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A Multi-Methods Qualitative Study of the Delivery Care Experiences of Congolese Refugees in Uganda

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Abstract

Introduction Uganda hosts over 1.4 million refugees and is regarded as one of the world's most hospitable places for displaced populations. However, reports suggest that comprehensive sexual and reproductive health (SRH) services remain inadequate. We aimed to explore the SRH experiences of Congolese refugees living in Uganda and ways that services could be improved. We focus this article on delivery care-related results.

Methods In 2017, we assessed Congolese women's SRH, including pregnancy and delivery care, needs in the Nakivale Refugee Settlement and Kampala. We conducted a review of published literature and institutional records, 11 key informant interviews, four focus group discussions with married and unmarried Congolese women, and 21 in-person in-depth interviews with Congolese women refugees. We analyzed these data for content and themes using inductive and deductive techniques. In the final analytic phase, we integrated findings from each study component to identify concordant and discordant results.

Results Our findings indicate that Congolese refugees experience significant challenges accessing delivery care in both camp and urban settings. The availability of trained healthcare staff is limited, health facilities and medication supplies are inadequate, and referral systems are deficient. Refugee women report that corruption, discrimination, language barriers, and lack of privacy characterize their delivery experiences.

Conclusion Efforts to increase trained healthcare staff, improve supply-chain management, and maintain infrastructure and equipment are imperative. Ensuring compliance with anti-bribery and anti-corruption policies and supporting respectful maternity care is also important. Creating approaches to overcome language barriers is crucial to minimizing miscommunication and building patient-provider trust.

Keywords Democratic Republic of the Congo · Maternal health · Pregnancy · Qualitative research · Refugees · Uganda

Significance

Understanding the barriers that refugee women face when seeking safe delivery care in both urban and camp settings is critical for improving the quality of and facilitating access to services. Addressing these service delivery challenges through fortifying the supply chain and supporting the training of health service professionals are clear priorities. When combined with efforts to combat discrimination and provide culturally and linguistically responsive care these efforts could improve service utilization.

Introduction

By the end of 2017, approximately 68.5 million people had been forcibly displaced globally as a result of insecurity, war, and natural disasters compared to 65.6 million people in 2016 (United Nations High Commissioner for Refugees [UNHCR] 2018a). Newly registered refugees accounting for this 2.9 million increase largely came from South Sudan, Myanmar, Syria, and several countries in central and eastern Africa, including the Democratic Republic of the Congo (DRC) (UNHCR 2018a). Of those displaced, 25.4 million are refugees (UNHCR 2018a); women and girls make up

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approximately 50% of this population (UNHCR n.d.). Low- and middle-income countries host the overwhelming majority of displaced people (UNHCR 2018a), a dynamic that further burdens already limited and weak health systems and infrastructure. For example, in 2017 Uganda, a lower-middle income country, was the largest refugee-hosting nation in Africa (UNHCR 2018a; United Nations Children's Fund [UNICEF] Uganda 2017). With a population of just over 41 million, Uganda hosts approximately 1.4 million refugees from 13 different countries; the number of refugees continues to increase. (UNICEF 2018; UNHCR and Government of Uganda 2018).

Historically, lack of prioritization of comprehensive reproductive health care characterized the humanitarian sector (Austin et al. 2008). However, over the last two decades, the global community has focused considerable attention on responding to the reproductive health needs of refugees and displaced populations. The creation of global networks (Inter-agency Working Group on Reproductive Health in Crises [IAWG] 2018a), the development of global guidelines (Foster et al. 2017; IAWG 2018b), and the launch of global and setting-specific initiatives (Al-Makaleh et al. 2017) have collectively aimed to reduce maternal death and disability in refugee, crisis, conflict, and emergency settings. Yet despite these efforts, in 2015, 61% of global maternal deaths occurred in 35 countries affected by humanitarian crises and/or defined as fragile states (United Nations Population Fund [UNFPA] 2015). Thus the availability and accessibility of safe, high-quality delivery care remains inadequate in many humanitarian settings (UNICEF 2016). In general, women in conflict-affected settings continue to be at a higher risk of unintended pregnancy, as a result of the increased risk of rape, coerced sex, and engagement in transactional sex, disruptions in contraceptive supply and use, and changes in pregnancy intentions from the pre-displacement period (Cohen 2009). These women are also at greater risk of dying during pregnancy due to unsafe abortion, pregnancy-related complications, and delivery complications, especially postpartum hemorrhage (UNFPA 2016).

