

Health care needs of displaced women: Osire refugee camp, Namibia

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Abstract

Aim: The aim of this study was to explore and describe the experiences of health care needs of displaced women in the Osire refugee camp in Namibia.

Background: Namibia is a country where displaced people from other African countries seek refuge as a result of their own country's political instability. All displaced people are hosted in the Osire camp, which is a highly protected area. There are more women than men in the camp and their health is often compromised.

Methods: In a descriptive phenomenological study the natural dimension of the experiences of the participants of their health care needs were explored through in-depth interviews and reflected upon through transcendental processes to formulate the phenomenological dimension thereof.

Findings: The essence of displaced women's health care needs was "the need for the restoration of hope and human dignity". Their needs refer to measures to enhance their autonomy and freedom; skills training; certainty about their future; security with aid distribution; protection against stigmatisation due to Human Immuno-deficiency Virus (HIV) infection; protection against abuse; and participation in reproductive health care.

Discussion: When displaced women are admitted in a camp they lose their freedom to make decisions about everyday functioning and future. They thus develop feelings of insecurity and vulnerability.

Conclusion: The participants referred to several factors that were detrimental for their wellbeing. The essence of their needs was "the need for the restoration of hope and human dignity" that could only be achieved when their needs are addressed.

Implications for nursing: As nurses are in close contact with displaced women in refugee camps they should negotiate opportunities for the women to discuss their concerns with the camp officials.

Implications for health and social development policy: Policies should make provision for the involvement of displaced people in all aspects that relate to their everyday and future living arrangements.

Key words: health care needs, displaced, women, human dignity, autonomy, nursing, phenomenological study, Namibia

Background

Displaced people are involuntary migrants forced by extraordinary circumstances to leave their homes and/or countries of residence to move to places they believe to be safe. In 2014 59,5 million people were forcibly displaced worldwide, of whom 3,7 million were in Africa (United Nations High Commissioner for Refugees [UNHCR] 2014). Namibia is regarded as a signatory country where displaced people from the rest of the African continent seek refuge as a result of the country's political stability (United Nations High Commissioner for Refugees in Namibia [UNHCR-Namibia] 2015). All displaced people are hosted in the Osire refugee camp that is managed by the UNHCR-Namibia in partnership with the Republic of Namibia's Ministry of Home Affairs and Immigration. The camp is a highly protected area and displaced people can leave it only with the permission of the camp administrator. They receive food and basic commodities from humanitarian organizations, as they are not allowed to be employed because of the high unemployment rate in Namibia (UNHCR-Namibia 2015).

Since the establishment of the Osire refugee camp in 1992, no research has been done with regard to the health care needs of the people who live inside it. The only research report that exists is about food security in the camp, which indicated that in 2006 some of the women had signs of malnutrition (UNHCR 2008). The researchers endeavoured with this study to address the lack of research-based information on the health care needs of women in the camp. Generally, more women than men are found in refugee camps and their health is often compromised (Abusharaf 2009).

Although studies have been conducted on displaced people globally it has mostly focused on the financial well-being of displaced persons (Dalton-Greyling 2008) or their adaptation to life after repatriation (Agier 2008). Little is said regarding their health care needs during their stay in refugee camps (Pavlish 2005). When displaced people's health care needs are not met, malnutrition, depression about their current situation and anxiety about their future develop (Martin & Tirman 2009).

In refugee camps women are very vulnerable because of the loss of support from their families and a lack of financial means (Abusharaf 2009). For this reason they rely on camp officials for protection (Agier 2008). Without such protection they become prone to psychological stress and related disorders (Pollock 2010). Feelings of insecurity are not limited to what will happen in future. The displaced are confronted every day with concerns about food, the fair distribution of humanitarian aid and all incidents of discrimination (Kälin 2008). Feelings of extreme vulnerability and powerlessness result when women cannot fulfil their roles of mothers and wives to feed their families (Ziegler 2001).

