Barriers to Maternal Healthcare in Kyangwali Refugee Settlement

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Introduction

“Listening to the voices of women is vital because it leads to improvements of services for childbearing women and their families, promoting the delivery of culturally sensitive quality health care” (Clark-Callister & Wilkinson 2010: 201).

Refugees living in Kyangwali settlement face unbearable hardship and the majority are unable to meet their basic needs. This report will assess the barriers to good maternal healthcare within Kyangwali refugee settlement. Kyangwali settlement is located in Hoima district in western Uganda and is a protracted refugee environment which continues to face challenges of poverty, poor healthcare and limited education opportunities. Maternal healthcare can be seen as one the biggest challenges within the settlement. Academic literature and government officials, among others, continue to assert that one of the dominant causes of maternal mortality in refugee settings, are cultural norms which prevent women from giving birth within a clinical setting. However, findings from this research suggest that barriers to maternal healthcare within Kyangwali extend beyond women’s cultural perceptions of childbirth. Economic, structural, gender and political factors also play a part in poor maternal healthcare amongst this refugee population. Findings which show women’s desire to engage with health professionals during pregnancy and childbirth, as well as their dissatisfaction towards the limited services currently available infer that health services need to be drastically improved. This paper will first present the purposes of study before offering an overview of maternal healthcare on a global, national and local level. Following a brief explanation of methodology, the findings will be presented. Finally, recommendations will be made to Think Humanity in order to promote good maternal health practices within Kyangwali. It should be noted that whilst research focussed specifically on maternal healthcare, many of the issues presented within this report refer to general healthcare as well as reproductive health which should be seen as closely related issues. By engaging in maternal health, Think Humanity would not only be safeguarding the lives of women; it would be ensuring the health and future of the next generation.

Context

Global maternal health

In spite of international efforts, maternal mortality remains a critical problem around the world – particularly in developing countries. The World Health Organisation (WHO) defines maternal death as:

“The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (WHO 2014b: 4).

It is estimated that globally, 800 women die every day as a result of complications during childbirth (WHO 2014a). Of these deaths, 99% occur in developing countries, with more than half occurring in sub-Saharan Africa (WHO 2014a). According to the WHO, the main causes of maternal mortality are
severe bleeding, infections, eclampsia, delivery complications and unsafe abortions (WHO 2014b: 4). Other causes of maternal death include malaria and AIDS and more indirect issues such as poverty, malnutrition, poor health infrastructure and lack of family planning have also been cited as factors increasing maternal mortality rates (WHO 2014b: 4). It is therefore reasonable to suggest that within a rural context, “childbearing is still one of the most dangerous moments in a women’s life” (Clark-Callister & Wilkinson 2010: 203).

A Brief history of global maternal health policies
Addressing maternal mortality has been on the global health agenda since the 1980’s (AbouZahr 2013: 13). In the early stages, it was identified that within developing countries a large proportion of women who suffered complications during childbirth were attended to by traditional birth attendants (TBA’s) as they were located in rural areas and did not have access to health clinics (AbouZahr 2013: 21). In order to address this problem, many countries, under the guidance of the WHO, attempted to improve the safety of TBA practices by implementing training programmes. By training TBA’s, it was hoped that even if a mother could not access a health clinic, she would receive adequate and safe maternal healthcare. However, following the implementation of these programmes, there has been a consensus that the “impact of training TBA’s on maternal mortality is low” (De Brouwere & Van Lerberghe 2001: 77). There is now global uncertainty as to whether women fare better when such an attendant is trained or not (Fleming 1994: 142).

During the mid-1990’s maternal health was redefined as a human right as “failure to take action to prevent maternal death amounts to discrimination because only women face the risk” (AbouZahr 2013: 18). This new found enthusiasm for maternal health led to it being incorporated into the United Nations (UN) Millennium Development Goals (MDG’s). Despite aims to reduce the maternal mortality ratio by three quarters and improve reproductive health, MDG 5 has failed to reach these targets and maternal health remains a critical problem in Uganda as well as other parts of the developing world.

