

# **HEALTH CARE NEEDS OF DISPLACED WOMEN LIVING IN OSIRE REFUGEE CAMP IN NAMIBIA**

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**HEALTH CARE NEEDS OF DISPLACED WOMEN LIVING IN  
OSIRE REFUGEE CAMP IN NAMIBIA**

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## DECLARATION

I, Lusia Ndahambelela Pinehas, hereby declare that the thesis **HEALTH CARE NEEDS OF DISPLACED WOMEN LIVING IN OSIRE REFUGEE CAMP** is my original work (except where acknowledgments declare otherwise), and that neither the whole nor any part of this work, has been, or is to be submitted for another degree at this or any other university.

.....  
Lusia Ndahambelela Pinehas

Date

**“THE LORD IS MY SHEPHERD I SHALL NOT WANT:  
EVEN IF I HAVE TO WANDER IN THE VALLEY OF  
DARKNESS, I FEAR NOT”. PSALM 23**

## DEDICATION

- A special dedication to my daughter, the late Justina Nangolo Ndapandula; my third born who together with her schoolwork did the household chores and cook for her father and her younger brother while I was away for studies.
- My father, the late Johannes Andjaba who instilled in me the spirit of hard work.
- My mother, the late Monika Abisai who passed away during my last year of study.
- My brothers, the late Mateus Andjaba and Joseph Andjaba who passed away during my study.

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- Ms. Barbara English for editing the thesis;
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## **ABSTRACT**

### **Health care needs of displaced women living in Osire refugee camp in Namibia.**

The aim of the study was to explore the experiences of displaced women living in the Osire refugee camp in Namibia about their health care needs, and to develop health care guidelines that will help to address the identified health care needs of displaced women.

A descriptive phenomenological study was used, using face-to-face interviews with participants in response to one question. The following question was asked: What are the health care needs of displaced women living in Osire refugee camp and how should they be addressed? Ten women were interviewed. Their ages ranged between 18 and 58 years. The duration of displacement was longer than 6 months.

Interviews were conducted in Osire Refugee Camp in Namibia. Displaced women were invited to participate in the study on a voluntary basis. The interviews were tape recorded and transcribed verbatim. During the analysis the essence substantiated by the constituents of their experiences regarding their health care needs were identified. The findings of the health care needs of displaced women living in Osire refugee camp reflect that they have a need for restoration of hope and human dignity.

A thorough literature review was done and the constituents were re-phrased to form guidelines on how to address the health care needs of displaced women. The guidelines were refined through a Delphi study.



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<b>LIST OF ABBREVIATIONS</b>	
AHA	African Humanitarian Action
AIDS	Acquired Immune-deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CBOs	Community Based Organisations
CMR	Cameroon
COD	Congo DRC
ELCA	Evangelical Lutheran Church in America
ETH	Ethiopia
GBV	Gender based violence
GRN	Government of the Republic of Namibia
FBO	Faith Based Organisations
FP	Family Planning
HIV	Human Immune-deficiency Virus
JAEM	Joint Assessment and Evaluation Mission (Namibia)
KEN	Kenya
LBR	Liberia
MoHSS	Ministry of Health and Social Services
NIG	Nigeria
NGO's	Non-governmental organisations
RWA	Rwanda
SOM	Somalia
UG	Uganda
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Emergency Fund
WMA	World Medical Association
WHO	World Health Organisation
WFP	Refugee Food Programme
ZIM	Zimbabwe

## CHAPTER 1

### INTRODUCTION TO THE STUDY

#### 1.1 INTRODUCTION

Displacement of people is a global problem. Historically, “displaced persons” were people who were uprooted by World War II. The term is currently applied to many refugees across the world that is uprooted as a result of persecution, political collapse, war, famine or natural disaster. Displaced persons are involuntary migrants forced by extraordinary circumstances to leave their homes or countries of residence to a place they believe to be safe. During their time of fleeing some displaced persons might believe that their status will be temporary, but only to realise later that their displacement status becomes long term or even permanent. Other displaced persons assume that they will never return to their homes or countries of residence and create a new life for themselves in a new country only to find out later that they are repatriated back home (Agier, 2008:2, 4).

The global overview of displaced persons (refugees and asylum seekers) conducted in 2008 indicates a total of 13,599,900 million displaced persons, of which 2,692,100 were from Africa, and 11,700 of them were found in Namibia (United States Committee for Refugees and Immigrants (USCRI) 2009:32). According to the USCRI (2009:32) the United Nations Development Programme (UNDP) indicates that there is an alarming increase in the number of displaced persons world-wide and that these people are forced to flee their places of habitual residence and live in camps or straw huts, or cross international borders to neighbouring countries for their safety. This is mostly the result of armed conflicts in some areas although it can also be attributed to political instability as well as internal rife and violence within countries. Most of the affected persons are defenseless women and children (United Nations High Commissioner for Refugees (UNHCR)-Namibia, 2007: paragraph 7). Reports on the life of refugees such as the report on the Dzaleka Refugee Camp in Malawi (Shadrak, 2010:1) and the report by Pavlish (2005:882) indicate how refugees live in poor conditions and their health needs not well addressed. The reports further stated that generally, refugees are treated as prisoners and their human dignity is not respected and their daily life routine has nothing in common with the rest of the world. Many researchers according to Pavlish (2005) fail to address the health needs of refugee women because they focused primarily on the

reproductive health rather than the complex factors that influence the women's health such as the social, cultural, economic and environmental factors. In Southern Africa, Namibia is regarded as a signatory country in the Southern Africa Developing Countries (SADAC) region (UNHCR, 2010:1) where displaced persons from neighboring countries and the rest of the African continent seek refuge due to Namibia's political stability and the policy of reconciliation (UNHCR-Namibia, 2007: paragraph 7), Ministry of Home Affairs of Namibia, 1999:19).

It is reported that there are over 8,000 displaced people in Namibia, of which seventy-nine percent (79%) are refugees and twenty one percent (21%) asylum seekers. Of these refugees and asylum seekers, seventy-five percent (75%) are from Angola, three percent (3%) from Burundi, nineteen percent (19%) from the Democratic Republic of the Congo (DRC), two percent (2%) from Rwanda, and the rest of the displaced persons are from across the African continent (UNHCR-Namibia Convention and Protocol related to the Status of Refugees, 2007:1; UNHCR-Namibia Regional Operation Profile, 2000:paragraph 1; UNHCR Namibia Refugee Agency, 2000:paragraph 13; UNHCR/World Food Programme Joint Assessment and Evaluation Mission (UNHCR/WFP JAEM)-Namibia, 2008:9).

## **1.2 BACKGROUND TO THE PROBLEM STATEMENT**

In Africa, although inter-country conflicts are under control people are being displaced both internally and externally due to intra-country conflicts, which include: political instability, poverty and insecurity; the search for proper education for themselves and their children; as well as better employment opportunities in the more stable countries on the continent. People move to Southern Africa Development Countries (SADC), which includes Namibia (UNHCR, 2010:1). The current situations in African countries such as Somalia, Ethiopia and Kenya and Libya are evidence of intra-country conflicts that causes people to become displaced (UNHCR-Somalia 2001:1).

Inter-country migration is mostly dominated by women (UNHCR, 2010:1). Factors such as civil war and limited access to livelihood opportunities as well as conflict over distribution of scarce land, and food insecurity have triggered displacement of millions of people from countries such as Eritrea, Southern Sudan, Somalia, Burundi, Ethiopia and Kenya (UNHCR, 2010:1; UN General Assembly, 2008:5-6). In the Democratic Republic of Congo (DRC), serious human



rights violation, such as sexual violence and civil war contribute to affected civilians fleeing their country seeking safety and protection (United Nations (UN) General Assembly, 2008:7-8).

Zimbabweans fled their country to neighboring countries including Namibia because of the persistent uncertainty in the country resulting from the decline in economic, political and humanitarian conditions within the country (UN General Assembly, 2008:8). Angolan nationals have been crossing the Namibian borders illegally long before Namibia's independence. Angolans fled their country because of the civil war (1975-1988) between the Angolan government forces, namely Movimento Popular de Libertação de Angola also known as the "Popular Movement for the Liberation of Angola" (MPLA), which gained power from 1975.

The MPLA was supported by the then Union of Soviet Socialist Republics (USSR) and Cuba, and the National Union for the Total Independence of Angola (UNITA) labels supported by the United States of America (USA) and South Africa (SA). Another reason Angolans fled their country was the destruction of their land and homesteads by the South African Defense Force (SADF), the South West Africa Territory Force (SWATF) and in particular the "Koevoet" that were operating in Namibia and in south-eastern Angola in search for Namibians who went into exile to join the South West People's Organisation (SWAPO) and the People's Liberation Army of Namibia (PLAN) fighters in Angola (van Berkel, 2002:1; Stiff, 1979-1989:1) because of the apartheid and colonialism in their country.

Some Angolans came to Namibia to seek medical assistance at Engela Hospital. The hospital is in Ohangwena region in the northern part of Namibia near the southern Angolan border. The war in Angola caused poor health services in that country, as hospitals were destroyed during the conflict. The war caused Angolans to flee their country to seek medical help in Namibia (van Berkel, 2002:1; Agier, 2011:117; Stiff, 1979-1989).

Although the number of displaced persons and asylum seekers continued to increase, in some areas little is known about their precise numbers, demographics, basic needs or protection problems (Shivute, 2010:3; Carrillo, 2009:528). Asylum seekers who do not seek legal recognition make it difficult for their adopted country to ascertain their accurate numbers; they are unidentifiable and as such are not legally protected against crimes and violence such as

rape or exploitation. Furthermore, they can be arrested as illegal immigrants and deported back to their home countries or be jailed (Gordon, 2008: paragraph 2-3).

Namibia has two refugee transit centres, one in Rundu in the Okavango region known as “Kassava”, and the other centre is Okakwa in Enama in the Ohangwena region both in Northern Namibia (van Berkel, 2002:1, UNHCR/WFP JAEM, 2008:9). It is from these centres that refugees and asylum seekers are transferred to Osire camp where they are hosted while waiting to be granted refugee status (Namibia Refugees (Recognition and Control) Act 2 of 1999) or be repatriated to their mother countries. Refugees are registered and those who are six years and older and who meet the requirements are provided with refugee identity documents. The process should take no longer than thirty days, but in reality some applicants wait more than thirty days for the documents to be issued.

The map on the next page shows the different regions of Namibia. Ohangwena region in the north and Okavango in the north-east are the two regions where the transit camps for refugees and asylum seekers are erected. It is also at these regions were some Namibian immigration offices are found. The map also shows other neighboring countries to Namibia.



the camp with no permission or with an invalid permission, he/she can be arrested and prosecuted and even be jailed (UNHCR/WFP JAEM, 2008:2, 9 & 17).

Table 1.1 shows the number of women refugee and women asylum seekers older than 18 years in Osire refugee camp. The number changes continually due to the on-going admission of women and the repatriation and death of women. The information was obtained by the researcher during a visit to Osire refugee camp in August 2010. The numbers are presented according to the country of origin.

**Table 1.1: The number of women refugees and women asylum seekers in Osire refugee camp in Namibia**

Refugees				Asylum seekers		
Country	18-59 years	60+ years	Total	18-59 years	60+ years	Total
Angola	1125	43	1168	-	-	-
Burundi	26	2	28	19	-	19
Cameroon	1	-	1	-	-	-
DROC	197	6	203	182	3	185
Ethiopia	-	-	-	1	-	1
Kenya	-	-	-	2	-	2
Liberia	-	-	-	3	-	3
Nigeria	-	-	-	1	-	1
Rwanda	6	-	6	19	2	21
Somalia	-	-	-	1	-	1
Uganda	2	-	2	-	-	-
Zimbabwe	5	-	5	18	-	18
<b>Total</b>			<b>1413</b>			<b>251</b>

**Source: Representatives-Namibia Ministry of Home Affairs and Immigration (August 2010) and UNHCR- Osire Office (April 2011).**

In Osire refugee camp displaced persons receive food and a monthly assistance of basic commodities from the United Nations Humanitarian Organizations such as the World Food Programme (WFP) through the African Humanitarian Action (AHA) office as the displaced

persons are not allowed to have formal employment as a result of the high unemployment rate in Namibia of 50.1% (according to the 2011 Namibian census) (UNHCR/WFP JAEM, 2008:10 & 15). According to the strict confinement policy of the Namibian Government against refugees they have no access to arable land for crop production, no access to labour markets or higher education facilities (UNHCR-Namibia, 2010:1; UNHCR/WFP JAEM, 2008:2, 10 & 15).

Although Namibia started hosting refugees in the mid-1970s there was no official recognition of refugees until 1990 (UNHCR-Namibia, 2007:1). The process of granting foreign displaced people refugee status is slow and causes the displaced people to stay long in the camp without being acknowledged as refugees (UNHCR-Namibia, 2007:1).

### 1.3 PROBLEM STATEMENT

According to Abusharaf (2009:39-40), and in reports of Dalton-Greyling (2008:8), the UN General Assembly (2008:13) and according to Mooney (2005:17) and Pavlish (2005:882) it is indicated that in all displaced communities, more women are displaced and that they are the most vulnerable group of all displaced groups because of their status as women. They need special protection, as their life world has changed and their physical environment might not be safe.

The prolonged civil war between the government of Angola and the rebel movement UNITA during 1999–2002 led to dilapidated health care services in Angola and resulted in many Angolans fleeing their country into Namibia. The Osire refugee camp became over populated mostly by Angolans (UNHCR/WFP JAEM, 2008:9). During the influx, the Government of the Republic of Namibia (GRN) made an official appeal to the WFP to provide refugees with humanitarian assistance.

When the war in Angola ceased negotiations were started for voluntary repatriation of the Angolan refugees. When the formal repatriation programme ended in 2005 the population in Osire became more manageable because of a decrease in number. Negotiations took place between the UNHCR and WFP and (GRN)-Namibia so that WFP could cease provision of humanitarian assistance to refugees in Osire and the GRN could take full responsibility of Osire refugee camp. Before the implementation of the agreement UNHCR and WFP Joint

Assessment and Evaluation Mission (JAEM) conducted two separate visits at Osire refugee camp UNHCR/WFP JAEM, 2008:21-2).

The first visit by the UNHCR/WFP JAEM was conducted in May 2006, and the second one from 28 February to 05 March 2008. The aim of these visits was to examine the food security and general safety measures in Osire camp and also to look at the livelihood options for refugees and asylum seekers, as well as the impact and effectiveness of UNHCR/WFP assistance to the camp (UNHCR/WFP JAEM, 2008:2).

The findings were that refugees were only food secured because of the monthly food supply from WFP and if the assistance were to be terminated refugees would suffer severe food insecurity and their nutritional status would deteriorate within a very short time (UNHCR/WFP JAEM, 2008:2 & 10). The findings also indicated that poor conditions of agriculture, Namibia's poor soil deficient in micro-nutrients and Namibia's increased unemployment rate of 50,1% (UNHCR/WFP JAEM, 2008:11 & 17) made it difficult for the integration of unskilled refugees into the local community (UNHCR/WFP JAEM, 2008:11 & 17).

It was also indicated that the strict confinement policy that applied to refugees and asylum seekers to restrict their mobility by the government made refugees and asylum seekers highly vulnerable because they had no access to resources needed for the enhancement of self-reliance opportunities. It was further found that the level of malnourishment of the people was moderate and that the women needed additional education on health issues (UNHCR/WFP JAEM, 2008:2, 10-1 & 15).

One-hundred and forty (140) children were reported to have malnutrition. At the time of the evaluation eight children were admitted to the hospital for supplementary feeding. Malnutrition was also identified among the women but no numbers were included in the report (UNHCR/WFP JAEM, 2008:28-9). There were about 400 people (7% of the total number) with severe food insecurity and 1,800 people (29% of the total number) with moderate food security (UNHCR/WFP JAEM, 2008:21-2). It is disturbing that 36% of the population in the camp had been identified as having had either severe or moderate food insecurity.

The UNHCR/WFP JAEM (2008:35) made recommendations to both the Government of the Republic of Namibia (GRN) and the AHA to look into matters affecting refugees in Osire refugee camp such as humanitarian aid distribution, repatriation, reintegration as well as resettlement. These matters will be discussed in full in Chapter 4.

Since the establishment of the Osire refugee camp in 1992, no evidence of a detailed research report about the experiences of refugees in general and of refugee women in particular is available with regard to their health care needs. The general reports of the international organisations and governing bodies (UNHCR, AHA) on the situation in the Osire camp are readily available. These reports include mostly services rendered, humanitarian aids provided, and the manner they are distributed, or indicate what is still needed with regard to humanitarian aid. The Namibian ministries that are in partnership with international organisations in the care of Osire refugees provide reports that are descriptive, but not research based.

According to Pavlish (2005:881), the women's health in a broader sense includes many aspects of life that should be addressed in a holistic manner. Furthermore, The National Black Women's Health Project's position statement regarding women's health as cited by Pavlish (2005:881) states that "... women are the only appropriate and best qualified individuals to define the nature of their health issues ... services necessary to address them". When the healthcare needs of a displaced woman are not met negative physical and psychological conditions such as malnutrition, anxiety and depression could develop (Pavlish, 2005:881) with decreased levels of self-reliance, self-actualisation, self-worth, self-respect, and self-esteem. Martin and Tirman (2009:232-3); Abusharaf (2009:46); Gordon (2008: paragraph 2) state that many displaced women are denied even the most basic human rights and they are condemned to an uncertain future because of limited resources.

Dalton-Greyling (2008:14) states that many studies have been conducted on displaced persons, but these studies mostly focused on the economic or financial well-being of displaced persons in general, while some focused primarily on the reproductive health of women. Little is written regarding their general health care needs and the broader social perspective of how

they experience life and the impact of this experience on their health care needs (Pavlish, 2005:880).

Reports about refugees according to Agier (2008:49) often concentrate on the experience of being a refugee after the war when the refugee has returned to his home country while the experiences during the time of displacement are left untouched.

The UN Fourth Conference on Women that was held in Beijing, in China, in 1995, described women's health as comprising various and complex issues that need to be addressed to ensure the optimal health of all women (Pavlish, 2005:880). The all-encompassing well-being of displaced women and their health care needs have generally been overlooked globally and this is also the case in Osire refugee camp.

#### **1.4 RESEARCH QUESTION**

The research question addressed in this study was:

**What are the health care needs of displaced women in Osire refugee camp and how should they be addressed?**

#### **1.5 AIM OF THE STUDY**

The aim of this study was to explore and describe the health care needs of displaced women in the Osire refugee camp and to develop guidelines to address these health care needs.

#### **1.6 RESEARCH OBJECTIVES**

The objectives for this study were to:

- explore and describe the health care needs of displaced women living in Osire refugee camp in Namibia; and
- Develop appropriate guidelines for nurses who work in Osire refugee camp for addressing the health care needs of displaced women in Osire refugee camp.



## **1.7 SIGNIFICANCE OF THE STUDY**

The significance of research in nursing according to Polit and Beck (2008:86) is the evidence from studies that have the potential to contribute meaningfully to and broaden the body of knowledge of the nursing profession. This research was the first of its kind to be conducted at Osire refugee camp with regard to the daily experience of displaced women regarding their health care needs.

Guidelines were developed for the management of their healthcare needs. The findings of this research will be communicated to the GRN especially the Ministry of Health and Social Services (MoHSS) and if these findings are used to restructure the health care of displaced women it could make a significant positive impact in service delivery of displaced women in Osire refugee camp.

The significance of this study was two-fold: theoretical significance and practical significance (Hofstee, 2009:89).

### **1.7.1 Theoretical significance**

The study is the first of its kind in Namibia and its findings would contribute to the broader understanding by nurses and the Namibian government of the health care needs of displaced women. The guidelines are a contribution to nursing theory regarding ways to address the health care needs of displaced women.

### **1.7.2 Practical significance**

The study provides a better understanding by nurses of the health care needs of displaced women. The guidelines will be made available to the Namibian Government, specifically the Ministry of Health and Social Services. From here the guidelines could be shared with health care workers, the Ministry of Gender Equality, international organisations that deal with displaced persons such as the UNHCR and AHA, NGO's such as faith-based organisations (FBO's), as well as community-based organisations (CBO's).

## 1.8 CLARIFICATION OF THE KEY CONCEPTS

In the context of this research, and for simplicity and consistency, the following key concepts are defined:

### **Displaced persons**

The Organisation of African Unity (OAU/AU) defines displaced persons as “persons who are forced to leave their native countries due to ‘aggression, occupation by an outside force, foreign domination or events seriously disturbing the peace in a part or all of the country of origin’ (Pavlish, 2005:882). Displaced persons are described as persons forced from their homes or country of origin either by war or revolution. They are referred to as ‘a legal group’ or ‘people of global concern’. To displace people, according to Kälin (2008:8 & 20), is “to force people to move away from their home to another place”.

A displaced person is referred to as a “refugee” or “forced migrant,” which refers to “anyone who has left his/her home... who enjoys specified international legal protection” and who is not the citizen of the host country Kälin (2008:8). The broader description of displaced persons according to international organisations and the United Nations (UN) includes refugees, asylum seekers, internally displaced persons, externally displaced persons, exiles, returnees as well as the stateless. The formal definition of a refugee is set out in article 1, section A, sub-section 2 of the United Nations Convention Relating to the Status of Refugees (1951) as follows:

*“Any person who owing to a well-founded fear of being persecuted on account of race, religion, nationality membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to fear, is unwilling to return to it” (Kälin, 2008:8; Pavlish, 2005:882).*

For the purpose of this study, the term ‘displaced persons’ pertains to refugees and asylum seekers- men and women, adults and children-, whereas the term ‘displaced women’ will refer to both women refugees and women asylum seekers, as the focus of the study is on the health

care needs of displaced women living in Osire Refugee Camp (Dalton-Greyling, 2008:4; Carrillo, 2009:529; Kälin, 2008:8 & 20; Ministry of Home Affairs of Namibia, 1999 section 3:3). The words 'displaced person' will also be used interchangeably with the word 'refugee' in this research. These persons are only recognised as refugees and awarded a refugee status when they have applied for refugee status and meet the requirements of a refugee according to the Ministry of Home Affairs of Namibia (1999:2 & 9).

### **Asylum seekers**

Asylum seekers are individuals who have sought international protection in a foreign country, who have applied for a refugee status and whose claims for refugee status have not yet been determined (UNHCR-United Nations Convention Relating to the Status of Refugees (UNCRSR) 1951 Resolution 2198 (XXI):16; Gordon, 2008: paragraph 2-3). They are officially referred to as "refugees" when they have applied for and meet refugee status according to the host country's legal policy, and receive legal recognition as refugees in the host country (Namibia Refugees (Recognition and Control) Act (2 of 1999: section 19; UNCRSR 1951: Resolution 2198 (XXI):16).

In this study, reference to displaced women or refugee women will also include asylum seekers.

### **Health care needs**

The World Health Organization's (WHO) classic definition of health is: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, 1978: paragraph 1). Alexander and Spradley (2001:6) also define health as a "holistic state of well-being, which includes soundness of mind, body, and spirit". According to Fitzpatrick and Whall (1996:277), health is a "pattern of evolving, expanding consciousness regardless of the form or direction it takes".

Health care is seen as "that service to human kind that is aimed at providing medical care" (Hornby, 2006:690). This care refers to nursing-related activities that cater for the physical, psychological and socio-economic and cultural healthcare needs of women in Osire refugee camp.

In this study the term “health care needs” refers to the physical-, psychological-, social-economic and cultural health care necessities of displaced women that should be provided through a range of health care services. The aim is to promote the health of women in Osire refugee camp and to enable them to become functional in all domains of life so that they contribute fruitfully to their own well-being, as well as that of their families.

## **1.9 FRAME OF REFERENCE**

A paradigm according to Polit and Beck (2004:13) is defined as “a general perspective of the real world”. Researchers use paradigms to organise their observations and reasoning through a basic set of assumptions that guides their inquiries. Paradigms for human inquiry are often noticed in terms of the nature in which they respond to basic philosophical questions and are viewed as lenses through which the researcher’s focus on a phenomenon of interest (Polit and Beck, 2008:17).

This study was conducted within a naturalistic paradigm. The researcher studied the phenomenon of health care needs of refugee women through interaction between herself and the participants (Polit and Beck, 2008:15). Naturalistic researchers use qualitative research to deal with human complexity and to fully understand the human experiences as described by those who lived them. They assume that knowledge is enhanced when the distance between the researcher and the participants is minimised (Polit and Beck, 2008:15). The phenomenon of health care needs was explored and described through phenomenological qualitative research.

Phenomenological researchers use naturalistic paradigms to understand the lived world of the participants. The findings of the research are the results of the direct interaction of the researcher and the participants. The phenomenon (their health care needs) is studied as it is perceived and experienced by the participants. Their perception of the phenomenon is not the focus of the research but rather the phenomenon as it is revealed by a description of their experience of it (Norlyk and Harder, 2009:428).

Naturalistic research takes place in the natural setting and yields rich, in-depth information because of its direct involvement with participants. Paradigms can be explained at the following levels: ontological, epistemological, axiological and methodological assumptions.

### 1.9.1 Ontological assumptions

Ontology is derived from Greek “on to” which means “to be”-, what is real versus fiction or appearance and is the study of “existence” (Solomon, 1978:158). It is a concept in philosophy which refers to “theory of existence” (Hornby, 2006:1020) with the emphasis on how something “is” (Holloway and Wheeler, 2002:171).

Phenomenological researchers are interested in the “consciousness of things”, how something “is”, and thus attempt to “learn to see the invisible and listen to that which is silent”, as they are looking for the essential meaning behind what was said (Solomon and Higgins, 1996:251; Holloway and Wheeler, 2002:171; Dahlberg, Dahlberg and Nystrom, 2008:39).

For the purpose of this research the researcher believes that the reality of the phenomenon (their health care needs) is only known by displaced women who live in a refugee camp. Only they can tell what their needs are.

### 1.9.2 Epistemological assumptions

Epistemology is a Greek word derived from *epistēmē* which means “*knowledge, science*” and *logos* which means the “study of”. Mautner (2005:194) defines it as “the branch of philosophy that inquiries into the nature and possibility of knowledge”. Epistemology, according to Polit and Beck (2008:13 & 339) and Holloway and Wheeler (2010:21), refers to the theory of knowledge and to what knowledge is considered as valid and what knowledge can be justified as true. In a researcher-participant relationship the researcher interacts with participants by listening and observing while assuming that the information that is provided to him/her by participants is valid and true. Participants know the phenomena because they have experienced them. In the naturalistic paradigm there is an interaction process between the researcher and the participants.

The epistemological viewpoint in this study is that displaced women know the phenomenon well and were thus given the chance to describe their lived experiences with regard to their health care needs. The researcher interacted with the participants while holding her personal beliefs, prejudices, pre-knowledge and biases in abeyance in order to prevent contamination of the research findings. She obtained rich, first-hand information regarding the phenomenon and accepted it as true.

Asp and Fagerberg (2005:3) state that philosophers such as Husserl (1970b); Merleau-Ponty (1962/1999), Heidegger (1962) and Gadamer (1980, 1998) believed that the epistemological perspective focuses on the following concepts: life world, intentionality and circularity.

Life world is a concept that is related to what is often cited in descriptions of phenomenological research as referring “to the things themselves” (Dall’ Alba, 2009:23). The concept of life world is fundamental to Husserl’s view of epistemology. Husserl, according to Dall’ Alba (2009:23) wants to reach the basics of all knowledge that transcend human experience and he used the term “life world” to describe the everyday world in which people are ‘embedded’ and from which they cannot escape (Dall’ Alba, 2009:23). Life world is described by Steinbock (1995:87-8) as interchangeable with the expressions “envirning-world”, “everyday world”.

Phenomenological researchers believe that the “envirning life world” is the original source of all evidence in research (Steinbock, 1995:88-9). In this study the researcher went out to participants to obtain the information from the original people who lived the experience and who had the knowledge about the phenomenon health care needs.

The concept of intentionality is derived from the Latin verb “intentio” which is also derived from the word ‘intendere,’ which means being “directed” or “directedness”. The phenomenological researcher is interested in the “directedness” of consciousness. The concept intentionality in phenomenological research expresses the basic properties of consciousness, namely that it only exists when it is directed towards an object (Streubert-Speziale and Carpenter, 2007:78; Smith, 2008:1). When human beings are conscious, that consciousness is aimed at something (Holloway and Wheeler, 2010:214). During the interviews with the participants they focus their

consciousness on their health care needs and discussed their lived experience thereof with the researcher.

Circularity is one of the important concepts of epistemological phenomenology that is essential for understanding the reality and reliability of the knowledge of the research and what is being researched (Liddle, 1988:41). Circularity is the total map of reality (Liddle, 1988:42). In this study the researcher interacted with the participants and gathered reliable and rich data from participants who have the knowledge.

### **1.9.3 Axiological assumptions**

“Axiology” which means “the philosophical study of values” is a Greek word comprising of “axia” which means “value” or “worth” and “logos” which means “value-laden and biased” (Free Online Dictionary). According to Polit and Beck (2008:14), axiology is the study of the nature of values or quality that involves ethics. Axiology also refers to the role of values in the research. This concept is used by philosophers to refer to theory of value (Mautner, 2005:62). The researcher subjectively interacted with participants in order to have an understanding of the reality of the phenomenon “health care needs”.

In this study the researcher regarded the information presented to her by participants as valuable and worthy. The researcher was open to the descriptions of the phenomenon health care needs as presented to her by the participants. The researcher had no connection with participants before or after the research, no statements of past experience about the phenomenon were made by the researcher before, during and after interviews in order not to bias the findings (Polit and Beck, 2008:14; Creswell, 2003:184). The researcher was the only person involved in the data collection process.

### **1.9.4 Methodological assumptions**

According to Polit and Beck (2008:13) methodology is based on methods used to gain data and on how evidence is best obtained. “Methodology” refers to the specific methods and tools that were used to conduct the study as well as the best methods by which knowledge about the phenomenon “health care needs” is gained (Fouche, 2002:120). “Methodology” also refers

to the inductive processes and tools that the researcher uses to seek in-depth understanding of the phenomenon under study (Polit and Beck, 2008:13). The researcher conducted in-depth face-to-face interviews with the participants and listened to the participants' descriptions of the phenomenon "health care needs". The researcher tape-recorded all the interviews at the same time as observing participants.

This study took the form of a qualitative, descriptive phenomenological study. This type of study gives the researcher an opportunity to gain first-hand quality data from participants. The researcher believes that the data gained is true and correct because it was described by those who lived the experience.

Knowledge is acquired through different methods and techniques. These are being taught in the classroom, shown procedures in the simulation laboratory, reading from the textbooks, reading published research articles, and being shown by senior nurses how to carry out procedures in the clinical setting and watching others carrying out procedures is valuable according to Polit and Beck (2008:12-3).

Carrying out research is another way of acquiring knowledge. The aim of research is to have quality, valid, reliable and scientific proven findings as evidence that support and clarify curiosity. Many ways of acquiring knowledge in the nursing profession are difficult to be scientifically evaluated and proven. However, the knowledge that is acquired through research is scientifically validated and scientifically acceptable and is proven as correct (Polit and Beck, 2008:12-3).

Knowledge in nursing practice is acquired through intuition. Intuiting is the direct perception of the truth and fact. It is the insight and understanding of something instinctively. Intuiting is a type of knowledge that is used in nursing practice that is not explained on the basis of reasoning or prior instruction. Intuiting is "an eidetic comprehensive or accurate interpretation of what is meant in the description of the phenomenon under investigation" (Streubert-Speziale and Carpenter, 2007:79) that leads to a greater understanding of the phenomenon and works hand in hand with bracketing.



The researcher remained open to the description related to the women's health care needs as presented to her by participants who experienced it until a common understanding about the phenomenon emerged (Streubert-Speziale and Carpenter, 2007:79). The researcher was able to ensure bracketing by suspending her own beliefs and assumptions about the phenomenon throughout the research process, so that no bias or prejudices arose throughout the research process.

Knowledge can also be acquired through reasoning. Inductive reasoning refers to “the process of developing generalisations from specific observations” Polit and Beck, 2008:13, 755; Streubert-Speziale and Carpenter, 2007:10; Streubert-Speziale and Carpenter, 2003:458-9; Burney 2008:4-7; Trochim, 2006:1). The researcher applied inductive reasoning approach to this study. The researcher gained details of the experiences from the participants first before generalisations (Streubert-Speziale and Carpenter, 2007:10).

Deductive reasoning according to Polit and Beck (2008:13, 751-755); Streubert-Speziale and Carpenter (2003:458-9) and Trochim (2006:1) refers to “the process that works from the more general to more specific observations or the “top-down” approach”. This approach is not applicable to phenomenological research therefore the researcher applied inductive reasoning approach.

In this study the researcher interacted with participants who lived the experience. The researcher sought in-depth understanding of the phenomenon: the health care needs of displaced women. The researcher sought what participants lived and what they truly knew. She collected rich data through in-depth face-to-face interviews with displaced women through their description of their living experiences related to health care needs and through data analysis. The information that the participants provided was valuable and reliable and regarded as true. The researcher confirmed the accuracy of the data through follow-up visits to the participants to ascertain the credibility of the findings (Polit and Beck, 2008:545).

## **1.10 OUTLINE OF CHAPTERS**

Chapter 1 provides the overview of the research, problem statement, significance of the study, research questions, aim of the study, research objectives, clarification of key concepts, background and rationale, the researcher's frame of reference and the researcher's assumptions.

Chapter 2 describes the research design and methodology. The design of the research, sampling and data collection methods, ethical requirements and measures for ensuring trustworthiness are described.

Chapter 3 describes the findings of Phase 1 of the research-data analysis according to the experiences of participants.

Chapter 4 is the discussion of the findings and a literature review for the development of guidelines for the health care needs of displaced women.

Chapter 5 covers Phase 2 of the research, which is the development of guidelines.

Chapter 6 covers the description of the guidelines, the final set of guidelines, limitations of the study, recommendations and conclusion.

## **1.11 SUMMARY**

Chapter one provides an introduction to the study that was conducted on the health care needs of displaced women living in Osire refugee camp.

## **CHAPTER 2**

### **METHODOLOGY OF THE RESEARCH**

#### **2.1 INTRODUCTION**

The previous chapter provided an introduction to the study under the following headings: introduction to the study; background to and the problem statement; aim and objectives of the study; research question; significance of the study; clarification of key concepts; and the frame of reference of the researcher.

Chapter two explains the phenomenological research design that was used to explore and describe the health care needs of displaced women who live in Osire refugee camp in Namibia. Phase 2 of the research, which is the development of health care guidelines to address the identified needs, is briefly described. A more comprehensive description is included in Chapter Four.

#### **2.2 PHENOMENOLOGY AS A RESEARCH PARADIGM**

According to Barkway (2001:2), phenomenology is a research methodology that enables researchers to open their own consciousness to the emergence of new meaning regarding the data that the participants provide. The researcher puts aside his or her pre-knowledge about the phenomenon from the start of research until the end as he or she seeks to understand the phenomenon from the participants' own experience (Barkway, 2001:5). The researcher thus focuses his or her consciousness on the experiences of the participants (Holloway and Wheeler, 2002:216).

A phenomenological researcher does not initiate the research process with a study of existing theory but generates theory that is inductively derived from the findings of the study. The researcher observes similarities in the research data and identifies essential emerging features that are grounded in the descriptions and observations of real-world phenomena (Polit and Beck, 2008:755; Streubert-Speziale and Carpenter, 2007:135-7).

The meta-theoretical perspective, theoretical perspective, and research methodology of the research are discussed.

### 2.2.1 Meta-theoretical perspective

“Phenomenon” or “phainemenon” according to Solomon and Higgins (1996:251) refers to the “things as they appear”. Phenomenology thus “attempts to penetrate illusion in order to get to the reality underlying that illusion” (Higgs and Smith, 2006:56) and encourages researchers to “to look and to look again, to explore and to reflect” on what is experienced (Higgs and Smith, 2006:56).

