents were married, one was separated and did not disclose his marital status. One man was from Juru, two from Base camp and three were residents of Rubondo. These men were selected using convenient sampling. In the next section, I present different key informants and their agencies.

## 5.10 Key informants and their organisations

Several key informants were approached to contribute to the study because it was important to get their experiences and conception of their contribution to promoting refugee women and children's health. Table 5.8 presents the profiles of key informants.

Table 5.8 Key informants and their organisations

<b>Agency</b>	<b>Positions</b>	<b>Total</b>
OPM	Commandant Assistant counsellor Community services assistant (2)	4
UNHCR	Community services assistant	1
MTI	Health promoter Clinical officers (2) Nurse Counsellor	5
IOM	National migration coordinator Nurse Operations assistant	3
Tutapona	Counsellor	1
HIJRA	Child protection officer	1
ARC	Protection officer/counsellor Hygiene promoter Community activist	3
Local Government	Senior community development officer Nurse Police officer	3
INTERAID	Senior programmes officer	1
FRC	Community development officer	1
Samaritans purse	Operations coordinator	1
SWSA	Lecturer	1
RMF	Country director	1
Refugee leaders	Ethiopian representative Congolese women's representative Defense Base camp	3
Private providers	1 Clinician 1 VHT Coordinators (2) Translator/VHT	3
	<b>Total</b>	<b>32</b>



The table shows that several (N=32) key informants were approached and these worked for different organisations including the Office of the Prime Minister (OPM), United Nations High Commissioner for Refugees (UNHCR), Medical Teams International (MTI), International Organisation for Migration (IOM), Tutapona, Humanitarian Initiative Just Relief Aid (HIJRA), American Refugee Council (ARC), Local Government (LG), Inter-Aid Uganda, Finnish Refugee Council (FRC), Samaritan Purse, Department of Social Work and Social Administration Makerere University, and Real Medicine Foundation (RMF), and a private providers.

### 5.11 Conclusion

This chapter has described the socio-demographic and economic characteristics. Profiles of the refugee women are important to get a foundation of the realities which shape women's and children's health and well-being. The differences particularly regarding marital positions, fertility, occupation, level of education and religion are fairly noticeable. These factors intersect with the refugee status and form multiple vulnerabilities for women and children as will be seen in the subsequent chapters. It has also opened up some of the key findings which will be examined in the next chapters. The next chapter explores the key health themes which came up from both qualitative and quantitative data including, women's health, adolescent health, children's health, gender-based violence and abuse and mental health concerns.

## CHAPTER SIX: WOMEN, CHILDREN AND ADOLESCENT HEALTH

*“You can't run away from issues of children when you are handling issues of women.”  
(Protection/Counsellor, ARC)*

### 6.0 Introduction

This chapter reports on the nature of public health concerns of refugee women and children in the NRS. It also gives an account of the existing health interventions and measures to maintain and sustain the health of women and children. Refugee health concerns are presented along with the existing efforts to support women and children. Findings are arranged and presented using the five key themes and subthemes which emerged from the qualitative data, the survey data as well as observations. The key themes of the chapter include (1) women's health, (2) adolescent and youth health, (3) child health, (4) mental health and (5) gender-based violence, abuse and torture. These will be examined in order, and are also further divided into subthemes to create precision and allow a better understanding of the findings.

#### 6.1.0 Women's Health

Women's health in this study is defined as the prevention, diagnosis and treatment of diseases and conditions that affect a woman's physical and emotional well-being. The status of women's health was explored by considering the situation and management of communicable and non-communicable diseases, their sexual and reproductive concerns and nutritional health.

##### *6.1.1 Management of communicable and non-communicable diseases*

The study respondents were unanimous that the living conditions in the settlement greatly influence the health and well-being of refugees and have an impact on the prevalence of communicable and non-communicable diseases. In my survey, residents gave details regarding the main source of drinking water, sanitation facilities, nutritional information, fuel used for preparing meals, sleeping and cooking space and information concerning prevention of diseases which are summarised below in Table 6.1

Table 6. 1 General living conditions in the settlement

<b>General health Matters</b>	<b>Number of women</b>	<b>Percentage (%)</b>
<b>The main source of drinking water</b>		
Tap-water	317	84.3
Borehole	7	1.9
Tank (Water brought in the truck)	46	12.2
Lake	5	1.3
<b>Means of making water safe for drinking</b>		
Boil	125	33.2
Distillation	9	2.4
None	242	64.4
<b>Type of toilet facility</b>		
Pit latrine	322	87.5
Piped pit latrine	28	7.6
Plastic slab	18	4.9
<b>Toilet sharing</b>	115	31.2
<b>Number of meals in a day</b>		
1	219	65.8
2	92	27.6
3	22	6.6
<b>Type of Cooking Fuel</b>		
Firewood	211	56.4
Charcoal	159	42.5
Cow dung	4	1.1
<b>Number of rooms</b>		
1	152	41
2	149	40.2
3+	70	18.8
<b>Space for Cooking</b>		
Indoors	343	91.5
Outside	32	8.5
<b>Availability of Mosquito nets for children</b>	231	63.6
<b>Spraying to avoid mosquitos</b>	15	4.0

The living conditions<sup>19</sup> in the settlement are unpleasant for instance, many households survive on a single meal (65.8%) a day while 41% had one-roomed huts which served as both sleeping and cooking space. The survey indicated that 91.5% of the participants were cooking inside

<sup>19</sup> See a video: Isingiro local leaders concerned over number of refugees posted on 11 June 2017 by NTV Uganda available at :  
[https://www.youtube.com/watch?time\\_continue=223&v=sV2r508fwcU&ab\\_channel=NTVUganda](https://www.youtube.com/watch?time_continue=223&v=sV2r508fwcU&ab_channel=NTVUganda)

their huts. This threatens the health of all household members especially women (who prepare meals) and children (who are always at home with their mothers). Huts typically lack proper ventilation and the fuels they use for cooking (mainly firewood, 56.4%) generate fumes associated with respiratory tract infections and lung cancer. According to UNHCR (2014), acute upper and lower respiratory infections are the leading causes of mortality among refugee populations worldwide (p.20). Tuberculosis also poses a serious health burden to refugees especially those in camps or settlements (Kimbrough et al., 2012). This is mainly because refugees end up in crowded, harsh conditions with poor shelter and nutrition and with no access to services which can help them to detect and treat such cases (Fernandes and Miguel, 2009). However, such conditions are not unique to refugees given the poor wider socio-economic conditions in the country which contribute to poverty and disadvantage in several parts of the country. For instance, it is argued that the high annual population growth rate (3.0%) due to high fertility rates not only stifle efforts to address the country's food and nutrition challenges but also aggravate the challenge of improving the health services to the general population (National Population Council (NPC), 2018).

Malaria is another major concern in the settlement. In this study, 96% of survey participants had never sprayed their homes to avoid mosquitoes and 36.4% had no mosquito nets. This exposes them to malaria from mosquito bites. The groups most vulnerable to malaria are pregnant women and children. According to UNHCR (2014), malaria ranked highly as the greatest cause of mortality among refugees in 2008 and that cases soared in 2011 in countries such as Uganda, Tanzania, and Zambia where malaria is endemic.

The lack of access to safe drinking water also contributes to a high prevalence of infections among women and children in the settlement. The survey revealed that the large majority of households in Nakivale settlement (84.3%) secure water for household consumption from the taps which are established within the settlement. Despite the proximity to some of the water sources, they have to wait for close to four hours at the minimum before they can be served at these sources. The other women (15.4%) get access to water from boreholes, tanks, and open water sources such as lakes and wells. Moreover, water which is supplied at the taps is also pumped from these open water sources. One of the critical issues is that water from these sources is not safe for drinking when it is not treated or boiled, but when the participants were asked about the means of treating their water or whether they boiled it to make it safe, more than half (64.4%) admitted to taking this water without boiling or distilling it, which exposes

them to serious water-borne diseases and infections. The photos below show the challenges of accessing safe water in the settlement.



**Water access points in the settlement**

In-depth interviews with men and key informants also confirmed the problem of water;

*The biggest challenge I have observed since I settled here is the problem of water, it disturbs and disorganises our stomach and causing diseases. (Congolese man, Base Camp)*

This was also reiterated by a women's leader,

*The most problem or the issues, we are facing here at Nakivale is water that we take is dirty. And sometimes it causes diseases/ health problems like stomach-aches, diarrhoea, typhoid. (Refugee woman leader, Base Camp)*

These narrations demonstrate that the quality of water in the settlement is a major cause of infections. It is also concerning to note that the water which would help them to improve sanitation and hygiene instead expose them to infections. These ailments are also exacerbated

by the general conditions of living in the settlement described in Table 6.1 which are distressing.

In addition to communicable diseases, there is also a high occurrence of non-communicable diseases among refugees. This was mainly revealed by the key informants. The common non-communicable diseases are high blood pressure and diabetes. One key respondent explained that,

*We have patients with heart issues... For example, most of my hypertensive clients, it's because of the loss, the trauma, the fears, everyday living here, renewing life in a country that is not yours. (Assistant counsellor, OPM)*

Another key respondent reiterated the prevalence of chronic conditions among refugees. However, he was emphatic about community differences,

*The trend of diseases here is mostly the same as the Ugandan [community]... the only difference we have are mainly chronic conditions which are a little too high in this place [NRS] like for instance hypertension and then diabetes. (General medical practitioner Nakivale Health Centre II)*

The high prevalence of non-communicable diseases among refugees was mostly associated with experiences of loss, trauma, insecurity, anxiety and violence. In fact, the respondents expressed excessive feelings of insecurity. Most respondents voiced concern about violent partners while others were afraid of repatriation to their countries of origin. I established the source of these threats (repatriation) when I listened to a discussion of OPM staff about the continued failed efforts to repatriate Rwandese refugees. I was curious to learn about this further and I talked to an OPM community services assistant about the issue. She confided that the Rwandan refugees had to return to Rwanda because the genocide ended and their country is seemingly stable. She, however, stated that the refugees were not willing to return. Because of this, the authorities resorted to forceful strategies for instance, food rations were reduced or denied and people were rounded up at meetings. Some of these measures violate the human rights of refugees as set out in international law (UNHCR and IDC, 2016), for instance, the refugees confided that two Rwandese died during the process of being forced to get on to trucks sent by the Rwandan government<sup>20</sup>. I followed this up with my respondents. One Rwandan

---

<sup>20</sup> A similar story was published by New York Times:  
<https://www.nytimes.com/2010/07/17/world/africa/17uganda.html>

refugee, who has stayed in the camp since 1997 disclosed that they would not return to Rwanda because of the unpredictable political environment. She further added that the Rwandans were being pursued even when in Uganda and that many of the people she knew were disappearing from the camp. In early 2018, the Ugandan government confirmed these suspicions by opening an investigation into the alleged kidnaps, torture, and murder of Rwandan refugees in the country. Table 6.2 indicates the insights of the residents regarding the security of the settlement.

Table 6. 2 The status of environmental safety for refugee women and children

<b>Environmental health</b>	<b>Number of women</b>	<b>Percentage (%)</b>
<b>Feeling physically safe</b>	224	59.6
<b>Feeling physically unsafe</b>	152	40.4
<b>Reasons for feeling physically unsafe</b>		
<i>Constant fear of perpetrators</i>	179	58.5
<i>Fear of living with strangers</i>	67	21.9
<i>Conflicts within the camp</i>	31	10.1
<i>Rampant rapes in the camp</i>	22	7.2
<i>Enemies from countries of origin</i>	7	2.3
<b>What have you done to enhance your physical safety?</b>		
<i>Keep indoors in the evening</i>	195	93.3
<i>Avoid my enemies</i>	6	2.9
<i>Reported to police</i>	7	3.3
<i>Prayer</i>	1	0.5

From the table, more than half of the respondents perceived the settlement as insecure. This was a result of constant fear of their perpetrators (58.5%), while others (41.5%) to living with strangers from different countries; conflicts within the camp especially over land distribution and spouses; fear of enemies from countries of origin and fear of sexual assault. Such threats kept them in constant fear for their lives and for their children. As way to cope with rampant insecurity the respondents stated that they restricted their movements in the camp especially in the evening (93.3%), while others endeavoured to avoid their enemies. These dynamics are substantial when seeking to identify further characteristics of women's health and in the subsequent section, I examine another key element of women's health, sexual and reproductive health.

### 6.1.2 Sexual and reproductive health

The UN Platform for Action (1995) defines reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes (Crawley 2001, p.147). Reproductive health problems may include maternal health complications, poorly-managed pregnancy, abortion, anaemia, sexually transmitted infections (STIs), female cancers such as cervical and breast cancer, unmet needs for family planning services, and maternal mortality due to haemorrhage during birth, among others. A large majority of women in Nakivale settlement experience reproductive health issues of which the common ones include poorly managed pregnancy, infertility, urinary tract infections, and sexually transmitted infections (like gonorrhoea). A clinician at Rubondo Health Centre II revealed the commonest health problems among the women:

*Most women who always come here for treatment present something concerning with reproductive parts, here I mean, pregnancy concerns, some say they are infertile, they cannot conceive, some come with STIs [sexually transmitted infections], some come with UTIs [urinary tract infections], some have PID [pelvic inflammatory disease]. (Clinical Officer, Rubondo)*

This denotes the common reproductive health concerns among refugee women and the great need for prevention, diagnosis, and treatment of such complications.

#### Sexually transmitted infections and other infections

This variable was analysed by considering women's knowledge about the existence of STIs apart from HIV, and whether or not they had actually contracted any sexually transmitted infections in the last twelve months. At least two in every ten participants had suffered a disease/health problem arising out of sexual contact. The most commonly reported STDs include candida (61.5%), gonorrhoea (11.5) and other unidentified infections (27.0%).

The other common infections among refugee women are urinary tract infections and pelvic inflammatory disease. Many of these are associated with poor hygiene and sanitation conditions in the settlement. For example, the type of toilet facility determines the exposure to urinary tract infections. Table 6.1 shows that a substantial percentage of the participants (12.5%) were using flushable toilets (piped pit latrine and plastic slab) despite the fact that water is a problem in the settlement. Moreover, some of the households have to share these toilets (31.2%).





### **A piped pit latrine found in the settlement**

A respondent showed concern about problems with sexual and reproductive health. She also linked these to the existence of poor living conditions in NRS:

*Most of the refugees are dying of infection because of the dirty water that we are using. Also, we are having pain from joints- all joints –even young children have those problems. The whole Nakivale if you go to all the homes they will tell they are dying [suffering] of infections and also joints. The infection is of down [genitals] because we Muslims, we use water when we are going to the toilet... if you boil there is that thing[dirt] that remains under the top-bottom of the saucepan... most of the refugees are suffering from the joints most of them especially the legs, I don't know why. (Somali woman, Base camp)*

This narrative shows that women and children suffer from infections because of exposure to poor sanitary conditions. These are also exacerbated by lack of access to clean water. Apart from STIs, the residents also suffer from HIV/AIDS due to various reasons as I examine in the following section.

## Women and HIV/AIDS

HIV/AIDS is mainly caused by blood and sexual contact. The findings revealed a high prevalence of HIV/AIDS within the settlement. This is due to various reasons such as promiscuity, vulnerability and poverty. As I examine in the ensuing section, women in the settlement are vulnerable to sexual abuse and rape. Others engage in survival sex to meet their basic needs. Another explanation comes from alcoholism as stated by a Congolese refugee man from Rubondo, “*they take a lot of alcohol, yeah they are always drunk.*” I also observed idleness in the settlement with both men and women spending vast amounts of time at the drinking joints especially in Base camp. A key informant raised the issue of HIV/AIDS in NRS and said:

*I look at the spread of HIV in the settlement, it's high, it's higher compared to the nationals and normally what happens when refugees have just come, many of them are negative but when they stay for some time you find many contracting the disease. (Senior official, OPM)*

This shows that refugees are vulnerable to HIV/AIDS due to the difficult circumstances they find themselves into while staying in NRS. This is because of the risky possibilities they invent in order to survive.

However, another key respondent revealed that some groups of refugees, Congolese in particular, espouse unrestrained sexual behaviour which exposes them to HIV/AIDS. He said:

*You will find high cases for example of HIV patients among the Congolese because their social lifestyles are different from maybe the Somalis who are more- how can I call it, not polygamous but their sexual network is small. (Assistant counsellor, OPM)*

This narration highlights that lifestyle and unrestrained sexual conduct among some groups of refugees cause a high prevalence of HIV/AIDS. The differences in ways of living are significant because they influence exposure. Moreover, some groups are extremely vulnerable as a result of embracing multiple sexual relationships.

## HIV testing and counselling

HIV treatment and support are important to fulfil Article 3 of the Universal Declaration of Human Rights– the right to life. Moreover, support provision for people with HIV/AIDS reduces the risk of transmission to other sections of society (Palattiyil and Sidhva, 2011). For example, provision of anti-HIV drugs to pregnant or lactating women can prevent mother-to-child transmission of HIV. Accessibility and utilisation of HIV testing and counselling services

were assessed. The respondents were asked to indicate if they had any information about the facts and causes of HIV/AIDS, availability of HIV testing and counselling services. They were also interviewed about how they minimised risks and vulnerability to contracting the virus, and whether or not they had received any pre- and post-test counselling. Quantitative data indicated that 95.6% of the sample had been tested for and received counselling for HIV and 90.5% of these had received their test results. Further analysis regarding the level of utilisation of HIV/AIDS services among the participants was determined by considering the period within which the participants had done their most recent test. Table 6.4 shows the period in months elapsed since the participants' access to HIV testing services.

Table 6. 3 Period (in months) elapsed since the most recent HIV test

Variable	Months elapsed (%)			
	1-3 moths	4-6 months	6-12 months	13+ months
<b>Zone</b>				
Base	30.5	24.8	22.9	21.9
Rubondo	39.3	24.1	31.2	5.4
Juru	46.4	18.2	24.4	9.1
	<i>p=0.003</i>			
<b>Age</b>				
18-24	34.7	34.7	19.4	11.1
25-29	45.6	10.5	36.8	7.0
30-34	37.7	17.4	30.4	14.5
35-39	40.0	21.8	23.6	14.5
40-44	44.4	22.2	22.2	11.1
45+	32.6	23.3	30.2	14.0
	<i>p=0.286</i>			
<b>Nationality</b>				
Congolese	38.7	24.3	24.3	12.7
Nyarwanda	36.7	14.3	34.7	14.3
Burundian	42.2	22.2	30.0	5.6
Others	12.5	25.0	12.5	50.0
	<i>p=0.024</i>			
<b>Religion</b>				
Pentecostal	36.6	22.1	32.7	10.6
Protestant	40.3	18.1	26.4	15.3
Catholic	41.3	25.3	22.7	10.7
Muslim	48.4	22.6	12.9	16.1
Other Christians	36.4	25.0	31.8	6.8
	<i>p=0.678</i>			
<b>Level of education</b>				
None	42.9	21.1	27.8	8.3
Primary	39.4	21.9	27.0	11.7
Post primary	26.3	26.3	26.3	21.1
	<i>p=0.179</i>			
<b>Marital status</b>				
Single	38.1	25.4	22.2	14.3
Married	37.5	21.5	32.0	9.0
Ever married	44.4	20.6	17.5	17.5
	<i>p=0.181</i>			
<b>Occupation</b>				
Farmer	33.1	25.7	30.9	10.3
Business	47.1	22.1	14.7	16.2
Employed	40.7	18.5	33.3	7.4
House wife	37.5	6.2	37.5	18.8
	<i>p=0.057</i>			

From Table 6.4, it is evident that 88.1% of the participants had done their tests within six months and only 11.9% had gone more than a year without checking their HIV/AIDS status. Juru camp had the highest number of women (64.4%) who had done HIV/AIDS testing within six months while Base had the least (55.3%). Most of the variables used to analyse this HIV testing did not exhibit any statistical significance, save for the zone of residence ( $p=0.003$ ) and nationality of the respondent ( $p=0.0024$ ). However, the key informants expressed enormous concern over the increased risk of transmission of the disease in the settlement. This is not to say that availability of services automatically leads to accessibility and effectiveness. Qualitative interviews identified several factors that influence outcomes for HIV/AIDS services, including lack of consistency with treatments, drug resistance, and a culture of silence or non-disclosure among the refugees. A key informant said:

*Then they also have trauma when it comes to HIV/AIDS services that we give, you find that some people have been taking ARVS in South Sudan, [but] here they are a little bit shy they don't want the community to know that. So they forget about taking the drugs until they are very sick, then they come and disclose and they are restarted on this HIV/AIDS treatment (Senior official, RMF)*

This indicates that the community is seen as potentially stigmatising, which leads people to avoid services even when they are available. It also denotes a weakness in the way the services are administered which is particularly unattractive for the service users. There is a lack of privacy which makes it challenging for refugee women to access these services.

This has consequences for women's health. Another element of reproductive health care concerns access to family planning.

#### Family planning services

While the unmet family planning demand remains high at 28% for the rest of the general population (NPC 2018, p.80), family planning services are provided to refugee women in the NRS. The variations between the participants' familiarity with the concept of family planning in comparison with their uptake of family planning are presented in Figure 6.1.

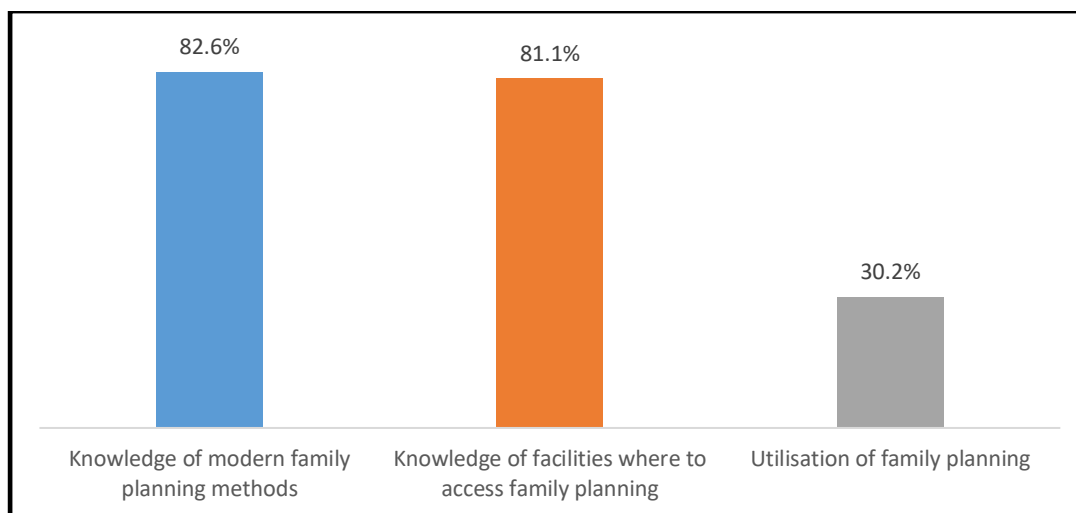


Figure 6. 1 Access to and utilisation of modern family planning methods

The findings revealed a high level of knowledge and awareness about family planning among refugee women (82.6%) there. Moreover, it was also found that women were conversant with facilities where they could access family planning services (81.1%) within the camp. Despite this, a high percentage of women did not agree with the use of family planning (69.8%). A key informant described the myths surrounding family planning mainly coming from testimonies of women who had tried family planning methods (such as, experiences of haemorrhage or inability to conceive when they want to resume reproduction:

*You will not teach them about family planning even if you teach, for them, they fear because she has been using, maybe the Implant, she bled...They also have their peer groups 'aah mama gundi [mother] what have you been using?' 'aah me I have been using this one of three months.' 'three months, me it affected me'. This one will also stop. Or if she is to go for family planning, 'for you what are you using?' 'I'm using Depo.' She will not come to inquire, ... If she has heard wrong about family planning, she will leave, and you find she is having six kids/children all of them no one goes to school and again she is pregnant. You start teaching this person, you find she goes to the 'other religion' whereby they don't accept family planning. (Enrolled comprehensive nurse, MTI)*

Similarly, another key informant stated the myths about family planning methods:

*When we are teaching about family planning, they[refugees] tell us that all methods of family planning can cause cancer. (Translator)*

Of the 377 women surveyed, 315 were sexually active. Above a quarter of these (30.2%) were found to be using modern family planning methods. The modern family planning methods used

by women include implants that are used by more than half (59.0%) of those who use family planning; condoms (9.5%); pills (6.7%); tubal ligation (5.7%) and IUD (1.0%). Less than a tenth was using traditional methods such as breastfeeding, abstinence and withdrawal; while a larger percentage (67%) were not using any family planning methods. This finding explains the existence of high fertility rates in the camp with a large number of women having more than six children, which compounds other problems. Families having a high number of dependants put the health of women and children at risk, due to malnutrition, poor hygiene and diseases arising from overcrowding in the small huts.

Different factors account for differential access to and utilisation of modern family planning methods by refugee women. Table 6.5 shows the level of utilisation of modern family planning methods by different characteristics. These include a zone of residence, age category, nationality, religious beliefs, level of education, marital status and type of occupation.

Table 6. 4 Level of utilisation of modern family planning methods by different characteristics (N= 95)

	No of women	Percentage (%)
<b>Zone</b>		
Base	18	17.0
Rubondo	8	8.2
Juru	58	52.3
		<i>p=0.000</i>
<b>Age</b>		
18-24	19	28.8
25-29	15	25.4
30-34	21	30.4
35-39	13	26.5
40-44	8	32.0
45+	7	16.7
		<i>p=0.669</i>
<b>Nationality</b>		
Congolese	50	29.2
Nyarwanda	13	25.5
Burundian	21	25.3
Others	1	10.0
		<i>p=0.555</i>
<b>Religion</b>		
Pentecostal	28	27.2
Protestant	23	37.1
Catholic	16	20.8
Muslim	5	17.9
Other Christians	13	30.2
		<i>p=0.191</i>
<b>Level of education</b>		
None	29	24.0
Primary	43	31.4
Post- primary	12	21.4
		<i>p=0.248</i>
<b>Marital status</b>		
Single	10	16.4
Married	62	31.8
Ever married	13	22.8
		<i>p=0.044</i>
<b>Occupation</b>		
Peasant/farmer	44	26.8
Business	18	29.0
Employed	7	26.9
Housewife	6	18.2
		<i>p=0.708</i>



The next section explores key variables such as the zone of residence, nationality, religious denomination level of education, marital status which significantly contributed to differential access to and utilisation of modern family methods.

#### *Zone of residence*

Juru camp had the highest percentage of women using modern family planning methods and there was a statistically significant relationship between the zone of residence and utilisation of modern family planning technologies ( $p=0.000$ ). This can perhaps be explained by the strategic location of Juru which is urban and close to district headquarters. Women living in this zone were thus more open and flexible to modern ideas compared to women from Rubondo which is rural.

There was no statistically significant relationship between women's age and birth control utilisation ( $p=0.669$ ). Similarly, there was no significant relationship revealed among the different nationalities of women ( $p=0.555$ ). Thus, observed differences among the nationalities, for example, showing high use among the Congolese could be due to chance or unmeasured variables.

#### *Religious denomination*

Religious denominations/ beliefs also determined the level of utilisation of family planning among women from different religious sects. The lowest uptake of family planning was observed mainly among the Muslims and Catholics, which appears to conform to the conventional beliefs of these sects being against the use of these technologies.

#### *Level of education*

The survey discovered that almost all the participants had not attended any formal education or only reached the primary level (81.7%). A key informant explained that despite their sensitisation women were obstinate to take up services such as family planning because of illiteracy,

*Just knowledge gap but obviously you keep on talking to someone, the ignorance I was telling you, understanding is very hard, that is how someone has been, they never studied, they never went school. (Counsellor, MTI)*

Another key informant stated,

*I want to tell you that the majority of these refugees come when they are totally illiterate. And you know when someone is illiterate, it becomes so hard to access different information, cannot read, probably some information is being delivered on the radio but cannot pick the language. (Community development officer, FRC)*

High levels of illiteracy among the refugee women negatively impact their uptake of services. Although these perceptions and observations were not statistically verified these denote complications surrounding the provision and utilisation of family planning services.

### *Marital status*

The decision as to whether or not use modern family planning technologies also depended on the marital status of the respondent ( $p=0.044$ ). Women who were married at the time of the survey mainly dominated in the category of those who used family planning as compared to the singles and the ever married (divorced, separated and widowed) category.

For example, two respondents mentioned their marital status as one of the reasons they were not using family planning:

*I don't use [family planning] ...because my daughter- the last born was born 2015, since that time, I don't get time to meet with my husband. (Somali woman, Base camp)*

This shows that she was not using family planning because she had not been in contact with her official partner for an extended time. Another woman gave a related reason,

*For me I never use it...because I'm not married I don't have a husband. (Somali Woman, Base camp)*

This echoes that she was not using family planning because she was not formally married. On the other hand, while the married women seemed to be greatly represented in the use of family planning services, these lacked the support from their partners for using family planning, as explained by a key informant,

*The biggest health problems which I can see in the settlement are basically on family planning, refugee men do not believe in family planning so it's a hassle and a struggle for women to make their husbands accept family planning. (Senior official, OPM).*

Whereas there were statistically significant relationships revealed between most of the socio-demographic characteristics and utilisation of modern family planning services among the participants, the study findings showed no significant relationship between main occupation and utilisation of the modern family planning services ( $p=0.708$ ).

Overall, the study findings revealed that most of the respondents in the settlement were not using modern family planning services and this was seen as a major factor contributing to high fertility rates among women in the settlement.

Table 6. 5 Logistic Regression analysis results for the dependent variable: Modern family planning utilisation

Variable	OR (95% CI)	Significance (p-value)
<b>Zone of residence</b>		
Rubondo zone	0.38 (0.15-0.92)	0.032
Juru zone	6.20 (3.17-12.11)	0.000
Base zone	1	
<b>Marital status</b>		
Currently Married	3.61 (1.44-9.08)	0.006
Not married/single	1	

Nagelkerke  $R^2=30.2\%$

The statistic Nagelkerke  $R^2$  indicates that the independent variables (zone of residence and marital status) explain 30.2 % of the variation in the dependent variable (modern family planning utilisation) in the logistic regression model developed.

While residents of the Juru zone are six times more likely ( $p<0.05$ ) to use modern family planning compared to Base, the residents of Rubondo had significantly lower likelihood ( $p<0.05$ ) of using modern family planning compared to Base.

The married women in NRS had a significantly higher likelihood of using modern family planning methods compared to their counterparts that are, the currently unmarried and never married (single).

This finding is important for prediction and planning for any interventions for improving contraceptive uptake in the NRS. For example, this explains that family planning service delivery activities in some zones like in Rubondo where there was a slightly lower uptake, should be scaled up and interventions should be drawn to attract the unmarried women in Rubondo.

Apart from access to family planning, the other aspects of women's health relate to access to prenatal, delivery and post-natal care. Access and utilisation of these help to prevent potential

health problems during pregnancy and promote healthy lifestyles for women and children. In the next section I present the status of women’s health in relation to pregnancy, childbirth and access to care.

### 6.1.3 Pregnancy, childbirth and postnatal care

#### Unwanted pregnancies

The issue of unintended pregnancies emerged as a major concern during the survey, with 93.6% of the sample having children at the time of the survey. A third of these had six or more children. However, in every ten respondents, three mothers had conceived without intent. Figure 6.2 represents the percentage of participants who had conceived without choosing to, the complications which occur during deliveries and the reasons why women had these unwanted pregnancies.

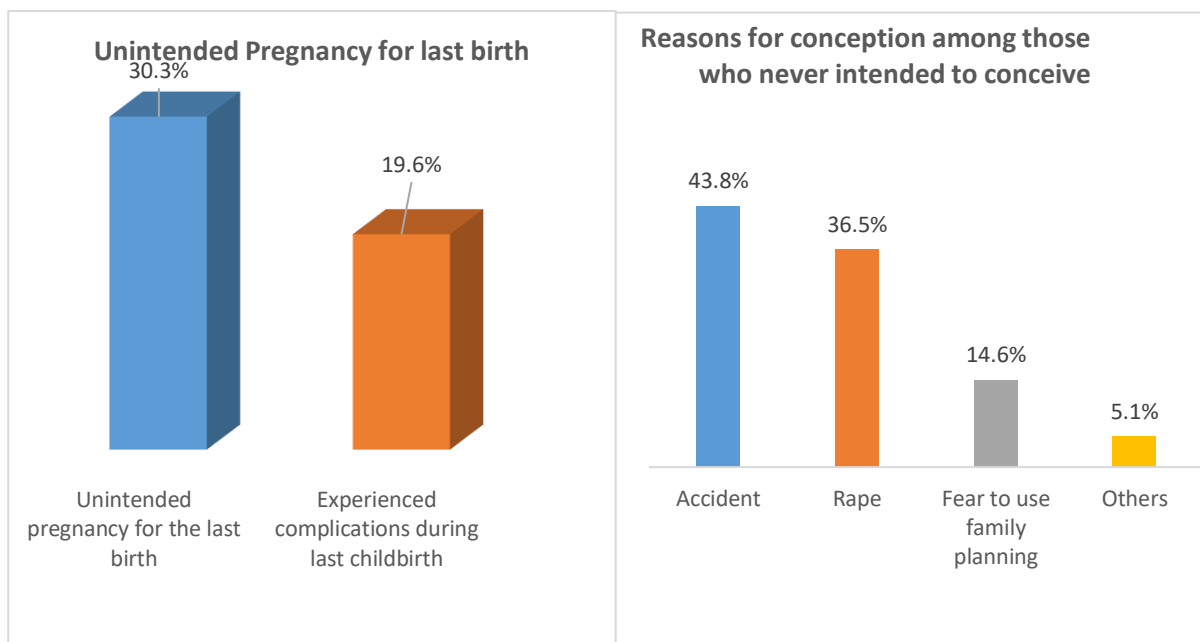


Figure 6. 2 Conception and reasons for conception among the participants

The figure shows that a significant percentage (30.3) of the women in the survey had produced children unwillingly for reasons such as rape (36.5%); negative attitude towards family planning (14.6%) while for some, conception was considered as having been

accidental/unplanned (43.8%). It is important to know that there were differences in the prevalence of unintended pregnancies among the refugee women as shown in Table 6.7.

Table 6. 6 Differentials in the rates of unintended pregnancies among the participants

<b>Characteristic</b>	<b>No of women</b>	<b>Percentage (%)</b>
<b>Zone</b>		
Base	46	38.3
Rubondo	32	28.8
Juru	20	21.1
		<i>p=0.022</i>
<b>Age</b>		
18-24	19	28.8
25-29	16	25.4
30-34	24	35.8
35-39	26	45.6
40-44	6	23.1
45+	7	16.3
		<i>p=0.026</i>
<b>Nationality</b>		
Congolese	68	38.0
Nyarwanda	10	20.8
Burundian	18	20.7
others	3	23.1
		<i>p=0.011</i>
<b>Religion</b>		
Pentecostal	29	27.7
Protestant	29	41.4
Catholic	16	20.8
Muslim	11	29.7
Other Christians	14	36.8
		<i>p=0.076</i>
<b>Level of education</b>		
None	29	22.3
Primary	40	28.8
Post primary	29	50.9
		<i>p=0.000</i>
<b>Marital status</b>		
Single	26	41.9
Married	56	27.1
Ever married	17	30.9
		<i>p=0.083</i>
<b>Occupation</b>		
Peasant/farmer	44	26.0
Business	16	26.7
Employed	16	50.0
House wife	9	25.7
		<i>p=0.047</i>

Table 6.6 suggests unintended pregnancies were mainly found to be a problem in Base camp. More than a third of the participants (38.3%) who had ever given birth reported this problem. Moreover, there was a statistically significant relationship between unintended pregnancy and the zone of residence ( $p=0.022$ ). Women in their thirties also reported more unintended pregnancies than the other age groups ( $p=0.026$ ). The respondent's nationality ( $p=0.011$ ), level of education ( $p=0.000$ ), and occupation ( $p=0.047$ ) also highly influenced the rates of unintended pregnancies. However, there was no statistically significant relationship observed with other demographic factors such as religion or marital status.

This finding (unintended pregnancies) has negative implications for health outcomes for both women and children in the camp. The qualitative findings revealed the negative effects unintended pregnancies such as loss of self-esteem, psychological torture, poor physical health and lack of motherly love for their children. All these also affect unborn children as well as leading to child abuse. For instance, one respondent who had been raped by a neighbour stated that she was so anxious about how to take care of herself and the unborn baby:

*I know the person. He called me to his home, 'come here and I tell you,' and he raped me. Then after he said 'I don't love you,' he rejected me...I'm worried because I'm pregnant, I'm about to give birth, no cloth, no money, no what, no food, I'm worried when I give birth what will happen? (Burundian Woman, Rubondo)*

This is revealing of the way women are affected by undesirable pregnancies. Although women had some access to antenatal (as I examine in the next section) care they still had concerns over self-care as well as child-care for fatherless children. These worries are also exacerbated by the lack of access to basic needs.

#### Antenatal care

Women in the settlement are provided with antenatal health care including but not limited to physical examinations during pregnancy, immunisation against tetanus, iron supplements, deworming and malaria prophylaxis. WHO recommends at least 4 antenatal visits during pregnancy (WHO, 2008). These visits are vital in screening women for pregnancy-related complications and providing early intervention to support the well-being of both mother and the foetus. Access to and utilisation of antenatal health care services was analysed by considering actual antenatal visits made by refugee women to health centres during pregnancy, the number of visits/appointments, and the support and care women received from professional

staff such as nurses, midwives, and doctors. Table 6.7 represents access to and utilisation of antenatal health care among refugee women.



Table 6. 7 Access to and utilisation of antenatal health care among the refugee women

Selected variables	No of antenatal visits for most recent pregnancy (%)				
	Once	Twice	Thrice	Four	Five+
<b>Zone</b>					
Base	4.5	14.3	30.4	28.6	22.3
Rubondo	3.2	8.5	40.4	35.1	12.8
Juru	3.2	6.5	19.4	54.8	16.1
	<i>p=0.003</i>				
<b>Age</b>					
18-24	3.3	5.0	30.0	40.0	21.7
25-29	6.5	6.5	19.4	43.5	24.2
30-34	1.6	15.6	37.5	31.2	14.1
35-39	3.9	7.8	29.4	49.0	9.8
40-44	4.8	14.3	42.9	33.3	4.8
45+	0.0	16.2	32.4	27.0	24.3
	<i>p=0.162</i>				
<b>Nationality</b>					
Congolese	4.8	9.6	26.3	40.7	18.6
Nyarwanda	2.2	13.3	28.9	40.0	15.6
Burundian	2.6	9.0	37.2	37.2	14.1
others	0.0	10.0	40.0	20.0	30.0
	<i>p=0.840</i>				
<b>Religion</b>					
Pentecostal	5.2	8.3	34.4	35.4	16.7
Protestant	4.4	4.4	20.6	50.0	20.6
Catholic	1.5	12.1	28.8	40.9	16.7
Muslim	6.9	20.7	37.9	24.1	10.3
Other Christians	0.0	12.8	33.3	38.5	15.4
	<i>p=0.275</i>				
<b>Level of education</b>					
None	1.7	11.2	30.2	40.5	16.4
Primary	3.9	8.5	28.7	41.1	17.8
Post primary	7.4	11.1	31.5	31.5	18.5
	<i>p=0.758</i>				
<b>Marital status</b>					
Single	3.8	13.2	34.0	35.8	13.2
Married	3.6	8.9	28.1	40.6	18.8
Ever married	3.8	11.5	34.6	34.6	15.4
	<i>p=0.925</i>				
<b>Occupation</b>					
Peasant/farmer	3.2	9.6	29.3	43.9	14.0
Business	3.6	8.9	33.9	33.9	19.6
Employed	7.1	10.7	14.3	35.7	32.1
House wife	3.2	6.5	29.0	41.9	19.4
	<i>p=0.627</i>				

A large percentage of mothers had at least sought and received antenatal care (91.7%). More than half of them (53.3%) had started their routine antenatal care between three and four months of the pregnancy (recommended period). Whereas no significant relationship was found between most of the socio-demographic characteristics and utilisation of antenatal health care services, the study found a significant relationship between the zone of residence and utilisation of antenatal care ( $p=0.003$ ). The women in Juru had sought antenatal care for up to four and more times (recommended number) compared to women in other zones (Base and Rubondo).

The qualitative findings, however, revealed that some antenatal health care services such as obstetric scans are not provided to refugee women due to a lack of technical equipment in the settlement health centres. One of the key informants affirmed this challenge:

*We lack this equipment, let's say ultrasound scan. Because a woman may be having a problem, you try to palpate, you observe, you feel something is in the uterus- you are not sure- you want to confirm with the ultrasound scan. So you have to refer to Mbarara. And you find sometimes we have ambulance here we always refer them to Mbarara for investigations. Then when you refer, they reach Mbarara they disturb them and then they come back without being worked on, then they go back the following day. (Clinician MTI, Rubondo)*

This equipment's absence is detrimental to the health of women and children. Both the refugee women and key informants expressed concern over the risks brought by lack of such medical equipment, for example, some refugee women give birth to children during transit to other health facilities that are outside of the settlement, such as Mbarara Referral Hospital.

#### Childbirth care

Childbirth services considered include actual places where mothers delivered their babies, physical examinations of mother and their new-borns, emotional support after childbirth and provision of vitamin A supplements. A large percentage (92.4%) of the respondents had their most recent delivery at health facilities and with the assistance of professional medical doctors compared to only 7.6% who delivered their babies from other alternatives such as traditional birth attendants, relatives, or self. The findings revealed no statistically significant relation between the zone of residence, religious background, level of education, marital status and type of occupation and the level of utilisation of delivery services among the participants. Nonetheless, clear differences were observed in relation to the level of education. The women with no education (10.2 %) used the services of non-medical practitioners as compared with those with primary and post-primary education.

Similarly, participants living in Base camp depended on non-medical practitioners more than those in other zones. The barriers to access and utilisation of health services such as delivery services will be explained in the next chapter. Nonetheless, one key informant stated that women were discouraged from accessing childbirth services:

*During childbirth like when somebody is pregnant yeah, sometimes they would make the situation hard by not attending to the pregnant mother but nowadays, because of should I call it complaints of women and children, they are improving step by step... most especially when the situation has worsened, that's when women can be attended to, when the situation is not yet bad they take long to attend to someone. (Refugee women's leader)*

This explains that refugee women endure bad treatment from the health workers during deliveries. Despite complaints, the quality of childbirth services in the settlement is lacking. This was also reiterated by a refugee man:

*When they [women] come here at the hospital, sometimes they [health workers] care for them, sometimes they don't care for them. Even there are some children who can die because of carelessness... Sometimes when they come, when a woman wants to give birth sometimes they can call the nurses, they can come at their pace, they are not very quick so sometimes there could be some complications on that woman. (Male Congolese refugee, Rubondo)*

On the other hand, there was a significant relationship between the age of the respondents and the level of utilisation of professional medical services (0.002) and the same scenario was observed between the participant's nationality and professional medical service utilisation (0.007). Women characterised as racially 'Other' (Somali, Ethiopian, Tanzanian and Eritrean) used more services of non-medical practitioners. This was also exposed by a key respondent:

*I don't remember if they are Burundians or Congolese who were saying that they don't want to go and deliver from the health centres because they don't give them the placenta. Ehm, maybe that comes from their home countries, such traditional beliefs; how they want to treat the placenta when the mother gives birth, or they take it [and] bury it somewhere. (Community development officer, FRC)*

Despite complaints about discrimination, this statement demonstrates that refugee women also have beliefs that discourage them from using professional childbirth services. Table 6.8 represents the differentials in access to and utilisation of childbirth services among refugee women.

Table 6. 8 Differentials in access to childbirth services

	Medical practitioners (%)	Non-Medical practitioners (%)
<b>Zone</b>		
Base	89.9	10.2
Rubondo	90.7	9.3
Juru	96.9	3.1
		<i>p=0.119</i>
<b>Age</b>		
18-24	98.3	1.7
25-29	93.4	6.6
30-34	95.7	4.3
35-39	89.9	11.1
40-44	96.2	3.8
45+	76.9	23.1
		<i>p=0.002</i>
<b>Nationality</b>		
Congolese	94.9	5.1
Nyarwanda	93.0	7.0
Burundian	90.0	10.0
Others	69.2	30.8
		<i>p=0.007</i>
<b>Religion</b>		
Pentecostal	93.9	6.1
Protestant	94.4	5.6
Catholic	90.9	9.1
Muslim	91.7	8.3
Other Christians	87.2	12.8
		<i>p=0.656</i>
<b>Level of education</b>		
None	89.8	10.2
Primary	93.1	6.9
Post- primary	96.4	3.6
		<i>p=0.281</i>
<b>Marital status</b>		
Single	92.7	7.3
Married	93.6	6.4
Ever married	88.1	11.1
		<i>p=0.506</i>
<b>Occupation</b>		
Peasant/farmer	91.5	8.5
Business	91.5	8.5
Employed	100	0.0
Housewife	90.6	9.4
		<i>p=0.419</i>

## Maternal complications

There were reports of complications after birth among refugee women. This is due to existing challenges in relation to access and use of professional medical services concerning birth. Figure 6.3 represents the common complications reported by refugee women.