Maternal health in Uganda
While it is beyond the scope of this research to explore the effectiveness of this policy in great depth, it is necessary to have a broad understanding of the government’s current policy on maternal healthcare. According to the United Nations Population Fund (UNFPA), Uganda’s maternal mortality rate stands at approximately 430 per 100,000 live births (UNFPA 2011). In order to contextualise this statistic, it can be compared to the maternal mortality rate in the UK at just 8.2 per 100,000 live births (Rogers 2013). The Ugandan Government reported in 2013 that improvements in maternal healthcare had stagnated (2013: I). As a reaction to failing to meet MDG targets and after disappointing results from TBA training programmes, in 2010 the Ugandan government decided to ban TBA’s – forcing all women to give birth in health clinics (Kabayambi 2013). Following Uganda’s ban of TBA’s, the Ministry of Health has to argue that the reason for continued poor maternal mortality rates is that women living in rural areas prefer to give birth in their home as opposed to clinics due to deeply embedded cultural birthing practice (Kabayambi 2013). Whilst conscious not to dispute the role of culture, there is also a case to say that the status of maternal health in Uganda may be shaped by structural factors such as the quality of antenatal and obstetric services, staff numbers and shortage of equipment. This report will assess the validity of this statement by
exploring different barriers to good maternal health within the context of an increasingly fragile refugee camp located within western Uganda.

![Image: Causes of maternal death in the world by percentage](http://www.who.int/mediacentre/factsheets/fs348/en/)

**Figure 1 - WHO 2014**

### Maternal Health amongst refugee communities

In order to effectively contextualise maternal healthcare within Kyangwali refugee settlement, a distinction between the experiences of refugee women compared to Ugandan nationals should be made. It is evident that within rural areas of Uganda maternal health remains a significant problem. It is clear that maternal mortality within Uganda, particularly in rural areas, continues to be a development challenge. Complicating this issue even further is the fact that Uganda is one of the largest refugee hosting countries in the world with an estimated 220,555 refugees from neighbouring countries (UNHCR 2014). Within this in mind, it has been argued that “the addition of a complex humanitarian emergency to an area with a pre-existing high rate of common maternal health complications create a lethal combination” (Gasser et al. 2004: 2). Unlike other countries, settlements within Uganda are owned by the government and not by UNHCR (UNHCR 2014). The clinics are funded by a variety of donors including UNHCR, the Ministry of Health and other NGO’s. Effective coordination between these actors is often a challenge. Further complicating the humanitarian situation are the increasing numbers of refugees entering the settlement. For
example, in August of last year, western Uganda received an influx of 66,000 refugees which put increasing strain on current health services and led to temporary emergency assistance from Médecins Sans Frontières (UNHCR 2014). In addition to the practical constraints of refugee environments, the existence of many different ethnic groups with different cultural norms and the psychological strain of past experiences are arguably likely to act as additional stressors. The “health professionals working in complex humanitarian emergencies must understand the links between the health needs and larger political, social, economic and historical contexts” (Gasser et al. 2004: 2). This study aims to look specifically at maternal healthcare within Kyangwali refugee settlement in the hope of providing recommendations for Think Humanity. In-depth interviews with women and key informants hope to reflect the fact that:

“Childbirth has emotional, cultural and spiritual dimensions beyond the physical experience…it cannot be described adequately or comprehensively by quantitative means alone” (Clark-Callister 1996: 67).

**Objectives of the Study**

The broad objective for the study was to explore the barriers which women face whilst living in Kyangwali refugee settlement with specific reference to;

i. Identifying the importance of good maternal care and why this is not being met within Kyangwali

ii. Exploring the power dynamics within the settlement which influence maternal healthcare

iii. Understanding women’s attitudes towards childbirth, healthcare and family planning

iv. Make recommendations for the improvement of maternal health services (with specific reference to Think Humanity), being mindful of the attitudes and perceptions of refugees.
Methodology

Study Area
Research was undertaken within Kyangwali settlement and Hoima town in Hoima district, western Uganda between May 20th and June 20th 2014.

Study Population
Statistics valid on the 31st March 2014, obtained from the Office of the Prime Minister in Kyangwali, estimated the total population within the camp at 38,897. Of the 38,897 within the camp, it is estimated that 92.2% are from the Democratic Republic of Congo (DRC) with additional 7% from South Sudan and smaller numbers from Rwanda, Burundi, Kenya and Somalia (OPM 2014). As the camp is ethnically diverse, efforts were made to access different areas and speak to different groups of women including Rwandese, South Sudanese and Congolese women from different ethnic groups.