Refugee women and girls residing in Uganda face similar challenges. Uganda is widely recognized for its positive response to humanitarian crises and its progressive refugee policies that encourage self-sufficiency and local integration and offer free healthcare (World Bank 2017). However, with the recent influx of refugees into Uganda, reproductive health services have been stretched thin (Ekayu 2017; Fosvik 2017). Uganda's tiered, decentralized healthcare system has long been plagued with insufficient financing, unclear referral systems, and a shortage of health care professionals, medical equipment, and supplies (Ministry of Health et al. 2012). Uganda has made strides in reducing maternal death and disability; the maternal mortality ratio fell from 430 deaths per 100,000 live births in 2010 to 375 deaths per 100,000 live births in 2017 (World Health Organization 2019). However, maternal mortality remains persistently high and access to quality reproductive care remains elusive for Ugandan nationals and refugee women alike. Indeed, recent studies show that emergency obstetric care remains unavailable in some higher-level health facilities that should be providing comprehensive services and specialized care (Wilunda et. al. 2014, 2015; Orinda et al. 2005).

The migration of Congolese populations into Uganda has been consistent since 2012, but recent armed conflict in the eastern DRC region of Ituri has displaced even more people. As of 2018, Uganda hosted the largest Congolese refugee population (over 316,000) which constituted 21.1% of all refugees in this resource-strapped country (UNHCR and Government of Uganda 2018). The majority of these Congolese refugees reside in rural refugee settlements in central and western Uganda; about 41,000 reside in Kampala, the capital city (UNHCR 2018b). Women and girls in refugee settlements in Uganda are at risk of sexual and gender-based violence (University of Waterloo 2016) and while research on urban refugees is limited, there is some evidence suggesting that urban refugees face difficulties accessing basic health services, finding shelter, and securing protection (Bernstein and Okello 2007; Human Rights Watch 2002; Women's Refugee Commission 2011).

This context motivated our decision to undertake a multi-methods assessment to understand better the comprehensive reproductive health needs of Congolese women living in Uganda and explore avenues by which services could be improved. In this manuscript, we focus specifically on the results related to delivery care.

Methods

Our multi-disciplinary, multi-national, multi-lingual study team collected data from May through August of 2017. We based our study design on the reproductive health needs assessment standards developed by the UNFPA (UNFPA 2010) and previous reproductive health needs assessments conducted with refugee and displaced populations (Hobstetter et al. 2012; Sheehy et al. 2015). As we have detailed previously (Nara et al. 2019, 2020) our assessment included a review of published literature and institutional reports and statistics, interviews with 11 key informants, four focus group discussions (FGDs) with married (n = 2) and unmarried (n = 2) refugee women, and 21 in-depth interviews with Congolese women. RN, then a Canadian-Congolese master's student at the University of Ottawa, led data collection for all study components after receiving training from AMF a medical anthropologist and medical doctor who has conducted reproductive health-related research with refugee populations in multiple countries.

Study Sites

In order to understand the needs and capture the experiences of both camp- and urban-based refugees, we conducted our study in the Nakivale Refugee Settlement and Kampala (see Fig. 1). The Nakivale Refugee Settlement was established in 1958 and was officially recognized 2 years later. Located in the Isingiro district in the southwestern region of Uganda, the Nakivale Refugee Settlement is one of the oldest camps in Africa and the oldest camp in Uganda (UNHCR 2018c). Currently, it is operated by UNHCR and hosts just over 100,000 refugees and asylum seekers (UNHCR 2018c). The camp stretches 185 square kilometres and is divided into 79 villages (UNHCR 2014). Characterized by hills, streams, and fertile land, with homes made of brick with corrugated tin roofs, the camp hosts refugees from Burundi, the DRC, Eritrea, Ethiopia, Rwanda, Somalia, and South Sudan (UNHCR 2018b); Congolese refugees constitute about 47.4% of the camp population.