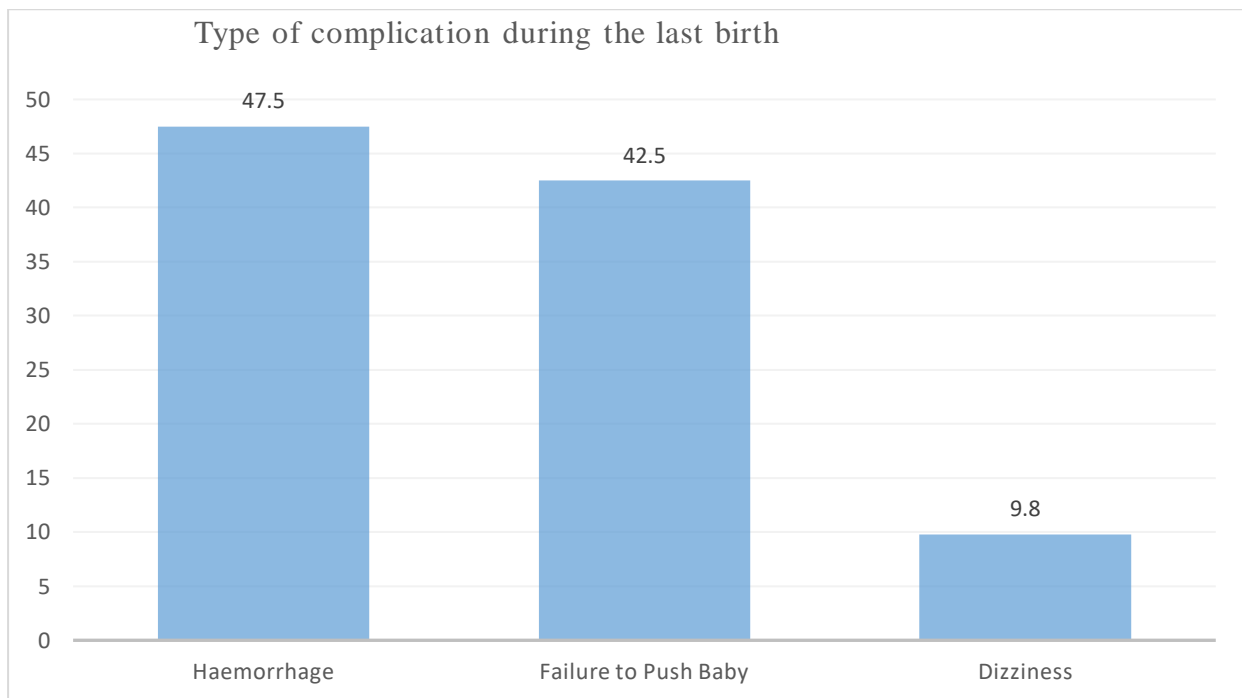


Figure 6. 3 The common complications during birth

Figure 6.3 illustrates that haemorrhage, failure to push children and dizziness were the common complications experienced by women during childbirth. Another complication related to childbirth was fistulae.

## Fistulae

Fistula is an abnormal opening between organs especially between the bladder and vagina or other body organs. The women who suffer from this condition often get urine and faeces to leak through the vagina and contract a bad body odour. A substantial (42.5%) number of women reported problems of failure to push children. This leads to tears and explains the existence of fistula among women particularly those who do not seek professional childbirth

care. Fistulae were seen to be common, especially among the Somalis, as a key informant explained:

*The Somali community has more people with paralysis- cerebral paralysis, developmental disorders and issues of fistula. The health concerns in that community about those health issues will be higher...because one, Somalis have a higher rate of early marriages than the rest— at thirteen years or a twelve-year-old having to bear a child at that age, they have many of those issues. And to make it worse they are a silent community. (Assistant counsellor, OPM)*

However, another key respondent diverged from this view and suggested that fistulae cases cut across the refugee women irrespective of nationality and background:

*Fistula is [a] very common condition here, before, we thought it was not there but when we started digging much deep into the community, we found that there exist a number of fistula cases... it's actually across...if you look at all that trend of movement, you know when there is war, there is always disruption in most of the services, so the same health services are disrupted, so and pregnancy doesn't have time, by the time they are moving they could already be pregnant or they may be expecting by that time, so imagine somebody moving through the bush and doesn't have care or doesn't have any available services to take care of. They would start the obstruction and then take more time, so obstruction during their flight is the main cause of most of the fistula you see in refugee settlements. (General medical practitioner, Nakivale Health Centre II)*

This denotes vulnerability caused by disrupted access to care especially during flight. The narrative is indicative of similar risks across refugee women because of similar experiences (such as war violence, forced movement and disrupted access to health care). However, some of the complications which women are exposed to can be minimised or even avoided if they get access to the needed services such as prenatal and post-natal care. In the next section, I examine access to and utilisation of postnatal care among the respondents.

#### Postnatal care for mother and baby

Postnatal care is important to prevent both maternal and neonatal (new-borns) death, as well as long-term complications. This study examined accessible post-natal services such as physical examinations of mothers before discharge, breastfeeding support and vitamin supplements for nursing mothers. A large percentage (71.6%) of participants who had given birth indicated that they received post-natal health care. The women who gave birth at home (7.1%) received support from traditional birth attendants (2.2%), relatives and friends (4.6%) while some did not get support (0.6%).



### **Refugee mothers and their children at Rubondo Health Centre II**

Access to and utilisation of post-natal health services was determined by analysing responses of women in relation to the support they and their new-borns had received from the professional staff such as midwives, doctors and community health workers. These include screening in the first seventy-two hours after delivery and support with breastfeeding. There was no statistical significance between utilisation of post-natal care services and any of the variables that were used to assess it. Table 6.9 presents levels of utilisation for postnatal health care services among refugee women.

Table 6. 9 Levels of utilisation for postnatal health care services

	No of women	Percentage (%)
<b>Zone</b>		
Base	80	70.2
Rubondo	64	71.9
Juru	69	72.6
		<i>p=0.921</i>
<b>Age</b>		
18-24	44	77.2
25-29	40	67.8
30-34	44	66.7
35-39	36	73.5
40-44	18	75.0
45+	28	71.8
		<i>p=0.807</i>
<b>Nationality</b>		
Congolese	118	69.4
Nyarwanda	33	76.7
Burundian	55	74.3
Others	8	66.7
		<i>p=0.712</i>
<b>Religion</b>		
Pentecostal	64	67.4
Protestant	51	73.9
Catholic	48	77.4
Muslim	25	71.4
Other Christians	24	66.7
		<i>p=0.651</i>
<b>Level of education</b>		
None	87	72.5
Primary	87	70.2
Post primary	39	72.2
		<i>p=0.913</i>
<b>Marital status</b>		
Single	36	70.6
Married	136	70.1
Ever married	40	78.4
		<i>p=0.490</i>
<b>Occupation</b>		
Peasant/farmer	104	66.7
Business	41	74.5
Employed	23	79.3
Housewife	22	75.9
		<i>p=0.388</i>



Apart from the management of communicable and non-communicable diseases, women's health is also influenced by access to proper diet and nutrition. In the following section I examine the status of nutritional health in NRS.

#### *6.1.4 Nutritional health*

Nutrition is a very important determinant of health. This study found that accessing food in the settlement was a challenge especially for pregnant women, single mothers and children. Poor nutritional conditions for women and children made them susceptible to micronutrient deficiencies, such as anaemia and iodine deficiency disorders. Iron deficiency anaemia comes mainly as a result of menstruation and pregnancy and the iron demands of lactation. Iodine deficiency disorders can lead to other health problems and goitre. For pregnant women, it can have effects on the unborn baby. Evidence suggests that these problems are severe in camp conditions where women have no access to essential food supplements (WHO, 2015). This exacerbates malnutrition levels in women as they miss out on their share of the limited resources. A nutrition survey in camps and settlements in Uganda done by UNHCR revealed that two-thirds (63%) of the surveyed camps and settlements showed global acute malnutrition (GAM) levels of 10% or more among infants and children aged 6-59 months (UNHCR 2014, p.48). Likewise, many households in Nakivale settlement survive on a single meal (65.8%) a day. Different reasons such as poverty, limited food rations, and lack of land for cultivation were responsible for such inadequate food intakes among women and children (UNHCR, 2019). The participants were concerned about the amount of food (6kgs) which they received per month. Moreover, some women from the Somali community complained about receiving maize flour which is not their staple diet:

*The food we get is not enough, it is small and the other thing is that Somalis-most of them, -all Somalis, are used to eating rice, spaghetti made from wheat flour. The maize is disturbing us a lot because we don't know how to eat; we can eat if we are hungry. (Somali woman, Base Camp)*

Due to the unavailability of familiar or even sufficient foods, refugees cope with eating for survival, not nutrition.

Other studies have explained the root of nutritional challenges from the 'male-centred paradigm' which governs response to survivors of warfare (Comas- Diaz and Jansen, 1995). This indicates that food rations are often distributed to male heads of households who tend to

eat first before women and girls (Deacon and Sullivan, 2009). A slightly similar scenario was echoed by one of the key informants in this study who explained that:

*They dig [plant crops] but the men sell off these things. So you find someone has this season got her beans to take care of the children but the husband got everything and sold [it], those are the cases which are just there, at OPM and Police. (Counsellor-MTI)*

This denotes a big challenge in families because as women make an effort to find alternatives to complement the inadequate food rations, they do not completely get support from their partners.



### **Food distribution point in Base Camp III**

The next section explores the second key theme of refugee health which emerged from quantitative and qualitative data, adolescent and youth health and well-being. Although this study did not directly engage refugees below Uganda's age of maturity (18), youth and adolescent health issues developed out the data analysis. These are considered in the next section as these influence the emotional, behavioural, and physical health of young people.

## 6.2.0 Adolescent and Youth Health and Well-Being

The World Health Organisation (WHO) defines adolescence as a phase in life between childhood and adulthood, in which individual experiences physical and psychological changes with enormous changes in social interactions and relationships (WHO, 1993). Adolescence is the stage between the ages of 10 and 19 years, and youth-hood refers to the period between 15 and 24 years; both these categories are referred to as young people—10 to 24 years (WHO, 1993). Young people's growth and development is largely influenced by the sociocultural environment in which they live (WHO, 1993). For example, as the main source of material and moral support, the family has a profound influence on the health of individuals. If this structure is altered or undergoes sudden change then the individual health of young people is also affected. In the settlement, however, the stability of the family has been seriously threatened by the rising numbers of men who abandon women with children. This has consequences on the health of young people in different ways. This section examines parenting issues, exposure to child sexual abuse and harmful practices such as early marriage and female genital mutilation as social and public health concerns affecting large numbers of young people.

### 6.2.1 Parenting

Parenting involves various activities which are done by parents or guardians. Parents and families have to direct and guide their children to grow and learn to be responsible adults. Jackson (2002, p.245) describes parenting as 'the performance of all actions necessary to promote and support the physical, emotional, social and intellectual development of a child from infancy to adulthood.' Both quantitative and qualitative data showed a high number of single-mothers in the settlement. The problem of single motherhood was also revealed by a key informant:

*We have big numbers of single mothers who are helpless and which scenario of being helpless puts them in high vulnerability corner and that high vulnerability also comes with its own accompanying effects. (Senior official, OPM)*

Nearly half (150, n=377) of the ever-married women indicated that they were not living with their husbands at the time of the survey. Yet only 70 (n=377) of these were widows, separated or divorced. A significant number of refugee women expressed their grief and communicated that their husbands had deserted them and married other women in the camp. Nonetheless, out of the 377 women sampled, only 24 (6.4%) did not have children. This is illustrative of the

problem of single motherhood in the camp which has a negative impact on the health of young people.

Single parenthood combined with poverty affects childhood experiences. This finding is in keeping with the findings of Wachter and colleagues (2016), who found that Congolese refugee women resettled in the United States were struggling with parenting responsibilities as single parents with household management alongside full-time jobs. Importantly, the refugee women in the current study did not have a sustainable means of support to enable them to feed or to provide material and moral support for their children. As a result of this, large numbers young of people in the settlement were seen moving in groups and idle, with some presenting behavioural problems such as fighting and use of abusive language.

In addition, the poor socio-economic conditions in the settlement also make many parents ill-equipped to prepare their children to mind their own health and well-being. This was expressed by several key informants:

*They are many children you will find in this community with jiggers. It would be because of the responsibility of their parents some of them are not following up. (Child Protection Officer, HIJRA)*

Another narrative from a key informant was specific to behavioural health concerns among children:

*We don't know how these young kids are going to behave because they are exposed to each and every evil... Like now, here, you go to a family when you reach you will ask, (now they are doing house to house immunisation), the mother will tell you, I have five kids, you find there is one and she will not know where the others are. You see them coming in the evening, where they have been, what they have done they don't know! (Enrolled nurse MTI, Juru Health Centre II)*

These narratives indicate the consequences of inadequate parenting and how they impact child growth and development. There is particular emphasis on the negative influence of the camp environment on children. Due to the lack of attention and supervision by parents, many children cope by looking for distractions somewhere else. Similar to Kanya (2017, p.229), children in these settings are exposed to severe harm that is not only likely to stay beyond childhood but also probably affects the next generation. Research supports the relationship between adversity experienced through initial years of life and developmental and long-term health problems (McDonald et al., 2016).

As the objective of this study was not to understand how the settlement environment influenced parenting and how children felt about the support they received from their parents, I did not

interview children. However, Paardekooper et al. (1999) conducted a study in which they interviewed 316 south Sudanese children in refugee camps and settlements in Northern Uganda. Compared with a group of 80 native Ugandan children, the south Sudanese children complained of a lack of emotional support, socialising and material support from their parents, family and friends (Paardekooper et al., 1999). This is not surprising based on the trauma which the parents themselves experience yet the set out of the settlements is also not child-friendly since the camps are extensive and crowded (ibid). For example, in NRS, many young people have dropped out of formal education because of the lack of schools. Part of the problem is that the settlement has only one secondary school serving all three zones, making it difficult for some children to access it. However, analysis of my interview and observational data also indicates that children lack moral support from their parents or even role models to support them stay in school. In addition to inadequate parenting and child neglect, child sexual abuse is widely regarded as a serious social and public health concern that affects large numbers of young people in NRS.

### 6.2.2 Child sexual abuse

According to the Convention on the Rights of the Child (1990), children have the right to be protected from any form of violence and sexual exploitation. However, many young people in the settlement are vulnerable to child sexual abuse from adults and fellow children. This is mainly caused by high exposure to sexual acts from their parents, strangers and fellow children especially because of limited space for accommodation. Several key informants revealed this type of vulnerability:

*They build this small house, the mother and the father are sleeping here, the kids are sleeping here, they are playing sex when the kid-they think kids have slept but they are seeing them, now when they go to school they say let me show you what my mother and my father were doing last night. Sometimes during the day, the kids are seeing them. (Enrolled nurse MTI, Juru Health Centre II)*

This shows how parents expose their children to sexual acts. Moreover, a specific, and direct, exposure was said to be happening to step-children, typically men abusing children from their partner's previous relationships.

There were reports of child exposure due to the existence of child-headed households. This is a particular problem for children who are separated and unaccompanied. The same key informant also revealed this type of exposure during the interview:

*There are some child-headed households in the settlement- some children are there, they don't have their parents- they are just staying alone when they are boys and girls. (Enrolled nurse MTI, Juru Health Centre II)*

This shows that unaccompanied children who end up living alone are at a greater risk of child sexual exposure. This is due to a lack of parental protection. These testimonies also reveal abuse of children's rights which affects their health and well-being. Child abuse, violence and exploitation in homes is widespread due to existing practices, attitudes and customs especially in the rural parts of the country (Ochen et al., 2017)

### 6.2.3 Early marriage and other harmful practices

#### Child marriage

Child marriage is the union of children, especially girls with men who are much older than them. Early marriage is a significant public health concern for adolescent girls in NRS. This is particularly driven by socio-economic reasons especially poverty. It is associated with various effects on children's health such as increased risk for sexually transmitted diseases and childbirth complications, especially obstetric fistulas as well as an increased risk for intimate partner violence (Mourtada et al., 2017). Adolescent girls in NRS are married off at increasingly younger ages to secure money for basic needs. One twenty-one-year-old woman narrated a terrifying ordeal in which girls in the settlement are traded for material things such as alcohol or even used to settle debts:

*One [parent/responsible adult] can go into the bar and drinks [alcohol], someone [stranger] gives her- him some beer then he sells her young girl. Then after the man comes and takes the girl by force because her father has drunk the money. (Burundian woman, Rubondo)*

This was reiterated by a key informant:

*With [the] Somalis, I can say that their culture is a little bit different and so that makes the women susceptible in a way that they believe...young women are supposed to be married –say a[s] virgin[s] and whoever has sex with a virgin girl, there is a way he praises himself... So you find a very old man because he has money, [he] comes for this*

*girl and the parent has no reason to say no because that is tradition. (Community development officer, FRC)*

This reflects arrangements between adults to exchange their children for material things but also because of gender inequality. The implication for children is that this leads to changes in roles from childhood to adulthood or parenthood when they give birth (Kamya, 2017). Further, child marriage is also associated with high school dropout among young girls (Mourtada et al., 2017). This affects them because programmes for developing adolescents are assumed to be targeted through primary and secondary schools (NPC, 2018). This finding replicates studies that were done among Syrian refugees in Lebanon and Jordan (Mourtada et al., 2017; Abdulrahim et al., 2017). For instance, Mourtada et al. (2017) state that there are higher risks of child marriage among Syrian refugees in Lebanon. They argue that although child marriage was a common practice in pre-conflict Syria, this practice is exacerbated by displacement-related factors such as feelings of insecurity, the worsening of economic conditions, and disrupted education for adolescent women (Ibid, p.53).

#### Female genital mutilation

Despite the existing Female Genital Mutilation (FGM) Act of 2010 which criminalises female genital mutilation and protects women and children from all harmful cultural practices (Ochen et al, 2017), young people in NRS are still being exposed to various harmful practices including FGM. These are normally inflicted on them by their parents, caregivers and even strangers, are done for cultural, religious, economic, political, or other (sometimes selfish) reasons. This was revealed by the key informant:

*For the case of Somalis, in fact, most of them, there is this, how do they call it? This activity in Bagishu<sup>21</sup>, where they circumcise ladies, is still happening, but it's very hard to find out because for them they rarely report... even if 'you' report a case like [that] at police, for them, they organise as a group, they go there [and] talk to 'you' and maybe convince 'you' to withdraw the case.(Community Service Assistant, OPM)*

Apart from this, young girls are also vulnerable to abusive acts by their parents so that parents secure grounds for resettlement. Nakivale is one of the settlements under the resettlement programme of the United Nations High Commission for Refugees (UNHCR). During interviews, many women (including those who were not part of the sample) wanted to know

---

<sup>21</sup> This is a particular ethnic group in Eastern Uganda which practice circumcision of adolescent boys.

what I was doing. When I explored this, I established that any visitors in the community were assumed to be registration officers for resettlement. The key informants revealed that the resettlement programme considers women and children as vulnerable and that many countries where the refugees are resettled such as Sweden, Canada, USA among others, easily accept women and children. Moreover, 36.8 % of the participants proposed the need for resettlement to developed countries. Although this is a genuine need given the socio-economic challenges (Ikanda, 2018; Papadopoulos, 2008), the desperate need for moving to developed countries sometimes put the lives of children at the danger of being abused by their parents with the ultimate objective to put forth a non-questionable case of vulnerability. For instance, some children are physically injured and at times defiled. Despite the fact that children may lack knowledge about the causes of these acts, this is done at times with the connivance of their parents. In an interview with an enrolled nurse, she echoed the practice of mothers scratching their girls in the reproductive organs so that these can report to UNHCR and get resettlement. She stated that,

*Those people who want to be taken outside for resettlement, so you find some even tell lies, a person comes to 'you'; that 'they have defiled my daughter or they have raped me' and in the due course when 'you' are checking, trying to do an examination, 'you' find they have even scratched a young girl, that child was not raped... when 'you' are examining 'you' find a child is ok and is just scratched, when 'you' try to ask a kid -if a child can talk, later when the parents are outside, the child can even tell that 'no it is my mother who scratched me'. (Government enrolled nurse, Nakivale Health Centre II)*

This statement shows the application of desperate measures to achieve decent protection through resettlement. Parents extremely harm their children so that they can claim protection in the form of resettlement to other countries where they hope to find financial security. Abusive behaviour and acts of parents and others towards children have a significant impact on the growth and development of children. Brandon (2000) asserts that children who face significant harm normally develop a distorted view of self and others because they find it hard to view others as reliable sources of security and comfort. Moreover, there is evidence specifying that childhood adversities like those resulting from domestic violence, structural and collective violence in conflict or refugee settings lead to mental health problems among children (Reed et al, 2011). However, other childhood studies suggest that even if cases of child sexual abuse exist, the structures where victims report are often not helpful and the burden of proof for such cases is prohibitive (such requiring expensive medical examinations) which



leaves such crimes unabated (Ochen et al, 2017). In the following section I examine the status of children's health in NRS.

### 6.3.0 Child Health and Development

This is another key theme of refugee health which developed from quantitative and qualitative data. It is estimated that more than 60 percent of Uganda's refugees are under the age of 18 (UNHCR, 2019). McDonald et al., (2016, p.21) identify risk factors which compromise children's growth and development including biological risk factors (such as, stunting, infections, anaemia,) psychosocial risk factors (inadequate cognitive stimulation, exposure to violence, household dysfunction) and sociodemographic risk factors (poverty)

This displays the need for efforts to provide families with children the support to achieve good health outcomes. This section addresses immunisation coverage, responsive caregiving and stimulation, treatment and management of childhood illness and concerns of unaccompanied and separated children.

#### 6.3.1 Immunisation

Prompt childhood care has significant implications for the growth and development of children. Providing support to refugee women with young children is important for them to have good health and well-being. For instance, vaccination services are important for children to achieve physical, mental and social well-being. The study sought to investigate the availability of immunisation and vaccination services for children in the settlement. Every child has a right to be immunised against fatal diseases based on country recommended doses. In Uganda, universal immunisation of children is recommended against the eight vaccine-preventable diseases including tuberculosis, diphtheria, whooping cough, tetanus, hepatitis B, influenza, polio, and measles. Women were asked if they had taken their children to receive vaccines during national immunisation day campaigns and whether children had been given medicine for intestinal worms. A large percentage (93.7) of women had taken their children for routine immunisation and vaccination services. Two key informants stressed the significance of administering vaccinations:

*Immunisation is done across the board. I think every year they immunise. (Senior official, OPM)*

*When it comes to immunisation, it is mandatory. (Community Development Officer Finish Refugee Council)*

These testimonies indicate a universal policy on vaccinations for the children. Figure 6.4 illustrates the percentage of women who had taken their children for routine immunisation and vaccination services

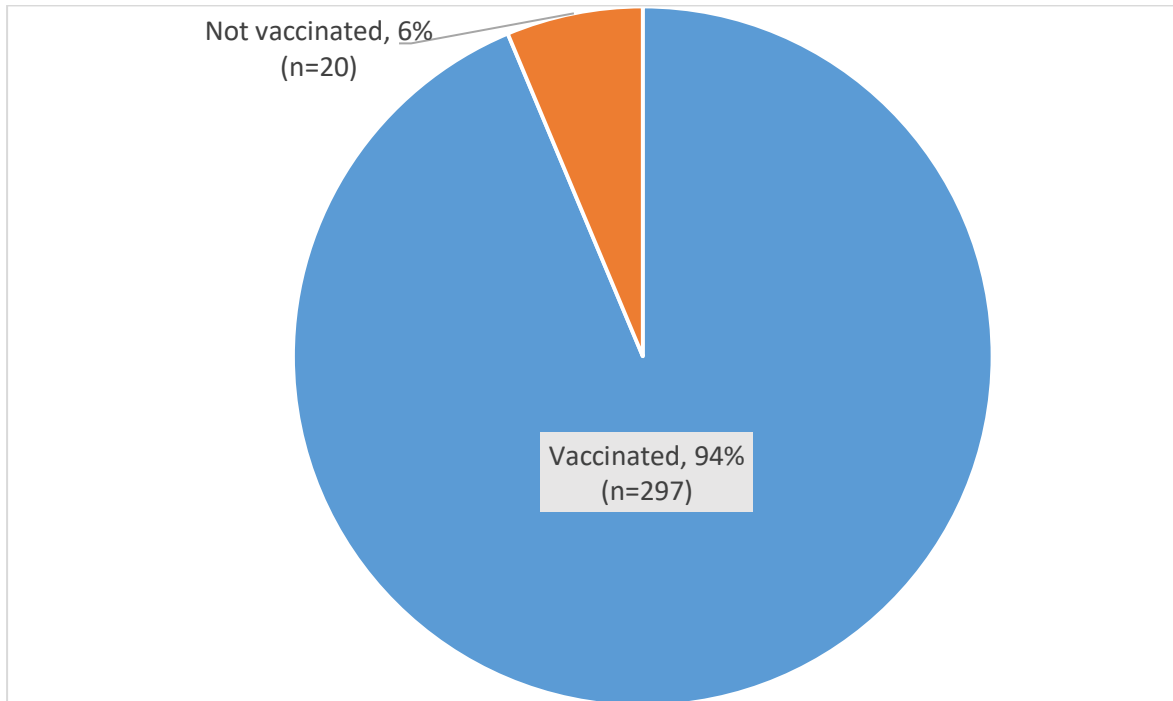


Figure 6. 4 Vaccination of children against diseases in the last 12 months

Despite these universal and routine immunisation campaigns, the children are nevertheless exposed to illnesses especially those associated with poor hygiene and sanitation including water-borne diseases such as typhoid, and diarrhoea. The prevalence rate for diarrhoea is high with children facing recurring episodes of acute diarrhoea. Statistics indicated that at least 15% of the refugee women had children suffering diarrhoea in the last two weeks before the survey. These were summarised by a clinician who stressed that out of the ten children they review each day at least four must be suffering from acute diarrhoea.

*Most of them have skin infections, wounds, skin rashes and they have upper respiratory infections, there are affecting them seriously because even you cannot spend two days without admitting a child with severe phenomena, then also there is a lot of diarrhoea... acute diarrhoea... diarrhoea and vomiting, if you see like ten children you have to get at least four of diarrhoea. (Clinical Officer, Rubondo Health Centre II)*

This shows the magnitude of the childhood illnesses among children in the settlement despite the fact that there is a universal policy for immunisation against these lethal diseases. Research indicates that refugees are at risk of not being effectively vaccinated, due to circumstances in their countries of origin and impediments to catch-up immunisation after arrival in their destinations (Paxton et al., 2011). A study which examined the immunisation status of recently arrived East African children and adolescents in Australia, found that almost all (97%) of the children had incomplete or unknown immunisation status based on parent report and vaccination records (ibid, p.888). Although the women in this study were not specifically asked for vaccination records, many of them came from poor countries where vaccination coverage seems to have been low due to political and social instability. Similar Paxton et al., (2011) the respondents reported several barriers to access and use of health services (See next chapter) which point to vaccine shortages /stock-outs.

The other extreme infections among children are skin infections such as skin rashes and wounds and upper respiratory infections.

### 6.3.2 Treatment and management of childhood illness

Apart from immunisation, other paediatric care for sick and injured children is not available in the settlement. This results in many undiagnosed cases and a majority of women I spoke with resorted to traditional or any readily available services from fellow refugees. A respondent described their methods and resources for managing acute conditions of children:

*Something comes like a tooth then [...]it will develop a maggot then a child dies, at the hospital they don't treat those but then when you go to local people in the community, they remove them, you find the child is okay but if you don't remove it, the child will have diarrheal, the child will vomit, will have fever. (Congolese woman, Base Camp)*

Support for mothers with young children, especially those with complicated illnesses, is practically non-existent. This was reiterated by a key informant:

*Then with regards to children which is another vulnerable population, we see limited access to basic childhood friendly services which include appropriate nutrition, which include appropriate paediatric related. (Senior official, IOM Uganda)*

These two quotations make emphatic the challenge of accessing paediatric services. Moreover, some respondents explained how their children suffer from untreated injuries while others are struggling to care for children who have disabling conditions. The next section addresses the issue of responsive caregiving and stimulation for children.

### 6.3.3 Responsive caregiving and stimulation

One of the approaches to meeting children's physical and mental needs is to provide them with responsive care. Responsive care involves observing children's cues and discerning their implications. This leads to effective and sensitive responses to children. The study finding that a large majority of the women in the study had experienced unwanted pregnancies is very important when seeking to understand the children's vulnerability in the settlement. Forced pregnancies were found to be key triggers for child abuse there, especially for those born to unconventional relationships, such as children of rape. Such children are often unloved by either one or both of the parents. In most cases, women thought of these children as reminders of the horrible experiences of torture which they went through. The other respondents explained that children born to rebels ruined their relationships/marriages. Women explained that their husbands labelled these children as intruders in their families and considered them to possess violent characteristics of their 'rebel fathers.' As result, they demanded that these children leave their families. These children face verbal abuse and are denied the opportunity to play with their half-siblings. Other participants revealed that their partners regard taking revenge on these children, for instance, they abuse them sexually, physically and emotionally. One of the respondents with a child born out of her marital relationship stated:

*That child is not his- he is not his biological father, so he got insane and cruel and got that child and-and tried to harass him sexually through his mouth and his private parts [she starts to cry]. (Congolese woman, Juru)*

These children are a unique category of vulnerable children because they are not cared for and catered to in most health services provided in the settlement. This is also because they have no one to speak for them.

Although childhood should constitute the fulfilment of both parental and child obligations (Kamya, 2017), many of these children are neglected in terms of feeding and are denied parental love which affects their growth and development. A key informant explained why the children who are born out of rape are at high risk of being abused and neglected:

*Children born out of rape are actually at risk because put yourself in her shoes, she was raped by rebels but she has a husband, even when she was raped this child is her child but the child is constantly being chased away by the husband- this is a child, this is a daughter or a son of a rebel. (Protection officer/ Counsellor, ARC)*

This clearly shows that this category of children experience torture and are highly vulnerable. They are also neglected because women in the settlement mainly care for children. Where the

women were also not concerned many cases of child abuse were hidden. In the photo, is a barely dressed child with two jerry cans (twenty-litre capacity), hastening through a heavy downpour to reach the water point.



### **A child with two jerry cans**

The children are also susceptible to abuse from strangers. This is partly because existing conflicts among adults and hence children become victims because they are the easy targets. Children are also targets because adults (women) leave them in homes and go to find part-time work, such as farming for local Ugandans or washing clothes of fellow refugees. In the following photo, a Somali mother shows her four- year old daughter's scars. This single mother of seven children disclosed that her daughter had been physically abused by a neighbour who poured hot water on her. At the time of this incident, the mother had gone to sell clothes around

the settlement. She explained that even when these wounds seemed healed, her child does not sleep well because of the painful scars. One of her other children had also been sexually abused.



### **A physically abused child**

The other category of vulnerable children is those who are unaccompanied or separated from their families most especially during flight and I examine this in the subsequent section.

#### *6.3.4 Unaccompanied and separated children*

Though at times children survive death during armed conflict, they sustain emotional scars and psychosocial trauma due to direct contact with violence, displacement, poverty and loss of family (Kamya 2017). Similarly, refugee children in NRS are separated from their families especially during an emergency. This was revealed by a key informant:

*We have the unaccompanied children, we have separated children, then we have the children at risk...they have very many problems...[the] majority of them arrive with health needs. (Child Protection Officer, HIJRA)*

These children unaccompanied by their families are the most vulnerable to exploitation and abuse. This also stated by another key informant:

*These days I have been interacting with the children who are- the girls who are defiled... One of them told me, 'I don't love him but at least he was honest he kept his promise, he promised five thousand every night I sleep at his home.' This is already a child mother at fifteen years and she is already pregnant... and she is, of course, an unaccompanied minor (Protection/ Counsellor ARC)*

With the loss of the basic pillar of social support, young girls are sexually exploited while attempting to secure money for basic needs. Abuse of children's rights deprives them of their childhood in terms of surviving, growing and developing into responsible adults (Kamya, 2017).

The next section explores another key theme of refugee health which emerged from quantitative and qualitative data, gender-based violence, abuse and torture among women and children

#### 6.4.0 Gender-Based Violence, Abuse and Torture Among Women and Children

According to the WHO, violence is one of the most ignored determinants of health for women and children as worldwide, they bear the brunt of non-fatal physical, sexual, and psychological abuse (WHO, 2015). Almost every participant had gone through some kind of experience which can be deemed as life-threatening such as psychological torture (53.3%), domestic violence (46.7%), physical torture (35.7%), sexual exploitation (25.2%), forced marriage (12.2%), forced prostitution (7.8%) and female genital mutilation (4.3%). A majority of the refugee women had experienced acts of violence, torture and abuse most especially in their countries of origin and also continued to face violence, insecurity and abuse within the settlement. Figure 6.5 presents the percentage of participants alongside the different experiences of violence and abuse.

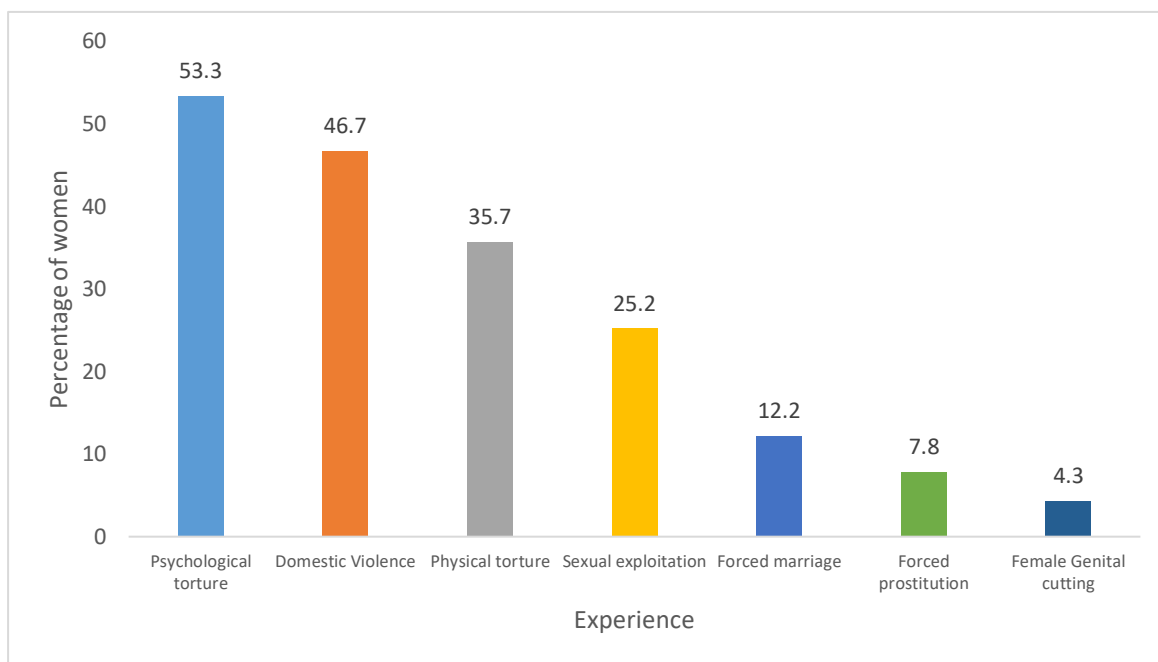


Figure 6. 5 Participants’ experiences of abuse and torture in the countries of origin and while in Uganda [N=377]

#### 6.4.1 Types of gender-based violence and abuse in the settlement

Refugee women in the settlement reported different types of violence and abuse, but narratives of physical and psychological gender-based violence featured in almost every interview. Stamatel and Zhang (2018) state that an intersection of factors such as race and ethnicity, social class, and legal status often disadvantage refugee women and exacerbate their risk of experiencing violence (before, during transit, and after seeking refuge) in the host nations. They report that refugee women in host countries with strong patriarchal values and known for having high rates of violence against women (such as Uganda, Kenya, Pakistan, Lebanon, Iran, Ethiopia and Jordan) are usually subjected to similar structures, cultural inequalities and risks which the local women experience (*ibid*). The effects of gender-based violence on the physical and mental health of women are appalling due to lack of human, social, and cultural capital in their new environments. The common types of gender-based violence and abuse in the settlement include domestic violence, community and peer violence, and sexual violence, including survival sex. Each will be discussed in turn.



## Domestic violence

The quantitative data indicated that nearly half (46.7%) of all the participants experienced domestic violence both in home countries and in the settlement. This is mainly perpetrated by male partners. This finding is congruent with studies of refugees in similar settings (Alsaba and Kapilashrami, 2016; Palattiyil & Sidhva, 2011). For example, in the study of asylum seekers and refugees in Scotland, Palattiyil & Sidhva (2011) report that the female respondents had fled their original homes to escape gender-based violence from their husbands. However, the participants in the current study disclosed that even in Uganda they were still being battered by their spouses. Moreover, a significant majority of those abused (57.4%) had not sought any support or assistance about domestic violence. One respondent stated:

*We work very hard, then we have the violence from the men. The men beat us, they leave us and go to find other women, and leave us at home alone, so we have those problems we work hard alone... women are the ones who go to find firewood which is a challenge here so the woman does not have time to rest, every time we face violence. (Congolese woman, Rubondo)*

This shows that in addition to a heavy workload, they are not appreciated. Instead, their partners abandon them in homes and engage in multiple relationships. A key respondent reiterated this, narrating the type of cases she handles:

*Most of the time when we have cases of men who have abused their wives-it doesn't even have to be physically for us here we have a lot of financial abuse, and emotional abuse- a lot of it. A man doesn't even have to beat a woman here, it happens, but it's not as much as the emotional abuse that's going on. (Assistant counsellor, OPM)*

These accounts point to physical and psychological abuse against women. Domestic violence in the settlement is mainly caused by trauma, high levels of poverty and alcoholism in homes. For example, due to poverty, many households lack food to feed their dependents which increases violence in their homes. The food rations which they receive (3kgs of flour and every other item) per month are not enough yet in other instances, men sell the food in order to buy alcohol. There is also a tendency of selling off the material assistance items which are provided by UNHCR. I observed this practice when I went with the OPM staff on a settlement mission. I observed the officers reading out the names of the new refugees who were on the register. After this exercise, the officers distributed assistance items but as soon as the exercise ended, the refugees (who have stayed longer in the settlement) were set to offer cash to the beneficiaries in exchange for the poles, blankets, utensils and all the material support which they had received. I sought an answer from the OPM staff for such a practice, but she responded

with a sigh *'they do it anyway despite our sensitisation,'* while pointing at those whom she knew as buyers. Some refugees even sell off the land which they are given and descend to renting which is unsustainable and increases their vulnerability. Although this might be considered important to cover other basics and non-food items which are not distributed by UNHCR and NGOs (UNHCR, 2018) in many situations, partners do not agree on these transactions. This results in domestic violence against women and children.



**Kabazana reception centre and refugees waiting for settlement assistance**

These photos were taken during a settlement exercise. On this day I observed the settlement mission, refugees were collected from Kabazana reception centre and transported to Juru camp (settlement place) by agency staff in charge of settlement (HIJRA). I joined the staff of OPM who were in charge of supervision. In the following section, I examine another different but related form of violence, community/peer violence.

#### Community violence/peer violence

Community or peer violence is a type of violence mainly perpetrated by refugees against other refugees who are not related but from the same country. The victims of this abuse are accused of breaching the conventional group values or customary rules such as rules on marriage, divorce or lifestyle. In many cases, this form of violence was happening especially due to group loyalty or group sense. This was found among the Somali community. In other cases, peer violence among refugees occurred due to long-dated conflicts like from their countries of origin or from the previous camps where they lived before moving to NRS. Many women reported cases of communal violence in the form of verbal abuse and ridicule which affected their confidence to be part of the community or to live mentally healthy lives. Some girls even dropped out of school because of peer violence. A Somali woman who was in another relationship by the time of the study explained how she was battling with her former in-laws:

*I came here [rented place] to rent, yeah, they don't want me to stay [in NRS] because they tell me the first children their father died, why did I get married to a second man? (Somali Woman, Base Camp)*

This denotes that when women enter other relationships they are perceived to have violated the cultural values. Similarly, another respondent had to change residence because of the verbal abuse which her daughter was being subjected to:

*Before I was staying in [the] Somali zone<sup>22</sup> but now I changed the place I used to stay, now I'm here in [the] Ethiopian zone. I changed because of the problem of my daughter, [name]...I registered myself to be a refugee in Kenya and I got a card 2008. And they took me 2009 in a refugee camp Kakuma. Since that time I was in Kenya...In 2016 in April, they raped my daughter in Kenya refugee camp. And my daughter became stressed, she is not ok even now. She was studying in secondary school. When I saw my daughter after they raped her and she was not ok, I decided to leave Kenya and came to Uganda. When I reached Uganda, there are people who knew me in Kakuma, we were in the refugee camp together. They are the ones who brought my message here.*

---

<sup>22</sup> Refugees are mostly clustered within ethnic enclaves for instance the Somalis stay in the Somali zone.

*They tell everyone this daughter was raped in Kakuma and two men raped her... she was studying senior three... she said 'I don't want to go school', she says when she goes to school, the students talk about her that she was raped in Kenya... Somalis who are here, who have known about her, they are the ones who went and told students. (Somali Woman, Base Camp)*

This form of harassment is detrimental to both the victims and their families. This is due to stigma, discrimination and isolation associated with it. This shows double jeopardy in the search for refuge (Palattiyil and Sidhva, 2011). In addition to being victims, refugee women are also subjected to the consequences of violence which complicate their lives. This treatment exacerbates the risk of mental health problems among victimised women and girls.

### Sexual violence

Sexual violence describes any kind of unwanted sexual act or an attempt to obtain a sexual act by coercion/force such as rape and sexual assault. Sexual violence and gender-based violence are usually common in conflicts (Wakabi, 2008), and include gang rapes, sexual slavery, purposeful mutilation of women's genitalia, and killing of rape victims. Further evidence suggests that sexual violence is often a serious issue in refugee settlements where women must travel long distances in search of water and firewood (WHO, 2015; Mulumba, 2011). Similarly, women and girls in the NRS are victims of sexual violence especially rape. This is partly due to the rural nature of the settlement with a wide area being covered with bush. The women are trapped by strangers along the routes. The narratives of rape came up in several interviews with refugee respondents and during key informant interviews. One participant who was conversant with the phenomenon due to the nature of her part-time translation job described the high-risk spots in the settlement and the gruesome assaults which women are subjected to:

*There is this valley from Nsangaano-this valley like when you are going from the camp to nationals [host community], you find there are some men who rape women. Others may be going to look for charcoal they are raped... they [authorities] try to investigate but of course because there [rape cases] are too many here, they try but of course, they can't finish it... many women, you find someone comes at the office, you see me yesterday I was going to 'kyalo' (village)-national villages then I met some men like five men raped me, three men raped, like that, you find they are reporting such cases at the police, even in the hospital. When you are going there [Health centre] you meet someone like they are bringing her-that this one has been raped. (Congolese woman. Base Camp)*

This narrative indicates that rape is a routine yet the victims seem not to get justice due to institutional limitations in terms of carrying out the necessary investigations to apprehend the

perpetrators. A key respondent was also very disturbed by the numerous acts of rape and how these impact women and children's health:

*For women and children, actually what I may begin with which is very common and disturbing, it may be this defilement...we've been having that drought, they don't have what to eat, so once they hear there is some free food at the health facility, some of them tend to wake up as early as they can. Take an example at 5[Am], they start walking away from home so that they can reach here fast and they get food fast, so men are tapping them on the way. Even going back maybe they have been here, they are too many, they have finished late so on the way back, they[men] are trapping them there. So they come with those cases, some first keep quiet, later on, they end up coming when they are already positive [with HIV]. (Counsellor, MTI).*

This shows that rape and defilement of girls in NRS proliferates due to vulnerability. The quote also indicates that the factors which make women vulnerable are multifaceted (UNHCR, 2019). Rape violates women's rights, leads to problems such as fistula, and sexually transmitted infections (STIs) and is associated with a plethora of mental health repercussions.

A victim of rape recounted how she got into trouble on the way to her home from one of the towns outside of the settlement. She was raped by a taxi<sup>23</sup> driver, recounting that:

*I was coming from Mbarara, the driver took us to a place called Lugaga, it was raining too much, we were waiting for the rain to stop first. Then the driver told us he wanted to take some people somewhere, he will return to take us. I was remaining alone waiting for the driver, then the driver himself raped me. (Congolese single mother, Base Camp)*

This denotes that the victims also fall into the tricks of their perpetrators but importantly it is due to existing socio-economic challenges that expose the weak targets. Next, I examine the occurrence of survival sex as another form of violence.

### Survival sex

Survival sex in the context of the settlement is a practice of engaging in sex so as to meet daily needs such as food. This mainly takes place at the reception centre where all newcomers live before they receive attestation cards which give them access to the required assistance and services. In an interview with a key informant, she referred to the Kabazana reception centre

---

<sup>23</sup> These are small cars used in the settlement, the drivers usually load these small taxis beyond capacity because these are few and travel less often.

as a *'hub for prostitution'* because the majority of women in the centre engage in commercial sex.

Other women engage in transactional sex based on promises of help, such as in the construction of shelter and providing basic requirements. For example, although they receive building materials such as poles and plastic sheets to put up a temporary shelter, many women household heads lack construction skills. They also lack money to pay for construction, as a result, the refugee men take advantage of these women by luring them into temporary sexual relationships to help them in the construction of the temporary shelter. This was revealed in several interviews with refugee women. One of the respondents described the shortcomings of her survival strategy:

*Because of the bad life that I'm living, I'm forced to have men and they always promise to help me and then when I produce, they reject me. (Congolese woman, Juru Camp)*

Although this clearly denotes self-imposed sexual violence, it also depicts social structural violence against women. Moreover, while prostitution may be perceived as a free choice for some women and girls in order to meet their own needs, for many others prostitution is forced unto them by their intimate partners in order to meet familial needs. This was revealed in a key respondent's statement about the practice:

*Most girls where we put them—that's in the reception centre, most girls indulge in prostitution because that's the only way they can get money, actually, we even heard sadder stories that some husbands also send out their wives to do that...do prostitution and get money for the family. It is that sad. (Assistant counsellor, OPM).*

This denotes that women's bodies are sold and entire families depend on this trade for survival. Conversely, studies elsewhere indicate that refugee women who usually seek refuge for themselves and their families and not in the company of men are sometimes exploited by border guards, soldiers and local officials who demand sexual favours or bribes in exchange for allowing them pass or get the necessary papers, while others are expected to serve as temporary wives for these exploiters (Ewles and Simnett 2003, p.118). Survival sex has long term negative impacts on the health and well-being of women and children.

The next section examines another key theme of the qualitative and quantitative findings, mental health concerns.

### 6.5.0 Mental Health Problems Among Women and Children

Mental health is defined by the WHO as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014)<sup>24</sup>. Mental illness is construed as either a physical disease based on specific signs and symptoms; or as a scientific construct subject to tests of its validity; or as a social construction to regulate societal definitions of normality and abnormality (Onyett, 2000, p.216). According to Ewles and Simnett (2003), mental health relates to an individual’s ability to think clearly and coherently at any given time regardless of the conditions he or she is facing. Refugee populations are more likely to experience mental health problems because they normally witness atrocities, violence and torture, before, during and sometimes even after migration (Papadopoulos, 2008). Refugees, in general, are often diagnosed with post-traumatic stress disorders, psychosomatic disorders, anxiety, and depression (Karunakara et al., 2004; Smyke, 1991; Palattiyil and Sidhva, 2015). The factors which have been found to contribute to depression in women range from infertility, marital conflict, violence, physical and sexual abuse, poverty and lack of social support (Karunakara et al., 2004; Smyke, 1991).