It is important to note that this study did not include internally displaced people (IDPs) due to political complications at the time of research. It is necessary to recognise that the Bunyoro Ugandan IDPs currently surviving outside of the camp face many unique and additional problems and should be included in any public health initiatives.

Study Design
Semi-structured interviews were conducted with 34 women between the ages of 19 and 65. A convenience method of sampling was used and an effort was made to interview women from different areas of the camp in order to represent the different ethnic groups present. The semi-structured interview consisted of 25 questions about perceptions of general health care, experiences of childbirth and reproductive health. The interviews varied in length depending on the individual but typically lasted approximately 20 minutes. Interviews with non-English speakers were conducted with the use of a translator.

Additionally, a number of key informant interviews were conducted. Interviews with the camp commandant and the UNHCR protection officer provided an ‘official stance’ on service provision within the camp and information about the structure and management of the settlement and the NGO’s that work within it. Interviews with clinical officers and midwives from 3 of the health clinics located in and around the settlement provided accounts of the challenges faced by women and the prominent maternal health problems faced by refugees. Additional key informant interviews were conducted with a refugee who was training to be a nurse and had undertaken work experience within the national hospital, as well as a doctor working at Hoima referral hospital. Throughout my two month period of living in Kyangwali, many observations were conducted within clinics and hospitals, in people’s homes and during Think Humanity distribution activities.

Sampling Procedures
The respondents were gathered with the use of a convenience sampling method by informally approaching houses within different areas of the camp. Other key informants were identified through purposive selection whereby I was informed that they would be able to add much to my research. These methods suited the environment well due to the fact that women often work long
hours during the day; interviewing women informally at convenient times for them allowed me to gather valuable and detailed data.

**Data Analysis**

Having recorded the interviews, they were all transcribed. Data was manually analysed by first identifying key themes, before analysing the contrasting attitudes and opinions presented by women and key informants. Quotations from individuals have also been used to enrich this report, illustrating specific issues voiced by women and key informants.

**Ethical Considerations**

In-keeping with ethical guidelines and code of practice set by Edinburgh University, information was given to participants about the purpose of research and how the findings would be used. All participants gave consent prior to interviews and agreed to be recorded. Recordings have been stored safely without personal details. Anonymity was been preserved by not taking any names during the interview process.
Findings

Summary of Findings - barriers to reducing maternal mortality in Kyangwali

- The role of culture in health seeking behaviours
- The role of poverty
- Medical complications during childbirth
- Limited health resources and infrastructure
- Lack of health education
- High birth rate and negative low use of family planning
- The role of the Think Humanity Clinic

Complications during childbirth

Of the women interviewed approximately 56% had endured complications during their childbirth. Of these women, a number had endured obstructed labour which may have been avoided with the availability of ultrasound machines. Talking to health workers within the camp and a midwife at Hoima referral hospital, there was an overwhelming consensus about the need to get ultrasound within the camp or in the surrounding area.

“It would make good actually to have such service. Like an ultrasound nearby. Actually mostly probably theatre. Because you find that it is quite challenging because you refer an obstructed labour actually a woman” Clinical Officer, Rwenyawawa

One of the most shocking findings was that Hoima referral hospital did not even have an ultrasound in use. Therefore, women who are referred from the camp to receive ultrasound must access treatment in one of the private clinics in town – at a cost of 20,000USH. Keeping mind the findings regarding poverty, this may not be an option for many women desperately in need of this service.

“Correct, we have it as a machine but we do not have the staff. It means that, this is how the government, they take a period where they are supposed to send staffs so government institution it can take almost six months to one year to find staff. Because these are specialists who come down to do the work” Midwife, Hoima referral hospital

When enquiring as to why the health clinics within the camp offer such limited services in spite of the large vulnerable population, the maternal and reproductive health minister from the ministry of health in Hoima district told me:

“The government does not wish to upgrade the health services within the camp as it views the population as transient” Annette, District reproductive and Maternal Health Officer, Ministry of Health

Of the 34 women I interviewed, 21 had been living within the settlement for over 10 years with 7 women having lived there for over 17 years. With no end in sight for the war in DRC, this government policy seems irresponsible. Refusing to upgrade the health services for refugees within
this remote settlement in Uganda, not only endangers the lives of refugees but is likely to have wider public health implications.