Phenomenology as a philosophy was founded by Edmund Husserl (1859-1938), a mathematical philosopher (Sharan, 2009:24 & 27) who adopted his ideas from those of his teacher Franz Brentano (1838-1917), a philosopher and psychologist, who proposed a “descriptive or phenomenal psychology”. Husserl defined phenomenology as the “scientific study of essential structures of consciousness”, meaning that the world can be studied through the consciousness of people (Cogswell, 2008:84; Solomon and Higgins, 1996:1). Through research the content of consciousness is studied (Appignanesi, 2003: 118).

Phenomenology was further developed by Merleau-Ponty (Finlay, 2008:1) who stated that the consciousness is always directed to an intentional object and that in phenomenological research the researcher focuses intentionally on the object of the experience in the same way as the research participant does when he or she experiences the phenomenon (Appignanesi, 2003:117-8).

Husserl’s motto “*to the things themselves*” rather than “*to the preconceptions researchers usually filter their experiences through*” (Cogswell, 2008:84) urges the researcher to get to understand the world through the experiences of his or her research participants. The focus is on studying what makes “some-‘thing’ what it is” (Streubert-Speziale and Carpenter, 2007:76-8). That ‘something’ reflects the essential structure of the phenomenon “that make the object into the type of object it is” (Zahavi, 2003:39). This means that researchers should look out for the purest description of the phenomenon by going to the sources themselves (research

participants) while all ready-made theories and preconceptions are bracketed (Cogswell, 2008:86).

Although the concept of phenomenology was used by philosophers such as Brentano, Mach, and Pfänder to look “beyond that which is directly given in our experience”, it was Husserl’s continued effort that established phenomenology as a method to find and guarantee the truth of the description of the phenomenon (Mautner, 2005:464; Giorgi, 2005:76).

Philosophers such as Heidegger (1889-1976), Sartre and Merleau-Ponty (Cox, 2009:26, 36 & 52) continued to refine the understanding behind the concept phenomenology of perception and essence of consciousness. Merleau-Ponty further described phenomenology as a transcendental philosophy which put in abeyance thoughts from the natural attitude in order to understand the dualism of body and mind better (Delius, Gatzemeier, Sertcan and Wünsch, 2005/7:98).

Through phenomenological research the detailed lived experience of the phenomenon is studied to gain a deeper understanding of the experience as it has been presented to the researcher’s consciousness (Lane, Newman, Schaeffer and Wells, 2011:3). “People’s everyday experiences” are studied through deep in-depth face-to-face interviews and by posing open-ended questions (Barkway cited in Lane, *et al.* (2011:5). Phenomenological research also requires a thorough descriptive data analysis until the essence of the phenomenon emerges. The phenomenological researcher tries to dig deeper into the illusion of a phenomenon to find the reality underlying that illusion (Higgs and Smith, 2006:56).

A deep understanding of the phenomenon is obtained when a preconceived understanding of the phenomenon is put aside and openness is applied to the experience as it is presented to the researcher by the research participants (Lane, *et al.* 2011:3-5).

Preconceived understanding refers to thoughts or knowledge and ideas that a person possesses about the phenomenon before the actual research is conducted. This knowledge is acquired either from a literature review or from reports of previous research findings. This prior knowledge can cause bias in the findings of the research and should be bracketed.

In the view of phenomenology acts are *noema* and consciousness is *noeses*. A *noema* is “the sum total of what is thought or meant of an object in an act” (Smith and Smith, 1995:88). What is immediately and primarily given to phenomenological researchers is unarticulated raw material, which their *noeses* should structure into objects, their properties and interrelations (Smith and Smith, 1995:81).

The essence is discovered through transcendental thought, which refers to the reflection on subjective acts and their objective relations (Smith and Smith, 1995:79). Moustakas (1994:2) defines transcendental thought as “a scientific study of appearance of things, of phenomena just as we see them and as they appear to us in our consciousness”. Transcendental phenomenology aims at “eliminating everything that represents a prejudgments or presupposition and describe things as they are and to understand the meanings of things and their essence in the light of intuition and self-reflection” (Moustakas, 1994:2). Phenomenological researchers should thoroughly explain the essence of the phenomenon according to its constituents (Moustakas, 1994:2). The constituents are parts of the whole of the phenomenon. In other words: there is a relationship between the subjectivity of knowing and the objectivity of the known (West, 1996:90).

Phenomenology as a philosophy and research method is also concerned with “going to the things themselves” (Cogswell, 2008:86). Things are the “things of experience”; thus, the understanding of the people’s world by the researcher as it is experienced by the people who lived it. Going to the things according to Solomon and Higgins (1996:270), means that phenomenological researchers avail themselves to the experience that is described to him or her so that the things (experiences) can “show” themselves to them. To avail one to the things means to suspend one’s pre-knowledge and assumptions and judgments about the phenomenon in question and open one’s mind to the pure descriptions of the phenomenon by those who have lived it (Solomon, 1978:151).

Phenomenological researchers should distinguish between natural standpoints and phenomenological standpoints (Solomon and Higgins, 1996:251). Natural standpoints according to Husserl are the “ordinary everyday viewpoints, describing things and state of affairs”, while phenomenological standpoints refer to “a special viewpoint achieved by a

phenomenologist as he focuses not on things, but his consciousness of things” (Solomon and Higgins, 1996:251). This means that phenomenological researchers should pay attention to “the things themselves” - meaning to the phenomena and not to natural objects.

Intentionality of consciousness is a core concept in phenomenology (Zahavi, 2003:14; Giorgi, 2005:76). It is also called the “axis of phenomenology” by Natanson (1973) cited in Lane, *et al.* (2006:5). It forms the central point of all phenomenological research as the essence of the phenomenon under study is explored through the study of the intentional consciousness of the participants.

The act of consciousness of the subjects (participants in the research) is intentionally directed at the object (their health care needs) (Solomon and Higgins, 1996:251), and can thus be studied through a description of the intentional consciousness of the participants. Intentionality is the relation between consciousness and its object (Zahavi, 2003:15), the combination of the “outward appearance of something and how it looks like inside ones’ head” (Moustakas, 1994:2). “No single appearance captures the entire object and the object is never exhausted in a single givenness” (Zahavi, 2003:16). This does not mean that objects hide but that researchers should look for what Zahavi (2003:16) calls “an identity connecting all of the different appearances”.

Intentionality also refers to experience, which means “back to the things” and according to Husserl (Moustakas, 1994:2), which means that the researcher will find meaning that was previously “hidden” from observation (Delius, Gatzemeier, Sertcan and Wünsch, 2005/7:97; Lane, *et al.* 2006:4). It does not mean that the researcher should go back to the natural attitude as it relates to the phenomenon, but rather that the researcher searches for confirmation of the phenomenological attitude of the phenomenon. Phenomenological researchers look again and reflect on what they have observed to have a full description of the phenomenon. They learn from those who have experienced the phenomenon (Moustakas, 1994:2-3; Giorgi, 2005:76).

Being human means “being-in-the-world, being engaged in the world and engendering meaning from the interaction with the world” (Lane, *et al.* 2006:5). The “existential idea of being-in-the-world means that meaning (in the world) emerges from the interaction of subjects

(persons) and objects (experiences)” that indicates the “interdependence of subject and world” (Lane, *et al.* 2006:5). Higgs and Smith (2006:55) summed the interdependence of the subject and the world as “we are in the world and the world is in us”. Consciousness is intentional and philosophers such as Sartre (Solomon and Higgins, 1996:281), believes that consciousness is always directed at something, an ‘object’.

Researchers need to distinguish between the intended objects (objects of consciousness) and the consciousness of such objects (Honderich, 1999:212). To Husserl, Solomon and Higgins (1996:251), “every act of consciousness is directed at some objects”. Without intended consciousness there is not consciousness, as consciousness only exists through intentionality. Thus, phenomenological researchers should be able to differentiate between intentional acts of consciousness and intentional objects of consciousness, which are defined through the content of consciousness. Phenomenological researchers should therefore look at “the conscious ideas of things not things of natural objects” (Solomon and Higgins, 1996:251).

In phenomenology, the intended objects are ‘essences’, and according to Husserl, objects of consciousness that appear to us are ‘phenomena’ (Solomon and Higgins, 1996:251). It is through phenomenological research that essences and their interrelations are explored and described (Honderich, 1999:212). The world, as presented in phenomena is described as it is experienced by people.

The phenomenon as the focus of the study of the world is defined as an essence which is “a structure of essential meanings that explicates a (the) phenomenon”, or “what makes the phenomenon that very phenomenon” (Cogswell, 2008:86).

The essence according to Husserl is “an almost occult quality, a hiddenness of things” (Zahavi, 2003:25). Meanings or essences are those defining traits and occult properties of the phenomena. According to Husserl, all the knowledge of objective phenomena is based on the subjective experience of those phenomena of people who are research participants (Cogswell, 2008:85).



When researchers rely on participants to reveal their understanding of the object to them they should be prepared to look and to listen without any preconceptions for the pure description of the phenomenon (West, 1996:87). Phenomenological researchers do not rely on generalisation of findings or prediction of findings, but, instead, they look at the phenomenon itself, which is “the thing and parts that constitute it” (Giorgi, 2005:75).

### **2.2.2 Theoretical perspective**

Theory, according to Polit and Beck (2008:144), is a word that is used in research to also include conceptual models. A theory does not only originate from facts and observable evidence, but also from the fact that facts are pulled together and, the researcher tries to make sense of them (George, 2002:5). In phenomenological research a theoretical framework does not structure the research.

Once the data has been collected, and the essence supported by the meaning units (constituents) has been formulated, a literature review is done to discuss the findings in comparison to existing literature for the development of guidelines to address the health care needs of displaced women.

In this research, because of its phenomenological nature the researcher is guided by an inductive approach and theory will emerge after data collection and analysis have occurred.

### **2.2.3 Methodological perspective**

The inductive approach allows the researcher through data analysis, to observe similarities and identify essential features and to develop guidelines to address the health care needs of displaced women (Polit and Beck, 2012:268). The result of phenomenological research, according to Polkinghorne (1989) and cited in Lane, *et al.* (2006:6), is the “description of the essential structure of the experience”. Phenomenological research allows the researcher to fully understand the phenomena in question and to do data collection and analysis with an open mind as prejudices are put aside.

In phenomenological research in the view of de Marrais (2004), the researcher aims to “attain a first-person description of some specified domain of experience” (Lane, *et al.* 2006:6). He or she learns from the experience of the participant while the participant is an expert because she or he has lived the experience. The participant leads the conversation and the researcher only asks few short, descriptive questions to guide the discussion (Lane, *et al.* 2006:6).

According to Edmund Husserl (Solomon, 1978:153), phenomenology as a research method does not explain findings but seeks to reduce experiences to essential meanings. Phenomenological researchers go beyond the natural standpoint as presented to them by the research participants to look for the meaning of the natural standpoint in order to formulate the phenomenological standpoint of the phenomenon (Solomon, 1978:159). The research methodology is based on how data is best obtained and it embraces the principles and ideas that assist in understanding the background to the method of research (Holloway and Wheeler, 2010:21).

The emphasis in phenomenological study is on how something ‘is’ as it is experienced by the subjects (Creswell, 2003:15; Wagner and Cohen cited in Streubert-Speziale and Carpenter, 2007:76-77). It is thus a search for how people understand their experiences (Groenewald, 2004:5; Brink, 2009:113). The focus of the research is thus to explore the phenomenon as ‘it is experienced by a subject’ (LoBiondo-Wood and Haber, 2010:104). It involves a study of people’s everyday life and their social interaction with their world (Sharan, 2009:25).

Husserl’s philosophy directs phenomenological researchers to the purest description of experiences with the aim of getting essential truth out of description and refraining from interpretation (Burns and Grove, 2007:228). Descriptive phenomenology according to Polit and Beck (2008:228) refers to the careful description of human experience of everyday life. It involves direct exploration, understanding as well as analysis, and description of a particular phenomenon while emphasizing the richness, breadth, and depth of those experiences gained through the words of participants. The researcher interviewed displaced women to gain in-depth understanding of their health care needs.

Descriptive phenomenology requires the researcher to identify his or her personal pre-knowledge and understanding of the phenomenon in question; to set them aside and make sure they do not influence or bias the descriptions of the participants (Solomon, 1978:182). The researcher opened up her mind to the world of phenomena as it is described and presented to her by those (displaced women) who lived it.

Descriptive phenomenology is described as three concepts: bracketing, intuiting and eidetic reduction. These concepts are described by Solomon and Higgins as essential to phenomenological research methodology (Solomon and Higgins, 1996:252). (Refer to 2.3.1.1).

## **2.3 RESEARCH METHODOLOGY**

The study was conducted in 2 phases:

- In Phase One the researcher explored and described the health care needs of displaced women living in the Osire refugee camp in Namibia.
- In Phase Two the researcher developed and refined guidelines for nurses to address the health care needs of displaced women living in Osire refugee camp.

### **2.3.1 Phase One of the research: Exploration and description of the health care needs of displaced women living in the Osire refugee camp in Namibia.**

#### **2.3.1.1 Introduction**

The researcher used a phenomenological research approach and, in particular, descriptive phenomenology to explore and describe the health care needs of displaced women living in Osire refugee camp in Namibia. Descriptive phenomenological research is described under the following sub-headings: bracketing, intuiting and eidetic reduction.

#### **Bracketing**

Bracketing, according to Polit and Beck (2008:228) refers to a situation in which the researcher withholds his or her thoughts and beliefs with regard to the phenomenon in question. According to Husserl (Solomon, 1978:165 & 178; Moustakas, 1994:3; Solomon and Higgins, 1996:251), to “bracket” is to put aside “all questions of truth or reality and simply describe the

content of consciousness” (Solomon and Higgins, 1996:252). With bracketing the researcher describes what is given to her without preconceptions. The researcher suspended all judgments of and interpretations of her own experiences to look at the phenomenon itself and to accept the experience of the research participants (the displaced women) as true and valid (Cogswell, 2008: 86-7). According to Sharan (2009:25), bracketing refers to a situation whereby the researcher puts aside and withholds all the thoughts and beliefs and theories with regard to the phenomenon in question and refrains from judgments, assumptions and personal prejudices so that the researcher can understand fully the experience as described by the participant in her own view. The phenomenological standpoint, in the view of Husserl (Solomon and Higgins, 1996:251-2) is achieved by applying phenomenological reductions, which is also referred to as “epoche” or “suspension” (Appignanesi, 2003:119).

Epoche helps phenomenological researchers to avoid contamination of the research findings (Solomon, 1978:178). All presuppositions and personal experiences with regard to the phenomenon are suspended. The pure descriptions of experience as presented by the participants are considered as the only true descriptions (Solomon and Higgins, 1996:251-2). Phenomenological epoche is aimed at accepting things the way they are given. In the view of Holloway and Wheeler (2010:216), phenomenological inquiry is important to help examine and realise lived experience that is usually taken for granted.

Through epoche the researcher suspends his or her beliefs about the phenomenon and allows the phenomenon to unfold to him or her (Hamill and Sinclair, 2010:16). With epoche, a phenomenological researcher purely describes the “content of consciousness” (transcendental reduction) or the “essences inherent in the experienced content” (eidetic reduction) (Mautner, 2005:196). The researcher then applied the bracketing as described in phenomenology: “cast aside all systems and preconceptions that filter the perceptions and look directly at the phenomenon itself” (Cogswell, 2008:86). The pre-knowledge that the researcher had about the phenomenon before the research was that displaced women are traumatised, poor, mentally disturbed, people who are dirty, helpless, hopeless, powerless and devastated, dependent and unable to make any decisions.

For the purpose of this research the researcher made sure that her pre-knowledge about the phenomenon, health care needs of displaced women, was held in abeyance. She was continually open to the descriptions participants gave. They were allowed time to describe their lived experiences with regard to their health care needs as displaced women. The researcher listened to their descriptions, tape-recorded these descriptions with the permission of the participants, and simultaneously took notes of key ideas of their descriptions and observed their non-verbal expressions. The notes and the observations were used in the analysis of data.

### **Intuiting**

Intuiting in phenomenological research according to Streubert-Speziale and Carpenter (2007:79) refers to the process whereby the researcher accurately varies the data presented to him or her and what is meant in the description of the phenomenon under study until a common understanding about the phenomenon in question emerges.

The two main aspects of phenomenological research according to Solomon (1978:144) are “necessary truth” and “essence”. In phenomenological research, the researcher aims at finding the truth about the phenomenon in question. Philosophers such as Husserl and Kant (Solomon, 1978:149), share a central point in this regard, as they focused on the “the search for necessary truths”, and in order to do that they advised that one should examine the “immediate data of consciousness”. The result of such examination produces certain “necessary truths based on the essence of consciousness”.

Researchers’ and all human knowledge begin with experience. Through knowledge researchers have intuition, the “eidetic intuition” or “essential intuition” which, according to Husserl’s and Kant’s philosophy (Solomon, 1978:155), is “that through which objects are immediately given”. These objects are phenomena. Because phenomenology is the study of phenomena, it is also the study of “whatever is immediately given in consciousness” (Solomon, 1978:155).

According to Husserl, all necessary truths are given in intuition (Solomon, 1978: 55) and, according to Kant’s philosophy of understanding; researchers need to understand these truths.

Phenomenon is “whatever is given in intuition and intuition is whatever is given to consciousness”. According to the philosophy of Husserl, researchers should bear in mind that what is given is not theoretical or abstract entities and is not an interpretation of something, but a description of something that is described apart from any theoretical or interpretive considerations. For Husserl, researchers can only know the truth through insight into essential intuition and through examination of essences.

Furthermore, Husserl indicated that, the search for absolute and necessary truth becomes the search for essence (Solomon, 1978:157) and researchers “can know the truth because they can examine essences”. For the researcher to know the truth s/he should exercise what Husserl calls “*epoche*” or bracketing (which is explained in the previous paragraph).

In phenomenological research, the knowledge and truth about the phenomenon is only known and can only be well described by those who lived it; i.e., the research participants. Intuiting is the step in descriptive phenomenology whereby the researcher begins to know the phenomenon as it is described by those who lived it and strictly pays attention to the phenomenon as it is presented by participants (Streubert-Speziale and Carpenter, 2007:85). Husserl in Solomon (1978:154-5 & 157) insists that “the necessary truth is given in intuition”.

The researcher as an instrument in the interview process was totally open to the descriptions as attributed to her about the phenomenon by displaced women as suggested by Morse and Field (2002:125). The researcher listened to participants, audio-taped the description of their health care needs and took notes of every participant’s descriptions to record all details pertaining to the researcher’s observations with regard to the participants’ behaviours and attitudes such as fear, facial expressions, and anxiety, which were then added to the transcribed data to help achieve the most comprehensive and accurate description of the phenomenon possible. The recorded interviews were transcribed verbatim and studied. The notes and observation was added to the data during analysis to ensure that no data is left out.

### **Eidetic reduction**

Eidetic reduction is derived from a Greek word “*eidos*” which means essence, and it is one of the key strategies in phenomenological research (Dahlberg, *et al.* 2008:54). According to

Bradbury-Jones, Sambrook and Irvine (2009:664), eidetic reduction is an “epistemological strategy that requires the person to reduce the world as considered in the natural attitude to a world of pure phenomena”, which is achieved through bracketing. Appignanesi (2003:119) states that reduction ignores metaphysical and theoretical distractions and seeks for content of consciousness and its essential features of “intentionality”. In this research the researcher tried to grasp the essence from the descriptions of the participants.

With eidetic reduction the researcher “eliminates the merely empirical content of consciousness and focuses instead on the essential features, the meanings of consciousness” (Solomon and Higgins, 1996:252; Giorgi, 2005:77).

For the purpose of this study the researcher was open to the information that was presented to her and during data analysis allowed the meanings to appear without making premature conclusions about the findings until the essence emerged.

### **2.3.1.2 Preparation for data collection**

In this study the researcher obtained permission to conduct the research from the relevant bodies. The Faculty of Health Sciences Research Ethics Committee-University of Pretoria, the UNHCR-Namibia in the Ministry of Home Affairs and Immigration Office in Windhoek, the UNHCR office at Osire camp, the camp police, the camp administrator and the leader of the women’s organisation in the camp studied the proposal and gave permission that the research be conducted. The UNHCR and the camp administrator were informed that the findings would be made known to them once the research has been completed and the report (thesis) assessed and approved.

The following is a description of the process that was followed:

#### **The role of the researcher**

The role of the researcher according to Creswell (2007:177-8) should include the gaining of entry to the research setting, identifying personal values and interests that might bias the findings of the study and issues concerning ethical requirements. In this

research the researcher acted as an outsider, while the research participants were insiders (TerreBlanche and Durrheim, 1999:402).

Confidentiality, privacy and anonymity, voluntary participation, and easy withdrawal from the study, informed consent and the participants' benefit from the research were discussed with participants in a group and with every participant individually before the commencement of each interview.

Participants were also asked to give written consent (Addendum 1). In the documentation all criteria for participation were explained. The participants were asked to give consent for the audio recording of the interviews. They were given opportunities to ask questions if something was not clear. Only when they were satisfied that they had made an informed decision were they requested to sign the "informed consent form" as an indication of their voluntary participation as well as permission for their interviews to be audio recorded.

During the interviews the researcher as an outsider allowed participants to describe the experiences regarding their health care needs as they lived and experienced them. The researcher allowed participants to ask questions before and after the interview.

### **Gaining entry to the setting**

Whoever enters Osire refugee camp should seek prior written permission from UNHCR in Windhoek stating the dates when one intends to visit the camp, the aim of the visit, where one will stay and the duration of one's activities in the camp. For the purpose of this study, permission to enter the refugee camp was sought and granted from the acting High Commissioner for Refugees-Namibia and the immediate supervisors of the camp in August 2010.

Final permission and consent to conduct research was also granted by the UNHCR office in Windhoek and by the immediate supervisors of the camp upon arrival at Osire refugee camp after they were provided with the written approval from the UNHCR during the actual research (April 2011) (Addendum 5B). These people were



gatekeepers in this research. Gatekeepers are defined as those people who have the power to grant or withhold access to the research setting and who can stop the research depending on the structure of the organisation (Holloway and Wheeler, 2002:47).

The gatekeepers were briefed with the reasons why the site was selected for the study, the aim and scope of the study, the activities that would occur during research, how they would be notified about the findings. Gatekeepers were also told that participation is entirely voluntary and that the research would not be disruptive to the daily official activities in the camp (Streubert-Speziale and Carpenter, 2007:22). Before an outsider proceeds to other offices in the camp one has to report again to the camp police as well as upon leaving the camp.

The research took place between 16 March and 21 April 2011. Because of the nature of the research and the environment the time frame for data collection was regarded sufficient. Upon arrival at the camp, the researcher reported herself at the camp police office before proceeding to the office of the camp administrator as per the policy of the camp. The camp administrator's office assigned a community woman leader (as per arrangement) to the researcher to work with. This community woman leader had the responsibility to assist the researcher with the selection of participants. The community woman leader first oriented the researcher by taking the researcher to the AHA offices and introduced her to the AHA officials, because according to her, she worked under their immediate supervision.

The researcher stayed in the camp for the duration of the data collection because of the scarcity of accommodation in the area. One female official in the camp administrator's office offered to share her room with the researcher because the nearest farm with a guesthouse was **15km** from the camp, while the nearest town was **140km** away and the road is not tarred. Owing to heavy rain it was difficult to drive every morning and afternoon to and from Osire on the mud road. Staying in the camp where the participants lived was advantageous to the researcher because she could interact with

many displaced people who were not participants in this research and also experience what it means and how it feels to live in the camp.

### **Exploring the research setting**

According to Creswell (2007:175), the research setting refers to the physical environment and location in which the research takes place. A natural setting is a place where the participants live or work. Although the setting is usually dictated by circumstances, Warren (cited in Polit and Beck, 2008:399) advocates that participants may be given the opportunity to choose the place where they prefer to be interviewed and where they feel more comfortable and less threatened. This is advisable because it provides the researcher with a good opportunity to observe the participant's interaction with her own world if the interview were to take place in her environment (Polit and Beck, 2008:399). In this study the researcher interviewed the participants in the Osire camp.

The Osire refugee camp is situated some 259 kilometers from Windhoek (the capital city of Namibia). This is the official place where displaced people in Namibia live. The camp is a very big open space which is not fenced except for government and NGO buildings. The UNHCR, the AHA and chief nurse offices are housed in temporary buildings. The other official facilities within the camp include a police station; a post office; a school; a healthcare centre; UNHCR offices; the AHA offices and a warehouse; the office of the camp administrator that falls under the Ministry of Home Affairs and Immigration; government houses for officials; the women's centre; and the youth centre. These official facilities are all fenced with a separate fence each and have electricity.

The exact place where the interviews took place was a room at the women's centre where the women meet for discussions. Other venues were participants' homes that gave the researcher the opportunity to observe the participants' interaction within their own environment.

In the women's centre is an office for the social worker, an office for the refugee women who manages the centre, a sewing room, and a computer room and some other extra

rooms that the women use as venues during their meetings. The section for gender equality has an office in the women's centre. Some of the offices in the women's centre are run by men. The researcher also observed a soccer field as well as a basketball court in the camp. No church building was observed, although some participants indicated that they do attend church.

In the camp, newly admitted displaced people are hosted in tents within the camp and separate from the other displaced people in the camp for a period of three months. After that period, they are allowed to live among the other displaced people and to erect their own houses within the camp. The camp consists of mud-brick houses and tents. The camp does not have a fence, but most houses are fenced. The explanation that was given to the researcher by one of the camp officials why the camp is not fenced is that for political reasons displaced people will be able to run away for hiding in time of danger or if the camp is attacked. The camp appears as an informal settlement such as a 'shanty' town.

The camp had at the time of the research a population of 7,610 displaced people of both sexes, including people across the lifespan as well as people with disabilities from all over the African continent. The displaced people receive on a monthly basis humanitarian aid from the AHA office upon admission to the camp. This aid includes *inter alia* sanitary towels for women, milk formula and nappies for babies and food such as soya beans, sugar, maize flour, salt, paraffin, charcoal and cooking oil. This aid, according to participants, is far too little.

All displaced people are given small pieces of land to build houses and many of them have erected houses made of mud-bricks while others live in tents. Those with houses cultivate some vegetables in their backyards such as spinach, sugar canes, cassava, sweet potatoes, corn, spring onions, and beans.

The houses are not electrified and displaced people are also not allowed to electrify them on their own. There are water points in the camp where refugees and asylum seekers get potable water for household use but displaced people are not allowed to

make water extensions to their houses. There were times during the research when there was no electricity and it rained so heavily that some tents were flattened by the rain while trees were uprooted. No injuries were reported as far as the researcher recalls.

The school has a lower primary phase (pre-grade to grade four), upper primary phase (grades five to seven) and a secondary phase (grades eight to twelve). The school falls under the Ministry of Education in Namibia and follows the Namibian curriculum for all the grades. There is also a literacy programme, mainly English, for people who cannot read and write, and a special English programme for non-English-speaking refugees. Refugee teachers are involved at the school.

The research was conducted at the time when the displaced people were in a crisis situation. The week before the research started, displaced people were visited by representatives of Namibia's Minister of Home Affairs and Immigration and the Namibian High Commissioner for Refugees. Displaced people were informed that they would be repatriated to their home countries. Those representatives informed them that repatriation is a voluntary process and they would be given time to prepare themselves for the repatriation. There was also a misunderstanding regarding food distribution between the people and the AHA officials. Displaced people are people who are vulnerable and need protection with their safety (physical, social psychological and emotional) and human rights. They react with uneasiness when their safety and human rights are compromised. The crisis situation had an influence on data collection in such a way that some participants feared to participate and withdrew from the research while others were afraid to be interviewed individually. The researcher, through the woman representative was able to go through the camp and walk from house to house to select participants who replaced those who withdrew from the research. The crisis situation could also affect the findings because some participants feared to reveal their experience but because the researcher gained trust from them and because of the researcher's profession (professional nurse) they trusted her.

The AHA officials changed the food distribution programme and every person had to present him or herself during food distribution and also their humanitarian aid cards/ration cards. Food was given only to those who were present and no one was allowed to receive food on behalf of a family member or friend who was absent, which was not the case before (UNHCR/WFP JAEM, 2008:260). The displaced people could not understand the decision. According to what people were saying while the researcher was busy in the camp, the first month after the decision was implemented, the displaced people complained, but accepted the food; at the time of the research, however, they boycotted the food distribution.

The researcher's overall impression of the situation at the camp is that people of all ages appeared fit and healthy. They also appeared to be friendly, humble and kind and showed respect to other people. However, they seemed to be bored and at times showed signs of anger about their circumstances. Their houses, though small, were clean and neat and built in rows in streets. There were many children playing in the streets.

### **Gaining trust of the participants**

Gaining trust is said to be the integral part of any research. The researcher needs to establish rapport with the participants so that they are able to reveal their private experiences to somebody they trust (Polit and Beck, 2008:384). In this research the researcher could not visit the camp many times prior to the research but stayed in the camp for the whole duration of the data collection to gain the trust of the research participants. The researcher was sensitive and empathetic towards the participants and managed to build trustful relationships with all the participants. Showing interest and listening attentively to participants' descriptions, asking probing questions and being eager to listen more were qualities that allowed participants to trust the researcher.

### **Identifying the research population**

The research population refers to all individuals with some common traits or defining characteristics (Polit and Beck, 2008:67; 337 & 761) and refers in this study to displaced women who were eighteen years and older, English and non-English speaking who had

been living in Osire refugee camp for at least six months. In the researcher's view six months is an adequate time span for displaced women to be able to reflect and have time to utilise the available health care services to form a perception about the needs that they had regarding health care.

### **Selection of the participants**

According to Burns and Grove (2007:76; 227 & 348), phenomenological research involves a small number of participants who often might be ten or fewer. For the purpose of this research, ten displaced women were interviewed. Participants were selected on the basis of their first-hand experience with the phenomenon under study and their ability to articulate what it is like to have lived that experience (Streubert-Speziale and Carpenter, 2007:29).

Purposive and snowball sampling methods were used. Purposive sampling refers to a non-probability sampling method whereby participants are selected to participate based on their first-hand knowledge and experience of the phenomenon (Groenewald, 2004:9). Purposive sampling was used to ensure that rich data were obtained and the sample size was determined by the quality of information that the participants provided (Burns and Grove, 2007:348). According to the Centre for Research on Violence against Women and Children, "the life experiences of women cannot be universalised, as the meaning of being a woman differs, depending on the particular place, situation, and time"; therefore, the researcher had purposefully selected women who were displaced, were living in Osire refugee camp and who were willing to describe and capable of describing their needs regarding health care.

The researcher investigated the phenomenon with the belief that its critical truth and reality were grounded in the participants' lived experiences (Streubert-Speziale and Carpenter, 2007:95). The sampling method was deemed to be appropriate, as the researcher sought descriptions of lived experiences of displaced women who lived in Osire refugee camp only. The participants provided first-hand information, which benefited the study (Polit and Beck, 2008:355).

Snowball sampling is a non-probability sampling method where participants are selected by asking early participants to nominate other participants who meet the inclusion criteria for the study (Frank and Snijders 1994:53; Browne, 2005:47-48; Charles, Dirk, Claire 1987:1). The researcher used this technique, as she was not acquainted with the displaced women in the camp. The initial recruitment of participants was made through the leader of the women's organisation.

The researcher held the first meeting with possible participants who were recruited by the leader of the women's organisation. The only reservation that the women had about the research was aimed at the planned individual interviews. They preferred to have group interviews, as they were concerned about the possibility that individuals could be identified in the report. The researcher explained the purpose of the research to them, as well as their rights not to take part and to withdraw during the research.

They were assured that all identifying information would be kept confidential and that no individual would be identifiable from the research report. Some of the potential participants withdrew from the research. The remaining potential participants were then asked to nominate other potential participants who met the inclusion criteria (Groenewald, 2004:9).

A chain of referrals and networking between the researcher and potential participants was then created. The advantage of this method is that it is cost effective although some researchers have the fear that it might carry biases with it (Polit and Beck, 2008:354). The researcher was obliged to re-introduce herself and the whole research process with every potential participant.

Inclusion criteria are the criteria that are used to ensure that participants meet the requirements to take part in the research (Streubert-Speziale and Carpenter, 2007:29). For the purpose of this research the inclusion criteria were: displaced women, aged 18 years and above, who were able to understand the content of the consent form and able to consent to the research to participate in the study; were from diverse socio-cultural backgrounds; were working or not working in the camp; and who had been in Osire camp for more than six months.

### 2.3.1.3 **Collection of data**

Data collection is the formal procedure by which needed information is gathered (Polit and Beck, 2008:75). In this study the researcher was the tool for data collection. Streubert-Speziale and Carpenter (2007:85 & 94) state that the researcher as a tool of data collection in qualitative research usually collects the data herself through face-to-face interviews with research participants. The researcher listened to the participants as they describe their lived experiences, took notes and observed each participant throughout the interview process (Groenewald, 2004:13).

Before the interviews, the researcher met with the potential participants and explained the research process and answered their questions. Informed consent was obtained from the participants before the interviews were conducted (Addendum 1).

Unstructured, in-depth face-to-face interviews were done to collect data from ten participants. Their ages ranged between 18 and 53 years old. They were from different countries and had different socio-cultural backgrounds. Their reasons to fleeing to Namibia were mainly civil war and political instability in their countries.

Unstructured interviews are referred to as “open-ended interviews” whereby the participant could provide a wide range of information (Denzin and Lincoln, 2000:652). The interviews were audio recorded with the permission of the research participants and field notes were written during and immediately after the interviews and observations of the participants were made. The field notes and the observation were used during data analysis. Audio recording enabled the researcher to give the participant full attention during the interview (Reinecke, 2008:40-1). Each interview was assigned a number in the audio recorder, which matched with the number on the researcher’s field notes for identification purposes.

The researcher was assigned a private room within the women’s centre where the first interviews were conducted. Not all interviews were, however, conducted in the centre. Some were conducted at participants’ homes. During the last day of the interviews the researcher went to houses in the camp with the community woman’s leader and



interviewed the last four participants in their own homes. These participants were also recruited by the leader of the women's organisation.

The interviews had to be done at the homes of the participants because of the unresolved food crisis in the camp and the displaced people's refusal to leave their homes while they had been waiting for feedback from the camp authorities. The home visits gave the researcher the opportunity to observe the living conditions of the participants. A female youth interpreter was purposefully recruited to translate the interview of one of the participants who was not able to communicate in English. The interpreter was of the same age as the participant and both the participant and the researcher felt comfortable to discuss women's healthcare issues in the presence of the interpreter. The interpreter was briefed of her role as an interpreter and the necessity of keeping all information confidential.

The research participants were asked to describe what health care needs they experienced during their stay in the camp and also to describe what health care services according to their experience are required which would address their health care needs. The question: "*What are the health care needs of women living in Osire refugee camp and how can these health care needs be addressed?*" were asked to all the research participants. Probing questions were used to encourage the participants to elaborate on their experiences in detail (Streubert-Speziale and Carpenter, 2007:95).

The researcher encouraged a reflective dialogue with each participant to address the phenomenon as thoroughly as possible. The researcher made a concerted effort to direct the participant's awareness towards the phenomenon of interest. According to Dahlberg *et al.* (2008:187) "questions and comments should be a matter of the researcher's spontaneity and commitment during the interview, but all the time lead to the phenomenon."

The participants seemed careful not to complicate their situation of being displaced people. They were, at the beginning of the interviews, hesitant to talk openly about their

health care needs as if they did not want to 'say something wrong'. The withdrawal of some potential participants was also a sign of a general feeling of insecurity.

One of the participants described the experience in no uncertain terms:

*"They help us, they are really helping, but we suffer..."*

*"...they will just tell you that you are selfish, you want someone to be fired or what..."*

*"You keep quiet and just watch them..."*

*"...if you try again may be they will give you punishment..."*

Only once the researcher had established a good rapport with the participants did they start to talk openly.

The researcher's profession also encouraged the participants to discuss their situation with them.

