Bringing Mobile Clinics to Urban Refugees in Kampala

Kampala, Uganda
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Background

As part of a series of urban gender-based violence (GBV) pilot interventions, in 2016 the Women's Refugee Commission (WRC) partnered with Reproductive Health Uganda (RHU) to address information, service, and support gaps affecting at-risk refugee populations living in Kampala. One component of the project involved bringing a free mobile clinic to neighborhoods in Kampala with high refugee populations.[1] The clinic provided a range of health and psychosocial support services, including for GBV survivors, and was especially aimed at reaching individuals who would otherwise not be accessing services. This included refugee women who reported being unable to travel to static sites due to stigma, fear, transportation barriers, and other reasons.

Taking Mobile Clinics to Refugee Neighborhoods

With the assistance of refugee community leaders, RHU identified five neighborhoods across the city with large refugee populations. RHU sent its mobile outreach clinics—typically used to target hard-to-reach Ugandan communities—to these areas. At least eight visits to these neighborhoods were conducted, reaching 200-300 urban refugees per visit. RHU's health and social services team provided diverse services to refugee men, women, and children. Team members included clinicians, nurses, a midwife, laboratory technologies, social workers and psychosocial counselors, data clerks, and peer educators. Among the services provided were:

- General clinical services/primary healthcare
- Respiratory tract infections
- Malnutrition
- Injuries
- GBV response, including post-rape examinations and psychosocial support for survivors
- SRH, STI/HIV testing and treatment
- Referrals to specialized service providers and clinics

RHU's mobile clinic visits a refugee neighborhood in Kampala.

Many of those served reported being unable to access alternative services for various reasons, including distance, transportation costs, discrimination, and language barriers. Across the five sites, RHU provided direct health and GBV services to 3,244 urban refugees.

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[1] A second component of the pilot project was integrating the peer education model into humanitarian response in Kampala and the Nakivale Settlement, to strengthen the skills and capacity of refugee women engaged in sex work to mitigate their GBV risks. For more information, see WRC. 2017. *Case Study: Supporting Refugee Women Engaged in Sex Work: Integrating the Peer Education Model into Humanitarian Response*, available on WRC's website.

Mobile clinics: A safer, less stigmatizing way to reach refugees engaged in sex work

RHU's mobile clinic visits were open to all refugees living in hard-to-reach neighborhoods: women, men, and children. One reason RHU takes this approach is because it helps facilitate access to services for "hidden" and marginalized individuals who may not otherwise access services. In the visits to refugee neighborhoods, the mobile clinics proved especially useful for bridging service gaps facing refugee women engaged in sex work. Of the 3,244 urban refugees served during the five mobile clinic visits, 923 were women who reported selling sex currently or previously as a form of income, regularly or on occasion. These women accessed a range of services, including SRH and GBV services; most reported feeling too stigmatized or fearful to travel to static sites to access services. Of those who received GBV response services, including for rape and gang rape, most had never before shared their experience with a service provider.

"If you try to target [refugees engaged in sex work], they cannot come. And some are married, so their husbands won't allow them. So you have to be open to all refugees."

- RHU Outreach Worker

Of the 923 women who identified as currently or previously engaging in sex work, 88 were found to be HIV positive and were referred for ART related services. Amongst those who were referred, 23 women were already aware of their serostatus but were not accessing treatment; 65 women did not previously know they were HIV positive.

Hence one benefit of bringing mobile clinics to refugee neighborhoods, and offering holistic services to the whole community, is that it can provide cover for refugees who are marginalized or at-risk to access tailored services--without them having to visit a specialized clinic.

Conclusion

Demand for the mobile clinics was higher than RHU could meet. RHU is currently seeking funding to continue sending its mobile clinics to refugee neighborhoods in Kampala, to provide the holistic services that proved to be a critical entry point for SRH and GBV services for refugees who cannot, or will not, access them in other ways.

Outcomes of this pilot suggest that meeting refugees where they live can expand access to health and GBV services for urban refugees. This is especially true where they live dispersed across a large city and face transportation and other challenges attempting to visit static sites. The mobile clinics particularly proved to be an important entry point for reaching refugee women engaged in sex work because of the fact that they offered multi-faceted service provision open to *all* refugees. This enhanced access for women who did not know of an alternative, friendly service provider and/or who did not want to visit one for fear of being judged or 'found out'.

For more information about these mobile clinics, or the related peer education project, please see the more comprehensive case study called: *Mitigating Urban Refugees' GBV Risks in Kampala: Working with Refugee Women Engaged in Sex Work & Bringing Mobile Clinics to Refugee Neighborhoods.*[2]

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[2] This and other urban GBV case studies are available at: https://www.womensrefugeecommission.org/gbv/resources/1462-urban-gbv-case-studies.