It is beyond the control of Think Humanity to encourage government investment in clinics in Kyangwali however, by offering services which are currently absent – such as ultrasound and a well-staffed and managed labour ward – the Think Humanity clinic would be able to serve a far greater number of patients and have a significant positive impact on the lives of many vulnerable and children. After speaking to staff at clinics within the camp and at the referral hospital it is clear that if Think Humanity decided to pursue this, the idea would be supported as it would relieve much stress of existing health clinics and the referral system.

The Role of Culture

Whilst interviewing it was clear that a large proportion of women had given birth outside of a clinical setting. Of the 34 women interviewed, 16 had given birth to at least one child from home or on the road. Given the fact that 18/34 women told me that they had experienced complications during child birth, it is possible to understand why maternal mortality remains high – complications are frequent and many women do not have the support they need to deal with unexpected circumstances.

An initial key informant interview with the camp commandant gave me an insight as to how the government officials working within the camp view the problem of maternal mortality. Firstly, the attitude of officials towards mothers seemed disdainful and they were described as “culturally backward”. The camp commandant also stated that he would refuse to register refugees if they chose to give birth from their homes. It was clear that the camp commandant believed that high maternal mortality rates within the camp were attitudinal and cultural – that women were actively choosing to endanger themselves by refusing to give birth within the clinics. However, responses from the women I interviewed contradicted this statement.

- The vast majority of women preferred to give birth in the clinic and did not use (or value) local medicine.
- 66% of women stated that did not use local medicine at all, and off the women that did, many stated that this was only as a final resort when they were unable to pay for medicines which were not available from the health clinics.
- An overwhelming majority of women agreed that new Ugandan legislation banning TBA’s was good.

Acknowledging that there is a population of women within Kyangwali who are keen to benefit from western medicine in order to deliver safely and without problems is vital. These findings do not suggest that cultural practices are not an important in childbirth but rather, that the perceptions of policy-makers are very different from the perceptions of refugee women. The question should be asked: if women in Kyangwali want to give birth within the clinics, what is really preventing them from doing so?
The Role of Poverty

Although not directly related to maternal healthcare, it is worth noting that a key theme that arose whilst interviewing women was poverty. Although this research is focussed on maternal healthcare, it would be futile to overlook the overarching issue of poverty in Kyangwali.

- 83% of women interviewed felt that they could not adequately provide enough health care and food for their children.
- The main reasons cited for this were poor harvesting, infertile land, reduced land not enough food aid and no medicines.
- The majority of women stated that they used the health clinics, most of these women could not access medicine due to endemic shortages with the camp and a phrase which women are repeatedly told is “go and buy”.

Hunger and poverty was particularly a problem for single mothers living around the Kirokore and Sudanese areas of the camp. As has already been stated, within humanitarian situations there is usually a far greater number of women and children than men. UNHCR attempts to settle these individuals near health clinics however, food is still not enough and many mothers do not have time or strength to cultivate enough food for the family.

It is interesting to note that throughout the interview process, many women viewed my questions as almost trivial; maternal healthcare is a huge problem but hunger and poverty is their immediate problem. Surely healthcare improvements should go hand in hand with efforts to improve the standard of living for many women. Put simply, poverty and malnutrition is the camp is endemic. Women are not trivial about the circumstances of their childbirth – they simply want to survive it and the majority agree that this is best made possible with the help of a doctor. The links between poverty and healthcare are cyclical:

![Figure 1 - A Kyangwali cycle of poverty](image-url)
Limited health Resources and Infrastructure within Kyangwali

Upon arrival within Kyangwali, it became immediately clear that the health services within the settlement were not sufficient for the number of people living there. Due to the complex structure of Kyangwali settlement, the clinics are funded through a variety of means including by Africa Action Help (AAH) in conjunction with UNHCR, the government as well as private clinics. It should also be noted that the government clinic, Kitooti, also serves Ugandan nationals living within Kyangwali sub-county.

Distance from the clinics

During my interviews, many women stated that they lived far from the clinics and were often unable to get there whilst they were giving birth. This led to people giving birth on the road or being unable to reach the clinics in case of emergency. There is no transport for women to clinics despite the fact that the settlement is 136km². Anecdotal evidence supports these findings as I have been told of numerous incidences where a woman has been forced to give birth on the roadside.