*"For you to understand, okay, because you are so...a nurse, I can talk..."*

Even though this participant had managed to reveal her situation, she was struggling to find words to describe her experiences. It seemed to the researcher as if the displaced women lived a life that was different from the life outside the camp. Many people in the camp knew the personal health information of others and even the HIV status of other people:

*"Everybody (is) scream on me, point fingers on me...I don't know how they find out...if they just find out that you are (HIV positive), they start pointing at you...yeah...they send smses to each other...they'll write the names of the people who are (HIV) positive they say the top ten HIV positive in Osire...the top ten prostitutes..."*

The researcher supported the participants when they showed signs of distress and made sure that they have regained composure before the interviews continued. She had also arranged for a counselor to be available should the need arise to refer one of the participants. The researcher made field notes of what she saw, heard and observed that could not be captured by audio recording during the interviews (Streubert-Speziale and Carpenter, 2007:43). The field notes also reflected the observations of the

researcher regarding the life in the camp and served as an additional source of data during data analysis.

The field notes are described under the following headings: observational, methodological, theoretical and reflective notes and each type will be discussed with examples.

### **Observational notes**

Observational notes are descriptions of observed occurrences, dialogue and information regarding actions. The researcher observed the participants' non-verbal behaviours such as facial expressions, crying, anxiety, making and maintaining eye contacts during the interviews (Polit and Beck, 2008:406-7).

<b>Examples of observational notes</b>
<p><b>Participant 1:</b> The participant was self-assured in the beginning but became emotional in the middle of the interview. She maintained eye contact. She seemed careful not to complicate their situation of being displaced persons. She was a bit hesitant to talk openly in the beginning, but later on relaxed.</p> <p><b>Participant 2:</b> She was very calm and focused throughout the interview process. She was clear about her concerns and maintained eye contact throughout. She showed powerlessness and helplessness and was concerned about the life in the camp. She seemed careful not to complicate their situation of being displaced people.</p>

### **Methodological notes**

Methodological notes are reflections on the methods and strategies used during the interviews that helped reminding the researcher to keep to the research methodology (Polit and Beck, 2008:407).

### Example of methodological notes

**Participant 1:** When the researcher listened to her descriptions she realised that because of the painful experiences the participant had been through she became too emotional that at times she deflected from the topic. The researcher allowed her to continue without stopping or interrupting her, but was able to probe and paraphrase.

### Theoretical notes

Theoretical notes enable the researcher to figure out and find the meaning of what is going on while in the field and what the starting points are for subsequent data analysis (Polit and Beck, 2008:407). The researcher made notes of the observation of the experiences that were described by more than one participant and attached a professional experience to it.

### Example of theoretical notes

**Participant 2:** The participant felt powerless in her description: *“You keep quiet and just watch them, life goes on...”*

### Reflective notes

According to Crabtree and Miller (1999:65); Finlay (2002:209; 2002:531) reflective notes are notes that the researcher writes to herself about his or her thoughts during the data collection process. The researcher identified her pre-knowledge about the phenomenon and suspended it through bracketing to eliminate any bias in the findings.

### Examples of reflective notes

**Participant 6:** The researcher suspended her feelings and emotions through bracketing as the participant described the abuse she suffered by her man.

**Participant 7:** From the researcher’s professional point of view (professional nurse) she almost showed concern as she was touched by the participant’s description of living with her HIV positive husband.

#### 2.3.1.4 **Analysis of data**

The researcher used the descriptive phenomenological data analysis method designed by Colaizzi (cited in Holloway and Wheeler, 2002:180-1) and the method of data analysis as described by Dahlberg *et al.* (2008: 231-250) to describe the phenomenon without interpretation or explanation (Dahlberg, 2006:12). The researcher considered the methods of data analysis both the one designed by Colaizzi (Holloway and Wheeler, 2002:181) and that is described Dahlberg (2008:231) appropriate because they allow the researcher to have feeling for the descriptions by identifying significant statements, spell out meaning of every statement and integrate it into exhaustive description of the phenomenon under study.

Data analysis in phenomenological research is aimed at understanding and describing the essence of the phenomenon and its substantiating constituents or, in other words, the meaning that constitutes the essence related to the phenomenon under study (Norlyk, 2009:4; Dahlberg, *et al.* 2008:231). Thus, the essence should appear in each meaning constituent and the constituents should be essential parts of the essence (Norlyk, 2009:4). Data, in phenomenological research is meaning oriented (Dahlberg, *et al.* 2008:232). In other words the aim of data analysis is for researchers to look for and to understand the “deeper meaning” of the phenomenon (Bloomberg and Volpe, 2008:127).

The researcher approached the data that was presented to her by participants with openness and applied ‘bridling’ to hold herself back from premature understanding of the phenomenon until the meaning of the phenomenon emerged (Dahlberg, *et al.* 2008:241). ‘Bridling’ refers to the attitude that a phenomenological researcher adopts during data analysis and wait until the meaning explicit itself (Dahlberg, *et al.* 2008:242). A ‘bridled’ researcher undertakes a ‘bridled’ attitude and is always careful not to make premature conclusions about the phenomenon. The researcher should approach the phenomenon as it is “lived” and, thus, as it is experienced by the participants and also as it shows itself to both the participants and the researcher without taking anything for granted about the phenomenon’s ‘real’ existence (Dahlberg, *et al.* 2008:242).

### **Preparation of the data**

The recorded interviews were transcribed verbatim by the researcher into a text format. Field notes and observation were added to the transcribed text during analysis to ensure that no data relating to an individual participant is left out. Verbal and non-verbal information such as periods of sighing, laughing, crying and hesitations were all included in the transcription. An empty column was left on the left margin of the pages for notes of analysis as advocated by Wertz (2005:172).

### **The initial whole**

The researcher read the whole text (all interviews) and the field notes several times to familiarise herself with the data (Broomé, 2011:13). She also listened repeatedly to the audio tapes while she read the transcribed text. The data was approached with openness in order to see the phenomenon in a new way and to apply bridling (Dahlberg, *et al.* 2008:238).

### **Phenomenological parts**

During this step the researcher divided the data into smaller segments and identified meaning units from the segments of data. The units signaled the experiences of the participants but remained parts of the whole. The researcher moved between the data and the emerging patterns of meaning while she remained open to the data as the participants described it to her. The researcher suspended her pre-understanding and pre-knowledge of the phenomenon and interacted only with the text. The focus was on what was said, how it was said, what content it carried and on what the meaning was (Dahlberg, *et al.* 2008:253).

The researcher clustered the meaning units that seemed to belong together. The clusters served as important intermediate “landing marks” that helped the researcher to identify essential meanings and structures (constituents) that describe the phenomenon (Dahlberg, *et al.* 2008:244).

### **Searching for the essence of the phenomenon-a new whole**

The data is again treated as a whole, but with a broader understanding than before. With the application of openness and bracketing the phenomenon (health care needs of displaced women in the Osire refugee camp) was understood better than before. The essence of the meaning of the phenomenon emerged from the data and its supporting constituents were described. The essence, essential meanings and the structure of meanings presented themselves to the researcher's consciousness.

The essence of a phenomenon "makes the phenomenon to be that very phenomenon" (Dahlberg, *et al.* 2008:245). The researcher grasped the essence from the descriptions of the participants by being open to their experiences. During the analysis process she allowed the meanings of the phenomenon to appear without making premature conclusions about the findings until the essence emerged.

The researcher grasped the essence of participants' lived experiences through "imaginative free variation" and the process of phenomenological reduction (Wertz, 2005:172). Imaginative free variation according to Wertz (2005:168) refers to a special method that was developed by Husserl (1913/1962) that provides the researcher rigor in order to know and understand the essence of the phenomenon. The researcher described the phenomenon as it was presented to her consciousness (Maggs-Rapport, 2001:377).

The essence of the phenomenon is supported by the constituents. The researcher focused on the relation between the constituents to describe how each constituent contributes to the experience of the phenomenon as a whole (Wertz, 2005:172). The constituents are interdependent and essential to the whole so that if one constituent is removed, the phenomenon is not that phenomenon anymore.

### **Literature review**

Related literature was incorporated into the findings to add to a comprehensive understanding of the essence and its constituents (Dahlberg, *et al.* 2008:273).

## Description of the findings

The step involves the synthesis and integration of constituents into a final description of the phenomenon under study. The researcher synthesised the constituents in relation to the whole and used descriptive statements to describe it based on their phenomenological “givenness” (Broomé, 2011:16). The description of the essence includes “its constituents and the meanings that constitute the actual essence” (Dahlberg, *et al.* 2008:255). The essence is described in an abstract manner. The constituents are described in a more in-depth manner to illustrate all possible nuances as they were in the original data (Dahlberg, *et al.* 2008:255).

Table 2.1 below shows the biographic information of women refugees who participated in the research.

**Table 2.1: Biographic information of participants: April 2011**

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	Cooking, 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 their church	None
9.	29	Married	1	DRC	Selling fat-cakes	None
10.	32	Single	3	DRC	Taking care of own household	None

### The demographics and general information of the participants

In this section more demographic and general information of the participants is presented. The researcher’s focus in this research was merely on the displaced women’s experience regarding their health care needs as displaced women in the camp



and how those health care needs can be addressed in the camp in the sense that they are all women and had been in Osire refugee camp for more than six months irrespective of the difference in age groups, social location and the years of stay in the camp of the participants. According to the researcher six months is a sufficient time for the displaced women to have lived the experience. Eighteen years is regarded as the legal age in Namibia when a person is can give a written consent. These differences in age group, social relation and years of stay in the camp allowed the researcher to collect broad information related to displaced women which cover all spheres of displaced women.

**Participant one** was from Rwanda and was 42 years old at the time of the research. She was a married woman and had 4 children. Her husband married her on their way to Namibia. Neither she nor her husband has any relatives who survived the conflict in Rwanda. She had been a secretary by profession before she had to flee her home country. She sought refuge in many African countries before she came to Namibia. She was in Burundi, Tanzania, Zambia, Angola, and now in Namibia. She had been in Osire camp since 2003.

**Participant two** was a married Angolan woman with 10 children. She worked as a teacher at the time of the research and had been in Osire for eighteen years.

**Participant three** was a married woman with 6 children from Angola. She did gardening to support her family. She lost both her parents because of the war in Angola. She suffered from hypertension, which she related to too many difficulties that she had to cope with. She did not get much support from her husband.

**Participant four** was a 20-year-old single woman from the DRC who did not complete school education. She could not understand or speak English and the interview was conducted with the help of a female interpreter. Participant four was an orphan and the head of the family of 4 sisters all younger than she was. She had been in Osire camp for three years.

**Participant five** was a 21-year-old single woman with one girl child. She had not completed school education when she got pregnant. She is a very sociable person and fluent in English. She was very open about her being HIV positive for the previous three years and she knew what her CD4 count was. She was not taking antiretroviral medication. Her daughter was also HIV positive and was taking antiretroviral medication. Her mother and sister also lived in Osire. The participant was actively involved in the youth programmes of the camp. She had been in Osire camp for six years.

**Participant six** was a disabled woman from Angola. She was at the time of the research 26 years old and the single mother of three children. The participant was employed as a cleaner of the women's centre for two days per week. She lost her parents, grandparents and siblings during the war in Angola. She had been in Osire for sixteen years.

**Participant seven** was a 23-year-old disabled Angolan married woman with four children. She did not complete school education and was a full time housewife. She had a three-months-old baby girl at the time of the interview and was breast-feeding her. Notwithstanding her husband being HIV positive, neither she nor her baby was HIV positive. Her mother and father had died and she did not know where her siblings were. She had been in Osire for ten years, but had been in Namibia since 1993. She came to Namibia when she was ten years old (in 1993) with her two friends and stayed in Rundu (north-east of Namibia) but was not in a refugee camp at that time.

**Participant eight** was an 18-year-old grade twelve learner who stayed with her parents and siblings in the camp. She was from Angola and fluent in English. She was a self-confident member of the Osire Girls Club (OGC) and also took part in youth activities at school, in the community and at church. She had been in Osire for ten years.

**Participant nine** was a 29-year-old married woman from the DRC with one child. She was very positive about life in the camp. She had been in the camp for five years.

**Participant ten** was a 32-year-old woman with three children from the DRC. She left her husband and a nine-year-old child in the DRC and brought the two youngest children with her. She had been in the camp for six years.

### **2.3.1.5 Trustworthiness of the findings**

Trustworthiness in qualitative research is described as the process whereby researchers seek to satisfy certain criteria so that they present convincing findings that their work is academically and scientifically sound. Researchers try to demonstrate a true picture of the phenomenon under study by providing sufficient detail information about the research method. They also go to great lengths to confirm and validate the correctness of the data (Shenton, 2004:63).

Lincoln and Guba, 1985 (cited in Polit and Beck, 2008:196 & 539) and Polit and Beck (2008:768) state that credibility, transferability, confirmability, dependability, and authenticity are criteria that ensure trustworthiness, so that the research findings may accurately reflect the experiences of the participants and not the perceptions of the researcher.

#### **Credibility**

In qualitative research and according to Lincoln and Guba (cited in Polit and Beck, 2008:196, 539 & 751), credibility is a criterion used to measure believability and confidence in the truth of the information. Credibility according to Shenton (2004:64) refers to whether a true picture of the phenomenon is provided. The researcher ensured credibility of the findings by having had in-depth interviews with participants. She also wrote field notes to add the richness to the data. The researcher also discussed the analysis of the data and the emerging essence and constituents with her study supervisors to ensure that the findings were grounded in the data provided by the research participants (Patton, 2002: 552; Williams and Morrow, 2009:578-9).

#### **Transferability**

Transferability refers to the extent to which the findings of the research can be transferred to or are applicable to other settings or similar groups (Shenton, 2004:63 & 69). The researcher's use of multiple data collection methods increased transferability of

the research (Polit and Beck, 2008: 543). The researcher used in-depth interviews with every participant, took field notes and made observations throughout the interviews and during her stay in the refugee camp. The researcher provided sufficient quotes from the participants to substantiate the findings to enable the consumers to recognise the applicability of the findings (essence of the experience and substantiating constituents) in other settings (Polit and Beck, 2008: 539 & 768).

### **Confirmability**

Confirmability involves the researcher's ability to ensure that the findings represented the data as it has been provided by the research participants and not the perspectives of the researcher (Shenton, 2004:63 & 72). Confirmability of the findings can, according to Streubert-Speziale and Carpenter (2007:49), be proved through a comprehensive description of the processes of data collection and data analysis to enable other researchers to follow the processes in another study. The researcher provided a comprehensive report of the processes under applicable headings in this chapter and in the following chapters of the thesis.

The researcher applied bracketing of her own perspectives throughout the data collection and data analysis processes.

### **Dependability**

According to Lincoln and Guba (cited in Polit and Beck, 2008:539 & 751), dependability refers to the stability of research data over time and under different circumstances. It is through this criterion that credibility can be attained. The researcher ensured dependability of the findings by attaching in addenda relevant supporting documents that could be used by other researchers to confirm the dependability of the findings (Polit and Beck, 2008:549). For verification purposes both the verbatim transcripts and audio-recorded tapes of all the interviews are available.

### **Authenticity**

Authenticity refers to the extent to which qualitative researchers exercise fairness and faithfulness in the analysis and the interpretation of the data so that readers of the

research report are able to develop heightened sensitivity towards and an understanding of the issues that are being reported on (Polit and Beck, 2008:540 & 748) To ensure authenticity the researcher adequately used quotations from the interviews to show to the reader of the report the range of realities of the healthcare challenges of the research participants.

### **2.3.2 Phase Two of the research: Development and refinement of guidelines for nurses to address the health care needs of displaced women living in Osire refugee camp**

In Phase Two the researcher covered the second objective, which was to develop and refine guidelines that could be used in addressing the health care needs of displaced women in Osire refugee camp in Namibia. The guidelines were developed on the basis of the findings of Phase One, and thereafter refined by experts in women's health care. The process is described in more detail in Chapter 4.

#### **2.3.2.1 Development of draft guidelines**

Guidelines according to the definition of the WHO (2010:4) are recommendations or statements of procedures that provide information about what policy-makers, health care providers or patients should do improve the health of an individual or group. The American Psychological Association (APA) (2002:1048) describes it as: "statements that suggest or recommend specific professional behavior, endeavor, or conduct", to facilitate "continued systematic professional development of the profession and to help assure a high level of professional practice". Guidelines are used by health care professionals in order to support and guide their interventions in making clinical decisions in the rendering of health care (Polit and Beck, 2008:34; WHO 2010:4-5).

The researcher developed the guidelines for nurses to address the health care needs of displaced women living in Osire refugee camp from the description of the constituents obtained in the first phase of the research. Each constituent became a guideline and through the literature review of Phase 1 the rationale and actions of the guidelines were compiled.

### 2.3.2.2 Refinement of the draft guidelines

Refinement is applicable when somebody states officially that something is true and useful and of acceptable standard (Hornby, 2006:1631). The draft guidelines were refined by experts in women's health care according to a set of criteria and by re-phrasing them. A Delphi technique was used in the refinement process. An expert is a person who possesses special knowledge, skills or training in the topic under discussion (Skulmoski, Hartman and Krahn, 2007:10). From the input of the experts the final set of guidelines to address the health care needs of displaced women in the Osire refugee camp was compiled.

To ensure quality of the guidelines the researcher was guided by the criteria suggested by Cluzeau (2003), WHO (2010) and APA (2002).

- **Reliability:** This criterion measures the internal consistency of each guideline (Cluzeau, 2003:19 & 21). Given a similar situation the guideline will be interpreted and applied consistently by health care practitioners.
- **Validity:** A guideline that leads to the desired outcomes is considered valid. Circulating the guidelines among a panel of experts is a method that ensures validity of the guidelines (Cluzeau, 2003:19; APA, 2002:1049).
- **Applicability:** Applicability of the guidelines is reached when in the view of a panel of experts the guidelines are clear, comprehensive, relevant and easy to use (Cluzeau, 2003:19).
- **Clarity:** The guideline is clear when it gives clear, understandable, easy to follow instructions, and when they are succinct and unambiguous in the language (APA, 2002:1049; Cluzeau, 2003:18).
- **Flexibility:** A guideline is flexible if it recognise the importance of professional judgment and discretion without unnecessary or inappropriate limitations of the practitioner (APA, 2002:1049), but should be client-oriented.

- **Representation process:** Where possible, the composition of the panel of experts should involve a representative of the participants of the research, so as to ensure that questions relevant to participants and their experiences are considered (WHO, 2010:17-8). Furthermore, the WHO (2010:18 & 21) states that where this is impossible, participants cannot be represented.
- **Schedule review:** According to the WHO (2010) and APA (2002:1049), guidelines should be reviewed to ensure applicability, clarity as well as feasibility. Although the time frame for review is determined by the situation in which the guideline was developed, it is recommended that guidelines be reviewed after the implementation in practice – approximately 5 years.
- **Documentation:** The process of guideline development is described in chapters 5 and 6 of this “thesis” (APA, 2002:1050).

### 2.3.2.3 Selection of participants for the refinement of the guidelines

Purposive sampling was used to select participants who were knowledgeable about the phenomenon under study (Polit and Beck, 2008:343). The criteria used to recruit them included documented clinical experience in women’s health, experience with refugees, published papers and conference presentations on the health of displaced women or an on-going programme of research in women’s health.

Polit and Beck (2008:481) advocate eight to twelve participants in a Delphi study to be sufficient to provide valuable information. Nine experts representing different institutions were recruited to participate. They were from different backgrounds to ensure a richness of opinions (Cline, 2000:2).

The participants were invited by e-mail to participate in the refinement of the guidelines through a Delphi study. After they indicated their willingness to participate, they were sent information explaining the study and what was expected from them. They were required to give their opinions, suggest strategies, make comments, and clarify ideas

about the guidelines until the final consensus was reached (Hasson, Keeney and McKenna, 2000: 1011).

#### **2.3.2.4 Delphi round 1: Data collection method and instrument**

All communication with the participants was by email. The participants were selected and contacted through e-mails. A cover letter explaining the objectives and the process of the Delphi technique was sent to them. An instrument to refine the guidelines including objectives of the study, instructions, deadlines and an informed consent form was sent to each participant (Addendum 2A).

The instrument consisted of a biographic information form, the eight draft guidelines and the pre-amble to, purpose of, rationale and actions entailed for each guideline. The participants were requested to rate each guideline, its purpose, rationale and actions using the criteria of clarity, applicability, validity, reliability and flexibility (Addendum 7B). The responses were based on a four-point Likert scale (Hasson, *et al.* 2000:1011). A space was provided for participants to provide comments and suggestions regarding the re-phrasing of the guidelines should rephrasing be required.

#### **Data analysis**

Responses from participants were analysed and the scores rated according to the four-point Likert scale. A consensus method using the Delphi technique to refine the guidelines for validity, applicability, reliability, clarity and flexibility was used. Consensus is the process by which all members of the group, in this case “experts”, agree on an issue under discussion (Hornby, 2006:3069). Through rating the experts indicated their agreement about the applicability, validity, reliability, clarity and flexibility and usefulness of each guideline.

Where necessary, the guidelines were adapted according to the suggestions of the participants (Hasson, *et al.* 2000:1012; Skulmoski, *et al.* 2007:3-5) and sent to the participants for further refinement.



### **2.3.2.5 Delphi round 2: Data collection method and instrument**

A second set of guidelines was sent to the participants. They also received emails with a cover letter to clarify the objectives of the Delphi study, conditions of participation, and the summary of the findings from round one as well as the process of round two. The cover letter, pre-ambles and instructions were also e-mailed to the participants (Addendum 2 B, 7B).

#### **Data analysis**

Data was analysed in the same way as in round one. The guidelines were corrected and finalised. From the input of the experts the final set of guidelines to address the health care needs of displaced women was compiled. The set of guidelines addresses the health care needs that had been identified in the first phase of the study. The final set of guidelines will be communicated to the group as soon as the study is completed and the thesis is evaluated (Stuter, 1996: paragraph 9; Cline, 2000:3). The final guidelines are presented in Chapter five.

### **2.3.2.6 Validity of the guidelines**

Participants are experts in the phenomenon under study (Keeney, Hasson and McKenna, 2006:208). More than one round was used until consensus was reached. Validity of the guidelines is assured through the procedure used for refinement. Participants are from different countries and institutions and might not or might know each other but might not be aware that they are involved in the refinement process. They did not meet face-to-face; each expert used his or her own expertise and applied it to the study without the influence of others or being dominated by others.

## **2.4 ETHICAL REQUIREMENTS OF THE STUDY**

Ethical requirements in research refer to those issues that are to be considered to respect and protect the participant's human rights, safety, wellbeing and dignity (Holloway and Wheeler, 2010:53). The researcher was guided by The Declaration of Helsinki adopted by the 18<sup>th</sup> World Medical Association (WMA) on the 29<sup>th</sup> June 1964 as amended by the 35<sup>th</sup> World Medical Association, October 1983 and 2008, articles 1-35.

### **2.4.1 The principle of respect for human dignity**

The declaration stipulates clearly that the rights of participants should be protected before, during and after the research, specifically the rights of those participants who are regarded as having increased vulnerability- such as displaced people.

Written permission to conduct this research was obtained from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria (Protocol No. 242/2010, Addendum 5A) as well as from the Namibian High Commissioner for Refugees, Windhoek and the Osire refugee camp administrator (Addendum 5B).

In Phase One of the study the participants were 18 years and older and could thus give permission for the participation in research. The purpose of the study and its importance were explained to the participants. They were informed both verbally and in writing that no information that could identify them would be included in the research report (thesis and articles) (Addendum 1).

In Phase Two of the study the participants were invited to participate through their e-mails. The invitation letter, participation information leaflet and informed consent form were sent to the participants by e-mail (Addendum 2A and 2B) after they had indicated their willingness to participate. The objectives of the research and activities of the Delphi technique were explained to them (Addendum 2A and 2B).

Participants were invited to participate and those who were willing to participate in the study accepted the invitation. They were also requested to sign a consent form, which was e-mailed together with the instrument, and to return it to the researcher by e-mail or by fax.

### **2.4.2 The principle of beneficence**

The principle of beneficence refers to the responsibility of the researcher to protect the participants from any harm. Participants confirmed that they took part in the study voluntarily by giving written informed consent (Addendum 1 and Addendum 2).

The participants of phase one of the study also agreed in writing that the interviews could be audio recorded (Streubert-Speziale and Carpenter, 2007:94; Groenewald, 2004:14). The right of the participants to withdraw was also explained to them. A female interpreter was recruited to interpret the aim of the research and the content of the informed consent to one of the participants (a displaced woman who was unable to read and speak English). The participant agreed to participate and signed the consent form. No identification information of participants of Phase One of the research appeared on the audio tapes and transcriptions of the interviews.

The participants of Phase One of the study were assured that permission had been obtained for the research to be done in the camp from the camp officials and that their usual humanitarian aid would not be affected and they would not be prosecuted for participating in this research. It was also explained to them that the information they provided would remain anonymous in that their names and contact details would not appear anywhere on the reports or researcher's notes (WMA, 2008: 2, articles 9, 16-7 & 33).

### **2.4.3 The principle of justice**

This principle provides for the wellbeing of the participants to take precedence over all other interests as well as equal representation of participants in the research where possible (WMA, 2008:2 articles 5-6). The participants were given equal opportunity to participate in the research; those who withdrew from participation were not persecuted. In this study both in Phase One and Phase One only participants who indicated their willingness to participate were included.

## **2.5 SUMMARY**

In this chapter the researcher explored and described the methodology that was used to describe the health care needs of displaced women who live in Osire refugee camp.

The researcher also used the Delphi technique for the refinement of the guidelines.

In chapter three the findings of Phase One of the study will be described.

## CHAPTER 3

### DESCRIPTION OF THE FINDINGS OF PHASE ONE

#### 3.1 INTRODUCTION

In Chapter Two the researcher discussed the research paradigm and methodology. In this chapter the researcher describes the findings of Phase One of the research. Descriptive phenomenological data analysis was used. The researcher solely used the data obtained from the research participants and her field notes and observation for data analysis (Dahlberg, *et al.* 2008:273). According to Kleiman (2004:7-8) phenomenological descriptive data analysis is a process that includes categorising and making sense of the essential meaning of the phenomena based on the narrative description of the lived experiences of the participants. In phenomenological data analysis in the Husserlian tradition, the identification of the essence of the experiences is central (Dahlberg, 2006:1).

#### 3.2 PHENOMENOLOGICAL ANALYSIS

The researcher acted as the data analyst herself, which means that she analysed the data by first extracting significant statements from the participants' descriptions, followed by the generation of meaning units and a clustering of the units to discover the essence of the phenomenon (Creswell, 2003:191). The researcher carried out the analysis in a descriptive way and looked for meanings of the experiences without interpreting them.

Descriptive phenomenological data analysis required the researcher to make use of 'bridling' which means that she had to be careful not to jump to conclusions in a hasty manner (Dahlberg, *et al.* 2008:241). In this type of data analysis the researcher aims at understanding the meaning between the "visible" and the "invisible", exploring the "invisible by using the visible", trying to explore what is "silent" and "invisible" and to "see (the) invisible" and to "listen to that what is silent" (Dahlberg, *et al.* 2008:39). While quantitative researchers use statistical analysis to search for the frequency of responses, qualitative researchers use participants' own experiences to look for emerging statements that are important and meaningful and that could increase the researcher's understanding of the phenomenon (Kleiman, 2004:7). During data analysis the researcher works with the rich descriptive data until essences begin to

emerge to ensure pure and thorough description of the phenomenon. The interview transcripts are thus read and re-read in their entirety in order for the researcher to get the overall sense of the whole and to justify the accuracy of the data. Bloomberg and Volpe (2008:127-128) emphasize the importance of the reduction of the large amount of raw data and the identification of the significant essence from the data.

The researcher used the steps of the data analysis method of Colaizzi (cited in Holloway and Wheeler, 2002:180-1) and Dahlberg's methods that specify the process that enables the researcher to formulate the essential structure (essence) of the phenomenon in the final phase of analysis and it also advocates for the returning to the participants by the researcher to ensure that a comprehensive description of the phenomenon was obtained (Streubert-Speziale and Carpenter, 2007:83). Dahlberg, *et al.* (2008:231-232) describes data analysis in phenomenological research as a way of gaining an understanding of the phenomenon through the use of life world descriptions of the phenomenon.

The researcher worked in this study with the life world descriptions that were presented to her by the research participants. This method advocates the describing and understanding of the essential structures of the phenomenon comprehensively (Dahlberg, *et al.* 2008:231-232).

The researcher used both Colaizzi's and Dahlberg's methods of data analysis in this study. She confirmed after every interview while in the field whether what she noted in her field notes was a true reflection of what the participants told her. She also went back to the participants after a few days to enquire whether they would like to add information to their descriptions of their experiences of their health care needs.

### **The following steps were adhered to during data analysis**

All the audio-recorded data were transcribed verbatim. Punctuations such as (...) for a pause, // for a break were added. Periods of silence, coughing, crying and hesitations, hums and yeahs, as well as sighs and laughs were recorded as these are significant utterances that were expressed during the interviews (Refer to Addendum 7).

The researcher read and re-read all the transcripts in order to gain a general understanding of the experiences. She compared the field notes to the transcripts to get a comprehensive understanding of the phenomenon. The transcripts and the field notes were analysed so that essential structures and their meanings could emerge (Carlsson, Dahlberg, Ekebergh and Dahlberg, 2006:290). In descriptive phenomenological research the aim is purely descriptive without interpreting the participants' descriptions and without making early conclusions. Descriptive phenomenology is different from hermeneutic phenomenology as the latter aims at the interpretation of the experiences (Polit and Beck 2008:222-3 & 755).

The transcripts were studied to pinpoint statements pertaining to the health care needs. The key words, phrases and statements were extracted in a process known as “extracting significant statements” (Holloway and Wheeler, 2002:181). The researcher used an attitude of openness to find the meaning in the text as suggested by Dahlberg, *et al.* (2008:238).

The data of each interview were divided into units with similar meaning and the units were merged into clusters of meanings. These clusters are called by Dahlberg, *et al.* (2008:244) the “essential meanings”. The analysis was carefully done in such a way that the actual description of the phenomenon was maintained. The clusters of meaning (essential meanings) were then compared with the original descriptions from participants in order to verify them. The results were integrated into an exhaustive description of the phenomenon. The essence of the phenomenon formed the fundamental structure of the phenomenon (Dahlberg, *et al.* 2008:238). The essence is supported by the constituents that were identified from the clusters of meanings. Quotes from the interviews are provided to show explicit examples of the meanings.

### 3.3 RESEARCH FINDINGS

The phenomenon of health care needs of displaced women is presented below. The essence is described first and followed by a description of the constituents.

Husserl (Dahlberg, *et al.* 2008: 245-6) describes essences as those structures of essential meaning that fully explain the phenomenon. It also refers to the fundamental features of the

phenomenon that “without which it cannot be that phenomenon”. Furthermore, Dahlberg, *et al.* (2008:246) describes the essences as “those occult and hidden qualities of something that make the phenomenon what it is”. In phenomenological data analysis for the researcher to come up with the essence, he or she should try to unfold the meaning without interpreting it (Dahlberg, *et al.* 2008:247). The essence is the abstract of the constituents of the findings (Dahlberg, *et al.* 2008:255).

The health care needs that the participants described were not limited to illnesses and diseases but also included factors that could optimise their health. The health care needs were more of a psychological and social concern rather than physical health. In the view of the participants physical and psychological disturbances and even illnesses and diseases would develop should their concerns not be addressed. They related their health care needs to not being sick and medically cared for but to being able to promote and maintain their health and being able to survive difficulties.

### 3.3.1 Need for the restoration of hope and human dignity

The **essence** of the phenomenon is “the need for the restoration of hope and human dignity”. The participants perceived their health care needs as broader than just the usual physical health concerns that can be addressed through reproductive health care. The lack of financial means, the mental distress that they experienced, and the concerns about their relationships were described as some of the factors that affected the health of the displaced women.

The findings of this research indicate the need to expand the women’s health care needs beyond reproductive health care only. The phenomenon of the health care needs of displaced women was experienced as the needs to improve socio-economic and political circumstances and to restore their hope and human dignity.

The following eight constituents support the essence “need for the restoration of hope and human dignity” and further describe the meaning of the phenomenon health care needs of displaced women: 1) Autonomy and freedom; 2) Skills training and income-generating projects to improve and sustain health; 3) Support for all vulnerable women and more specifically for those with special health care needs; 4) Protection against stigmatisation if one has an HIV-

positive status; 5) Security with regard to humanitarian aid distribution and the need for supportive communication; 6) Protection against harassment, threats of harm, abuse by men and domestic violence; 7) Reintegration to home countries; 8) Participation in reproductive health care.

The eight constituents and how they relate to the phenomenon health care needs are described below:

### 3.3.1.1 **Autonomy and freedom**

Participants expressed that they felt inferior to the camp officials and not in control of their own lives and emotions. They felt restrained by the situation and were thus not able to raise their concerns during meetings with camp officials: “...no, I didn’t say anything//”. The participants carried out orders given to them even when they did not agree with what the officials had ordered: // *we are only listening...*” They did not air their views as they had a feeling of “*who am I to talk to somebody in a high position?*” In many situations decisions were made by the camp officials on behalf of the people in the camp.

The participants expressed that they were not physically sick but that they did not feel good about the control over their movements. They were able to make their own decisions before coming to the camp and they seemed to long for the freedom that they once had: “*I’m okay, ‘cause I’m not sick, but when it comes to ... the issue of the camp, my life is somehow not so good (sigh)... I can say that I’m healthy because I’m not bound to the bed... but // I’m limited*”.

Their movements were limited (controlled) as they could not leave the camp without the permission of the camp officials which they experienced as a “*lack of freedom*”: “...*if I want to go outside from the camp...I must ask permission...I must ask somebody to allow me to go out...*” They were also not allowed to do what they wanted to do. “... *I can’t say that the life is so good, ‘cause the person who is in a good life they can do whatever they want ...!*”. According to them, they did not have good lives as they were



not allowed to decide how they want to live: *“I can’t say that I want to do this today, because somebody controls me”*. They live according to the rules of the camp officials. The lack of involvement in decision-making processes had detrimental effects on their mental health as some of them gave up trying to take control over their situation: *“You can say like this (give a suggestion) then no one going to answer...that’s why people (displaced people) they leave it like this...”* When the camp authority did not attend to their suggestions they felt hopeless and eventually gave up on taking part in decision making and that influenced their lives.

### 3.3.1.2 **Skills training and income-generating projects to improve and sustain health**

One of the participants was working as a teacher in the camp’s school, one disabled participant was a cleaner in the women’s centre, and five participants were unemployed. They stayed at home to cook for their families, to clean their houses and to take care of their children. One participant (22 years) did not complete school and headed the household of four siblings; while a 22-year-old participant was a youth activist and another participant was a secondary school learner. Three of the participants had backyard gardens and cultivated spinach, cassava, corn, spring onions, sweet potatoes, beans and sugar cane to supplement their food ration.

Some displaced people had small pieces of land where they cultivated millet and beans. The cultivation depended on the rain season which is very short-starting in November and ending in March. For the rest of the year the people had no food to supplement the humanitarian aid and there was also no means for irrigation of the gardens.