On the same note, poor mental health represents one of the greatest burdens of disease for refugee women and children in NRS. This is because the majority of the women in the settlement have suffered loss in various ways including partners, children, relatives, and property. The women confided that they would hear the voices of rapists who had attacked them or their close relatives before they fled their countries. Others would still hear gunshots while others appeared distracted or had difficulty concentrating even in interviews. One respondent recollected:

*My son, the children he left-back, when they fight, they cry, sometimes children come and ask me, ‘mam where is my father’, then I start crying, thinking about what I passed through. (Somali woman, Base Camp)*

These memories of war and loss and hyper-arousal are all symptoms of post-traumatic stress disorder (PTSD). A considerable number of participants (88.7%) reported difficulties in coping with their disheartening memories.

---

<sup>24</sup> [https://www.who.int/features/factfiles/mental\\_health/en/](https://www.who.int/features/factfiles/mental_health/en/)



Moreover, almost all the key informants confirmed that mental health is a serious threat to refugee women and children in the NRS. One key informant emphatically stated that women experience trauma as a result of violence during their journeys.

*We know the whole concept of change- mobility, that is movement from perhaps what you know to what you do not know has its own psychological effects and [the] majority of the migrants tend to have psychosocial and mental related issues as a result of trauma in the process of migrating but also exposure to violence which is both physical or sexual- sexual induced violence like rape but also discrimination. (Senior official, IOM).*

This statement reveals various causes of mental health problems including forced movement, exposure to violence as well as discrimination. Reports of such discrimination in NRS replicate research findings that refugees often end up being socially and culturally isolated in their new settlements (Carey-Wood et al., 1995; Fernandes and Miguel, 2009).

In addition, some women expressed suicidal thoughts and anxiety disorders, sleep disturbances, impaired concentration and memory loss due both to the traumatic events and safety issues in the settlement (see above). A key respondent also re-affirmed this:

*We are all mad [laughs] but the degree matters but we see many people with mental health problems. Women— they are like five of them with suicidal tendencies and two of them are actually ‘Nalongos’ [mother of twins] ... but she tells you for me the only thing I want is to kill these children. (Protection Officer/counsellor, ARC)*

This shows symptoms of extreme mental illness. Another respondent also disclosed the existence of mental health problems among children:

*In this community, we also have many children who are sicklers [sickle cell disease], mental retardation- those are many- common conditions if you compare with other places, here, there are a bit more. (General medical practitioner Nakivale Health Centre II)*

A previous study of psychosocial challenges among refugee women and young girls in NRS reported a high prevalence of psychological concerns such as trauma, murders, suicide, social distress, psychotic complaints, depression, post-traumatic stress disorder and anxiety (Refugee Law Project, 2015). The study indicated that an average of 60 cases of mental disorders per month was recorded by the main medical service provider—Medical Teams International (*ibid*, p.35). Studies which have investigated the settlement of refugees in the United Kingdom report that in addition to the stress of involuntary migration, some refugees had traumatic experiences as a result of persecution, torture or imprisonment which all aggravated their mental health problems (Carey-Wood et al. 1995; Palattiyil and Sidhva, 2011, Stewart, 2005). Besides,



refugees also experience trauma after settlement due to hopelessness, the absence of employment opportunities and perceived social dysfunction (UNHCR, 2014). Likewise, a combination of environmental and psychological factors contributed to the burden of mental health issues among the participants. Socio-economically, and as I will examine in Chapter Nine, many women lacked jobs and lived in abject poverty. As a result, they showed signs of poor mental health such as depression and anxiety due to the stress of taking care of homes and children.

Psychologically, women struggled to cope with the past and current traumatic experiences of violence, abuse and loss. Violence especially sexual and gender-based is rampant in the settlement and greatly contributed to the burden of mental health problems among refugee women. This is in keeping with the findings of Karunakara et al., (2004), who reported that refugees continued to be targets of violence and experienced high levels of insecurity, attacks and threats within settlements, despite being under the watch of the government of Uganda and the United Nations High Commission for Refugees (UNHCR). They state that the Sudanese refugees they studied, presented with symptoms of PTSD due to continued exposure to violent events (*ibid*, p.91). Likewise, a large proportion of participants (40.5%) in this study felt insecure in the camp.

Yet mental health programming was less pronounced in most of the interventions mentioned by the service providers. Jain and Jadhav (2009) state that the existing mental health services in low and middle-income countries generally face several gaps specifically in terms of assessments. Because of this, there is scanty health literacy surrounding mental health problems among the women which leads to fewer disclosures. Karunakara et al (2004) state that humanitarian organisations pay less attention to mental health problems faced by forced migrants than to physical health challenges. This is because mental health is not easily diagnosed (Palattiyil and Sidhva, 2011; Papadopoulos, 2007). Moreover, due to the stigma associated with mental disorders majority of refugees facing it tend to believe that they can cope without seeking help (Pringle et al., 2011). In addition, it is not uncommon for resettled African refugees to rely on community support and networks such as self-help groups, religious leaders and community elders for support with health problems (Pringle et al., 2011). This is partly important from the cultural perspective given the collective lifestyle and traditions of Africans, however, severe mental health challenges such as PTSD and recurrent depression require professional mental health interventions (*ibid*). Some factors which limit proper

reporting of mental health problems among refugee women is the lack of language skills to be able to describe their symptoms (UNHCR and IDC, 2016). This also limits proper diagnosis and management of the same and exacerbate their vulnerability. Moreover, the organisations working in the settlement lack both the technical and financial capacity to identify, handle and address psychological issues presented by refugees (Refugee Law Project, 2015).

## 6.6 Conclusion

This chapter presented the nature of public health concerns among refugee women and children in the NRS. It also gives an account of the existing health interventions for the promotion of health. The statistical realities and qualitative findings show that multiple factors arising from the environment affect women's and children's health as well as access and use of health care services. More specifically, the determinants of women's and children's health include the social and economic environment, the physical environment as well as individual characteristics and behaviours. By developing an understanding of these realities, this chapter provides a background for understanding the public health needs, vulnerabilities and experiences of refugee women and children in NRS. The next chapter develops a clear picture of the vulnerability by exploring obstacles which impede access to and utilisation of health services.

## CHAPTER SEVEN: MAJOR BARRIERS TO ACCESS AND UTILISATION OF HEALTH SERVICES AMONG REFUGEE WOMEN AND CHILDREN

### 7.0 Introduction

The preceding chapters have shown a detailed account of some of the public health concerns in the Nakivale refugee settlement. I have shown that refugee women and children have specific health care needs arising from the adverse effects of war and forced migration such as violence and persecution, psychological trauma and deprivation. These are also exacerbated by disrupted access to health care before, during and after the flight as well as the unhealthy environmental conditions in exile. In addition, social factors arising from unequal access to opportunities, information, and basic health practices, further increase the health risks for women and children (WHO 2009, p.1). Fernandes and Miguel (2009, p.20) argue that “access to services needs to be broad and integrated, and should include health promotion, disease prevention, treatment, rehabilitation and palliative care.” Informed by this understanding, this chapter provides an examination of the major barriers and/or underlying gaps in health service provision for refugee women and children in NRS. These are discussed under five key themes including communication, institutional, structural, infrastructural and societal challenges and these will be presented in turn.

#### 7.1.0 Communication Problems

##### *7.1.1 Language barriers*

Language is a very important factor which determines provision, access and utilisation of health care services, as individuals need to clarify their problems well and be comprehended by the provider. Once there is a misconception by either party amid consultations and prescriptions, the whole procedure is rendered futile. As I revealed in Chapter Five, the refugee participants spoke 15 languages starting with Kinyabwisha, Kirundi, Kinyarwanda, Kiswahili, Somali, Kirega, Kifulero, Ubembe, Kinande, French, Kiviira, Mashi and Oromo. The commonest among the respondents were Kinyabwisha (31.9%), Kirundi (26.6%), Kinyarwanda (20.2%), and Kiswahili (10.9%). None of these are spoken by most professionals working for government and humanitarian organisations. Both the service providers and refugees recounted the challenges involved in their communications/ interactions. One key informant explained that:

*There is some language problem, and so misunderstandings [happen], maybe, you can go to the doctor and when you don't have someone who can explain your problem in your own language, that is very hard... people can misinterpret, even the doctor can change his [prescription] because he is not understanding what you are saying, so maybe you can get wrong drugs. (Ethiopian refugee leader, Base Camp)*

This denotes that poor communication leads to misinterpretations and misconceptions during diagnosis which eventually causes incorrect prescriptions. Apart from wrong diagnosis, the statement also indicates that limited language skills lead to wastage of time during treatment due to misunderstandings. Another key informant reiterated:

*The basic majority are facing [a] language barrier. This is even for those who've been here for two or three years: they still have difficulties with communicating, but it's worse for the new arrivals. (Senior official InterAid, Uganda)*

This implies that linguistic problems complicate interactions for protracted periods of time although it is more complex for some groups particularly those that are recently settled. This creates a need for interpreters.

### *7.1.2 Insufficient interpreters and utilisation of non-professional interpreters*

Where refugees cannot effectively communicate their needs, language support services are vital to close this gap. In an investigation of the barriers to health and social services among refugee claimant women in Montreal and Toronto, Merry et al., (2011) identified language barriers and an absence of translators as the main challenges for refugee women and service providers, and as a result there were cases of misconstruction of health care messages.

Notably, many refugee women in this study mentioned that at times they have sensitive issues that they want to share with doctors or service providers, but are unable to do so without interpreters. Some research has demonstrated the significance of interpretation services in refugee human services arrangements (Palattiyil and Sidhva, 2015; George et al., 2018). Although language interpreters are important to minimise barriers to access and delivery of health care, the trust in the interpreter is a vital determinant throughout the engagement (George et al., 2018). Some organisations and health centres have one or two interpreters whom they invite to offer services. However, these live within the same communities with women and this frustrates them because they don't want to share sensitive issues in the presence of interpreters who may go on to spread the information.

At present the implication is that there are distinct problems to those using volunteer interpreters. The interpreters have basic English skills and may not be able to appropriately translate some ailments, prescriptions and health information. A key informant disclosed this problem while she was examining the challenges she experienced in the health education of refugees:

*The instructors we use, especially for English, the English skills they have are basic, at times they don't deliver as expected. Yes, it's true we train them, we give the skills on how to handle these classes and the learning sessions and all that, but we cannot give them the exact words they can use to teach... it is challenging, the people we want we can't have them so we end up taking those who can try to speak. (Community development officer, FRC)*

This statement denotes intricacies in conveying health care messages. It means that there are inadequacies in the information interpreters/instructors pass on since they cannot fully comprehend the messages they are supposed to deliver. Hence, they might be passing on folk remedies rather than medical knowledge.

### 7.1.3 Lack of information

Communication about accessible services helps target service users to benefit from such to understand the importance of seeking services. Lack of information was revealed to be a major barrier to accessing and utilising health services among refugee women and children. One key informant was speaking about an escalation of fistula cases in Base camp and he disclosed that:

*I think there is no awareness of such kind of diseases. There is no much effort which has [been] done to make these people aware of this issue or to just to be encouraged to go to the health center (Community activist, ARC)*

However, a different respondent stated that information is individually established by some refugees who are around the center or who have some education. She said:

*We have VHTs- village health team's members, the care group promoters...but then many community members are not aware of such programmes...Like those ones who are educated, we are the ones who know that such members are in the community but they are some other old people who don't even know that such people are in the communities (Congolese woman, Base camp)*

One other key respondent echoed that:

*They do have radios[but] if some programmes are in English they will not pick maybe some information, there are some posters in the community but if someone cannot read*

*or write, [they] may not know that there is this service and this service because -MTI normally does that. (Community development Officer, FRC)*

These denote that some groups of people fail to benefit from some accessible services due to lack of awareness. I now move on to examine the institutional factors affecting refugee health services.

## 7.2.0 Institutional and Structural Barriers

This section presents the institutional barriers to access and use of health care amongst refugee women and children pointing out barriers such as lack of health care, medicine and testing equipment shortages, long queues in the health facilities, poor attitude of health care providers, low trust between health service providers and refugees, lack of coordination and low funding. As stated in Chapter Two, this thesis follows Lonquist (2003, p.117) in defining institutional barriers as the upstream or social structural processes and procedures influencing access to health care.

### 7.2.1 Lack of health care services

The structural model of health considers that availability and accessibility to health-enhancing products are vital for improving health outcomes (Cohen et al., 2000). The lack of health care is a key challenge for refugees, particularly women because they have tight schedules of often having to take care of their children and families. Consistent with previous studies (e.g., Deacon and Sullivan, 2009), this study identified that refugee women have inadequate access to health resources and encounter other challenges such as long queues at the understaffed and understocked health centres. This was revealed in a key informant interview:

*Sometimes the services are simply not there. So you can't access what's not there you know, and for example I have seen in most of these refugee settlements, UNHCR and a few other organisations provide the normal basic services— the normal packages, but if you have for example a condition, like I mentioned these chronic illnesses and diseases and you need a referral to move to a more specialised hospital, the process becomes, a little bit difficult. You need clearance from UNHCR, you need what, blah- blah- blah...sometimes this information is not very clear to the refugees. (Social Work Academic).*

This denotes a lack of availability of health services. In addition to an absence of health care services specifically for specialised illness and complex processes, there is also inadequate

information about accessible services. These dynamics were also reiterated in another key informant interview:

*Though we don't want again to appear as if we are treating but we are thinking about this because of the continuous complaints we are receiving from refugees that hey— 'we go to hospitals, [but] you can't even get a bed when you are admitted'.* (Senior official, InterAid, Uganda)

This implies that limited availability of health care resources also affects the referral pathway to services which is a big challenge to the refugees. This indicates an even bigger challenge concerning access to medicine and specialised care.

### *7.2.2 Medicine and diagnostic equipment shortages and long queues in health facilities*

A major problem facing primary health care centres in the settlement is the lack of appropriate medicine for treating diverse illnesses. This was alluded to by refugee women and men and key informants. Most survey participants (55.5%) pointed out that the only medication distributed for the management of all illnesses is Panadol (a paracetamol-based painkiller). At times, the practitioners diagnose the actual illness but simply because the recommended medication for specific diseases is not always available, they distribute Panadol as an alternative. This frustrated not only the service users but also the health care providers who called it symptomatic treatment for pain relief, not a cure. As I already mentioned, this fact discouraged refugees to seek professional services. One of the key informants explained that refugee women are turned down and disappointed at the lack of medicine in the facilities:

*At times, they[refugees] come and the drugs[medicine] are not there so that discourages them, you find a mother has walked all the way from X or the extreme end of whatever village, comes, lines up say from 8:00 up to 4:00 and finally, after the doctor says... this kind of drug is not there, they write for them at times— 'go and buy it from somewhere.' Remember at times they don't have this money, and, they also look up to us the service providers as their "parents", they know UNHCR is there for them, working with MTI<sup>25</sup> so 'why in the first place would you tell me to come and seek for medical services, then when I come you again tell me to go and buy the drugs',... when they come today and there are no drugs, they say it, that -ahh 'me— Kashoswa sita rudi [I will not go back to Kashoswa Health Centre]. (Community development officer, FRC)*

This reflects the pain involved in trying to access medical services as well as the unmet need for health care. A refugee woman reiterated that:

---

<sup>25</sup> Medical Teams International

*You go there they [health care providers] tell you, 'you know we don't have drugs'. Like on Wednesday if it is over, from Monday to Tuesday, then Wednesday[again], Thursday that there are no drugs. (Congolese woman, Base Camp)*

This statement reflects frustration from the perpetual stock out of medicine at the health facilities. Some key informants said that medication is often available but the population was too large to service. The health facilities and resources in the settlement are meant to serve both the refugees and the host community. The local hosts are served by the settlement facilities because it is a way of rewarding them for providing land for refugee settlement (UNHCR, 2019). A key informant cited that it was impossible to satisfy the demands of a huge population:

*You know we are getting supplies from UNHCR, sometimes we get from the government and the population we are serving is too big. So, we are having nationals, [...] and we have like forty-eight villages around here. Although sometimes they can bring drugs [medicine], within one week we are out of stock, then you get someone you know the condition can be treated with this type of drug [but] you find that at that time you don't have that type of drug, then you try to improvise with another type of drug which is not good for treating that condition but you have nothing to do [or]what to give. So, you just give it. (Clinical Officer MTI, Rubondo)*

Another key informant reaffirmed the challenge of a large population on the available provisions:

*The medicine we have in the health centre is always not enough because it is shared with the nationals, though sometimes also government gives us but the consumption rate is too much because even we have very many new arrivals not planned for and they have to share what was planned for a smaller population. (Commandant, OPM)*

Apart from an overwhelming demand for the available services, these statements also indicate a limitation in planning for the delivery of health services to refugees. Other key informants said that the problems of insufficient medication and stock-outs were due to interruption in supply by the major partners:

*We don't have supplies throughout, sometimes we have stock-outs, so if there are stock-outs that's when the barrier comes in and of course they will not be able to access everything they need. (Clinician, Nakivale Health Centre II)*

This indicates fundamental supply issues arising from poor planning which leads to stock-outs of the drugs UNHCR and the government do provide/produce. Another supply chain issue arose from shortages of foreign-produced drugs. This was revealed by one of the key informants:

*They[refugees] usually complain that the drugs they receive at whatever age are not enough and yet you know it that [depends on] the international procurement of drugs.*



*There are some specific drugs that are not made by UNHCR. But there is some money whereby these drugs can be produced on the other side [abroad] though it takes time to procure these drugs from pharmacies, so it's also a problem. Such as drugs include diabetic drugs, cancer and other complications. (Community Services Assistant, UNHCR)*

Beyond these difficulties in providing the correct care, institutional barriers also impact the management and diagnosis of specialised conditions. Key informants explained that the facilities in the settlement do not have specialised technology and diagnostic tests (such as malaria testing kits and ultrasound scans) to manage health issues:

*I told you about specialised care, like for instance ultrasound machine, x-ray...if we had the ultrasound machine here we would not refer most cases. So, some of the equipment if they were available it would be more easy for us to provide the service instead of referral, which is with far distance. (General medical practitioner Nakivale Health centre II)*

Because of this, clinicians either have to use guesswork or refer patients to other hospitals such as Mbarara Hospital and Mulago National Referral Hospital which are outside of the settlement. This is a big challenge for children and pregnant women and most refugees who do not have the capacity (financial and transport) to go to these hospitals.

Some specialised care such as those for people with special needs (PSNs) and particular services for children are not available in the settlement. This results in under diagnosis. In fact, the lack of experts (specialists) who can diagnose or manage particular conditions or groups such as paediatricians were frequently reported. One key informant said:

*Then with regards to children which is another vulnerable population, we see limited access to basic childhood friendly services which include appropriate nutrition, which include appropriate paediatric related [care]. (Senior official, IOM Uganda)*

The lack of paediatric care is a major challenge because of the sensitive nature of childhood illnesses. One of my respondents revealed that some acute conditions among children in NRS can only be managed by experienced people within the refugee community:

*Something comes like a tooth then [...]it will develop a maggot then a child dies, at the hospital they don't treat those but then when you go to local people in the community, they remove them. (Congolese woman, Base Camp)*

This denotes that the absence of specialised care forces refugees to invent other unapproved options for managing ill-health. The lack of specialised care is not the only problem, the respondents also cited another challenge relating to long queues and over waiting at the facilities.

Queuing for many hours is another challenge to gain access to health services in NRS. 10.3% of the women talked about long queues in the facilities as a routine and that waiting stretched between five hours or more. One of the key informants also pointed out this problem:

*Just like you are seeing everywhere [she points outside her office], all the people out [there] are waiting for services, even at the health centre there are long queues so that is one hindrance because for Nakivale we have five health centres. (Child protection officer, HIJRA)*

This statement reflects several interrelated hindrances. The first challenge is due to the large population which creates a high demand for services. Second, space is inadequate in terms of physical structures where cases can be handled, as another key informant revealed:

*Though I'm one month here, we need [more] space. They have promised us [and] we are still waiting, but now...sometimes privacy to get a room to counsel, you are interfered [with]...and we try to create like how we have closed here [interview room], obviously it is not simple. (Nurse/Counsellor, MTI)*

Apart from the limited facilities and physical space, the long queues exist because of an inadequate number of health care providers in the health facilities. One refugee respondent stated that:

*Health workers are too few, some nurses, doctors. The patients are too many compared with the workers who are there...you go in the morning, you come back in the evening very tired. We don't blame them that they don't work on us but it's because the number is few compared to us the clients. (Congolese woman, Base Camp)*

The key informant above expanded on this, citing the ways in which bureaucratic and practical concerns exacerbated the workload:

*Three counsellors, you may hear three as if we are many but things [workload] are too many. Because if we are to now look for the lost follow-ups, we have five cohorts, we may talk of cohorts, these are ART[Anti-Retroviral Therapy] books, those who are already on ART, they are there [she points at files and exhales], we have to update those registers there [she points at other files], we have to see daily people who are sick, those ones who missed their appointment date- they are here [shows me other files], those ones who have been tested today and they have turned positive— they need counselling, they need may be to be opened the files, to be dispensed. You know, you may talk of three, maybe one has gone for leave, maybe one you never know has fallen sick, you find you are one with your peer educators and yet they also have their boundaries. (Nurse/ Counsellor, MTI)*

This statement reflect that the bureaucratic requirements complicate the high caseload by necessitating many different forms of recording and follow-up Another one reiterated:

*In the probation office, there is only one staff so she went for leave now I'm now the only staff in that office. Community Development Officer, District)*

Both statements from the key informants also reflect a difference between the number of staff on paper and in practise. This shows that the staff is overwhelmed with high volumes of work which leads to other problems like fatigue and lack of interest or empathy to support refugees. Hence it is not surprising that my respondents cited ill-treatment when they went to seek services.

### *7.2.3 Inconsiderate attitude of health care providers*

The negative attitude of the health care providers in the facilities discouraged refugee women from seeking health services. About 6.6% of women surveyed mentioned that health care providers are so rude to them and disrespected them because of their status. Possible causes include overpopulation, long queues, the limited staff at the health facilities and extended working hours for these health service providers. A key informant reported the kind of distress and afflictions which the women experience under the watch of the health workers:

*Another problem facing mainly women during childbirth, you find out that in the hospital room, there is only one doctor maybe who is to attend to 10- 8 mothers who are pregnant and they are all going to give birth... some are not attended to, and some give birth on the floor and the children, sometimes we face a problem of doctors or maybe nurses who are proud and they cannot, ok they feel, they don't feel it like to help, to help us give birth. (Refugee women's leader, Base Camp)*

Another key informant focussed less on individual psychology, and pointed towards the high doctor-patient ratio as the primary cause for these social/emotional dynamics:

*But the number within the settlement is so big, is so big in the way that you find that every day, the clinical officers are attending, I don't know to how many patients and at times they are so tired and because he is so tired, at times they just write because they want the lines to go. They at times don't give them the attention of others who would be sent to the laboratories are not sent, they treat clinically because they are so tired, because the more he sends them to the laboratory, the more he keeps himself there waiting. (Community development officer, FRC)*

The two narratives mainly suggest the poor doctor-patient ratio which jeopardises the quality of attention and care. However, there are also indications of lack of empathy by service providers which leads to poor relationships and mistrust between the refugees and the service providers.

#### 7.2.4 Low trust between health service providers and refugees

The success of any service depends on the relationship between the service provider and service user(s). A lack of trusting relationships affects the outcome of the services, for example, by preventing women from accessing and using available health care due to frustration. It is stated that women tend to see problems of migration as irrelevant to service providers such as their (experiences of sexual and gender-based violence) which makes them reluctant to share with health care and other service providers (Deacon and Sullivan, 2009). Also, unwillingness to share could be due to other emotions such as shame and language problems. Moreover, the cultural inappropriateness of services for some conditions like depression or sexual abuse may also give rise to mistrustful relations which all affect when or if services are sought out (Merry et al., 2011). Svenberg et al, (2009) argue that expectations and experiences of health and illness vary between these immigrant groups and citizens, and sometimes even within immigrant groups. The key informants reported that mistrust was a major barrier to accessing and utilising health services among refugees in NRS. One such individual stated that:

*Some people think that it is better to deliver from their homes. Probably one thing I have realised, what they comment, they don't trust our doctors, like for them they perceive that it is their doctors back in Congo who can do it. There were people here who had started clinics and they were forced to shut them down, some were even doing operations, you see, and they [refugees] would say; 'this is the Muganga' [the doctor] because he was doing it [at] home. So that kind of perception, it is a barrier... that's what they say our Waganga [Ugandan doctors] 'ahh these ones are not qualified (Community development officer, FRC)*

This means that entrenched doubts about the health system affect whether refugees seek formal health care. Cultural beliefs about disease and cure can be a further cause of mistrust in the Ugandan doctors. In addition, mistrust may arise from bad experiences that refugees face and sometimes from trusted officials such as government authorities (UNCHR, 2018). Human rights abuse at the hands of government authorities, and cultural and language barriers between refugees and health care providers also decrease trust and affect the relationships between refugees and the health care system. This finding is similar to that of Gerritsen et al., (2006) among Somali refugees living in The Netherlands. They state that Somali refugees do not have much faith in the Dutch health care system and often consult health care practitioners in health camps organised by German relief workers. The difference lies in the alternatives. Whereas refugees in the Netherlands turned to practitioners who are not natives of the country of resettlement, the refugees in NRS mainly resorted to (sometimes crude) services provided by

fellow refugees. Another key informant reiterated the alternatives used by refugee women as a result of distrust in professional procedures:

*We still have the issue of traditional health workers, I think I can call them that, because mothers are still giving birth in their communities other than coming [to health centres] ...actually most maternal deaths we have there are caused because of that, by the time she made up her mind and she and came to her senses that 'no', this is not going to work, I need to go to a well-equipped health centre, it was too late... Even with these normal diseases, most people are going, to begin with their traditional doctors[healers] and we actually even have a little health camp, I wouldn't call it [a] camp, there is traditional doctor who has a whole little camp in his compound— little huts where people stay and get health support, I don't know if it works. (Assistant Counsellor, OPM)*

This reflects that refugees have confidence in their own support systems compared to those made available by the humanitarian organisations. Ease of access, this quote suggests, maybe a factor that compounds or amplifies mistrust in driving treatment decisions. This contrasts with Pringle et al. (2011), who stated that the West African refugee women resettled in Australia had confidence in the Western approaches to health care and were more likely to attend hospital outpatient clinics for all complaints than the local Australian women.

Besides confidence, there are other reasons why refugees ignore professional health care. One of these was revealed by a key informant:

*They associate most [of] these diseases [with]witchcraft, so instead of coming to health centres they always run to witch doctors [traditional healers]. Sometimes you find someone is sick in a village and they are saying...they have bewitched him, they have bewitched her. (Assistant Commandant, OPM)*

This denotes that refugees are reluctant to seek professional services because they perceive most illnesses to come from demonic causes not requiring medical mediations. This replicates Svenberg et al, (2009) whose respondents inferred djinns (evil spirits) to explain reasons for illness, particularly on the subject of mental health.

Sometimes, as we have seen, mistrust may be well-founded, as when service providers offer inappropriate treatments in order to avoid additional recording or coordination work.

### 7.2.5 Lack of coordination

The provision of services to refugees must be coordinated to achieve comprehensive service delivery for refugees (UNHCR, 2019). Key informants stated that lack of coordination between the service providers is a pressing and an ongoing challenge against the efficient provision of

health services in NRS. Collaborations among providers not only help to harmonise and streamline services but also reduce duplication and wastage of the meagre resources in the camp. One key informant expressed concern about the dilemma of incoordination regarding health data:

*There is data here and there. IOM has data, UNHCR has its data, the International Labour Organisation has its data but that harmonisation is a problem.” (Senior Official, IOM)*

Lack of cooperation also affects the quality of services. This was reflected in the words of a key informant:

*Sometimes you find like ten organisations, providing more or less the same things...and there is limited coordination of these services and this also can be seen in terms of the actual outputs and results on the ground, okay? So you find that in health we have a structure of VHTs for instance, but you find say organisation X has health promoters, organisation Y also has health promoters, but in terms of the competencies that these people have in terms of the training that these people receive they are completely different so there is no harmonisation of these interventions and how they actually provide these services. (Social Worker Academic)*

Uncoordinated approaches in service provision create needless duplication, wastage and diminish the actual outcomes of interventions in terms of the people reached by the services. Many agencies in the settlement work autonomously and are faced with the fact that they need to compete for funding from the main partner—UNHCR. The local agencies’ desire for funding can be at odds with UNHCR’s desire to streamline services.

#### 7.2.6 Inadequate funding

A lot of refugee work depends on international donations and funding. However, this is not enough to meet the needs of the overwhelming numbers of refugees in NRS. The key informants were concerned about the insufficient funding for humanitarian assistance programmes. One key informant said:

*We depend on donor communities, and actually our calendar year ends by 31<sup>st</sup> December [2017] which we are coming to, so we start now worrying about 2018 because under [the] emergency everyone is touched—everyone is willing to donate but as refugees stabilise the donors also start giving less and that may compromise our services. (Senior Official, RMF)*

This means that funding for refugee assistance is unstable, leading to uncertainty in the provision of services. Another key informant confirmed that donor support is piecemeal and does not meet the demand for the services:

*The refugees are becoming many and many any other day that comes around, but the support that comes is still the same, so the services are not marching with the population on the ground. (Community services assistant, OPM)*

When speaking about the challenges they encounter in the provision of services to refugees, a key informant specifically stated that the budget for the health sector in 2017 had been reduced to an upsetting level:

*Funding, that is my one and biggest[challenge] that I can talk of. I'm not sure if it's supposed to be a secret, but this year [funding] was really cut especially for the health department. (Assistant Counsellor, OPM)*

Decreasing budgets for key sectors like health is dangerous, creating not only precarious circumstances for refugees who entirely depend on humanitarian assistance but also generating pressure and anxiety among service providers. Although reduction in aid is partly related to the economic crisis in the Eurozone, it is also due the perceptions of high corruption<sup>26</sup> rates in Uganda, especially after the suspected mismanagement of refugee resources at the office of the Prime Minister (NPC 2018, p.16).

In the next section, I will examine the structural barriers to access and utilisation of health services in NRS.

### 7.3.0 Structural Barriers

In this thesis, structural barriers refer to environmental influences on health and health care. These comprise poverty and lack of food and transport.

#### 7.3.1 Poverty

Haughton & Khandker, (2009) define poverty as a “pronounced deprivation in well-being.” WHO (2010) differentiates between absolute or relative poverty. Relative poverty refers to the overall distribution of income or consumption in a population whereas absolute poverty is a standard of what households count on in order to meet their basic needs (*ibid*, p.4). Similarly, a lack of financial resources emerged as the main challenge for women to access and utilise

---

<sup>26</sup> See Reuters: <https://www.reuters.com/article/us-uganda-refugees/uganda-investigates-allegations-of-refugee-aid-fraud-idUSKBN1FQ1C1>

health services in the settlement. Approximately half of the survey participants listed this as a major barrier. This is irrespective of the fact that most of the health care services are supposedly provided free of charge. As I pointed out earlier, the underlying challenge is that the health facilities are understocked and under-equipped. This creates a gap that is supposed to be covered by the refugees themselves. A participant complained that they receive prescriptions from the doctors but cannot afford to buy medicine:

*Because here the doctors can treat us but we reach the time of getting some medicines they say that there is no medicine so you can go and buy. So, at home, you don't have food, you don't have anything, so money for buying medicine— it is also a challenge. (Burundian woman, Rubondo).*

This is consistent with Fernandes and Miguel (2009, p.24) who argue that “poverty affects access to care, the ability to care for one’s health as well as the health of the children.” One of the respondents complained that even at times medicine for pain relief [paracetamol] are not provided leaving them with no option but to seek divine interventions through praying:

*Even [if] you ask people [health workers] [for] Panadol [Paracetamol], sometimes they tell you we don't have this medicine you go and buy it, sometimes they say like that, they say you go and buy it and I don't have money to buy medicine. Now it is good I pray to God to help us. (Somali woman, Base Camp)*

The lack of income deprives women and children of access to proper health care and basic necessities like shelter and food. Like the rest of the Ugandan population, the high levels of poverty in the settlement are due to lack of employment and dependence on unpredictable rain-fed agriculture (NPC, 2018). For example, several respondents reported a recent severe dry season affected their crops and led to scarcity of food.

### 7.3.2 Lack of food

Proper nutrition is good for health but also some medications can only be taken after eating. Most of my respondents said that they were not getting sufficient food for themselves and their children. And due to poverty, they cannot afford to purchase the required food. One refugee respondent said:

*I'm worrying because I'm pregnant, I'm about to give birth, [but I have] no cloth, no money, no food. (Burundian woman, Rubondo)*



Not having enough food is a challenge because it leads to illnesses related to malnutrition and undernutrition, such as ulcers. One of the key informants reported that the number of refugees suffering from diseases which are related to malnutrition was on the rise:

*Most of them complain these days that they give them like three Kgs of maize per person in a month so that one is not really enough. So, I believe they don't have enough food, so they end up getting the ulcers that they come complaining of. (Nurse IOM, Base, Camp).*

Moreover, some medications cannot effectively work without proper nutrition such as anti-retroviral therapy for HIV/AIDS patients.

### 7.3.3 Lack of transport

The presence of infrastructure can affect physical access to services. Women and children need transport to go to health facilities. Lack of transport limits access and utilisation of health services. All the three zones in NRS have at least one health centre in their respective localities. In reality, this would reduce the walking distance to these facilities, but, as already mentioned, these facilities are both understocked and under-equipped. One of the respondents stated that she finds it very difficult to take her children to the health facility due to lack of transport:

*I have children like these ones who are growing sometimes they often fall sick and I often get difficulties, you know, getting the transport to take them from where I stay to the health centre. (Congolese woman, Juru)*

Given that the settlement is located in an isolated community it is also difficult for women and children to travel to access desired health care services. This is due to transport costs or lack of transport links particularly for those who are referred for treatment outside of the settlement. Refugees with complicated conditions are referred to hospitals that are outside the settlement yet transportation in the settlement and public transport outside are underdeveloped and poorly organised. This was also echoed by one of the key informants arguing that refugees struggle to seek health services which are outside of the settlement:

*These guys come by themselves, certain times they are put on public transport means to come to Kampala. Of course, with a phone contact that when you reach Kampala call this number. Honestly, some get lost on the way. (Senior Official, InterAid Uganda).*

Transportation is also needed by the service providers to take services closer to the refugee communities. For example, the community service assistants, the police, village health teams and counsellors all need transport to be able to conduct community outreach activities. For

example, in emphasising the kind of support which he needed to perform his work and take services closer to the refugee communities, a Village Health Team (VHT) worker requested for, “mostly transport and at least lunch because [they] have big villages to cover.” Along similar lines, another key informant provided a vivid illustration of the challenges she faced:

*Maybe this baby has turned up for the SPCR<sup>27</sup> and it is positive, the baby needs to begin on the drugs immediately... and you find this person doesn't have the contact. Yes, we have the phone here, but there is no phone number, there is no phone number of the neighbour, you yourself you have maybe to make a follow-up. We use the VHTs sometimes, sometimes they also fail because these people, they call themselves 'mama gundi-mama Brenda- mama what' so if you tell the VHT the name you find even themselves they don't know the names of those people in their area, but they know the nicknames. So we try to pick the nicknames to put them on the paper but obviously, you have to trace. Even to go and even we to look for the VHT our network or the signal is very poor. (Nurse/ Counsellor, MTI)*

This denotes several challenges that arise due inadequate transport and communication facilities. I will now examine the societal factors which affect refugee health services in NRS.

#### 7.4.0 Socio-Cultural and Religious Barriers

This thesis defines socio-cultural barriers as influences on health and care which arise from social norms and cultural values. These incorporate gender dynamics, cultural and religious limitation, lifestyle and social stigma.

##### 7.4.1 Gender dynamics

Gender and power relations affect the quality of health and health-seeking behaviour. WHO (2010) identifies gender inequality as an important social inequality that can affect access to health care. This is particularly important when seeking to understand decision-making concerning health choices. The key informants pointed out the effect of gender relations on health outcomes:

*The issues of power[and] gender dynamics also play out in these dynamics—in these refugee settlements in terms of how they access health care services...in terms of who makes a decision...it has a huge impact, you know on the health of women and girls. (Social Work Academic).*

---

<sup>27</sup> She explained that: “SPCR, there are the blood that we test for HIV, actually exposed infants to take it to PHL in Kampala then they bring [It back], they tell you if the baby is positive or negative. Yeah that is what I can explain for you to understand.”

This was also reiterated by another key informant:

*Some women have disagreements with their husbands so when they are eager to come to health centres, they are not allowed by their husbands. (VHT coordinator)*

These denote that gender determines and influences health choices. In fact, it was revealed that health interventions which only targeted women do not achieve their intended outcomes. This is because women live in a cultural context that is dominated by men as the main decision-makers (Nalukwago et al., 2019). Male disregard to health care interventions was referred to by a key informant as the ‘missing link’ in the empowerment measures to achieve good health:

*We are looking at gender we also need to factor in, with regards to the men- where is the missing link? So, also men need to be empowered. They need to be empowered to empower their women to be more informed, to be more independent in taking decisions... Empower men to empower their women, one of the things is addressing some cultural norms, addressing what we call patriarchal norms but also involving men in whatever interventions, okay? Because at the end of the day, even if you train the woman, she still has a locus she is accountable to and that is the cultural context. So if you involve the men and just let them appreciate in terms of... increasing their knowledge and letting them know that empowering their women is not to disempower them, on the contrary, it is to empower them. (Senior Official, IOM)*

This was reiterated by another key informant:

*We are trying to empower women especially in our communities to take care of themselves, stand up for themselves, cater to their families but this has in some way increased men walking off, yes. (Assistant Counsellor, OPM)*

The spirit of this is that men perceive that empowering women is intentionally disempowering them. This is a challenge because it frustrates interventions intended to improve health. Despite this, it is also important to note that integrating male refugees into some health initiatives and programmes is a challenge, especially those lacking financial incentives. For instance, the clinicians cited that women suffer from recurrent episodes of sexual infections because their male partners do not want to seek medical services. Moreover, it was also difficult to have men attend some services even when they were required to attend such as counselling which were mainly dominated by female service providers. This was revealed in a key informant interview:

*We see more women seeking health services but not men, but we don't know what is keeping those men there. The reason [is that] they think it is a responsibility for women, or others are not sensitised and others don't trust or they don't want to confide in the female counsellors. (Community development officer, FRC)*

Therefore, gender and power relations influence health and the outcomes of health interventions. Most organisations were required to integrate gender into their humanitarian work, however, this is problematic as revealed by one of the key informants:

*Whereas the UNHCR standards actually talk about aah you know, the need to focus on men, women, gender, but in terms of how it actually plays out, in terms of these communities, [it] doesn't actually come out clearly. (Social Work Academic).*

This denotes that pronouncements about gender are prominent in ink, but rarely in action. It is noted that gender biases in power, resources, entitlements, norms and values, and the structure of organisations and programmes impair women and children's health (CSDH, 2008). Most gender aspects affecting health and health services primarily originate from cultural and religious influences which I now turn to.

#### *7.4.2 Cultural and religious limitations*

These usually manifest in the form of cultural norms and religious beliefs that normally restrict certain groups, especially women and children, from accessing and utilising health services. One key informant examined the key cultural limitations which affect the health behaviour of refugees:

*You know because people move with their cultures anyway. The cultures of the South Sudanese or the Congolese or the Rwandese doesn't actually stay there [home countries], you know it sort of moves with them and leaves or continues with them into the places where they settle... You know in terms of the gender roles, the social norms that govern these communities, the cultural beliefs... I believe there are also cultural limitations in terms of how these women actually access the [health services] and who would- who makes what decisions for them to actually access the services. (Social work academic).*

Culture influences health outcomes by determining who decides what and when, discriminatory norms, violence against women, biased divisions of work, leisure, and prospects of improving one's life (CSDH, 2008).

Aside from these restrictions, culture and religion create perceptions that affect decision making in relation to accessing and utilising of health services. As mentioned in the preceding sections, refugees perceived some of their illnesses to be witchcraft that required traditional interventions rather than professional solutions. A key informant confirmed that this is commonplace in the settlement:

*Congolese, they always talk about witchcraft...they always bring up such cases. Someone develops a rash on the body, maybe had a quarrel with the neighbour and thinks maybe my neighbour is bewitching me something like that. Someone has goats at home or pigs and they are all dying and think someone is doing something bad against him or her. (Community services assistant, OPM)*

Actually, some of my respondents alluded to witchcraft as a cause of their suffering, particularly in cases of infertility. A key informant also confirmed this:

*When we tell somebody that you are not producing because of this and this, maybe you had this disease, it was badly treated, then they go for investigations, they will tell her, they have said your fallopian tubes are blocked and it could be due to this and this, she may not accept, 'aah they bewitched me', then that's what they always say, 'they bewitched me, it is not true, me I was bewitched'. (Clinician MTI, Rubondo)*

A different key respondent further reaffirmed the mind-set of witchcrafts as a standard-issue affecting the women's health-seeking behaviour,

*And another thing they associate most these diseases to witchcraft [Laughs] so instead of coming to health centres they always run to witch doctors sometimes like you find someone is sick in a village and they are saying someone the- like they have bewitched him, they have bewitched her. Yes, like they don't believe someone can get sick, someone can get sick and die for them they believe, they always think that it is maybe associated with something else, yes. (Assistant commandant, OPM)*

Another key informant criticised the choices which the refugees make based on perceptions from religious and faith-based systems,

*Some deny drugs that for them they are going to pray, for example, HIV, 'aah me I will pray -God will cure me everything (Counsellor MTI).*

Culture and perceptions also shape the lifestyle of refugees in terms of choices and decisions and practices as we shall see shortly.

### 7.4.3 Lifestyle

Like all the other societal factors, lifestyle also determines the health of communities through choices and decisions. For instance, some differences were cited among the refugees which lead to exposure to disease. One key informant stated that some groups of refugees behave in ways that jeopardise health standards. He was referring to the cause of infections among refugee women:

*The Somalis cannot remove their clothes fully to bathe or clean their bodies in the water [lake] whereas for the Congolese it's something familiar-very usual-they can remove*

*their clothes and clean their bodies in the lake which contaminates the water (Private clinician, Base Camp).*

This denotes a challenge faced by the entire community due to lifestyle differences. Water from open sources is used for drinking and preparation of meals. Some lifestyle choices were said to be affiliated with some cultures and religions practiced by refugee women. Different key respondents named various practices which jeopardise the health of women and children in the settlement. One key informant stated:

*When you are interacting with these people [refugees], they will tell you, there are specific things they can't do, there are specific foods they cannot cook, there are specific foods that cannot be warmed irrespective of how dirty it is, she will eat it like that. They have this 'Sombe [vegetable]' they say they don't warm it...vegetable, once it is cooked, it cooked. They will eat it like that. So if it was cooked today lunchtime, in the evening they will eat like that, and if there is another leftover- of course, no food is thrown here in the camp you know the conditions, so if it's there tomorrow still someone will eat it. So, if at all it was contaminated yesterday afternoon, still that contamination will push on to tomorrow. (Health promoter, MTI)*

Likewise, another key respondent stated that some refugees specifically the Somalis have a secretive culture that condones and covers up child abuse. She said:

*With Somalis, I can say that their culture is a little bit different and so that makes the women susceptible in a way that they believe young women are supposed to be married [off], say a virgin and whoever has sex with a virgin girl, there is a way he praises himself... So you find a very old man, because he has money, comes for this girl and the parent has no reason to say no because that is tradition, they have to do it...[and] the way they behave they are always isolated, to reach out to them becomes a problem. (Community development officer, FRC)*

These lifestyle factors influence health and health outcomes especially because they are embraced by communities. Besides some respondents mentioned that attempts to go against group values (such as marriage among the Somalis) lead to isolation and stigmatisation which I will clarify in the next section.

#### *7.4.4 Stigma*

Stigma is also an important societal barrier to access and utilisation of health services, especially for problems that are considered private or personal. Key informants stated that stigma was a major restriction to access and use of health services particularly for gynaecological complications like fistulae; and chronic conditions such as HIV/AIDS. This was echoed in many key informant interviews. One of the key informants stated that:

*The Somalis, Eritreans and Ethiopians because of their culture that when you are defiled or when you are raped, you are actually they put a mark on you so to avoid that, you keep it your-to-yourself not knowing that you are keeping a health problem (Protection/ Counsellor, ARC)*

A key informant stated that this was a specific challenge for young women:

*For the survivors [particularly] the teenagers [face] stigma! They would not want [it] to be seen that they are pregnant, they would not want to be seen reporting that I was raped, so that stigma. (Child Protection Officer, HIJRA)*

This shows that some conditions were classified as stigmatising and to a large extent this is due to cultural norms and values. This also suggests an interaction between infrastructure and norms, for instance a lack of a friendly environment or privacy in the provision of some personal services such as counselling.

It is important all the barriers to health and health care may occur independently or can intersect and impact women's access and utilisation of health services in settlement.

## 7.5 Conclusion

This chapter has provided an overview of the factors which limit or prevent refugees from receiving adequate health care within NRS. The key barriers originate from personal, the wider group factors, institutional and structural factors. The central point of all these factors is the cost of health care (social, economic and political) amidst the deprived conditions. A critical examination of the factors manifests multiple and intersectional factors that create vulnerability for refugee women and children. Given the existing gaps in service provision indicated in the current chapter, the next chapter provides insights into the role of social work in health promotion in NRS.

## CHAPTER EIGHT: SOCIAL WORK AND HEALTH IN THE SETTLEMENT

### 8.0 Introduction

One specific objective of this study was to articulate the role of social work in supporting refugee women and children to achieve considerable outcomes in health and well-being. The social work profession improves the quality of life and well-being of individuals, groups, and communities through alleviating the conditions which cause suffering and social deprivation. This is because the philosophy of the profession is distinctively grounded in human rights. Social work and health are inextricably linked because the main concern of the profession is to address the social determinants of health (Bywaters and Davis, 2012; Delavega, et al., 2019) such as access to health services, income and social status, education and literacy, social support and coping skills, healthy behaviour, gender and culture among others. From the previous chapters, I have indicated the socio-economic factors which influence the health of refugee women and children in NRS. In this chapter I examine the practice of social work in the settlement.

