REACH Informing more effective humanitarian action

QUALITATIVE STUDY ON ATTITUDES TOWARDS HEALTH AND MEDICINE

YIDA REFUGEE SETTLEMENT, UNITY STATE

MAY-JUNE 2013

ACTED

IMPACT Initiatives

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ACRONYMS

ACTED	Agency for Technical Cooperation and Development
AJS	Acute Jaundice Syndrome
CPA	Comprehensive Peace Agreement
FGD	Focus Group Discussion
GFD	General Food Distribution
IDP	Internally Displaced Person
IRC	International Rescue Committee
NFI	Non-Food Items
NGO	Non-Governmental Organisation
OPD	Out Patient Department
SPLA	Sudanese People's Liberation Army
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendants
UNHCR	United Nations High Commissioner for Refugees

Note: REACH and IMPACT initiatives are not acronyms

EXECUTIVE SUMMARY

ACTED, in partnership with IMPACT Initiatives and within the framework of its REACH initiative, has received funding from UNHCR for information management within camps in Unity and Upper Nile States, South Sudan. Within Unity, REACH has concentrated thus far on Yida, as it hosts the largest population of refugees, but it has also done work in Nyeel, Pariang and Ajuong Thok.

In response to a lack of qualitative information regarding health practices and beliefs in Yida, this assessment was undertaken in May and June 2013. All medical partners in Yida were consulted throughout the process and contributed to the tool design.

The primary finding of this assessment was that participants all used both traditional and modern medicine, often at the same time for the same illness. If one form of medicine did not appear to be effective in treating the ailment, then the other type would be sought in addition. All traditional doctors noted the utility of modern medicine and stated they often referred patients to the NGO clinics, especially for STIs, or if they were unsure what the disease was. Conversely, for other ailments, including Hepatitis E and broken bones, there was a perception amongst all participants that traditional medicine was more effective than modern.

The role of traditional medicine as a crucial underpinning of Nuban culture was repeatedly emphasised, both through the role of traditional doctors but also in curative home remedies that all people could use, including the use of food items and plant parts to treat common illnesses or wounds.

Participants showed a lack of understanding of the causes of even the most common diseases, explaining for example that malaria was caused by working in the hot sun, and Hepatitis E by eating too much oil. A lack of knowledge of the role of sanitation and hygiene in the spread of disease was clearly apparent, as well as a slight uncertainty about whether what people had been told at NGO clinics was true or not.

Almost all participants were very unwilling to speak about sexual health, with the notable exception of Dinka adults. Contraception was thought of specifically in relation to preventing pregnancy, and this was seen by almost all participants as something they would never want, instead saying the more children one could conceive the better. It was seen by all as preferable to give birth in an NGO clinic, with the primary reason for not doing so being the onset of labour before transport to the clinic could be arranged.

1. BACKGROUND

Decades of civil war in Sudan, during which millions lost their lives and countless became IDPs, eventually led to the implementation of the Comprehensive Peace Agreement (CPA) in 2005. Following this, a referendum was held in the south which led to the succession of South Sudan from Sudan in July 2011. This peace agreement did not, however, address all internal issues within the former Sudan, with several areas that had been active in the conflict against the Khartoum government being left out of the peace agreement. Two of these, the states of Blue Nile and South Kordofan, continued with active SPLA-North fighting against the government, as they felt disenfranchised by the CPA. In 2012, this conflict escalated and led to nearly 200,000 refugees fleeing these areas into South Sudan. Refugees from Blue Nile settled in several camps throughout Maban County, Upper Nile State, whereas those from South Kordofan settled in Pariang County, Unity State.

There are currently two refugee camps and one refugee settlement in Unity, of which the settlement, Yida, is home to the vast majority of the refugee population, with 71,159 refugees living there as of June 2nd, 2013. As Yida is not an organised camp but a settlement where refugees have organised themselves, the need for mapping and information systems is of high importance. Yida is located very close to the border with South Kordofan, and as such has strong links to the populace in the Nuba Mountains. This results in a highly mobile population, with thousands of people moving across the border to South Kordofan after General Food Distribution (GFD) having been observed by UNHCR. In addition, there are ongoing difficulties with the militarisation of the camp, which humanitarian actors are trying to address. Yida is organised along tribal lines, with traditional leaders forming the backbone of the social structure. Despite this, there has been no intertribal violence amongst the refugees; although in March 2013 there was fighting between the host and refugee communities which led to some deaths and the displacement of thousands.

In early 2012, the main health problem in Yida was malnutrition, but this has now tapered off to become relatively stable. In 2013, the main challenge faced by health actors has been the Hepatitis E epidemic, although this has never reached the levels it did in the camps in Maban County. Other common ailments have been malaria, diarrhoea, and skin diseases. STIs are also common, and NGOs working in sexual health have faced great resistance from the community when trying to distribute condoms.