The participants felt that if a woman was full-time employed outside the camp she could be financially independent and she would thus have no problems even if her husband abandoned her: *“Because if you have a job, even that husband run away from you...aah...there’s no problem”*. The participants were unfortunately not allowed to work outside the camp and those who had been employed in the camp did not get acceptable

salaries. One participant worked as a cleaner and complained about her salary as she only got N\$120.00/month, which was not enough to buy food and clothes for herself and for her children: *“They give me N\$120.00 per month...yes...is not too much money, and nothing, ...you (are) going to buy maybe shoes of (for) one person”...*

The participants expressed the lack of financial means as a barrier to sustain their own health. They believed that women were responsible for the needs of the family and in the camp the women were unable to carry out that responsibility due to a lack of money: *“everything you are struggling for it...there is no job really, there is no job...”* They were convinced that should they have had certificates of training they could have been employed by the Namibian government to work in the camp for decent salaries: *“No paper (certificate), no work, (and) no money...life is not good// I don’t have any documents (sigh)...I can’t get a job because I don’t have my documents (certificates); thus why I said I can’t get a job because I don’t have my diploma because all things (were) destroyed”.*

They were also concerned about the overall difficulty to get employed, as some Namibians also find it difficult to get decent jobs: *“I don’t have a job but even my kid (s) (are) schooling (but) I know that...here (referring to Namibia) to get a job even if the kid finish schooling is a big problem...only some have a job” (after school).*

The participants strongly raised the need to be trained in skills such as cooking, catering and childrearing. They felt that only if they were provided with vocational training and equipped with skills they might be able to find jobs in their own countries or in Namibia: *“The woman in the Osire need the training of the cook so that we can...help our family...we want a training centre here in Osire...so that we can help us after”.*

The participants indicated that their children had health care and other needs and without a proper income they do not have the money to attend to the needs of their children: *“Even for kid you have a...for example young boy, okay, the boys, the girls thirteen, fourteen years up, twenty years up, but where to get money to, to satisfy the (needs of) your kid (s) if you don’t have a job...”*

The participants, according to the researcher's own observation, appeared to be healthy and strong people. Even the two women with disabilities were healthy. They all indicated their willingness to supply for their own needs should they get a chance to do so. It was only the lack of income that forced them to rely heavily on the humanitarian aid provided by UNHCR through the AHA office: *"If you don't have job is a big problem even food...even food if you eat food you receive already finish then you start struggling..."* Inability to supply for their own needs made them bad that they had to rely on humanitarian assistance for all their nutritional and health care needs. They felt that if they could have been given the chance to have income generating projects and small business, they would have been able to supply for their own needs and that of their families to maintain their health. Their inability to provide own their daily needs to maintain their health was aggravated by a lack of resources and a lack of employment.

The interviews revealed that the participants' pleas to get training in income-generating projects to maintain their own health were not supported: *"Is only to train women because women in Osire I think is very...very dawn (not clever enough) for training, they don't know anything..."* Some participants accepted that they were unable to provide for their daily needs: *"... we are refugees and...to be a refugee is not easy, ... many people are suffering a lot mm...//"*. When they asked for projects they did not receive favorable responses and they decided to accept the situation: *"...you keep quiet, even you have a wound inside, you keep quiet..."*

The participants were not happy with their living conditions. They were doing nothing all day whereas there was a lot to be learnt. They raised a need for training in child rearing so that when their husbands abandon them, they would not struggle with the kids but would be able to cope with the demands of child care: *"We need...to learn to live with kid because there are some who don't know (how) to care of kids...when (their) husbands leave (them) with a kid (they) cannot take care...is not good"*. They felt that older women who had child-rearing experience should be used to guide the younger women so that they would be able to continue rearing their children on their own and not fall apart when their husbands disappeared: *"There is some women (who) can also teach...this training will empower women so that they do not rely on men"*.

### 3.3.1.3 **Support for all vulnerable women and more specifically for those with special health care needs**

“Special health care needs” refers to the needs of individuals who have an increased risk for a disease. They require special health care and related services beyond what is required by individuals in general. All refugees are vulnerable persons and women with special health care needs are those with disabilities, those who head families, those who are pregnant or lactating and those who are mentally disturbed. According to the UN all refugees are a “population of concern”.

The participants got poor support from the authorities during times when they were vulnerable and in need of support. They expected that in times of difficulties there should be an accessible reporting channel and a prompt response to their problems: *“yeah...I was there, they say they will do something but then they never do anything. I went back and (...) when I went back there is no solution...”* They expected that there should be someone who could listen to them and not only listening but also responding to their pleas in an urgent manner. They longed to see a helping hand from the authorities whenever they approached them for help. Instead they were often insulted when they asked for help: *“...we just live like that with the person insulting you every time...”*

The participants described the environment in the camp as not conducive to good health because of the harassment from refugee men and a poor response on harassment by the authorities: *“...but like for me we don't live with our parents so if someone wants to enter in our house without any respect they can do whatever they want because there is nobody, nobody can do anything...”* The participants are vulnerable and have special needs and they expected the authorities to do something about it: *“...she reported the cases to the social worker, community councillor and UNHCR office...nothing was done...’cause even though you tell them they don't do anything...really they don't do anything”*.

The participants were totally dissatisfied with the manner in which reported cases had been handled. Women in the camp expected care, support and protection from every camp official including the pastors: “...*people from here you don't trust anyone... 'cause you might tell even your church pastor, he will go and tell the wife, the wife go and tell other people...*” The care, support and protection that they had been denied not only refer to physical care, but also to psycho-social care and protection.

The women with disabilities relied heavily on help from family members, the community and the camp officials. They were vulnerable and fragile. One of them stated: “*I have many problems (sigh)...my husband is sick*”. She was worried that she would not be able to cope should her husband pass away: “*like me...(disabled), then my husband also has a problem (HIV positive)...I don't know where we can stay... we don't know how we can do*”. They felt helpless and hopeless and did not know whether it would have been better for them to return to their country.

The participants expressed their dissatisfaction with the response system in the camp: “...*nothing can be done. You can go to the police if you want to open the case, they will leave the person*”. Although in some instances perpetrators were warned not to harass the women, the women felt that warning alone was not enough as the perpetrators usually came back to insult the complainant: “...//*sometimes you may just see someone from nowhere starting insulting you just like that...that also brings depression in somebody's life.*”

Displaced women described poor support from the authorities as the reason why they feared the occurrence of problems: “...*we use to be afraid of problems if I mention...they (police) might call me in front of them (perpetrators)...I'll be a bad person in front of them which is not good...to avoid being in trouble, you keep quiet*”. They also felt that confidentiality or anonymity is not maintained by camp officials. According to them the complainants were not protected by the police: “*They will tell you it's confidential but afterwards they pass that (information on to others)...*”// They also complained that they were often threatened with death should they report cases of harassment: “*When you tell them (police) and they (perpetrator) know they might and in jail...when they come back they will come for you and (you) might be killed*”.

The vulnerability of the displaced women with special health care needs made them fear to return to their home countries: "... a disability (disabled) like me, they are suffering there too much in Angola". Although the refugee camp did not offer her the ideal living circumstances she knew that it might be worse in her home country where a war impoverished the people.

The participants felt that the reporting of cases had become a waste of their time so they had no courage to do it anymore: "*//...no, I never go there...// because I could not go to anything just wasting of time going there*". They feared to report officials who did something wrong as that could put themselves in trouble: "*...because if you try much you are in trouble*". That made them feel that they could not trust anyone anymore: "*...you do not trust anyone...and no respect for human dignity: //...no respect to everyone...*"

#### **3.3.1.4 Protection against the stigmatisation if one has an HIV-positivestatus**

The participants indicated that there was a lack of confidentiality among health care workers in the camp. Some of the participants therefore knew the personal health-related information such as the HIV status of other displaced people.

The participants complained about the stigmatisation that happened because of the lack of confidentiality in the camp: "*Like some days ago there were some boys...text messages to each other...writing the names of the people...who are positive...(calling them) the top-ten HIV positive in Osire...all our names were there, me...my sister and all other girls here, the top-ten prostitutes...they put our names there...*". One of the participants was traumatised because her HIV-positive status is known in the camp: "*Cause everybody is screaming on me...(they) point fingers at me that I'm HIV...I don't know how they know...*" Exposure of one's private information tarnishes the person's physical and psychological image so that the person develops fear of exposing his or her personal matters in future and he or she loses trust in health care professionals. It also lead to other women in the community fearing to go for voluntary testing because they did not trust health care professionals and they feared that their HIV status would also be known to others: "*People from here you don't trust anyone...*" It seemed to be a

culture in the camp to discuss people's affairs with detrimental consequences for the person's physical and psycho-social health.

The participants felt bad that their health-related information was known by other residents in the camp and those who could afford it travelled to clinics outside the camp to keep their HIV status confidential: *"I go to Windhoek for a test to go and get my blood tested-CD4 count"*. It made them feel bad that scarce resources had to be used to travel to clinics outside the camp, but they had no choice if they wanted to keep their health information confidential. *"... 'cause each time I'm losing money to go to Windhoek for a test...I go every three months...next month I have to go again..."* The decision to go to other clinics indicated that the patients should have had the right to be treated fairly and with dignity and that their right to confidentiality of health information was infringed.

Although the participants were not sure how their personal information became known, they told the researcher that they got the idea that health care professionals even from the mere look *"... 'cause really even those people working there, just from the looking..."* could tell which patients were HIV positive.

In an ideal nurse/patient relationship the patient is empowered to improve his or her health. The participants therefore expected the health care professionals to do individual pre- and post-test counselling when HIV tests were conducted. They unfortunately did not receive the expected counselling. One of the participants stated that she was tested at the clinic in the camp for HIV when she was pregnant, but she could not remember being individually counselled before or after the test: *"I was tested when I was pregnant...here (Osire) during blood tests for pregnant women...I was not counselled but only counselled when I went for CD4 count test in Windhoek..."* According to her she did not know that the routine antenatal blood tests also included HIV testing. She felt betrayed by the health care professionals.

#### **3.3.1.5 Security with regard to humanitarian aid distribution and the need for supportive communication**

Proper nutrition is a basic human need and the lack of adequate nutrition contributes to health problems. In Osire camp displaced people were provided with food ration cards with which they received food and other humanitarian assistance on a monthly basis.

They had no choice than to rely on the humanitarian assistance. They expected fair distribution from responsible officials which did not happen: *“It’s like...how can I say...they discriminating people from other people...”* The camp officials decided who should be given food ration cards: *“...but they discriminate teachers from receiving food which is not good..., no they say they give to those people who doesn’t have anything...”*. Displaced people are regarded as “people of concern” by the UNHCR and other international organisations. They are the people who need security and protection in both the physical and mental sense including security with regard to humanitarian aids. Insecurity with humanitarian aid distribution in the camp was characterised by inequality in the distribution of food and other materials.

According to the participants ill people need special diets to improve their immunity: *“But the other issue like other sickness...is difficult because a person when you are not feeling well and you lose your appetite you need special food so that you recover very fast...”* When the women related food to health they indicated that for a person to be healthy, one needs to eat a balanced diet: *“...a person cannot eat the same food every time, like we eat beans in the morning; eat beans in the lunch time, beans in dinner time...”* They described that the food was not sufficient: *“aah... but things we receive is not enough”*. They related healthy food to good health. For a person to be healthy one needs to eat healthy food: *“...UNHCR is doing their level best to help us to give some kind of food, but (it) is not healthy to eat every day the same food like we are getting ...”*

Owing to the unavailability of money to supplement their diets the participants felt helpless. They had tried to get help from the social workers, but without any success: *“Yeah, I was there, they say they will do something...but then they never do anything...”* They would have liked to supplement the diets of their family members on ARV. One participant who is HIV positive believes that her CD4 count is going down because of her poor diet: *“...my CD4 is going down...when I went to the hospital nurses told me that it is poverty related to HIV...”* This participant’s mother worked at the time of the research in the women centre doing needle work and because of her employment she did not receive the full food ration. The HIV-positive participant thus expected that her condition would deteriorate as a result of her poor diet.



The participants expressed their dissatisfaction with regard to the distribution of other humanitarian aid such as shoes and school uniforms. They also felt that the AHA officials discriminated against some displaced people: “...and is not distributed in the correct way //...they discriminate...” The discrimination applies when people who do some work in the camp are not given humanitarian aid although they are entitled to it: “... but those people they are working they are not receiving food, which is not fair...” Displaced women who work as teachers and cleaners are discriminated against although their salaries were not sufficient to meet all their needs. Married and unmarried women also received different humanitarian support with the result that the unmarried women benefited more than the married women: “...those one who are not married they are living better than those who are married, but the things come they say no, this one are for women who don't have husbands and these are for women having husbands.” The participants would like to see that individual situations be evaluated before decisions are made regarding who should get what: “...might see the person they are giving is even better than the one they are not giving...”.

Other forms of discrimination were also observed. The 22-year-old participant who was taking care of her siblings was not allowed to receive shoes as she was older than 18 years. She had no income and could not buy any shoes for herself: “...if also like this people are not having parents, they say from 18 what, what you don't have to receive...”

When officials who had been involved in discrimination during the distribution of humanitarian aid were reported, the officials in charge covered for their colleagues. They told the complainants that they were selfish and wanted an official to be fired: “... they will just tell you that you are maybe selfish...and you want someone to be fired.” This attitude made the participants keep quiet and not to report officials who discriminated against them or who have mistreated them.

Participants felt powerless because they had no ability to decide about the type of food that they should receive: “...life goes on they do not give.” They received what was available and they got only what they had been given. They anticipated a call for them

to be part of the planning committees that dealt with humanitarian assistance (informal discussion with a participant after the interview). They felt powerless because even when they complained nothing was done. Some participants indicated that they have stopped complaining because nobody did anything to address their complaints. Some decided to “*keep quiet and just watch them*”.

### 3.3.1.6 **Protection against harassment, threats of harm, abuse by men and domestic violence**

The participants in the study felt that the life in the camp was not comfortable and the environment was bad, because the displaced men had no respect for women’s rights and dignity. The participants reported incidents where women were humiliated, stigmatised, labelled and called names but the authorities did nothing about it (as discussed previously). Acts of harassment, threats of harm, abuse and violence caused fear among the participants.

Some participants lived in relationships characterized by gender-based violence. Men carried out different abusive behaviours which affected the women’s physical and mental health. When they reported the misbehaviour of their partners, the authorities who should support them did nothing. The police, social worker and the pastor also kept quiet. This caused the participants to lose trust in the camp officials. One participant, a married woman, described how men in the camp had been abusive and how women had suffered because of their behaviour. The participant continued to say that some men, because of drinking alcohol harassed their wives: “*...men drink beer, doing nothing, men behaviour not good...have girlfriends*”; can stay away from home until late and when he comes back in the middle of the night: “*...come late at home at 00h00...*” and fight with their wives.

Some men abused their wives and partners by withholding financial assistance, “*...even if (they) have (jobs), (some are teachers and security guards in the camp) (they) bring anything (nothing) at home...many men (who are) staying in the camp always (have) big problems (with) fighting... abusing, drinking beer, have girlfriends...*” She carried on reporting that a man can have a bank account which the wife is not aware of: “*//...when woman suffering, they (men) don’t care, can have a bank account, woman don’t know*”.

During situations of harassment and threats the participants expected protection from the camp officials and the social worker but they did not respond appropriately and the women no longer reported abuse: “...*you keep quiet*”.

It emerged from the interviews that the participants were living in fear of male refugees and were therefore hesitant to report their misbehaviour: “...*they might end (up in) jail, when they come back they come for you and you might be killed...*” It made them feel vulnerable, fragile and insecure. At the same time they felt powerless: “...*nothing can be done, you can go to the police if you want to open the case, they will leave the person, they will just give the warning, they just give warning and the person goes like that*”.

### 3.3.1.7 **Reintegration to home countries**

The participants revealed that they felt uncertain to go back to their home countries: “...*to go home to Angola is what (the UNHCR-Official in Namibia) says. He was coming (came) here (to Osire), (to) say, (that) all Angolans can go to home (to Angola)*” because the Angolans feared that if they go back they could be prosecuted and imprisoned or even killed. Some participants had lost their loved ones and felt that they could not go back to their home countries: “...*until now, I can't say, because nowhere...to go because I know that even those people (the people who they fear) are there we...hear...(over) the news (and) the internet (that they are there) still there...*”

The participants were not convinced that there was no more war in their countries. They felt that even if the actual war of fighting with guns had ended, the civilians were still being terrified by their governments especially if one did not belong to the ruling party: “...*they said there is peace but...we know that there is no peace*”. They were not convinced that their governments had adopted policies of reconciliation and nation building. They feared that because they were in guerrilla camps before, they would be prosecuted when they went back: “...*my mother was (on) UNITA side*.” They also did not know where their parents had lived so that they could ask to be repatriated to places where they might find some family members: “...*you can (t) say that me I am going to 'Huambo', to 'Bengela', I don't know*”. It made them feel very uncertain about their future: “...*like me, my mother is the one who brought me here when I was small then*

*she died here, at this camp, (in) 2007, now I'm live alone (sigh) ... now these day they say all the Angolans should go home, I don't know where I am going to go, because I don't know the place of my mother how can I go there? I don't know my father; my mother told (me) that my father died in Angola...*" Some participants wanted an alternative place to live in other than their own countries: *"...if they going to help us please...allow us (to go) somewhere (third country) or to put us...somewhere in Namibia..."*

Some participants seemed to have experienced an un-noticed post-war syndrome that might have affected their mental health. When referred to their previous experiences they talked incoherently and started crying afresh as if the event had happened the previous day: *"...I said life is difficult, (crying)...I thinking about my future, I say I can't go back to my country...I do not have a family...even in my country there I don't have any family, because when I fled my country I saw many things, many died, (me) I saw (with) my eyes (crying), thus why I said I cannot (go back), it make me to...think, I said I do not have any family even my husband we were married on the way even him he don't know where (his)...parents are...what is my future. I can't go back to my country".* The participants were not convinced that the war and conflicts in their mother countries were over or whether political parties had reconciled.

The participants felt that the camp officials should conduct a survey with regard to repatriation so that they could get information on why the participants did not want to go back to their home countries. They felt that they needed a platform where they would be given a chance to talk and air their reasons of not wanting to go back to their home countries: *"...and the problem here again they (authorities) always say no go back to your country, they (authorities) do not know how...and they don't ask you why...you don't want to go back...because you...you are afraid..., because...there is something wrong there, that is why I said I can't go back".*

Some participants preferred to be given work permits or Namibian identity documents: *"...they can give me...maybe we can get identity documents if they...accept and then (I can) stay here as a refugee"* and allowed to leave the camp or rather be given another

place in Namibia where they can work “...like me alone, I can stay, I can stay working” and earn a living other than staying in Osire camp. Some participants felt that going back to their countries and staying in Namibia’s Osire refugee camp was the same because it could cause the same suffering. Other participants preferred to go to another country as long as they did not have to go back to their countries of origin: “...or if Namibia don’t want (us) to stay here in Namibia they can talk with UNHCR so that US can take (us) out to its country but not to my country because I can’t go back to my country...”

The participants also feared that they could get lost if they went back to their home countries because they no longer remembered the paths and the towns and the cities. Some did not know the language and the currencies that were used in their countries: “...but the kwanza (Angolan currency), I don’t know the kwanza, how can I do (work) with this money of Angola...”

The participants had fled from their countries with no possessions and in some cases also without family. Their parents had died and their brothers and sisters had died. Their belongings had been destroyed. That remembrance alone scared them: “...but like me, I’m afraid to go back because ...I know that when I go back sometime I can recall directly...how my brother and sister died because when they died I saw (it with) my own eyes ...” Some lost their mothers while in Osire and they did not know the place where their mother came from. They were scared when they thought of going back. They said that they would suffer a lot.

To some participants there was no difference in going back or staying in Osire. Their argument was based on the fact that in Osire they had no family members or relatives, which, according to them, would be the same if they went back to their home countries where they also had no family or relative. They felt that they should be allowed to stay in Namibia: “...is the same because we don’t have...a family there, and there...there in Angola we don’t have family, and when we go there we are suffering, to stay, we have to stay here also suffering, I saw that all the things are the same...”

### 3.3.1.8 Participation in reproductive health care

Among the participants was a disabled woman who had a two-month-old baby girl; her fourth child. She told the researcher that she was never told to go to the clinic for a post-natal examination. When the researcher encouraged her to go she laughed very loud and said: “...for what, I ‘m okay, I ‘m fine, it is always like that if nurses see that you are okay, they don’t tell you to come back...”, except for the baby’s vaccine “//...but I’m going next week to take the baby for vaccine”. She lacked knowledge of what the vaccine was specifically for: “...I do not know, just to prevent disease...”

It emerged from the interviews that because the participants came from diverse socio-cultural backgrounds, they had different perceptions about the use of condoms and hormonal contraceptives, “...use condom if you want to prevent yourself being pregnant, these pills you can take these pills, but only for people who are mature enough...those who’re not matured they are not allowed to take the pills or to use condoms...” There were those who strongly felt that contraceptives especially hormone-containing substances should only be given to married women and perhaps to people who were 18 years and older: “those people who are...let me say those people who are mentally updated (mature) like those people who are eighteen years above...”

In many African cultures a girl is not supposed to have sex before marriage and is expected to start a family immediately after marriage. When a girl is married and is taking long to fall pregnant people close to her (relatives, in-laws, friends and neighbours) will start questioning her pre-marital behaviours. They will accuse her of having used ‘Depo Provera’, because it is believed that if one has used ‘Depo Provera’, one will take long to conceive.

In conservative Christian religions unmarried women are not supposed to take contraceptives because they are not supposed to have sex. Some participants still held the belief that only married women should be allowed to use contraceptives: “family planning is...there for the married people...” This means that some cultures and religious convictions encourage abstinence before marriage: “We grow up in different ways...you said you abstain... you until you get married...”

From the interviews it emerged that, although cultural aspects were very important and there was a need for the Ministry of Health and Social Services in Namibia (MoHSS) to review the policy on contraceptives so that family planning (FP) health care service could be provided at public health clinics to adolescents younger than 18 years, the participants were not convinced that the services should be available to adolescents younger than 18 years: “...children of today they do their things...at the age of thirteen...while me...the mother don’t know mmm...not like us...they do their things...on their own...” Another participant said: “Those are the people that are allowed (referring to 18 years old)... but still some people under-age they go, some they receive but they are not really allowed, that’s what we were told that only people who are mature enough like eighteen (and) above they can go there (to the clinic) and receive some contraceptives ‘cause they don’t want to abstain, use some contraceptives...”

The participants expressed a lack of knowledge about contraceptives and they had misconceptions and myths about the pharmacological actions of contraceptives “...but there are someone they say no this one disturb me”. They therefore fear that the contraceptives could harm them: “...they start...bleeding, it brings many problems”. The women needed education to understand how contraceptives work and therefore needed to be more involved in their own reproductive health care.

Some participants did not really care for or fear the side-effects of contraceptives but felt relieved when they did not become pregnant: “...even can destroy me (referring to hormonal contraceptives) there is no problem”. They felt that because men abuse women by impregnating them and not marrying them or supporting them it is better for women to use contraceptives.

Patients are supposed to use the community health nurse before they go to the hospital who refer them to the hospital for further management but the role and presence of community nurses in the camp seemed to be invisible in comparison to hospital-based care. The participants indicated that: “...I go to the hospital when I need to”.

### 3.4 SUMMARY

Chapter Three was about the **description** of the findings on the health care needs of displaced women living in Osire refugee camp. A description of the essence and supporting constituents was given.

In Chapter Four the literature will be used to provide a **discussion** of the essence of the findings and the supporting constituents.



## CHAPTER 4

### DISCUSSION OF THE FINDINGS AND LITERATURE REVIEW FOR THE DEVELOPMENT OF GUIDELINES ON THE HEALTH CARE NEEDS OF DISPLACED WOMEN

#### 4.1 INTRODUCTION

In Chapter 3 the researcher described the essence of the phenomenon of health care needs of displaced women in the Osire refugee camp: “Restoration of hope and human dignity”.

The following constituents substantiate the essence: 1) Autonomy and freedom; 2) Skills training and income-generating projects to improve and sustain health; 3) Support for all vulnerable women and more specifically for those with special health care needs; 4) Protection against stigmatisation if one has an HIV-positive status; 5) Security with regard to humanitarian aid distribution and the need for supportive communication; 6) Protection against harassment, threats of harm, abuse by men and domestic violence; 7) Reintegration to home country; 8) Participation in reproductive health care.

This chapter covers the discussion of the essence and the constituents against the existing literature. Literature sources from various academic disciplines were used.

#### 4.2 RESTORATION OF HOPE AND HUMAN DIGNITY

From the phenomenological point of view “restoration of hope and human dignity” is perceived as a result of being-for-others. People are not always subjects that view and react on objects in their environment. They themselves are objects to which other people react (Dahlberg, *et al.* 2008: 59). From the nursing theory perspective “restoration of hope and human dignity” is an integral part in health promotion (MoHSS 1998:2).

In this study the participants experienced a dire need for the restoration of their hope and dignity because of the way other people reacted towards them. Being-for-others became the focus of their lives as they had been in constant confrontation with the existence of the people who judged them. They also became aware of themselves (a heightened self-consciousness) and how other people viewed them. The ‘other’ is thus never absent as the participants

remained aware of the way the 'other' treated them and during the interviews they voiced their experiences.

One never escapes the judgement of the 'other'. These 'others' were the subjects that passed imagined judgements on the participants as their objects. The others were for the participants all the camp officials and fellow displaced people who treated them badly and who made them into people that they felt they were not.

The 'others' put them in a position where they experience feelings of hopelessness and indignity as it reflects the participants' powerlessness as an absolute. The participants experienced the 'others' as persons who were free to judge them and to treat them as inferior and they became victims of alienation (Svenaesus, 2009:1; Dastur 2011:1).

The participants wanted the 'others' to help them to restore their hope and dignity as their related needs (described as constituents) would then be manageable or would even disappear.

### **4.3 THE DESCRIPTION OF CONSTITUENTS**

Constituents, according to Dahlberg (2006:14), are the "meanings that constitute the actual essence". In other words they are the "individualisations" or "particulars" of the essence so that the essence is observed in every constituent. Dahlberg (2006:14) further states that through describing the constituents textual flavour is contributed to the essence.

#### **4.3.1 Autonomy and freedom**

The participants viewed their health care needs in a holistic manner that corresponds with the view of Pavlish (2005:881-2), who believes that displaced women's health care needs include more than just their reproductive health needs and should thus be broadened to include all aspects of health (Lee, *et al.* 2012:2). The participants of this study were far more concerned about the loss of their freedom and autonomy than about physical determinants of health. Displaced people, according to Agier (2011:133), Pavlish (2005:883-4 & 889) and (Shadrak, 2010:1-2) suffer a lack of autonomy and freedom in expressing themselves and "have very little or no control over the circumstances in which they live" (Pavlish, 2005:888), and that has

a negative impact on their mental and physical health. It causes them to lose hope for the future and they tend to develop a sense of dependency (Stein, 1980:6), which has a “deeply pathological effect” on their mental health (Stein, 1980:6).

When there is a loss of autonomy people cannot function independently and cannot make their own existential decisions because they lack the ability to take charge of their lives (Carson, 2008:5). They start to develop a feeling of “poor in spirit”, a sense of dependency on those who control them and they lose their ability to take rational decisions. They experience that they are treated as prisoners or people who are not capable to care for themselves with the result that they start to question their own identity (Stein, 1980:6; Aguiar, 2013:3; Shadrak, 2010:1-2) to the extent that displaced people will find it difficult to adjust to freedom when they are repatriated to their home countries. They also feel sad and lonely when there is no one with whom they can share their burdens (Pavlish, 2005:889-90).

“Autonomy” refers to the freedom and independence of people (Hornby, 2006:85) who are capable of taking responsibility for their own actions. It includes the ability to make own decisions and to function within the norms of society (Rathus, 2008:107), and the right to move freely within the territory of the host country (USCRI, 2009:2; Davis and Palladino, 2004:746; Human Rights Watch, 2002:27).

The ability to live autonomously serves as an indicator of the person’s physical and psychological health (Woolfolk, 2007:378; WHO-Africa, 3). The occurrence of depression is often associated with a loss of autonomy (Agier, 2011:133; Pavlish, 2005:882). The participants in this study were not allowed to practise their skills in autonomous living as they were controlled by external people who made decisions on their behalf. They were not allowed to practice “inward autonomy” by making their own decisions and “outward autonomy” by making decisions that were not limited by others (Woolfolk, 2007:378). This kind of autonomy refers to a normal development milestone of all human beings and it indicates that a person has reached an acceptable level of psychological development (Nettina, 2006:12). It is thus a normal and healthy expectation that people should not have to function under the command of others (Kozier, Erb, Berman and Snyder, 2000:75; Aguiar, 2013:3).

In refugee camps displaced women should be regarded as valuable sources of knowledge but are more often excluded from decision making processes and are less often consulted for input regarding decisions that affect their health (Human Rights Watch, 2003:23 & 27; Pavlish, 2005:884 & 892). This makes them suffer an inferior position in society, economic dependence and a lack of social autonomy. They feel resentful, stressed, depressed and marginalised (Carson, 2008:3). Decision making refers to the process of deciding about something very important, whether in a group, or as an individual or as an organisation (Hornby, 2006:379) and from the interviews it was clear that the participants wanted to be included in decision making in the camp, especially when the outcomes of the decisions impacted on their health and well-being.

Owing to the exclusion of displaced people from decision making, authors such as Stein (1980:6) and Shadrak (2010:1) compared the conditions and the life in refugee camps to those of prisoners. The UNHCR (2007:25) recommends that the planning and management of programmes (including health care programmes) for displaced persons should not be done without proper consultation with the displaced people. Their representatives should also serve on the planning and management committees in the camp.

The rights of displaced women (who are considered as a vulnerable group) should be respected. They should be allowed to participate at the different levels of decision making processes and their contributions to decision making should be acknowledged (UNHCR/WFP JAEM, 2008:33; Pavlish, 2005:899-90; Benjamin and Fancy, 1998:23). Displaced women's voices should be regarded as "essential elements for devising alternative responses to their problems and demands" (Aguiar, 2013:3). Furthermore, Aguiar (2013:3) states that the governments of host countries should allow displaced women to take their own decisions and to live an autonomous life.

Leadership training of displaced persons can enhance a sense of autonomy and freedom, as it encourages them to become less dependent on others and to make the most of what they have. In support of this the camp officials should allow the displaced people as much freedom as legislation allows to live as normal as possible without infringement of their autonomy and freedom (Pavlish, 2005:884). According to Indra, cited in Pavlish (2005:884) refugee women's

perspectives regarding the health care that they need should be explored and new innovative programmes should be established.

The UN General Assembly (2008:11 & 13) indicates that the UNHCR in partnership with the International Association of Refugee Law Judges (IARLJ) recognised the need to improve the protection of the refugee status and undertook a pilot project that involve the deployment of judges to refugee camps so that they could support the capacity building of refugees' status in decision making processes. The report further states that displaced people need to be allowed meaningful participation in decision making processes in order to enhance their empowerment and dignity. Respect for a person's autonomy includes the acknowledgement of their freedom of choice, their right to self-determination and their right to privacy (Nettina, 2006:12).

Displaced persons should be given the chance to voice their concerns to the camp officials (Pavlish, 2005:91) and the camp officials should be willing to provide the structure that encourages information sharing in order to ensure the physical and mental health as well as autonomy and self-reliance of displaced persons (UNHCR, 2007:8; Hathaway, 2009:1; UNHCR/WFP JAEM, 2008:33).

#### **4.3.2 Skills training and income-generating projects to improve and sustain health**

Owing to displacement women lose their social and partner support systems (Benjamin and Fancy, 1998:15-6). They become heads of families and then find themselves forced by the situation to fulfil numerous roles in their families (Carrillo, 2009:528; Pollock, 2010:532; Benjamin and Fancy, 1998:13 & 15). They have to find the means that the family needs to survive (UNHCR/WFP JAEM, 2008:38; Pavlish, 2005:888). Poverty affects their ability to care for themselves, their children and families, and makes them vulnerable to potential sexual exploitation (Benjamin and Fancy, 1998:14). Without opportunities to earn a decent income displaced women may consider to trade sex for food and clothes (WRC, 2011:1; UNHCR/WFP JAEM, 2008:35) with male camp and border officials (Martin and Tirman, 2009:218, 221 & 229; Benjamin and Fancy, 1998:15-6, 18 & 22) with detrimental consequences for their health. The struggle of displaced women to survive the poverty and hardship also forces them to sell their food rations (Pavlish, 2005:887) which leads to malnutrition and more health problems. Over

the long term the hardship can cause mental health problems (UNHCR/WFP JAEM, 2008:20; Stein, 1998:6).

It is thus a concern that displaced people do not get permits that allow them to work outside the refugee camps or are provided with micro-finance or loans to start small businesses (Agier, 2011:138; Cavaglieri, 2003:2) and that training opportunities are scarce in the camp (UNHCR/WFP JAEM Namibia, 2008:36). Through proper income-generating projects women would have money to pay for food and clothes (Hornby, 2006:755) and exploitation could be prevented (UNHCR/WFP JAEM Namibia, 2008:36-7; Cavaglieri, 2003:1 & 4).

The participants experienced challenges to survive with the humanitarian aid and complained about the insufficient food rations. Their opportunities to generate an income both inside and outside the camp were very limited through a lack of vocational training, restrictions on their movements and the strict requirements in obtaining a work permit (UNHCR/WFP JAEM, 2008:36; Shadrak, 2010:1-3).

They received no vocational training in the camp that could prepare them to earn an income. They thus had very limited opportunities to generate an income while they were in the camp and even after returning to their home countries (Benjamin and Fancy, 1998:22; UNHCR/WFP JAEM, 2008:36 & 38; Pavlish, 2005:888).

The displaced women were grateful for the food rations that they received, but preferred to supply for themselves. People do not want to be dependent on others while they are eager to work toward self-sufficiency (Benjamin and Fancy, 1998:22). The monthly humanitarian aid that displaced people receive is an emergency measure and is not sufficient for long-term survival (Pavlish, 2005:887). They need to be given the opportunity to become independent from the humanitarian aid as financial independence is a determinant of a stable lifestyle and a contributor to mental health (Agier, 2011:38).

According to Stein (1980:4), many refugees were successful and well-integrated individuals before they became displaced. Should they be given a chance to work in or outside the camp they would be able to support themselves and their families (Shadrak, 2010:3). Displaced

people experience several economic losses as they have lost their jobs, income generating resources, training opportunities, and often the certificates that indicate their qualifications and their assets (Kälin, 2008:46).

Although the participants received basic house hold equipment such as cooking utensils and food rations their need to eat a variety of well balanced meals was not addressed by the organisations that are responsible for displaced persons. When basic needs are not attended to, people resort to finding other ways to get an income such as selling cigarettes and snacks (Agier, 2011:137-9; UNHCR/WFP JAEM, 2008:38; Benjamin and Fancy, 1998:22; UN General Assembly, 2008:7) and their humanitarian aid to other displaced people (Pavlish, 2005:883 & 887).

The skills training of displaced people and opportunities to earn an income can help them to live a meaningful life (Hornby, 2006:1378; UNHCR/WFP JAEM, 2008:38) and contribute to the economic growth and the social upliftment of the people of the host country (World Refugee Survey, 2007:92). Skills training would also equip them with the necessary skills to earn an income and to contribute to the livelihood costs of their families. According to the Women's Refugee Commission (2011:1) "livelihoods" refer to "the capabilities, assets and strategies that people use to make a living". It also refers to the strategies that displaced people are supposed to use to earn money to take care of their families (Pavlish, 2005:887, Agier, 2011:138-9; UNHCR/WFP JAEM, 2008:38).

Without opportunities to earn an income displaced people who have previously been very successful become dependent (Stein, 1980:2). The ability to sustain a way of living relates to the emotional well-being of people as "a working life is a route to social acceptance" (Scheffer, 2011:308). In refugee camps the people do not have 'working lives' and livelihoods programmes thus has to cover other activities such as programmes to enhance self-reliance through vocational and skills training, income-generating projects and apprenticeships (WRC, 2011:1; Benjamin and Fancy, 1998:22). They should be equipped with all the skills they need to become independent when they return to their home countries (UNHCR/WFP JAEM Namibia, 2008:17 & 36).

### **4.3.3 Support for all vulnerable women and more specifically for those with special health care needs**

Agier (2011:151, 158 & 161) states that “all the refugees are vulnerable because they know moments of fear and wandering, extreme conditions of life- ...and has been close to death of their loved ones,” but then there are those that are regarded as even more vulnerable. Some of them lack knowledge regarding their rights as displaced people and the protection that they require (Abusharaf, 2009: 39-40). These refugees, according to the UN General Assembly (2008:13) have specific needs for empowerment to reduce their vulnerability (Mooney, 2005:17). They are the young women who have lost their parents during the conflict the disabled women, and the women who have lost their husbands. These women become the heads of families who have to survive with scarce livelihood opportunities and need support from camp officials to prevent the development of psychological stress (WHO-Africa, 2012:72; Agier, 2011:125-6 & 133; UNHCR, 2003:124; Kälin, 2008:90-2; UNHCR-Namibia, 2008:1 & 13; Abusharaf, 2009:46; Carson, 2008:3). Without the necessary support they struggle to take care of their families, which have a detrimental effect on their health (Stein, 1980:9; Agier, 2011:136 & 144; 2008:10-1).