Kampala is Uganda's capital and the largest city in the country. Situated on Lake Victoria, the city is divided into five boroughs: Kampala Central Division, Kawempe Division, Makindye Division, Nakawa Division, and Lubaga Division. With a population of just over 1.5 million, Kampala is one of the fastest-growing cities in Africa (Uganda Bureau of Statistics 2016). Many refugees choose to self-settle in Kampala due to discrimination and limited services in refugee camps (Human Rights Watch 2002) as well as the

Fig. 1 Map of Uganda and location of study sites

employment, education, and business opportunities available in the city (Kigozi 2015). Refugees often reside in slum areas of Kampala and typically aggregate in areas according to country of origin. Congolese refugees from the eastern region of the DRC primarily populate neighbourhoods in the Makindye Division (Women's Refugee Commission 2016).

Data Collection: Key Informant Interviews

We conducted 11 in-person interviews with well-positioned key informants including policy makers, health service providers, and non-governmental organization (NGO) representatives working in the humanitarian sector or with refugees. We purposively recruited participants based on publicly available information, study team contacts, and early participant referral. Using a semi-structured interview guide, we aimed to explore key informants' perspectives on the availability, accessibility, and affordability of comprehensive reproductive health services, facilitators and barriers to service utilization, and priorities for improvement. RN conducted all interviews in English with AB, a Ugandan student and local research assistant, present. Interviews took place at a time and location convenient for participants and lasted an average of 45 min. We audio-recorded, took notes during, and formally memoed after each interview.

Data Collection: Focus Group Discussions

We worked with two local NGOs to recruit women of reproductive age (age 15 to 49, inclusive) for our focus group discussions. To ensure some degree of homogeneity and consistent with practices in other refugee and conflict-affected settings (Sheehy et al. 2016; Gure et al. 2015; Hobstetter et al. 2015), we stratified discussion groups by marital status and geography. Thus, as indicated in Table 1, we conducted two FGDs in Nakivale Refugee Settlement and two FGDs in Kampala; a total of 36 women participated in the four FGDs. RN facilitated the discussions, which took place in a combination of French, Lingala, and Swahili, with the assistance of one female Congolese research assistant at each site. We used an FGD guide, developed specifically for this study, that explored central topics (maternal health and delivery care, contraception, and abortion/post-abortion care) and community knowledge of, access to, and utilization of reproductive health services, facilitators and barriers to access, and priorities for improvement. We held our FGDs in conference rooms of local NGOs. We audio-recoded all FGDs which averaged two hours in length; RN debriefed with each research assistant after each discussion and formally memoed soon thereafter.

Data Collection: In-Depth Interviews

Finally, our team conducted 21 in-person in-depth interviews with refugee women from the Nakivale Refugee Settlement (n = 10) and Kampala (n = 11). Two women participated in both FGDs and in-depth interviews. We present demographic information about our in-depth interview participants in Table 2. RN conducted interviews in French, Lingala, and Swahili (with assistance from one of two local research assistants). We recruited participants with the assistance of two local NGOs as well as through flyers at health facilities and word-of-mouth. The interviews followed a semi-structured format and focused on women's individual sexual and reproductive health experiences both before and after displacement, the care and services available, as well as

Table 2 Key demographic characteristics of in-depth interview participants (N = 21)

Characteristic	Number (%)
Residence in Uganda	
Kampala	11 (52%)
Nakivale Refugee Settlement	10 (48%)
Age	
Under 25	4 (19%)
26–35	7 (33%)
36–45	5 (24%)
46 and older	5 (24%)
Martial status	
Single	4 (19%)
Married	9 (43%)
Widowed	8 (38%)
Education attainment level	
Less than high school diploma	10 (48%)
High school diploma	5 (24%)
Education/training beyond high school	6 (29%)

Table 1 Characteristics of focus group discussion participants (N = 36)

FGD	Type	Number of participants	Location	Age range
1	Married women	10	Nakivale Refugee Settlement	27–48
2	Unmarried women	10	Nakivale Refugee Settlement	16–23
3	Married women	6	Kampala	27–46
4	Unmarried women	10	Kampala	15–25

individual perspectives on how services could be improved. We conducted our interviews at times and places that were convenient for participants, including the conference rooms of local NGOs. Interviews lasted an average of 50 min; we audio-recorded all but two. RN took notes during the interviews and formally memoed immediately thereafter. This process allowed us to determine when we had reached thematic saturation (Sandelowski 1995).