The global definition of social work (IFSW et al., 2014) summarises the overall objective of the profession and states that,

*Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance well-being.*

This definition states the functions of social work and challenges social workers to intervene on behalf of vulnerable populations. It identifies key themes for social work practice such as the promotion of social change, empowerment and liberation, enhancing well-being, human rights and social justice (Thompson and Thompson, 2016; Palattiyil et al, 2016). In partnership with service users, social work aims at solving or supporting people to cope with the social and economic factors which influence their health. The practice of social work in NRS is generic. One of the implications of this is that government and humanitarian staff trained in social work do not identify themselves as social workers. This can also be reflected in the words of a key informant when I asked her about the staff composition in her organisation. She quantified:



*I'm not sure about social workers, but we are 7 community service persons. Yes, we are 7, of those 7, one is a counsellor that's me, and then the other 6 support, I don't need to know what they did whether social work or development studies, I don't know, but all of us do the same activities. (Assistant counsellor, OPM)*

This denotes that both professional social workers and other professionals who are not trained in social work perform social work functions. Table 8.1 summarises the professional social workers who were interviewed, and their titles in various organisations.

Table 8. 1 A summary of the professional social workers' titles in various organisations

<b>Organisation</b>	<b>Training</b>	<b>Title</b>
HIJRA	Social work	Child Protection Officer
ARC	Social work	Protection officer/Counsellor
OPM	Social work	Assistant counsellor
OPM	Social work	Senior settlement commandant
OPM	Social work	Community services assistant
Makerere	Social work	Lecturer
UNHCR	Social work	Community services assistant

From the table, it is clear that qualified social workers in NRS identified themselves with quite a range of designations such as child protection officer, protection officer, (assistant) counsellor, senior settlement commandant, and community services assistant. One social worker works as an academic at Makerere University. On the other hand, other people with training in other fields or subjects such as Adult and Community Education, Administration, Social Sciences, Counselling Psychology, Midwifery and Nursing were undertaking social work tasks as I will examine below. Moreover, the titles for both trained social workers and other professionals did not differ. Like trained social workers, some of these were designated as community development officers, child and family protection officer, community services assistant. The others who mainly performed administrative work held titles like operations assistant, national migrations coordinator, senior programmes officer, senior community development officer and country director. Based on the global commitment for social work, I will discuss the findings from all the identified categories as the role of social work in

supporting women and children to achieve good health. As stated earlier, social workers in NRS do not universally identify themselves as social workers but with the designated roles and in this chapter, I will use these titles. I now discuss the range of social work functions performed by these individuals, ranging from psychosocial support to community capacity building.

## 8.1 Psychosocial Support

Psychosocial support is an approach for helping individuals or groups of people to come to terms with their circumstances so that they can devise ways of coping and/or moving on. It promotes positive physical and mental well-being. Push factors of migration such as conflict, violence and migration experiences such as loss and trauma have severe psychosocial consequences for women and children. Psychosocial problems typically include anger, post-traumatic stress disorder (PTSD) and depression (Palattiyil & Sidhva, 2011). In addition, the women in this study expressed suicidal thoughts and anxiety disorders, sleep disturbances, impaired concentration and memory loss due to experiences of traumatic events and gender-based violence. One of the responsibilities of the professionals in NRS is to help people with support to cope with distress and suffering related to these experiences. This was echoed by a key informant:

*For example, like the GBV survivors, those ones who have been raped along the way, after getting the medication, our role is to provide psychosocial support and to help them heal and to come back to the society and be able to engage, be productive and play for their own good. (Child Protection Officer, HIJRA)*

This denotes support at individuals, group and community levels to improve social functioning and productivity. Mental health practitioners work in partnership with mentally distressed individuals and families to improve social functioning, recognising the complex interplay of interpersonal, intra-psychoic and structural influences (Papadopoulos (2010). He adds that it is possible to strengthen the mental well-being of individuals by improving circumstances within their socio-cultural sphere (p.30). Individual, group and family counselling are thus essential to address issues of depression, anxiety, post-traumatic stress disorder and gender-based violence. This was also reflected by another key informant:

*I'm not married, but most of the cases I handle here are actually marital counselling, and the woman will tell you, 'he just keeps saying I'm dirty, I'm filthy, I'm what-things*

*like those and she shows you that because of that, she couldn't even make friends with people in her community... that isn't one story- that is multiple stories...Actually, let's leave the Somalis, there is also another Rwandese community in a village called Kiretwa that has also been happening a lot. The issue of fistula is common there but for them it's covered because men tell them that you won't get the support, how will people look at you after you step out of this house smelling like urine, stuff like that, the issues you have is a curse, something like that- you were a bad wife this is what happened. (Assistant Counsellor, OPM).*

Another key informant also reiterated that providing psychosocial support helps people to cope well or restore their normal lives. However, she expressed concern that such efforts intended to restore women's health are not widely valued by refugees as they would prefer to satisfy the more pressing needs for survival instead. She said:

*Well they demand more of material support at first but after we have a long session with them, they realise the need for counselling also but because they have this dependence syndrome whereby they always look for partners to provide so if you just use words sometimes they are like- 'I wish you had given us soap', like- those are still needed but because of what we provide, so we feel like sometimes they demand more of material support than psychosocial which is also very important in their lives- because if the mind is not settled even if you get ten boxes of soap you will still lack something. (Counsellor, Tutapona).*

Despite the importance that staff attaches to psychosocial support, in the short-term, it is not appreciated as much as material aid. One of the reasons that could explain disregard for such support is that their support is limited to refugees who come to their organisations for other personal reasons. This was revealed in a statement by a different key informant:

*We have organisations doing like counselling, we also have Medical Teams [International] with counsellors, but most of the time their work is to counsel those who come to the health centre...but what about someone who is dying down there and cannot reach here or who have not received information. (Community development Officer, FRC)*

This shows a shortcoming in the current interventions. They are limited in scope and coverage leaving out a vast majority of the vulnerable who do not come to their premises or who lack information about accessible services. I turn now to another way social work is supporting refugees- group work.

## 8.2 Group Work

The professionals engage in the formation of groups of women and children and facilitate group activities. Group interactions enable individuals to interact and learn from the experiences of

other social group members. This is a form of direct social work practice to meet individual and collective needs. This was reflected in the statement of a key respondent who said that:

*We get women who are neighbouring each other, those women will select for us one volunteer out of themselves, like 10-15 women select for us, one volunteer... So now when we get 10-15 of those volunteers we make what we call a Care group, so now I will go and health educate those mothers, I specifically deal with the mothers, and mothers of child-bearing age, mother[s] with children under five and also the lactating and pregnant. So now after health educating these mothers- these volunteers who were selected by the other women, they will also go back and spread the message that I taught them to their fellow women. (Health promoter, MTI)*

These denote that social group work through guided activities helps to resolve internal conflicts and is important to enhance social functioning in the community.

### 8.3 Community Work

Community social work is important for establishing and providing support to groups of people and helps to develop and sustain social support networks within communities (Thompson, and Thompson, 2016). The majority of professionals employed by different organisations organise outreach services for refugees who are incapable of seeking services and for sensitisation to the local culture and customs. For instance, community sensitisation activities usually involve dissemination of information about the laws of Uganda or accessible health services. The words of a key informant reflected this obligation:

*Sometimes they are not able to move from their homes but of course we always refer, we always do outreaches, we always sensitise them about health issues and so many things concerning health. (Community Services Assistant, OPM)*

This shows that community work is important for taking services closer to those who are unable to go to health centres but also to share health information (Valtonen, 2008). Community outreach is also used to sensitise the community about some stigmatised health issues/conditions such as fistulae. This was reflected by another key informant:

*We have recently had a sensitisation drive in [the Somali community] about the fistula campaign that was around. MTI was the one heading it and we were calling upon people to come and no one was interested but their numbers are there in their houses very alarming. (Assistant counsellor, OPM)*

This shows that some refugees have conditions needing attention which are not reported due to stigma and a lack of awareness about such issues and availability of services (Koser, 2007).

However, community work is one of the interventions used to create awareness about these isolated problems. This was reiterated in a different key informant interview:

*We do awareness rising in SGBV prevention and response and also awareness like community dialogues, we organise focus group discussions and we also do capacity building for community structures because we are believing in community-based protection. (Protection/ Counsellor, ARC)*

This statement further denotes that community work facilitates community-based protection for the vulnerable (Valtonen, 2008). Another key informant also reiterated the importance of community-based protection, she said:

*We do focus group discussions with children, we do parliaments with the children, we engage the children directly to be able to participate in their own protection. We discuss a number of things like adolescence, their dreams, we discuss their referrals, for example if you were a victim of rape what do you do? How does it help you, we discuss with them all those so that they can be able to participate in their own protection? (Protection Officer, HIJRA)*

As mentioned in Chapters Five and Six, the children are vulnerable to child abuse and harmful practices. This reveals how social work helps children to understand their rights and direct their dreams in a challenging environment. We turn now to the social worker as a peace-maker and broker.

#### 8.4 Mediation

A major strength of social work is its mediatory role between the state, society and individuals (Oko, 2011). Social workers intervene in disputes and conflicts which exist among the refugees, for instance, within refugee families in the form of family support, as well as between the refugees and the host community. They strive to strengthen relationships among refugee families to promote, restore, maintain, and enhance the well-being of individual women and children, families and communities. A key informant inherently expressed this duty when she was commenting on the challenge of child neglect in NRS and its emotional impact on children. She specified that:

*I call both parties, then I advise the man that the UN is helping you as a person but you as a parent you are also supposed to help. Even though you are getting 3 kilogrammes [of food assistance] you can sell 1 and the 0.5 you give to children, you also remain with 1.5. For 6 kilogrammes, you can give the woman 3 and you also remain with 3 because you are saying you cannot go back to the woman. But if you say you are ready to go back, it is better you go back with those kilogrammes the woman also knows— than leaving, you say I don't have support I'm a refugee. [I tell them] whether you a*

*refugee, that 1 kilogramme you can give to the family the woman will appreciate.”*  
(Child Protection Officer, Police)

This indicates how mediation services help to settle differences, particularly arising out of inadequate provisions. As stated in Chapter Six, violence against women and children (in all forms) is commonplace in the settlement. However, mediation by social workers is one way to reduce its prevalence. This was revealed in one key informant interview:

*Because for example, somebody has fistula, she is ever smelling, we have intervened held responsible meetings with couples, provided couple counselling to make sure that these couples accommodate each other. (Protection/counsellor, ARC)*

This denotes the significance of mediation in safeguarding families and protecting women and children from violence and its consequences which also contributes to improved physical, social and emotional well-being. Casework represents a particular type of mediation.

## 8.5 Casework

Working with individual refugees is another obligation of professionals in the settlement. These focus on the individual experiences of women and children. The social workers revealed that they help refugees in understanding their emotions and teach them coping skills to improve their personal experiences. This was reflected in one of the accounts of a key informant, who said:

*Sometimes I will handle a case of— even just last week I was actually handling a case of a mother who wanted support for feeding, she had a three months old baby, I asked her where is your husband to support you? She ran off, that is a very common question. (Assistant Counsellor, OPM)*

This also shows the challenges in managing cases. It is vital to note that the majority of women are already traumatised, which affects the assessment of health needs. Another key informant stated that they conduct home visits to support individual women as well as their families. She said:

*Sometimes you have a client, let's say a woman, she has never bathed, she never cleans her home, her children are always filthy, so like we usually want to catch up and see... They've lost hope, they feel like life is not worth living so they don't care, they are like I'm done with life, whatever comes let it be, I don't really care about this, but then as we continue with sessions, you go back for home visits, you find a home that was full of flies and dirt everywhere, there is a big improvement. The kids are bathed, sometimes you find that she has also bathed. (Counsellor, Tutapona)*

This indicates that professional support through casework enables people to understand their emotions and find solutions to their problems. This helps them to adjust and be able to cope better. In other words, this restores self-confidence to manage their lives. However, to achieve this goal there is a need for following up and building trusting relations. This was revealed by one key informant who said that:

*You find a mother explaining that you see I went to the hospital, I have been requested to take my husband but he says 'no', so what do I do? So our part there, me as a person what I can do is to counsel this person if she feels it is ok, the husband can come or let me go to the home. (Community development officer, FRC)*

This was also revealed by another key informant who was pleased with her organisational culture that let refugees open up:

*What I'm very proud of as ARC is that people have confined in us, they open to us they disclose [and] so understanding one's problem is a step towards it... when they open up to us we refer them to the health centre... where we find that somebody may not even be able to open up to the health worker, we physically take them and we explain we support them to disclose*

Apart from trusting relations and follow-ups, another component of casework is making referrals. The key informants explained that they initiate referrals for service users who need services outside what they provide. They refer them to other service agencies in order to provide comprehensive services. This was revealed in the statement of a key informant when she spoke about the process of managing SGBV cases:

*We receive them, we do these assessments- we identify the needs, [and] we refer them to relevant service providers which ARC does not provide...what is key with health is that we work closely with Medical Teams especially regarding the preparedness for the management of survivors of SGBV, mainly defilement, rape and sexual assault. Our main referral centre for medicals services is MTI, we refer to other partners like Windle Trust for education, then Nsamizi for livelihood but within ARC we also have a livelihood component. (Protection/Counsellor, ARC)*

This implies that interviews are crucial for finding out the diverse needs of refugees and what support is required to improve service users' circumstances. Some areas where referrals are frequently needed include medical care, education and livelihood support.

Moreover, because of multiple needs, the referrals are managed through inter-agency as well as inter-professional practice. This can be reflected in the following statements:

*They have the psychological burden to carry with them probably for the rest of their lives. Some of them we can support, some of them we cannot. Some of them, it is above*

*us, this is where we are asking assistance from other institutions like even mental institutions. (Counsellor, OPM)*

In other cases, it isn't severity, but a need for specialist care which necessitates referrals:

*If you have a medical case you will refer to the person who knows, if we have a case that needs trauma counselling we refer. (Community Services Assistant OPM).*

This indicates inter-professional practice. It has been noted that inter-professional collaboration happens when practitioners, patients, clients, families, and communities develop and sustain inter-professional working relationships that facilitate optimal health outcomes (Ambrose-Miller & Ashcroft 2016, p.101). One key aspect of making referrals is the skill of administration.

## 8.6 Administration

Many social workers employed by both the department of refugees and the non-governmental sector are engaged in administrative work. Social work administration involves making policies and procedures, implementing strategies and supervising individual cases. Some professionals are part of the refugee eligibility committee (REC) formed by ministries of internal affairs, foreign affairs, external security organisations, internal security organisations, and local government. These social workers perform roles like registration, documentation and/or adjudication on applications for asylum. A key informant stated:

*When they come here we handle. Ours is to receive them, screen those for instance who are going for specialised health services in private health service points or those who are going for these complicated ailments that need to be handled either in Mulago or Kiruddu.” (Senior official, InterAid)*

Another key informant was explicit about monitoring and supervision. She said:

*Our place in this settlement is to coordinate, monitor and supervise all these organisations... Usually, by the time they[refugees] reach my office it's because they have been to the health partner (MTI), either way, I will refer them back but now with, how can I call it, but now, I will have more follow up on the case... when they come to us or to UNHCR to say- 'I went to MTI, my child has this and this issue but I'm not being supported'. So I will go— because I'm not a doctor, I will go back to them[partner], ask them what's up, they could let me know, whether it needs a referral, I will write one. (Assistant Counsellor, OPM)*

Social work administration thus involves making management decisions such as visits to other organisations, paperwork, making phone calls and communication with staff from other organisations. This requires that social workers are conversant with social policy and several



chains of partners dealing with the different sectors. This denotes an organisational function of social work and this is important in meeting the needs of women and children. The next section considers the role of social workers as health educators.

## 8.7 Health Education

Providing health literacy is important to improve refugee women's and children's health. This mainly concerns providing information about healthy living and the prevention of diseases. As I indicated earlier, less than 20% of the survey participants attained above primary education (18.3%). Social workers revealed that they helped to impart knowledge and life skills to the refugee women and children. For example, giving them health education such as nutritional information, information about sexual and reproductive health, vocational skills education, many key informants stressed the role of education:

*We also look at poverty-stricken areas where we do community services, livelihood, education and so forth. We look at a person as a whole" (Senior Official, RMF)*

*We do health promotion specifically on waterborne diseases such as cholera, some of the interventions which we do are awareness campaigns both from the household level to a mass level to sensitise communities on water usage but also safety, access to safe water but also ensuring that the environments in which they live in are secured." (Senior official, IOM)*

*Our main task is to deliver adult education services to the refugees mainly adults who came from their own countries, who do not know how to read and write and we teach them a second language which is used here English" (Community development officer, FRC).*

Laverack (2004) asserts that health promotion without health education indicates manipulative processes of social coercion and community control. Health education is important for raising consciousness about the available health programmes while and aims at complementary social and political actions such as advocacy and community development that facilitate change to enhanced health (Laverack, 2004, p. 10). Facilitating change further necessitates legal support.

## 8.8 Legal Support

The legal status of refugees, especially when newly arrived, is one of the factors which affects health. The key informants confided that the process of settling usually takes three months or longer depending on the conditions of these refugees and during these months many refugees

have very limited access to humanitarian assistance. In order to qualify for legal documents, refugee women must show proof of the reasons which forced them to flee their countries of origin. Hence they are required to give detailed personal witness accounts to the refugee eligibility committee established under section 11 of the Refugee Act, 2006. The professionals also revealed that providing legal support is one of their tasks and that this complements other services.

*But my office is, in a sense, of course being under the sector of community services is in a sense broad as well as may be smaller. Because we are going to deal with things from protection, we are going to deal people with special needs, we are going to deal with educational needs and health needs of people in the settlement even up to issues that deal with legal support. We may not be lawyers as per se but we can give that support where needed. (Assistant Counsellor, OPM)*

This was also revealed by another key informant who said that:

*We have child protection activities that we conduct in the refugees... They ask us to give them some legal support, even going to the settlement to do some social inquiries and we give them support. (Community development officer, District)*

This denotes that social workers providing legal support also contribute to the protection of children from harm. Other research has provided evidence regarding the need for legal support among refugees (e.g. Palattiyil and Sidhva, 2015). They argue that due to memory loss and sometimes stigma, many refugees get traumatised when asked to produce witness accounts and physical evidence to the authorities. Thus without legal support, these factors delay or even impede their resettlement (Palattiyil and Sidhva, 2015). This brings to another role of social work which is assistance with basic needs.

## 8.9 Basic Needs Support

Being that refugees come from impoverished countries to a settlement with poor living conditions, most of the social work in refugee settlement is about providing and distributing material support for survival such as and food and other personal items. They try to help refugees with their primary needs. They allot aid and tents and food which is important as response to crisis as stated by one of the key informants:

*For the case sanitary pads, we always distribute like twice a year and we always like to give a packet for each and every one...we consider the reproductive age 12 to*

49...*We give a packet of sanitary pads, soap and knickers. (Community Services Assistant, OPM)*

Another key informant said:

*For the referral component, we have a hostel, we only receive them, accommodate them, transport them, we feed them, of course, a night they 've spent, transport them to and from these facilities. (Senior official, InterAid)*

All these denote social work which is being done in the form of material aid/ assistance to support refugee women and children. However, the challenge is that this support is insufficient does not meet the refugee demand. This is (as mentioned in Chapter in Seven) due to insufficient resources and large numbers of refugees. Public awareness ins another form of support provided to refugees.

#### 8.10 Public Awareness

Raising awareness about women's and children's rights and the laws of the country is one of the long term solutions for improving health. This is important because there are usually variations between the laws in the host state and the refugees' countries of origin (Koser, 2007). Therefore, this information is important for refugees especially new arrivals to settle in. One of the roles of the humanitarian workers is to raise public awareness and this was reflected in the statement of a key informant:

*For example in Congo, you find a child is somebody below the age of 16 and they have some cultural practices that are not good like early marriage so you find a 17-year-old who is ready for marriage, so we do a lot of awareness about the laws of Uganda in relation to child protection so that they know that as far as Ugandan is concerned, the age is 18 and we do not want such practices like circumcision- female genital mutilation for the girls, early marriages, dropping out of school, we keep following up on those rights of the children to make sure they are protected through the awareness creation in the community and to the children themselves (Child protection officer, HIJRA).*

This indicates that public awareness is also done to influence refugees to re-examine and change traditions and values which are seen as unfair to women and children. However, my respondents reported that some values must be respected in order for consciousness-raising to occur:

*If I may take an example of Muslims- Somali community- most of them are Muslims whereby they expect only men to talk to fellow men, women to talk to fellow women- which is very important, we respect their culture still because we want them to feel like*

*their culture is respected and we also want to extend our services there. (Counsellor, Tutapona).*

This indicates that interventions of this nature should be culturally appropriate and be aligned with the values of the refugee community (Palattiyil and Sidhva, 2015) except where these violate the local law such as early marriage and female genital mutilation. Evidence suggests that one of the challenges of dealing with mental health problems among refugees relates to social contrasts in the perceptions of mental health which more often than not vary from those in host communities (Hiegel, 1991; Carey-Wood et al. 1995; Ewles and Simnett, 2003). Moreover, the findings in this study revealed the tensions which arise as refugees seek to become part of the host community while holding on to their own cultures and values such as female genital mutilation. As I mentioned in Chapter Seven, the Somali community tried to avoid engagements with authorities in order to hide such cases.

### 8.11 Community Capacity Building

WHO (2018) defines capacity-building as the process of increasing community assets, skills and attributes so that people are able to take control over their own health and well-being, and cope with challenges. This is essential for developing, executing and maintaining effective community-based health promotion interventions (WHO 2018, p. 15)

Community capacity building involves working with families and communities to create sustainable networks for social capital. Community organising to achieve health goals encompasses various but interconnected concepts including empowerment, critical consciousness, community capacity, social capital, issue selection, participation and relevance. Likewise, a key informant described her work as involving capacity building:

*We organise focus group discussions and we also do capacity building for community structures because we are believing in community-based protection. (Protection/Counsellor, ARC)*

This is done to improve the skills of women to take charge of their own health issues. Similarly, other key informants expressed concern about the need for micro-entrepreneurial training and skilling and how this might help to improve the health of women and children,

*And then also empowering women in terms of making themselves self-reliant, whatever we do much as we are doing health, you integrate it- interlink to other self-reliant interventions- self-reliant interventions such as livelihood which can be both agriculture and non-agriculture. But also schemes empowerment through vocational*

*skills training... we want to increase self-reliance but also...increase women's access to finances because we know at the end of the day women are the ones who take on the burden of the household in terms of childcare, in terms of ensuring their nutrition, so empowering them and financially would also improve their health care because they have more access but they've also been empowered to make decisions. (Senior official, IOM)*

This concerns empowerment in all aspects of life other than only in one area. This was also emphasised by another key informant,

*Sometimes a lady comes as a single a mother, has ten children, the husband was left back and she has nowhere to start from and again maybe if we could get some things to support women with so that we can empower women so that they can work independently, they can support themselves, they can work and get some money to support themselves. And if we could introduce like these tailoring, hairdressing for free, maybe trainings for free and then give them start-up things, something like that it would help them support themselves other than thinking office will always provide for me, in this problem I go to office and maybe you come to office when things are not there. (Community Services Assistant, OPM)*

This also shows that social work is important in supporting women to become autonomous in matters affecting their complete health and well-being. Although from the statement, it is clear that there is an unmet need for this.

## 8.12 Conclusion

This chapter has examined the contribution of social work in promoting the health and well-being of refugees. As I mentioned earlier, the role of social work is broad. I have shown that improving the health of refugee women and children involves an inter-disciplinary team involving professional social workers and other professionals who are not trained in social work. However, based on the broad definition of social work all these activities have been considered as social work in the settlement. I have shown that social work is important although there are still limitations in its contribution to the well-being of women and children. In the current structure of service provision, social work is invisible and their approaches seem indistinct. These issues will be explored further in Chapters Nine and Ten considering conclusions and recommendations for social work practice. The next chapter presents a discussion of the qualitative and quantitative findings and provides a synthesis of these in relation to the existing body of literature.

## CHAPTER NINE: ANALYSIS AND DISCUSSION

### 9.0 Introduction

The previous three chapters presented the study's qualitative and quantitative findings. They describe the determinants of migrant health that is: health status, health determinants and access to health services (Fernandes and Miguel, 2009). The chapters presented the living conditions, experiences and health concerns of women and children in NRS, accessible health services, the factors which impede effective access and utilisation of health services. What is apparent is an increased disadvantage, exposure to communicable and non-communicable diseases, gender-based violence and abuse and mental health issues and scarce access to quality healthcare. Chapter Eight provided the nature of social work interventions to promote health among refugee women and children to reduce vulnerability. The current chapter attempts to reflect further on the five main themes emerging from the data: The life of women and children in exile, gendered dimensions of health in exile, vulnerability, reflections of the imagined homeland and enunciates the role of social work. Each will be analysed in turn.

### 9.1 Life in Exile

The impact of conflict in the countries neighbouring Uganda (such as the Democratic Republic of Congo, South Sudan, Burundi, Somalia) has been felt by hundreds of women and children forced into exile. There are well-developed theoretical models of aspects of the refugee experience. I have combined these on the basis of my empirical findings. After articulating this complete theory of exile, I will examine how it applies to life at NRS.

Exile is described as a social, political and psychological phenomenon that affects human beings according to the particular circumstances (Svenberg et al, 2009; Papadopoulos, 2007). Alternatively, it can be conceptualised as the unhealable rift forced between a human being and a native place—between the self and its true home (Svenberg et al, 2009). In fact, Papadopoulos (2007) explicitly argues that becoming a refugee is exclusively a socio-political and legal phenomenon and not necessarily a psychological condition (p.301). Living in exile is fairly challenging (particularly the loss of a home) and encompasses psychological implications. (Papadopoulos, 2008). Majodina (1989) states that experiences of exile depict enforced choices which rupture people's cultural past, geographical environment and attachment to society.

According to Papadopoulos (2010), the refugee experience comprises three stages including pre-flight, flight and post-flight. Each phase of the refugee experience presents unique stressors and complications which determine the life and health of refugees. Most refugees fled to NRS to escape a war between the government soldiers and militias in their countries of origin, ethnic violence, persecution, or insecurity. At the outset, their flights to NRS are not stress-free. Once they flee from their homes, refugee women and children spend periods of time in transit routes before reaching places of sanctuary. Refugees make long, gruelling and life-threatening journeys, withstand threats of criminals and sex offenders, and generally face severe travelling conditions (such as starvation and poverty) (Refugee Council, 2009 cited in Papadopoulos 2010, p.18). Papadopoulos (ibid; p.18) states that although obstacles facing refugees have their roots in the socio-political contexts that forced them to flee their countries, their problems can become aggravated by the flight and post-flight stage. Qualitative findings and observations indicate that reaching NRS usually brings about a deep sense of relief, especially from war and gunfire. However, this does not mean that their worries are over. In fact, it is the start of a new stage in their life cycle course called— life in exile. The question is: what are the prospects and experiences of life in exile?

Similar to Svenberg et al., (2009), this study found that life in exile is deeply stressful and psychologically exhausting. This is due to disruptions in access to basic needs (such as food, shelter, health services), disorientation and bereavement (Papadopoulos, 2010). Moreover, after some time of calm, a profound sense of loss of security in various aspects begins to be felt. This comes due to the loss of the emotional security normally provided by family and the broader support system. According to Galambos (2005) refugees experience three types of loss: 1) material loss such as— loss of property, assets and employment; 2) emotional loss which is as a result of the death of close family members or the familiar social support system, and; 3) cultural loss which relates to norms and values. How does this theory capture the experiences of women and children at NRS? The majority of refugee women and children did not make an orderly exit from their homes but were forced to flee unexpectedly (Papadopoulos, 2010). Most of my respondents re-counted disconnection from family, friends and community and loss of property. This is in keeping with the findings of Freedman (2019). In her study of vulnerability amongst the asylum and refugee women in Greece and France, she states that a majority of women arrived in Europe either without any male partner or with only their children (Freedman, 2019). Likewise, some respondents in this study had been able to come to the

settlement with the surviving family members, in particular children. As a result of this, many of the refugee women in NRS are single mothers. This was also affirmed by the key informant from OPM who said: *“We have big numbers of single mothers who are helpless.”* This is revealing of a life which is disconnected from their previously predictable home environment.

With few social connections, their lives are full of isolation. Social isolation contributes to poor physical, emotional and mental health among refugees in exile (UNHCR, 2019; Fassetta et al., 2016) and sets up a vicious circle of further isolation and discrimination (Papadopoulos, 2010; Fernandes and Miguel, 2009). For instance, along with communicable and non-communicable diseases, my respondents also suffer from poor mental health such as anxiety disorders, sleep disturbances, impaired concentration and memory loss, suicidal thoughts, recollections, depression and post-traumatic stress disorders. Mental health problems are also a result of the horrific experiences of violence and continued fears for insecurities among refugee women. Papadopoulos (2007) states that people who have been forced to move into exile without preparation, face a greater risk of suffering psychosocial trauma than those who anticipated the possibility of exile. The main categories of exiles at risk are single people and separated children, and those who have experienced violence and the deaths of close relatives (Papadopoulos, 2008). However, this is not to imply that the existence of family and social connections is a complete assurance of conflict-free exile. Although the family certainly serves as a safety net in exile conditions, in some cases it is also a source of distress (Svenberg et al, 2009). Family conflicts often arise in exile due to diverse causes. Some studies have linked family conflicts to the occurrence of a high number of divorces in refugee communities, which results in male refugees deserting the women, leaving them sole responsibility for the children (e.g. Svenberg et al, 2009; Fernandes and Miguel, 2009).

As would be expected, women and children acquire a new label in exile: refugee women and children. This position marks a loss of national identity and a sudden turning point, being equated with an inferior status compared to the native-born. It is unclear whether they prepare for this transformation when they embark on their journeys. Still, what is apparent is that a search for a place of sanctuary amidst conflict and violence may possibly not allow them time to think about their exile and what will become of them. Reality can only be ascertained at arrival, at which point it remains difficult to change their perceptions. For instance, one Somali woman said: *“I’m a single mother, I have seven children and the father of my children died*



*but I'm not sure, I don't know where he is now, and Nakivale life is very hard... Life is not easy.*" Although this identification (refugee status) has some opportunities and many highly anticipate it (by receiving an attestation card issued by the government) because it guarantees protection, this label is also associated with some challenges.

It is argued that exile is "a brutal interruption of personal history, a brutal process of transplantation that produces a period of mourning for the loss, in different degrees, of a sense of social and institutional belonging" (Majodina 1989, p. 87). This is important when analysing internal conflicts faced by exiled people between the links in their country of origin and the need to be integrated into the host society (Svenberg et al, 2009). This conflict produces a permanent feeling of transition (Papadopoulos, 2010). Since this label reflects a transitional status, it sometimes disempowers the exiles to have control over their destiny and exacerbates feelings of uncertainty about the future. Refugees persistently feel unsettled or disoriented, as characterised by feelings of inexplicable gaps, unreality, unsafety, unpredictability, lack of confidence, pervasive anxiety and frozenness (Papadopoulos (2010).

For instance, the policy of 'community settlement' embraced by the Ugandan government, produces two institutional logics; temporary status— official or bureaucratic logic and another sort of practical logic indicating people staying for an inordinate length of time. An example is that the refugees are intended as temporary, which precludes building permanent homes (Dunn, 2016). As a result, my respondents dwelled in one-roomed informally constructed houses/huts with basic materials provided by UNHCR. This is challenging as it constitutes pathetic health concerns because of poor ventilation and congestion. A study by Allan (2014) reported that the Palestinian refugees in Shatila camp in Lebanon lived in poorly built and insecure homes with the average size of dwellings being 131 square feet with a population density of 5.6 inhabitants per unit (p.18).

Labelling and loss of identity and the subsequent uncertainty nurture feelings of apathy for some refugees who may want to build permanent homes due to both the psychological motivations I described above, and the protracted periods that are usually spent in the settlement.

Nonetheless, it is difficult to determine whether acquiring a new refugee label essentially disconnects them from their home countries. In a study of Somali refugees in Sweden,

Svenberg et al, (2009) observed that even after years of resettlement, their informants had memories of the native country (Somalia) and that these continuously served as a background and a contrast to their experiences in Sweden. Papadopoulos coined the concept of 'nostalgic disorientation' to refer to the exceptional psychological experience of refugees which summarises the totality of home in terms of the physical, geographical, social, and cultural aspects. He (2010, pg. 19) states that:

The 'nostalgic' characterisation of this particular disorientation refers to the original meaning of the word *nostos* that in classical Greek means 'the yearning for home' and *nostalgia* is the pain (*algos*) that accompanies the feeling of pining to return home. Refugees do not constitute anyone coherent diagnostic category of psychopathological characteristics, but the fact that they all have lost their homes involuntarily makes them share a deep sense of nostalgic yearning for restoring that very specific type of loss.

Hence, home is associated with positive feelings, emotions and strong attributes such as warmth, nurture, protection, safety, security, support, and acceptance (Papadopoulos, 2014). These feelings often provoke powerful positive or negative attitudes among refugee populations.

Considering that most women and children lose their property as a result of the conflict in their home countries, their life in exile is further deteriorated by economic deprivation, poor physical conditions and inadequate access to basic needs and services. Similar to Fernandes and Miguel (2009), the poor health status of refugee women and children in NRS was due to a combination of factors such as poor living conditions and limited access to disease prevention, treatment and rehabilitation services. As result, it is very difficult for women to cope and support their children without the wider family, social support and cultural resources available at home. Yet it is impossible for UNHCR to provide for all their needs. According to Papadopoulos (2007) these needs are multi-faceted and multi-dimensional and may cover the entire spectrum of human needs from the basics of human survival (safety, food and shelter) to the higher ones in Maslow's (1943) hierarchy of needs, such as the need for love, belonging, status, self-esteem and self-actualisation (p.302). Thus, in spite of surviving, the experience of exile is subjectively felt as distressing, degrading and dehumanising. This fact easily fits into experiences the refugees documented in a large body of literature concerning the poor living conditions of refugees (e.g., Palattiyil and Sidhva 2011; Allan 2014; Wachter et al., 2016). The implication

is that people's lives are reduced to 'bare life,' which further symbolises an exclusion of these from the human race (Grayson, 2017).

The qualitative accounts reveal that the respondents find it hard to adapt to life in NRS. They come with expectations of protection and achieving a decent life but they end up suffering additional challenges to life. Uganda, as a party to various international treaties, including The International Convention Relating to the Status of Refugees and the Universal Declaration on Human Rights has, therefore, national and international obligations to ensure that refugees within the country's boundaries live a decent life. For various reasons, these obligations are more or less unmet. For instance, the government maintains an open-border policy, allowing all asylum seekers to enter the country without any restriction. This is humane and commendable; however, this suggests that there is no prior planning for new refugees. As a result, new arrivals ultimately live on the edge and they subsist on humanitarian aid. Depending on humanitarian assistance for meeting all their needs is distressing. Papadopoulos (2002) states that humanitarian assistance in various refugee situations is often provided based on the multiplicity of socio-political rather than on the objective appreciation of their needs. Grayson (2017) describes this as minimalist protection that ensures bare survival, but not a dignified life. Being caught in a precarious existence and in desperate need of basic services and security for themselves and their children, the most of the respondents (as I will expand later in this chapter) wished to be resettled in the developed countries where they believe that their life will be better (Ikanda, 2018; Papadopoulos, 2008). That said, the majority have remained in NRS, and remain exposed to a range of social and economic deprivations.

Refugee status also impacted the experience of life in exile more directly in the form of discrimination. Olivius (2014) describes refugee camps/settlements as enclaves that are intentionally situated outside of the social and political systems of the host state. About 6.6% of the women interviewed indicated that they had experienced negative treatment from service providers precisely by being rude and disrespectful of them. This was confirmed in several interviews with refugee women. For instance, when answering the question about how to improve health care for women and children in the settlement, a refugee woman made an explicit request. She said: *"It is better those who work at the health centres, those nurses, midwives or doctors to be counselled and trained so that when we go there they could treat us well."* Their perception is that they are treated in this manner because of their low refugee

status. Although humanitarian assistance is essential during crises, it may well cause inadvertent harm and increase pain if it is not administered in a sensitive way (Papadopoulos, 2010). The finding of disrespect in this study indicates that refugee women could be experiencing oppression and are treated as people without autonomy. This finding is very consistent with previous research, which has shown a high degree of stigma, discriminatory and authoritarian policies against forced migrants (Palattiyil and Sidhva, 2011; Freedman, 2019). Freedman reveals a type of symbolic violence that is ordinarily experienced by refugee women arriving in Europe, and particularly those who are easily identified as Muslim. During an individual interview with a Syrian woman in Paris, she said: *“They gave me 1kg of chocolate biscuits, and I told them I don’t like chocolate. But then they said «I thought you said you were hungry. If you’re hungry you’ll eat them». I felt so humiliated. They just treated me as if I was stupid”* (Freedman 2019, p.10). This kind of discrimination marks the refugees as exceptions rather than as ordinary citizens, as required by international law. Discrimination of refugee women deprives them of the agency for communicating their needs. In addition to decreased access to health services, it affects physical and mental health (Fernandes and Miguel, 2009). Experience of alienation and problems with integration into the host community is also associated with poor health outcomes (Svenberg et al, 2009). Discrimination highlights the ways in which refugee status interacts with gender as a social determinant of migrant health, which I will now consider more closely.

## 9.2 Gendered Dimensions of Health in Exile

Gendered realities of refugee women in relation to their context provide a comprehensive understanding of their health needs and those of their children. Gender ascertains the social relationships among men and women (Moser, 2003). CSDH (2008, p.16) states that the position of women in society is directly linked with child health and survival. Gender attributes are context- and time-specific social constructions which determine differences and inequalities between women and men (Moser, 2003). Gender is a vital element of health because it impacts exposure to common drivers of ill-health, health-care seeking patterns, and the response of the health systems to illness (Hawkes et al., 2017). Refugee settlements are described as “contact zones or social spaces where disparate cultures meet, clash, and grapple with each other, often in highly asymmetrical relations of domination and subordination” (Pratt, 1992 cited in Olivius 2014, p.30). The refugees are routinely administrated by international humanitarian

organisations (which deliver life-saving relief) and a variety of actors—characterised by complex and unequal divisions of labour, authority and control.

The findings reveal the manifestations of gender diversities among exiles in NRS. First, it is important to recognise that NRS is characterised by highly asymmetrical power relations between men and women and among the different groups of refugees. Many of the refugee women came from societies with varying gender norms and gender relations and hold diverse cultural norms. These (such as violence against women and children, cultural and faith-based beliefs, cultural perceptions and lifestyle) remain intact even within the refugee setting and affect their quality of life. In this study, the Somalis were for instance reported as having a secretive culture that covers up domestic and child abuse. Stamatel and Zhang (2018) suggest that gendered behaviours, coupled with the loss of social support networks and language difficulties exacerbate the risks of violence for refugee women. For instance, refugee women are often more isolated than men because of cultural influences and attempts to “protect” them from unknown dangers; despite that this reduces their social connections, access to community resources and cultural influences (Stamatel and Zhang, 2018). This (as I will indicate later in the chapter) implies a careful consideration of the interplay of social determinants, the behaviours of all stakeholders as well as responses of health-systems in relation to gender.

The key informants explained that the gender position and identity of women also depended on their nationality. This also implies that not every woman faces challenges the same way, for instance, the patterns and experiences of violence vary across refugee women and children (Alsaba and Kapilashrami, 2016). For example, it was revealed that the Somali culture forbids frequent interactions between women and men—and this affected their access and utilisation of health services. Similarly, Somali and Burundian women were reported as highly vulnerable due to a culture of subordination and silence; they were also unlikely to report violence against women and children to authorities. Many key informants expressed this concern. For instance, a police officer said: *“Somalis, they say, like those rape cases and defilement, ‘don’t go and report, why do you report?’ with Somalis believing in their religion, defilement is not there.”* Research shows that refugee women are often reluctant to report violence or seek assistance because they have been socialised into subordinate gender roles that embrace the culture of shame and silence in response to violence against women (Stamatel and Zhang, 2018; Alsaba and Kapilashrami, 2016). For instance, Alsaba and Kapilashrami (2016) state that while the

Syrian women experience violence such as domestic violence and sexual harassment, these are portrayed as private issues shaped by patriarchal beliefs around men's rightful control over women's sexuality and that challenging the privacy of these or any attempts by women to report are constructed as betrayal of family and violation of social cohesion (p.9). The gender norms that exalt male sexual dominance limit women's ability to control their reproductive and sexual health (Nalukwago et al., 2019). These dynamics are important in seeking to understand the gendered division of labour.

The gendered division of labour in NRS depicts variations in the social relations between women and men. Moser (2003, p.230) offers a precise conceptualisation of gender roles. She considers that low-income women always have a triple role including reproduction<sup>28</sup>, production<sup>29</sup> and community management activities<sup>30</sup> while men simply focus on production and community politics<sup>31</sup>. Erez and Bhat (2010) highlight the role of patriarchy (or male hegemony) as the cultural basis underlying gender roles and power differentials between the sexes. This was also reflected in the words of an assistant counsellor saying “*we have communities where women will tell you, for example their husbands don't allow them to go for such treatments... You find that because of that patriarchy thing— to them it's still a huge thing here actually*”. Following Crawford et al. (2017, p. 65), I argue that gender analysis should not be confined to relations between men and women but should be broadened to include relations to wider social contexts such as the household, community, the public and the state (*ibid*, p.65). The findings reveal that responsibilities of women and men in NRS are diverse and reflect male domination. For example, refugee women were responsible for carrying out domestic chores and agricultural work. However, the respondents stated that while they spend large amounts of time working without rest, their partners sell their produce (and sometimes even the food rations) and divert the income to their personal desires like drinking alcohol while some are ‘rewarded’ with violence. This was revealed in an interview with a Congolese woman: “*We*

---

<sup>28</sup> The reproductive role refers to child bearing and rearing responsibilities and domestic tasks done by women, required to guarantee the maintenance and reproduction of the labour force (Moser 2003, p.230)

<sup>29</sup> This refers to work done by both women and men for pay in cash or kind (*ibid*).

<sup>30</sup> These denote voluntary and unpaid activities undertaken primarily by women at the community level as an extension of their reproductive role to ensure the provision and maintenance of scarce resources of collective consumption such as water (*ibid*).

<sup>31</sup> These are activities undertaken primarily by men at the community level and they are either paid directly by cash or indirectly through status and power (*ibid*).

*work hard alone...women are the ones who go to find firewood which is a challenge here [NRS] so the woman does not have time to rest, [and] every time we face violence.*” This reflects proliferation of gender inequitable norms (Nalukwago et al., 2019). Being occupied with such roles has consequences for their health and that of their children, for instance, this results in less time for attending health sensitisation efforts and fewer opportunities for cultural interaction. Conversely, there have also been reports of increased violence against women in contexts where ordinarily gender and power relations within families are altered to favour women as a result of migration (Alsaba and Kapilashrami, 2016; Freedman, 2019). In a study of Somali refugees in Sweden, Svenberg and colleagues (2009) observed that gender roles among Somali families in Sweden suffered dramatic transformations with women generally assuming a higher place in the family hierarchy than in their homeland. Moreover, it was revealed that due to unemployment, the men lost their authority as breadwinners of the family, which further strengthened women’s influence. A similar situation was revealed by a Congolese man in Rubondo stating that *“if a woman goes to the village and brings that little thing when they go to eat[it], she starts abusing [him]you are eating my food you don’t buy[it].”* These complex relations between the household, community and the public reproduce gendered dynamics that impact on women and children’s health.

Another vital aspect concerning gender was the reality of high rates of sexual and gender-based violence (SGBV) in NRS. SGBV is defined as any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to persons on the basis of their sex or gender, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life (UNHCR 2018, p.10). A key finding of this study is that almost all the sampled refugee women had faced significant sexual and gender-based violence both in the countries of origin and while in the NRS. This mirrors the finding of Papadopoulos (2008) among Somali refugee camps in Dadaab, Eastern Kenya. He reveals that they were confronted with serious threats from roaming bandits who often attacked, robbed and raped women who ventured out of the camps to collect firewood. It is assumed that conflict and forced displacement jeopardises women and children’s health because such events create new forms of violence and intensify its already existing patterns (Alsaba and Kapilashrami, 2016). Some studies suggest that during the conflict, several actions of sexual violence such as rape, forced marriage and early marriage happen in inexplicit and complex ways (Kamya, 2017).

The New York Declaration for Refugees and Migrants appeals that all responses to large movements of refugees and migrants must fully respect and protect the human rights of women and girls especially by combating SGBV and providing access to sexual and reproductive health care services (United Nations, 2016). Despite this, it is important to note that refugee women still experience these acts of human rights violations. My respondents experienced psychological torture (53.3%), domestic violence (46.7%), physical torture (35.7%), sexual exploitation (25.2%), forced marriages (12.2%), forced prostitution (7.8%), and female genital mutilation (4.3%). The most recent Uganda Country report ranks rape as the most prevalent form of SGBV (36%) among Congolese and Burundian refugees (UNHCR, 2019). Likewise, several qualitative interviews in this study revealed high rates of rape in NRS. One Congolese woman said: *“Others[women] may be going to look for charcoal they are raped... they [authorities] try to investigate but of course because there [rape cases] are too many here, they try but of course, they can't finish it.”* SGBV reflects men's ability to control and dominate women, for instance, feminists argue that the root causes of rape are, inequality and male dominance (Erez & Bhat, 2010). In fact, rape has always been reported as a weapon of war (Alsaba and Kapilashrami, 2016) although as I articulated earlier, other forms of SGBV occur as a result of alterations in the traditional power balance within households which follow as a result of migration (UNHCR, 2019). The proliferation of SGBV such as endemic rape in NRS reflects lack of access to adequate protection as well as limitations in the laws and policies, for instance, the availability of inadequate police in NRS and refugees' limited utilisation thereof. This shows that the social-cultural processes which shape gender dynamics in refugee situations are ignored by the authorities. As a result, the experiences and needs of women and girls are still not given vital attention in terms of robust responses. According to UNHCR guidelines, all SGBV prevention interventions should be mainstreamed in all responses both during the emergency phase and programming across all sectors of humanitarian assistance (UNHCR, 2018).