Displaced women are entitled to protection from the camp officials and treatment from the clinic staff that meets their special health care needs (Cook, 2011:1; Kälin, 2008:20 & 22). The health care needs refer to services that are designed for a particular purpose, which is to the vulnerabilities that women experience (Hornby, 2006:1414-5).

In refugee camps displaced women are often unable to defend themselves (Hornby, 2006:1649; Charlton, 1999:853). They expect the camp officials to protect them and would like to have representatives who can communicate their needs to the camp authority (Agier, 2008:43).

Participants in the study felt vulnerable, even powerless because of their homelessness. They had lost their homes and their families and had had to adjust to an unknown environment in the camp. They therefore felt that they were entitled to the protection that they needed to build new lives in a foreign country. When displaced women are exposed to feelings of insecurity, unemployment, poverty and poor shelter their needs for protection increase (Abusharaf,



2009:45 & 52). It was clear that the UNHCR and its partner organisations including camp authorities do not execute safety policies as set out in the Women's Refugee Commission (2011:1, points 1, 3, 8); Agier, 2008:102-4). When displaced women are denied the human rights of having a safe and secure life, they are condemned to an uncertain future (Gordon, 2008: paragraph 2).

A lack of appropriate health care contributes to the displaced women's exposure to physical and psychological health risks (Abusharaf, 2009:51 & 57; Marcuse, 2008:11 & 13). Reports such as that of Maguire, Morgan and Reiner, (1997:592) indicate that vulnerable persons take longer to recover from hurt. According to Stein (1980:6), it has been noted that being a refugee has a "deeply pathological" effect on the displaced person's mental health. Displaced women's health care needs should be continuously monitored to ensure that their health care needs are met (Mooney, 2005:15 & 17; Abusharaf, 2009:43; Dalton-Greyling, 2008; the UN General Assembly report, 2008).

When people flee their countries, they are in life-threatening circumstances and are forced to abandon their belongings to flee from danger. They thus do not prepare themselves for the unfamiliar circumstances that await them and develop extreme feelings of vulnerability. Displaced women experience loss (Kälin, 2008: 2 & 32; Cernea, 2002:1) of support systems and familiar circumstances and become often prone to psychological stress and related disorders (Pollock, 2010:529; Dalton-Greyling, 2008:4).

Vulnerable displaced women should continuously be monitored and taken care of throughout their entire stay in the camp. The UNHCR and state agencies responsible for the care of displaced women are obliged to attend to all situations that require special protection of the displaced women such as episodes of threat of safety and security. All displaced women should have access to information regarding their rights to protection from harm (UNHCR Convention on the rights of persons with disabilities; Stein, 1980: 2).

#### **4.3.4 Protection against stigmatisation if one has an HIV-positive status**

Stigmatisation of a person happens when they are marginalised by others on the basis of characteristics or behaviour (Hornby, 2006:1452). In the case of the participants in this study,

they were marginalised because of their HIV and AIDS. Stigmatisation is also described as “significantly discrediting” in such a way that they feel very bad about themselves (Charlton, 1999:222). People often experience stigmatisation as humiliating Joint United Nations Programme on HIV/AIDS (UNAIDS) 2000:11).

Reports such as that of Evangelical Lutheran Church in America (ELCA) (2007: 2) and the UNAIDS (2000:31) indicate an association between the occurrence of HIV and AIDS and gender inequality that can result in the stigmatisation of people. When people are stigmatised by others they are called names, are labelled, get harassed and victimised. Stigmatisation can also be self-initiated, when people internalise the stigmatisation from others. Reports state that although progress has been made in educating displaced people regarding stigmatisation of people with HIV and AIDS, it still remains a major hurdle in the fight against HIV in refugee camps (UNHCR-Kenya, 2007:2).

In a strategy to combat HIV and AIDS member States of the UN are urged to “foster a spirit of understanding and compassion for HIV-infected people and those suffering with AIDS; to protect and safeguard the health care rights and dignity of affected individuals and population groups and discourage discrimination and stigmatisation of people living with HIV and AIDS in the provision of services” (UNAIDS, 2000:6). Furthermore, individual policies and legislation promulgated by member states should aim at a more compassionate and caring response to empower people with HIV and AIDS (UNAIDS, 2000:34 & 36; MoHSS, 1998:5; Kälin, 2008:53 principles 11; UNHCR/WFP JAM Namibia, 2008:37).

HIV-infected participants in this study believed that they experienced stigmatisation from other displaced people and camp officials due to the nurses who communicated their infection to others. Feelings of vulnerability developed and they also felt that they no longer could trust the nurses. They refused to disclose any further information about their health to the nurses. When patients and nurses cannot communicate openly health care services are not optimally utilised (Human Rights Watch, 2003:60) with a detrimental effect on the patient’s general health status. According to international human rights standards, all people- including those with or at risk of having HIV and AIDS- should feel free to utilise all healthcare services. The

“discrimination against people living with HIV and AIDS or those perceived to be at high risk of infection is legally prohibited” (Hathaway, 2009:1; UNAIDS, 2000:7).

Displaced women experience physical, social and psychological harm when health-related information is divulged or disclosed without their consent (Charlton, 1999:621). People feel betrayed when they become aware that the chain of confidentiality is broken and confidential information is divulged (Kozier, *et al.* 2004:75). Confidentiality is the act of keeping someone’s information-including health-related information- private, so that personal information is not made known or revealed to an unauthorised person or the public (Hornby, 2006: 304; Charlton, 1999:154). Nurses are legally obliged to keep all information regarding patients confidential and use this information only for the purpose of treatment and when they are legally obliged to reveal it for the purpose of therapy (MoHSS, 1998:5; Human Right Watch, 2003:60; Muller, 2009:16; UNAM HIV and AIDS Resource Guide, 2008:473).

Displaced women feel unhappy when confidential information is wrongly shared with other people (Charlton, 1999:219). Disclosure refers to making confidential information known or public or revealing confidential information to someone unauthorised or to the public (Hornby, 2006:415), while the disclosure of the HIV status of people refers to the sharing of a person’s HIV status with someone such as a friend for the purpose of gossiping about the infected person.

The confidentiality of the test results that indicate the status of HIV and AIDS should be discussed during the pre-test counselling. The UNAM HIV and AIDS Resource Guide (2008:176-7 & 473) emphasises voluntary or client-initiated and confidential counselling and testing for HIV and the WHO (2001:79) requires that all information about the people and their test results should be kept confidential. During the post-test sessions the people should be reassured about the confidentiality of test results and that no information will be communicated to anyone without his or her consent. Without re-assurance that information will be kept confidential no HIV testing should be done (UNAM HIV and AIDS Resource Guide, 2008:474). Displaced women indicated the need for pre-test- and post-test counselling sessions for HIV tests. The UNAM HIV and AIDS Resource Guide (2008:176-7 & 473) emphasises the encouragement of voluntary or client-initiated and confidential counselling and testing for HIV

and that HIV testing should be done only with informed consent. The counselling sessions are important because during these sessions the counsellors apply professional ethical behaviour and get into a deeper discussion with the client of what HIV itself is; gets to know the client; and the testing process. During the pre-test session the client's knowledge about HIV, is determined. This kind of testing covers how HIV is transmitted and how it is prevented and issues of confidentiality of the test results (WHO, 2001: 79 & 10; WHO-Africa, 2012:21-3). The counsellor also provides the client with comprehensive information on the technical aspects and possible implications of testing (UNAM HIV and AIDS Resource Guide, 2008:176).

It is a policy in Namibia (UNAM HIV and AIDS Resource Guide, 2008:173) that the society (including displaced people) is encouraged and advised to go for HIV voluntary testing and counselling. Testing centres are available country wide where people are counselled and tested voluntarily and the test results are made available in less than twenty minutes (20). Although displaced people have access to all national HIV and AIDS centres in Namibia they get tested in the camp due to the easy access to the camp healthcare services. It is at these services that information according the research participants is not kept confidential.

The wrongful disclosure of information of the participants and the stigmatisation that they experienced because of it can be perceived as gender-based violence (GBV). The UNHCR Guidelines for Prevention and Response (2003:123 appendix 1, 124-7 & 129) has set out the code of conduct for combating gender-based violence based on international legal standards. The code of conduct obliges employees of the UNHCR to maintain and safeguard the lives of displaced persons irrespective of the circumstances. The Guidelines for Prevention and Response (UNHCR, 2003:29) serve as a guide for all UNHCR employees as well as other staff members who work in direct contact with displaced persons, including nurses, to uphold the standard of the UNHCR organisation and to protect displaced persons from harm (Human Rights Watch, 2003:50-60). All UNHCR staff members and non-UNHCR employees who work with displaced persons sign a code of conduct to ascertain that they respect the dignity and worth of displaced persons (Human Rights Watch, 2003:124). The UNHCR Guidelines for Prevention and Response (2003:131, appendixes 2) provide a report form that should be used to report incidents of misconduct.

#### 4.3.5 Security with regard to humanitarian aid distribution and the need for supportive communication

Displaced women depend on international humanitarian aid (UNHCR/WFP JAEM, 2008:19) to meet their basic needs (Africa Renewal, 2010:1), which, according to Ziegler (2002:Resolution 2001/25:7), includes access to food and other means of survival.

Displaced women leave their home countries and depart to destinations they were never prepared for in order to escape misery (Africa Renewal, 2010:1; Agier, 2011:151-4) and to find solutions to their problems (UNHCR Policy on Refugee Women (n. y: 4), only to find that their new circumstances cause new problems. Although the UN Reports of the Special Rapporteur (2003:1-2) state that displaced people have the right to adequate food and other humanitarian aids regardless of where they live and who they are (UN Special Report, 2003:1-3), not all displaced people are satisfied with the support that they get.

Food security is defined by Ziegler (2002) cited in Cavaglieri (2005:25) and The UN Economic and Social Council report (2001:2) as follows:

*“The right to food is the right to have regular, permanent and unobstructed access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensures a physical and mental, individual and collective, fulfilling and dignified life free from anxiety.”*

Having adequate food is a basic right of all people (UN, 2001:14), which means that displaced people should be provided with nutritious food through humanitarian organisations. In the refugee camp the distribution of food and other humanitarian aid materials is done in accordance with the policy of the UNHCR and its partner organisations such as the African Humanitarian Action (AHA). Adequate food supply according to the UN E/CN.4/2001/53:8) is dependent on socio-cultural and climatic conditions but should always ensure “long-term availability and accessibility of food”.

The UN Reports (Special Rapporteur, 2003:1) emphasise that food security is accomplished when all people have either physical or economic access to food that meet their preferences

and dietary needs to lead an active and healthy life. Dietary needs is another component of the right to adequate food that, according to Ziegler (2002: Resolution, 2001/25:8), implies that the diet has to contain a mix of nutrients for physical and mental growth, development and maintenance (Ziegler 2002: Resolution 2001/25:8) and has to enhances their health and well-being (WHO-Africa, 2012:1, 57, 67, 79 & 82).

The right to adequate food does not only include materials such as clothing, shelter and solid food, but also the right to safe and easily accessible water (UN Special Report, 2003:8; Ziegler, 2002: Resolution 2001/25:11). Water-borne diseases easily spread in refugee camps when a lack of safe water is experienced. Diarrhoea is therefore a major cause of severe dehydration and death among the under-fives in refugee camps (Kälin 2008:85). The Women's Refugee Commission (2011:1 points 2, 5, 8 & 10; Ziegler, 2002:Resolution 2001/25:14) feels very strongly about the problems that water scarcity can cause and states that denying displaced people the right to adequate food and water is illegal.

Humanitarian aid is applied in crisis situations to save lives, to alleviate suffering and to maintain the dignity of people. The distribution of the aid needs to be done without any discrimination against people (Kälin, 2008:113-4). Situations of conflict are increasing in Africa and it is foreseen that an influx of people to host countries will require more money to be spent in order to provide humanitarian aid to displaced people (UN General Assembly, 2008:3; Agier, 2011:154 & 161).

The humanitarian aid that is needed does not only include food. It should include health care and medical care, proper shelter, clothes, toiletries, stoves and other household utensils (Agier, 2011:121-214). The provision of charcoal is a special added subsistence that has been specially recommended by Women's Refugee Commission (2001:1 point 1), (Ziegler, 2002: Resolution 2001/25:11-2) and (Puechguirbal 2010:1) to ensure the safety of women and girls in the wake of increased report of rape and sexual abuse, coercion and exploitation cases of displaced women and girls when they go in the bushes to look for fire-wood. The provision of humanitarian aid is supposed to be of a short-term arrangement, but due to situations of long-term displacement, they turn into a lifelong aid (Agier, 2008:53).

Food security does not only refer to the access of sufficient food, but more often to the proper utilisation of food (UNHCR/WFP JAEM Namibia, 2008:22). When people in the household do not know how to prepare food and what a balanced diet consists of, food insecurity occurs (UNHCR/WFP JAEM Namibia, 2008:22). A family with members with special dietary needs also experience food insecurity when they receive the same aid as other families that do not have members with special needs.

Food in Osire refugee camp is provided by the World Food Programme (WFP) in cooperation with the African Humanitarian Action (AHA) as a distributing agent. During the UNHCR/WFP/JAEM Namibia's (2008:15) visit at Osire refugee camp, about 14 children were moderately under nourished and were put on supplementary feeding programme. According to the report of the UNHCR/WFP JAEM Namibia (2008:16), some non-food items are distributed on a monthly basis in the Osire camp. These items include paraffin, soap and sanitary pads, building materials, stoves and blankets. The UNHCR office provides the materials while the AHA officials do the distribution. The report states that when a focus group discussion was conducted with some of the displaced people it appeared that materials were not enough compared with the daily needs of the people.

Participants in this research were not happy about the way in which humanitarian aid was distributed. They felt that the distribution was done in a discriminatory manner. According to them some displaced people received more aid than others. Participants complained about the quantity and quality of the food that they received. They experienced food insecurity and what concerned them most was their inability to provide nutritious meals to their families. The uneasiness (Kälin, 2008:84; UN, 2001:14; Ziegler, 2001:11) that they experienced refers, according to Hornby (2006:771), feelings of vulnerability that also threatens the self-image of the people involved (Ziegler, 2002: Resolution, 2001/25:10). The participants could not fulfil their roles as mothers and wives due to insecurity with regard to food and other humanitarian aid and the feeling of vulnerability (Ziegler, 2002: Resolution 2001/25:10).

To address the problem of food insecurity and discrimination with regard to humanitarian aid Kälin (2008:84) writes: "Where the basic humanitarian assistance is available care must be taken that refugees have safe access to them". Care must be taken that humanitarian

materials are not diverted from their legitimate destination. Acts of denying displaced people the right to adequate food are addressed in the United Nations (UN) Special Rapporteur (Ziegler, 2002 Resolution 2002/58:12) that: “Any person or group who is a victim of a violation of the right to adequate food should have access to effective judicial or other appropriate remedies at both national and international levels”... all victims of such violations are entitled to adequate reparation, compensation (Ziegler 2002: Resolution 2002/28:12). All people including displaced people should never be deprived of means of subsistence (UN, 2001:14). Displaced people like all other people have the right to subsistence (Kälin, 2008:92) and it is therefore advisable that governments are transparent in disclosing cases of irregularities in the distribution of humanitarian aid to displaced people in their territories (UN, 2001:18; Namibia Fundamental Human Rights and Freedoms article 10:1-2). Displaced people should have an adequate standard of living (Kälin, 2008:50) and require access to all basic necessities and not only food. A favourable environment has to be provided to them that shows respect to their dignity and safeguards their fundamental human rights (UN General Assembly, 2008:16; Ziegler, 2002: Resolution 2001/25:14).

In order to address discrimination related to food insecurity camp authorities should make sure that lines of communication exist and are appropriately used. Complaints should be investigated and measures should be taken to address the complaints. Feedback should be provided to all involved (Women’s Refugee Commission, 2011:1 point 3). The International law, according to the Human Rights Watch (2003:64) “protects the rights of women refugees...to be free from discrimination in the enjoyment of their rights” (Ziegler, 2002: Resolution 2002/58: 22; Resolution 2001/25: 12-22).

Displaced women indicated the need for supportive communication, especially when there are new developments and when major decisions that affect them are instituted- such as the change in policies. They were dissatisfied when the change in the distribution of food was implemented without their knowledge. They reported that they would appreciate it if they were informed about changes in the policy that affect them. In many refugee situations the participatory role and contribution of ideas from displaced people’s side especially displaced women, is undermined because of lack of autonomy, which was described under 4.3.1 (Pavlish, 2005:882, 885-6 & 889-90). Lack of supportive communication of displaced people in



refugee camps contributes to discriminatory practices by humanitarian aid officers and other camp officials (Human Rights Watch, 2003:36). Furthermore, the Human Rights Watch (2003:14 & 60) explains that the lack of autonomy in decision making by displaced people can contribute to them not having the say in managerial issues which leads to their dignity not to be respected and their health to suffer. In Nepal refugee camp where the Nepalese camp management members did not understand the need to discuss cases, plans and policies with displaced people and this failure to communicate contributed to a crisis in the camp (Human Rights Watch, 2003:61). Pavlish (2005:884 & 892) encourages the participatory role of displaced women in planning as well as the acknowledgement of their ideas.

#### **4.3.6 Protection against harassment, threats of harm, abuse by men and domestic violence**

Displaced women are at risk of being victimised, sexually exploited and abused, and even raped by male camp officials and displaced men (Abusharaf, 2009:52; Pavlish, 2005:882-3; Refugee World Survey, 2007:91). They often arrive in the host countries without their husbands or parents and are also physically weaker than the men who abuse them (Puechguirbal, 2010:1; Orach, Musoba, Byamukama, Mutambi, Aporomon, Luyombo and Rostedt, 2009:6).

Harassment, according to The Combating of Domestic Violence Act of Namibia Act No. 4 of (2003:5) refers to “any act of continually following, pursuing and accosting the complainant his/her family member or dependant by making persistent unwelcomed and annoying actions by one party or a group, including but not limited to threats, watching, loitering outside or near the place where the complainant resides and demands for the purpose of intentionally irritating, disturbing or upsetting or threatening and teasing or tormenting the victim”. The participants reported three types of harassment that happened in Osire refugee camp. They were exposed to sexual, psychological and community-based harassment. Community-based harassment happens when one person is stalked by multiple individuals within the community who use psychological techniques that are difficult to prove and have long-lasting emotional consequences (Keygnaert, Vettenburg and Temmerman, 2012:6). Psychological harassment is difficult to detect because it does not leave physical evidence (Goldblatt, 2009: 651; Keygnaert, *et al.* 2012:5-6). Victims of harassment feel victimised, humiliated, intimidated, and vulnerable and often develop low self-esteem if they do not get support from others (Human

Rights Watch, 2003:54; WHO–Africa 202012: xix). Participants indicated how HIV and AIDS positive displaced women in the camp due to their HIV/AIDS status are harassed, labelled and called names.

Threats of harm, according to The Combating of Domestic Violence Act of Namibia Act No. 4 of (2003:4) refers to “any physical or psychological acts of forcing another person to behave in an involuntary manner through the use of threats, rewards, or intimidation or some form of pressure or force or harm”. Threats are made intentionally to intimidate victims in order to manipulate their behaviour to cause them to fear for injury or harm (Agier, 2008:15; Agier, 2011:173), while the perpetrator is pleased with what he or she has accomplished. In refugee camps intimidation is often experienced by displaced women (Agier, 2011:163). Police officers who are supposed to arrest perpetrators often do not do their duty with the result that perpetrators get away with their crime, leaving the victims and future victims neglected (Abusharaf 2009: 43, 45, 52 & 60; Kälin, 2008:55).

Abuse refers to the “maltreat, hurt, insult, battering, injure, and exploitation” of people (The Combating of Domestic Violence Act of Namibia Act No. 4 of 2003: 4). It is described as the disruptive behaviour of people (the perpetrators) with poor interpersonal skills who misuse situations where poor support is available for their victims (Mason, Leavitt and Chaffee, 2012:429). In refugee situations, abuse of displaced women occurs when organisations and professionals responsible for their safety fail to protect them (UN General Assembly, 2008:13, 16; UNHCR, 2003:12). According to Pavlish (2005:880-2, displaced women are often neglected as laws and policies to protect them are not properly implemented. According to the UNHCR (2003:8) report, “sexual and gender-based violence violate a number of human rights principles enshrined in international human rights instruments”. These include among others, the report continues: “the right to life; the right to attain the highest standard of physical and mental health; the right to freedom of movement and expression; the right to personal development...”

Domestic violence refers to violence between partners (whether married or cohabiting). It is more often directed at the physically weaker and less powerful partner (the woman) and includes gaining control over a person as well as forms of physical, emotional, verbal or

psychological, sexual and socio-economic abuse (The Combating of Domestic Violence Act of Namibia Act No. 4 of 2003 Part IV (General: 29, 30, 31, 32, 33, 34), the UNHCR (2003:12) and Keygnaert, *et al.* (2012:6). When women are abused in relationships with people close to them they feel vulnerable and it can have a detrimental effect on their health (Agier, 2011:161-2 & 197). In domestic violence long-term patterns of “abusive behaviour and control” (WHO–Africa 2012: xix) are observed as the women find it difficult to report their partners/husbands to the police. Much damage has already been done when they finally decide to take action. According to Hagi (2010:1), domestic violence is increasing in refugee camps, as both partners have to cope with stress of displacement.

Some people who are exposed to violence experience multiple health problems (Roberts, 2011:1); with long-lasting physical, emotional and psychological consequences (Avdibegović and Sinanović, 2006:6-7). Abuse has serious effects on women’s self-esteem that leads to their alienation from groups that could have rendered support to them (Carrillo, 2009:54 & 528; Pollock 2010:532-40) and thus feelings of helplessness (Davis and Snyman, 2005:70). Other psychological problems that survivors of abuse might experience are depression, posttraumatic stress disorder, anxiety, suicide ideations, drug and alcohol dependency (UNHCR, 2003:54). On the physical health side women might suffer reproductive health disorders and even unwanted pregnancy (WHO–Africa, 2012: xix, 1, 23).

To address domestic violence in refugee camps responsibly the governments of host countries should put measures in place to prevent the occurrence and to manage cases effectively (WHO–Africa, 2012:7; Pavlish, 2005:890). Humanitarian workers according to the Human Rights Watch (2003:50) are “obliged to create and maintain an environment which prevents... and abuse and promotes the implementation of their code of conduct”. The UNHCR (2003:25) recommends that governments and camp authorities should set up a comprehensive prevention and response strategy. All camp officials should be trained to address gender-related issues in time and effectively (Human Rights Watch, 2003:65-9; Keygnaert, *et al.* 2012:7-8). Accessible reporting services and fast response systems include forensic and mental health care are required (Mason, *et al.* 2012:430; Hagi, 2010:1). The safety and dignity of the victims should be protected at all times (Pavlish, 2005:890). They need to be assured

that no retaliation will happen (Human Rights Watch, 2003:64), that their complaints will be addressed and that they will receive feedback on how cases have been managed.

Displaced women have to be informed on their arrival in the camp about their rights regarding safety. It should be explained to them and each one should receive a written or picture copy of such a document (UNHCR, 2003:43, 55 & 58). The women should be encouraged to report incidents of violence against them as soon as possible. Camp managers have the responsibility to develop support programmes for women who have reported incidents of abuse (Human Rights Watch, 2003:50).

According to Hagi (2010:1), the management of abuse of displaced women is not only the responsibility of the government of the host country. It requires a multi-sectorial collaboration between the governments; the UNHCR; the NGO's; the church organisations as well as the whole camp community. Measures to combat abuse of women have to include awareness about the existence and management of abuse of women in the camp. The camp community should change their attitude against survivors of abuse and not to blame or stigmatise them (UNHCR, 2003:24-5).

The empowerment of displaced women should contribute to the prevention of abuse of women in refugee camps. Violence against women is associated with unequal power relationships between men and women (UNHCR, 2003:38). The camp management should ensure a gender balance structure in leadership and in decision making with the aim of representing and empowering displaced women (WHO-Africa, 2012:57, 60; UNHCR, 2003:37).

The UNHCR (2003:40) also suggests the building and development of recreational facilities in refugee camps to help potential perpetrators of abuse of women to manage their stress. High levels of stress contribute to the occurrence of abuse of women (Agier, 2011:141 & 143-4) and the potential perpetrators should be given opportunities to reduce their stress levels. Refugee camps should be designed in such a way that they provide space for recreation and social activities (UNHCR, 2003:40).

#### 4.3.7 Reintegration to home countries

Although displacement is supposed to be a short-term refuge, in many situations it ends up a long-term event. The participants also experienced their placement in Osire camp as long term and indicated that they would have liked to be involved in the planning of their future placement or repatriation. According to Kälin (2008:129 & 132), “special efforts should be made to ensure full participation ... in the planning and management of their return, resettlement and reintegration”. Displaced people feel helpless and fearful when they are excluded from the planning of their future. Many of them fear that they may be relocated to territories when they may be persecuted which should be avoided by all means (The UNHCR Convention and Protocol relating to the status of refugees of 1951, 2007:5).

Displaced people should have the right to either voluntarily return to their mother countries, be integrated into the host community or be resettled in a third country as soon as the reasons for their displacement have ceased (Kälin, 2008:129 & 132). The planning of those processes should involve the displaced people (Chatelard, 2009:8). Repatriation refers to the return of a displaced person from a host country to his or her home country but not necessarily to his or her home, while resettlement refers to the moving of the displaced person to a third country. Reintegration refers to integrating the displaced person into the local community. These three processes are strictly voluntary and should be coordinated by the UNHCR (Adelman, N. Y: 1; Chatelard 2009:8). In cases where the displaced person opts for a reintegration a visa, a permanent residence permit or a national identity document should be issued to the person (Banham, 2004:1; Chatelard, 2009:6). When integration is the option efforts (by the host country) should be made to monitor the accommodation of the displaced person’s needs, which includes employment opportunities, housing and access to health services (Australia’s Refugee and Humanitarian Program (ARHP) 2007/8:63).

According to the UNHCR/WFP JAEM Namibia report (2008:38), the GRN and UNHCR have been engaged in discussions to find lasting solutions for either voluntary repatriation or reintegration of displaced people in the Osire camp. In many refugee settings displaced people do not welcome the idea of repatriation because of their experience of war in their home countries. They might want to go home but distrust either the process of repatriation itself what will happen to them back home (Agier, 2011:118-9). Other issues that make refugees hesitate

about their repatriation are poor communication regarding the arrangements for transport and the provision of food and health services while in transit and at their destination as well as possible conflict with the reunion with their families and friends (Chatelard, 2009:8). Displaced people should thus undergo a thorough trauma counselling by trained trauma counsellors in order to prepare them for repatriation if that seems to be the preferred option.

According to the International Federation of Social Workers (IFSW)-International Policy on Refugees (IPR) (1998:3), social workers should work with individual displaced persons through counselling and community-development programmes so as to prepare them for repatriation. The policy also stipulates that before repatriation the governments of the receiving countries for returnees should ensure that the necessary preparations have been made for the repatriation of displaced people and each displaced person has received individual counselling and will be assisted with his or her repatriation. They should be supported to rebuild their lives in their home countries (Kälin, 2008:127, 129).

#### **4.3.8 Participation in reproductive health care**

Displaced women often have poor access to health care services (UN General Assembly, 2008:11 & 13; Mooney, 1978-2009:11; Abusharaf, 2009:12-3; Okanlawon, Reeves, Opeyemi and Agbaje, 2010:17) and limited participation in their own reproductive health care (Kälin, 2008:90, RHRC, 2011:2; Gurnah, *et al.* 2011:1) due to language barriers, ignorance and lack of decision-making power of the women (Kurth, Jaeger, Zemp, Tschudin and Bischoff, 2010:2 & 4; Woodward, Howard, Souare, von Roene and Borchert, 2011:2). Displaced women who lack knowledge of the use of contraceptive measures may distrust the health care professionals and believe that contraception could be dangerous (Okanlawon, *et al.* 2010:21) and cause them to become permanently infertile. Unwanted pregnancies result, which lead to illegal abortions and increased morbidity and mortality of the women (Gurnah, Khoshnood, Bradley and Yuan, 2011:1; Orach, Musoba, Byamukama, Mutambi, Aporomon, Luyombo and Rostedt, 2009:72).

In many refugee situations according to Kurth, Jaeger, Zemp, Tschudin and Bischoff (2010:4 & 6) and Pavlish (2011:8) poor communication and language are the major reasons why women do not make use of reproductive health care (Kurth, *et al.* 2010:5). Health care professionals

are often unable to improve the communication with the women who do not get the necessary care (Pavlish, 2011:5 & 9). Providers of health care services should make sure that the information does “reach” the heart of the women to offer them the privilege to choose to make use of contraceptives and to decide on the type of contraceptives they prefer (Kälin, 2008:90). The practice of sharing information about contraceptives should be a continuous engagement between health care professionals and women of the childbearing age (WHO-Africa, 2012:32; CEDAW, 2003:3) Misconceptions about contraceptives can be addressed when displaced women are actively involved in their reproductive care (von Roenne, von Roenne, Kollie, Swaray, Sondorp and Borchert, 2010:16).

The maternal health of women in Sub-Saharan African still poses huge challenges to the governments of these respective countries. A WHO report (2011) indicates that although there is some improvement in women’s health, the risk of women dying during or following delivery is still high in Sub-Saharan countries. The deaths are mostly caused by bleeding, sepsis, and malnutrition among other things (RHRC, 2011:2). The statement about women in Sub-Saharan Africa includes displaced women whose situation is even worse. Kälin (2008:90) states that in refugee situations it is seldom possible to provide the health care needed due to crisis situations that emerge. Many countries are not capable of offering a comprehensive health care service in crisis situations.

According to Carrara, Hogan, De Pree, Nosten and McGready (2011:11) and Kurth, *et al.* (2010:8), a suitable health care service for women should at least include full physical examinations, access to proper maternal health care services, a health education programme and a reproductive health care service. CEDAW (2003:3) specifies that the reproductive health care service should be integrated in a comprehensive primary health care service. A health care service with maternal and new born health care should be accessible to all displaced women. Their sexual health needs to be promoted during resettlement.

The prevention and treatment of sexually transmitted infections including HIV/AIDS is of utmost importance (Woodward, *et al.* 2011:2; McMichael and Gifford, 2010:265). Where armed conflict is going on and in temporary shelters, it might not be possible to deliver a

comprehensive health care service but in refugee camps it should be a priority (Kälin, 2008:90).

Displaced women often are from different cultural backgrounds, a fact that the health care professionals carrying out maternal and reproductive health care need to acknowledge. It is important that culture congruent care be delivered (The Dadaab Report, 2011:1). Religious beliefs may also discourage the use of contraceptives (Okanlawon, *et al.* 2010:23).

Limited participation of displaced women in reproductive health care has a detrimental effect on the health of displaced women (Women's Refugee Commission, 2011:1; McMichael and Gifford, 2010:263). Unwanted and poorly spaced pregnancies occur despite the presence of the applicable health care services in refugee camps (Gurnah, *et al.* 2011:1 & 8).

#### **4.4 SUMMARY**

In Chapter 4 the researcher discussed the findings about the phenomenon of the health care needs of displaced women living in Osire refugee camp in relation to the literature review. The researcher discussed the constituents and their philosophical meaning and their relation to health care needs and how the health care needs should be addressed.

Chapter 5 will deal with the development and refinement of the health care guidelines for displaced women.



## CHAPTER 5

### PHASE 2: DEVELOPMENT AND REFINEMENT OF GUIDELINES FOR NURSES TO ADDRESS THE HEALTH CARE NEEDS OF DISPLACED WOMEN IN THE OSIRE REFUGEE CAMP

#### 5.1 INTRODUCTION

In Phase Two of the study the researcher covered the second objective, which was the development and refinement of guidelines for nurses to address the health care needs of displaced women in the Osire refugee camp.

#### 5.2 DEVELOPMENT OF GUIDELINES

Practice guidelines are recommendations for the improvement of practice based on research findings (Polit and Beck, 2008:34).

The guidelines for nurses to address the health care needs of displaced women in Osire refugee camp were developed on the basis of the findings of Phase 1 of the study. The 8 constituents that substantiate the essence of the phenomenon were captured in 8 guidelines. The literature review set out in Chapter 4 served as background for the formulation of action plans and the subsequent operationalisation of the guidelines.

##### 5.2.1 The guidelines were developed to meet the following criteria:

- **Validity of the guidelines:** The researcher enhanced the validity of the guidelines by basing them on the empirical findings of Phase 1 of the study and a comprehensive literature review described in Chapter 4 of the thesis.
- **Clarity of the guidelines:** The guidelines must be clear and the language should be simple, understandable and concise. This means that terminologies that are used should be easy to follow by the target group (APA, 2002:1049).
- **Applicability of the guidelines:** The guidelines should apply to a specific target group and

context (APA, 2002:1049). The guidelines in this study are meant to be used by nurses to address the health care needs of displaced women living in the Osire refugee camp.

- **Reliability of the guidelines:** The guidelines could be used to guide nurses to address the health care needs of displaced women living in similar circumstances. Although the target group are nurses who work in the Osire refugee camp nurses who work with displaced women in similar circumstances may also find them useful. A thorough description of the development of the guidelines is therefore provided in the pre-ambule of the guidelines so that nurses can decide whether they could be used in other refugee camps.
- **Flexibility of the guidelines:** The guidelines focus on ways to address the health care needs of displaced women living in the Osire refugee camp, but do not prescribe rigidity how the needs should be addressed. The flexibility of guidelines enhances their usability (APA, 2002:1049).
- **Reproducibility of the guidelines:** The criterion refers to the possibility that another person could have formulated the same guidelines under similar circumstances (APA, 2002:1049). The researcher provided a thorough description of Phase 1 of the study and how it relates to the development of the guidelines as well as the process of guideline development.
- **Representation of the target group:** The researcher based the guidelines on the perspectives of displaced women regarding their health care needs, although the target group is the nurses who work in the Osire refugee camp. The researcher believes that the displaced women were well equipped to tell what their health care needs were.
- **Expiration of the guidelines:** Guidelines become out-dated therefore a periodic review is needed. It is recommended that the guidelines be reviewed between five and seven years after development. The recommended time to review guidelines is every five years (APA, 2002:1049).
- **Respect of human rights and dignity:** Practice guidelines are sensitive to individual and

cultural differences between nurses and their clients (APA, 2002:1049).

### 5.3 DRAFT GUIDELINES

The researcher developed the following draft guidelines based on Phase 1 of the study. The document includes a pre-amble and the guidelines.

#### **GUIDELINES FOR NURSES TO ADDRESS THE HEALTH CARE NEEDS OF DISPLACED WOMEN IN THE OSIRE REFUGEE CAMP**

##### **PRE-AMBLE**

The researcher conducted a descriptive phenomenological study on the health care needs of displaced women who live in the Osire refugee camp in Namibia. The participants were displaced women from different nationalities and socio-cultural backgrounds whose ages ranged between 18 and 59 years and who had been in the camp for six months and more. Displaced women were requested to answer the question: *“What are your health care needs as a displaced woman and how can those health care needs be addressed?”*

The displaced women described their health care needs in a broader view of the interconnectivity of physical-psychological-social-cultural-economic-political and environmental determinants of health.

The findings of Phase 1 revealed that the essence in the study was “restoration of hope and human dignity”. This essence is embedded in the following 8 constituents: 1) Autonomy and freedom; 2) Skills training and income-generating projects to improve and sustain health; 3) Support for vulnerable women and more specifically for those with special health care needs; 4) Protection against stigmatisation if one has an HIV-positive status; 5) Security with regard to humanitarian aid distribution and the need for supportive communication; 6) Protection against harassment, threats of harm, abuse by men and domestic violence; 7) Reintegration to home countries; 8) Participation in reproductive health care.

Each constituent became a guideline. The literature review enabled the researcher to write the actions for each guideline.