Data Analysis

We employed an iterative, multi-phased analytic plan that began during data collection. Based on our research objectives, interview and discussion guides, and knowledge of the literature we developed an initial codebook comprised of a priori (predetermined) codes and categories. We then used inductive techniques to add emergent codes and categories as we reviewed the data. We coded our data, which included transcripts (translated to English), notes, and memos, first for codes and categories and then later for themes (Denzin and Lincoln 2011; Elo and Kyngäs 2008); we used *NVivo 11.4.3* to manage these data. Team meetings between RN and AMF guided our interpretation; we resolved differences through discussion.

We initially analyzed each study component separately; the final analytic phase included combining our findings, paying specific attention to concordant and discordant results. In 2017–2018, we presented our preliminary findings to stakeholders at several international meetings; we incorporated the feedback we received into our final recommendations. Triangulation of multiple data sources allowed us to identify prominent themes, which we present in the results section.

Ethics

The Social Sciences and Humanities Research Ethics Board at the University of Ottawa approved this study. We also received ethics approval from Makerere University and the Uganda National Council of Science and Technology and research permission from the Office of the Prime Minister in Uganda. In this manuscript, we have removed or masked all personally identifying information and assigned pseudonyms to our participants.

Results

Availability of Trained Healthcare Staff is Limited

Our findings suggest that the availability of trained maternity care staff in health facilities is limited in both refugee camp and urban refugee settings. Key informants reported that health care facilities are significantly understaffed. As explained by a physician at the Nakivale Refugee Settlement, "[The recommended] clinician-patient ratio per day, for UNHCR, it's 1 to 50…But you will find in Nakivale, you have 1 to 80 per day, 1 to 100 per day." In Kampala, key informants highlighted the same challenges. As one service provider from Kampala mentioned, "There are many women who need care and the providers are not enough."

Consistent with our key informants, women who participated in both our FGDs and in-depth interviews repeatedly reported that upon arriving at maternity wards, there were no trained professionals to provide delivery care. Indeed, multiple women in both Nakivale Refugee Settlement and Kampala explained that health service professionals would often ask women or those accompanying the patient to help those in labour. Several refugee women explained that they had assisted each other with delivery because health service professionals were unavailable or indisposed. As Prudence, a 48-year old refugee from the Nakivale Refugee Settlement explained:

> There was a day I accompanied a woman who was going to give birth [to the health facility]. There was only one nurse who was alone and already tired and she had to go and get lunch. But there was a woman who was already giving birth and she was shouting, "Doctor! Doctor!" So I entered and got some materials and when the nurse came in she asked if I was a nurse, I said yes. I could not see a woman suffering.

Health Facilities, Equipment, and Medications are Inadequate to Meet Existing Needs

Women and key informants alike reported challenges surrounding health facility infrastructure, emphasizing the small size of delivery rooms and the inadequacy of equipment. For example, a physician in Nakivale Refugee Settlement explained that there are only two delivery beds, even though approximately 150 women deliver in the facility each month. This information is consistent with the experiences of refugee women; many participants reported having witnessed women giving birth on the floor due to the lack of hospital beds. Patricia, a 15-year-old from the Nakivale Refugee Settlement, described her experience when she accompanied her friend to the hospital: "Women give birth from the floor and others lose their children in the womb because there is no one to help them." Participants also reported being asked to move to the floor so that a labouring woman who was further along could use the bed. As described by Nadia, a 30-year-old refugee woman living in the camp, "Women here do suffer. First of all, there are only two beds. If you are in pain and you are on the bed, [and] someone else who comes in, is [in worse] condition, they will ask you to

go down and sleep on a plastic bag". One unmarried participant in the FGD from the Nakivale Refugee Settlement described her experience: "I gave birth at the hands of the person who was with me. There are only two beds which are used to give birth from. There was a woman who came in [after me]. They told me [to move] to the ground, and as I stood up, my child came out and went down [on the floor]."