Although some services such as family planning are available, some refugee women had limitations for decision making in matters concerning their health choices. The survey data revealed that 93.6% of respondents (N=377) had children at the time of this study. However, in every ten respondents, three mothers had conceived without intent. Several accounts of refusal by husbands to use family planning methods were received in spite of women having



the most responsibility for childcare. Over 19.8% of women (N=202) stated that using contraception was not their decision. A similar description was offered by women who engage in survival sex. Some of the women were forced by their husbands in order to earn income and meet the family's needs. Unwanted pregnancies and other issues such as STIs resulting from lack of women's autonomy reveal pain and distress. Notably, these inequalities contribute to reproductive health problems and exacerbate the risk of mental health problems among refugee women. Sociocultural norms and related patterns of behaviours such as physical and sexual violence and women's lack of autonomy in decision-making in matters affecting their health are expressions of masculinity which impact women's health.

There is evidence indicating that the private, familial and personal relationships between men and women are sites of male domination and oppression to women (Orme and Karvinen-Niinikoski, 2012). The experiences of poor reproductive health, sexual and gender-based violence such as rape, harmful traditional practices, unwanted pregnancies and STIs including HIV/AIDS infection among women in NRS show a denial of reproductive rights and reflects lack of equal status. As specified by Orme and Karvinen-Niinikoski (2012), inequality relates to power and its distribution. Alsaba and Kapilashrami (2016), argues that the gendered dimension of violence during and after displacement is linked to patriarchy and is influenced by the impact of conflict on the gendered distribution of economic and social resources. As I mentioned earlier in the chapter, the refugee women and children live in abject poverty and as I will examine in the ensuing sections, have low social status and social capital.

In refugee situations, the concept of gender needs to be considered in relation to other intersecting forms of marginalisation that structure women's lives differently from those of men (Alsaba and Kapilashrami, 2016; Olivius, 2014). The interconnections between gender, forced migrations, violence and insecurity have been commented on in the large body of literature (Alsaba and Kapilashrami, 2016; Palattiyil and Sidhva 2011; Fassetta et al; 2016; Crawford et al, 2017; Manandhar et al, 2018; Fassetta and Quinn, 2018; Freedman, 2019). Manandhar et al, (2018) state that gender intersects with other elements such as ethnicity, class and economic position, to create complex effects on health and well-being.

In addition, Freedman (2019 p.3) argues:

Different push and pull factors, migration control regimes, as well as social and economic conditions in countries of origin, transit and destination create

varying types of insecurity and violence for men and women, depending on their varying social and economic positions and the relations of power between them.

The concept of intersectionality can be inferred to the experiences of women in NRS due to their precarious immigration status, and experiences of trauma and gender-based violence. The social determinants of health such as exclusion from national citizenship by way of becoming refugees, ethnicity or origin, their settlement in the Global-South, their socio-economic status, and their confinement to a refugee setting influence their health, safety, and well-being (Alsaba and Kapilashrami, 2016). For instance, a key informant from IOM said: *“It depends on the environment where they come from, for example... this population from Congo, there are a lot of health-related issues there, and of course if we take like TB...when they come, they stay first in the transit centres where people are very many so we don’t know the conditions of everybody, so they may end up getting certain diseases.”* The social determinants also determine access health care services. While the migratory process involves varied health risks, it is also known that their refugee status (in terms of ethnicity, gender, or socioeconomic status) limits behavioural choices, alters their social positioning, and places individuals in uncertain and hostile relationships with service providers (Fleischman et al., 2015; Zimmerman et al. 2011). A variety of factors such as exposure to risks earlier in the migratory process (pre-departure, in transit, upon arrival); social factors (language skills, race/ethnicity, gender, level of literacy and/or education, degrees of social cohesion/integration, discrimination, social inequalities); bureaucratic and legal factors (legal status, organisation of the health care system); economic factors (access to paid work , income); environmental factors (living and working conditions, physical environment); and rights-related factors ( availability, accessibility, acceptability and quality of services) intersect to determine the health of refugee women and children (Fleischman et al. 2015, p.89; Alsaba and Kapilashrami, 2016). These intersectional aspects shape the health of migrant women and children need to be carefully considered alongside gender (United Nations, 2016). Moreover, these dynamics determine gender inequalities and are critical when seeking to understand health needs. A consideration of these is also crucial for designing appropriate gender-sensitive and gender-balanced services.

The implementing partners in the settlement are encouraged by UNHCR to incorporate the concept of gender in delivering humanitarian assistance to refugees. During qualitative interviews, the majority of key informants remarked upon the importance of gender-awareness and -sensitivity in response to the health needs of refugees. However, several women pointed

to the continued gender inequities, indicating that the narrations of key informants were ideals not corroborated in subsequent practice. The complex nature of the setting might contribute to this minimal or lack of effective action. Given the poor living conditions exacerbated by multiple deprivations, it is likely that all refugees seem disadvantaged and needy. As stated by a Somali refugee woman: *“We are refugees. Refugees, they have a lot of problems.”* Hence it is not a surprise that authorities perceive everyone to be vulnerable regardless of gender. Subsequently, organisations succumb to pressure to implement gender-sensitive interventions but without proper planning and preparation of how to do so. Some organisations try to include the concept of gender into their policies, however, this is not fully reflected in their practice, as outlined by an academic: *“Whereas the UNHCR standards sphere actually talks about the need to focus on men, women, gender...how it actually plays out in terms of these communities doesn’t actually come out clearly.”* During interviews, it was revealed that organisations used men in most of their interventions such as hygiene promotion even when they knew that some roles are dominated by women. This is not intended to indicate approval of the prevalent gender division of labour or deliberate in any way to support imbalanced gender stereotypes. Conversely, as I stated earlier, refugee women are preoccupied with household work such as preparation of family meals, collecting firewood and water. Hence, interventions that focus on such aspects to improve health outcomes should engage as many women. However, because of power and financial incentives attached to leadership in these roles such as hygiene promoters or water user committees, the women appeared to be largely neglected in these roles.

In a broader sense, a gendered analysis needs to focus on social-cultural norms which create unequal gender relations and women’s oppression. It should adopt a gender mainstreaming perspective, promote gender equality and empower women and girls (United Nations, 2016). As a result, women’s dignity must be the goal of all gendered actions in refugee contexts such as NRS; where women are dominated by men and where levels of violence against women are very high. Moreover, it is also crucial to note that gender inequities and experiences of oppression resulting from these are not universal. There are different across refugees from different cultural and religious backgrounds. What is universal is that their effect on women and children’s health and well-being. This means that any attempts to achieve gender equity in these contexts must listen and respect the experiences and voices of women. Therefore, in addition to the transformation of gender relations/roles, gender-sensitive interventions must also concentrate on realising women’s rights and improvement in women’s well-being

(Crawford et al 2017, p.81). At the same time, this calls for recognition of women in communities (different needs, vulnerabilities, opportunities and capacities), to ensure that they equally participate in the development of responses to address their concerns (United Nations, 2016). We turn now to those vulnerabilities of exile specific to women and children in NRS.

### 9.3 Vulnerability in Exile

Women and children face varied risks and vulnerabilities during the migration process for different reasons (IOM, 2017). The concept is relative and dynamic, depending on the context and individual circumstances (UNHCR and IDC, 2016). Describing vulnerability in the context of refugee settings is not only crucial for categorising situations wherein refugee women and children are vulnerable, but it also allows for early interventions and leads to effective care of individuals in need (UNHCR and IDC, 2016). It is also important in the process of determining protection. Nugent et al. (2014, p.680) assert that the definition of vulnerability must take into consideration the pre-risk characteristics, the wider structural conditions, the type of suffering or risky event and the various complex interactions between these dimensions.

These are important given the different push and pull factors, social and economic conditions of forced migrants in their countries of origin, during transit, in their final destinations as well as the migration policies which determine their status in host nations. Hence, determining vulnerability requires answering two critical questions: 1) To what threat is the individual vulnerable; 2) what exactly makes them vulnerable to that threat? (Nugent et al. 2014).

Women and children in Nakivale are vulnerable to various threats for different reasons. Different physical, economic, social and political factors lead to vulnerability and also determine people's capacity to resist, cope with and recover from it (WHO, 2019). With this background, vulnerability depends on the contextual, relational and dynamic<sup>32</sup> aspects of each individual or group. The refugee women and children in this study may well be considered vulnerable due to physical, social, and economic factors. We will review the influence of each of these broad factors in turn.

---

<sup>32</sup> Contextual (i.e. dependent on its contexts of time, place and conditions), relational (i.e. dependent on the interaction with others, persons, groups and services) and dynamic (i.e. not static but subject to change in time, responding to the surrounding changing circumstances) (Papadopoulos 2010, p.25).

Physically, the settlement is located in one of the rural districts with minimal access to services such as transportation, police, judicial services, and communication. It is noted that the location of forced migrants is crucial in the production of their vulnerability and exclusionary experiences (Papadopoulos, 2008; Stewart, 2005). A recent Uganda country report indicates that refugees in remote areas face significant challenges in accessing justice and police services, especially female police officers, and maintains that this is a barrier for female refugees to report SGBV incidents (UNHCR 2019, p.14). Respondents and key informants attest that the location of the settlement increases residents' vulnerability. For instance, the words of the social work academic reveal this: "*Actually in the West [of Uganda], Isingiro [research district] is one of the poorest districts in terms of access to social services, so you wonder why the refugees then have to settle in those areas*" As well, a wide area of NRS is covered with hills and bushes. Yet in order to support their families, refugee women are usually forced to travel long distances away from home in search of firewood (UNHCR, 2019; Mulumba, 2011; Papadopoulos; 2008) or farm-work to make income. A substantial percentage (93.3%) of respondents said that they restricted their movements in the camp especially in the evening due to insecurity. Similarly, Allan revealed that Lebanon's Shatila camp was occupied with poorly constructed structures that lean precariously into one another, reducing the amount of natural light in the camp and leaving homes and walkways insecure for the residents (2014, p.18). It is important to note that the location of refugees is also important when seeking to understand exclusionary policies of host governments. Although settlements serve as central points for delivering aid and health services to refugees, Dunn (2016) states that keeping refugees in remote places benefits host governments who often want to keep refugees from resettling themselves permanently in major urban labour markets. This also simplifies work in case of any need for deporting refugees to their countries of origin (*ibid*, 2016). All these aspects influence refugee integration into host countries.

Low social capital in refugee situations is manifest considering the circumstances that push people out of their countries and experiences throughout their journeys and while in exile. In view of this, the respondents had limited social networks and social support. Research indicates that refugees, who have extended social networks are able to receive remittances from them (Papadopoulos, 2008; Massey, 1999) which is crucial during crises (such as water and food shortages). With this, they may also be in a better position to build additional networks, while those deprived of social networks often experience greater social exclusion (UNHCR, 2018).

The survey revealed that refugees perceived themselves as having limited care and assistance: for instance, 65.5% of those sampled (N=377) revealed that they lacked family assistance. A significant percentage did not perceive either their neighbours (50.1%) or their community (55.1%) as dependable or supportive. Being deprived of necessary social networks denotes a lack of resources for emotional support, information and advice, or companionship and sometimes financial assistance (Massey, 1999). This also implies that without such networks refugees might resort to precarious survival strategies such as survival sex, which in turn further aggravates their vulnerability. A Congolese woman from Juru's words reflects this: "*Honestly if I don't sleep with men, there is no way they [her children] can eat.*" Therefore, the lack of proper social connections shows significant challenges in terms of coping with life in exile. It is noted that social vulnerability in foreign contexts is also intensified by a sense of not belonging, traumatic memories as well as experiences of dysfunctional family situations in alien conditions (Svenberg et al., 2009). Moreover, low social capital innately affects the economic well-being of refugees.

Economic vulnerability is predictable due to poverty and lack of formal employment. Like previous studies, I argue that poverty is the most significant factor influencing vulnerability (e.g. Papadopoulos 2010; Dunn, 2016). Further research indicates a close connection between destitution and poor mental health (Fassetta and Quinn, 2018; Quinn and Knifton, 2014). It has been noted that at least 80 percent of refugees in Uganda live below the international poverty line of US\$ 1.9 per day (UNHCR 2019, p.26). According to Adger (2000) vulnerability leads to disruption of a group or individual livelihoods and loss of security. This has greater implications for economic and social status, for instance, in the cases of lack of income and resources. A significant percentage (58%) of women live on subsistence farming and mainly work for the local hosts (Ugandans). This leads to increased vulnerability specifically exploitation and abuse. Moreover, working for the locals is a cause for concern because they also live in poverty. In some districts where the refugees have been settled, the local community considers themselves to be more vulnerable than refugees since they don't obtain assistance like their refugee guests. This was also reflected in an interview with a community development officer at the district<sup>33</sup> who said that: "*At least the- in the settlement those people [refugees]*

---

<sup>33</sup> This refers to Isingiro District Headquarters

*have even almost better services than Ugandans because there are many organisations.*” In the Yumbe<sup>34</sup> district, the host community perceived the refugees to be better off due to the food assistance which they receive (UNHCR 2018, p.92). In fact, it has been reported that lack of support for host communities generates tensions between host communities and refugees in Uganda including those in Nakivale (UNHCR, 2018). This is unlike Allan (2014) who highlights that unemployment for Palestinian refugees in Lebanon led to extreme poverty among refugees which was four times greater than the native Lebanese. Extreme poverty deprives the refugees of a decent level of living and exacerbates distress in exile.

Despite a genuine need for relief, economic vulnerability among the respondents can also be cited (as I indicated at the start) due to complete dependence on humanitarian assistance for practically meeting all their basic needs such as food, medical care and personal items. One of the complications revealed by the findings is that support to refugees is mostly available during a crisis (for instance when there is new conflict in the neighbouring countries where refugees came from) and often does not meet the demand created by the surging numbers of refugees. This further implies that the refugees are affected by the unreliable and unsustainable nature of assistance programmes. Put bluntly, institutional logics and humanitarian decision-making directly touch refugee’s lives. Dunn (2016, p.772) argues “that humanitarian aid is a temporary solution to a permanent problem, a stopgap that not only does not help displaced people resettle but, instead, makes it more difficult for them to move on with their lives.” Indeed, here bureaucracy (funding cuts, inadequate planning or failure to respond to need can mean life or death for women and children. A recent report states that the rates of dependence on humanitarian assistance in NRS are alarming (67%) due to the lack of sustainable and resilient livelihoods (UNHCR, 2019). In protracted refugee situations, international support is reduced or suspended to focus on high profile refugee crises where people are either fleeing or repatriating in large numbers (Omata, 2017). The worries and anxiety created by reduction and suspension of assistance lead to uncertainty about survival. Moreover, it has been noted that relief programmes create insecurity, increase clientelism and account for normalisation of dependency among refugees (Allan, 2014). Reports of key informants indicated similarly high levels of helplessness due to dependency on external support at Nakivale. A key informant

---

<sup>34</sup> This is another refugee hosting district in Uganda

from UNHCR said: *There is still that tendency of dependency syndrome whereby we cannot hear that someone feels he can stand on his own or her own. What people think, pursue is that 'we are refugees- we are refugees'*. Such normalisation of dependency among refugees often demonstrated by less will to take up work and responsibility at times is attributed to legislation and policies which classify women as vulnerable victims (Freedman, 2019). While this guarantees protection for refugee women who experience difficult circumstances like gendered forms of violence, persecution and discrimination, internalising the 'refugee label' negatively impacts individual self-worth.

Similarly, Stewart (2005) notes that although the vulnerability label may be associated with some opportunities such as the provision of special care, support and protection, it also has negative connotations. Labelling individuals as '*vulnerable*' risks viewing them as problems, different, marginalised, and pitiable (King, 2016). Moreover, some scholars warn that although the concept is intended to empower, it may well exaggerate the circumstances of its holders and at worst infantilise them (Brown and Hunter, 2016). With this, refugees respond by preserving their accumulated experiences in exile to keep their vulnerability alive (Ikanda, 2018) so that they can maintain compassion instead of moving on or transforming their lives. Hence, vulnerability may then be perceived as a stable and enduring trait, further heightening hopelessness and risk of dependence. These dynamic forces reflect another level of vulnerability—political vulnerability.

Political reasons additionally made some dimension of vulnerability for exile women and children in the NRS. Usage of politics here denotes administrative, policy and decision making relating to matters of refugee support within the settlement. The settlement is managed by the Office of the Prime Minister (OPM), mainly by the settlement commandant, although UNHCR oversees and monitors the implementation of sub-projects in protection, community services, health, nutrition, water, sanitation and hygiene (WASH), livelihoods, and environmental activities (UNHCR, 2014). The general service provision in the camp is run by a number of implementing partners (IPs) which mainly include NGO partners for each sector such as health and education. The main implementing partner for health and nutrition in NRS is Medical Teams International (MTI). This is significant for refugees because various NGOs and agencies are working to improve their conditions. However, this is confusing for women and children who must discover the roles of each provider in order for them to access desired services. Moreover, confusion is also caused by the complexity of the process due to communication



problems and the lack of clear channels to distribute information (Papadopoulos, 2010, p.36). This is exhausting and laborious especially when people lack means to do so. Hence, the processes and procedures of accessing services expose them to shocks and stressors. Nugent et al, (2014) assert that shocks (sudden events) and stressors (challenges in service delivery) often threaten the well-being of individuals. For instance, the survey found that close to half of the respondents (46.2%) did not know which specific office to approach in case they had problems. Another factor causing confusion is the present duplication of services. This, as stated by a community development officer that: “*MTI also delivers the same services that the government does,*” has adverse consequences. In addition to causing misunderstandings for refugees, it also leads to wastage of already insufficient resources. Dunn (2016, p. 773) states that humanitarian agencies operate in a chaotic and improvisational “adhocracy<sup>35</sup>” which leads to aiding that does not address the issues of the general population to whom it is given. Moreover, limited or lack of coordination between organisations providing services for refugees produces additional despair since this affects the referral pathway to services. The respondents narrated how they re-told their experiences every time they went to a different organisation causing them emotional distress and trauma. Several accounts of the respondents reflect these inconsistencies in service delivery. Some women narrated how they moved from one organisation to the other and even gave up seeking support. This was specifically when they required referral for specialised medical examinations, or when they needed land or with requests for resettlement. A key informant from IOM also made reference to this weakness. She said: “*There is data here and there. IOM has data, UNHCR has its data, International Labour Organisation has its data but that harmonisation is a problem.*” It is claimed that agencies may be generally unwilling to share planning or information with each other because of existing competition for funding from donors (Dunn, 2016, p.773). The inconsistencies and lack of coordination among service providers lead to bureaucracy in managing and responding to the needs of women and further escalate their exposure to risk and harm. Delays in support provision are associated with high levels of stress and result in poor mental health and anxiety (Fassetta and Quinn, 2018; Dunn, 2016).

---

<sup>35</sup> Dunn (2016, p.773) states that States that when there are many organisations responding to one crisis, they do not coordinate their efforts with one another. For example, they can conduct identical surveys, deliver the same goods to easy-to-reach camps but will not deliver other urgently needed supplies, and will overlook people who are more distant but equally in need

Politics is also not absent in the administration of resettlement— which is identified as a durable solution for refugees under the UNHCR’s mandate. NRS is one of the settlements under the resettlement programme of UNHCR however, the screening and verification criteria were unclear to participants creating further vulnerability for exile women and children. Resettlement encompasses the selection and transfer of refugees from a state in which they have sought protection to a third state which has agreed to admit them with permanent residence status (UNHCR 2011, p.3). It has three main purposes:

- a) to provide international protection and meet the specific needs of individual refugees whose life, liberty, safety, health or other fundamental rights are at risk in the country where they have sought refuge;
- b) a durable solution for larger numbers or groups of refugees, alongside the other durable solutions of voluntary repatriation and local integration; and
- c) a tangible expression of international solidarity and a responsibility-sharing mechanism, allowing states to help share responsibility for refugee protection, and reduce problems impacting the country of asylum (UNHCR 2011, p3).

Despite these key functions, Freedman (2019) asserts that EU asylum and immigration policies embrace a gendered categorisation of women as vulnerable. Certainly, the key informants shared that the resettlement programme considers women and children vulnerable and that many countries where the refugees are resettled such as Sweden, Canada and USA readily accepted women and children. It is reasonable that UNHCR cannot have the capability to resettle all refugees which necessitate criteria to eliminate some people or to prioritise others based on individual circumstances. Although identification of certain people as vulnerable is vital to mainstream services to meet their needs, generalised grouping of certain categories of people as vulnerable without contextualising their circumstances country such as access to services is problematic (Papadopoulos, 2010). Freedman (2019) advises that any efforts to define and utilise the category of vulnerability should fully acknowledge the contextual and relational nature of being vulnerable and recognise that anyone, whatever their identity or status, may sometimes be rendered vulnerable (p.12). Given the general deprivation in the settlement, individual respondents assumed that they were vulnerable and met preconditions for resettlement. Moreover, the fact people are assigned new labels such as ‘refugee’ denotes a certain level of vulnerability (Stewart, 2005). While resettlement is considered by UNHCR

as a last option to resolving refugee problems, more than one-third (36.8%) of the respondents found this possibility appealing, as an opportunity to better their lives for two reasons.

First, correspondence that life in developed countries is comfortable; and secondly, camps are rightly seen as unproductive (Ikanda, 2018).

Some studies also describe this as a resettlement syndrome citing that certain groups appear more susceptible or inclined to chain migration, particularly the Somalis (Papadopoulos (2008). Clearly, the respondents knew that one had to prove vulnerability in order to qualify for resettlement. Those who supposed that they would not be perceived as vulnerable resorted to precarious measures to put forth a non-questionable case of vulnerability to secure their futures. An interview with a nurse specified the practice of mothers scratching their daughters' genitalia so that they reported to UNHCR and would be considered for resettlement. This shows multiple and interacting vulnerabilities including self-inflicted, connivance and planned crimes. The finding parallels to the animation of 'refugeeness' through vulnerabilities reported by Ikanda (2018) in a study of Somali refugees in Kenya. Drawing on Ticktins' exceptionalism in humanitarianism (which states that recipients must exhibit a limited version of humanity, personified by the apolitical, suffering body to qualify for humanitarian assistance. Ikanda shows that 'refugeeness' was a labour-intensive process that demanded sacrifice, new ideas and response to uncertainty (Ikanda 2018, p.582). This is also referred to as maintenance of 'victim identity' by Papadopoulos (2008). This is done to reaffirm the 'rescuer' position of the humanitarian workers (for instance this could be through masking connections or other sources of support) so that refugees are able to acquire maximum benefits from them (Papadopoulos 2008; Ikanda, 2018).

Although, UNHCR and IDC (2016) state that certain categories such as children are readily acceptable as vulnerable and in need of social care, support and protection, it is not clear what the individual circumstances and contextual determinants of vulnerability exist for other groups of people. Despite the fact that officials are required to follow prescribed guidelines and screening tools, a range of factors might contribute to omissions and inaccuracies. Individual service user characteristics such as the inability to communicate, shame or stigma and lack of trust at times make them unclear or hesitant to disclose certain experiences (UNHCR and IDC, 2016). Hence officials may not conduct a reliable identification of vulnerability.

Given the perceptions of high corruption rates and the alleged mismanagement of refugee resources<sup>36</sup> at the office of the Prime Minister (NPC, 2018), the competence and integrity of the professionals in the assessment are also essential to the process. All these situations produce consequences for refugees including 1) increased vulnerability arising from the pressure for them to be identified as vulnerable and 2) depending on the vulnerable criteria, professional expertise and ethical conduct, vulnerable groups are either omitted or excluded because they are generally not thought of as vulnerable. Ikanda (2018) shows that UNHCR's revolving and imprecise selection criteria for resettlement created uncertainty among refugees, thereby prompting them to invent identities that correspond to privileged vulnerabilities (Ikanda, 2018). Moreover, such situations recount conflicting intentions between refugees and staff of agencies. As a result, refugees tend to perceive staff as being 'detached' and staff tend to perceive refugees as being 'greedy' (Papadopoulos 2008, p.12).

The refugee women and children are also structurally vulnerable, which occurs when individuals are subject to structural violence (Quesada et al., 2011). This refers to a situation when both the macro-political and economic factors combine to disempower and disenfranchise some population groups which are easy targets (Alsaba and Kapilashrami, 2016). According to Quesada et al., (2011, p.346) structural vulnerability is described as

A positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways; it is a product of class-based economic exploitation and cultural, gender/sexual, and racialised discrimination, as well as complementary processes of depreciated subjectivity formation.

The structural vulnerability involves a systematic misdistribution of power and resources which further undermines the resilience of the vulnerable groups (Tippens, 2017). The positionality of refugee women and children can be described as invisible and inferior. The refugee women encounter major difficulties within the families because a majority are abandoned by their spouses to take care of children yet at the same time they are poor, have low education and have inadequate access to health care and formal employment. This is

---

<sup>36</sup> See NTV story titled: OPM Commissioner Apollo Kazungu forced out over refugee scam [https://www.youtube.com/watch?v=1luHR0rCiqs&ab\\_channel=NTVUganda](https://www.youtube.com/watch?v=1luHR0rCiqs&ab_channel=NTVUganda)  
Daily Monitor Thursday 01 March 2018. Government orders reshuffle of refugee department as Kazungu is interdicted at: [https://www.monitor.co.ug/News/National/Gov-t-orders-reshuffle-refugee-Kazungu-interdicted-UNHCR/688334-4324050-15kd9cw/index.html?utm\\_source=newzmate&utm\\_medium=email&utm\\_campaign=2326](https://www.monitor.co.ug/News/National/Gov-t-orders-reshuffle-refugee-Kazungu-interdicted-UNHCR/688334-4324050-15kd9cw/index.html?utm_source=newzmate&utm_medium=email&utm_campaign=2326)

similar to Quesada et al. (2011), who found that Latino migrants to the United States occupy a subordinated location in the over-all economy, depreciated cultural status and legal persecution. Moreover, this type of vulnerability tends to cut across other vulnerable groups (including the poor), due to shared status attributes (i.e., gender, age, ethnicity, etc.), conditions (i.e., legal status, economic and living conditions, etc.), and individual misfortunes (Quesada et al. 2011, p.346). This denotes a lack of political will by the people of authority to develop practical interventions such as remedying social inequality, protection gaps and legal oversights. To alter these, therefore, requires a multi-level analysis of women's experiences and lived realities as well as their responses in such settings (Alsaba and Kapilashrami, 2016).

It is, however, crucial to note that refugees are not passive recipients of humanitarian assistance but often strive to improve their lives despite contextual impediments and institutional policies that are perceived as hindrances (Dunn, 2016). In other words, they exhibit resilience which enables them to cope with distress and uncertainty. An important consequence of the narratives is that while these indicate situations of present and impending vulnerability, these also indicate the resilience of the respondents. Adger (2000) introduces the concept of social resilience which is important in the context of refugee situations. Boyden and Mann (2005) describe resilience as the person's capacity to recover from, familiarise, and endure amidst harsh conditions. It indicates the "observable, often measurable, processes that are identified as helpful to individuals, families and communities to overcome difficulties (Ungar 2012, p.387). However, Papadopoulos (2007) distinguishes between resilience and adversity-activated development (AAD). Resilience refers to positive characteristics of a person which existed before the exposure to adversity and were retained despite the person experiencing adversity (e.g. their ability to look after themselves) whereas AAD refers to new positive qualities and characteristics that were developed as a result of a person being exposed to adversity such as compassion for other persons' pain or valuing now every moment of living having come close to death (Papadopoulos 2008; p.14). He states that resilience retains qualities that existed before the adversity (people are considered resilient if they withstand pressures and do not alter their basic values, skills or abilities) whereas AAD introduces new characteristics that did not exist before the adversity (*ibid*, p.308). This means that empowerment approaches need to focus on both resilience and AAD (the strengths, capacities and resourcefulness of refugees) in order to support them reconstruct their lives.

Although a majority of my refugee respondents did not indicate substantive social connections as I showed earlier, a few exiles relied on refugee friends and depended on links with the wider Ugandan local community which they have developed over time. For example, some respondents cited financial support from friends to buy medication or food to supplement food rations. Like Adger (2000), this study found resilience has greater meaning when referring to the wider context of the community rather than to individuals, as it is linked social capital. In fact, Valtonen (2008) identifies community enclaves and connections as opportunities for identifying problems as well as resources that could be utilised to increase outcomes of interventions.

However, it is also vital to recognise that although resilience is always portrayed as a strength, it is not free. The respondents in this study made difficult decisions in order to increase resilience, such as working for long hours with little pay or in exchange for foodstuffs. Also, as I mentioned earlier, some engaged in survival sex to earn small incomes, a majority (65.8%) survived on one meal a day to cope with inadequate food rations while some would sell the non-food humanitarian assistance items supplied by UNHCR and OPM. These are challenging choices which exiles make on a regular basis to increase resilience amid adversity. These affect the formation and sustenance of social relations as people try to put up with binary lives and living in rejection. However, these strategies are not unidentified by humanitarian actors and authorities. In fact, this engenders radical and perhaps more oppressive interpretations of refugee vulnerability and resilience. Ikanda (2018) states that refugee registration in Kenya had been affected by such provocations which led to the suspension of refugee registration and consequent intents to close existing camps. One of his Government respondents (*ibid*, p. 588) stated:

It is wrong for you to sympathise with those people. They are former warlords who should be facing charges of crimes against humanity, yet they are highly protected here. The picture I have about refugees is that of helpless people. Here the so-called camps are full of millionaire merchants and murderers who are establishing themselves in every part of this country. That is why we are determined to close the camps.

Similar perceptions of refugees as schemers or undeserving people could also be inferred from comments of the key informants about the women who preferred to be resettled. Moreover, this might explicate the poor treatment and disrespectful experiences in exile. Although such perceptions may not be disproved, it is important to recognise that particular contexts create

vulnerabilities, instead of espousing certain predefined and essentialised categories of vulnerability (Freedman, 2019). Immigrant resilience doesn't automatically eliminate vulnerability in exile and must not be a base for denying support. It is noted that notions of resilience and coping need be applied with caution and must not be perceived as permanent conditions (Boyden and Mann, 2005). Essentially, resilience must be one of the measures for assisting refugees.

I have examined in the preceding sections, that women in particular face extreme challenges and are vulnerable because of their gender, social-economic status, family responsibilities or reproductive role and due to political factors. It is also important to note that the migration process itself involves significant experiences of trauma for women and children. Factors such as insecure livelihoods, lack of safety and lack of assistance lead to adverse effects on their physical and mental health. Nevertheless, it is important to recognise that not all vulnerable people are equally vulnerable (UNHCR and IDC, 2016). Some show strong resilience and adaptation. The study found that some categories of women and children were more vulnerable than others, with pregnant women and single mothers being most vulnerable. These groups had to manage both self-care and familial responsibilities. The most vulnerable children were unaccompanied children, children born out of rape and children with disabilities, as they faced a greater risk of neglect, abuse and exploitation by parents/caretakers or other adults. This leads to the theme concerning the illusion of imagined sanctuaries in exile.

#### 9.4 The Imagined Homeland Traumatized by Violentisation

What this research reveals are complex experiences of an imagined and unrealised refuge for women and children at NRS. Instead, they find exile, vulnerability, and gendered oppression. A combination of pre-migration factors such as conflict, war, poverty, persecution, violence, and gang-rape not only push women and children out of their countries to seek refuge and safety but also make them vulnerable to physical, mental and social health issues. Moreover, post-migration factors such as violence and oppression while in exile continue to negatively impact their health (Palattiyil and Sidhva, 2011). Consistent with the literature, women who participated in this study experienced significant vulnerability relating to patterns of violence, insecurity and abuse in NRS. A number of authors (e.g., Palattiyil and Sidhva 2011; Allan, 2014) reveal how refugees return to past or even worst experiences while in exile. Palattiyil

and Shidva (2011, p.89) describe a state of moving ‘from vulnerability to vulnerability’ to conceptualise dehumanising and marginalising conditions or further risks that many refugees continue to face within-host environments. Although the reasons for continuous vulnerability may differ depending on the context, their impact on health and well-being is largely comparable. For instance, in the study of Palattiyil and Sidhva (2011), reasons for further vulnerability amongst refugees resettled to Scotland included negative media coverage, stigma, breakdown of families due to dispersal policies of the UK Government, false perceptions and inadequate representation (2011, p.89). As I discussed earlier (See: Chapter Six) the main risks to women in this study were exposure to communicable and non-communicable diseases due to poor sanitary conditions; abject poverty; and exposure to gender-based violence and abuse. It is not uncommon that the burden of disease and poverty is high in the settlement given that Uganda is a low-income country and that refugees usually have to start from scratch to rebuild their lives. This is not to suggest that all refugees experience the same level of vulnerability to diseases and poverty or to justify confinement of refugees to bare life. However, what is difficult to comprehend is a realisation that people who have fled their countries due to wars, violence and persecution start being abusive or violent to the same people with whom they escaped violence. Given that violence unravels and fragments communities (Tippens, 2017) it is expected that after seeking safety, people would focus on building peace and rebuilding their lives. Nevertheless, several accounts of respondents revealed experiences of violence while in exile. This was also implied in the words of a key informant from ARC who identified that: *“Continued Intimate partner violence it is actually- on average we have sixteen cases reported monthly...we still have cases of early marriages, cases of defilement, intimate partner violence, [and] denial of resources.”* Examining the types of post-migration factors that contribute to continual violence leads to conceptualisation of abuse by Brown and Hunter (2016). They assert that abuse can be construed either by considering the types of abuse such as physical, sexual, psychological and financial abuse or by way of contextualising the actual violent acts. The latter conception considers (*ibid*, p.111):

The relationship between the person abusing and the person who has been victimised, the setting in which such abuse has occurred and been allowed to continue, the motivation of the perpetrator and the dynamics that have created opportunities for them to abuse or lacunae within which harm could not be prevented.

The findings identified that women and children continued to face violence and abuse perpetrated by either family members, relatives and/ or community members. Normally, these



should be the first source of protection. The question is why does this kind of violence take place among refugees in exile? My findings resonate with the concept of ‘violentisation’ as a cause of violent actions (Hsiao, 2010).

Violentisation refers to the development process of violence (Athens 2003 cited in Hsiao 2010, p3). Although most social experiences are negligible, violent social experiences are usually consequential and unforgettable (Hsiao 2010, p.3). According to Athens, the process of violentisation evolves through four stages:

- 1) brutalization,
- 2) defiance,
- 3) violent dominance engagement, and
- 4) virulence.

In the first stage, brutalization involves violent subjugation, personal horrification and violent coaching. In violent subjugation—subjects are violently dominated by their subjugators, such as parents, older siblings, and schoolmates and forced to obey the command. In personal horrification, subjects do not receive violence themselves but witness what violence imposes onto people close to them, such as family members and close friends (Athens, 2003, cited in Hsiao 2010, p.4). Violent coaching teaches subjects that violent action is a personal responsibility/obligation (*ibid*). The second stage is defiance. When subjects realise that they are suffering from brutalisation, they desperately search for solutions to relieve their pain including memories of past experiences because their past experiences were all about violence, they realise that the only way to overcome brutalisation is to become violent (Hsiao 2010, p.3). With this realisation, subjects move onto the third stage—violent dominance. Subjects begin to imagine themselves as violent subjugators, assign other people as subordinates, start to issue commands and throw insults to the subordinates which end in violent actions if subordinates don’t play along (Hsiao 2010, p3). The final step of violentisation is virulence. When subjects experience successful violent dominance, they learn that they are not only capable of violence, but proficient in it, and they start to pose as violent subjugators creating fear among other people (Athens, 2003 in Hsiao 2010, p.4).

The concept of violentisation can indeed be inferred in the case of exiles in Nakivale. Brutalisation especially applies as the main push factors are conflict and violence. Most people undergo horrific experiences and torture, they witness violent acts and see some of their family members being tortured or killed which might lead to violent coaching. All these traumatic

experiences cause pain and might explain why individuals resort to violence as a way to overcome pain. For instance, Alsaba and Kapilashrami (2016) state that the changes brought about by displacement, loss of economic and social capital and the changing gender roles sometimes disempower men, who tend to re-assert their power over women through further acts of violence in the public sphere or in the private sphere (p.12).

Principally, it should be the role of the state to protect refugees within their territory. However, when abuses of women are not brought to justice, questions are raised regarding the role of the state in protecting vulnerable people. The key informants revealed that each zone was supposed to have one police post, despite the fact that the zones were extensive. The police post in Base camp lacked reasonable office space for handling cases and yet in Rubondo, a structure was just being set up to become the police post at the time of the survey. This was also poignantly reported by a police officer who spoke about the difficulties in meeting the needs of individuals who had experienced violence and abuse: *“Somebody comes and sits there. If you don’t call that person, they will finish the whole day there seated but [she] has a problem. Feels like entering, sees others entering, feels like to enter, others are entering.”*

This anxiety is also caused by the stigma associated with particular conditions such as rape that may lead to isolation by the rest of the group. Experiences of violence, abuse and other vulnerable situations for women and children with little recourse to justice, reflect weaknesses in the protection systems. This, for instance, was revealed in the account of a Burundian woman raped by a neighbour. She said: *“I went to this office,<sup>37</sup> I told them the issue, they then said they will come to me to do follow up, I waited and waited nobody came.”* Ochen et al, (2017, p.272) suggest that weak enforcement of laws on child protection and limited awareness among caregivers and law enforcers of existing laws and policies are the key reasons exacerbating child abuse in Uganda. Unfavourable conditions such as one police post per zone and lack of privacy or confidentiality in the public spaces which should provide protection seem to reflect a non-prioritisation of the refugee women and child protection agenda. This makes it difficult or even impossible for women and children to report abuse so that the perpetrators are reprimanded (Alsaba and Kapilashrami, 2016). It is also noted that survivors might not voice their problems due to shame, self-blame, fear of reprisals or re-victimisation and mistrust of

---

<sup>37</sup> She was not sure of the name of the office but she could confirm that she found a woman in that office, who promised to report the case to the settlement commandant.

the system (UNHCR, 2019). As a result, they fail to access services to which they are entitled and the patterns of abuse and the motivation of the abusers are not investigated by the authorities. This could explain the third and fourth stages of violentisation: violent dominance engagement and virulence. This is because the immediate outcome of first violent dominance engagement (testing step) is crucial in shaping the future violent actions (Hsiao, 2010). Because many cases of violence against women take place and the subjugators are not reprimanded, this gives them a victory which also motivates them to continue to dominate their subjects. Upon this triumph, they not only act violently to resolve their crisis from brutalisation but relishing any opportunity to become violent (Hsiao 2010, p.4).

However, the theory of violentisation overly focuses on the interpersonal nature of violent acts and actors and overlooks the larger picture involving the social structural and cultural influence of violent crimes. This was also reflected in the statement of a protection officer/counsellor at ARC: *“Having nine nationalities within one area is not easy and they have their differences even those people coming from the same country, you will agree with me [for instance,] the differences between the Tutsis and Hutus have remained standing even up to now.”* The structural and cultural factors such as lifestyle, perceptions, values and norms sometimes influence violence and influence people’s decisions of whether to report it not. It could be that ethnic diversity in NRS, with various refugees from different countries, values and norms is a cause of violence. For instance, models which examine the existence of rape contend that it is not only about sex, but also intended to show power and control over the victim by the rapist (Alsaba and Kapilashrami, 2016; Erez & Bhat, 2010). Moreover, many rapes and sexual assault survivors often do not report due to fear of not being believed by their support system, or because they do not define themselves as rape victims due to prevailing social and cultural biases related to rape (Erez & Bhat, 2010). This was reflected in the words of a key informant from ARC who stated: *“They [survivors of rape] only come here to report it when they have had medical complications, for example, fistula, [or] unwanted pregnancies.”*

Yet it is important that the victims receive justice and therewith, new hope. For the refugees, this is the reason they went into exile in the first place. Brown and Hunter (2016, p.115) advise that any responses to ameliorate vulnerability to abuse must progress through three levels:

- 1) primary (focussing on building safe communities and services to stop abuse);

2) secondary (including measures to ensure that any abuse which has occurred is promptly recognised, referred on and stopped); and

3) tertiary (providing remedies and preventing long-term harm, recovery strategies and ensure that people get justice and move on.

For most refugees returning to their countries of origin is not an option and life in NRS is by and large troublesome, if there are no adequate and timely responses (such as strengthening security in NRS and the surrounding local communities), for many, NRS remains an imagined homeland.

### 9.5 Articulation of the Social Work Role

A ‘fundamental aspect to the health of migrants is the accessibility to healthcare’ (Fernandes and Miguel, 2009, p.19). Consistent with SDG 3, The Global Strategy for Women, Children and Adolescents’ Health (2016–2030) provides a framework of action for improved health and well-being. Although Uganda allows refugees to access healthcare services, their large numbers place inordinate pressure on its already strained health system. The country has enacted laws and is signatory to various international instruments that protect refugee rights. Although it receives aid to support refugees, this does not correspond with reality. It is inadequate to meet the collective and specific health needs mainly because the country has an open border policy that accepts refugees ‘*en masse*’ (OPM, 2017). This was also reaffirmed by the social work academic that, “*our approach to the refugees has not been matched to the resource envelop that we actually have.* As mentioned in Chapter Three, many of the refugees in Uganda come from countries affected by poverty and conflict, poor health systems and high burdens of disease (UNHCR, 2019). In addition, the socio-economic conditions surrounding migration and the structural conditions in the settlement pose challenges and intensify their vulnerability to poorer health outcomes (WHO, 2018). Refugee women and children in this study are vulnerable and struggled to meet their own health needs and those of their children yet they lack support systems and adequate protection from the state. The key question is: why is social work better suited to respond to these needs?

Like other researchers, I perceive the central goal of social work as effecting change, empowerment and liberation of the vulnerable groups and individuals in society (IFSW et al., 2014; Thompson and Thompson, 2016; Palattiyil et al, 2016). Chapter Three of this thesis

presented the evolution and social-political context of social work in Uganda. Chapter Eight provided a vivid illustration of the nature of social work in NRS. These are important in seeking to understand the context and purposes of social work in promoting refugee health.

Social work as a frontline profession is key in responding to the social determinants of health because of its focus on the person and their environment (Bywaters and Davis, 2016; Delavega, et al., 2019). Mwansa (2011) argues that social problems not only open doors for the profession as eventful and exciting but also instigate social workers to reach out for innovations or new techniques and knowledge to create opportunities for transformation, empowerment and development. The social workers in this study provide various services to refugees including, psychosocial support, legal support, basic needs support, public awareness, and community capacity building which improve welfare and contribute to change. Nevertheless, it is noted that social work services are highly criticised for not yielding any kind of surplus to the recipients and for fostering dependence (Weinbach, 1998 cited in Mwansa, 2011). Mwansa (2011) argues that social work in sub-Saharan Africa has failed to bring about change in the clinical and the development needs of the region mainly because of a culture of inertia among social work educators and practitioners. As mentioned earlier, social workers in this study did not identify themselves with their profession. Although it is reasonable to comply with specific organisational policies, this seems to indicate low esteem and appreciation of the profession as that which can bring change. This was also echoed by the social work academic, *“I have seen like organisations advertising for opportunities of social workers but I mean, they end up taking people who are not actually social workers.”* This has further implications for social work education and practice. First it explains the low morale among social workers to take up positions to support vulnerable groups. Moreover, those who take up these positions receive minimal and in most cases no support from their employers. Several accounts from key informants reflect this situation. Part of the key informant’s account at the beginning of this thesis echoes this; *“sometimes [you] feel I think I should stop working here, not because ‘you’ are not paid well, but you become so emotional [and] you feel the best thing to do is actually to abandon this work.”* It is noted that extended periods of exposure (listening or reading) to stories about trauma which other people experienced often lead to vicarious trauma (VT) among social care practitioners such as social workers, psychologists and counsellors (Palmer, 2017). Aparicio, et al. (2013, p.205) state that VT has both affective impacts (such as general sense of feeling overwhelmed, the loss of a positive outlook, or a sense of helplessness and

cognitive impacts (manifested in changes of how social workers conceptualise their clients, their work, and themselves in relation to their clients). This affects people's behaviour and relationships and leads to withdrawal, conflict, disconnection and inability to do their work (Palmer, 2017). Service providers need to be both prepared and supported in order for them to be able to support vulnerable people. The protection officer/counsellor above added that *“to manage the stress, you listen to music... it's not something easy- actually that is the most challenging thing...well, we are trying to help them but we also become affected.”* Support and professional self-care increase determination and self-esteem among professionals to offer empathetic and sensitive services required by vulnerable women and children. Self-care strategies involve having strong support systems and reactions (*Ibid*, 2017) such as needed resources, decent work environment, responsive supervision and caring family and colleagues.