Hoima to Kyangwali

In addition to the distance to clinics within the settlement, the location of Kyangwali in reference to Hoima referral hospital is also problematic and serves as a barrier to maternal healthcare. Within the literature it has been argued that government “investment in the rural road network, for instance, can improve access to emergency obstetric care and reduce the large share of maternal deaths that result from complications more than a day after delivery” (Government of Uganda 2013 : V). The road between Hoima and Kyangwali takes two hours when it is in good condition. With 8 ambulances in the camp, this road is used throughout the day and night in order to transport patients to Hoima Referral hospital. During my stay I spent two months travelling between the two places, it became very clear how rain could make it impassable. During a key informant interview with a midwife at Rwenyawawa she stated that:

“\textit{The distance is far because sometimes you find a mother, for example, a mother who has a previous scar may report to our centre when she is fully dilated and that distance of two hours’ drive is too much to hold such a condition and not only that, another example, in case a baby is distressed, much as we resuscitate, still that distance is too long to save the life of this baby}” Midwife, Rwenyawawa
Whilst interviewing medical professionals at all of the clinics within the camp and at Hoima referral hospital, all expressed the dire need to upgrade the facilities in the settlement.

**Staff Shortages**

Clinics within the camp are largely staffed by Ugandan nationals and whilst interviewing staff from Rwenyawawa it was stated that the shortage of staff within the clinics was reducing the quality of care:

“We are really understaffed because you find that if you were to start checking what we do when we are clerking these mothers, we do maybe 50 per cent of what we are supposed to do. We want to save time, we want to handle all of them” Midwife, Rwenyawawa

**Discrimination**

In addition to inadequate care, a number of interviewees and key informants also stated that discrimination is commonplace within these clinics. One young man, who was a refugee doing work experience for psychiatric nursing within Renyawawa clinic, reported that:

“A child was also in the hospital, so I got ready a woman, she was on drip so this normal saline which was running was over. So the canular needed to be disconnected. But the staff could not manage. ... so I felt very bad because I Knew what kind of pain the person was having” Psychiatric Nurse student

Many women gave examples of poor treatment within the clinics:

“There was one time. I was just there with a patient, the woman just gave birth on the cement, the doctor delayed to come to look after the mother. When he found out he abuses them. Yet he is the one who delayed to attend to the mother”

Whilst not excusing discrimination and poor treatment, it is possible to see it as the result of low staffing numbers within the clinics in the camp. One nurse made it very clear why Ugandan medical professionals do not wish to work in Kyangwali:

“The salary is very little, very little. Very little being, you are staying in a very remote area, and you have families to take care of and you are working under pressure and you have little time to rest. Work pressure is too much. You don’t have enough time to go and see your family. And then the money is also small. That is one other factor that others also run away. They will say, let me go to a government setting where they pay less but I have my time, my children” Midwife, Rwenyawawa

Barriers to efficient maternal healthcare can be seen in the limitations due to staff numbers and poor working conditions. Poor working conditions can lead to discrimination which may prevent...
women from attending the health clinics for antenatal care or childbirth – putting them at increased risk to maternal mortality. Equally, lack of staff may also mean that women are not attended to quickly enough.

**Health Education**
Many of the women interviewed demonstrated limited knowledge on maternal health and many were unaware of the complications that could arise during childbirth.

- Of the 34 women interviewed, only 14 had received any sort of health education in the camp.
- Furthermore, when asked whether education on reproductive health and maternal health would be well received, the vast majority agreed that this would be a good initiative.

Offering health education is an affordable and effective preventative health care measure which should not be overlooked. It is vital that efforts from organisations adopt both a preventative and curative approach.

**High Birth Rate**
The birth rate in the camp is extremely high. Even from the small sample I used, this was obvious as many women had up to ten children.

These findings are supported by a document on demographics within the camp which show that the number of children stands at 29,177 compared to just 9,720 adults over the age of 18 (OPM 2014). This finding is important as it highlights how health services within the settlement are only likely to become more stressed once these children grow and begin producing themselves.

**Perceptions of Family Planning**
In order to reduce the birth rate, tackling fertility rates and the quality of health services within the camp should be made a priority. While this research originally set out to look at maternal health, I was struck by how women wished to talk about family planning. While the overwhelming majority of women interviewed felt that they could not provide enough food for their children and did not wish to have any more, many women did not use any sort of family planning.