This lack of infrastructure was not unique to camp-based refugees. Both key informants and Congolese women raised concerns about health facilities in Kampala as well. A key informant working for a non-governmental reproductive health service provider in Kampala explained that because of the sheer number of women seeking maternal and delivery care, "[A woman in labour] has to delay and sleep on the floor because there are no beds in the facility."

Women also mentioned that facilities lacked the necessary equipment to ensure the provision of high-quality maternal health care. As 42-year-old Aminata from the Nakivale Refugee Settlement explained, "Here there are no machines that operate. There is no echography here. They don't have machines!" Key informants confirmed that women's individual experiences were reflective of a common problem. As one physician at the Nakivale Refugee Settlement explained, "There are moments when the resources are inadequate and, in reality, you will find [that in] the facilities, there are no medicines, there are no supplies." These supply-side challenges were echoed by another physician in the Nakivale Refugee Settlement: "And of course, like in a refugee setting like this, we really have challenges in service delivery. The resources are always limited; mainly, medicine."

Referral Systems for Complicated Pregnancies are Deficient in the Camp

Women in the Nakivale Refugee Settlement consistently reported that obtaining a referral due to a pregnancy-related complication is a significant challenge. As one FGD participant stated, "The challenge we have here giving birth is related to transfer, especially when your case cannot be handled by that specific hospital. It has been difficult to get a transfer and we don't know what to do." Another woman during a FGD at the Nakivale Refugee Settlement described taking her friend to the hospital when she was in labour and doctors told them to go home as she was not ready to give birth. They returned to the hospital within three days, and she still had not given birth. "They told us to go back home yet the child was about to be born and had a big head, so it could not come out…[Then] I told them to help us they refused and I asked them to transfer us [to another hospital] and after pleading they just kept quiet." She continued to plead for her friend's case and in the end, they were transferred to a regional hospital in Mbarara, approximately 74 kms away. They were finally able to obtain care and the baby was delivered safely.

Unlike our other service delivery-related findings, key informants did not feel that there were systematic problems with referral systems. While physicians acknowledged that referral systems and transportation out of the Nakivale Refugee Settlement can be challenging to navigate, they reported that the Ugandan government had made an effort in recent years to improve the referral system by providing ambulances.

Women are Required to Offer Bribes to Receive Care

Both camp-based and urban refugee women reported that if and when there is a health service professional at the facility, to obtain care or be seen urgently, they must offer some sort of "incentive." One married FGD participant from Kampala reported to lots of nods of agreement, "I have accompanied at least three women to deliver. You reach the hospital and the doctors will not take care of you. They will see you suffering and in pain and they will not mind. Sometimes the doctor will come in if you give them something and that is [a] bribe." This sentiment was echoed by Imani, a 33-year-old Congolese woman living in Kampala, "Look even at the way they give medicine. They will want you to give them money despite the fact that these drugs are from the government. They will ask for a bribe, but at the same time they are the ones [prescribing] the medicine and [asking] you to go and buy [the medication] at their pharmacy".

Women from the DRC Face Discrimination and Language Barriers When Accessing Care

The Congolese women in our study repeatedly reported experiencing discrimination when seeking care. As Marie, a 33-year old refugee living in Kampala explained, "You go to the hospital and you have [an] emergency case, but they will not mind. Sometimes they will ask you for money and you don't have it. Or sometimes they will say, 'Ah, leave that Congolese'. When they hear you are a Congolese, they always increase the price." Marien, a 23-year old refugee also residing Kampala said:

> Sometimes when you arrive at the hospital, the first person you meet asks you 'Where do you come from?' When you say you are Congolese...it's something. There is no warm welcome. They say 'ah this Congolese.' But they also want your money, so they do their job and that's why they receive you. But it's not to say that they receive you like in a good way. Other nationalities are fine, but [for] Congolese and Sudanese, it's much worse.