Besides, low morale also leads to a lack of confidence in social work services and less visibility of the profession. This was revealed in the survey data. For instance, although 53.8% of my respondents said that they knew an office where they would seek support, with a majority (75.6%) indicating OPM, followed by MTI (13.4%), HIJRA (9.1%) and others (1.8%) such as UNHCR and ARC. When I explored with the respondents their awareness of professional service providers, none could mention a social worker. The respondents were mostly conversant with health workers (73%) and only a handful said they knew a counsellor (2.8%). This does not imply that social work is not being practiced in the settlement or that it is not valued. Social work is significant—the OPM and many humanitarian organisations employ both social workers and other non-social work professionals (who practice social work). Moreover, as revealed by a protection officer at ARC that; *“We have the ‘boda-boda<sup>38</sup> riders’ and taxi drivers whom we have trained in SGBV prevention and response, then we have the home-based caregivers like I have told you they are also within the community. We have the church leaders...who we have also empowered in SGBV prevention and response and even in case management.”* Some organisations recruit people within the community to execute social work functions. This, however, suggests that social work lacks structure and is invisible (Twikirize, 2014). It denotes that social work is diverse, however it is not streamlined to provide comprehensive services to cause considerable transformation and restore hope among

---

<sup>38</sup> Local word meaning motorcyclist

refugee women and children. In order to broaden the remit of social work and improve its visibility, there is a need to expand the current social work model through innovation and adaptation of interventions based on the specific needs of refugee women and children. Similar to Palattiyil and Sidhva (2015), I argue that interventions should mirror the cultural expectations and norms of the refugees. In addition, indigenous knowledge should be prioritised in the development of social work practice and educational programmes, whereas Western approaches could also be adapted to respond to the needs of refugees who settle in Uganda (Osei-Hwedie, 2001 cited in Mwansa, 2011). There is a need for establishing curricular and practice methods that tackle the needs of vulnerable groups. In this, both educators and practitioners have to find paradigms that address health needs arising from the socio-cultural, economic, political, and environmental conditions pertaining to refugee situations in NRS and the country at large (Mwansa, 2011). The creation of programmes to empower refugee women and children across the micro-mezzo-macro continuum is urgent to assume responsibility for their lives and reduce vulnerability. Mwansa states that as a growing profession, social work practice should focus on the community firstly— as the client and the location of unmet needs and secondly, as a primary resource for meeting needs. This theory is important for improving refugee women's and children's health. Analysis of qualitative and quantitative data indicate that a large proportion of women and children's health needs arise from the social injustices and/or discrimination such as, gender inequities which cause unequal distribution of work between women and men, sexual and gender-based violence and lack of decision making power on issues affecting their health. This was also echoed in an interview with an assistant counsellor at OPM who said that *"we have communities in our settlement which still practice FGM—a battle we battle; we are fighting [it] but the silence is too much because we are not sure who we are fighting with."* Ochen et al, (2017) state that rural communities in Uganda generally have an inadequate understanding of the law and lack information about reporting cases of abuse. Besides, most barriers to access and utilisation of health services among refugees originate from their communities (while in the settlement and from the countries of origin). As suggested by the social work academic that *"in these refugee settlements we need to think more about the community,"* it is vital that community work should be brought to the fore alongside individual/casework because each is equally important. Through community involvement and engagement social work would learn about the most pressing health needs. This is also important to inform and drive empowerment so that refugees develop agency and become self-reliant. This should start from designing curricula that prosper this goal or which expose

students to right attitudes and values to work in these communities and to understand the needs of refugees. The social work academic above stated that *“we need to actually reorient ourselves to these things and that -you -know goes back right to the curriculum –how it is designed, how do we pay attention to you- know the kind of teaching we provide to the social workers?”* The social work curriculum should provide information and paradigms that prepare students with practice knowledge which adequately responds to the complex needs of vulnerable groups (Mwansa, 2011, IFSW, 2012). Similarly, the findings of organisational approaches seem to indicate a limited understanding of social work roles. The qualitative findings revealed that organisations employ trained social workers, other professionals and unskilled people to implement their programmes—particularly social work interventions. Though these are trained on-the-job, it was, however, revealed by the social worker academic that *“the approach and the orientation that they receive is always different”* and *“based on what the organisation they are working for actually wants them to do.”* However, it is essential that organisations which provide social work services pay attention to the universal and core values of the profession. This must happen irrespective of the differences in priorities of practice.

In addition, social work must consider refugees as experts in the struggle to improve their conditions. In an interview with the social work academic he articulated that: *“I don’t think there is much that has been done to actually tap into these resources of refugees so that they actually implement programmes for themselves so that they actually own these interventions.”* This shows that refugee women and children must be taken as partners in dialogue about solutions and not as mere victims or service users (Turcu, 2017). This will lead to changes in their conditions and assert the basic values of social justice and human dignity (IFSW et al., 2014).

## 9. 6 Conclusion

This chapter has provided a synthesis of the major findings that emerged from both quantitative, and qualitative data. These have been presented based on the key main themes; looking at the life of women and children in exile, experiences of gendered oppression and vulnerability, the case of an imagined homeland and the role of social work. Exile is described as a social, political and psychological phenomenon that affects human beings according to the particular circumstances. From enduring long, gruelling and life-threatening journeys, the life



of women and children in NRS largely continues in a precarious state due to harsh conditions: scarce resources and very basic living conditions. This implies that settlement does not necessarily improve the life and health of women and children (Fernandes and Miguel, 2009). Although most refugees have invented ways of coping through vulnerabilities, a lot is needed to improve their health and well-being. Social work is significant although it needs to reconsider its operation and broaden its remit. The next chapter presents the conclusions from the findings and suggests recommendations for social work and policy makers. The chapter also provides a model for improved refugee health.

## CHAPTER TEN: CONCLUSION AND RECOMMENDATIONS

### 10.0 Introduction

This research provides insights into the health needs and service provision for refugee women and children living in Uganda's refugee settlements and explores the role of social work in health promotion for refugees. In line with SDG 3, this research aims to improve health service delivery to ensure healthy lives and well-being for refugee women and children.

The study asked three questions:

- (a) What were the public health needs, vulnerabilities and experiences of refugee women and children?
- (b) What health services were accessible to refugee women and children?
- (c) Which barriers impeded access to and utilisation of health services?

All three questions were united by the overarching goal of interrogating social work's role in health promotion for refugee women and children.

The findings have so far indicated gaps in the availability of quality health services. On the other hand, the insights gained from this study suggest implications in the areas of social work practice, social policy, and directions for further research. This chapter explores these implications and provides a comprehensive model for improving refugee women's and children's health. I will first describe the model and subsequently delineate the collective responsibilities of social work and the policymakers.

### 10.1 A Comprehensive Model for Improved Refugee Women and Children's Health

The comprehensive model for improved refugee women and children's health presents the rights-based approach to understanding and responding to the health needs of refugees. It developed out of a process of reflection and synthesising the varied experiences of refugee women and children in NRS and the barriers to access and utilisation of health services. It draws on better-rounded empirical evidence, the World Health Organisation (WHO, 1986) model of health, the Global Strategy for Women, Children and Adolescents' Health (2016–2030), the structural and health belief models of health as well as the social work approaches.

The model depicted in Figure 10.1 presents the concept of holistic wellbeing (health) which is placed at the center. The other components— social determinants of migrant health, the action areas and the seamless health care package are detached but they have arrows directed at the idea of health. This is because they all foster better health outcomes.



Figure 10.1 A Comprehensive Refugee Health Model

Health in this research was conceived as holistic well-being, rather than simply the absence of disease (Delavega, et al., 2019). It describes the extent to which an individual or group is able to realise aspirations and satisfy needs and to change or cope with the environment. It is a resource for everyday life highlighting social and personal resources, as well as physical capacities (WHO, 1986). Physical health refers to the capacity for self-care, mobility, and engagement in physical tasks; mental health describes psychological well-being and social wellbeing reflects socialising and networking elements with friends, family or acquaintances (Weiss and Lonquist 2003). The components of health (physical, mental and social well-being) are placed at the centre of the model because these are critical for overall well-being and while they are affected by processes in all other aspects, the objective of the comprehensive model to realise improved holistic wellbeing.

The right to health embraces social factors that promote conditions in which people live and the underlying determinants of health (WHO, 2010). Valtonen (2008, p.152) states that “settlement services need to be responsive to the need profile in immigrant cohorts of increasing diversity”. The model presents the determinants of refugee health that must be understood before designing any responses. The social determinants of health were described in Chapter One, as the conditions in which people grow, live, work, and age (CSDH, 2008). Throughout this thesis, I have argued that refugee women and children’s health is determined by pre-migration events, experiences during flight and after settlement (WHO, 2018; Fleischman et al., 2015). The experiences and conditions in the places of origin include war, conflict and human rights violations, sexual violence, trauma, epidemiology, nature of health systems and vulnerability. During transit, refugees face precarious flight conditions, exposure to disease, violence and loss (material, emotional and cultural) lack basic health needs, vulnerability to disease and violence, loss and traumatic events. The qualitative and quantitative findings reported in this study suggest the availability of the complex and difficult circumstances faced by refugee women and children living in NRS. They live under deprived conditions with minimal or no access to basic needs; combined with continued violence and vulnerability and generally have unmet need for health care due to both individual and structural factors.

The model further presents action areas based on the provisions of the Global Strategy for Women, Children and Adolescents’ Health (2016–2030). The Global strategy provides a framework of action for health interventions aiming at three goals: 1) survive—end preventable

deaths; 2) thrive—ensure the health and well-being and; 3) transform—expand enabling environments (WHO, 2016). These are aligned with the Sustainable Development Goals (SDGs) especially Goal: 3 on health and well-being. The model depicts the action points as the foundation upon which women and children should be supported to accomplish their potential for and rights to well-being and prosperity including, those in refugee situations (Kuruville et al., 2016).

Within the model, survive depicts ending or reducing preventable maternal and child deaths from communicable and non-communicable diseases, and promoting mental health and well-being (WHO, 2016). Chapter Six revealed the key themes of women's health, adolescent and youth health, child health, mental health and gender-based violence, abuse and torture. A further reflection on these indicates that there could be a presence of preventable mortality among women and children in NRS as a result of HIV/AIDS, infections, malaria and tuberculosis. These are intensified by gender-based violence and mental health concerns.

In the model, thrive reflects a need to safeguard health and well-being (WHO, 2016). Besides staying alive, women and children must prosper. For the women and children in NRS, this means guaranteeing universal access to health coverage (medicines and vaccines) to prevent or manage communicable and non-communicable diseases and childhood illnesses, sexual and reproductive health-care services and rights, addressing the nutritional needs of women and children, access to early childhood development and some essential services (such as mental health support).

Transform reveals a need to change the lives of women and children by expanding enabling environments (WHO, 2016). Based on my data, such measures should consider eradication of extreme poverty; access to education, information and communication support; elimination of harmful practices, discrimination and violence against women and children; ensuring reasonable access to safe drinking water and to sanitation and hygiene; co-production of services; enhancement of scientific research and global partnership for sustainable funding and support; building capacity for health system resilience (emergence and protracted plans) as well as integration and monitoring.

Lastly, the health care package describes holistic and comprehensive interventions that extend beyond survival to guarantee thriving and transformation. An understanding of the social determinants of migrant health requires that a comprehensive response model of health services for refugees must address both carried and acquired health problems at all levels (Fernandes and Miguel, 2009). A comprehensive approach to human rights infers responsibility and collective action by the government and its partners, professionals and individual refugees. The structural model of health and the health belief models explain the factors which determine people's choices and decisions in terms of seeking health services or support. These models also highlight how health services should be designed and implemented to achieve better outcomes.

Utilising right-based approaches, critical social work, strengths, empowerment and ecological perspectives, social work intervenes in the lives of immigrants at the micro, meso and macro levels (Valtonen, 2008). Based on my data, the health care package is a combination of measures that target individuals and groups such as the adequate provision of basic needs and health-enhancing commodities, empowerment, mental health and psychosocial support, health education and information, protection and supportive parenting. Further, there is a need for measures that address barriers at the social structural level such as gender mainstreaming in programming, training and support of health workforce and other service providers, development of infrastructures like roads and health facilities, development of policy and enforcement of the law and justice and facilitate enjoyment of human rights. Although the package necessitates coordination between agencies and sectors as well as inter-professional teams, social work practice must identify its niche of assisting refugees to realise their rights through problem-solving, networking assisting and challenge of all injustices.

The following section presents concrete commitments and collective action that is needed to realise the comprehensive health care package for refugees

### 10.2.0 Implications of the Findings for Social Work Practice

Because of the topic, it examines and the vulnerable population it studies, this research has important implications for social work since the profession aims to assist service users to take

responsibility for their lives (Rushton and Beaumont, 2002). The challenges faced by refugee women and children like poverty, violence, ill-health or loss of close family and support system have serious implications for their physical and psychological well-being. As stated by Protection/Counsellor at ARC that: “*Understanding one’s problem is a step towards it,*” social work aims to address life challenges and enhance people’s well-being through principles of social justice and human rights (Rushton and Beaumont, 2002; IFSW, 2012). Social workers engage in health work by creating the conditions for improved health or through supporting people to cope with the impact of poor health on themselves and their family (IFSW, 2012). This unique role of social work implicates dealing with care and control, protection and empowerment (Rushton and Beaumont, 2002). In Chapter Eight, I indicated that social work practice in NRS is generic in a way that both professional social workers and professionals in other disciplines (such as Adult and Community Education, Administration, Social Sciences, Counselling psychology, Midwifery and Nursing) perform rather similar tasks. There are two implications to this. As earlier specified (see: Chapter Eight) that the staff of government and humanitarian organisations who are professional social workers do not universally identify themselves as social workers. Like other professionals, they identified themselves using their titles such as an assistant counsellor, protection officer, community services assistant. This denotes that social work does not work alone to promote the health of service users but works as part of an inter-professional team (Delavega, et al., 2019). This was also reiterated by an assistant counsellor at OPM who said that “*we have to work with each other because, in one way or another, one issue has a way of involving all of us.*’ However, another statement made by a community development officer at FRC that, “*we also have Medical Teams [International] with counsellors, but most of the time their work is to counsel those who come to the health centre... I have seen some organisations who are doing rehabilitation something...but also their rehabilitation is people who have come*” indicates the limitations of inter-professional teams and the prevalent gaps which must be addressed. Throughout this section, I will attempt to show social work’s unique, positive contributions to service users in this inter-professional environment. Given that this research adopted a holistic definition of health which takes into account all aspects of a person’s life and circumstances, I argue that social work is in a unique position to promote refugee health because of its attention to the social determinants of health (Delavega, et al., 2019). In addition to what they are doing now (See Chapter Eight) social work could be streamlined to provide broader and comprehensive services and advocate for change to improve social conditions for women and children in NRS.



To effectively do these, they need proper professional and interpersonal skills. First, I examine the significance of psychosocial support as a direct social work service.

### *10.2.1 Psychosocial support*

Psychosocial support essentially links the social and psychological approaches. Psychosocial support promotes positive mental health and well-being. According to Papadopoulos (2010, p.30), psychosocial support intends to address three different but inter-related realms:

- (1) intrapsychic— aspects relating to psychological experiences ‘within’ an individual, i.e. feelings, fears, hopes, wishes;
- (2) interpersonal— concerning interactions with others;
- (3) socio-political— referring to wider social, cultural and political dimensions.

This is important because my respondents’ experiences can be situated within these realms. In addition to deprivation, the findings show that women and children suffer the physical and emotional health consequences of violence, loss and trauma. Critical analysis of the data revealed that migration seriously impacts women's and children’s health. Unsurprisingly, the circumstances surrounding and events during migration shape refugees socially and psychologically. As recommended by key informants, individual, group and family counselling are necessary to address issues such as depression, anxiety, post-traumatic stress disorder and gender-based violence. A protection officer at ARC stated that couple counselling supports and improves relationships particularly in circumstances of “*fistula where women smell or in discordancy.*” Family therapy can help refugee women and children cope with and adapt to changes brought about by migration or ill health (Berkman et al.,1990). It is also vital to build family strengths so that they are able to provide a safe and nurturing environment for children and youths.

This support is also an essential element for empowering those who might have to reveal their stories to the authorities during legal procedures (Palattiyil & Sidhva, 2011). Moreover, social workers need not only to assess the risk of developing poor mental health but must identify the needs of those women with mental health problems as well. Counselling provides a space for service users to speak freely, express their emotions, and learn how to cope. Social workers with great focus on the service user in relation to their wider social environment (such as family, community support systems, cultural attitudes, and policies), are able to provide rehabilitative care to refugees reporting experiences of torture and abuse. This care helps to

heal the emotional pains and trauma and helps to restore hope to refugees like those who disclosed suicidal ideation and feelings of worthlessness.

Berkman et al. (1990, p.20) state that the emphasis on social work practice in health care is on the interaction of the patient and the patient's context. Social workers have to intervene in disputes and conflicts which exist within the refugee settlement, particularly among refugee families and the community. Some of these conflicts are due to the experiences of trauma, loss and poverty. If these are not resolved amicably, these exacerbate gender-based violence and increase the risks of mental health problems among women and children. A Congolese man in Rubondo zone said that, *"poverty at home is also a challenge which cannot bring peace in the family"* and thus suggested that *"It needs some people to come to the community and counsel women with their husbands and give them some advice what they can do to put together and work for their homes."* Social workers are able with their skills to facilitate conflict resolution and reconciliation of differences to achieve the physical, social and emotional well-being of women and children.

With a majority of women having barely any education, this is a challenge to quality health service provision and consumption. This was also revealed by a community development officer at FRC who said that *"women and children who are not accessing the medical services is because they lack the right information."* The implication is that most of them lack basic knowledge about some of the essential skills required to maintain minimum health for themselves and for their children. An enrolled nurse described her knowledge that *"these are people who are sometimes not informed"* as motivation for *"giving them health education talks."* Given that social workers are skilled to address personal and social factors that affect health and well-being they are able to impart knowledge and life skills to refugee women and children such as information about nutrition, sexual and reproductive health. This was also reaffirmed by a Clinician at MTI who said that: *"I know for women, yes they also trust in us as health workers, but they think for us we are just psychological but if they get... some people who are not part of us here, as health workers, someone like a social worker, they come and talk to them directly, they can easily accept, because for them they say for us we don't believe in witches."*

Education and information initiatives might also raise awareness about laws and policies. Raising awareness about women's and children's rights and the laws of the country is one of

the long-term solutions to improve the health and well-being of women and children. This is important because as reported by several key informants, there are general differences between the laws of Uganda and the refugees' countries of origin. A protection officer at HIJRA said that: *“Most of the problems come, [because] some people are ignorant especially about the laws of Uganda. You find, for example in Congo, a child is somebody below the age of 16.”* Therefore, this information is important for refugees especially new arrivals to settle in very well and desist from committing a crime such as early marriage. With diverse experience and critical consciousness of inequality and social justice, social workers are more placed to raise awareness about the available health services in and outside the settlement. However, these should be conducted in a culturally competent<sup>39</sup> manner (Palattiyil and Sidhva, 2015; Harrison and Turner, 2011; Sakamoto, 2007). The next section examines another implication of the findings for social work practice—empowerment.

### *10.2.2 Empowerment*

Another core implication of the findings to social work practice is a need to empower refugee women and children to take control of their lives (Rushton and Beaumont, 2002). Empowerment does not have a clear definition. Broadly, it has been defined as a process of supporting disadvantaged people to gain greater control over events that impact their lives (Laverack 2004, Thompson and Thompson, 2016). It aims to achieve the social justice objectives of social work (Payne, 2014). Empowerment is primarily regarded as a practical public health strategy yet the success of empowerment initiatives for health basically depends on the context, agency and leadership of the people involved in the process. The findings presented the multiple and intersecting vulnerabilities associated with life in exile. This provides the rationale for an empowerment approach in the interventions aimed at assisting refugees to achieve improved physical, mental and social well-being. This was also reflected in an OPM assistant counsellor's words: *“one thing I learnt about empowerment in this place [settlement] is [that] once you break one barrier, you break multiple barriers.”* Empowering social work aims at eliminating dependence and equipping service users to be able to deal with future problems and challenges (Thompson and Thompson, 2016). This was reiterated by an

---

<sup>39</sup>This is about providing culturally responsive services to a multicultural clientele (Harrison and Turner, 2011)

ARC community activist, “*maybe we can put much effort into teaching people how to promote health on their own without depending on ARC or MTI just to make them keep that habit.*” This process aims at building the capacities and skills of service users to analyse their circumstances and priorities and to access information on their rights (UNHCR, 2008).

According to Thompson and Thompson (2016 p.289) empowerment must take place at three levels—personal, cultural and structural. The figure presents levels of empowerment and strategies for promoting empowerment.

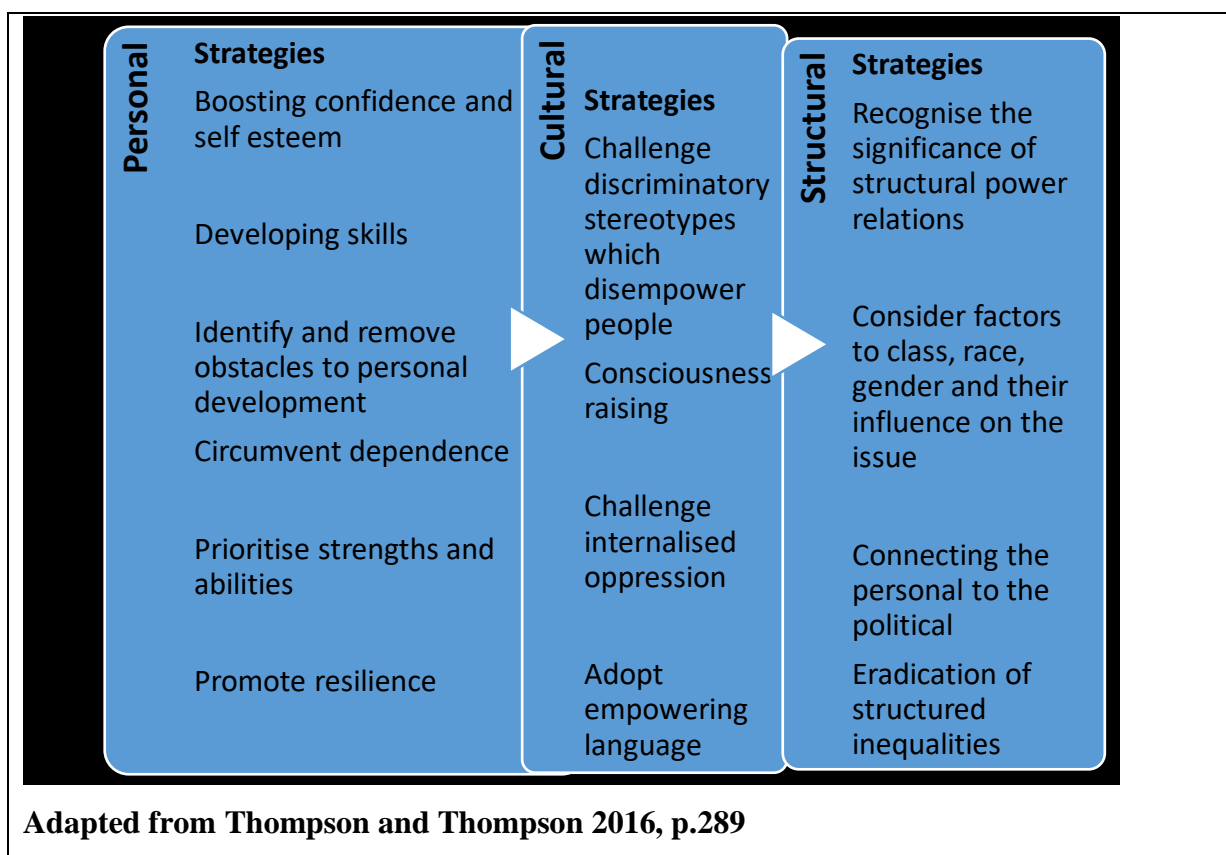


Figure 10.1: Levels and strategies for empowerment

Empowerment at the personal level helps to build a sense of internal strength in disadvantaged individuals: for instance, through boosting their confidence and self-esteem, removing obstacles to personal development and restriction of dependence. This was equally echoed in an illustration of an assistant counsellor referring to women suffering from fistulae: “*Once I’*

*know 'I can heal from this, that means that everything that you have said to 'me', to depress 'me', to put 'me' down was a lie, 'I can actually overcome this.'* Empowerment for personal action must be based on the identification of the service user's own needs and problems (Laverack 2004, p.48). For example, the refugee women in this study faced difficult experiences such as violence, poverty, and trauma which affected their physical and mental health. In these situations, one- to-one counselling for refugee women would help to restore hope and build confidence. Empowerment at this level negates the problem-saturated narratives that nurture grounds—on which people who seek help tend to be seen by the community and themselves as being in trouble and hence unable to see any other options in their view of themselves or their world (Michael White 1989 cited in Hartman 1993). This is important for service providers who focus on seeing refugees as victims while they ignore their lived experiences, strengths and available resources which might be mobilised to achieve desired outcomes (Hartman, 1993). The definition of the problem is important, however, social work needs to co-construct the lived experiences of the disadvantaged into non-problematic narratives and also what Laird (1989) calls “restorying” so as to figure out new ways of conceiving the past and thus shaping the future (cited in Hartman 1993, p.27).

At the cultural level, it is important to empower refugees to challenge discriminatory stereotypes that disempower them. Moreover, social workers need to support refugees through challenging any internalised oppression through consciousness-raising and adopting an empowering language. Empowerment at this level goes beyond personal issues yet it tends to focus inwards on the needs of its immediate members. The settlement commandant stressed this, saying that small groups are crucial for defining, analysing and acting on individual challenges of members. He said: *“If Congolese can't dig, even if you push them back to the village, then it's as if you are imprisoning them, but can't we support them where they are, can't they form groups and they start saloons, tomato stalls?”* Empowerment at this stage should enable individuals to gain skills and develop stronger social support systems and networks for advocacy (Laverack, 2004). The women expressed diverse problems, such as experiences of violence from men and the burden of taking care of families. For instance, with the majority of the single mothers abandoned by their partners to raise children on their own amid depriving conditions, the development of self-help groups for single mothers is essential for instance, these could be supported to have shared gardens to produce sufficient food to feed their large families. The refugees expressed the need for support to start small projects. One of the refugee women requested earnestly that: *“We can rare either some goats or come together*

*and dig, then after we divide what we have harvested.*” There are specific examples of programmes which have been developed in some countries like Germany, United States, Switzerland, United Kingdom, Australia and Netherland such as “*language and parenting schemes for young mothers, homework clubs and or leisure activities for young people; individual and group strategies to help with job seeking, groups for children with disabilities or their siblings; and mediation and advocacy schemes*” (Hall 2006, p. 202). In addition, Cuadra (2009) also identifies examples of programmes which have been put in place to improve the health of refugees in Sweden, by health professionals, non-Governmental organizations (NGOs) and churches. These range from underground clinics, information giving, cultural mediation, interpretation services, all of which help to improve their health. As stated in Chapter Eight, one of the organisations used group work as reflected in the statement of a health promoter, “*we get 10-15 of those volunteers we make what we call a Care group, so now I will go and health educate those mothers.*” This approach needs to be adopted by several organisations and be supported and developed to meet the various needs of refugee women and children beyond health education.

Similar to other studies (UNHCR, 2014; Hiegel, 1991) this research found that though refugee women mainly experience trauma due to desperateness, absence of employment opportunities and perceived social dysfunction, most of the organisations focused on meeting the immediate needs of food and water and elementary health care needs. In such tight circumstances, there is a very high likelihood that the mental and psychological needs of refugees are neglected. According to Laverack (2004), self-help groups around mutual projects create shared places that are essential for realising short term goals (like producing food) and for social mobilisation to address broader issues of social change affecting the lives of vulnerable people. This would help refugees to network and be able to meet their psychosocial and emotional needs in the long-term.

Empowerment at the structural level focuses on the interplay of structural power relations and their influence on health and the goal is to reduce structured inequalities and to connect the personal to the political (Thompson and Thompson, 2016). At this level, groups must be empowered to form community organisation structures such as church/religious groups, youth groups, community councils, peasant farmers’ associations, and water user associations among others. Social workers employed by NGOs are able to mobilise and motivate refugee women to actively participate in programmes which are intended to improve their health and welfare

such as community health programmes, literacy programmes and life skills and/or economic programmes and organise refugees to mobilise resources and opportunities from the broader environment that creates those needs in the first place (Laverack 2004, p.51). Empowerment at this level is about mapping internal resources (for instance, skills, talents, knowledge) so as to build from a position of strength when soliciting for external resources (Laverack, 2004). One example of an Organisation that would suit the needs of women is one focusing on community policing to reduce rape in the settlement. The statement from the police officer saying that *“even this office where we are seated, is for chairman LC III for refugees. It is not for police, he just assisted us. There is no way you can handle, because now if a victim comes, this is the place where you sit, another one is also seated there. Sometimes she fears to talk.”* is a clear indication that the Ugandan police in the settlement have limited capacity to maintain law and order or even stop violence against women. Community policing organised by the refugees could be cheaper, sustainable and effective because they live with and have information on the perpetrators. Nevertheless, Betts et al (2017) advise that the policymakers and actors must create an enabling environment to allow autonomous, community-led initiatives to thrive. For instance, providing forums where women can meet and learn about their rights and discuss their challenges.

Finally, empowerment needs to be considered in a context (Oko, 2011). Social work is uniquely poised to do this work due to the disciplinary focus on action and actors as socially situated. Empowerment should not be seen as a tool to fix refugees because they are considered incapacitated in terms of self-regulation, responsibility and autonomy but must be approached as a humanitarian intervention to foster these capabilities and make refugees self-reliant and productive (Olivius, 2014). The key informants expressed concern that refugees do not want to accept responsibility for their own lives and families but want to shift this to UNHCR. Thompson and Thompson (2016) warn that at times service users are not interested in being empowered because of anxiety, a history of dependence, the misconception of empowerment, negligence, and hostility. On this basis, the service providers ought to be careful not to push their own policy agendas or those of their organisations because empowerment must come from within a group and not be given (Laverack, 2004; Payne 2014, Thompson and Thompson, 2016). Social workers must espouse critical and interpersonal skills to achieve effective empowerment. Anything less leads to oppressive practice like giving up or imposing empowerment (Thompson and Thompson, 2016).

Refugee resilience should not be underestimated and must be the basis for empowerment. The refugee women in this study showed great resilience, resourcefulness and courage in adapting to the environment of the settlement for example, by working for local Ugandans to secure supplementary food for their families. Despite being victims of human rights violations, they are also strong survivors and these qualities are essential for empowerment (UNHCR, 2008). Empowerment, according to Thompson and Thompson (2016) involves building on existing strengths and where possible, trying to turn the weaknesses into strengths (2016, p. xxvi). For instance, this can be done through more micro-entrepreneurial or job skills training, providing them with start-up capital or finance to set up small businesses to enable them to earn income to be able to afford the basic welfare needs for themselves and their children. A community services assistant at OPM stressed this saying: *“Sometimes a lady comes as a single a mother, has ten children, the husband was left back and she has nowhere to start from... Maybe if we could introduce like these tailoring, hairdressing for free, maybe training for free and then we give them start-up things, something like that it would help them support themselves other than thinking the office will always provide for me.”* Moreover, rather than a strategy that provides relief for people, it is better to empower them so that they start fending for themselves. The respondents expressed the need to be trained in vocational skills and the English language. One Somali woman specifically stated that: *“English is the key to the world.”* This is important for women to develop communication and social skills as well as confidence in airing out their concerns and strengthen their resilience. Further, the need to unlock and strengthen the resilience capacities of refugees is fundamental for developing informal care systems which would potentially assist in meeting health needs. Some techniques were identified by key informants to increase resilience among refugees include building networks with others from comparable regions or cultural backgrounds; support from refugee leaders and strengthening family relationships (Mason and Pulvirenti, 2013). I now move on to examine co-production as an important element for improving refugee health.

### *10.2.3 Co-production of services*

Social work considers respect for service users, promotion of their rights and the advancement of equal opportunities paramount (Cossar and Neil, 2015). This implies that service users must participate in making decisions about the direction and priorities of health service provision at the individual and policy levels (Bywaters and Davis, 2012). The refugee women were



concerned that their views were not considered while planning and delivering services to them. More than a third of women surveyed (38.8%) reported being mistreated by the service providers when they went to seek services. Mindful of individual differences and cultural and ethnic diversity among refugees as reflected in both key informants and refugees, there is a need to reconcile and work in on-going partnerships (Cossar and Neil, 2015). Given that the refugees are the experts of their experiences, this is important to understand their specific needs and make referrals when necessary. A Congolese refugee woman from Base camp stated that *“if they [service providers] are putting programmes they [have to] involve refugees...for example if I’m involved in a programme I will encourage my fellow women.”* MacIntyre and McCusker (2016) argue that respect for the needs and wishes of service users leads to efficient and effective services. One key informant (Social work academic) spoke of the need to make use of the strengths, abilities, talents and expertise of the refugees in designing and delivering services: *“I also feel that we can tap into the resources that these refugees have themselves.”* Co-production ensures that refugees are involved in each phase of health service development and the planning, implementation, and evaluation of health services must be based on the needs of the refugees. Social workers need to engage the refugee women to identify their priorities in relation to available resources and encourage them to contribute to solutions (Cossar and Neil, 2015) to improve their health and that of their children. To achieve this, they must reach out to the women and listen to their experiences. These should be used to inform service provision as well as social work practice. In the succeeding section, I present another crucial component of social work—advocacy.

#### *10.2.4 Advocacy for rights and resources*

Recalling that social work is a human rights profession (IFSW, 2012), it is important to appreciate that refugees are entitled to human rights regardless of their status (UN, 2016). However, (as I indicated in Chapter Nine) due to the nature of their vulnerability, some of their rights are either violated or neglected in exile. Social work must promote and protect the fundamental right to health for the refugees by helping them to access health services. For instance, by raising issues that may not be apparent to other team members supporting this vulnerable group such as cultural or religious impediments to access and use of health services (Delavega, et al., 2019). A social worker academic in this study accentuated this in his words by giving an actual situation: *“If you find an abused child in the community of refugees, and*

*you know that actually this child has been abused by even the same people who are supposed to protect her okay, you have a referral system that says do ABCD, but you as a social worker, you know, beyond following the established structure...beyond the immediate support that we provide, that we also need to have a long term strategy to uproot these things.”*

Moreover, social workers have to assist in assessing refugee women's and children's health needs and problems to ensure that, health care programmes and projects respond to their needs (Mwenyango and Palattiyil, 2019). Further to this, the right to health involves the right to resources that maintain and sustain health and access to universal, affordable health care (Bywaters and Davis, 2012). Refugee work greatly relies on aid in the form of humanitarian assistance to refugees. Social workers must advocate for resources to meet the need for medicines, testing equipment, medical personnel, health facilities and other infrastructure in the settlement. Through advocacy, social workers would communicate to the relevant authorities such as UNHCR or to convince the well-wishers of the legitimate needs of refugee women and children since they have this evidence from their community outreach and programmes.

There is also an underlying expectation that social work should exercise leadership in the planning and delivery of services. For example, by identifying the health needs of refugees, communicating with providers, providing information to refugees, acting as liaison officers in the community and working as advocates for health care to ensure that requisite health services are delivered in a timely manner (Allen and Spitzer, 2016). In addition, social workers also have to mediate between the refugees and the authorities or the different service providers and influence them to streamline processes and procedures for a better service organisation. To achieve this, social work professionals should work and liaise with a range of partners through research and advocacy for the rights of refugees. Moreover, there is a need to strengthen the integrated multi-disciplinary approach connecting social workers and other professionals such as psychiatrists, counsellors and health workers to promote the seamless practice.

Given that social work challenges social injustice, social workers are able to challenge any deleterious health effects of social policies on people's life chances and experience and to advocate for the development of health-promoting, protecting and sustaining policies for refugees (IFSW, 2012). Moreover, social work must ensure that institutions and the practices of professionals are within the law and in case of failures, these must be held responsible. The analysis of the findings confirms a high level of uncertainty especially concerning issues of

assistance and resettlement. A community development officer at the district made a proposition and cited that: *“Some of them[Refugees] have stayed there for more than twenty years... so there is also a need for resettlement of those refugees to their mother countries, yes because if they are settled, I believe vulnerability would reduce...because in the settlement there is no freedom to just do what you want...so if there would be a policy on resettlement. Some countries that have started having peace like Burundi and other countries, of course, the whole country is not full of insurgency.”* Social workers need to advocate for policies for assisting refugees to return to their countries of origin or to resettle in third countries in decent ways. The ensuing section explores the implication of the findings for social work training.

#### *10.2.5 Social work education*

As employees of government and non-government institutions in the settlement, social workers need to understand the local policies and laws relating to refugees and act and make decisions consistent with these policies (Mwenyango and Palattiyil, 2019). All these necessitate that they obtain specialised knowledge relating to human rights, social justice, advocacy, cultural competency, community development, problem-solving abilities and the relevant national and international law (Nash et al., 2006 cited in Hall 2006, p. 196). An academic social worker enunciated that:

*“Anybody now can work in this humanitarian emergency situation but social workers have to be trained differently to be exposed to the right attitudes, they have to be exposed to the right values, you know to provide, to understand the needs of the refugees.”*

There is a need for developing the competence of social work students so that they are equipped to understand the plight and vulnerabilities of refugee women and children. Formal social work education should include refugee studies, cross-cultural counselling and specialised training in the counselling of refugees and victims of torture and trauma (IFSW, 2012). The training should impart knowledge “relating to the trauma of up-rootment, separation and loss, hardship and persecution; world conditions which lead to displacement, and knowledge relating to cultural factors, and the effects of xenophobia in the host community” (IFSW, 2012). The training of social workers is also necessary to enable them to develop a strong professional identity, confidence in their skills, and areas of expertise that are relevant to inter-professional teamwork supporting refugees (Delavega, et al., 2019). Further, data also suggest a need for the inclusion of vicarious trauma training in the social work curriculum (Aparicio et al., 2013)

This foregoing section has deliberated on the role of social workers as employees of government and organisations and as part of inter-professional teams. I have demonstrated that social workers are trained in human rights and also have the obligation to abide by the principles and values of the profession such as being just, fair, and non-judgmental. This preparation puts them in a better position to balance humanistic values, social care, and welfare. However, it is challenging or even impossible for social workers to fulfil their obligations without the support of the government, UNHCR and partners. An assistant counsellor at OPM explained that: *“Sometimes to do these sensitisations we need support, maybe vehicles, fuelling because sometimes these sensitisations are intense...Sometimes we need all those little support.”* The government and its partners need to engage more with social workers as part of inter-professional teams supporting refugee work. Moreover, social workers are employees of these organisations and generally act on their behalf. Now I go on to examine the implications of the findings for government and partners in refugee work.

### 10.3.0 Policy Recommendations for the Government, UNHCR and Partners

This research has implications for authorities in refugee work. These include developing a rights-based approach, putting in place durable solutions, providing social protection, ensuring comprehensive and coordinated assistance, gender mainstreaming in health care and humanitarian assistance, clarifying processes and procedures and research. These will be discussed in turn.

#### *10.3.1 Developing a rights-based approach*

The right to health is very important because it interconnects with other rights such as the right to life, liberty and security of the person, freedom from torture, or cruel, inhuman or degrading treatment or punishment, freedom of information, and equality. Article 25 of the United Nations' 1948 Universal Declaration of Human Rights states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UN, 1949).

Protecting the rights of refugee women and children is necessary to improve their health and well-being. This was also implied in a statement of a Congolese man from Base camp referring to an inadequate food provision, *“of course I know we cannot get the same food as if we are eating in the luxury home but at least to improve on health, at least they should improve.”* The rights of the refugees in Uganda are protected under the Refugee Act (2006), which is an adaptation of the 1951 Convention relating to the status of refugees. The specific rights of refugee children and women are covered under articles 32 and 33 of the same Act respectively. For example, refugee women are entitled to equal enjoyment and protection in economic, social, cultural, and civil human rights, have equal opportunities and access to procedures relating to refugee status; and affirmative action is suggested to protect women refugees from gender discriminating practices. Like women, the refugee children are accorded the same treatment as national children and are entitled to the enjoyment of the rights and freedoms contained in the Convention of the Rights of Children and all conventions relating to the rights of children. The survey and qualitative findings revealed that refugee women and children lack sufficient access to medical services, sanitation facilities, adequate food, decent shelter, and healthy lives in a secure environment. Moreover, most health interventions for refugee women and children focus on meeting their physical, biomedical needs. This is important, however, reports of exposure to violence, discrimination and deprivation necessitate adoption of a rights-based approach to address these complex needs.

A rights-based approach is “a conceptual framework that integrates the norms, standards and principles of the international human rights system into the policies, programmes and processes of development and humanitarian actors” (UNHCR 2008, p 26). Such an approach is founded on the principles of participation and empowerment. As reflected in Chapter Three and by several key informants, the current provision of health care for refugees is, in general, integrated into the national health care system. For example, a senior community development officer at the district stated that: *“I know they receive services like any other resident of Isingiro district because when they come for the health services at the facility in Rwekubo or any other health facility, they don’t segregate that this is a refugee [or] this is a Ugandan.”* This is essential because it facilitates cohesion and peaceful co-existence and may even reduce stigma. However, given that refugee women and children have specific health needs and distinctive health care challenges (such as language barriers), the general structure of health services may not adequately respond to these. For instance, refugee women complained of poor treatment

from the health care providers because of their refugee status. The findings (see Chapter Seven) show that poor treatment was due to overwork, a disconnect between formal and practical logics, and in some cases individual prejudice. A rights-based approach to health care considers respect, protection and fulfilment of human rights an obligation. The question is how would the adoption of human rights approach help to improve the health of women and children?

Given that Uganda is a low-income country, its national health care system is also facing severe challenges some of which were identified in Chapter Seven (such as lack of adequate staff and shortage of medicine). This denotes that refugees do not have the opportunity to enjoy full access to their rights including comprehensive quality health services. The social work academic cited this saying that: *“If you look at the West Nakivale, if you look at Kyangwali, if you look at Kyaka, most of these communities where these refugees are settled are areas that have always had low access to social services, people are generally poor, so you don’t expect that because the refugees have settled the situation will, you know, change overnight so they actually also end up within that kind of mix.”* Adopting a human rights approach will lead to proper analysis of refugee women and children’s situation in the settlement and also involve them in the design and implementation of services that effectively respond to their needs. For example, recognising that there are multiple and intersecting barriers (such as their refugee status, social-economic status, language problems, oppression and trauma) for them to effectively access and use health services.

In addition to basic needs provision, a human rights approach will allow the government and humanitarian actors to apply both international and national law to identify other needs of women and children arising from the migration experience and the settlement environment. For instance, I stated in Chapter Six that women experience rape both in the countries of origin and while in the settlement. Children born out of rape are both neglected and abused. A protection/ counsellor at ARC stated that: *“What is practical is for them [children born out of rape] to have special services, maybe we look at training people to foster them, give them support in a special way because we know that they are being battered. It is a very big number but we cannot document that because it looks like stigma.”* The human rights-based approach is essential to achieve humanitarian assistance which is responsive to these and other invisible needs of women and children.

Another important element regarding rights and obligations is legal status. Women and children need to be legally recognised as refugees for them to enjoy these rights. Both the refugee

participants and key informants strongly emphasised the significance of attestation cards<sup>40</sup>. These cards assume priority over the right to health because access to health care and basic necessities for life is almost impossible without them. It is important to assist refugees in the process of registering with the appropriate authorities and to ensure that the registration process and the whole refugee experience prevent and minimise traumatisation. As stated by a senior official of IOM, a rights-based approach ensures that: *“The migration process is done in a humane, orderly and respective way without stripping people of their dignity but also ensuring that their rights are met.”* For instance, in addition to the available health services, putting in place specific parallel health programmes to the health needs of refugee women and children is essential to reduce vulnerability and critical to the enjoyment of their rights. This is not to suggest that they should be prioritised over local Ugandans, given that the Government of Uganda is struggling to meet the local demand; however, based on the findings refugee women and children are very vulnerable and need more protection. For instance, the findings of trauma, violence or even communication difficulties are indicative of the need for special care such as the extended time during consultations so that they able to express their problems clearly. Although there are shortcomings of rights-based approach in “protracted refugee situations<sup>41</sup>” (UNHCR 2016), neglect of this implies that women and children cannot achieve improved health outcomes. Most respondents were considered to be in protracted refugee situations and largely depended on assistance. Gerber et al. (2017) assert that refugees in such situations face significant limitations on their basic rights and that their essential economic, social and psychological needs remain unfulfilled or neglected. The next section examines the need for durable solutions.

### *10.3.2 Durable solutions*

Uganda is a low-income country, where public health provision is inadequate even for the local population, yet it also hosts large numbers of refugees for protracted periods. How can the country be able to provide improved health services without straining its health system? Society counters social problems by putting social policies in place. Thompson and Thompson define social policy as the variety of policies developed through the state and related institutions in

---

<sup>40</sup> These are legal documents provided to all refugees by the Office of the Prime Minister .

<sup>41</sup> This refers to refugees who have been in exile for at least five years, “often in an intractable state of limbo, and sometimes remaining as refugees for decades” ( Gerber et al., 2017, p.2).

response to what are perceived to be social problems (2016, p.132). The government has goodwill to support refugees, however, without proper policies (both during a crisis and long-term), this puts a strain on the already strained health system. Most refugee services are supported by UNHCR and donors whose funding is highly unpredictable and unreliable. Any fluctuations or cuts in funding disorganise planning and implementation of assistance programmes and directly impact the quantity and quality of health service provision in the settlement. Data (see Chapters Seven and Nine) shows that these cuts lead to reductions in food distribution, medical supplies and all other services which are essential for health and well-being. The government has in place a self-reliance framework where it provides a plot of land to refugees for housing and cultivation (UNHCR, 2019). However, this is not enough, there is a need to consider more durable solutions such as integration of refugees to replace the present method of settlement in isolated areas (Dunn, 2016). Recognising that empowered refugees are better able to contribute to their own and their communities' well-being necessitates host countries provide livelihood opportunities and labour markets, and build human capital and transferable skills important for self-reliance (UN, 2016). This might also reduce over-dependency on international aid, which is presently insufficient. However, securing local durable solutions is one of the principal goals of international protection (UNHCR, 2018; UN, 2016) and is essential in the midst of the unpredictable international environment. Moreover, durable solutions such as self-reliance, resettlement (as a last resort) and local integration<sup>42</sup> and are the practical means of protection which I now turn to discuss.