The implementation of the guidelines by the nurses might enable them to identify and define the interconnectivity of the determinants of the health care needs of displaced women and address them.

### **Guideline 1: Involvement of displaced women in decision-making processes to enhance their autonomy and freedom and to promote their health**

#### **Purpose**

The purpose of this guideline is to ensure that displaced women are involved when their health care needs are determined and addressed. Their representatives should be democratically elected to serve as a link between them and the clinic and hospital authorities. Displaced women need to be valued partners in the health care team and be empowered to make informed decisions about their own health care.

#### **Rationale**

Displaced women should be allowed to be involved to exercise their autonomy and freedom through participation in and contributions to different levels of decision making processes in the camp (United Nation Higher Commissioner for Refugees (UNHCR), 2007:25). Acknowledging their contribution and participation contributes to their mental well-being. They are likely to feel respected because their right to human dignity is valued (Benjamin, 1998:23).

They need to have a platform where they are able to communicate their experiences and feelings about their health needs (Pavlish, 2005:889; Woolfolk, 2007:378).

The UNHCR and the Universal Declaration of Human Rights recommend that governments and organisations responsible for refugees should ensure sufficient women representation

on committees to allow them to air their views and to take part in major decisions that affect them and their health (UNHCR, 2007:25; Pavlish, 2005:889-91).

### **Actions**

- Manage the democratically election of women representatives on clinic- and hospital committees.
- Empower the women representatives through training programmes to express the health care needs of displaced women.
- Institute hospital and clinic forums to create opportunities where all displaced women can discuss their health care needs with the hospital and clinic authorities.
- Provide regular feedback to the displaced women regarding changes to the health care to address their concerns.
- Involve the displaced women to institute changes to the health care delivered at the clinic and hospital.
- Encourage displaced women to evaluate the health care.

### **Guideline 2: Skills training and income-generating projects to improve and sustain health**

#### **Purpose**

The purpose of this guideline is to improve displaced women's livelihood through income-generating projects. Displaced women find themselves in an all-in-one situation in which they act as the mother-father-family provider when their parents, husbands or partners are killed in a war or could just not escape with the family. They found themselves not able to provide for their own needs and that of their families and need financial means to survive. They are therefore eager to have somebody who understands their need for income-generating projects and vocational training in order to own money to pay for food and clothes.

## **Rationale**

According to Kälin (2008:170) every human being has the right to education. Displaced women should have full access to educational programmes, which includes vocational training. Displaced women need to undergo training to equip themselves with cognitive and psychomotor skills to generate an income for themselves and for their families to improve their health (Pavlish, 2005:887-8 & 892). Opportunities for women to earn an income prevents them from selling the food and other materials that they receive as humanitarian aid and sometimes also their own bodies in order to survive (Pavlish, 2005:888; WRC, 2011:1).

Through income-generating projects displaced women could build new lives, create new social structures and enhance their social status (Agier, 2011:138).

## **Actions**

- Determine the skills profile of the women.
- Acknowledge the women's skills.
- Encourage the women to share their skills with other women.
- Create opportunities for the women to share their skills in health promotion programmes.
- Encourage the women to learn from each other in the health promotion programmes.
- Lobby for formal skills training programmes in the camp.
- Lobby for formal income generating projects in the camp.
- Enhance the development of power-from-within by encouraging women to make use of the income-generating projects.

## **Guideline 3: Support for vulnerable displaced women and more specifically for those with special health care needs**

### **Purpose**

The purpose of this guideline is to ensure that all displaced women in the camp including the most vulnerable individuals- the young women who have lost their parents, the women who have lost their husbands and the disabled women- are supported and their dignity respected.

## **Rationale**

Displaced women need to be supported to regain their strength and dignity as human beings. Their displacement made them vulnerable to being harmed and being hurt. They develop emotional wounds that are more severe and painful than physical wounds (Goldblatt, 2009:1651). The guideline will enable nurses to support their vulnerable patients through health care and to negotiate protection for them with the camp officials.

## **Actions**

- Establish a trusting therapeutic interpersonal relationship with the women.
- Involve women in their own health care through enabling health education.
- Create opportunities for the women to restore their strength and dignity in the health promotion programmes.
- Encourage women to take part in health promotion programmes that help them to feel less vulnerable.
- Acquaint oneself with the legislations related to the rights of displaced persons and ascertain that policies are being implemented in the clinic.
- Collaborate with other camp authorities to ensure that the legislation related to the rights of displaced people is implemented in the camp.
- Negotiate reporting channels for incidents of violations of safety and swift reaction to complaints on behalf of the women with the camp officials.
- Negotiate regular meetings between camp officials and representatives of the women regarding their safety and security.
- Ensure that policies regarding disabled persons be implemented in the clinic and the camp.

## **Guideline 4: Protection of displaced women against stigmatisation if one has an HIV-positive status**

### **Purpose**

The purpose of the guideline is to ensure that displaced women living with HIV-positive status and AIDS are protected from stigmatisation and to ensure that their dignity is respected at all times. The guideline is focused on the protection of all confidential

information of displaced women living with HIV-positive status and AIDS in refugee camps. No information about them or their HIV-positive status and AIDS should be communicated to others without their consent.

### **Rationale**

According to Kälin (2008:163), every person has the right to dignity, physical, mental and moral integrity, which should be respected. The stigmatisation of displaced women through discrimination on the basis of HIV and AIDS positive status is prohibited by existing international human rights standards (UNAIDS, 2000:34 & 36). The implementation of this guideline can ensure that HIV testing is done voluntarily and that all information relating to the testing is kept confidential.

### **Actions**

- Promote HIV and AIDS awareness in the camp.
- Discourage ignorance about the existence of HIV and AIDS.
- Encourage voluntary HIV testing.
- Conduct all interviews and procedures with HIV-infected-and potentially infected people in safe and supportive private settings.
- Maintain confidentiality of all information about the women and the test results.
- Conduct pre- and post-test counselling to reassure the women about the confidentiality of all information that relates to them and the test results.
- Empower women with information and coping skills regarding HIV and AIDS.
- Empower women with information and coping skills regarding possible stigmatization related to HIV and AIDS.
- Empower camp officials and displaced people with information about the prevention and management of stigmatisation of people living with HIV and AIDS.
- Respect the dignity of HIV-affected- and infected persons by discouraging all forms of stigmatisation in the health care services and in the camp.
- Acquaint oneself with national and international policies regarding the protection of the rights of persons living with HIV and AIDS and observe that policies and legislations that aim at the protection of people living with HIV and AIDS are adhered to.
- Stay abreast of new trends in caring for people living with HIV and AIDS.



## **Guideline 5: Security with regard to humanitarian aid distribution and the need for supportive communication**

### **Purpose**

The guideline refers to the collaboration with camp officials to ensure a fair distribution of humanitarian aid to displaced persons. The aid should include all support that is needed for a healthy and dignified life.

### **Rationale**

Every human being regardless of their sex, age, social status and ethnic or religious origin has the fundamental right to adequate food that is also culturally acceptable (Kälin, 2008:83-4 & 113-4; UN Special Rapporteur (2003:1). Displaced people depend on the government of the host country and non-governmental organisations to supply food, shelter, health care services, emotional and psychological support to meet their needs. The distribution of the aid should be done in a fair and transparent manner (UN Economic and Social Council report 2001: 2; CEDAW, 2003: 2; Ziegler, 2001:8).

### **Actions**

- Lobby with camp officials for equal access of displaced women to humanitarian aids.
- Lobby for displaced women's representation on and meaningful participation in humanitarian aid distribution committees.
- Collaborate with the camp management to ensure that the humanitarian aid relates to all the needs of displaced people and not only to the need for food.
- Lobby for displaced women's representation and meaningful participation in humanitarian-aid distribution committees.
- Form discussion groups with women to discuss issues of nutrition and health.
- Support endeavours to teach displaced women to prepare well-balanced meals with the food supplied to them.
- Report to the camp management any suspected acts where humanitarian aid is diverted from its legitimate destination.
- Disclose to the camp management epidemiological information relating to the prevalence

of disease that has developed as a result of insufficient humanitarian aid.

- Collaborate with the camp management to adjust the humanitarian aid when the displaced people develop diseases related to insufficient humanitarian aid.

## **Guideline 6: Protection against harassment, threats of harm, abuse by men and domestic violence**

### **Purpose**

The purpose of this guideline is to ensure that displaced women are protected from harassment, threats, harm and abuse in the camp. The guideline provides for the implementation of a multi-sectoral collaboration to prevent on primary and secondary level gender-based violence towards displaced women.

### **Rationale**

The dignity of displaced women should be respected (Kälin, 2008:53) and camp officials should make sure that their safety is not threatened in any way (Abusharaf, 2009:52; Keygnaert, Vettenburg and Temmerman, 2012:9). The guideline might enable nurses to collaborate with camp officials in the prevention and management of violence against displaced women.

### **Actions**

- Collaborate with camp management and officials to ensure the safety of displaced women in the camp.
- Ascertain that the rights of displaced people regarding their safety are explained to them on arrival in the camp.
- Negotiate with camp management that all camp officials attend on-going in-service training regarding the protection of the safety of displaced people.
- Negotiate with camp management that programmes be instituted for the empowerment of displaced women to counteract unequal power relationships in the camp.

- Lobby for women's representation on the camp committees.
- Initiate and manage awareness of abuse of women campaigns in the camp.
- Cooperate with camp management and officials in programmes to prevent abuse of women.
- Lobby for more recreational facilities to reduce the stress of displaced people and the related incidents of violence and abuse of women in the camp.
- Cooperate with camp management and officials to ensure that the dignity of abused women is respected during the reporting and management of the abuse.
- Negotiate with camp management an efficient response to reported incidents of abuse of displaced women.
- Lobby for strict law enforcement regarding abuse of women in the camp.
- Facilitate trusting relationships between nurses and displaced women to encourage women to disclose incidents of abuse.
- Provide forensic nursing care to survivors of abuse according to the country's legislation in an empathetic humane manner.
- Ensure that holistic care is rendered to survivors of abuse.
- Be willing to provide evidence in court should the survivors report the abuse to the police.
- Encourage victims of violence to report cases of abuse to the police.
- Educate the camp community to support survivors of abuse.

### **Guideline 7: Reintegration to home countries**

#### **Purpose**

The purpose of this guideline is to ensure the participation of displaced women in the repatriation to their home countries or resettlement in other countries. Many displaced people fled from their home countries not only because of conflict but also because of lack of support from their governments. They are thus fearful to return to their home countries. They fear that they will not be safe and that they may even be persecuted. Some displaced people do not have any relatives left in their home countries and on repatriation may not have people who can support them.

Displaces women are equally fearful of being resettled in other countries where they may be considered as foreigners and where they will have to adjust to unfamiliar circumstances without the support of family and friends.

### **Rationale**

The rationale of the guideline is to ensure that displaced women will be able to safely return to their home countries or being supported in their resettlement in other countries. In many refugee situations repatriation causes displaced people to fear to go back to their home countries (IRRI, 2011:1-3 & 8) or to be resettled in a foreign country (Chatelard, 2009:8). It is thus of utmost importance that the displaced people be involved in the process (Kälin, 2008:129 & 132).

### **Actions**

- Negotiate with the applicable officials for the involvement of displaced women in the planning and implementation of repatriation or resettlement.
- Ensure that the displaced women be oriented for the repatriation or resettlement by a team of camp officials and health care staff.
- Ensure that the displaced women have enough time to prepare themselves for the repatriation or resettlement.

### **Guideline 8: Participation in reproductive health care**

#### **Purpose**

The purpose of this guideline is to ascertain that displaced women have access to reproductive health care in the refugee camps. They should also receive health education to enable them to take care of their reproductive health.

#### **Rationale**

The participation of women in their reproductive health care enables them to improve their health, to detect early signs of pathology and get help timely. Poor participation results in ignorance of the women and confusion about contraception and other aspects of their

reproductive health (Pavlish, 2005:889). Their involvement enables health care providers to, respect and consider the interconnectivity of cultural practices and reproductive health care. The optimal education of displaced women to be involved in their reproductive health care is thus a priority (Kälin, 2008:90).

### **Actions**

- Acknowledge the cultural, religious and educational background of displaced women that may influence their participation in their reproductive health care.
- Deliver a culture-congruent comprehensive reproductive health care service to displaced women.
- Encourage the involvement of displaced women in their reproductive health care.
- Enhance participation of displaced women in their reproductive health care through well planned appropriate health education.

## **5.4 REFINEMENT OF THE GUIDELINES**

Experts in women's health and the care of displaced women were involved in the refinement of the guidelines. They were asked to use an instrument with a Likert scale to rate the draft guidelines to indicate whether they agree that the guidelines were appropriate for addressing the health care needs of displaced women. The experts were also asked to provide comments on how to improve the guidelines (Refer to Addendum 7A).

With a separate instrument the experts were requested to indicate whether the guidelines were clear, applicable, reliable and flexible (Refer to Addendum 7 B).

### **Data collection method and instrument: Delphi round 1**

The Delphi technique is defined as a systematic, interactive forecasting method in which a panel of experts is used to gather their input and opinions about a phenomenon in question without their being brought together face-to-face. Data is gathered through repetitive rounds till the experts reach consensus about the phenomenon (Cline 2000:1, Polit and Beck, 2006:498, 2008:327). According to Kennedy (2003:504-5), the Delphi technique gives the chance to

experts to communicate their ideas and knowledge anonymously with regard to a phenomenon. In this study the experts were requested to refine the draft guidelines.

The experts were purposively selected according to their expertise in women's health and, more specifically, their experience in caring for displaced women. Purposive sampling involves the selection of participants who are knowledgeable about the phenomenon under study (Polit & Beck, 2008:343). Ten experts were recruited to participate in the refinement of the guidelines and they agreed. One expert withdrew from research without giving reasons. The experts were from different countries and had a variety of qualifications to ensure a richness of opinions (Cline, 2000:2) (Refer to Table 5.1 for the biography of the experts).

A cover letter explaining the objectives and the process of the Delphi technique was sent to the participants after they indicated their willingness to participate. They gave informed consent to be participants in the study. Their willingness to participate was also considered as informed consent.

An instrument to refine the guidelines including the objectives of the study, a summary of the findings of Phase One of the study, and instructions to take part in the refinement of the guidelines were sent to the participants individually (Refer to Addendum 3) to ensure that they did not know who the other participants were. Each expert ranked the guidelines individually and, strictly anonymously (Hasson, *et al.* 2000:1012; Cline, 2000: paragraph 5; Skulmoski, *et al.* 2007:2; Kennedy, 2004:505).

The validity of the findings of the ranking of the experts was ensured through the involvement of experts regarding the topic as well as the use of more than one round of refinement (Hasson, *et al.* 2000:1013). Although the reliability of the findings gathered through a Delphi technique study is often questioned, the involvement of experts and the gathering of data through more than one round contributed to the reliability of the refinement of the guidelines (Hasson, *et al.* 2000:1013; Skulmoski, *et al.* 2007:10).

After the feedback from the participants had been received the researcher analysed the responses and identified the guidelines on which consensus was reached. Consensus refers to the process by which all members of the group, in this case "experts", agree on an issue

under discussion (Hornby, 2006:309). The recommendations of the participants for the reformulation of some of the guidelines were attended to and included in the document that was used in the second round of the refinement (Hasson, *et al.* 2000:1011-2).

**Table 5.1: The biographic information of the participants of the Delphi technique**

Occupation	Professional qualifications	Current employment and experience	Reason for Selection	Country
Professional nurse	<ul style="list-style-type: none"> <li>Registered Nurse/Midwife/ Psychiatry</li> <li>Bachelor of Nursing Science</li> <li>Bachelor of Nursing Science Honours</li> <li>MCur Nursing Science</li> <li>PhD</li> </ul>	University lecturer in Psychiatric Nursing Science;  Experienced in group and individual therapy	Professional nurse, has a background on women's health from her nursing training	South Africa
Professional nurse	<ul style="list-style-type: none"> <li>Registered Nurse/Midwife</li> <li>Master Degree</li> <li>PhD</li> </ul>	University lecturer in Community Nursing Science;  Nurse and midwife for 25 years	Professional nurse, has a background on women's health from her nursing training	Malawi
Professional nurse	<ul style="list-style-type: none"> <li>Registered Nurse/Midwife</li> <li>Bachelor in Nursing Science: Nursing Education &amp; Community health</li> <li>Advanced Diploma in Paediatric Nursing Science</li> <li>Master in Public Health: Community Health</li> </ul>	Chief Health Programme Administrator;  Employed in the Osire Refugee Camp from 2007 to 2010	Worked as a health programme officer at Osire refugee camp	Namibia
Professional	<ul style="list-style-type: none"> <li>Registered Nurse/Midwife</li> </ul>	University lecturer in	Professional nurse, has a background	Namibia

nurse	<ul style="list-style-type: none"> <li>• PhD</li> </ul>	Midwifery Science;  Researcher in women's health	on women's health from her nursing training	
Professional nurse	<ul style="list-style-type: none"> <li>• Registered Nurse/Midwife</li> <li>• Bachelor of Nursing Science/Nursing Education</li> <li>• Master degree</li> </ul>	University lecturer in Community Nursing Science and Mental Health	7 years of Community teaching; 15 years of experience in working as a nurse in the community as well as in the hospital; experience in working with women in communities and prisons on gender and sexual and reproductive health and rights issues; a national trainer in adolescent sexual reproductive health and rights and peer education among young people especially the girl child; activist in women SRHR issues	Malawi
Professional nurse	<ul style="list-style-type: none"> <li>• Associate Professor</li> </ul>	University lecturer and researcher in women's health	Researched refugee's health and published articles on refugee health	United States of America
Professional nurse	<ul style="list-style-type: none"> <li>• Lecturer</li> </ul>	Clinical nurse;  Worked with refugees at the Osire Refugee Camp as a programme officer responsible for the overall management of the health issues in the camp	Worked with refugees at Osire refugee camp as a program officer responsible for the overall management of the health issues in the camp under NGO's (AHA in	Namibia



			partner with UNHCR); 2002-2005.	
Professional nurse	• Professor	University lecturer in nursing research	25 years of experience as a nurse	Namibia
Professional nurse	• Humanitarian worker	Clinical nurse; Employed by MEDECINS SANS FRONTIERES; 9 years' experience in humanitarian work	Professional experience	South Africa

### The analysis of the feedback from experts: Delphi round 1

Nine participants were selected for refinement of the guidelines. All nine agreed that the guidelines were applicable and some made suggestions for the improvement of the actions. The numerical findings are presented in Table 5.2 below and comments to improve the construction of the actions were used to re-phrase the guidelines for the second round of the Delphi study.

**Table 5.2: Analysis of the findings: Delphi round 1 (n=9)**

Guideline 1	Strongly agree	Agree	Disagree	Strongly disagree
Action 1	6	3	0	0
Action 2	7	2	0	0
Action 3	8	0	1	0
Action 4	7	2	0	0
Action 5	6	2	0	1
Action 6	7	2	0	0
<b>Guideline 2</b>				
Action 1	5	4	0	0
Action 2	7	2	0	0
Action 3	7	2	0	0
Action 4	5	3	1	0
Action 5	5	4	0	0
Action 6	5	4	0	0
Action 7	4	4	1	0
Action 8	6	3	0	0
<b>Guideline 3</b>				
Action 1	7	2	0	0

Action 2	7	2	0	0
Action 3	5	4	0	0
Action 4	6	3	0	0
Action 5	8	1	0	0
Action 6	9	0	0	0
Action 7	7	1	1	0
Action 8	7	2	0	0
Action 9	8	1	0	0
<b>Guideline 4</b>				
Action 1	7	0	2	0
Action 2	5	3	1	0
Action 3	9	0	0	0
Action 4	9	0	0	0
Action 5	9	0	0	0
Action 6	7	2	0	0
Action 7	7	2	0	0
Action 8	7	2	0	0
Action 9	7	2	0	0
Action 10	8	1	0	0
Action 11	9	0	0	0
Action 12	8	1	0	0

<b>Guideline 5</b>				
Action 1	6	3	0	0
Action 2	6	3	0	0
Action 3	8	1	0	0
Action 4	8	1	0	0
Action 5	9	0	0	0
Action 6	8	1	0	0
Action 7	7	2	0	0
Action 8	7	2	0	0
Action 9	9	0	0	0
<b>Guideline 6</b>				
Action 1	6	3	0	0
Action 2	6	3	0	0
Action 3	8	1	0	0
Action 4	6	3	0	0
Action 5	7	2	0	0
Action 6	9	0	0	0
Action 7	5	4	0	0
Action 8	4	5	0	0
Action 9	7	2	0	0
Action 10	6	3	0	0
Action 11	6	3	0	0
Action 12	7	2	0	0
Action 13	8	1	0	0
Action 14	8	1	0	0
Action 15	8	1	0	0
Action 16	7	2	0	0
Action 17	8	1	0	0
<b>Guideline 7</b>				
Action 1	7	2	0	0
Action 2	8	1	0	0
Action 3	7	2	0	0
<b>Guideline 8</b>				
Action 1	9	0	0	0
Action 2	8	1	0	0
Action 3	7	2	0	0
Action 4	9	0	0	0

Another rating scale was sent to the participants together with the guidelines. They were requested to rate the guidelines using the criteria of clarity, applicability, reliability and flexibility (Addendum 7B). In Table 5.3 their rating of the guidelines is presented.

**Table 5.3: Analysis of the findings on the criteria of clarity, applicability, reliability and flexibility: Delphi round 1 (n=9)**

	Criteria	Clarity				Applicability				Reliability				Flexibility			
		S A	A	D	S D	S A	A	D	S D	S A	A	D	S D	S A	A	D	S D
<b>Guideline 1</b>		6	2	1	0	7	1	1	0	8	1	0	0	8	0	1	0
<b>Guideline 2</b>		5	2	0	2	8	1	0	0	6	3	0	0	9	0	0	0
<b>Guideline 3</b>		6	3	0	0	8	1	0	0	7	2	0	0	9	0	0	0
<b>Guideline 4</b>		8	0	1	0	8	1	0	0	9	0	0	0	9	0	0	0
<b>Guideline 5</b>		8	1	0	0	9	0	0	0	8	1	0	0	3	6	0	0
<b>Guideline 6</b>		8	1	0	0	8	1	0	0	9	0	0	0	8	1	0	0
<b>Guideline 7</b>		7	1	1	0	9	0	0	0	7	2	0	0	9	0	0	0
<b>Guideline 8</b>		9	0	0	0	9	0	0	0	9	0	0	0	9	0	0	0

**Instrument: SA= Strongly agree; A= Agree; D= Disagree; SD= Strongly disagree**

Number of D/SD: Guideline 1=3; guideline 2=2; guideline 3=0; guideline 4=1; guideline 5=0; guideline 6=0; guideline 7=1; guideline 8=0.

Number of highest SA/A: guideline 1=8; guideline 2=9; guideline 3=9; guideline 4=9; guideline 5=9; guideline 6=8; guideline 7=9; guideline 8=9. The consensus that was reached in this research is 89 -100 percentage.

### **Data collection method and instrument: Delphi round 2**

A second set of guidelines was developed following responses from the experts in round one. Participants who agreed to participate in the Delphi process round one were contacted through e-mails with a cover letter to clarify the objectives, condition of participation, and the summary of the findings from round one as well as the documentation of round two (Addendum 2B).

The recommendations for the improvement of the actions were implemented in the revised set of guidelines that was sent to the participants. They were requested to evaluate the revised

guidelines and to indicate whether they strongly agreed, agreed, disagreed or strongly disagreed with the content of the guidelines and the actions.

Data was analysed in the same way as in round one. As soon as the researcher had obtained the comments, inputs and recommendations from the participants these were incorporated in the guidelines. The majority of the participants that responded during the second round (n=8) strongly agreed with the guidelines and the actions. (Refer to Table 5.4).

The guidelines were considered as refined when the participants had reached consensus about the applicability of the guidelines to attending to the health care needs of displaced women (Polit and Beck, 2008:327-8; Hasson, *et al.* 2000:1011-2). A consensus is reached when 51% of the experts agree on an item (Keeney, *et al.* 2005:210).

**Table 5.4: Analysis of the findings of the Delphi round 2 (n=8)**

<b>Guideline 1</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Action 1	8	0	0	0
Action 2	8	0	0	0
Action 3	8	0	0	1
Action 4	8	0	0	0
Action 5	8	0	0	0
Action 6	8	0	0	0
<b>Guideline 2</b>				
Action 1	8	0	0	0
Action 2	8	0	0	0
Action 3	8	0	0	0
Action 4	8	0	0	0
Action 5	7	1	0	0
Action 6	8	0	0	0
Action 7	7	1	0	0
Action 8	7	1	0	0
<b>Guideline 3</b>				
Action 1	8	0	0	0
Action 2	8	0	0	0
Action 3	8	0	0	0
Action 4	8	0	0	0
Action 5	8	0	0	0
Action 6	8	0	0	0
Action 7	7	1	0	0
Action 8	8	0	0	0
Action 9	8	0	0	0

<b>Guideline 4</b>				
Action 1	8	0	0	0
Action 2	8	0	0	0
Action 3	8	0	0	0
Action 4	8	0	0	0
Action 5	8	0	0	0
Action 6	8	0	0	0
Action 7	8	0	0	0
Action 8	8	0	0	0
Action 9	8	0	0	0
Action 10	8	0	0	0
Action 11	8	0	0	0
Action 12	8	0	0	0
<b>Guideline 5</b>				
Action 1	8	0	0	0
Action 2	8	0	0	0
Action 3	8	0	0	0
Action 4	8	0	0	0
Action 5	8	0	0	0
Action 6	8	0	0	0
Action 7	8	0	0	0
Action 8	8	0	0	0
Action 9	8	0	0	0
<b>Guideline 6</b>				
Action 1	8	0	0	0
Action 2	7	1	0	0
Action 3	8	0	0	0
Action 4	8	0	0	0
Action 5	8	0	0	0
Action 6	8	0	0	0
Action 7	8	0	0	0
Action 8	8	0	0	0
Action 9	8	0	0	0
Action 10	8	0	0	0
Action 11	8	0	0	0
Action 12	8	0	0	0
Action 13	8	0	0	0
Action 14	8	0	0	0
Action 15	8	0	0	0
Action 16	8	0	0	0
Action 17	8	0	0	0
<b>Guideline 7</b>				
Action 1	8	0	0	0
Action 2	8	0	0	0

Action 3	8	0	0	0
<b>Guideline 8</b>				
Action 1	8	0	0	0
Action 2	8	1	0	0
Action 3	8	2	0	0
Action 4	8	0	0	0

## 5.5 THE REVISED SET OF GUIDELINES

The revised set of the guidelines shows that there is a need for a collaborative effort between nurses and other sectors in the camp in order to meet the health care needs of the displaced women. Collaboration with the camp officials, NGO's; volunteer workers and faith-based organisations is required. The changes that have been made to the draft set of guidelines are indicated in italic and in bold in the revised set of guidelines in this chapter.

### PRE-AMBLE

The researcher conducted a descriptive phenomenological study on the health care needs of displaced women who live in the Osire refugee camp in Namibia. The participants were displaced women from different nationalities and socio-cultural backgrounds whose ages ranged between 18 and 59 years and who had been in the camp for six months and more. Displaced women were requested to answer the question: *“What are your health care needs as a displaced woman and how can that health care needs be addressed?”*

The findings of phase 1 revealed that the essence in the study is “Restoration of hope and human dignity”. This essence is embedded in the following 8 constituents: 1) Autonomy and freedom; 2) Skills training and income-generating projects to improve and sustain health; 3) Support for all vulnerable women and more specifically for those with special health care needs; 4) Protection against stigmatisation if one has an HIV-positive status; 5) Security with regard to humanitarian aid distribution and the need for supportive communication; 6) Protection against harassment, threats of harm, abuse by men and domestic violence; 7) Reintegration to home countries; 8) Participation in reproductive health care. Each constituent became a guideline. The literature review enabled the researcher to write the actions for each guideline.

The implementation of the guidelines by the nurses should enable them to identify and define the interconnectivity of the determinants of the health care needs of displaced women and address them.

### **Guideline 1: Involvement of displaced women in decision-making processes to enhance their autonomy and freedom and to promote their health**

#### **Purpose**

The purpose of this guideline is to ensure that displaced women are involved when their health care needs are determined and addressed. Their representatives should be democratically elected to serve as a link between them and the clinic and hospital authorities. Displaced women need to be valued partners in the health care team and be empowered to make informed decisions about their own health care.

#### **Rationale**

Displaced women should be allowed to be involved to exercise their autonomy and freedom through participation and contributions in different levels of decision-making processes in the camp (United Nation Higher Commissioner for Refugees (UNHCR), 2007:25). Acknowledging their contribution and participation contributes to their mental well-being.

They will feel respected because their right to human dignity is valued (Benjamin, 1998:23). They need to have a platform where they are able to communicate their experiences and feelings about their health needs (Pavlish, 2005:889; Woolfolk, 2007:378).

The UNHCR and the Universal Declaration of Human Rights recommend that governments and organisations responsible for refugees should ensure sufficient women representation on committees to allow them to air their views and to take part in major decisions that affect them and their health (UNHCR, 2007:25; Pavlish, 2005:889, 90-1).

#### **Actions**

##### **The nurses in the camp would:**

- Lobby with camp management to manage the democratic election of women representatives on clinic and hospital committees.



- Empower the women representatives to mobilise the displaced women through training programmes on how to identify, assess and clearly voice the health care needs of the displaced women.
- Institute hospital and clinic forums to create opportunities where all displaced women can discuss their health care needs with the hospital and clinic authorities.
- Motivate displaced women to evaluate the health care delivered at the clinic and hospital.
- Provide regular feedback to the displaced women regarding changes to the health care system they access to address their concerns.
- Provide opportunities for and involve the displaced women in recommending and evaluating required changes to the health care delivered at the clinic and hospital.
- Ensure training of the health care providers about effective ways of communication so that they actually listen to the women's voices.

## **Guideline 2. Skills training and income-generating projects to improve and sustain the health of displaced women**

### **Purpose**

The purpose of this guideline is to improve displaced women's livelihood through income-generating projects. Displaced women find themselves in an all-in-one situation when they act as the mother-father-family provider when their parents, husbands or partners are killed in a war or could just not escape with the family. They found themselves unable to provide for their own needs and that of their families and need financial means to survive. They are therefore eager to have somebody who understands their need for income-generating projects and vocational training in order to own money to pay for food and clothes.

### **Rationale**

According to Kälin (2008:170) every human being has the right to education. Displaced women should have full access to educational programmes, which includes vocational training. Displaced women need to undergo training to equip them with cognitive and psychomotor skills to generate an income for themselves and for their families to improve their health (Pavlish, 2005:887-8 & 892). A lack of opportunities for women to earn an

income prevents them from selling the food and other materials that they receive as humanitarian aid and sometimes also their own bodies in order to survive (Pavlish, 2005:888; WRC, 2011:1). Through income-generating projects displaced women will build new lives, create new social structures and enhance their social status (Agier, 2011:138).

## **Actions**

### **The nurses in the camp would:**

- Collaborate with the social worker to assess and determine the knowledge and skills' profile of the women.
- Acknowledge and appreciate the women's knowledge and skills and include activities that build their confidence.
- Sensitise and advocate displaced women on their fundamental human rights
- Develop a platform where women who have the necessary knowledge and skills can share them with other women.
- Organise with NGO's for opportunities such as weekly basket weaving days where women can meet and share their knowledge and skills in health promotion programmes.
- Collaborate with the social worker and NGO's to persuade women who are less skilled to learn from other women who are more skilled in the health promotion programmes.
- Lobby with the social worker, volunteers, church groups and NGO's for formal skills training programmes in the camp through the programme officer.
- Lobby with volunteers, faith-based groups and NGO's for formal income-generating projects in the camp, including business management skills such as record-keeping, making and managing money, marketing the small business, forming a women's co-operative and growing a business as ways to develop women's confidence in themselves and to empower them.
- Enhance the development of power-from-within by encouraging women to make use of the income-generating projects.

### **Guideline 3: Support for all vulnerable displaced women and more especially those with special health care needs.**

#### **Purpose**

The purpose of this guideline is to ensure that all displaced women in the camp- including the most vulnerable individuals such as the young women who have lost their parents, the women who have lost their husbands and the disabled women- are supported and their dignity respected.

#### **Rationale**

Displaced women need to be supported to regain their strength and dignity as human beings. Their displacement made them become vulnerable to being harmed and being hurt. The guideline will enable nurses to support their vulnerable patients during the provision of health care and to negotiate protection on their behalf with the camp officials.

#### **Actions**

##### **The nurses in the camp would:**

- Establish a trusting therapeutic interpersonal relationship with the women through showing empathy and respect to them.
- Involve women in their own health care through enabling *holistic* health education.
- Create opportunities such as a women's forum and women's meetings for the women to restore their strength and dignity in the health promotion programmes.
- Sensitise and advocate all persons *in the camp* about fundamental human rights *including rights of women*.
- Motivate women to take part in health promotion programmes that help them to feel *more resilient* and less vulnerable such as community development programmes.
- Acquaint *oneself* with the legislations related to the rights of all displaced persons, spread awareness about the legislations, and ascertain that policies are implemented in the clinic.
- Collaborate with other camp authorities to ensure that the legislations related to the

rights of displaced people are implemented in the camp.

- Use the safety and security officials' reporting channels for incidents of violations of safety and implement swift reaction to complaints on behalf of the women with the camp officials.
- Negotiate regular meetings between camp officials and representatives of the women regarding their safety and security.
- Ensure that policies regarding disabled persons are implemented in the clinic and the camp.
- Lobby with NGO's and camp management for the training of security officials in the camp to take women's safety and security concerns seriously.
- Involve women *and men* in **discussions about how to create** a safe environment especially for women and girls.

#### **Guideline 4: Protection of displaced women against stigmatisation if one has an HIV-positive status**

##### **Purpose**

The purpose of the guideline is to ensure that displaced women living with HIV and AIDS are protected from stigmatisation and to ensure that their dignity is respected at all times. The guideline is focused on the protection of all confidential information of displaced women living with HIV in refugee camps. No information about them or their HIV and AIDS status should be communicated to others without their consent.

##### **Rationale**

According to Kälin (2008:163), every person has the right to dignity, physical, mental and moral integrity which should be respected. The stigmatisation of displaced women due to discrimination on the basis of HIV and AIDS is prohibited by existing international human rights standards (UNAIDS, 2000:34 & 36). The implementation of this guideline can ensure that HIV testing is done voluntarily and that all information relating to the testing is kept confidential.

## Actions

### The nurses in the camp would:

- Promote HIV and AIDS awareness and discourage ignorance of community members about the existence of HIV and AIDS through support groups, volunteers, *faith-based* HIV and AIDS action groups and community-based organisations and community education.
- Persuade women to go for voluntary HIV testing through voluntary counselling services.
- Conduct all interviews and procedures with HIV infected and potentially infected people in safe and supportive private settings.
- Maintain confidentiality of all women's health information and the test results.
- Conduct pre- and post-test counselling to reassure the women about the confidentiality of all information that relates to them and the test results.
- ***Empower people living with HIV and AIDS with the knowledge on how to respond to stigmatisation behaviours from community members.***
- Collaborate with International HIV and AIDS organisations, volunteers, faith groups, psycho-educational groups and NGO's to empower women with information, reading materials and coping skills regarding possible stigmatisation related to HIV and AIDS.
- Provide avenues so that camp officials and displaced people can have open access to information about the prevention and the management of stigmatisation of people living with HIV and AIDS and to take part in combating stigmatisation due to HIV and AIDS positive status.
- Respect the dignity of HIV-affected-and infected persons-, and discourages all forms of stigmatization in the health care services and in the camp ***through education and policy development.***
- Acquaint self and teach others about national and international policies regarding the protection of the rights of persons living with HIV and AIDS and observe that policies and legislations that aim at the protection of people living with HIV and AIDS are adhered to.
- Stay abreast of new trends in caring for people living with HIV and AIDS through attending personnel-development seminars and workshop and self-reading.
- Lobby with international HIV and AIDS organisations to provide reading and psycho-educational material to empower women with information and coping skills regarding possible stigmatisation related to HIV and AIDS.