The first contact of displaced people with the health care service of host countries happens in interaction with nurses (McEwen et al. 2015) who address their immediate physical health needs (Eklöf et al. 2015) and help them to establish social support systems (Strijk et al. 2011). When people get displaced they leave their family and friends behind (Baird & Boyle 2012) to arrive in a country with an unfamiliar culture. Without a support system challenges with everyday life are experienced (Babatunde-Sowole et al. 2015) that lead to the occurrence of stress related diseases if not addressed timeously (Strijk et al. 2011). Nurses in health care services for displaced people often become part of their new support networks. They help them to form relationships to replace those that they have lost. One way of doing that is through 'befriending' that refers to the creation of 'emotionally connected friend-like relationships' (Balaam 2014) to enable displaced people to adjust during the period of transition (Babatunde-Sowole et al. 2015).

Aim of the study

The aim of this study was to explore and describe experiences of health care needs of displaced women in the Osire refugee camp in Namibia.

Ethical considerations

Written approval of the research proposal was obtained from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria (Protocol No. 242/2010) and permission to conduct the research was obtained from the Namibian High Commissioner for Refugees and the Osire refugee camp administrator. The matter of informed consent was thoroughly explained to probable participants with the assistance of translators. They could disrupt their participation without any negative consequences. The participants consented in writing to partake in the study. Interviews were conducted at a private venue in the women's organisation centre or at the homes of the participants. Their privacy was protected and all information was treated in a confidential manner. Their real names do not appear on any documentation. The participants were concerned about possible negative implications of their participation in the study and had to be reassured that no information that could be used to identify them will be included in the research report. Their survival in the camp depended on good relationships with camp officials and they did not want the study to jeopardize it.

Pre-understanding

During visits prior to the research to the camp the first author who also collected the data got the impression that the women experienced hardship and had many challenges in everyday life. In an interview with the co-authors she acknowledged her perceptions about life in a refugee camp. It enabled her to suspend her impressions and to accept the experiences of the participants as true and valid.

Method

The researchers used a descriptive phenomenological research approach and 'bracketed' (identified and put on hold) their own perceptions about the phenomenon (health care needs of displaced women in the Osire refugee camp) in order to be open minded to the participants' understanding of their health care needs (Sharan 2009; Appignanesi 2003). Only people who experience the phenomenon can describe how they understand it (Zahavi 2003) and are therefore considered as the most reliable source of information (Cogswell 2008). Human beings are in a

relationship with their environment (consisting of phenomena) (Giorgi 2006) which is intentional as they try to make meaning of it (Dahlberg et al. 2008). The human mind becomes conscious of the phenomena with the intention to attach meaning to it (Rapport & Wainwright 2006).

Research in a descriptive phenomenological approach focuses on exploring the intentional consciousness of the participants of the phenomenon (Solomon & Higgins 1996) to enable researchers to describe “how the phenomenon is and not what the informants said about it” (Dahlberg et al. 2008). Intuiting (a process to vary the data presented by the participants to understand what is meant by it) was used in this study to explore how the phenomenon (health care needs of displaced women in the Osire refugee camp) had been experienced and not to describe what the participants said about it.

The researchers ‘bracketed’ their own understanding of the phenomenon (Holloway & Wheeler 2010) to come to a new understanding of the health care needs of the participants in the raw data that the participants provided (Hamil & Sinclair 2010) in the form of the natural dimension of the phenomenon (Solomon & Higgins 1996). In the natural dimension an unchallenged description of the phenomenon is presented (Wertz 2005).

The natural dimension of the phenomenon (health care needs of the participants) was obtained through interviews with ten displaced women from Rwanda, Angola and the Democratic Republic of the Congo who had lived in the Osire refugee camp for at least six months at the time of the research. The reason for their having fled to Namibia was political instability in their home countries. The initial recruitment of participants was done through the leader of the women’s organisation in the camp and thereafter snowball sampling was used. Table 1 shows the biographic information of the participants.