That many refugee women are unable to communicate effectively with their health service professionals overlaps with the issue of discrimination. As Josephine described:

> The problem we always get first [is] the language barrier. If you manage to get someone who can interpret for you, you can be helped. But when the doctor asks you, he or she realizes that you don't know the language and then asks people to jump in and [interpret]. So if God helps you [and sends] you someone who can interpret for him, then you can go in and talk to him. But if not, sometimes the doctor can only look… and sometimes the doctor will test what he wants and sometimes the doctor will write what he thinks and you will not be able to tell the doctors what you need.

The language barriers compromise the quality of care as well as the rapport between health service professionals and women requiring services. Consequently, many women recognized the importance of having someone present who can understand the language a woman is speaking when she presents herself at the hospital. As 33-year old Georgina, a refugee in Kampala, said, "It is easier to communicate and explain the whole situation [to an interpreter].[Then] you can tell the nurse about the situation…and she can easily understand. If you cannot communicate with the nurse, you may risk losing the baby."

Women Lack Privacy During Delivery

In FGDs and interviews with refugee women both in the settlement and Kampala, concerns were often raised about the lack of privacy in the maternity ward. As Prudence stated,

> [T]he room where women give birth from should be private and should not be the same place for other work. Here you find that the [maternity ward] is more of a public place. [A woman] is giving birth and other people that she doesn't even know are there looking at her, even the cleaners.

Although refugee women in our study appreciated the necessity of having health service providers in the room, they were shocked that "anyone" could enter the maternity ward and therefore see women in labour. Congolese women who had experienced delivery in the DRC were particularly surprised by the contrast. As Josephine age 34, explained:

> To the issue of those giving birth here, I don't understand. Because this is not our country, maybe they have their own way of doing things. For example, in Congo, if you are in the labour they put you in a room and that room is only for you and the doctor, no one else can enter there. Maybe if it is another doctor because he or she has to come for the work-related issues. [And] in case there is another woman who is also in labour they [may] also bring her in but when it comes to the time of giving birth they will put you in a separate room. In Congo, a woman cannot give birth when others are looking at her, but the problem which is where you enter the labour unit and it is like a public place, everyone is passing by, it is same room – doctors, men, and children.

Discussion

International standards prioritize the provision of respectful maternity care (RMC) (World Health Organization 2016; IAWG 2018b) and Ugandan legislative provisions state that refugees have several rights, including access to Ugandan social services such as healthcare and education (Government of Uganda 2006, 2010). Section 29 (1)(b) of the 2006 Refugee Act, states that refugees are entitled to fair and just treatment without discrimination. However, our study reveals that Congolese refugee women living in both the Nakivale Refugee Settlement and the capital of Kampala experience significant challenges in accessing high-quality maternal health and delivery care in Uganda related to both service delivery and service utilization.

Notably, our findings show that there is a great need for trained healthcare professionals in both camp-based and urban health facilities. This lends support to Okello and colleagues' study (1998) that highlighted that a shortage and inequitable distribution of qualified health staff in Uganda affects service delivery. Moreover, in 2006 Uganda was listed as one of 57 countries in the world that had a shortage of health workers even though training of health care workers had increased (World Health Organization 2006). This shortage has remained persistent in the Ugandan health system and has been attributed to unemployment, poor staff motivation due to low salaries, and inadequate maintenance of facilities (Madinah 2016). This contributes to the migration of healthcare workers, including physicians, who leave to seek "better terms and conditions of service" (Omaswa et al. 2017, p. 6). It is clear that insufficient human resources delays access to basic care. Efforts to reduce the brain drain through appropriate incentives and retention strategies and to diversify the cadre of health service professionals could also alleviate this burden on other healthcare professionals.

Our study also highlights drug stock-outs as a challenge in service delivery. Our findings are consistent with results from previous facility surveys that explored the availability of medicines present on Uganda's essential medicines list (Armstrong-Hough et al. 2018; Masters et al. 2014). Results from both studies indicated that medication availability remains inadequate across different facilities in Uganda and that stock-outs remain a common challenge. The lack of drug

availability is a direct barrier to care; better management of supply chains should be encouraged.