## **Guideline 5: Security with regard to humanitarian-aid distribution and supportive communication with humanitarian-aid distribution**

### **Purpose**

The guideline refers to the collaboration with camp officials to ensure a fair distribution of humanitarian aid to displaced persons. The aid should include all support that is needed for a healthy and dignified life.

### **Rationale**

Every human being regardless of their sex, age, social status and ethnic or religious origin has the fundamental right to adequate food that is also culturally acceptable (Kälin, 2008:83-4, & 113-4; UN Special Rapporteur (2003:1). Displaced people depend on the government of the host country and NGO's to supply food, shelter, health care services, emotional and psychological support to meet their needs. The distribution of the aid should be done in a fair and transparent manner (UN Economic and Social Council report. 2001:2; Convention on the Elimination of all forms of Discrimination against Women (CEDAW) 2003:2; Ziegler, 2001:8).

### **Actions**

#### **The nurses in the camp would:**

- Lobby with camp officials for equal access of displaced women to humanitarian aids.
- Lobby with the programme officer for displaced women's representation and meaningful participation in humanitarian aid distribution committees.
- Collaborate with the camp management to ensure that the humanitarian aid relates to all the needs of displaced people such as the safety during humanitarian aid distribution and the need for a balanced diet and not only just to the need for food.
- Form discussion groups with women to discuss issues of nutrition and health **especially with the food that are available**.
- Support endeavours to teach displaced women to prepare well-balanced meals with the food supplied to them through the programme officer.
- Report to the camp management any suspected acts where humanitarian aid is diverted from its legitimate destination.

- Disclose to the camp management epidemiological information relating to the prevalence of disease that has developed due to insufficient humanitarian aid.
- Collaborate with the camp management to adjust the humanitarian aid when the displaced people develop diseases related to insufficient humanitarian aid.

## **Guideline 6: Protection against harassment, threats of harm, abuse by men and domestic violence**

### **Purpose**

The purpose of this guideline is to ensure that displaced women are protected from harassment, threats, harm and abuse in the camp. The guideline provides for the implementation of a multi-sectorial collaboration to prevent on primary and secondary level gender-based violence of displaced women.

### **Rationale**

The dignity of displaced women should be respected Kälin (2008:53) and camp officials should make sure that their safety is not threatened in any way (Abusharaf, 2009:52; Keygnaert, Vettenburg and Temmerman, 2012:9). The guideline will enable nurses to collaborate with camp officials in the prevention and management of violence against displaced women.

### **Actions**

#### **The nurses in the camp would:**

- Collaborate with camp management and officials to ensure the safety of displaced women and girls in the camp.
- Ascertain that the rights of displaced people ***especially the rights of women*** with regards to their safety are explained to women ***and men*** on arrival at the camp including policies on how they should report safety concerns.
- Negotiate with camp management that all camp officials attend on-going in-service training regarding the protection of the safety of displaced people.
- Negotiate with camp management that programmes be instituted for the empowerment ***and education*** of displaced women to counteract unequal power relationships in the

camp.

- Lobby with camp management for women representation in the camp committees.
- Initiate and manage awareness of abuse of women campaigns in the camp with the assistance of NGO's; volunteers; **faith-based** HIV/AIDS groups and gender-based organisations in developing programmes that aim at the prevention of abuse among women in the camp.
- Offer programmes on the impact of violence and abuse on the total well-being of the survivor of violence and abuse as part of the campaign on abuse and violence prevention.
- Cooperate with camp management and camp officials; volunteers; gender-based organisations, **faith-based organisations** and NGO's in developing programmes that aim at the prevention of abuse among women in the camp.
- Lobby with camp management for more recreation facilities to reduce the stress of displaced people and the related incidents of violence and abuse of women in the camp.
- Cooperate with camp management and camp officials, volunteers, gender-based organisations, **faith-based** organisations and NGO's to **develop educational programmes that aim at educating the camp community about the health effects of violence and abuse.**
- Negotiate with camp management for efficient **medical and legal** responses to reported incidents from abuse of displaced women.
- Lobby for the strict law enforcement regarding abuse of women and girls in the camp.
- Negotiate with camp officials for the training and awareness campaigns on the legislation about the abuse of women.
- Facilitate trusting relationships between nurses and displaced women to encourage women to disclose incidents of abuse.
- Provide forensic nursing care to survivors of abuse according to the country's legislation in an empathetic humane manner.
- Ensure that holistic care is rendered to survivors of abuse.
- Be willing to provide evidence in court should the survivors report the abuse to the police.
- Motivate victims of violence to report to the police cases of abuse.
- Educate the security forces and camp community to support survivors of abuse through community-based organisations; volunteers and gender-based organisations; formal



counselling, mutual understanding and respect of their dignity.

- ***Support efforts to hold perpetrators of violence accountable for their actions and the harms that resulted from their actions.***

## **Guideline 7: Reintegration to home countries**

### **Purpose**

The purpose of this guideline is to ensure the participation of displaced women in the repatriation to their home countries or resettlement in other countries. Many displaced people fled from their home countries not only because of conflict, but also because of lack of support from their governments. They are thus fearful to return to their home countries. They fear that they will not be safe and that they may even be persecuted. Some displaced people do not have any relatives left in their home countries and on repatriation may not have people who can support them.

They are equally fearful of being resettled in other countries where they may be considered as foreigners and where they also will have to adjust to unfamiliar circumstances without the support of family and friends.

### **Rationale**

The rationale of the guideline is to ensure that displaced women will be able to safely return to their home countries or being supported in their resettlement in other countries. In many refugee situations repatriation causes displaced people to fear to go back to their home countries (IRRI, 2011:1-3 & 8) or to be resettled in a foreign country (Chatelard, 2009:8). It is thus of utmost importance that the displaced people be involved in the process (Kälin, 2008:129 & 132).

### **Actions**

#### **The nurses in the camp would:**

- Negotiate with the relevant officials for the involvement of displaced women in the planning and implementation of repatriation, reintegration or resettlement.

- Ensure that the displaced women be oriented for the repatriation or resettlement by a team of camp officials and health care staff.
- Ensure that the displaced women have enough time to prepare themselves *and their families* for the repatriation, *local integration* or resettlement *especially those who are willing to stay in Namibia*.
- *Ensure that displaced women receive trauma counselling by a trained trauma counsellor as part of their preparation for repatriation, reintegration or resettlement.*

### **Guideline 8: Participation in reproductive health care**

#### **Purpose**

The purpose of this guideline is to ascertain that displaced women have access to reproductive health care services in the refugee camps. They should also receive health education to enable them to make informed choice and take care of their reproductive health issues.

#### **Rationale**

The participation of women in their reproductive health care enables them to improve their health, to detect early signs of pathology and get help timely. Poor participation results in ignorance of the women and confusion about contraception and other issues of their reproductive health (Pavlish, 2005:889). Their involvement enables health care providers to, respect and consider the interconnectivity of cultural practices and reproductive health care. The optimal education of displaced women so that they can become involved in their reproductive health care is thus a priority (Kälin, 2008:90).

#### **Actions**

##### **The nurses in the camp would:**

- Acknowledge the cultural, religious and educational background of displaced women that may influence their participation in their reproductive health care.
- Deliver a culture-congruent comprehensive reproductive health care service to displaced women.
- *Openly discuss with displaced women their reproductive health concerns on how cultural*

*beliefs affect their reproductive health concerns and deliver women-centred culture-aware comprehensive reproductive health services to displaced women.*

- *Motivate displaced women to openly discuss reproductive health concerns with their daughters.*
- Motivate active involvement of displaced women in their reproductive health care through discussion groups to **assess their reproductive health concerns and** educate them to have an understanding of the value of female reproductive organs and to learn about the importance of the reproductive health care services and concerns.
- Enhance participation of displaced women in their reproductive health care through well planned appropriate health education.
- Lobby with the programme officer for comprehensive sexual and reproductive health services for displaced women.

## 5.6 SUMMARY

In Chapter 5 the researcher described the draft guidelines and its refinement.

In Chapter 6 the researcher describes the final set of guidelines to address the health care needs of displaced women, makes recommendations for further study and discusses the limitations of the research and conclusion.

## CHAPTER 6

### DESCRIPTION OF GUIDELINES, RECOMMENDATIONS, AND CONCLUSION

#### 6.1 INTRODUCTION

In Chapter five the development of guidelines to address the health care needs of displaced women was discussed. The guidelines were refined by experts through the Delphi technique. Measures to ensure validity of the guidelines were taken. In this chapter the final set of the guidelines is presented and recommendations for the use of it are made.

#### 6.2 SUMMARY OF THE STUDY

The research was conducted with female displaced women who were at the time of the research 18 years and older and living in the Osire refugee camp. They had undergone different kinds of psycho-somatic-socio-cultural trauma during refuge as well as in the camps. They perceive that if their health care needs are met that would contribute to their total well-being. Their life in the camp was challenging. In Phase One a phenomenological inquiry was used to explore and describe the health care needs of displaced women. Face-to-face interviews were conducted with the participants. A literature review was done to help the researcher to understand the phenomenon.

In Phase Two of the study the constituents were changed into guidelines for nurses to address the health care needs of displaced women in the Osire refugee camp. The guidelines were refined by experts in women's health and the care of displaced women.

## 6.3 FINAL SET OF GUIDELINES

### **GUIDELINES FOR NURSES TO ADDRESS THE HEALTH CARE NEEDS OF DISPLACED WOMEN IN THE OSIRE REFUGEE CAMP**

#### **PRE-AMBLE**

The researcher conducted a descriptive phenomenological research study on the health care needs of displaced women who live in the Osire refugee camp in Namibia. The participants were displaced women from different nationalities and socio-cultural backgrounds whose ages ranged between 18 and 59 years and who have been in the camp for six months and more. Displaced women were requested to answer the question: *“What are your health care needs as a displaced woman and how can those health care needs be addressed?”*

The displaced women described their health care needs in a broader view of the interconnectivity of physical-psychological-social-cultural-economic-political and environmental determinants of health.

The literature review enabled the researcher to write the actions for each guideline. The implementation of the guidelines by the nurses will enable them to identify and define the interconnectivity of the determinants of the health care needs of displaced women and address them.

#### **Guideline 1: Involvement of displaced women in decision-making processes to enhance their autonomy and freedom and to promote their health**

##### **Purpose**

The purpose of this guideline is to ensure that displaced women are involved when their health care needs are determined and addressed. Their representatives should be democratically elected to serve as a link between them and the clinic and hospital authorities. Displaced women need to be valued partners in the health care team and be empowered to make informed decisions about their own health care.

## **Rationale**

Displaced women should be allowed to be involved to exercise their autonomy and freedom through participation and contributions in different levels of decision-making processes in the camp (United Nation Higher Commissioner for Refugees (UNHCR), 2007:25). Acknowledging their contribution and participation contributes to their mental well-being. They will feel respected because their right to human dignity is valued (Benjamin, 1998:23). They need to have a platform where they are able to communicate their experiences and feelings about their health needs (Pavlish, 2005:889; Woolfolk, 2007:378). The UNHCR and the Universal Declaration of Human Rights recommend that governments and organisations responsible for refugees should ensure sufficient women representation on committees to allow them to air their views and to take part in major decisions that affect them and their health (UNHCR, 2007:25; Pavlish, 2005:889, 890-1).

## **Actions**

### **The nurses in the camp would:**

- Lobby with camp management to manage the democratic election of women representatives on clinic- and hospital committees.
- Empower the women representatives to mobilise the displaced women through training programmes on how to identify, assess and clearly voice the health care needs of the displaced women.
- Institute hospital- and clinic forums to create opportunities where all displaced women can discuss their health care needs with the hospital- and clinic authorities.
- Motivate displaced women to evaluate the health care delivered at the clinic and hospital.
- Provide regular feedback to the displaced women regarding changes to the health care system they access to address their concerns.
- Provide opportunities for and involve the displaced women to recommend and evaluate required changes to the health care delivered at the clinic and hospital.
- Ensure training of the health care providers about effective ways of communication so that they actually listen to the women's voices.

## **Guideline 2: Skills training and income-generating projects to improve and sustain the health of displaced women**

### **Purpose**

The purpose of this guideline is to improve displaced women's livelihood through income-generating projects. Displaced women find themselves in an all-in-one situation whereby they act as the mother-father-family provider when their parents, husbands or partners are killed due to war or could just not escape with the family. They found themselves unable to provide for their own needs and that of their families and need financial means to survive. They are therefore eager to have somebody who understands their need for income generating projects and vocational training in order to own money to pay for food and clothes.

### **Rationale**

According to Kälin (2008:170) every human being has the right to education. Displaced women should have full access to educational programmes which includes vocational training. Displaced women need to undergo training to equip them with cognitive and psychomotor skills to generate an income for themselves and for their families to improve their health (Pavlish, 2005:887-8 & 892). Opportunities for women to earn an income prevents them from selling the food and other materials that they receive as humanitarian aid and sometimes also their own bodies in order to survive (Pavlish, 2005:888; WRC, 2011:1). Through income generating projects displaced women will build new lives, create new social structures and enhance their social status (Agier, 2011:138).

### **Actions**

#### **The nurses in the camp would:**

- Collaborate with the social worker to assess and determine the knowledge and skills' profile of the women.
- Acknowledge and appreciate the women's knowledge and skills and include activities that build their confidence.

- Sensitise and advocate displaced women on their fundamental human rights.
- Develop a platform where women who have the necessary knowledge and skills can share them with other women.
- Organise with NGO's for opportunities such as weekly basket weaving days where women can meet and share their knowledge and skills in health promotion programmes.
- Collaborate with the social worker and NGO's to persuade women who are less skilled to learn from other women who are more skilled in the health promotion programmes.
- Lobby with the social worker; volunteers; church groups and NGO's for formal skills training programmes in the camp through the programme officer.
- Lobby with volunteers, faith based groups and NGO's for formal income generating projects in the camp including business management skills such as record-keeping making and managing money, marketing the small business, forming a women's co-op and growing a business as ways to develop women's confidence in themselves and to empower them.
- Enhance the development of power-from-within by encouraging women to make use of the income generating projects.

**Guideline 3: Support for all vulnerable displaced women and more especially those with special health care needs**

**Purpose**

The purpose of this guideline is to ensure that all displaced women in the camp including the most vulnerable individuals namely the young women who have lost their parents, the women who have lost their husbands and the disabled women are supported and their dignity respected.



## **Rationale**

Displaced women need to be supported to regain their strength and dignity as human beings. Their displacement made them to become vulnerable to being harmed and being hurt. They develop emotional wounds that are more severe and painful than the physical wounds (Goldblatt, 2009:1651). The guideline will enable nurses to support their vulnerable patients during the provision of health care and to negotiate protection on their behalf with the camp officials.

## **Actions**

### **The nurses in the camp would:**

- Establish a trusting therapeutic interpersonal relationship with the women through showing empathy and respect to them.
- Involve women in their own health care through enabling holistic health education.
- Create opportunities such as women forum and women meetings for the women to restore their strength and dignity in the health promotion programmes.
- Sensitise and advocate all persons in the camp about fundamental human rights including rights of women.
- Motivate women to take part in health promotion programmes that help them to feel more resilient and less vulnerable such as community development programme.
- Acquaint oneself with the legislations related to the rights of all displaced persons, spread awareness about the legislations, and ascertain that policies are implemented in the clinic.
- Collaborate with other camp authorities to ensure that the legislations related to the rights of displaced people are implemented in the camp.
- Negotiate through safety and security officials' reporting channels for incidents of violations of safety and implement swift reaction to complaints on behalf of the women with the camp officials.
- Negotiate regular meetings between camp officials and representatives of the women regarding their safety and security.
- Ensure that policies regarding disabled persons be implemented in the clinic and the camp.

- Lobby through NGO's and camp management for the training of security officials in the camp to take women's safety and security concerns seriously.
- Involve women and men in discussions about how to create a safe environment especially for women and girls.

#### **Guideline 4: Protection of displaced women against the stigmatisation if one has an HIV-positive status**

##### **Purpose**

The purpose of the guideline is to ensure that displaced women living with HIV-positive status and AIDS are protected from stigmatisation and to ensure that their dignity is respected at all times. The guideline is focused on the protection of all confidential information of displaced women living with HIV and AIDS in refugee camps. No information about them or their HIV and AIDS status should be communicated to others without their consent.

##### **Rationale**

According to Kälin (2008:163), every person has the right to dignity, physical, mental and moral integrity which should be respected. The stigmatization of displaced women due to discrimination on the basis of HIV and AIDS is prohibited by existing international human rights standards (UNAIDS, 2000:34 & 36). The implementation of this guideline can ensure that HIV testing is done voluntary and that all information relating to the testing is kept confidential.

##### **Actions**

###### **The nurses in the camp would:**

- Promote HIV and AIDS awareness and discourage ignorance of community members about the existence of HIV and AIDS through support groups, volunteers, *faith based* HIV and AIDS action groups and community-based organisations and community education.

- Persuade women to go for voluntary HIV testing through voluntary counselling services.
- Conduct all interviews and procedures with HIV infected and potentially infected people in safe and supportive private settings.
- Maintain confidentiality of all women's health information and the test results.
- Conduct pre- and post-test counselling to reassure the women about the confidentiality of all information that relates to them and the test results.
- Empower people living with HIV and AIDS with the knowledge on how to respond to stigmatisation behaviours from community members.
- Collaborate with international HIV and AIDS organisations; volunteers; faith based groups; psycho-educational groups and NGO's to empower women with information, reading materials and coping skills regarding possible stigmatization related to HIV and AIDS.
- Provide avenues so that camp officials and displaced people can have open access to information about the prevention and the management of stigmatisation of people living with HIV and AIDS and to take part in combating stigmatisation due to HIV positive status and AIDS.
- Respect the dignity of HIV affected and infected persons, and discourages all forms of stigmatization in the health care services and in the camp through education and policy development.
- Acquaint self and teach others about national and international policies regarding the protection of the rights of persons living with HIV and AIDS and observe that policies and legislations that aim at the protection of people living with HIV and AIDS are adhered to.
- Stay abreast of new trends in caring for people living with HIV and AIDS through attending personnel development seminars and workshop and self-reading.
- Lobby with international HIV and AIDS organisations to provide reading and psycho-educational material to empower women with information and coping skills regarding possible stigmatization related to HIV and AIDS.

## **Guideline 5: Security with regard to humanitarian aid distribution and supportive communication during humanitarian aid distribution**

### **Purpose**

The guideline refers to the collaboration with camp officials to ensure a fair distribution of humanitarian aid to displaced persons. The aid should include all support that is needed for a healthy and dignified life.

### **Rationale**

Every human being regardless of their sex, age, social status and ethnic or religious origin has the fundamental right to adequate food that is also culturally acceptable (Kälin, 2008:83-4 & 113-4; UN Special Rapporteur (2003:1). Displaced people depend on the government of the host country and non-governmental organisations to supply food, shelter, health care services, emotional and psychological support to meet their needs. The distribution of the aid should be done in a fair and transparent manner (UN Economic and Social Council report, 2001:2; CEDAW, 2003:2; Ziegler, 2001:8).

### **Actions**

#### **The nurses in the camp would:**

- Lobby with camp officials for equal access of displaced women to humanitarian aids.
- Lobby through the programme officer for displaced women's representation and meaning-full participation in humanitarian aid distribution committees.
- Collaborate with the camp management to ensure that the humanitarian aid relates to all the needs of displaced people such as the safety during humanitarian aid distribution and the need for a balanced diet and not only just to the need for food.
- Form discussion groups with women to discuss issues of nutrition and health especially with the food that are available.
- Support endeavours to teach displaced women to prepare well-balanced meals with the food supplied to them through the programme officer.
- Report to the camp management any suspected acts where humanitarian aid is diverted from its legitimate destination.
- Disclose to the camp management epidemiological information relating to the prevalence

of disease that developed due to insufficient humanitarian aid.

- Collaborate with the camp management to adjust the humanitarian aid when the displaced people develop diseases related to insufficient humanitarian aid.

## **Guideline 6: Protection against harassment, threats of harm, abuse by men and domestic violence**

### **Purpose**

The purpose of this guideline is to ensure that displaced women are protected from harassment, threats, harm and abuse in the camp. The guideline provides for the implementation of a multi-sectorial collaboration to prevent on primary and secondary level gender-based violence of displaced women.

### **Rationale**

The dignity of displaced women should be respected Kälin (2008:53) and camp officials should make sure that their safety is not threatened in any way (Abusharaf, 2009:52; Keygnaert, Vettenburg and Temmerman, 2012:9). The guideline will enable nurses to collaborate with camp officials in the prevention and management of violence against displaced women.

### **Actions**

#### **The nurses in the camp would:**

- Collaborate with camp management and officials to ensure the safety of displaced women and girls in the camp.
- Ascertain that the rights of displaced people especially the rights of women with regards to their safety are explained to women and men on arrival in the camp including policies on how they should report safety concerns.
- Negotiate with camp management that all camp officials attend on-going in-service training regarding the protection of the safety of displaced people.
- Negotiate with camp management that programmes be instituted for the empowerment and education of displaced women to counteract unequal power relationships in the camp.

- Lobby with camp management for women representation in the camp committees.
- Initiate and manage awareness of abuse of women campaigns in the camp with the assistance of NGO's; volunteers; faith based HIV/AIDS groups and gender-based organisations in developing programmes that aim at prevention of abuse among women in the camp.
- Offer programmes on the impact of violence and abuse on the total well-being of the survivor of violence and abuse as part of the campaign on abuse and violence prevention.
- Cooperate with camp management and camp officials; volunteers; gender-based organisations; faith based organisations and NGO's in developing programmes that aim at the prevention of abuse among women in the camp.
- Lobby with camp management for more recreation facilities to reduce the stress of displaced people and the related incidents of violence and abuse of women in the camp.
- Cooperate with camp management and camp officials; volunteers; gender-based organisations; faith based organisations and NGO's to develop educational programmes that aim at educating the camp community about the health effects of violence and abuse.
- Negotiate with camp management for efficient medical and legal responses to reported incidents of abuse of displaced women.
- Lobby for the strict law enforcement regarding abuse of women and girls in the camp.
- Negotiate with camp officials for the training and awareness campaigns on the legislations about the abuse of women.
- Facilitate trusting relationships between nurses and displaced women to encourage women to disclose incidents of abuse.
- Provide forensic nursing care to survivors of abuse according to the country's legislation in an empathetic humane manner.
- Ensure that holistic care is rendered to survivors of abuse.
- Be willing to provide evidence in court should the survivors report the abuse to the police.
- Motivate victims of violence to report to the police cases of abuse.
- Educate the security forces and camp community to support survivors of abuse through community-based organisations; volunteers and gender-based organisations; formal counselling, mutual understanding and respect of their dignity.
- Support efforts to hold perpetrators of violence accountable for their actions and the

harms that resulted from their actions.

## **Guideline 7: Reintegration to home countries**

### **Purpose**

The purpose of this guideline is to ensure the participation of displaced women in the repatriation to their home countries or resettlement in other countries. Many displaced people fled from their home countries not only because of conflict, but also because of lack of support from their governments. They are thus fearful to return to their home countries. They fear that they will not be safe and that they may even be persecuted. Some displaced people do not have any relatives left in their home countries and on repatriation may not have people who can support them.

They are equally fearful of being resettled in other countries where they may be considered as foreigners and where they also will have to adjust to unfamiliar circumstances without the support of family and friends.

### **Rationale**

The rationale of the guideline is to ensure that displaced women will be able to safely return to their home countries or being supported in their resettlement in other countries. In many refugee situations repatriation causes displaced people to fear to go back to their home countries (IRRI, 2011:1-3 & 8) or to be resettled in a foreign country (Chatelard, 2009:8). It is thus of utmost importance that the displaced people be involved in the process (Kälin, 2008:129 & 132).

### **Actions**

#### **The nurses in the camp would:**

- Negotiate with the relevant officials for the involvement of displaced women in the planning and implementation of repatriation, reintegration or resettlement.
- Ensure that the displaced women be oriented for the repatriation or resettlement by a team of camp officials and health care staff.

- Ensure that the displaced women have enough time to prepare themselves and their families for the repatriation, resettlement or local integration especially those who are willing to stay in Namibia.
- Ensure that displaced women receive trauma counselling by a trained trauma counsellor as part of their preparation for repatriation, reintegration or resettlement.

### **Guideline 8: Participation in reproductive health care**

#### **Purpose**

The purpose of this guideline is to ascertain that displaced women have access to reproductive health care services in the refugee camps. They should also receive health education to enable them to make informed choice and take care of their reproductive health issues.

#### **Rationale**

The participation of women in their reproductive health care enables them to improve their health, to detect early signs of pathology and get help timely. Poor participation results in ignorance of the women and confusion about contraception and other issues of their reproductive health (Pavlish, 2005:889). Their involvement enables health care providers to, respect and consider the interconnectivity of cultural practices and reproductive health care. The optimal education of displaced women to be involved in their reproductive health care is thus a priority (Kälin, 2008:90).

#### **Actions**

##### **The nurses in the camp would:**

- Acknowledge the cultural, religious and educational background of displaced women that may influence their participation in their reproductive health care.
- Deliver a culture congruent comprehensive reproductive health care service to displaced women.
- Openly discuss with displaced women about their reproductive health concerns on how



cultural beliefs affect their reproductive health concerns and deliver women-centred culture-aware comprehensive reproductive health services to displaced women.

- Motivate displaced women to openly discuss reproductive health concerns with their daughters.
- Motivate active involvement of displaced women in their reproductive health care through discussion groups to assess their reproductive health concerns and educate them to have an understanding of the value of female reproductive organs and to learn about the importance of the reproductive health care services and concerns.
- Enhance participation of displaced women in their reproductive health care through well planned appropriate health education.
- Lobby with the programme officer for comprehensive sexual and reproductive health services for displaced women.

## **6.4 RECOMMENDATIONS FOR PRACTICE, EDUCATION AND RESEARCH**

### **Recommendations for practice**

The following recommendations are suggested:

- States, non-governmental organisations and international organisations such as UNHCR that is responsible for the care of displaced women already have policies and regulations as well as codes of conduct in place. They are encouraged to incorporate the guidelines into the implementation of their policies. They should also monitor the implementation of the guidelines to ensure that displaced women's rights are not violated.
- Nurses who take care of displaced women should apply the guidelines diligently.
- The nurses should be oriented on appointment regarding the implementation of the guidelines and follow-up training should be provided.
- Nurses should explore current models that can be utilised to empower and emancipate displaced women.

Multi-sectorial collaboration (host government departments and ministries, non-governmental organisations, faith based organisations, United Nations, United Nations Children Emergency

Fund, community based organisations and the United Nations High Commissioner for Refugees) is needed to support the nurses to implement the guidelines.

### **Recommendations for nursing education**

The following suggestions are recommended for nursing education:

- Schools of nursing that are responsible for pre-service training of nurses are encouraged to incorporate the guidelines relating to the health care needs of displaced women in their curricula at all levels.
- The guidelines should be made available in the libraries of nursing schools, hospital libraries as well as in public libraries for referrals for student nurses and other nurses.
- The findings of this research should be presented and shared with other nurses at international nurses' conferences and seminars.
- The concept of vulnerable populations towards which nurses have an obligation to advocate on their behalf and protect their rights should be emphasised during nurses' pre-service education and during in-service training.

### **Recommendations for further research**

The following recommendations are suggested for future research:

- The guidelines should be tested in practice.
- Research is needed to explore the experience of nurses regarding the implementation of the guidelines.
- The applicability of the guidelines to other settings should be investigated.
- Research is needed to explore the deeper psychological experiences of displaced women and the development and application of models to help these displaced women to heal.

## **6.5 LIMITATIONS OF THE STUDY**

The findings of phase 1 and the guidelines that have been formulated and refined in phase 2 of the study focus on the health care needs of displaced women living in Osire refugee camp only. The reader should decide whether he/she can apply the findings to other similar settings.

## 6.6 CONCLUSION

The researcher conducted the research under the following objectives:

- Explore and describe the health care needs of displaced women living in Osire refugee camp in Namibia.
- Develop appropriate guidelines for nurses and other officials to address the health care needs of displaced women in Osire refugee camp.

The researcher used a phenomenological inquiry to explore and describe the health care needs of displaced women in the refugee camp. The findings were described by terms of essence that emerged through constituents. The literature review helped the researcher to have a deeper understanding of the phenomena.

Based on the findings of the phenomenological inquiry, draft guidelines were developed. The draft guidelines were refined through a Delphi technique. Final guidelines were developed following the recommendations by a panel of experts.

The guidelines that are developed will add to the knowledge development in nursing and nursing practice. Through the implementation of the guidelines, the empowerment among displaced women is enhanced. To ensure validity and reliability, review of the guidelines is done after five years of implementation. The researcher recommended future research to ascertain applicability and flexibility of the guidelines in other refugee camps.

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## **ADDENDUM 1: INFORMATION LEAFLET AND INFORMED CONSENT TO PARTICIPANTS FOR NON-CLINICAL RESEARCH**

### **TITLE OF THE STUDY**

**Health care needs of displaced women living in Osire Refugee Camp in Namibia**

Dear Participant

### **1. INTRODUCTION**

I invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any question that this leaflet does not fully explain, please do not hesitate to ask the interviewer: **Mrs. Lusia Ndahambelela Pinehas (+264 812358250 or +264 65 223 2251)**

### **2. THE NATURE AND PURPOSE OF THIS STUDY**

The aim of the study is to explore the health care needs of displaced women living in Osire refugee camp Namibia and to develop guidelines that will address these health care needs.

You as a participant are a very important source of information on the lived experiences of displaced women with regard to their health care needs.

### **3. EXPLANATION OF THE PROCEDURES TO BE FOLLOWED**

The study will involve information with regard to where you come from, and where you stay, for how long you have been here, your age, marital status, parity and employment status.

I will then ask you a question about your experiences on your health care as a displaced woman and I will observe your behaviours during the interview process.



The whole interview process will be conducted in privacy, recorded, and some notes will be taken where necessary, but rest assured that confidentiality and privacy will be maintained throughout the interview process.

#### **4. RISK AND DISCOMFORT INVOLVED**

There are no risks involved in this study. Some of the processes may cause minimal or some discomfort or take some of your time. The question that I am going to ask you if it makes you uncomfortable, you may not answer it if you do not want to.

The interview will take about 45 minutes of your time.

#### **5. POSSIBLE BENEFITS OF THIS STUDY**

You will not benefit directly from the study, but the results of the study will enable us to manage displaced women more caring and respectfully in future

#### **6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is entirely voluntary.

You can refuse to participate or withdraw at any time during the interview without giving any reason.

Your withdrawal will not affect you in any way.

#### **7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics committee of the Faculty of Health Sciences at the University of Pretoria and copies of the letter of approval are available if you wish to have one.

## **8. INFORMATION AND CONTACT PERSON**

The contact person for the study is Mrs. Lusia Ndahambelela Pinehas. If you have any questions about the study please do not hesitate to contact her at cell: +264 812358250. Alternatively you can contact my supervisor at cell: +27 **0827761649**.

## **9. COMPENSATION**

Your participation is voluntary. No compensation or payments will be given to you for participating in this study.

## **10. CONFIDENTIALITY**

All information that you give will be treated with strict confidentiality. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

## **CONSENT TO PARTICIPATE IN THIS STUDY**

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study.

I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details, will be anonymously processed.

I am participating willingly.

I have had time to ask questions and have no objections to participate in the study.

I understand that there is no penalty should I wish to discontinue with the study.

I have received a signed copy of this informed consent agreement.

Participant's name: ..... (Please print)

Participant's signature: ..... Date: .....

Investigator's name: ..... (Please print)

Investigator's signature: ..... Date: .....

Witness's name: ..... (Please print)

Witness's signature: .....Date: .....

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participants whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report.

The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview.

S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect any **treatment** and access to **humanitarian aid** in any way.

I hereby certify that the client has agreed to participate in the study.

Participant's name: ..... (Please print)

Person seeking consent: ..... (Please print)

Signature:.....Date: .....

Witness's name: ..... (Please print)

Signature: ..... Date: .....

## **ADDENDUM 2: INFORMATION LEAFLET TO EXPERTS**

### **2(A): DELPHI LETTER FOR ROUND ONE**

### **2(B): DELPHI LETTER FOR ROUND TWO**

## **INFORMATION LEAFLET TO EXPERTS**

### **TITLE OF THE STUDY**

#### **Health Care Needs of Displaced Women Living in Osire Refugee Camp in Namibia**

Dear Sir/Madam

### **1. INTRODUCTION**

I invite you to participate in my research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any question that this leaflet does not fully explain, please do not hesitate to contact me: **Mrs. Lusia Ndahambelela Pinehas**.

### **2. THE NATURE AND PURPOSE OF THIS STUDY**

The aim of the study is to explore the health care needs of women living in Osire Refugee Camp in Namibia and to develop guidelines that will address these health care needs. Due to your expertise on the subject of displaced persons (women) your participation will be appreciated. In total eight experts will participate in the validation process.

### **3. EXPLANATION OF THE PROCEDURES TO BE FOLLOWED**

The study will involve several rounds of validation via e-mail. I will provide you with a set of draft guidelines, and a Likert rating scale via e-mail.

On the rating scale you need to indicate if the guidelines will be applicable to address the health care needs of displaced women living in Osire Refugee Camp.

You will rate whether you strongly agree [SA], agree [A], uncertain [?], strongly disagree [SD] or disagree [D]).

You will also be expected to suggest what should be done with items that you are uncertain of as well as those that you do not agree with.

After each round of validation you will be informed of the outcomes and a new set of guidelines and a rating scale will be e-mailed to you.

This process will be repeated until consensus is reached.

#### **4. RISK AND DISCOMFORT INVOLVED**

There are no risks involved in this study.

#### **5. POSSIBLE BENEFITS OF THIS STUDY**

You will not benefit directly from the study, but the results of the study will enable a holistically address of the health care needs of displaced women in Osire Refugee Camp.

#### **6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is entirely voluntary.

You can refuse to participate or withdraw at any time without giving any reason.

Your withdrawal will not affect you in any way.

#### **7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria as well as from the Higher Commissioner for Refugees in Namibia. Copies of the letters of the approval are available if you wish to have one.

#### **8. INFORMATION AND CONTACT PERSON**

The contact person for the study is I, Mrs. Lusia Ndahambelela Pinehas. If you have any questions about the study please do not hesitate to contact me on my cell: +264 **812358250** or **lpinehas@unam.na**. Alternatively you can contact my supervisor Professor Neltjie van Wyk at cell: +27 **827 761649**

## **9. COMPENSATION**

Your participation is voluntary. No compensation or payments will be given to you for participating in this study.

## **10. CONFIDENTIALITY**

All information that you give will be treated with strict confidentiality. Once I have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that could identify you.

## **2(A): DELPHI LETTER FOR ROUND ONE**

Dear Expert

### **AN INVITATION TO PARTICIPATE IN THE REFINEMENT OF THE GUIDELINES FOR THE HEALTH CARE NEEDS OF DISPLACED WOMEN IN THE OSIRE REFUGEE CAMP IN NAMIBIA**

I am a PhD student in the Department of Nursing Science, Faculty of Health Sciences at the University of Pretoria. I am conducting a study on “The health care needs of displaced women living in the Osire refugee camp in Namibia” under the supervision of Professor Neltjie van Wyk and Dr. Ronéll Leech.

The objectives of the study are to:

- Explore and describe the health care needs of displaced women living in the Osire refugee camp in Namibia.
- Develop guidelines for nurses to address the health care needs of displaced women in the Osire refugee camp.

The study is conducted in two phases. In phase one of the study a descriptive phenomenological approach was used to explore and describe the health care needs of displaced women living in the Osire refugee camp. In-depth face-to-face interviews were conducted with displaced women from different socio-cultural backgrounds aging between 18 and 58 years, English and non-English speaking (through an interpreter), who had been in Osire refugee camp for more than six months.

The findings revealed that displaced women do not only view their health care needs as medically related but as a combination of physical, psychological, emotional and socio-cultural needs. According to them, they feel that if for example a social need is not met then their whole well-being is affected.