Table 1. Biographic information of participants

No.	Age in years	Marital status	Number of children	Country of origin	Activities during the day	Health-related information
1.	42	Married	4	Rwanda	Looking after her children	None
2.	53	Married	10	Angola	Teaching at a school in the camp	None
3.	48	Married	6	Angola	Gardening	Hypertension
4.	20	Single	0	DRC	Taking care of own household	None
5.	21	Single	1	DRC	Volunteering as a youth activist	HIV positive
6.	26	Separated from husband	3	Angola	Cleaning offices 2 days/week, washing the clothes of other people	Disabled
7.	23	Married	4	Angola	Looking after her family	Disabled
8.	18	Single	0	Angola	Attending school (Grade 12 learner) and youth activist at the church	None
9.	29	Married	1	DRC	Selling cakes	None
10.	32	Single	3	DRC	Taking care of own household	None

No., number assigned to participant. DRC: Democratic Republic of Congo.

The data were collected by the first author in March and April 2011 through in-depth interviews in English at the women’s organisation centre and at the participants’ homes. The home interviews gave the first author the opportunity to observe the living conditions of the participants. All the participants were fluent in English except one for whom an interpreter was used. A main question was asked of all participants: “*What are the health care needs of women living in the Osire refugee camp and how can the needs be addressed?*” Probing questions were used to encourage the participants to elaborate on the needs that they experienced. The interviews were audio-recorded with the permission of the participants and field notes were written on their emotions and gestures during the interviews.

Through transcendental reduction the researchers put their own perspectives about the phenomenon on hold and focused on the ‘sphere of consciousness’ of their participants (as presented in the natural dimension of the phenomenon) to explore the immanent essence of their health care needs (Hintikka 1995:79). The latter is also referred to as the phenomenological dimension of the phenomenon. The naïve belief associated with the natural dimension was replaced by a transcendental reflection of the life-world of the participants in the refugee camp and their understanding of their health care needs (Wertz 2005).

The researchers used the data analysis methods of Colaizzi (1978) and Dahlberg et al. (2008) to describe the phenomenon without interpretation or explanation (Dahlberg 2006). Data analysis in descriptive phenomenological research is aimed at understanding the essence (the core meaning) of the phenomenon and its substantiating constituents (units of meaning) (Dahlberg et al. 2008). The essence should appear in each constituent and the constituents should be essential parts of the essence (Norlyk 2009).

The transcribed interviews and notes were read and re-read to get a sense of the whole of the experiences. Phenomenologist researchers refer to this ‘whole’ as the ‘initial whole’ of all the experiences of the participants (Carlsson et al. 2002). The researchers explored the health care needs exactly as they were experienced through while putting reality and their own pre-understanding on hold (Zahavi 2002). They distanced themselves from the experiences of the participants to overcome the hurdles of the natural dimension of the experiences. Through a process called transcendental reduction they ‘lifted themselves off the ground to look down on the phenomenon’ in order to get a clear understanding of the participants’ health care needs (Rapport & Wainwright 2006:232). The researchers also tried to get a sense of what it might have been to ‘live in the participants’ skin’ (Wojnar & Swanson 2007:177) when one of them stayed in the camp during the data collection to get to know what it means to live in a refugee camp.

The researchers made use of ‘free imaginative variation’ to ensure that the essence represented the phenomenon. They started with a concrete example of the health care needs and ‘imaginatively varied it in every possible way in order to distinguish essential features from those that were accidental or incidental’ (Wertz 2005:168).

The data were divided into meaning units and clustered according to similar meanings to reveal the essence of the experiences, also called the ‘new whole’ of the experiences (Dahlberg et al. 2008). The researchers withheld themselves from premature conclusions (Kumar 2012) and looked beyond what was observed to replace the natural dimension of the experiences of the participants (their concrete needs) by the phenomenological dimension (an understanding) of

their needs (Finlay 2002). Once the essence of the experiences was revealed the clusters were related to one another. Similar clusters were incorporated in a constituent and the degree to which they substantiated the essence determined their inclusion in the list of constituents (also called themes) (Dahlberg et al. 2008).

Findings

The essence of the phenomenon health care needs of displaced women was shown as *“the need for the restoration of hope and human dignity”* which reflects the need for the participants to receive holistic health care. The displaced women suffered losses and needed interventions that would help them to regain their dignity and their hope for the future. Moreover, they interpreted health care needs as more than clinic services and expected nurses to support them in coping with their poor circumstances. Nurses were the only people other than the camp officials, whom they considered to be responsible for their circumstances, that they had contact with regarding health related issues.