Finally, our results are consistent with previous studies (Madinah 2016; Okello et al. 1998) that suggest health facilities in Uganda are often ill-equipped, and not adequately maintained, to provide quality care. Our final recommendation on the service delivery side is that facility condition assessments should be conducted regularly so that actionable improvement strategies can be developed. It would also be useful to explore further the dynamics surrounding referrals, as women and key informants had decidedly different perspectives on how complicated pregnancies and deliveries are being handled.

Discussions surrounding improving RMC and ensuring safe, accessible, and quality maternal and newborn health care globally are ongoing (Reis et al. 2012; World Health Organization 2015). RMC extends beyond simply preventing maternal morbidity or mortality; rather RMC incorporates basic human rights for the woman, including her autonomy, dignity, and feelings (Reis et al. 2012). Despite these international discussions, and the number of tools and frameworks that define, measure, and aim to prevent disrespectful treatment of women seeking maternal and delivery care (Bohren et al. 2015; Shakibazadeh et al. 2018), our study suggests that RMC is not actively practiced in Uganda for Congolese refugee women. The experiences reported by women in our study suggest that mistreatment and discrimination are common.

Bohren et al. (2015) outline seven categories of mistreatment, including verbal abuse, stigma and discrimination, failure to meet professional standards of care, and poor rapport between women and providers, and argue that these dynamics significantly shape maternal health and delivery care outcomes. For example, women may be reluctant to seek help from a trained professional in anticipation of negative treatment and may instead seek care from an unskilled individual or forgo care entirely (Bohren et al. 2015). Therefore, it is imperative RMC be an integral component of maternal and delivery care, for all women—including refugee women. Unfortunately, our results are consistent with several studies and reports showing that refugee and non-refugee women alike are not receiving respectful and dignified care (Al-Makaleh et al. 2017; Bohren et al. 2015; Bowser and Hill 2010; Shakibazadeh et al. 2018).

Our study also suggests bribery is a problem. A study by Hunt (2010) showed that healthcare workers, particularly in the public sector, extort bribes from richer Ugandans and also seek payments from the poor, even though policies are supposed to ensure free care. Our findings indicate that this same dynamic is impacting refugees and displaced populations as well. Acknowledging this problem is a necessary first step in developing, implementing, and ensuring adherence to anti-bribery and anti-corruption policies.

Finally, recognizing that refugees in Uganda come from 13 different countries and are not a homogenous group, engaging healthcare professionals in cultural sensitivity training could help address discrimination. Identifying creative strategies to address the evident language barriers would also help build trust between patients and providers.

Limitations

While we are confident in the themes identified, this multi-methods qualitative study was not meant to be representative or generalizable (Crouch and McKenzie 2006). We only recruited participants from Nakivale Refugee Settlement and Kampala, thus the perspectives of Congolese women living in other areas of Uganda are not reflected in our findings. Nonetheless, based on the rigour of our approach we are confident that these results are transferrable to other Congolese populations in Uganda. Further, we conducted this study in multiple languages (English, French, Lingala, and Swahili). Although this allowed us to engage with a range of participants in the language that was most comfortable for them, it is certainly possible that some nuance or subtlety was lost in translation. We tried to minimize this limitation by working with local NGOs and research assistants. Finally, we recognize that RN's positionality as a Congolese-Canadian woman influenced her interactions with Congolese participants, but also Ugandan stakeholders. Through memoing, debriefings, and regular team meetings, as well as including local research assistants in the team, we believe that we were able to understand these influences and increase the credibility and trustworthiness of this study.

Conclusion

The global humanitarian crisis has left many populations displaced worldwide; Uganda is a leading refugee host nation. But despite its progressive refugee policies, our study suggests there are considerable maternity-related service delivery and service utilization challenges in both camp and urban settings. Efforts to improve the accessibility and quality of respectful maternal health and delivery care in Uganda should be prioritized.

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