The findings of phase 1 revealed that the essence in the study is “restoration of hope and human dignity”. This essence is embedded in the following 8 constituents: 1) Autonomy and freedom; 2) Skills training and income-generating projects to improve and sustain health; 3) Support for vulnerable women and more specifically for those with special health care needs; 4) Protection against stigmatization due to HIV positive status; 5) Security with regard to humanitarian aid distribution and the need for supportive communication; 6) Protection against harassment, threats of harm, abuse by men and domestic violence; 7) Reintegration to home country; 8) Participation in reproductive health care.

Each constituent became a guideline. An extensive literature review as done on the essence and constituents that represented the health care needs of displaced women. The literature review enabled the researcher to write the actions for each guideline. In phase two of the study the researcher developed draft guidelines to be used by nurses in the Osire refugee camp to address identified health care needs of displaced women.

You are invited to participate in the refinement of the guidelines. The researcher chose a Delphi technique for the verification process. National and international experts will be expected to participate using the Delphi technique to refine the guidelines and to obtain consensus on the content of the guidelines.

There are eight guidelines with the pre-amble, rationales and actions to address the health care needs of displaced women. Please read through each guideline, rationale and actions and then complete the rating scale in accordance with the criteria of validity, reliability, flexibility, clarity and applicability of the guideline. When possible, please provide your suggestions in the space provided at the end of each section. Please complete the biographical information of your professional, academic experience and current work in the first part of the instrument. This will enable the researcher to describe the sample. No names or identification number will be mentioned in the research report or publications. The refinement process should take approximately one hour to complete.

Your participation and comments will be highly appreciated. Comments received will be analysed for further refinement in the next round. Attached please find the consent form for participation and

please return it with the comments. For further clarifications please contact me or my supervisors at the following addresses.

Lusia Ndahambelela Pinehas

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Professor Neltjie van Wyk

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Dr. Ronéll Leech

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Fax: +27 12 354 1490

## CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study.

I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details, will be anonymously processed.

I am participating willingly.

I have had time to ask questions and have no objections to participate in the study.

I understand that there is no penalty should I wish to discontinue with the study.

I have received a signed copy of this informed consent agreement.

Expert's name: ..... (Please print)

Expert's signature: ..... Date: .....

Investigator's name: ..... (Please print)

Investigator's signature: ..... Date: .....

You may sign this consent electronically and send it to [lpinehas@unam.na](mailto:lpinehas@unam.na) or your positive response to this e-mail will be considered your consent to participate in the study.

Thanking you.

Sincerely,

Lusia, N. Pinehas (PhD student)

## 2(B): DELPHI LETTER FOR ROUND TWO

Dear Expert

### REFINEMENT OF THE GUIDELINES TO ADDRESS THE HEALTH CARE NEEDS OF DISPLACED WOMEN LIVING IN OSIRE REFUGEE CAMP IN NAMIBIA

Thank you for the feedback received on the first round with regard to the study on: “The health care needs of displaced women living in Osire refugee camp in Namibia” under the supervision of Professor Neltjie van Wyk and Dr. Ronéll Leech.

The guidelines were revised in accordance with the feedback received from experts in the first Delphi round. The actions are adjusted according to the input received. Kindly receive the actions that have been adjusted so that you can see how the suggested changes have been incorporated. Please read and evaluate the revised actions. Where possible, please provide suggestions and comments for re-formulation of the actions in the space provided at the end of each section. No names will be provided in the report or publications. The refinement process will take approximately 45 minutes to complete.

Your participation and suggestions or comments are highly appreciated. The comments and suggestions will be put together and analysed to formulate the final guidelines. For any further clarifications that may be needed please contact me or my supervisors on the following:

Lusia Ndahambelela Pinehas

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### **ADDENDUM 3: BIOGRAPHIC INFORMATION: PARTICIPANTS OF PHASE 1**

You are kindly requested to answer the following questions with regard to your biographic information. (This will only take 3 minutes to complete).

1. How old are you?
2. From which country are you?
3. For how long have you been in this camp?
4. Are you married?      **OR**
5. Were you married before moving to this place?
6. Do you have children?
7. How many?
8. How do you keep yourself busy during the day?

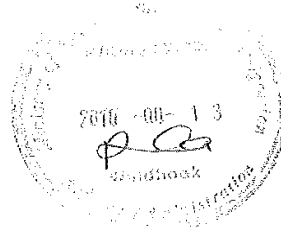
**The following exploratory questions will be asked:**

- What are your health care needs as a displaced woman?
- How can your health care needs as a displaced woman be addressed?

Thank you.

## ADDENDUM 4: APPLICATION LETTER TO CONDUCT THE RESEARCH

To: The High Commissioner for Refugees  
Windhoek  
NAMIBIA



From: Mrs. Lusie Ndahambelega Pinehas  
P. O. Box 1506  
Ondangwa  
NAMIBIA

Date: 22/07/10

**Subject: Permission to conduct a research in Osire Refugee Camp: Otjiwarongo, Namibia**

Dear Sir/Madam

I hereby apply for the permission to conduct a research in Osire Refugee Camp, Otjiwarongo district, Namibia.

I am a Namibian citizen, and a nurse by profession. I am a university scholar, currently registered with the University of Pretoria's School of Health Sciences for my PhD in Nursing Science for the academic year 2010. My student number is 22181688.

The broader aim of the study is Community-Oriented Nursing Education with the main goal to target the health of women and children. I am therefore interested in the women's health.

The title of my research is: **Health Care for Women Living in Osire Refugee Camp in Namibia.**

The research is a requirement to pursue my degree at the abovementioned institution. The intended period of data collection is September – November 2010

Enclosed please find the following two documents:


- A copy of my identity document
- A copy of the letter from my research supervisor

I hope my application will favorably be considered

Thank you in advance for your understanding and consideration

Yours Sincerely

Lusia N. Pinehas

 16/08/10

## ADDENDUM 5(A): LETTER OF APPROVAL UNIVERSITY OF PRETORIA

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

\* FWA 00002567. Approved dd 22 May 2002 and Expires 13 Jan 2012.

\* IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and Expires 13 Aug 2011.



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee  
Fakulteit Gesondheidswetenskappe Navorsingsetiekkomitee

DATE: 27/01/2011

PROTOCOL NO.	242/2010
PROTOCOL TITLE	Health care needs of displaced women living in Osire refugee camp in Namibia
INVESTIGATOR	<b>Principal Investigator:</b> Mrs Lusia Ndahambelela Pinehas
SUBINVESTIGATOR	None
SUPERVISOR	Prof NC van Wyk & Dr R Leech <b>E-Mail:</b> <a href="mailto:neltjie.vanwyk@up.ac.za">neltjie.vanwyk@up.ac.za</a> / <a href="mailto:ronell.leech@up.ac.za">ronell.leech@up.ac.za</a>
DEPARTMENT	<b>Dept:</b> Nursing Science; Steve Biko Academic Hospital <b>E-Mail:</b> <a href="mailto:ronell.leech@up.ac.za">ronell.leech@up.ac.za</a> <b>Phone:</b> 012 354 2447/2129 <b>Fax:</b> 012 354 1490 <b>Cell:</b> 0827761649 / 0824414576
STUDY DEGREE	PhD (Nursing Science)
SPONSOR	None
MEETING DATE	24/11/2010

The Protocol and Informed Consent Document were approved on 26/01/2011 by a properly constituted meeting of the Ethics Committee subject to the following conditions:

1. The approval is valid for 3 years period [till the end of December 2013], and
2. The approval is conditional on the receipt of 6 monthly written Progress Reports, and
3. The approval is conditional on the research being conducted as stipulated by the details of the documents submitted to and approved by the Committee. In the event that a need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

*Members of the Research Ethics Committee:*

Prof M J Bester	(female) BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc(Biochemistry); PhD (Medical Biochemistry)
Prof R Delpont	(female) BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof JA Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr NK Likibi	MBBCh – Representing Gauteng Department of Health
Prof TS Marcus	(female) BSc(LSE), PhD (University of Lodz, Poland) – Social scientist
Dr MP Mathebula	(female) Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(female) BA(Hons)(Wits); LLB; LL.M(UP); PhD; Dipl.Datametrics(UNISA) – Legal advisor
Mrs MC Nzeku	(female) BSc(NUL); MSc(Biochem)(UCL, UK) – Community representative
Prof L M Ntlhe	MBChB(Natal); FCS(SA)
Snr Sr J Phatoli	(female) BCur(Eet.A); BTec(Oncology Nursing Science) – Nursing representative
Dr R Reynders	MBChB (Prêt), FCPaed (CMSA) MRCPC (Lon) Cert Med. One (CMSA)
Dr T Rossouw	(female) M.B., Ch.B. (cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Dr L Schoeman	(female) B.Pharm, BA(Hons)(Psych), PhD – Chairperson: Subcommittee for students' research



Mr Y Sikweyiya

MPH; SARETI Fellowship in Research Ethics; SARETI ERC/TP; BSc(Health Promotion)  
Postgraduate Dip (Health Promotion) – Community representative

Dr R Sommers

(female) MBChB; MMed(Int); MPharmMed – **Deputy Chairperson**

Prof TJP Swart

BChD, MSc (Odont), MChD (Oral Path), PGCHE – School of Dentistry representative

Prof C W van Staden

MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM - **Chairperson**



**DR R SOMMERS;** MBChB; MMed(Int); MPharmMed.  
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

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◆ E-Mail: [manda@med.up.ac.za](mailto:manda@med.up.ac.za)

◆ Web: [//www.healthethics-up.co.za](http://www.healthethics-up.co.za)

◆ H W Snyman Bld (South) Level 2-34

◆ P.O.BOX 667, Pretoria, S.A., 0001

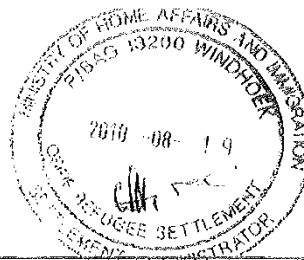
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## ADDENDUM 5 (B): LETTER OF APPROVAL-UNHCR

2



REPUBLIC OF NAMIBIA



### MINISTRY OF HOME AFFAIRS AND IMMIGRATION

Enquiries:

Private Bag 13200  
WINDHOEK

Tel.: (061) 2922111

Fax: (061) 2922185

Our Ref: .....

Your Ref: .....

### INTER-OFFICE MEMORANDUM

TO: MR. JASON ABSALOM  
OSIRE SETTLEMENT ADMINISTRATOR

FROM: MR. N.A. MUSHELENGA  
THE COMMISSIONER FOR REFUGEES

PP PEG

DATE: 17 AUGUST 2010

SUBJECT: MRS LUSIA NDAHAMBELELA PINEHAS VISIT TO OSIRE.

Please be kindly informed that Ms. Lusia Pinehas is a student from the University of Pretoria, South Africa who wishes to come to Osire and conduct a research study on Health issues as part of her academic curriculum. She has approached our office for assistance in this manner. Please render her your usual cooperation during her stay in the settlement.

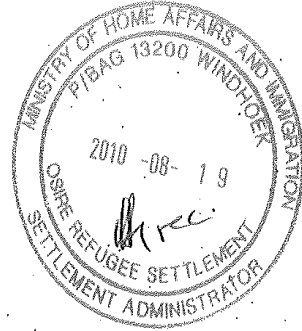
Find attached with this memo supporting documentation regarding the reasons for her visit and her permit to enter Osire.

Kind regards.

All official correspondence must be addressed to the Permanent Secretary



REPUBLIC OF NAMIBIA



**MINISTRY OF HOME AFFAIRS AND IMMIGRATION**

Regulates:

Private Bag 13200  
WINDHOEK

Tel: (061) 2922111  
Fax: (061) 2922185

Your Ref: \_\_\_\_\_

Our Ref: \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

THE HOLDER

MR/MRS/MS/DR/PROF: LUISA NDAHAMBELELA PINCHAS

Is granted permission to visit Osire Refugee Camp. For the period commencing

19 August 2010 and ending 19 August 2010

Remarks: TO VISIT THE SETTLEMENT FOR  
STUDY PURPOSES.

Commissioner for Refugees as contemplated in Section 6 of the Namibian Refugee Recognition and Control Act, No. 2 of 1999.

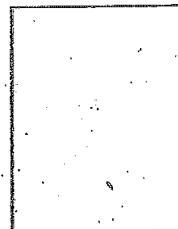
Note: This document is to be submitted to the Camp Administrator on arrival at Osire.

Date: .....

Time: .....

This document is only applicable within Osire Refugee Camp or any other identified protection center.

pp. [Signature]  
Commissioner for Refugees' signature





REPUBLIC OF NAMIBIA

MINISTRY OF HOME AFFAIRS AND IMMIGRATION

Enquiries:

Tel: (061) 2922111  
Fax: (061) 2922185

Our Ref: .....

Private Bag 13200  
WINDHOEK

Your Ref: .....

TO WHOM IT MAY CONCERN

THE HOLDER

MR/MRS/MS/DR/PROF: PINEHAS LUSIA NDAHAMBELELA

Is granted permission to visit Osire Refugee Settlement for the period  
commencing: 18-04-2011 21-04-2011  
16 March 2011 and ending 25 March 2011

Remarks: To do a research on the health needs of displaced women living in Osire Refugee Settlement.

By the Commissioner for Refugees as contemplated in Section 6 of the Namibia Refugee Recognition and Control Act, No 2 of 1999.

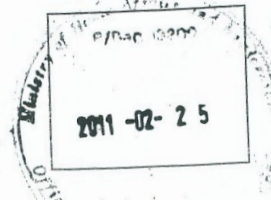
Note: This document is to be submitted to the Settlement Administrator on arrival at Osire.

Date: 18/04/2011

Time: 13:00

This document is only applicable within Osire Refugee Settlement or any other identified protection center.

[Signature]  
Commissioner for Refugees' signature



## **ADDENDUM 6: A FACE-TO-FACE INTERVIEW WITH A REFUGEE WOMAN OSIRE, NAMIBIA (APRIL 2011)**

The participant is a refugee woman from Angola, 53-years-old, married with 10 children. She works as a teacher in the refugee camp at the time of the interview. She was calm throughout the interview. According to her, life in the camp is not “a piece of cake”, is not proper as there are many problems and many concerns. Food, according to her is the same for the whole life. Proper diet need to supplement medication for a quick recovery. Teenagers should not receive contraceptives and or without the knowledge of their parents. She sees culture as very important in the issue of sexual and reproductive health. She wants a work permit instead of repatriation. She has been in Osire camp for 18 years.

**Interviewer:** Please tell me, what are your healthcare needs as a displaced woman and how can these needs be met?

**Participant:** Yeah, I see...//yeah, life something like not a piece of cake, yeah, I feel better, I'm okay, but when it comes the...the...the issue of the camp, my life somehow not so sober...//yeah, the there are many thing we can talk on women life in the camp, say my life... aah, I can say that I'm health because I'm not s...found there on the bed, but it's not so... somehow like needed, aah...in a timer, an...an issue of... aah being a person, I'm okay, I'm okay, 'cause I'm not sick, (a child screams at the background) but the other issue, like the one who can feel like a person who is in h... her or his proper country is different, very different, 'cause I'm not, I'm limited, let me say, in a short way, I'm limited, because I cannot say that I want to do this today, 'cause somebody must be control me, eeh I'm saying like, maybe if I want to go outside from the...the camp, I must ask permission. I must ask somebody to...to allow me to go out. In this way I cannot say that the life is so good, 'cause the person who is in a good life he can do whatever they want at a...

**Interviewer:** Okay, when it comes to your health care needs, how can you explain that to me? What are your health care needs?

**Participant:** Yeah, you know, the health mean a lot things, a lot of things, the...my health mean so many things. Imagine, to a person to be health, you need to get also health things. I think that I'm co... concerning on the...the s... the side of the food, now, 'cause a person to be health need eat well, now... when we go to...to the side of a...a...a food, is really problem, is a problem, is a concern,

'cause UNHCR is doing their level best to help us to give some of kind of food but is not somehow is not healthy to eat every day the same food like we are getting, people are getting, some people, some are not getting 'cause they are working somehow, but the way they are giving food, they are helping really, but that those food cannot help, yeah, other person to person because beans, must get beans, eeh, some sugar and maize and cannot eat the same food every time like we eat beans in the morning, eat beans in the lu... the lunch time, beans in the eeh...eeh...eeh dinner time, that cannot help. According to diet a person must make a diet when you get...get your meal, you must mix up, now for us sometimes difficult, you must do your level best to do something so that you can eeh, also cover those program. That is eh...eeh my concern of my... my...my thing that I can tell you. Really they are helping, but the problem is the food is the same for the whole life...

**Interviewer:** Is there any other health issue that you feel is not well addressed apart from food? Other services that are health related?

**Participant:** Other services that are health related, we have like when a person sick, now when it comes to sickness now, there are some areas that they can help very quickly, eeh, sometimes also we see that is delay , it is delay, eeh, I'm concerning, I'm talking about people who are HIV and Aids, those people are under treatment. I think they are helped, they are helped, 'cause the hospitals are caring them, but the other issue like a...other sickness, mmh-mmh (shaking her head), is difficult, is difficult, because a person when you are when you are not feeling well, and you lose, you lose your appetite, if they give me...medicine, you need to put something also so that they can work with medicine, and that that side really, they are helping the health side are helping people, but there is no way to wha... what can I say, to help people how to get medicine with some type of foo...food. There is no way, no way, I can feel diarrhoea they can treat me there, but by going home I need to put something to the medicine can work fast as possible and I recover, but some time because of food problem the medicine also...

**Interviewer:** So, here do you mean that the food is there but they are not enough or they are just the same?

**Participant:** The food is just the same (sounds heard at the background). The food is just the same. Then those that type of food or that people are getting several time the same, they cannot also help. If you are sick they cannot help because you need to mix up like you need the nake, you need some

salad so that you can recover very fast, but if there is nothing like that, you get medicine to their side they can do, but when you go home you, eah, spend the whole lot more... more time to recover...

**Interviewer:** And when they, when somebody is sick and he is in the hospital they give mixed food, ne?

**Participant:** Jaa, they give.

**Interviewer:** When you go home?

**Participant:** Home, nothing, there is a problem, jaa, they get problem...

**Interviewer:** Other services? You mentioned HIV, you said HIV, people who are HIV they are getting treatment?

**Participant:** Mmh, they are getting treatment...

**Interviewer:** And, is there any service for those who are still not HIV or who don't know their status? Is there such a service?

**Participant:** Jaa, you mean who don't know their status, you are, you are talking about aah, again on HIV? Somehow difficult, because even there those service they cannot serve a person who did not appear there. If a person go goes there, and make test, do the test, is found that's positive, they will see the amount of a CD4, is really need to be cared or not, but those who do not go there somehow difficult also to discover that this one has this... this he need this...this, difficult...

**Interviewer:** How do people go there for the test? Only when you are sick or is there any nurse who is calling?

**Participant:** They have the programme. There's a programme like I'm also a member of that HIV task force. There is a programme of doing a campaign a...a...a, during that campaign many people they decide themselves 'cause, yourself must care yourself and people many people may decide to go and know their status. People, who are not going that..., people who are ignoring. They know that the virus exist, but ignoring.

**Interviewer:** So it means the service is there, you do campaigns so that people can go and get tested?

**Participant:** That's true... that's true... that's true...

**Interviewer:** And after you are tested, if you are positive they test you further for the CD4?

**Participant:** That's true... that's true... that's true...

**Interviewer:** And if you're negative, they just tell you to go back home or what?

**Participant:** If you are negative on the site of HIV, if you are negative, it doesn't mean that you live negative forever, you is a process maybe you are negative, maybe you are "*wind of period*" (participant was supposed to say "*window period*"), you don't know, you never know. Then you still go the process is still there, you must go there again tested, until you feel like really I went several times I'm free and you must continuous negatively if you are negative, they tell you please do your best to continue negative.

**Interviewer:** Okay, there is again a service for people to stay negative?

**Participant:** Is true!

**Interviewer:** Okay, now you mentioned the part of the food, you mention the part of the sickness; you also mention the part of HIV. Is there any other health service that is catering the needs of let me say your need as a displaced woman?

**Participant:** Mmm, mtjisa...aah! My need as a displaced for us women, mmm... I think I need to be...to...to the side of the...the health service to care also the...the elder people.

**Interviewer:** Can you explain that? Do you have elderly people here?

**Participant:** Eeh, aah, I have, we have yes, we have. So...// You see, mentally themselves they feel already like they are old, and they need that care, eeh, I mean what I need is like when they care an old person, they must consider that person like eah, eah, eah a baby, because whenever I say...aah, you are already old, and you finish with everything, they will never trust you again, cause they will feel like aah, when you say mum go to hospital, they say ah, me I'm ooh...not person when I go there they will tell me that you are old, is oldness, the word oldness must not be worked there at the hospital...

**Interviewer:** Now, what do you think what should be done for these old people what service can be given?



**Participant:** The service must be the same as they are treating kids. Only the... the...the...the...the...the way of speaking to them to say... tell you are ... mama is oldness, if you say she is feel like she is not feeling well, and you say again is an oldness, now you finish everything, they never trust again, I go to the hospital they will tell me that this is an oldness, let me remain home. That is only the...the...the side the care that I need, jaa, only the word of oldness. When co...come the time that they offer treatment, to treat the...the old people, don't make again that is an oldness mama is not... you don't have problem, is an oldness, because you are old, that's why you are complaining always now they...they their mind even though I go there they will tell me that you are old. Jaa only that side, // now to care, they are caring everyone...everyone who is sick. Those people do not discrimination everyone who comes complain, they are caring...

**Interviewer:** Is there anything else that you want to mention to me when it comes to the health care needs and what to be done?

**Participant:** Yes, the other thing that I'm think is about teenage. The teenage...teenagers need to be cared very well according to a person that create the person as the person is. Really the care they help u...helping us. Currently our children of nowadays somehow stubborn. They are stubborn. What I'm saying is like I don't know now you the... the hospital what can I do to them, those we found ourselves as a mother you are, you are at home you don't know, you never know concerning to family plan. Family planning its stand there for married people. Now what I know, but nowadays we find ourselves you are at home, you never know while your daughter of 14 years getting family planning.

**Interviewer:** Is it the policy or what?

**Participant:** Is not the policy, they are stubborn, you never know. Us when we grow up, we grew up, we grew up in different way, you said you abstain; you're until you get married, but just imagine in days this children of u-u-us. Fourteen years bringing a baby, themself also now they open their eyes that if you go there, eah, before the family plan, you never get pregnant. But that ones can destroy them, because those medicine they are so strong are so strong than...than if we apply to...to kids, then when the time when they need kids, they would, they won't get pregnant because they kill everything inside, thus why we are afraid...

**Interviewer:** This family planning, which is given to children even who are fourteen years, do they consult the parents?

**Participant:** Aah~aah (shaking her head) ... I don't think so; I don't think so, because even those children who are going there, they never tell their parents that we are getting some tablets from there. They never get the parent, and you never know, you never know, they are stubborn. So, if at the side of the hospital they could also look in this matter, they must see to the age of kid, so that they cannot give them those kind of medicine. They will give them problem tomorrow.

**Interviewer:** Now, parents have noticed this one, especially mothers, have they discussed it in their meetings maybe?

**Participant:** Ja,

**Interviewer:** How do they feel as parents?

**Participant:** Very bad, very bad! The thing that you did not do in your life and you see your child doing, you won't feel well, you will feel bad. We still doesn't mean we are not educating our kid, the time now are change. The way we grow up is not the way they are growing up. They are seeing many thing and nowadays you cannot... anything to your child, you must explain everything, not like when we grow up, the culture that you must send your daughter to you're the auntie no, now you say everything to your children, to your child, but themselves they are learning, they are learning from the school, they are learning from TV, there, you see, maybe they are showing up everything. If you don't teach they will learn from outside, and we are teaching, but by teaching, by learning some the they start try, // let me touch, let me try if is true, you see. Then you find yourself your child already pregnant, 15 years old, no school. Some of them they won't ...aah, my parents if you become pregnant they will chased you, let me go to the family planning, and the health service...

**Interviewer:** Some are going to the service because they are afraid to be chased out of the house?

**Participant:** Yeah~yeah, Even you do not chase away, the way you educate, you educating your child, she will feel that if I...I do so, like I am not spending my mother the way she is did, the way our parents are telling us, then to be let us go there, we're doing but you will... they will never discover it, by doing that, thatsi... that side that kind of service, maybe they are destroying something in their...// because they are still young, they are still young, so I don't know now at the side of health service what can they can do for this young generation, 'cause I'm organise they cannot afford that type of injection. What about if you apply to your kid or give that type of those tablet to the kid and the

tomorrow they find themselves they won't get pregnant, is a problem now. Found problem that is the other side that I realise...

**Interviewer:** And this service of family planning is it also available for older the women?

**Participant:** Yeah, it stands for old, old people. Is a plan, must make a plan, and your husband whatever, if you see that a number especially us refugee, the life that we are carrying. We, we look at...at a number of the children that you have, aah, we got what again, what are we going to do tomorrow. They will need the school and they were have nowhere, that's a process that something like planned between two people. The couple, not for the kids...

**Interviewer:** Any other thing that you want to address? How do people use the information about HIV?

**Participant:** Aah...When they get information then they come up with a decision, they get information, they also inform other, they understand, they go now...

**Interviewer:** Do you have a counseling service in the camp?

**Participant:** O, yeah! But the hospital getting their job we have social worker here, other side of the hospital there are doctors, even some of the institution at school there we have also counseling room there helping those small, the learners so that they can grow up the supervision, eeh, yeah.

**Interviewer:** Anything else?

**Participant:** Mmh-mmh...no

**At the end of the interview the researcher validated the information with the participant to make sure she has the correct information. She then thanked the participant for revealing to her the life of women in the camp.**

**ADDENDUM 7: REFERENCE TO LIKERT SCALE**

**7(A): BIOGRAPHICAL INFORMATION OF EXPERTS**

**7(B): DELPHI INSTRUMENT RATING SCALES**

**7(A): BIOGRAPHIC INFORMATION OF THE EXPERT**

1. What is your highest academic qualification?	
2. What is your occupation?	
3. Where do you work?	
4. Please state your current position and what you do in that position	
5. For how many years have you been in that position?	
6. State your professional experience related to women's health.	
7. Have you worked with refugees?	
8. If yes to question 7, what were your responsibilities with them?	
9. Did you do any research on refugee women's health?	
10. Did you do any publication in journals on refugees' health related issues?	
11. Provide the name of the article and the website of your recent research publication (if any)	
12. Do you have any other experience related to your work that you would like to share?	

## 7(B) DELPHI INSTRUMENT RATING SCALES

### LIKERT SCALE

DRAFT GUIDELINES	RATING SCALE			
	1	2	3	4
<p><b>1. Involvement of displaced women in decision making process to enhance their autonomy and freedom and to promote their health.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Manage the democratic election of women representatives on clinic and hospital committees.</li> <li>• Empower the women representatives through training programmes to identify and voice the health care needs of the displaced women.</li> <li>• Institute hospital and clinic forums to create opportunities where all displaced women can discuss their health care needs with the hospital and clinic authorities.</li> <li>• Involve the displaced women to recommend and evaluate required changes to the health care delivered at the clinic and hospital.</li> <li>• Encourage displaced women to evaluate the health care delivered at the clinic and hospital.</li> <li>• Provide regular feedback to the displaced women regarding changes to the health care system they access to address their concerns.</li> </ul> <p><b>Comments:</b></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>				

<b>DRAFT GUIDELINES (contd.)</b>	<b>RATING SCALE</b>			
	1	2	3	4
<p><b>2. Skills training and income generating projects to improve and sustain the health of displaced women.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Lobby for NGOs and volunteer organisations to determine the skills base of women and provide space for skills training.</li> <li>• Acknowledge and appreciate the women’s skills.</li> <li>• Create opportunities for the women to share their skills with other women in health promotion programmes such as cooking.</li> <li>• Motivate the women to take part and learn from each other in the health promotion programmes such as cooking.</li> <li>• Lobby with church groups; volunteers and NGOs for formal skills training programmes in the camp.</li> <li>• Lobby with church groups; volunteers and NGOs for formal income generating projects in the camp.</li> <li>• Enhance the development of power-from-within by encouraging women to make use of the income generating projects.</li> </ul> <p><b>Comments:</b></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>				

DRAFT GUIDELINES (contd.)	RATING SCALE			
	1	2	3	4
<p><b>3. Support for all vulnerable displaced women and more especially those with special health care needs.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Establish a trusting therapeutic interpersonal relationship with the women.</li> <li>• Involve women in their own health care through enabling health education.</li> <li>• Create opportunities for the women to restore their strength and dignity in the health promotion programmes</li> <li>• Encourage women to take part in health promotion programmes that help them to feel less vulnerable.</li> <li>• Acquaint oneself with the legislations related to the rights of displaced persons and ascertain that policies be implemented in the clinic.</li> <li>• Collaborate with other camp authorities to ensure that the legislation related to the rights of displaced people be implemented in the camp.</li> <li>• Negotiate reporting channels for incidents of violations of safety and swift reaction to complaints on behalf of the women with the camp officials.</li> <li>• Negotiate regular meetings between camp officials and representatives of the women regarding their safety and security.</li> <li>• Ensure that policies regarding disabled persons be implemented in the clinic and the camp.</li> </ul> <p><b>Comments:</b>.....</p>				

DRAFT GUIDELINES (contd.)	RATING SCALE			
	1	2	3	4
	<p><b>4. Protection of displaced women against stigmatisation due to HIV positive status.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Promote HIV/AIDS awareness in the camp.</li> <li>• Discourage ignorance about the existence of HIV/AIDS.</li> <li>• Encourage the community in the camp to go for voluntary HIV testing.</li> <li>• Conduct all interviews and procedures with HIV infected and potentially infected people in safe and supportive private settings.</li> <li>• Maintain confidentiality of all information of the women and the test results.</li> <li>• Conduct pre- and post-test counselling to reassure the women about the confidentiality of all information that relates to them and the test results.</li> <li>• Empower women with information and coping skills regarding HIV/AIDS.</li> <li>• Motivate HIV positive women who want to disclose their HIV positive status to do so without fear of stigmatisation.</li> <li>• Empower women with information and coping skills regarding possible stigmatization related to HIV/AIDS.</li> <li>• Empower camp officials and displaced people with information about the prevention and management of stigmatization of people living with HIV/AIDS.</li> <li>• Respect the dignity of HIV affected and infected persons by</li> </ul>			



<p>discouraging all forms of stigmatization in the health care services and in the camp.</p> <ul style="list-style-type: none"> <li>• Acquaint self with national and international policies regarding the protection of the rights of persons living with HIV/AIDS and observe that policies and legislations that aim at the protection of people living with HIV/AIDS are adhered to.</li> <li>• Stay abreast of new trends in caring for people living with HIV/AIDS through personnel development; attending workshops and seminars.</li> </ul> <p><b>Comments:</b></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>				
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<b>DRAFT GUIDELINES (contd.)</b>	<b>RATING SCALE</b>			
	1	2	3	4
<p><b>5. Security regarding humanitarian aid distribution and supportive communication.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Lobby with NGO representatives and camp officials for equal access of displaced women to humanitarian aids.</li> <li>• Lobby for displaced women’s representation and meaning-full participation in humanitarian aid distribution committees.</li> <li>• Collaborate with the camp management to ensure that the humanitarian aid relates to all the needs of displaced people and not only to the need for food.</li> <li>• Form discussion groups with women to discuss issues of nutrition and health.</li> <li>• Support endeavours to teach displaced women to prepare well-balanced meals with the food supplied to them.</li> <li>• Report to the camp management any suspected acts where humanitarian aid is diverted from its legitimate destination.</li> <li>• Disclose to the camp management epidemiological information relating to the prevalence of disease that developed due to insufficient humanitarian aid.</li> <li>• Collaborate with the camp management to adjust the humanitarian aid when the displaced people develop diseases related to insufficient humanitarian aid.</li> </ul> <p><b>Comments:</b>.....            .....</p>				

DRAFT GUIDELINES (contd.)	RATING SCALE			
	1	2	3	4
<p><b>6. Protection against harassment, threats of harm, abuse by men and domestic violence.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Collaborate with camp management and officials to ensure the safety of displaced women in the camp.</li> <li>• Ascertain that the rights of displaced people with regards to their safety are explained to women on arrival in the camp.</li> <li>• Negotiate with camp management that all camp officials attend on-going in-service training regarding the protection of the safety of displaced people.</li> <li>• Negotiate with camp management that programmes be instituted for the empowerment of displaced women to counteract unequal power relationships in the camp.</li> <li>• Lobby for women representation in the camp committees.</li> <li>• Initiate and manage awareness of abuse of women campaigns together with NGOs; volunteers and Catholic AIDS action and ELCIN AIDS action groups in the camp.</li> <li>• Cooperate with camp management and camp officials together with NGOs; volunteers and Catholic AIDS action and ELCIN AIDS action groups in programmes to prevent abuse of women.</li> <li>• Lobby together with NGOs; volunteers and Catholic AIDS action and ELCIN AIDS action groups for more recreation facilities to reduce the stress of displaced people and the related incidents of violence and abuse of women in the camp.</li> <li>• Cooperate with camp management and officials to ensure that the</li> </ul>				

<p>dignity of abused women is respected during the reporting and management thereof.</p> <ul style="list-style-type: none"> <li>• Negotiate with camp management for efficient response to reported incidents of abuse of displaced women.</li> <li>• Lobby with camp officials for the strict law enforcement regarding abuse of women in the camp.</li> <li>• Facilitate trusting relationships between nurses and displaced women to encourage women to disclose incidents of abuse.</li> <li>• Provide forensic nursing care to survivors of abuse according to the country's legislation in an empathetic humane manner.</li> <li>• Ensure that holistic care is rendered to survivors of abuse.</li> <li>• Be willing to provide evidence in court should the survivors report the abuse to the police.</li> <li>• Encourage victims of violence to report to the police cases of abuse.</li> <li>• Educate the camp community to support survivors of abuse through community based organisations; mass meetings; NGOs and volunteer counselling workers.</li> </ul> <p><b>Comments:</b></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>				
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DRAFT GUIDELINES (contd.)	RATING SCALE			
	1	2	3	4
<p><b>7. Reintegration to home country.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Negotiate with the applicable officials for the involvement of displaced women in the planning and implementation of repatriation or resettlement.</li> <li>• Ensure that the displaced women be oriented for the repatriation or resettlement by a team of camp officials and health care staff.</li> <li>• Ensure that the displaced women have enough time to prepare themselves for the repatriation or resettlement.</li> </ul> <p><b>Comments:</b></p> <p>.....</p>				
<p><b>8. Participation in reproductive health care.</b></p> <p><b>Actions</b></p> <p><b>The nurses in the camp will:</b></p> <ul style="list-style-type: none"> <li>• Acknowledge the cultural, religious and educational background of displaced women that may influence their participation in their reproductive health care.</li> <li>• Deliver a culture congruent comprehensive reproductive health care service to displaced women.</li> <li>• Encourage the involvement of displaced women in their</li> </ul>				

<p>reproductive health care.</p> <ul style="list-style-type: none"><li>• Enhance participation of displaced women in their reproductive health care through well planned appropriate health education.</li></ul> <p><b>Comments:</b></p> <p>.....</p> <p>.....</p>				
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## VALIDITY SCALE

CRITERIA	GUIDELIN	RATING SCALE			
	E	SA(4)	A(3)	D(2)	SD(1)
<b>Clarity:</b> The guideline is clear, simple, concise and understandable. <b>Comments:</b> ..... ..... ..... .....	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
<b>Applicability:</b> The guideline is applicable to the intended target group. <b>Comments:</b> ..... ..... ..... .....	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
<b>Reliability:</b> The guideline can be used to guide nurses to address the health care needs of displaced women. <b>Comments:</b> ..... ..... ..... .....	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
<b>Flexibility:</b> The guideline is flexible in addressing the health care needs and is not a rigid rule. <b>Comments:</b> ..... ..... .....	1				
	2				
	3				
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..... ..... .....	5				
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	8				