The constituents that substantiate the essence are needs for measures to enhance the displaced women’s autonomy and freedom; skills training; certainty about their future; security with aid distribution; protection against stigmatisation due to Human Immuno-Deficiency Virus (HIV) infection; protection against abuse; and participation in reproductive health care.

Get autonomy and freedom

The participants verbalized that they were not physically sick but that they did not feel well because of their lack of freedom: *“I’m okay, because I’m not sick, but when it comes to issues of the camp, my life is not so good.”* Not having been allowed to leave the camp when they wanted caused much distress: *“if I want to go outside the camp I must ask permission. I cannot say that the life is so good, because persons who are in a good life can do whatever they want.”* In the camp they also had to live according to rules of the officials that limited their autonomy: *“I cannot say that ‘I want to do this today’, because somebody controls me.”*

Obtain skills training

A lack of financial means was considered as a barrier to sustaining their health. They believed

that women are responsible for the needs of the family and in the camp the women were unable to carry out that responsibility through a lack of money, as they were not allowed to earn a living: *“there is no job really, there is no job.”* Although they accepted that they could not change the policies, they expressed a need for vocational training so that they would in future be able to provide for their families: *“we want a training centre here in Osire.”* Although the institution of a training centre is not the responsibility of health care providers the participants believed that the nurses should help them to get opportunities to improve their skills. They also wanted to be trained in childrearing: *“some do not know how to care of kids.”*

Get certainty about their future

A need for help to secure their future was communicated by the participants. They were worried about their safety after repatriation as they did not believe that the conflict has ended: *“those people (the people who they fear) are there; we hear over the news that they are still there”*. They also did not know where they would find some family members after repatriation: *“I don’t know where my family lives.”* One of the participants was a small girl when she arrived at the camp with her mother, who had since passed away. Her father died in Angola and she does not know where to go to when she is repatriated to Angola: *“now these days they say all the Angolans should go home, I don’t know where I’m going to go, because I don’t know the place of my mother or father.”*

Some participants preferred to be given work permits or Namibian identity documents: *“maybe we can get identity documents and stay here as refugees.”* They wanted to leave the camp and be allowed to earn their living: *“like me I am alone, I can stay and start working.”* Some participants preferred to go to another country as long as they did not have to go back to their countries of origin: *“if Namibia does not want us to stay here; another country can take us.”* Other participants were very fatalistic and felt that going back to their home countries or staying in the camp were associated with suffering and that it thus did not matter to them where they would have to live out the rest of their lives: *“it is the same; because we do not have families here; in Angola we do not have families, and when we go there we will suffer, to stay here is also suffering; I saw that all the things are the same.”* The participants wanted to be assisted to convince the camp officials that they should be involved in the decisions about their future.

Nurses could negotiate with the camp officials on their behalf as the camp officials did not want to listen to them: *“they don’t ask you why we do not want to go back”*.

Have security with aid distribution

The participants expected a fair distribution of food rations and other means on a monthly basis, which according to them did not happen: *“they (the camp officials) are discriminating between people.”* The camp officials decided who should be given food rations: *“they [the camp officials] say they give to those people who do not have anything.”* Married and unmarried people also received different rations, with the result that the unmarried women received more food than the married women: *“those ones who are not married are living better than those who are married”*. The type of food included in the ration remained the same every month and the participants complained about the lack of variety: *“a person cannot eat the same food every time. Like we eat beans in the morning, eat beans at lunch, and beans for dinner.”* They were very upset that no special food parcels for sick people were available: *“when a person is not feeling well, one needs special food so one recovers fast.”* The participants would have liked to receive supplements for their family members on anti-retroviral treatment. One participant who is HIV positive believed that her CD4 count was going down because of her poor diet: *“my CD4 count is going down and when I went to the hospital nurses told me that it is because of poverty.”* The food that they received per month was not enough to last for a month: *“but things we receive are not enough.”* The participants wanted nurses to intervene on their behalf as they were unsuccessful when they complained: *“they (the camp officials) will just tell you that you are selfish.”*