During the interview process, women were eager to share their thoughts and experiences of family planning with me. Of the 34 women interviewed, 22 had used family planning but many did not like it and reported extreme side effects such as:

“Sometimes you can have one in the arm then it makes you paralysed then you can no longer work”
“Some people think that those injections, they may cause them diseases. They fear the side-effects of injections. After some people start family planning there is an observable effect. Someone may have swollen legs, someone has a negative attitude”

“After using family planning I had pain in my stomach and could not produce for two years, I closed for two years, I do not like it”

“They injected me, after three months then they removed. I was badly off”

“[I got a] headache, I grew thin”

“Some women say that once you use family planning you bleed a lot”

Misconceptions around family planning are likely to prevent women from utilising it to prevent the services. In spite of the negative perceptions voiced during the interview process, one woman described family planning as a way to:

“Protect you because getting more children when you have nothing, it is really very hard and the family planning can help you, protect you”

Education which reinforces this view of family planning is likely to enhance women’s understanding of family planning and give them full choice – free from negative preconceived ideas.
**Think Humanity Clinic**

It is first necessary to report observations and findings from the Think Humanity clinic.

- The staff working at the clinic are profoundly hard-working and work throughout the day and night in order to provide efficient care for patients.
- Compared to other clinics in the settlement, Think Humanity clinic provides efficient care which is free from discrimination.

**Provision of Drugs**

Despite being a private clinic, the staff correctly recognise that many of the patients may not be able to pay the full amount for their medications. The lenient attitude towards payment reflects the compassionate attitude of all the staff. For example, when questioned about the expansion of the clinic, one clinical officer stated;

*“The money doesn’t matter, expanding the clinic would allow us to treat more patients”*

It can also be noted that although government clinics are supposed to provide free medication, findings suggest that medication shortages occur frequently. Think Humanity clinic always maintains a good supply of medication.

**The Staff**

The clinic offers a range of services and the clinical officers and nurses often go beyond their call of duty. Despite not being fully trained doctors, William and Derek demonstrate a huge amount of expertise and have obviously learnt a lot within the challenging working conditions. All of the staff at the clinic are Ugandan nationals and, unlike other clinics in the camp, no distinction is made between nationals and refugees. Patients are treated with respect.

**Services**

HIV counselling and testing is available at the clinic and is very important. Many routine procedures are conducted and I was able to witness many instances where patients had come to the Think Humanity clinic after receiving poor services at Rwenyawawa or Kitooti. One of the challenges voiced by people within the camp is that the clinic is some distance from the camp and many people choose to go to Kitooti instead. Although it is recognised that the clinic is strategically located – serving both refugees and Ugandans – it is possible to argue that a taxi service or some sort of transportation to and from the clinic could serve to increase the number of patients.
Recommendations

1. Whilst interviewing refugees within the camp it became very clear that the main reason that people were not satisfied with the health services was due to lack of drugs. It is vital that the clinic continues to maintain a good stock of drugs at all times so that all patients can be treated effectively. Advertising and increasing pharmacy services would be a way to increase the income of the clinic.

2. I would contend that there is a need to offer health education. Health and development professionals have a duty to engage with preventative measures as well as curative ones. Education in reproductive health, maternal health, water and sanitation and HIV/AIDS would not only benefit the refugee and local community but it would also encourage more people to use the clinic for general health problems. Expanding the clinic into the back buildings would offer a space for health education lessons. Utilising the varied expertise of interns, doctors, nurses and visitors and getting different people to teach lessons would be fantastic.

3. The staff the clinic are fantastic however, one critique is that, at times, hygiene lapses. It is really important for health and for the integrity of the clinic that gloves are worn all the time.

4. A taxi service or some sort of transportation to and from the clinic would increase the number of patients attending the clinic. This would be a cost efficient way to increase patients attending the clinic.

5. Despite initial intentions, ultrasound, antenatal and maternity services are not currently available at the Think Humanity clinic. These facilities would be a valuable asset to the community and refugees – undoubtedly saving lives. With an understanding of the challenges faced by many women in the camp with regard to maternal healthcare, introducing these services at Think Humanity clinic seems a vital investment.

Unlike other development projects, with the correct expertise and planning, the clinic has the potential to be self-sustaining. The staff and health director at the Think Humanity clinic are invaluable and without their dedication the clinic could not run. In spite of the challenges presented here, I would contend that the clinic is vital for the community which it serves and investment in its expansion is paramount.
Bibliography