### *10.3.3 Social protection*

Social protection consists of policies and programmes designed to reduce poverty and vulnerability (IFSW, 2014). Social security is a human right enshrined in the Universal Declaration of Human Rights and in the Covenant of Economic, Social and Cultural Rights (*ibid*, 2016). Refugees, like all other human beings, need to have access to social protection systems. This was stressed by a Protection/Counsellor at ARC saying that “*protection is the main purpose of where people moved from, wherever they came [from], they came to camp here it is [because of] protection.*” The 1951 United Nations Convention and the 1967 Protocol

---

<sup>42</sup> This is a complex and gradual process that involves refugees establishing themselves (legally, economically, socially, culturally) in a country of asylum and integrating into the community and with time, this should lead to permanent residence rights and acquisition of citizenship (UNHCR 2018, p.33)



relating to the status of refugees adopted by the United Nations General Assembly are international instruments that guide in the formulation of safeguards and protections for the rights of refugees. However, as I have discussed in the preceding chapters the refugee women and children in NRS face poor health due to various factors such as poverty and social vulnerability. Women and children experience violence, abuse, torture and a number of harmful practices. The IFWS' international policy on social protection asserts that '*social protection systems should have a preventive and sustainable effect; strengthening the resiliency of individuals, families and communities and enhancing the capability to react to risks of life*' (IFSW, 2014). This statement represents the need to go beyond the provision of basic needs (such as food) to enhancing social protection systems so that the refugee women and children are able to live securely in the settlement with the full realisation of their rights. One of the key informants stated that: "*There are some child-headed households in the settlement- some children are there, they don't have their parents, they are just staying alone when they are boys and girls. So because of having inadequate shelter the child abuse cases arise so if there would be some policy to improve the shelter for the refugees, I think some of the challenges would be reduced like that of child abuse.*" This denotes a need to strengthen child protection in the settlement through provision of adequate shelter for child-headed families and other measures such as fostering as suggested by the child protection officer at ARC. However, Brown and Hunter (2016), advise that the protection of vulnerable people should be co-produced by individuals, communities and professions. For example, at the individual level, measures must be in place to work with abusive individuals in such a way to sensitise them about the kind of harm and the pain of trauma this has inflicted on the victim. This engagement is essential to change the abusers' mind-set and reduce their risk of future abuse, but also is a step toward restoring hope in the victims. The government of Uganda also needs to tighten up security measures in the settlement and also be able to put in place proper justice systems to ensure that the survivors of abuse receive justice for example by improving settlement policing. Doing all that require collective comprehensive and coordinated plans. UNHCR (2018, p.27) states lasting solutions necessitate collective commitment and only a coordinated and comprehensive approach by governments, humanitarian and development actors, supported by a well-funded international response, can lead to full protection of the most vulnerable.

#### 10.3.4 Comprehensive and coordinated assistance

Comprehensive refugee services should combine material, medical, socio-economic and legal help (Papadopoulos, 2010). Currently, there are a number of organisations which are supporting refugee work in the settlement. However, it was reported that their programmes are uncoordinated which leads to massive inefficiencies (Dunn, 2016). This was reflected in the statement of the social work academic: *“Sometimes you find like ten organisations you know, providing more or less the same things... so you find that in health we have a structure of VHTs for instance, but you find say organisation X has health promoters, organisation Y also has health promoters, but in terms of the competencies that these people have, in terms of the training that these people receive they are completely different so there is no harmonisation.”* There is a need for collaboration between organisations which are supporting refugees in order to ensure that adequate and holistic support is put in place for refugees (Fassetta and Quinn, 2018; Dunn, 2016). This will not only reduce duplication but will also improve the referral pathway for accessing services. An excellent example of comprehensive refugee intervention programme is provided by the Institute for Family Health (IFH)<sup>43</sup> in Jordan. IFH provides integrated health care including medical and reproductive health services, psychological, social and legal counselling, child protection, and rehabilitation services for Iraqi and Syrian refugees living in Jordan. In addition, it conducts national gender-based violence initiatives, human rights awareness programmes, and implements capacity building for community-based, national and international organisations (IFH, 2008). It also provides training for professionals and caretakers in the areas of family health care, child protection, and rehabilitation for survivors of gender-based violence and torture to ensure effective and sensitive service delivery to vulnerable groups. Berends, (2017) provides specific examples of comprehensive humanitarian assistance programmes which can be adapted to address the diverse health concerns of refugees such as creation of child-friendly spaces, youth empowerment programme centres, and women and girl’s safe spaces. According to Berends (2017), child friendly spaces create safe spaces where young children can engage in recreation, psychosocial, and informal education activities; youth empowerment programme centres support teenagers build life

---

<sup>43</sup> King Hussein Foundation:

<http://www.nooralhusseinfoundation.org/index.php?pager=end&task=view&type=content&pageid=35>

skills, self-confidence, and plan for the future while the women and girls safe space provides recreational activities and vocational training for women.

Despite the existing competition among organisations to secure funding from donors (see Chapter Nine) these examples could be adapted to the Ugandan context by harmonising the current provision of services to improve health and well-being for refugees. The protection officer/ counsellor at ARC stated that: *“Health is part of protection, prevention and response is part of protection, education is part.”* The social work academician reaffirmed that; *“if you are talking about an approach to addressing the health needs of people you need a holistic approach, okay? You can’t only address WASH<sup>44</sup>-for example related diseases without talking about livelihoods, without talking about protection.”* This denotes a need for cross-sector coordination such as health sector, security, education, livelihood and food and nutrition, water, sanitation and hygiene (WASH) to ensure consistency in programming and mutual assistance (UNHCR, 2019).

In addition, the provision of basic services such as medication, food and water are policy issues determined by the government and UNHCR. The findings have shown a scarcity of these basics despite the fact that the respondents cannot afford to pay for these. Moreover, data shows an urgent need for the provision of mental health services at the primary health level. There is a need to meet the immediate and long-term humanitarian and protection needs of refugee women and children in the settlement to ensure long-term recovery and reduce the traumatic impacts of forced migration (Berends, 2017). Similar to Dunn (2016), I argue that measures to assist refugees should not be considered as temporary because forced displacement seems like a permanent state for refugees in NRS (See: the section on length of stay in Chapter Five). The community development officer at the district also reiterated that *“some of them have stayed there [settlement] for more than twenty years and they seem as if they are even not bothered to try to go.”* The government runs a comprehensive refugee response framework (CRRF) in supporting refugees. The CRRF currently embedded into the National Development Plan II (NDP II, 2016-2021) was launched in March 2017 and aims to implement humanitarian refugee response (in emergencies and protracted situations) alongside development-oriented interventions like the Refugee and Host Populations Framework (ReHoPE) (UNHCR 2019,

---

<sup>44</sup> This stands for water, sanitation and hygiene

p.7). If successful, this is expected to strengthen the sustainable delivery of essential services and infrastructure for both refugees and host communities. Since success depends upon funding, the government must intensify its fundraising actions to accomplish this agenda. One initiative this research suggests as necessary is gender mainstreaming in refugee health services.

#### *10.3.5 Gender mainstreaming in health care and humanitarian assistance*

The need for putting in place a more gender-responsive approach to health care was acutely accentuated by the key informants. In fact, it is also a global obligation that humanitarian assistance programmes should incorporate a non-discriminatory and gender mainstreaming approach throughout (UN, 2016; Valtonen, 2008). My respondents indicated that the factors which affect refugee women and children's health originate from existing gender constructions and inequalities in power distribution between women and men. These imply that gender and power relations influence health and the outcomes of health interventions. A gender perspective should involve empowering women to participate in making decisions that affect their health. In addition, there should be an inclusive and participatory process, involving both women and men in the design and implementation of interventions (Alsaba and Kapilashrami, 2016; Moser, 2003). As revealed earlier (See: Chapters Six, Seven and Nine), the men have a very big influence on women and children's health since they are the main decision-makers in households and measures which only target women are thought not to achieve their intended outcomes. The resolve is that the men must be empowered so that they can empower their women to be more informed, and more independent in taking decisions. Moreover, a rise in gender-based violence in response to empowerment initiatives must be remedied through preparing male refugees to live with empowered women. This is also important to reduce gender-based violence which largely arises from the transformation of roles in exile.

In addition, policymakers must increase the availability of safe and confidential gender-related medical services and enforce gender balance in recruitment within humanitarian agencies—to encourage female refugees to seek services. Similar to Fernandes and Miguel (2009), there were reports of Somali women being anxious to seek health services because they did not want to be seen by male clinicians (see Chapter Seven). As a result, many cases of fistulae were not reported. This further implies that decision-makers and service providers must also be well-prepared to understand and effectively respond to the gendered and social determinants of

health (Manandhar et al., 2018). This brings me to the need to clarify processes and procedures for refugees.

### *10.3.6 Clarifying processes and procedures*

The study revealed the existing vulnerability connected to the need for resettlement and the complications surrounding the screening and assessment criteria. It is the duty of UNHCR and OPM to address this level of desperation and uncertainty by clarifying the legal procedures for the refugees and make sure that legitimate individuals access the services. This is both important to solve resettlement vulnerability such as those revealed in Chapter Six and Nine about inventing vulnerabilities through abusing children (like scratching their daughters in genitals and reporting it as defilement) and to empower refugees so that they reflect on additional options to secure their future such as rebuilding their lives in Uganda through business or study opportunities. Dunn (2016, p.773) states that the international humanitarian system for refugees is both ‘broke’ and ‘broken’ citing that:

Aid is largely given ad hoc which implies that neither aid agencies nor donors tell refugees what kind of aid they can expect or when it will be delivered. Nor do they tell them when aid will stop. In this unpredictable and chaotic situation, it is difficult for refugees to plan for the future, much less to leverage their own resources and take action. (ibid, p.773)

This adhocacy was also reflected in the interventions in NRS. A community services assistant at OPM stated that: *“Sometimes the materials themselves are not enough. Yes, because we also get them from donors, in fact, UNHCR being the head donor if I may call it. And sometimes they are few, and distributing them becomes a problem. Sometimes they come late, instead of giving them [refugee women] like twice a year we find ourselves like giving them once a year. Yeah, and then sometimes, again according to the UNHCR standard, we are supposed to give to the reproductive age of which for them they put it at 12 to 49, and yet women like above also claim to be still going through their periods.”* This method of working creates uncertainty, increases vulnerability and desperation. Based on this, I argue that there should be some degree of predictability in decisions, plans and policies such as those relating to humanitarian assistance to ensure that women and children live dignified lives.

In addition, UNHCR and the global community have a duty to fulfil their promise of mutual responsibility for refugee support. As indicated, many programmes are deficient because the present funding is inadequate and unsustainable. It is therefore important for UNHCR to

increase its support to Uganda in accordance with existing humanitarian principles (UN, 2016). For instance, this can be through increased funding to meet the demand for the surging numbers of refugees. From a broader perspective, UNHCR should persuade affluent countries that have not yet established resettlement programmes to consider doing so and to encourage those who have already done to increase the size of their programmes based on the principles of international cooperation and on burden- and responsibility-sharing (UN, 2016). The next section examines the implication of the study for further research.

### *10.3.7 Research*

This research shows that refugee populations are growing, and yet they are not homogenous in terms of their experiences and needs. Newly arriving groups of refugees have diverse needs. This was also stressed by an assistant counsellor at OPM that: *“There was a time maybe we were just an old settlement, now, we are both old and new settlement because we have new arrivals coming every now and then. I think, you see how- you notice the people who are in our window- yeah those are new arrivals”* Given the scarce resources, there is a need to account for evidence both refugees’ immediate needs upon arrival as well as their long-term needs. This is not only essential for prioritising humanitarian assistance but is also central in terms of preparedness for protracted refugee situations (Dunn, 2016).

Research on refugees, in general, would benefit from further studies in other settings (both regionally and internationally) in order to understand similarities and differences between countries and situations. This was also stressed by the social work academic saying that, *“we need to engage in serious research to understand the refugee dynamics.”* With the requirement of sharing best practices (UN, 2016), specific research on health needs and services for vulnerable groups of refugees may also benefit from interdisciplinary methods as well as responses from other contexts.

*“Thank you for coming to hear about our problems. And we think maybe these things will help us, maybe something will change in our future” (Congolese woman, Base Camp).*

## BIBLIOGRAPHY

Abdulrahim, S. et al., 2017. Estimates of early marriage among Syrian refugees in Lebanon in 2016 compared to Syria pre-2011. *The European Journal of Public Health*, 27(suppl3), p.3.

Adelman, H., et al., ed. (1994) *Immigration and Refugee Policy: Australia and Canada compared*. Vol.1. Melbourne: Melbourne University Press.

Adger, W.N., 2000. Social and ecological resilience: are they related? *Progress in Human Geography*, 24(3), pp.347–364.

Allan, D., 2014. *Refugees of the revolution: experiences of Palestinian exile*, Stanford, California: Stanford University Press.

Allen, K. M. And Spitzer W. J. (2016) *Social Work Practice in Health Care: Advanced Approaches and Emerging Trends*, London: Sage.

Allsop, J. (1995) *Health policy and the NHS: Towards 2000* ( 2nd edition, Longman social policy in Britain series). London: Longman.

Al-Qdah, T., & Lacroix, M. (2011). Iraqi refugees in Jordan: Lessons for practice with refugees globally. *International Social Work*, 54(4), 521-534.

Alsaba & Kapilashrami, 2016. Understanding women's experience of violence and the political economy of gender in conflict: the case of Syria. *Reproductive Health Matters*, 24(47), pp.5–17.

Alston, M., and Bowles, W. (2003) *Research for Social Workers: An Introduction to Methods*, 2<sup>nd</sup> edition, London: Routledge

Ambrose-Miller, W. & Ashcroft, R., 2016. Challenges Faced by Social Workers as Members of Inter-professional Collaborative Health Care Teams. *Health & Social Work*, 41(2), pp.101–109.

Anleu Hernández, C.M. & García-Moreno, C., 2014. Migration, Resilience and Social Work: Latin Americans in Tarragona. *British Journal of Social Work*, 44(suppl1), pp.i88–i104.

Anon, 1986. Ottawa Charter for Health Promotion Charte D'ottawa Pour La Promotion De La Santé. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, 77(6), pp.425–430.

Aparicio, E., et al., 2013. An Examination of the Psychometric Properties of the Vicarious Trauma Scale in a Sample of Licensed Social Workers. *Health & Social Work*, 38(4), pp.199–206.

Babbie, E. (2010) *The Practice of Social Research*. 12<sup>th</sup> ed. Belmont: Wards worth, Cengage Learning.

Bani, I. A. (2008). Health needs assessment. *Journal of Family & Community Medicine*, 15(1),13–20. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3377051/#ref27> [Accessed 22 January 2017].

Baragaber, A. (2006) *Conflict, and the Refugee Experience: Flight, Exile, and Repatriation in the Horn of Africa*. Burlington: Ash gate.

Basaza, R., Criel, B., Van der Stuyft, P. (2007) Low enrolment in Ugandan community health insurance schemes: underlying causes and policy implications. *BMC Health Serv Res*. 2007; 7:105 available: [http:// www.ncbi.nlm.nih.gov/pmc/articles/PMC1940250/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1940250/) Accessed on 22/ Jan /2017.

Bascom, J. (1998) *Losing Place: Refugee Populations and Rural Transformations in East Africa*. New York: Beg Hahn.

Beauchamp, L. T., et al. (1982) *Ethical Issues in Social Science Research* (eds). Baltimore. John Hopkins University Press.

Becker, M. H. (1974) *The health belief model and personal health behaviour*. Thorofare, N.J.: Thorofare, N.J: C.B. Slack.

Berends, M., 2017. Beyond the Basics: Holistic Humanitarian Assistance for Syrians. *American Diplomacy*, pp.1–2.

Beresford, P. & Evans, C., 1999. Research note: research and empowerment. *British Journal of Social Work*, 29(5), pp.671–677.



- Berkman et al., 1990. Social work in health care: Directions in practice. *Social Science & Medicine*, 31(1), pp.19–26.
- Bickman, L., & Rog, D. (1998) *Handbook of applied social research methods*. Thousand Oaks, Calif.; London: Sage Publications.
- Blaikie, N. (1991) A critique of the use of triangulation in social research. *Quality and Quantity*, 25(2), 115-136.
- Blaikie, N. (2001) *Designing Social Research: The Logic of Anticipation*. Oxford: Black well Publishers Ltd.
- Bloch, A., et al. (2013) *Race, Multicultural and Social Policy*. New York: Palgrave Macmillan.
- Boyle, P., & Norman, P. (2010) Migration and Health. In Brown, ed. *A Companion to Health and Medical Geography*. West Sussex: Blackwell Publishing Company limited. Ch.19.
- Bradshaw J. (1972) “A taxonomy of social need.” in McLachlan G (ed.) *Problems and progress in medical care*. Seventh series NPHT/Open University Press.
- Brandon, P.D., 2000. Did the AFDC Program Succeed in Keeping Mothers and Young Children Living Together? *Social Service Review*, 74(2), pp.214–230.
- Brian, T. and Laczko, F. (2014) (eds). *Fatal Journeys: Tracking Lives Lost during Migration*. International Organization for Migration; Available at: [http://publications.iom.int/bookstore/free/FatalJourneys\\_CountingtheUncounted.pdf](http://publications.iom.int/bookstore/free/FatalJourneys_CountingtheUncounted.pdf)
- Brown, H., and Hunter, S., (2016). What Kinds of Violence and Abuse affect vulnerable people? Reflections on the evolving context of adult protection and safeguarding in the United Kingdom: legislation, regulation and professional practice, in Palattiyil, G., et al., 2016. *Social work in a global context: issues and challenges*, Abingdon, Oxon; New York, NY: Routledge.
- Bryman, A. (2001) *Social Research Methods*. New York. Oxford University Press.
- Bryman, A. (2006) Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6(1), 97-113.
- Bundy-Fazioli, K., et al. (2013) Graduate Students' Perceptions of Professional Power in Social Work Practice. *Journal of Social Work Education*, 49(1), pp.108–121.

Bukuluki, P., & Mubiru, J.B. (2014) *The status of social security systems in Uganda: challenges and opportunities*. Kampala: Konrad- Adenauer-Stiftung.

Bywaters, P. & Davis, C., 2012. Social work and health. In *The SAGE Handbook of International Social Work*. SAGE Publications Inc., pp. 217–231.

Carey-Wood et al. (1995). *The Settlement of refugees in Britain* (A Home Office Research and Planning Unit report). London: H.M.S.O.

Chen, M., & Land, K. (1986) Testing the Health Belief Model: LISREL Analysis of Alternative Models of Causal Relationships Between Health Beliefs and Preventive Dental Behaviour. *Social Psychology Quarterly*, 49(1), 45-60. Available at: <http://www.jstor.org.ezproxy.is.ed.ac.uk/stable/2786856>

Cohen, D. A., Scribner, R. A. & Farley, T. A. (2000) A Structural Model of Health Behaviour: A Pragmatic Approach to Explain and Influence Health Behaviours at the Population Level. *Preventive Medicine*, 30(2), 146-154.

Comas-Diaz, L., & Jansen, M. A. (1995) Global conflict and violence against women. *Peace and Conflict: Journal of Peace Psychology*, (1) pp315-331.

Commission on Social Determinants of Health (CSDH), (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

Corbin, J., and Strauss, A., (2008 (3rd ed). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Cossar, J. & Neil, E., 2015. Service User Involvement in Social Work Research: Learning from an Adoption Research Project. *British Journal of Social Work*, 45(1), pp.225–240.

Crawley, H. (2001) *Refugees and Gender: Law and process*. Bristol: Jordan.

Creswell, W. J. (1994) *Research Design: Qualitative and Quantitative Approaches*. London. Sage.

Crotty, M. (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London. Sage.

Crawford, G., et al., 2017. *Understanding Global Development Research*. London: Sage Publications Ltd.

Cuadra B. C., 2009. *State of the Art Report (SOAR) Sweden* [online].

De Vaus, D. (1991). *Surveys in social research* (Third ed.). London: UCL Press.

De Vaus, D. (1996). *Surveys in social research* (Fourth ed., Social research today; v.5). London: UCL.

De Vaus, D. (2014) *Surveys in social research* (6th ed., Social research today (Routledge (Firm)). Abingdon: Routledge.

De Vaus, D. A. (2001) *Research design in social research*. London: Sage.

De Vaus, D. A. (2002) *Analysing social science data*. London: Sage.

Deacon, Z., & Sullivan, C. (2009) Responding to the Complex and Gendered Needs of Refugee Women. *Affilia*, 24(3), 272-284.

Delavega, E. et al., (2019). Preparing Social Work Students for Inter-professional Team Practice in Health-Care Settings. *Research on Social Work Practice*, 29(5), pp.555–561.

Dunn E. C., 2016. Refugee protection and resettlement problems. *Science*, 352(6287), pp.772–773.

Edwards, R., & Mauthner, M. (2014) Ethics and Feminist Research: Theory and Practice. in Miller, et.al., (eds) (2014). *Ethics in Qualitative Research*. London. Sage. Online. [Accessed 24 February 2017].

Erez, E. & Bhat, M. (2010). Rape myths and violence against women. In F. T. Cullen & P. Wilcox (Eds.), *Encyclopaedia of criminological theory* (pp. 772-773). Thousand Oaks, CA: SAGE Publications,

Ewles, L., and Simnett, I. (2003) *Promoting health: a practical guide* (5th ed). Bailliere Tindall, London.

Fassetta, G, Da Lomba, S & Quinn, N., 2016, *A Healthy Start? Experiences of Refugee and Asylum Seeking Women in Scotland*. Glasgow.

Fassetta, G. & Quinn, N., 2018. A healthy start? Experiences of pregnant (refused) asylum seeking women in Scotland. *European Journal of Public Health*, 28(s1), pp.102–103.

Fernandes, A. and Miguel, J.P., (2009). Health and Migration in the European Union: Better Health for All in an Inclusive Society. Instituto Nacional de Saúde Doutor Ricardo Jorge. Lisboa. Available at: <http://www2.insa.pt/sites/INSA/Portugues/Publicacoes/Outros/Documents/Epidemiologia/HealthMigrationEU2.pdf>. Accessed [9 September 2019].

Fielding, N. & Lee, R. M. (1991) *Using computers in qualitative research*. London: Sage Publications.

Finlay, L., 2002. “Outing” the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, 12(4), pp.531–545.

Finlay, L., Gough, B. & Wiley InterScience. (2003). *Reflexivity a practical guide for researchers in health and social sciences*, Malden, MA: Blackwell Science.

Fleischman et al., 2015. Migration as a social determinant of health for irregular migrants: Israel as case study. *Social Science & Medicine*, 147, pp.89–97.

Freedman, J., 2019. The Uses and Abuses of «Vulnerability» In EU Asylum and Refugee Protection: Protecting Women or Reducing Autonomy? *Papeles del CEIC*, 2019(1), pp.1–15.

Galambos, C., 2005. Natural Disasters: Health and Mental Health Considerations. *Health & Social Work*, 30(2), pp.83–86.

Gallopin, G.C., 2006. Linkages between vulnerability, resilience, and adaptive capacity. *Global Environmental Change*, 16(3), pp.293–303.

George, S., et al., 2018. A qualitative study into the perceived barriers of accessing health care among a vulnerable population involved with a community centre in Romania. *International Journal for Equity in Health*, 17(1), pp.1–13.

Gerber, M.M. et al., 2017. Nepali Bhutanese Refugees Reap Support Through Community Gardening. *International Perspectives in Psychology: Research, Practice, Consultation*, 6(1), pp.17–31.

- Gerritsen, A. et al., 2006. Use of health care services by Afghan, Iranian, and Somali refugees and asylum seekers living in The Netherlands. *European Journal of Public Health*, 16(4), pp.394–9.
- Gibbs, R. G., Friese, S., and Mungabeira C. W. (2002) The Use of New Technology in Qualitative Research. Introduction to Issue3(2) of FQS.
- Gilbert, N. (2008) *Researching Social Life*. 3<sup>rd</sup> ed. Los Angeles and London: Sage Publications.
- Golafshani, N. (2003) Understanding reliability and validity in qualitative research. *Qualitative Report*, 8(1), 597-607.
- Government of Uganda (GoU). (2006) *The Constitution of the Republic of Uganda (1995)*.
- Government of Uganda (GoU). (2006). *The Refugee Act 2006* [Uganda], Act 21, 24 May 2006, available at: <http://www.refworld.org/docid/4b7baba52.html> [accessed 4 November 2016]
- Government of Uganda (GoU). (2015) Office of the Prime Minister Editorial.
- Government of Uganda (GoU). (2015) Second National Development Plan (NDP II) 2015/16 – 2019/20.
- Grayson, C.-L., 2017. Refugees in Extended Exile: Living on the Edge Jennifer Hyndman and Wenona Giles \*. *International Review of the Red Cross*, 99(904), pp.453–457.
- Greener, I. (2011) *Designing Social Research: A Guide for the Bewildered*. London. Sage.
- Hall, N. ed. (2006) *Social Work Making a World of Difference: Social Work Around the World IV in the year of IFSW' 50<sup>th</sup> Jubilee*. Oslo: IFSW and Fafo.
- Handmarker, J., Anne de la Hunt, L., Klaaren, J. (2008). *Advancing Refugee Protection in South Africa*. Eds London: Berghahn.
- Harrison, G. & Turner, R., 2011. Being a 'Culturally Competent' Social Worker: Making Sense of a Murky Concept in Practice. *The British Journal of Social Work*, 41(2), pp.333–350.
- Hartman, A., 1993. The professional is political. (social workers) (Editorial). *Social Work*, 38(4), p.365.

Haughton, J. & Khandker, S.R., 2009. *Handbook on Poverty and Inequality*, Washington, DC: World Bank.

Hawkes, S., Buse, K. & Kapilashrami, A., 2017. Gender blind? An analysis of global public-private partnerships for health. *Globalization and health*, 13(1), p.26.

Hiegel, P. (1991) Psychosocial and mental health needs of refugees: Experiences from Southeast Asia. *Tropical Doctor*, 21 (Supplement 1), 63-66

Hochfeld, T., et al., (2009). Developmental Social Work Education in Southern and East Africa. Johannesburg. Center for Social Development in Africa.

Hsiao, Y. (2010). Athens, Lonnie: interaction and violence. In F. T. Cullen & P. Wilcox (Eds.), *Encyclopaedia of criminological theory* (pp. 63-65). Thousand Oaks, CA: SAGE Publications: <https://www.unhcr.org/uk/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html>

Hunter, D. (2003). *Public health policy*. Cambridge: Polity.

Hycner, R. (1985) Some guidelines for the phenomenological analysis of interview data. *Hum Stud*, 8(3), 279-303.

ICF International. 2011. Demographic and Health Surveys Methodology - Questionnaires: Household, Woman's, and Man's. MEASURE DHS Phase III: Calverton, Maryland, USA. Available at: <http://www.measuredhs.com/publications/publication-DHSQ6-DHS-Questionnaires-and-Manuals.cfm> accessed [1 June 2017]

Ikanda, F.N., 2018. Animating 'refugeeness' through vulnerabilities: worthiness of long-term exile in resettlement claims among Somali refugees in Kenya. *Africa: The Journal of the International African Institute*, 88(3), pp.579–596.

International Federation of Social Workers (IFSW), 2012. Policy statement on Refugees. Available at: <https://www.ifsw.org/refugees/>. Accessed 22 January 2019.

International Federation of Social Workers, International Association of Schools of Social Work & International Council On Social Welfare, (2014). Global Definition of Social Work. Available at: <http://ifsw.org/get-involved/global-definition-of-social-work/>. [Accessed 24<sup>th</sup> November 2016]

International Organisation for Migration (IOM) (2015). Policy Brief - Migration: A Social Determinant of the Health of Migrants. Available at: [http://www.migrant-health-europe.org/files/Migration%20a%20Determinant%20of%20Health\\_Brief\(3\).pdf](http://www.migrant-health-europe.org/files/Migration%20a%20Determinant%20of%20Health_Brief(3).pdf)

International Organization for Migration (IOM), 2010. *World Migration Report, The Future of Migration: Building Capacities for Change*. Geneva: IOM.

International Organization for Migration. (2004) *International Migration Law No. 10*, Glossary on Migration, Geneva: IOM.

International Organization for Migration. (2014) Migration Initiatives – Health of Migrants; Geneva, Available at: <http://publications.iom.int/bookstore/>

International Rescue Committee- Legacy of War Uganda. (2015) The International Rescue Committee Provides vital support to Ugandans who are rebuilding from decades of war while hosting a large influx of refugees. Available at: <https://www.rescue-uk.org/country/uganda>. [Accessed 12 November 2016].

International Rescue Committee/Health Care(IRC) (2014): IRC addresses urgent health concerns of South Sudanese refugees in Uganda. Available at: <https://www.rescue-uk.org/article/irc-addresses-urgent-health-concerns-south-sudanese-refugees-uganda>. [Accessed 12 November 2016]

IOM. (2011) *Healthy Migrants I Healthy communities*. Nairobi. IOM

IOM. (2009) *A Response Analysis of HIV& AIDS Programming Along Transport Corridors in Uganda*. Kampala: IOM.

Jackson, C., 2002. Perceived legitimacy of parental authority and tobacco and alcohol use during early adolescence. *Journal of Adolescent Health*, 31(5), pp.425–432.

Jaco, E. (1972) *Patients, physicians, and Illness: A Sourcebook in behavioural science and health* (Second edition reprint with corrections. ed.). New York: Free Press.

Jain, S & Jadhav, S., 2009, 'Pills that Swallow Policy: Clinical Ethnography of a Community Mental Health Programme in Northern India ' *Transcultural Psychiatry*, vol. 46, no. 1, pp. 60-85. DOI: 10.1177/1363461509102287

Kabadaki, K. (1995) Exploration of social work practice models for rural development in Uganda. *Journal of Social Development in Africa*,10(1), 77-88.

Kagolo, F. (2014). 'Health insurance Scheme to start soon.' *New Vision*, Thursday 20 November 2014.

Kamya S. (2017) Human Rights Abuse and Deprivation of Childhood: A Case of Girl Mothers in Northern Uganda. In: Kaawa-Mafigiri D. and Walakira E. (eds) *Child Abuse and Neglect in Uganda. Child Maltreatment (Contemporary Issues in Research and Policy)*, vol 6. Springer, Cham

Karunakara, U.K. et al. (2004) Traumatic events and symptoms of post-traumatic stress disorder amongst Sudanese nationals, refugees, and Ugandans in the West Nile. Amsterdam, The Netherlands, Vol 4(2) *Journal of African Health Sciences*.

Kikulwe, D. et al., (2017) Education for All: Reflections on the Schooling Status for the Girl Child in Uganda. In: Kaawa-Mafigiri D. and Walakira E. (eds) *Child Abuse and Neglect in Uganda. Child Maltreatment (Contemporary Issues in Research and Policy)*, vol 6. Springer, Cham

Kimbrough, W., et al., (2012) The burden of tuberculosis in crisis-affected populations: a systematic review. Available: <https://www.ncbi.nlm.nih.gov/pubmed/23174381>.

Kimmel. J. A. (2011) An overview of Ethical problems in social research' in *Ethics and Values in Applied Research*. London Sage.

Krejcie, R. & Morgan, D. (1970) Determining Sample Size for Research Activities. *Educational and Psychological Measurement*, 30(3), 607.

Kumar, N. B. (2011) *Health and Migration*. Norway.

Kuruvilla et al., 2016. The Global strategy for women's, children's and adolescents' health (2016-2030): a roadmap based on evidence and country experience. *Bulletin of the World Health Organization*, 94(5), pp.398–400.

Kvale, S., and Brinkmann, S. (2009) *Interviews: Learning the Craft of Qualitative Interviewing*. 2<sup>nd</sup> ed. London: Sage Publications Limited.



Kyadondo, D. and Mugisha, J. (2014) Assessing the state of Uganda's traditional social protection systems and implications for formal social protection policy and programming.

Laurier, E. (2010) 'Participant Observation'. in N Clifford, S French & G Valentine (eds), *Key Methods in Geography*. 2nd ed, Sage Publications, London, pp. 116-130.

Laverack, G., 2004. *Health promotion practice power and empowerment*, London: SAGE.

Leppo et al. (2013). *Health in All Policies: Seizing opportunities, implementing policies*(eds). Ministry of Social Affairs and Health, Finland, Malta.

Lincoln, Y. S., & Guba, E. G. (1985) *Naturalistic inquiry*. Beverly Hills: Sage.

Loparimoi P., 2011: Sanitation Worsens at Water Sources in Kyangwali.

Lymbery, M. (2005) *Social work with older people: Context, policy, and practice*. London; Thousand Oaks, Calif.: Sage Publications.

MacIntyre, G and McCusker, P., (2016) Involving service users and carers in social work education: A consideration of the UK and global perspectives: in Palattiyil, G., Sidhva, D. & Chakrabarti, M., 2016. *Social work in a global context: issues and challenges*, Abingdon, Oxon; New York, NY: Routledge.

Majodina, Z., 1989. Exile as a Chronic Stressor. *International Journal of Mental Health*, 18(1), pp.87–94.

Makerere University Department of Social Work and Social Administration, (2011). Undergraduate Curriculum for Bachelor of Social Work and Social Administration- B (SWSA) and Bachelor of Arts in Social Sciences-BA(SS). Kampala.

Manandhar, M. et al., 2018. Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, 96(9), pp.644–653.

Marshall, C., & Rossman, G. (1995) *Designing qualitative research* (Second ed.). Thousand Oaks, Calif.; London: Sage.

Marshall, C., & Rossman, G. (2006) *Designing qualitative research* (Fourth ed.). Thousand Oaks, Calif.: Sage Publications.

Massey, Douglas S. 1999. "Why does immigration occur? A theoretical synthesis." In: Hirschman et al. (Eds), *The Handbook of International Migration: The American experience*, New York: Russell Sage Foundation.

Mason, G. & Pulvirenti, M., 2013. Former Refugees and Community Resilience. *British Journal of Criminology*, 53(3), pp.401–418.

Mauther, N. S., and Doucet, A., (2003). *Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis*. Thousand Oaks, Sage, London.

Mcdonald et al., 2016. Risk and protective factors in early child development: Results from the All Our Babies (AOB) pregnancy cohort. *Research in Developmental Disabilities*, 58(C), pp.20–30.

McKinlay, J. A. (1979) Case for refocusing upstream: The political economy of illness. In *Patients, Physicians and Illness: A Sourcebook in Behavioral Science and Health*; Gartley, J., Ed.; Free Press: New York, NY, USA, pp. 9–25.

Merry, L. A., Gagnon, A. J., Kalim, N. & Bouris, S. S. (2011) Refugee Claimant Women and Barriers to Health and Social Services Post-birth. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, 102(4), 286-290.

Meserve, C. H. (1963) What is Health? *Journal of Religion and Health*, Vol. 2, No. 4 (Jul. 1963), pp. 265-266. *Springer*. Available: <http://www.jstor.org/stable/27504584> [mighealth.net/se/images/9/93/State\\_of\\_the\\_Art\\_Report\\_%28SOAR%29\\_Sweden\\_Sweden\\_09.pdf](http://mighealth.net/se/images/9/93/State_of_the_Art_Report_%28SOAR%29_Sweden_Sweden_09.pdf) [Accessed 19 November 2016]

Miller, K.E. et al., 2002. The relative contribution of war experiences and exile-related stressors to levels of psychological distress among Bosnian refugees. *Journal of Traumatic Stress*, 15(5), pp.377–387.

Ministry of Health, (2010). *Health Sector Strategic and Investment Plan, 2010/11-2014/15*. In: Department of Health Planning, ed. Kampala: Ministry of Health, Republic of Uganda, 2010.

Mogalakwe, M. (2006) The Use of Documentary Research Methods in Social Research. *African Sociological Review / Revue Africaine De Sociologie*, 10(1), 221-230. Retrieved from <http://www.jstor.org/stable/afrisocirevi.10.1.221>

Moser, C., 2003. *Gender Planning and Development: Theory, Practice and Training*, Taylor and Francis.

Moran-Ellis, J., Alexander, V. D., Cronin, A., Dickinson, M., Fielding, J., Sleney, J. & Thomas, H. (2006) Triangulation and integration: Processes, claims, and implications. *Qualitative Research*, 6(1), 45-59.

Mourtada, R., et al., 2017. A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon. *Conflict and Health*, 11(Suppl 1), pp.53–65.

Mugerwa, Y. (2013)'Shelved health insurance plan gets new lease of life'. The New Vision, 20 July 2013-<http://www.monitor.co.ug/News/National/Shelved-health-insurance-plan-gets-new/-688334/1920238/-/7wypnrz/-/index.html>. [Accessed 22 January 2017].

Mullaly, R. (1997) *Structural social work: Ideology, theory, and practice* (Second ed.). Toronto; Oxford: Oxford University Press.

Mulumba, D. (2011) The Gendered Politics of Firewood in Kiryandongo Refugee Settlement in Uganda. *African Geographical Review*, 30(1), 33-46.

Mulumba, D., & Wendo, M. O. (2009) *Policy Analysis Report: Mapping Migration in Uganda*. Kampala: Fountain publishers.

Mwansa, L.-K. (2011). Social work education in Africa: whence and whither? *Social Work Education*, 30(1): 4–16.

Mwenyango, H. and Palattiyil, G. (2019). Health needs and challenges of women and children in Uganda's refugee settlements: Conceptualising a role for social work. *International Social Work*. DOI: 10.1177/0020872819865010.

Nalukwago, J. et al., 2019. Gender norms associated with adolescent sexual behaviours in Uganda. *International Social Science Journal*, 69(231), pp.35–48.

Nassaji, H. (2015) Qualitative and descriptive research: Data type versus data analysis. *Language Teaching Research*, 19(2), 129-132.

National Population Council (NPC) (2018). State of Uganda Population Report 2018: Good Governance; A prerequisite to harness the Demographic Dividend for Sustainable Development. Available at: <http://npcsec.go.ug/wp-content/uploads/2013/06/SUPRE-2018-.pdf>. Accessed [08 August 2019]

Nugent, N.R., Sumner, J.A. & Amstadter, A.B., 2014. Resilience after trauma: from surviving to thriving. *European Journal of Psych traumatology*, 5(1), pp. Article 25339.

Nyanzi, S. (2013) Homosexuality, Sex Work, and HIV/AIDS in Displacement and Post-Conflict Settings: The Case of Refugees in Uganda. *International Peacekeeping*, 20(4), 450-468.

Ochen E.A. et al., (2017) Do Child Rights Legislation and Policies Effectively Protect Children from Maltreatment? Reflection from a Nationwide Sectoral In-Depth Analysis. In: Kaawa-Mafigiri D. and Walakira E. (eds) Child Abuse and Neglect in Uganda. Child Maltreatment (Contemporary Issues in Research and Policy), vol 6. Springer, Cham.

Office of the Prime Minister(OPM). (2015) *A Concept Paper for the settlement and Transformation Agenda Project 2016- 2021*. The government of Uganda.

Okitikpi, T. and Aymer, C. (2000) The price of safety: refugee children and the challenge for social work. *Social Work in Europe*, 7, 51–58.

Oko, J., 2011. *Understanding and using theory in social work* Second., Exeter: Learning Matters.

Oktay, J. S. (2012) *Grounded theory*. Oxford: Oxford: Oxford University Press.

Okwero, P. et al., 2010. *Fiscal Space for Health in Uganda*, World Bank.

O'Laughlin, K. N., et al., (2015) The Refugee Cascade of Care: Prospective Assessment Reveals Attrition from HIV Care in Nakivale Refugee Settlement in Uganda. *Annals of Emergency Medicine*, 66 (Supplement 4)

Olivius, E., 2014. *Three Approaches to Gender in Humanitarian Aid: Findings from a Study of Humanitarian Aid to Refugees in Thailand and Bangladesh*,

Omata, N., 2017. *The myth of self-reliance: economic lives inside a Liberian refugee camp*, New York: Berghahn Books.

Omata, N., and Kaplan, D. J. (2013) *Refugee Livelihoods in Kampala, Nakivale and Kyangwali Refugee Settlements*. Refugee Studies Centre, Oxford Department of International Development: University of Oxford.

Orach, C., and De Brouwere, V. (2005) Integrating refugee and host health services in West Nile districts, Uganda. *Health Policy and Planning*, 21(1), 53-64.

Orach, C., Dubourg, D., & De Brouwere, V. (2007) Costs and coverage of reproductive health interventions in three rural refugee-affected districts, Uganda. *Tropical Medicine & International Health*, 12(3), 459-469.

Orme, J. & Karvinen-Niinikoski, S., 2012. Social work research. In *The SAGE Handbook of International Social Work*. SAGE Publications Inc., pp. 179–200.

Paardekooper, B., et al., (1999). The Psychological Impact of War and the Refugee Situation on South Sudanese Children in Refugee Camps in Northern Uganda: An Exploratory Study. *Journal of Child Psychology and Psychiatry*, 40(4), pp.529–536.

Palattiyil, G & Sidhva, D., 2011. They Call Me You Are AIDS...: A Report on HIV, Human Rights and Asylum Seekers in Scotland. The University of Edinburgh.

Palattiyil, G. & Sidhva, D., 2015. Caught in a Web of Multiple Jeopardy: Post-Traumatic Stress Disorder and HIV-Positive Asylum Seekers in Scotland. *Clinical Social Work Journal*, 43(4), pp.362–374.

Palattiyil, G., et al., 2016. *Social work in a global context: issues and challenges*, Abingdon, Oxon; New York, NY: Routledge.

Palmer, J., 2017. Preventing vicarious trauma among researchers., London, United Kingdom: SAGE Publications Ltd.

Paolisso, M. & Leslie, J. (1995) Meeting the changing health needs of women in developing countries. *Social Science & Medicine*, 40(1), 55-65.

Papadopoulos, R.K. (2002) Refugees, home and trauma. In *Therapeutic Care for Refugees. No Place Like Home*, edited by R. K. Papadopoulos. London: Karnac. Tavistock Clinic Series.

Papadopoulos, R.K. (2007) Refugees, Trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling*, 9 (3), September, 301-312.

Papadopoulos, R.K. (2008) Systemic Challenges in a Refugee Camp. *Context, the Journal of the Association of Family Therapy*, August, p 16-19.

Papadopoulos, R.K. (2010) Enhancing Vulnerable Asylum Seekers' Protection. *Trainers' Manual. Trainer's Manual*. Rome: International Organisation for Migration.

Patton, Q., M. (2002) *Qualitative Research and Evaluation Methods* (3<sup>rd</sup> ed). London Sage.

Paxton, Georgia A. et al., 2011. East African immigrant children in Australia have poor immunisation coverage. (Report). *Journal of Paediatrics and Child Health*, 47(12), pp.888–892.

Payne, G. and Payne, J. (2004) *Key Concepts in Social Research*. London: Sage Publications

Payne, M. (1996) *What is Professional Social Work?* Birmingham: Venture.

Peled, E., & Leichtentritt, R. (2002) The Ethics of Qualitative Social Work Research. *Qualitative Social Work*, 1(2), 145-169.

Pringle, J., Drummond, J., McLafferty, E., Hendry, C. (2011) Interpretative phenomenological analysis: a discussion and critique. *Nurse Researcher*, 18 (3), 20-24.

Quesada, J., Hart, L.K. & Bourgois, P., 2011. Structural Vulnerability and Health: Latino Migrant Laborers in the United States. *Medical Anthropology*, 30(4), pp.339–362.

Quinn, N. & Knifton, L., 2014. Beliefs, stigma and discrimination associated with mental health problems in Uganda: Implications for theory and practice. *International Journal of Social Psychiatry*, 60(6), pp.554–561.

Rachuonyo, D. (2016) More Hubs for Refugees in Kenya and Uganda. TAMUKA News Letter. Uganda Issue, April 2016

Ransome, P., 2013. *Ethics and values in social research*, Basingstoke: Palgrave Macmillan.

Rawls, J. (1971) *A Theory of Justice*. Harvard University Press. Cambridge.

Reed et al., (2011). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *The Lancet*, 379(9812), pp.266–282.

Refugee Law Project Uganda, 2015. *Psychosocial Challenges Among Refugee Women and Girls in Nakivale Refugee Settlement*. Available at: <http://www.refugeelawproject.org/resources/briefing-notes-and-special-reports/16-sprpts-mental-health/357-psychosocial-challenges-among-refugee-women-and-girls-in-nakivale-refugee-settlement.html>. [Accessed 2 March 2017]

Robson, C. (1993) *Real world research: A resource for social scientists and practitioner-researchers*. Oxford, [England]; Cambridge, Mass., USA: Blackwell.

Rubin, A., & Babbie, E. (1989) *Research methods for social work*. Belmont, Calif: Wadsworth.

Rushton, A. & Beaumont, K., 2002. Social Work in Health Care Settings: Turning Full Circle? *Clinical Child Psychology and Psychiatry*, 7(2), pp.295–302.

Sakamoto, Izumi, 2007. A critical examination of immigrant acculturation: toward on anti-oppressive social work model with immigrant adults in a pluralistic society. *British Journal of Social Work*, 37(3), pp.515–535.

Sapsford, R. (2007) *Survey research*, (2nd ed). London: Sage.

Scott, J. (1990) *A Matter of Record, Documentary Sources in Social Research*, Cambridge: Polity Press.

Sidhva, D., 2004. Living with HIV/AIDS: turning points, transitions and transformations in the lives of women from Bombay and Edinburgh, pp.PQDT - UK & Ireland.

Sieber E. R. (1998) Planning Ethically Responsible Research in Rog, J. D., and Bickman, L., (eds) *Handbook of Social Research Methods*. London: Sage.

Silverman, D. (1998) *Qualitative Research: Theory, Method, and Practice*. Eds. London: Sage.

Smyke, P. (1991) *Women and health* (Women and world development series). London: Zed.

Spitzer, H., et al., eds. (2014) *Professional Social Work in East Africa: Towards Social Development, Poverty Reduction and Gender Equality*. Kampala: Fountain Publishers.

- Ssenyonga, J., Owens, V. & Olema, D. K. (2012) Traumatic Experiences and PTSD Among Adolescent Congolese Refugees in Uganda: A Preliminary Study. *Journal of Psychology in Africa*, 22(4), 629-632.
- Stamatel, J.P.P. & Zhang, C., 2018. Risk factors for violence against refugee women. In *Refugees and Migrants in Law and Policy: Challenges and Opportunities for Global Civic Education*. Springer International Publishing, pp. 625–646.
- Stewart, E., 2005. Exploring the vulnerability of asylum seekers in the UK. *Population, Space and Place*, 11(6), pp.499–512.
- Svenberg, K., et al., 2009. ‘A person of two countries’. Life and health in exile: Somali refugees in Sweden. *Anthropology & Medicine*, 16(3), pp.279–291.
- The Office of the Prime Minister. (2017). We stand with Refugees; what about you? The Premier Executive Magazine, Vol.2.
- The organization, World Health Organisation WHO. (2005) *World Health Report 2005 make every mother and child count*: World Health Organization.
- Thomas, S., Douglas, P. & Smith, M. (2010) Refugee health. *New South Wales public health bulletin*, 21(3-4), 101-102.
- Thompson, N., and Thompson, Sue. (2016) *The Social Work Companion*, 2<sup>nd</sup> edition, London: Macmillan.
- Thorne, S. (2000) Data analysis in qualitative research. *Evidence-Based Nursing*, 3(3), 68–70.
- Tippens, J.A., 2017. Urban Congolese Refugees in Kenya: The Contingencies of Coping and Resilience in a Context Marked by Structural Vulnerability. *Qualitative Health Research*, 27(7), pp.1090–1103.
- Turcu, R., 2017. The Place of Environment in Social Work. Case Study: Social Workers Working with Refugees in France. *Revista de Asistentă Socială*, (1), pp.29–38.
- Twikirize, 2014 in Spitzer, H., et al., (eds.) (2014). *Professional Social Work in East Africa: Towards Social Development, Poverty Reduction and Gender Equality*. Kampala: Fountain Publishers.