Get protection against abuse and stigmatisation

According to the participants a lack of confidentiality existed in the camp, with the result that HIV-positive people were stigmatised by fellow displaced people: *“some days ago there were boys who sent text messages to each other calling us the top-ten HIV-positive prostitutes in Osire; all our names were there; me, my sister and other girls.”* The exposure of private information led to other participants being hesitant to be tested as they did not trust others: *“people from here you do not trust.”*

In addition to stigmatisation of HIV-positive participants harassment took other forms. The participants reported that some displaced men abused alcohol as a result of boredom related to their unemployment, had girl friends and physically abused their wives: “*men have girlfriends, stay away from home until late and when they come back in the middle of the night fight with their wives*”. Out of fear of being killed the women keep quiet: “*they (the perpetrators) might end up in jail and when they come back you might be killed.*” Often the police were not prepared to intervene when the participants wanted to lodge complaints: “*you can go to the police if you want to open a case; they will just give the perpetrator a warning.*” The participants therefore wanted the nurses to negotiate with the camp officials on their behalf to ensure that they get the necessary support when they report incidents of abuse.

Participate in reproductive health care

The participants were from different countries and socio-cultural backgrounds and had varying perspectives on reproductive health care. For some the use of condoms and hormonal contraceptives should be limited to mature women: “*those who are not matured are not allowed to take the pills or to use condoms.*” Some felt strongly that hormone-containing contraceptives should be given only to women who were 18 years and older: “*those people who are eighteen years and above should use it.*” Others believed that only married women should be allowed to use contraceptives: “*family planning is for the married people*” and that abstinence should be encouraged before marriage: “*you should abstain from sex until you get married.*” While some of the participants were against sex before marriage and the use of contraception by young girls, the nurses at the clinic in the camp provided contraception for young girls. Participants, therefore, felt that their authority over their daughters was being undermined: “*children of today they do it (have sex) while the mothers do not know.*” The participants wanted to be involved in reproductive care at the clinic so that they could ensure that their cultural perspectives on the use of contraceptives by young girls could be respected.

Discussion

The core essence of health care needs of displaced women in the Osire refugee camp in Namibia; “*the need for the restoration of hope and human dignity*” shows that the participants viewed their health care needs in a holistic manner which corresponds to Pavlish (2005) who found that

displaced women's health care needs include more than just their reproductive health needs. Their needs should thus be considered broadly enough to include all factors that could influence their health (Lee et al. 2012). The health care needs of displaced people are influenced by their livelihood and environment (Guterres & Spiegel 2012). When displaced people feel safe and are satisfied with their living conditions they have a bigger chance of being physically healthy (Crea et al. 2015). The participants of this study did not feel safe and were not satisfied with their circumstances. They also suffered a lack of autonomy and freedom in expressing themselves and have very little or no control over the circumstances in which they live. Their general health is thus compromised.

The participants experienced challenges in surviving even with the humanitarian aid and had no opportunity to generate an income during their stay in the camp by reason of restrictions on leaving the camp and a lack of vocational training. Without proper training and work permits displaced people have very little chance to become valuable citizens after repatriation (Cavaglieri 2003). The participants had thus no chance to become valuable citizens and independent from the humanitarian aid.

Displaced people do not report incidents of abuse when they fear that the information will not be dealt with in a confidential manner and that their concerns will not be addressed (Asgary et al. 2013). The participants of the study did not get the necessary protection as set out in the recommendations of the Women's Refugee Commission (2011). Displaced women who do not feel secure in their current situations develop concerns about their future (Gordon 2008) as communicated by the participants.

The participants were traumatized by the lack of confidentiality of health-related information when they realized that HIV-positive women were a target of gossip. People who are stigmatized as a consequence of their HIV status cannot openly utilize healthcare services (Human Rights Watch 2003), and such secrecy has a detrimental effect on their wellbeing.

Trustworthiness of the findings

The first author stayed in the refugee camp during data collection to gain the trust of the

participants and to get a sense of what it means to live under their circumstances. The pre-understanding of the phenomenon (health care needs of displaced women in the Osire refugee camp) that she gained during previous visits to the camp to get approval for the research was bracketed to ensure that the essence of the experiences of the participants was revealed as it was experienced by them (Flood 2010). Once the essence and the supporting constituents were formulated, 'un-bracketing' took place and the findings were re-integrated into the study context and existing literature (Gearing 2004). Quotations from the transcribed interviews were used to substantiate the constituents.

Implications for nursing and nursing policy

In this study the participants held the camp officials responsible for many of their concerns and thus expected the other group of people with whom they had contact (namely the nurses) to negotiate on their behalf with the camp officials. Nurses should thus negotiate gender-balanced camp committees to contribute to better representation of women and increase the opportunities for women to report their needs to camp officials (WHO-Africa 2012).

Harassment of women in refugee camps happens as a result of unequal power relationships between men and women and camp officials and displaced people (UNHCR 2014) and requires a collaborative intervention of the government of the host country, church organisations, non-governmental organizations and the entire displaced community. Nurses should support the displaced women through initiation and management of such collaboration.

As women from different countries are admitted to refugee camps, nursing care in the camps should be culture congruent to ensure optimal use of it (Dadaab Report 2011). Limited access to health care services is often associated with poor quality services. Ongoing evaluation of health care service is thus recommended (Casey 2015). Displaced people should be invited to evaluate the health care services in refugee camps. Limited participation in health care has a detrimental effect on their health (McMichael & Gifford 2010).

Displaced women often arrive in their host countries without family and friends and thus without a social support system. Nurses should help the women to establish a new support system with

other displaced women, but also with nurses. Balaam (2014) refers to it as ‘befriending’ and describes the process as ‘the creation of an emotionally connected friend-like relationship’ that also includes negotiation of power. Nurses should thus empower the women to ‘befriend’ the camp officials in order to negotiate their position in the camp and their relationships with the officials.

Nurses should not underestimate their ability to contribute to the development of policies for housing and health care of displaced people (Lori & Boyle 2015). This study revealed that displaced women trust nurses and expect them to be their advocates. The participants wanted nurses to negotiate on their behalf with the camp officials for better living circumstances.

Implications for health and social development policy

The monthly humanitarian aid should be only an emergency measure (Pavlish 2005) and should be complemented with support to help displaced people take responsibility for themselves and their families (Agier 2011). Many displaced people were successful and well-integrated individuals before they had to leave their countries and they should be given a chance to carry on being responsible people (Shadrak 2010) instead of people dependent on humanitarian aid (Kälin 2008). Opportunities to earn an income during displacement can help the people to live a meaningful life (UNHCR 2014). People should never be deprived of the means to make a basic living and governments of countries that host displaced people should ensure that humanitarian aid be distributed responsibly to secure an adequate standard of living for displaced people (Kälin 2008).

Whether the future of displaced people involves repatriation to home countries or resettlement in other countries their involvement should be non-negotiable (Kälin 2008). Displaced people should not be repatriated when they fear that they may be in danger when they return to their home countries (United Nations General Assembly 2007). Individual counselling should precede the repatriation or resettlement and the displaced people should be supported to rebuild their lives (Kälin 2008).

All forms of harassment of displaced women should be acted upon immediately (UNHCR-

Namibia 2015). The women should feel free to report incidents and the camp officials should have programmes in place to react appropriately (Human Rights Watch 2003).

Displaced women should also be involved in decision-making processes in reproductive health care as they come from socio-cultural backgrounds that are different from that of the host country (Gurnah et al. 2011). Cultural beliefs prevent some African women from using hormonal contraceptives (Okanlawon et al. 2010).

Conclusion

The participants of this study stated their health care needs as being broad and referred to several factors that were detrimental for their wellbeing. The essence of their experiences is “*the need for the restoration of hope and human dignity*” that could only be achieved when their needs – related to autonomy and freedom, skills training certainty about their future security with aid distribution, protection against stigmatisation resulting from HIV infection, protection against abuse and participation in reproductive health care – could be addressed.

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