Twikirize, J. M. (2013) *The Role of Social Work in Poverty Reduction and the Realisation of Millennium Development Goals in Uganda*. Kampala: Fountain Publishers.

UBOS. (2014) Census 2014 Results. Available at: <http://www.ubos.org/2014-census/census-2014-final-results/>. [Accessed 16<sup>th</sup> January 2017].

Uganda Bureau of Statistics (UBOS) (2015) Statistical Abstract. The government of Uganda. Available at: [http://www.ubos.org/onlinefiles/uploads/ubos/statistical\\_abstracts/Statistical%20Abstract%202015.pdf](http://www.ubos.org/onlinefiles/uploads/ubos/statistical_abstracts/Statistical%20Abstract%202015.pdf). [Accessed 18<sup>th</sup> January 2017].

Uganda: *The Refugee Act 2006* [Uganda], Act 21, 24 May 2006, available at: <http://www.refworld.org/docid/4b7baba52.html> [Accessed 4 November 2016]

UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p.137, available at: <http://www.refworld.org/docid/3be01b964.html> [Accessed 29 November 2016]

UN High Commissioner for Refugees (UNHCR), UNHCR and IDC, (2016). Vulnerability Screening Tool - Identifying and addressing vulnerability: a tool for asylum and migration systems, 2016, available at: <https://www.refworld.org/docid/57f21f6b4.html> [accessed 14 September 2018]

UNHCR (2011) UNHCR Resettlement Handbook. Geneva: United Nations High Commissioner for Refugees (UNHCR)

UNHCR (2018) Development Pathways, 'Analysis of Refugee Vulnerability in Uganda and Recommendations for Improved Targeting of Food Assistance', April 2018

UNHCR, 2012. Global Trends 2011: A Year of Crises. Available at: <https://www.unhcr.org/uk/statistics/country/4fd6f87f9/unhcr-global-trends-2011.html>. Accessed 4 July 2017

UNHCR, 2016. available: [http://www.unhcr.org/afr/uganda\\_](http://www.unhcr.org/afr/uganda_) Accessed 7 February 2017.

UNHCR, 2018. Global Trends: Forced Displacement in 2017. Available at: <https://www.unhcr.org/uk/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html> Accessed 2 July 2018.

UNHCR, 2019. Uganda Country Refugee Response Plan: The integrated response plan for refugees from South Sudan, Burundi and the Democratic Republic of the Congo January 2019 — December 2020. Available at: <https://data2.unhcr.org/en/dataviz/19> [Accessed May 2019]

UNHCR, 2019. Global Trends: Forced Displacement in 2018. Accessible at: <https://www.unhcr.org/5d08d7ee7.pdf>. Accessed 26 July 2019.

United High Commissioner for Refugees (UNHCR). (2016) Working Environment: Available at: <http://www.unhcr.org/afr/uganda>. [Accessed 7 February 2017].

United High Commissioner for Refugees (UNHCR). (2014) Nakivale Fact Sheet. Available at: [data.unhcr.org/drc/download.php?id=1048](http://data.unhcr.org/drc/download.php?id=1048). [Accessed 3 March 2017].

United High Commissioner for Refugees (UNHCR). (2015) Global Report Africa .pdf

United Nations (2016). New York Declaration for Refugees and Migrants A/71/L.1. 2016. Available from: [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/71/L.1](http://www.un.org/ga/search/view_doc.asp?symbol=A/71/L.1) [Accessed May 26, 2016].

United Nations Development Programme(UNDP) in 2016. Human Development Report: Human Development for Everyone. Communications Development Inc. Washington DC.

United Nations General Assembly, (1979). Convention on the Elimination of All Forms of Discrimination against Women

United Nations General Assembly, (1989). Convention on the Rights of the Child.

United Nations High Commission for Refugees (UNHCR) 2015. *Country Operations Profile-Uganda*[online]. Available at: [www.unhcr.org/pages/49e483co6.html](http://www.unhcr.org/pages/49e483co6.html) [Accessed 21 August 2015]

United Nations High Commissioner for Refugees (2008). Handbook for the Protection of Women and Girls, UNHCR, First edition, January 2008.

United Nations High Commissioner for Refugees (2011) Global Trends Report: 800,000 new refugees in 2011, highest in this century. Available at: <http://www.unhcr.org/uk/news/latest/2012/6/4fd9e6266/global-trends-report-800000-new-refugees-2011-highest-century.html>. [Accessed 11 November 2016].

United Nations High Commissioner for Refugees (2016) Figures at Glance: Available at: <http://www.unhcr.org/uk/figures-at-a-glance.html>. [Accessed 11 November 2016].

United Nations. (2015) The Universal Declaration of Human Rights. Geneva.

United Nations. General Assembly, 1949. *Universal Declaration of Human Rights: adopted and proclaimed by the General Assembly of the United Nations on the tenth day of December 1948; final authorized text.*, New York]: United Nations Department of Public Information.

Vingilis, E. & Sarkella, J. (1997) Determinants and Indicators of Health and Well-Being: Tools for Educating Society. *Social Indicators Research*, 40(1), 159-178.

Wachter, K. et al., 2016. Unsettled integration: Pre- and post-migration factors in Congolese refugee women's resettlement experiences in the United States. *International Social Work*, 59(6), pp.875–889.

Wacker, E., Becker, U. & Crepaz, K., 2019. *Refugees and Forced Migrants in Africa and the EU Comparative and Multidisciplinary Perspectives on Challenges and Solutions*, Wiesbaden: Springer Fachmedien Wiesbaden: Imprint: Springer VS.

Wacker, E., Becker, U. & Crepaz, K., 2019. *Refugees and Forced Migrants in Africa and the EU Comparative and Multidisciplinary Perspectives on Challenges and Solutions*, Wiesbaden: Springer Fachmedien Wiesbaden: Imprint: Springer VS.

Wakabi, W. (2008) Profile - Eric Laroche: expert on health needs in humanitarian crises. *Lancet*.

Weiss, L. G., and Lonnquist, E. L. (2003) *The Sociology of Health, Healing, and Illness*. 4ed. New Jersey. Prentice-Hall.

WHO, (2003). *Addressing unmet needs in women's health: hearing before the Subcommittee on Public Health of the Committee on Health, Education, Labor and Pensions, United States Senate, One Hundred Seventh Congress, second session on examining women's health issues*.

World Health Organisation(WHO). (2015) From MDGs to SDGs: General Introduction. WHO Library Cataloguing.

World Health Organisation(WHO). (2016) *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. WHO Library Cataloguing.

World Health Organization (WHO), (2013) *International Migration, Health, and Human Rights*. Geneva: IOM.

World Health Organization (WHO), 1946. Constitution of The World Health Organization. Available at: <https://www.loc.gov/law/help/us-treaties/bevans/m-ust000004-0119.pdf>, Accessed 12 November 2016.

World Health Organization (WHO), 2009. *World Health Statistics 2009*: World Health Organization.

World Health Organization (WHO), 2010. Poverty, social exclusion and health systems in the WHO European Region. Briefing on policy issues produced through the WHO/European Commission equity project. Copenhagen: WHO Regional Office for Europe. Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/127525/e94499.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf). Accessed 2 July 2019.

World Health Organization (WHO), 2018. Health of refugees and migrants: Regional situational analysis, practices, experiences, lessons learned and ways forward. Copenhagen: WHO Regional Office for Europe; 2018 Available at: (<http://www.who.int/migrants/publications/EUROreport.pdf?ua=1>, Accessed 14 December 2018).

World Health Organization (WHO), 2018. Health promotion for improved refugee and migrant health. Copenhagen: WHO Regional Office for Europe, (Technical guidance on refugee and migrant health). Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/388363/tc-health-promotion-eng.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/388363/tc-health-promotion-eng.pdf?ua=1). Accessed 19 July 2019

World Health Organization (WHO). (2007) *The health of Migrants*. WHO

World Health Organization (WHO). (2008) *Bulletin of the World Health Organization | August 2008*.

World Health Organization (WHO). (2010) *Report of a Global Consultation. The health of Migrants- The Way Forward*, Madrid: WHO.

World Health Organization (WHO). (2015) Every Woman, Every Child, Every Adolescent: Achievements and Prospects. The Final Report of the independent Expert Review Group on

Information and Accountability for Women's and Children's Health. WHO Library Cataloguing.

World Health Organization. (1993) .The Health of young people: a challenge and a promise. World Health Organization. <https://apps.who.int/iris/handle/10665/37353>

Wright, J. (2008) Development and the importance of health needs assessment. *British Medical Journal* Apr 25; 316(7140): 1310–1313. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113037> [Accessed 22 January 2017]

6, P. and Bellamy, C., 2012. *Principles of methodology research design in social science*, Los Angeles: SAGE.

## Appendix 1: Interview Guide for Key Informants

Name: Title: Organization: Gender: Level of Education: Position in the organisation:

1. What are the health issues usually presented by refugee women and children? (Probe on Physical, mental, psychological and emotional)
2. How big are the problems (frequency and prevalence?)
3. Do these health issues vary among women and children from a different age, ethnic or religious background?
4. Are the health problems presented by women and children different from those presented by men?
5. What practices make these health problems worse/ more difficult for women/ children to overcome? (Probe on cultural/ traditional practices, practices by organizations)
6. What policies are there to address these health challenges?
7. What policies make health problems worse/ more difficult for women and children to overcome these challenges? (Probe on Refugee Act, Organizational policies, Self-Reliance Policy, Health Policy and other relevant policies)
8. What support do you give to those that present with health problems? (Support programmes in education, health, economic and social services)
9. What care/ support do you give to people with mild and severe health problems? (nature of services or programmes)
10. What structure, locations, staffing, and resources do you have to respond to women and children's health issues?
10. What are the gaps/ challenges in you providing this care?
11. What do you think is required to improve health care and support for refugee women and children in Nakivale?
12. Do you have any other information which you would want to add to our discussion?

Thank you for participating!

## Appendix 2: Interview Guide (Refugee Women and Men)

Name: Age: Nationality: Gender: Zone:

1. What health needs/challenges do you have/face as a woman /what health needs/challenges do you think women or children have/face here?
2. Are these health needs/ challenges different from those of men?
3. What practices/policies compound these needs/ challenges?
4. How have you tried to address these health needs/ challenges?
5. What other resources are available that you could use to counter these health needs/problems?
6. How else can these health needs/challenges be addressed?

Thank you for your participation!

Appendix 3: Survey Tool for Refugee women

**Section 1: Demographic Characteristics**

*Firstly, I would like to ask you some background questions about yourself.*

PIN.....

101. What is your name (optional).....Telephone .....

102. What is your age.....

103. Where do you stay? Zone .....Village.....

104. What is your nationality.....

105. What is your main language?.....

106. What is your religion?.....

107. What is your refugee status.....

108. When did you seek refuge in Uganda(year)?.....

109. Have you ever attended school? Yes=1 No=2.....

110. If yes, what is the highest level of school you attended: (Tick as appropriate)? Primary, Secondary, University, Vocational.

111. What is your marital status now (Single, Married, Widow (Skip next question if not married)? .....

112. What was your age at first marriage.....

**Section 2: Reproductive Health**

**Now I would like to ask you about all the births you have had during your life.**

201. Have you ever given birth? (Tick as appropriate); Yes/ No.....

202. How many children do you have?.....

203. What is the sex of your children? Girls..... Boys.....



204. What are the ages of your children?.....
205. Do all your children live with you? Yes / No .....
206. If not where are they?.....
207. Were all these children born in Uganda? Yes/ No.....
208. Have you ever given birth to a child who was born alive but later died? Yes/No .....
209. What was the cause of death? .....
210. Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth? Yes/No.....
211. When did the last such pregnancy end (Year)?.....
212. What was the cause of miscarriage, abortion, or stillbirth?.....
213. Are you pregnant now? Yes, No, Unsure.....
214. How many months pregnant are you?.....
215. Since you moved into Uganda have you had any other pregnancies that did not result in a live birth? Yes/ No.....
216. If Yes, what was the cause of the miscarriage, abortion, or the stillbirth?.....

**Section 3: Family Planning History**

*Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.*

301. Have you ever heard about family planning?.....
302. Do you know of a place where you can obtain a method of family planning? Yes/ No.....
303. Where is that?..... Any other place?.....
304. Are you currently doing something or using any method to delay or avoid getting pregnant? Yes/ No.....
305. Which method are you using?.....

306. In what facility did you access this family planning method?.....
307. Where did you learn to use the current method of family planning that you are using?.....
308. Have you experienced any challenges with the current method that you are using? Yes/ No.....
309. At the time you started using family planning, were you told about any side effects or problems you might have with this method which you are using? Yes/ No.....
310. Were you told what to do if you experienced any side effects or problems with this method? Yes/ No.....
311. At that time, were you told about other methods of family planning that you could use? Yes/ No.....
312. In the last 12 months, were you visited by any fieldworker who talked to you about family planning? Yes/No.....

**Section 4: Maternal and Child Health**

**Now I would like to ask some questions about your children born in the last five years.**

401. When you got pregnant with (each of them), did you want to get pregnant at that time? Yes/ No.....
402. If Not, why instead did you get pregnant? .....
403. In the last pregnancy, did you see anyone for antenatal care? Yes/No.....
404. If Yes, whom did you see?.....
405. How many months pregnant were you when you first received antenatal care for this pregnancy? .....
406. How many times did you receive antenatal care during this pregnancy?.....

407. During (any of) your antenatal care visits(s), were you told about things to look out for that might suggest problems with the pregnancy? Yes/ No.....

408. During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth? Yes/ No.....

409. During this pregnancy, were you given or did you buy any iron tablets or iron syrup? Yes/No.....

410. During this pregnancy, did you take any drug for intestinal worms? Yes/No.....

411. During this pregnancy, did you take any drugs to keep you from getting malaria? Yes/No.....

412. Where did you give birth to your last child?.....

413. Who assisted with the delivery of your last child?.....

414. When your (last-child) was born, was the baby weighed at birth? Yes/ No.....

415. How much did your last child weigh?.....

416. How long after (your last-child) was delivered did you stay there?.....

417. Did you experience any complications during the delivery? .....

418. What was the complication?.....

419. How was it managed?.....

***I would like to talk to you about checks on your health after delivery (for example, someone asking you questions about your health or examining you) and that of your new-born baby and other children.***

420. When you delivered, did anyone check on your health or that of your baby while you were still in the facility? Yes/ No.....

421. Who checked on both your health at that time? (*Probe for most qualified auxiliary person*).....

422. In the two months after (last-child) was born, did any health care provider, field worker or a traditional birth attendant check on his/her health? Yes/No.....
423. Who checked on his/her health at that time?.....
424. Where did this first check of (NAME) take place? (*Probe to identify the type of source, if unable to determine centre name of the place*) .....
425. In the first two months after delivery, did you receive a Vitamin A? Yes/No.....
426. Have you had sexual intercourse since the birth of (last-child)? Yes/ No.....
427. For how many months after the birth of (last-child) did you not have sexual intercourse?.....
428. Did you ever breastfeed your last child? Yes/ No.....
429. For how long did you breastfeed your last child? .....
430. How long after birth did you first put (last-child) to the breast?.....
431. Did any of your children ever have any vaccinations to prevent them from getting diseases, including vaccinations received in a national immunisation day campaign? Yes/ No.....
432. Have any of your children been given any drug for intestinal worms in the last six months? Yes/ No.....
433. Have any of your children had diarrhoea with blood in the last 2 weeks? Yes/ No.....
434. Did you seek advice or treatment for the diarrhoea from any source? Yes/ No.....
435. Where did you receive advice or treatment?.....
436. What kind of advice or treatment was she/he given to treat this diarrhoea?.....
437. The last time (your children) passed stools, what was done to dispose of the stools?.....

438. Have any of your children been ill with a fever at any time in the last 2 weeks? Yes/ No.....

439. At any time during the illness, did (NAME) have blood taken from his/her finger or heel for testing? Yes/ No.....

440. Have any of your children had an illness with a cough with difficulty breathing at any time in the last 2 weeks? Yes/ No.....

441. Where did you first seek advice or treatment?.....

442. How many meals does your household have in a day?.....

### **Section 5: Marital and Gender relations**

*Now I'm going to ask you about some details regarding your marital life*

501. Are you currently married or living together with a man as if married? Yes/ No.....

502. Is your (husband/partner) living with you now? Yes/ No.....

503. If not, where does he live?.....

504. Does your (husband/partner) have other wives or does he live with other women as if married? Yes/ No.....

505. Including yourself, in total, how many wives or live-in partners does he have?.....

506. Are you the first, second, ... wife?.....

### **Section 6: Sexual Activities and Decision Making**

**Attention: Check for the presence of others before continuing, make every effort to ensure privacy.**

*Now I would like to ask some questions about your sexual activity in order to gain a better understanding of some important life issues. Let me assure you again that your answers are completely confidential and will not be told to anyone. If we should come to any question that you don't want to answer, just let me know and we will go to the next question.*

601. When was the last time you had sexual intercourse? *If less than 12 months, the answer must be recorded in days, weeks or months. Weeks ago. If 12 months (one year) or more, the answer must be recorded in years.*.....

602. What was your relationship to this person with whom you had sexual intercourse?.....

603. Apart from (this person) have you had sexual intercourse with any other person in the last 12 months? Yes/ No.....

604. Did you use any form of protection when you had sexual intercourse with this person?.....

605. Do you know of a place where a person can get condoms (Name the place)? Yes/ No.....

606. If you wanted to, could you yourself get a condom? Yes/ No.....

607. Do you know of a place where a person can get female condoms (Name the place)? Yes/ No.....

608. If you wanted to, could you yourself get a female condom? Yes/ No.....

***Now I have some questions about your decisions regarding the future.***

609. Would you like to have(a/another) child, or would you prefer not to have any (more) children? Yes/ No.....

610. You have said that you do not want (a/another) child soon. Can you tell me why you are not using a method to prevent pregnancy?.....

611. Would you say that using (or not using) contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together? Yes/ No.....

612. How old was your (current husband/partner) on his last birthday?.....

613. Did your (last) (husband/partner) ever attend school? Yes/ No.....

614. What is the highest level of school he attended: Primary, Secondary, University or Vocational?.....

615. What is your (husband's/partner's) occupation?.....

**Section 7: Survival strategies**

*Now I would like to ask you some questions about your survival strategies*

701. Aside from your own housework, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last seven days, have you done any of these things or any other work? Yes/ No.....

702. What is your main occupation?.....

703. Do you do this work for a member of your family, for someone else, or are you self-employed? Yes/No.....

704. Are you paid in cash or kind for this work or are you not paid at all? Yes/ No.....

705. Who usually decides how the money you earn will be used: you, your (husband/partner), or you and your (husband/partner) jointly?.....

706. Who usually makes decisions about making major household purchases?.....

707. When you or your children are sick, who usually makes decisions about seeking health care? .....

708. Do you own this or any other house either alone or jointly with someone else? Yes/ No.....

709. Do you own any land either alone or jointly with someone else? Yes/ No.....

710. In your opinion, is a husband justified in hitting or beating his wife in the following situations:

(a) If she goes out without telling him? Yes/ No.....

(b) If she neglects the children? Yes/ No.....

© If she argues with him? Yes/ No.....

(d) If she burns the food? Yes/ No.....

(d) If she refuses to have sex with him? Yes/ No.....

## **Section 8: HIV/AIDS Awareness and Services**

*Now I would like to talk to you about HIV/AIDS.*

801. Have you ever heard of an illness called AIDS? Yes/ No.....

802. Do you know of a place where people can go to get tested for the AIDS virus (Name the place)? Yes/ No.....

803. I don't want to know the results, but have you ever been tested to see if you have the AIDS virus? Yes/ No.....

804. How many months ago was your most recent HIV test?.....

805. I don't want to know the results, but did you get the results of the test? Yes/ No.....

806. Where was the test done?.....

807. Is it possible for a healthy-looking person to have the AIDS virus? Yes/ No.....

808. Can people get the AIDS virus from mosquito bites? Yes/ No.....

809. Can people get the AIDS virus by sharing food with a person who has AIDS? Yes/ No.....

810. Can people get the AIDS virus because of witchcraft or other supernatural means? Yes/ No.....

811. Can the virus that causes AIDS to be transmitted from a mother to her baby:

(A) During pregnancy? Yes/ No.....

(B) During delivery? Yes/ No.....

(C) By breastfeeding? Yes/ No.....



812. Are there any special drugs that a doctor or a nurse can give to a woman infected with the AIDS virus to reduce the risk of transmission to the baby? Yes/ No.....

813. During any of the antenatal visits for your last birth were you given any information about:

(a) Babies getting the AIDS virus from their mother? Yes/ No.....

(a) Things that you can do to prevent getting the AIDS virus? Yes/ No.....

(b) Getting tested for the AIDS virus? Yes/ No.....

814. I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care? Yes/ No.....

815. All women are supposed to receive counselling after being tested. After you were tested, did you receive counselling? Yes/ No.....

816. Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact? Yes/ No.....

817. During the last 12 months, have you had a disease/health problem which you got through sexual contact? Yes/ No.....

818. What was the health problem? .....

819. The last time you had a health problem did you seek any kind of advice or treatment? Yes/ No.....

820. Where did you go (Name the place)? .....

821. Can you say no to your (husband/partner) if you do not want to have sexual intercourse? Yes/ No.....

822. Could you ask your (husband/partner) to use a condom if you wanted him to? Yes/ No.....

### **Section 9: General Health Matters**

*Now I would like to ask you some other questions relating to health matters.*

901. What is the main source of drinking water for members of your household?.....

902. Where is that water source located?.....
903. How long does it take to go there, get water, and come back?.....
904. What do you usually do to make the water safer to drink?.....
905. What kind of toilet facility do members of your household usually use?.....
906. Do you share this toilet facility with other households? Yes/ No.....
907. How many households use this toilet facility?.....
908. What type of fuel does your household mainly use for cooking?.....
909. Is the cooking usually done in the house, in a separate building, or outdoors? Yes/ No.....
910. How many rooms in this household are used for sleeping?.....
911. Do you currently smoke cigarettes or use any (other) type of tobacco? Yes/ No.....
912. What (other) type of tobacco do you currently smoke or use? .....
913. Do you or children have any mosquito nets which can be used while sleeping? Yes/ No.....
914. How many mosquito nets does your household have?.....
915. At any time in the past 12 months, has anyone come into your dwelling to spray the interior walls against mosquitoes? Yes/ No.....
916. Who sprayed the dwelling?.....

**Section 10: Accessibility to Health Care Services**

*Now I'm going to ask you some questions concerning access to health care.*

1001. What do you do to ensure financial security for health care?.....

1002. Do you know any programmes which are available to support women like you to meet your health care needs (name them)? Yes/ No.....

1003. Do you know any programmes which are available to support children with health care (name them)? Yes/ No.....

1004. How did you know about them?.....

1005. Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?

(a) Getting permission to go to the doctor? Yes/ No.....

(b) Getting the money needed for advice or treatment? Yes/ No.....

(c) The distance to the health facility? Yes/ No.....

(d) Not wanting to go alone? Yes/ No.....

1006. What other hindrances do you face in accessing health care for yourself and your children?.....

1007. Are you or your children covered by any form of health insurance? Yes/ No.....

1008. What type of health insurance are you or your children covered by?.....

1009. What other measures would you want in a place to improve health care for women like you and children?.....

1010. Do you read a newspaper or magazine at least once a week, less than once a week or not at all? Yes/ No.....

1011. Do you listen to the radio at least once a week, less than once a week or not at all? Yes/ No.....

1012. Do watch television at least once a week, less than once a week or not at all? Yes/ No.....

## Section 11: Health and Well-being (Physical/ Personal Safety)

*Now I'm going to ask you some questions regarding general well-being and accessibility to health services.*

1101. Have you suffered any of the following experiences, abuse, and torture? Describe where such happened, the perpetrator, effects and the kind of assistance that you received.

<i>Type of experience/ abuse/ torture (Tick appropriate)</i>	<i>If yes where did happen (Tick appropriate)</i>	<i>Who did this to you (Tick appropriate)</i>	<i>Current effects (Tick appropriate)</i>	<i>Have you accessed care/assistance? (Tick appropriate)</i>	<i>Where did you get assistance? (Tick appropriate)</i>	<i>Issue resolved (Tick appropriate)</i>	<i>If no and somehow what remains unresolved Specify</i>	<i>What do you intend to do next</i>	<i>What else can be done to help you (elaborate)</i>
Domestic Violence Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify)	Medical, physical, psychological, social, sexual, economic, Other (specify)	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office)	Yes/No/ Somehow			
Forced marriage Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify)	Medical, physical, psychological, social, sexual, economic, Other (specify)	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office)	Yes/No/ Somehow			
Forced prostitution Yes/ No	COR/ Uganda/ other	Intimate partner,	Medical, physical, psychological, social, sexual,	Yes/No	Family, friend, relative, community	Yes/No/ Somehow			

		relative, other (specify	economic, Other (specify		members, community leader, professional person, office (specify office				
Female Genital Cutting Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify	Medical, physical, psychological, social, sexual, economic, Other (specify	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office	Yes/No/ Somehow			
Sexual exploitation Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify	Medical, physical, psychological, social, sexual, economic, Other (specify	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office	Yes/No/ Somehow			
Early marriage Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify	Medical, physical, psychological, social, sexual, economic, Other (specify	Yes/No	Family, friend, relative, community members, community leader, professional person, office	Yes/No/ Somehow			

					(specify office				
Physical torture Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify	Medical, physical, psychological, social, sexual, economic, Other (specify	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office	Yes/No/ Somehow			
Psychological torture Yes/ No	COR/ Uganda/ other	Intimate partner, relative, other (specify	Medical, physical, psychological, social, sexual, economic, Other (specify	Yes/No	Family, friend, relative, community members, community leader, professional person, office (specify office	Yes/No/ Somehow			

1102. Do you feel physically safe in this environment? Yes/ No.....

1103. What makes this environment physically safe/ unsafe? .....

1104 When do you feel physically safe (in terms of time)

.....

1105. What have you done to enhance your physical safety?.....

1106. What would be changed/ improved to make this environment/ space/ place/ time/ person safe?

.....

## Section 12: Social Security for Health

*Please answer as appropriate to the following statements.*

1201. I have a plan that I can use in case of unexpected occurrences like accidents/illness and their adverse impacts? Yes/ No.....

1202. In case I get a problem like an accident/illness, I know my family can help me to deal with the adverse effects? Yes/ No.....

1203. In case I get a problem like an accident/illness, I know my neighbours can help me to deal with the adverse effects? Yes/ No.....

1204. In case I get a problem like an accident/illness, I know my community members can help me to deal with the adverse effects.....

1205. In case I get a problem like an accident/illness, I know a professional person who can help me to deal with the adverse effects? Yes/No..... Specify the professional person.....

1206. In case I get a problem like an accident/illness, I know an office that can help me to deal with the adverse effects? Yes/ No .....Specify the Office.....

1207. What do women and children around here do to ensure security against unplanned catastrophes?.....

1208. What other measures would you want in a place to see that adverse effects of such events are solved?.....

1209. Are you facing any problem with any of these primary support systems? Yes/ No.....

1210. If yes, Specify the problem? .....

1211. Have you accessed help in solving this problem? (professional/ or unprofessional help) Yes/ No.....

1213. If yes, what help have you accessed? Specify.....

1214. From where/ whom have you accessed help? .....

1215. If no, what has been the challenge in accessing this help? .....

1216. How would you like in the future or currently be helped to solve this problem?

.....

**Section 13: Health Aspirations**

1301. Please answer the following questions

<b>Need</b>	<b>Yes/No</b>	<b>What is it that makes you feel that way</b>	<b>If No, What have you done about it?</b>	<b>Who has helped you in solving this challenge?</b>	<b>What else would you wish to be done to help you deal with this?</b>
I feel respected as a woman					
I feel segregated as a woman					
feel valued					
I can freely express my opinions without fear					
I can express my culture/traditions without fear					
I usually take time to rest and relax					
I usually have a choice over people I relate with					
I usually have choice in making decisions that affect me					
I have my privacy to do things that I want to do					
I can freely express my religion without fear					



I have the right to move and go places that I want					
I have access to education					
I have access to pertinent information regarding my life					
I am/ can be a leader in my community					

Thank you for your participation!

**INTERVIEWER'S OBSERVATIONS**

**TO BE FILLED IN AFTER COMPLETING INTERVIEW** (*Along with survey observe and make notes on these after the Interview*)

**A. Comments About Respondent**

- 1. The unmentioned economic circumstances

.....  
.....  
.....  
.....  
.....

- 2. The unmentioned social circumstances

.....  
.....  
.....  
.....  
.....

- 3. The unmentioned cultural circumstances

.....  
.....  
.....  
.....  
.....

- 4. People's behaviour and conduct

.....  
.....  
.....  
.....  
.....

5. The existing social and gender relations

.....  
.....  
.....  
.....  
.....

6. Health practices Ideas, beliefs, and norms

.....  
.....  
.....  
.....  
.....

7. Events and ceremonies

.....  
.....  
.....  
.....  
.....  
.....

**B. Comments on specific questions**

.....  
.....  
.....  
.....  
.....

c. Any other comments

.....

#### Appendix 4. General Observation Checklist

Along with survey and interviews observe and take note on these:

1. The unmentioned economic circumstances
2. The unmentioned social circumstances
3. The unmentioned cultural circumstances
4. People's behaviour and conduct
5. The existing social and gender relations
6. Health practices Ideas, beliefs, and norms
7. Events and ceremonies

## Appendix 5: Participant Information Sheet- Key Informants

### **Health needs and services for refugee women and children in Uganda's settlements: articulating a role for social work**

You are being requested to take part in a research study on **the health needs and services of refugee women and children and to articulate social work's role in health promotion in refugee settlements in Uganda**. My name is Hadijah Mwenyango and I'm currently a Ph.D. student in Social Work, at the School of Social and Political Sciences, University of Edinburgh, United Kingdom. My supervisors are Dr. George Palattiyil and Prof. Harish Nair. This research project has been approved by The University of Edinburgh School of Social and Political Science Ethics Committee; Makerere University School of Social Sciences Research and Ethics Committee; The Uganda National Council for Science and Technology; and the Office of the Prime Minister Uganda.

In this study, you will be asked to discuss public health needs, vulnerabilities and experiences of refugee women and children in Nakivale refugee settlement; consider the extent to which refugee health is featured in health-related policies and programmes of the state; exchange your views on key health initiatives or services available to refugee women and children in Nakivale settlement; weigh up the challenges and barriers to accessibility and utilisation of health services among refugee women and children; and deliberate on social work's role in health promotion for refugee women and children. Participation in this study involves, giving your views through an interview session, as at the same time being observed.

The interview typically takes approximately 45 minutes of your time. You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed without any penalties. You have the right to refuse to answer or respond to any question that is asked of you without any penalty. You have the right to have your questions about the procedures answered (unless answering these questions would interfere with the study's outcome). If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.

There are no direct benefits or risks for you in this study. Your participation in this study is voluntary. You will not receive any payment/compensation in return for your participation. However, the research is intended to gather the life stories and experiences of refugee women which might hint at health problems that some people would want to discuss with appropriate health professionals and humanitarian workers.

The data I collect do not contain any personal information about you except your name, age, occupation, marital status and level of education. No one will link the data you provided to the identifying information you supplied (e.g., name, address, email). My study hopes to publicise the public health needs of refugee women and children in refugee settlements; make clear the challenges that are encountered by women and children in the process of seeking health care; the roles that different stakeholders have played to address such issues; as well as the existing gaps. Hence data will be used to produce a Ph.D. thesis; publication of papers and presented at conferences.

If you agree to participate in this study; your views will be tape-recorded and the researcher may take some notes at different intervals, so that your valuable responses are not lost or missed with time. These tapes will be stored securely and it is only the principle researcher and her supervisors who will have full access to them. And after serving their purpose the tapes will be destroyed. But since this is a very big study involving collecting of huge amounts of data, I will be aided by two research assistants especially in the data collection process; and in instances where communication difficulties might occur, I will need the service of a translator (upon your consent) to make our dialogue meaningful.

I will be glad to answer your questions about this study at any time. You may contact me by email at [h.mwenyango@ed.ac.uk](mailto:h.mwenyango@ed.ac.uk) or by phone at +256 752408330/+44 7786536924. If you want to find out about the final results of this study, you should also get in touch with me on the same contacts. Additionally, if you would like to talk to someone else other than the researcher about (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects' issues, you can get in touch with my supervisors through email; Dr. George Palattiyil ([g.palattiyil@ed.ac.uk](mailto:g.palattiyil@ed.ac.uk)) and Prof. Harish Nair ([harish.nair@ed.ac.uk](mailto:harish.nair@ed.ac.uk)) both stationed at the University of Edinburgh, United Kingdom.

Alternatively, you can also get in contact with Dr. Stella Neema, The Chair, Makerere School of Social Sciences Research Ethics Committee, Telephone: +256- 772 457576; E-mail: [sheisim@yahoo.com](mailto:sheisim@yahoo.com)

Participant's Name: .....

Signature or thumbprint: .....Date: .....

Signature of a person obtaining consent: .....Date: .....

**The witness of a person in case person is illiterate**

Signature/thumbprint: .....Date: .....



## Appendix 6: Participant Information Sheet (Refugee Women and Men)

### **Health needs and services for refugee women and children in Uganda's settlements: articulating a role for social work**

You are being requested to take part in a research study on **the health needs and services of refugee women and children and to articulate social work's role in health promotion in refugee settlements in Uganda**. My name is Hadijah Mwenyango and I'm currently a Ph.D. student in Social Work, at the School of Social and Political Sciences, University of Edinburgh, United Kingdom. My supervisors are Dr. George Palattiyil and Dr. Harish Nair. The research project has been approved by the School of Social and Political Science Research Ethics Committee.

In this study, you will be asked to discuss public health needs, vulnerabilities and experiences of refugee women and children in Nakivale refugee settlement; consider the extent to which refugee health is featured in health-related policies and programmes of the state; exchange your views on key health initiatives or services available to refugee women and children in Nakivale settlement; weigh up the challenges and barriers to accessibility and utilization of health services among refugee women and children; and deliberate on social work's role in health promotion for refugee women and children. Participation in this study involves, giving your views through an interview session, as at the same time being observed.

The survey typically takes approximately 45 minutes of your time. And you might also be selected to participate in the second round of in-depth interviewing which will happen after this initial survey.

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed without any penalties. You have the right to refuse to answer or respond to any question that is asked of you without any penalty. You have the right to have your questions about the procedures answered (unless answering these questions would interfere with the study's outcome). If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.



There are no direct benefits or risks for you in this study, although I acknowledge that re-telling some of your experiences may be traumatising. Your participation in this study is voluntary. You will not receive any payment in return for your participation. However, the research is intended to gather your life stories and experiences which might hint at health problems that some people would want to discuss with appropriate health professionals and humanitarian workers.

The data I collect do not contain any personal information about you except your name, age, occupation, marital status and level of education. No one will link the data you provided to the identifying information you supplied (e.g., name, address, email). My study hopes to publicise the public health needs of refugee women and children in refugee settlements; make clear the challenges that are encountered by women and children in the process of seeking health care; the roles that different stakeholders have played to address such issues; as well as the existing gaps. Hence data will be used to produce a Ph.D. thesis; publication of papers and presented at conferences.

If you agree to participate in this study; your views will be tape-recorded and the researcher may take some notes at different intervals, so that your valuable responses are not lost or missed with time. These tapes will be stored securely and it is only the principle researcher and her supervisors who will have full access to them. And after serving their purpose the tapes will be destroyed. But since this is a very big study involving collecting of huge amounts of data, I will be aided by two research assistants especially in the data collection process; and in instances where communication difficulties might occur, I will need the service of a translator (upon your consent) to make our dialogue meaningful.

Hadijah Mwenyango will be glad to answer your questions about this study at any time. You may contact her by email at [h.mwenyango@ed.ac.uk](mailto:h.mwenyango@ed.ac.uk) or by phone at +256 752408330/+44 7786536924. If you want to find out about the final results of this study, you should also get in touch with me on the same contacts. Additionally, if you need further information about this research, you can get in touch with my supervisors through email; Dr. George Palattiyil ([g.palattiyil@ed.ac.uk](mailto:g.palattiyil@ed.ac.uk)) and Prof. Harish Nair ([harish.nair@ed.ac.uk](mailto:harish.nair@ed.ac.uk)) both stationed at the University of Edinburgh, United Kingdom.

**Health needs and services for refugee women and children in Uganda's settlements: articulating a role for social work**

This research aims to examine the health needs and services of refugee women and children and to articulate social work's role in health promotion in refugee settlements in Uganda. It will specifically examine the public health needs, vulnerabilities and experiences of refugee women and children in Nakivale refugee settlement in Uganda; explore the extent to which refugee health is featured in health-related policies and programmes of the state; identify key health initiatives or services available to refugee women and children in Nakivale settlement; investigate challenges and barriers to access and utilisation of health services among refugee women and children and analyse social work's role in health promotion for refugee women and children. It will comprise of a survey of 377 refugee women living in Nakivale refugee settlement. This research has been commissioned by the Common Wealth Scholarship Commission (CSC) in the United Kingdom which awards scholarships and fellowships for postgraduate study and professional development to Commonwealth citizens each year. The study has been approved by The University of Edinburgh School of Social and Political Science Research Ethics Committee; Makerere University School of Social Sciences Research and Ethics Committee, the Office of Prime Minister Uganda, and the Uganda National Council for Science and Technology (UNCST).

As part of the migration process, I understand that you are likely to have experienced difficult circumstances such as violence that may have long-term effects on your health. I do understand that having to recall, recollect and retell some of these experiences may be disturbing. This is to assure you that all the information you provide to me will be kept confidentially however as part of my obligation as a researcher, if with any information that you give to me, I find that you need help or have a health concern that requires urgent attention; I will advise you about availability of support and upon your consent, I will refer you to relevant agencies to obtain care. Also note that significant new findings that are made during the course of the study, whether by the researchers or others that may relate to your willingness to continue your participation, shall be provided to you immediately.

By signing below, you are agreeing that: (1) you have read and understood the Participant Information Sheet provided to you or had the above information read to you, (2) questions about your participation in this study have been answered satisfactorily, (3) you are aware of the potential risks, (4) you are taking part in this research study voluntarily (without coercion), (5) there is no incentive/compensation for participating in the study and that (6) you are an adult (18 years and above).

Participant's Name.....

Signature or thumbprint..... Date.....

Signature of a person obtaining consent..... Date: .....

**The witness of a person in case person is illiterate**

Signature/thumbprint.....Date.....

**Statement of consent to participate in additional interviews**

I have read or have had the information read to me about the additional interview. I have received answers

to the questions I have asked and I understand that I can change my mind and refuse the additional interview.

Yes, I agree to participate in an additional interview about “The health needs and services of refugee women and children and to articulate social work’s role in health promotion in refugee settlements in Uganda” at each follow up if selected as eligible

Signature or thumbprint: ..... Date: .....

I do not agree to participate in additional interviews in this study at each follow-up visit if selected as eligible.

Signature or thumbprint: ..... Date: .....

Signature of the person obtaining consent: ..... Date: .....

**The witness of the person in case person is Illiterate**

Signature or thumbprint: ..... Date: .....

I will be glad to answer your questions about this study at any time. You may contact me by email at [h.mwenyango@ed.ac.uk](mailto:h.mwenyango@ed.ac.uk) or by phone at +256 752408330/+44 7786536924. If you want to find out about the final results of this study, you should also get in touch with me on the same contacts. Additionally, if you would like to talk to someone else other than the researcher about (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects' issues, you can get in touch with my supervisors through email; Dr. George Palattiyil ([g.palattiyil@ed.ac.uk](mailto:g.palattiyil@ed.ac.uk)) and Prof. Harish Nair ([harish.nair@ed.ac.uk](mailto:harish.nair@ed.ac.uk)) both stationed at the University of Edinburgh, United Kingdom.

Alternatively, you can also get in contact with Dr. Stella Neema, The Chair, Makerere School of Social Sciences Research Ethics Committee, Telephone: +256- 772 457576; E-mail: [sheisim@yahoo.com](mailto:sheisim@yahoo.com)

**Health needs and services for refugee women and children in Uganda’s settlements:  
articulating a role for social work**

This research aims to examine the health needs and services of refugee women and children and to articulate social work’s role in health promotion in refugee settlements in Uganda. It will specifically examine the public health needs, vulnerabilities and experiences of refugee women and children in Nakivale refugee settlement in Uganda; explore the extent to which refugee health is featured in health-related policies and programmes of the state; identify key health initiatives or services available to refugee women and children in Nakivale settlement; investigate challenges and barriers to access and utilisation of health services among refugee women and children and analyse social work’s role in health promotion for refugee women and children. It will comprise of a survey of 377 refugee women living in Nakivale refugee settlement. This research has been commissioned by the Common Wealth Scholarship Commission (CSC) in the United Kingdom which awards scholarships and fellowships for postgraduate study and professional development to Commonwealth citizens each year. The study has been approved by The University of Edinburgh School of Social and Political Science Research Ethics Committee; Makerere University School of Social Sciences Research and Ethics Committee, the Office of Prime Minister Uganda, and the Uganda National Council for Science and Technology (UNCST).

As a key person working with the refugee populations, you have been purposely selected to participate in this study because you have wide knowledge and experience in handling refugee health matters. This information will add rich insights into the research topic.

By signing below, you are agreeing that: (1) you have read and understood the Participant Information Sheet provided to you or had the above information read to you, (2) questions about your participation in this study have been answered satisfactorily, (3) you are aware of the potential risks, (4) you are taking part in this research study voluntarily (without coercion), (5) there is no incentive/compensation for participating in the study and that (6) you are an adult (18 years and above).

Participant’s Name.....

Signature or thumbprint: ..... Date:

.....

Signature of a person obtaining consent..... Date: .....

**The witness of a person in case person is illiterate**

Signature/thumb print.....Date: .....

**Statement of consent to participate in additional interviews**

I have read or have had the information read to me about the additional interview. I have received answers

to the questions I have asked and I understand that I can change my mind and refuse the additional interview.

Yes, I agree to participate in an additional interview about “The health needs and services of refugee women and children and to articulate social work’s role in health promotion in refugee settlements in Uganda” at each follow up if selected as eligible

Signature or thumbprint: ..... Date: .....

I do not agree to participate in additional interviews in this study at each follow-up visit if selected as eligible.

Signature or thumbprint: ..... Date: .....

Signature of the person obtaining consent: ..... Date: .....

**The witness of the person in case person is Illiterate**

Signature or thumbprint: ..... Date: .....

I will be glad to answer your questions about this study at any time. You may contact me by email at [h.mwenyango@ed.ac.uk](mailto:h.mwenyango@ed.ac.uk) or by phone at +256 752408330/+44 7786536924. If you want to find out about the final results of this study, you should also get in touch with me on the same contacts. Additionally, if you would like to talk to someone else other than the researcher about (1) concerns regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects' issues, you can get in touch with my supervisors through email; Dr. George Palattiyil ([g.palattiyil@ed.ac.uk](mailto:g.palattiyil@ed.ac.uk)) and Prof. Harish Nair ([harish.nair@ed.ac.uk](mailto:harish.nair@ed.ac.uk)) both stationed at the University of Edinburgh, United Kingdom.

Alternatively, you can also get in contact with Dr. Stella Neema, The Chair, Makerere School of Social Sciences Research Ethics Committee, Telephone: +256- 772 457576; E-mail: [sheisim@yahoo.com](mailto:sheisim@yahoo.com)

Appendix 9: The University of Edinburgh School of Social and Political Science Ethical Approval Letter

---





THE UNIVERSITY of EDINBURGH  
Graduate School of Social  
& Political Science

The University of Edinburgh  
Chrystal Macmillan Building  
10a George Square  
Edinburgh  
EH8 9LD

Tel 0131 850 1000

D/D 0131 651 5122

gradschool.sps@ed.ac.uk

[www.sps.ed.ac.uk/gradschool](http://www.sps.ed.ac.uk/gradschool)

12 June 2017

UUN: S16084141

To whom it may concern,

This is to confirm that Hadijah Mwenyango, born 04 August 1984 is a full-time, fully matriculated student studying to achieve a PhD In Social Work within the Graduate School of Social and Political Science at The University of Edinburgh.

Ms Mwenyango commenced her PhD study on 01 October 2016 and is due to complete her study on 20 September 2020.

I can confirm that Hadijah Mwenyango has submitted her ethics form which was approved and I attach an email which I have verified and stamped.

If you have any queries regarding the above, then please do not hesitate to contact me via email on [morag.wilson@ed.ac.uk](mailto:morag.wilson@ed.ac.uk) or by telephone on 0131 651 5122.

Yours faithfully,

*Morag Wilson*

Morag Wilson, Senior Secretary  
Graduate School Office  
School of Social and Political Science



*Official University stamp goes here*

Pp. Ms Toni Dismore  
Graduate School Administrative Officer

Appendix 10: Office of the Prime Minister Research Approval Letter



THE REPUBLIC OF UGANDA



**OFFICE OF THE PRIME MINISTER**

PLOT 9-11 APOLLO KAGGWA ROAD, P.O. BOX 343, KAMPALA, UGANDA

TELEPHONES: General Line 0417 770500, Web: www.opm.go.ug, E-mail: ps@opm.go.ug

In any correspondence on this subject, please quote No: OPM/R/13

21<sup>st</sup> December 2016

Ms Mwenyango Hadijah,  
c/o Makerere University,  
Department of Social Work and Social Administration,  
Kampala.

**Re: Request to Access OPM Office Premises/Library.**

Reference is made to your letter dated 21<sup>st</sup> December 2016 regarding the above subject matter.

This is to inform you that permission has been granted to you to access OPM Office Premises/Library to read and interact with officers of the Department of Refugees and other partners dealing with refugees to get the necessary information for your PhD studies.



c.c.: File No.: R/160/230/01

**Vision:** A Public Sector that is responsive and accountable in steering Uganda towards rapid economic growth and development.