UNHCR

Refugee Response in Unity: Yida Boma Mapping 2013

Yida Camp - Shelters: 16,641 (March 2013) Population: 70,689 (March 2013)

For Humanitarian Relief Purposes Only
Production date: 12 Jul 2013

Sudan
Yida
Unity State
South Sudan

Airstrip
Shelters
Host Community

Angola, Adda Dabakia, Fama, Tess, Dar, Saraf Jamus, Reka, Boram, Tabanya, Torodi, Umdoreen, Kurungu Abdallah, Umsharan, Damam, Gulu, Kawinyaro, Tira, Werni, Lagawa, Dilling, Darfur, Tolodi, Alliri, Safaya, Nuss, Ganay, Kolo, Tora, Doloka, Bilenya, Taballa, Tisare, Tafre, Hajer Anaba, Chururu, Miri, Kawalib, Lera, Shawaja, Atoro, Katcha, Kafina, Jabal Tagali, Mazarig, Abbu Hashim, Jabal, Kutang, Kutam, Tarawi, Tillo Mashisha, Damba, Tuna, Faruk, Yida Host Community

N

0 500
Meters

Data Sources: Boma Data - ACTED/ Vector Data - UNHCR / Samaritan's Purse / Solidarites/ MSF;
Coordinate System: GCS WGS 1984
Contact: adrian.combrinck@acted.org

REACH An initiative of ACTED - UNOSAT IMPACT Initiatives

2. METHODOLOGY

This research seeks to better illuminate the attitudes of the refugee and host communities in Yida towards health and medicine, to be shared with all health actors working in the camp, in order to help inform their policy. The vast majority if not all information regarding health in Yida has been quantitative, a source of information made more difficult by ongoing uncertainty about the population of the camp due to the mobile nature of the refugees. It was therefore felt that a qualitative study could give a new perspective to the situation and give an added value to already existing information. The data collected in this assessment is not statistically significant, and therefore should not be seen as something that can be generalized to represent the entire camp.

This research was purely qualitative in nature, seeking to understand aspects of complex belief systems. As such, it was not possible within the given timeframe to have a statistically significant sampling size. Despite this, various clusters were utilized, in order to ensure a cross-section of a variety of people within the camp. These were around the following axes:

- Gender: Male/female
- Youth/Adult - NB this research will use an international definition of youth as 15-24 as opposed to South Sudanese definitions, which typically go from 15-35.
- Tribe: Angolo/Shatt/Dinka/Moro/Kadugli – these are the main tribes present in Yida
- Occupation: general populace/traditional doctor

Therefore, this research consisted of the following Focus Group Discussion (FGD), each 'x' representing one FGD:

Tribe	Male Youth	Female Youth	Male Adults	Female Adults	Traditional Doctors
Angolo	×	×	×	×	
Shatt	×	×	×	×	
Dinka	×	×	×	×	
Moro	×	×	×	×	
Kadugli	×	×	×	×	
n/a					××[1]

Of these different tribes, the Dinka people are the host community, whereas the rest are refugees from South Kordofan. The Dinka people are a Nilotic tribe, and the largest tribe of South Sudan. The host community of Pariang County are from the clan Dinka Ngok, the same sub-tribe as that found in the disputed region of Abyei. All other tribes are from different areas of Nuba, speaking different language and having different tribal histories, although also to some extent a shared Nuban culture. The Nuban tribes chosen were identified as the main tribal groups in Yida during a previous REACH assessment of the community structure of Yida, conducted in October 2012.

Due to the sensitive nature of this research, all participants were clearly informed of the parameters of the research and the anonymous nature of participation. Only females were present for the female FGDs, in order to create a freer atmosphere. Participants received some light refreshment (soda, biscuits) for their time, as each FGD is expected to take two hours. Participants were selected by asking boma sheikhs to mobilize people, although sheikhs will not be present for any of the discussions except the Male Adults.

FGDs were at first conducted by a female expat with a Nuban female, of a different tribe to any of those in the FGDs, acting as a translator. The translator had previous experience of translating for NGOs in Kenya and was therefore familiar with the importance of being precise in translation. For the Dinka FGDs, the translator was a Dinka man, as no Dinka

[1] One FGD was done with Dinka and one with Nuban traditional doctors.

females who spoke English could be found in the community. In order to cope with translation bias, both translators first attended a training session. During this session, the tools were thoroughly explained, and they were asked to translate each question into Arabic, a common language between them, in order to ensure that they both understood the question correctly. Following this, they were asked to translate each question into their own language, and then to explain in English what the question was asking and what the underlying purpose of the question was.

After several FGDs, the Nuban translator took on the role of facilitator herself, as she had become familiar with the methodology of probing questions in response to answers given by participants. In all FGDs, the tools found in the annex were used, however it was emphasized throughout that these were merely a guide, and the questions should be led by the conversation, rather than structuring the conversation around inflexible questions. Due to time and capacity restraints, the tools were not tested before use in the assessment, however they were distributed to all health partners for input prior to starting.

Participants in each FGD were chosen by first meeting with the chief, and then asking him to either aid in locating the required people, or to facilitate an introduction to someone else who would be able to. For example, in the case of speaking to women, most often the senior midwife was contacted, who was then able to gather together a group of women.

FGDs varied between four to ten participants. As many people within the Nuba mountains or in South Sudan are unable to give an accurate age, the ages of participants were not recorded, however it was ensured that they fell into the two broad categories of ‘youth’ or ‘adult’. The time each FGD lasted varied widely between groups. In general, FGDs with youth, especially young women, were far shorter than those with adults. With young men this was due to their general unwillingness to spend time participating in the FGD, as demonstrated by repeated failure to show up at prearranged times. For young women, however, cultural barriers presented the greatest difficulty, as well as a lack of confidence. For example, many young women did not say anything with respect to the general health of their community other than that the elder women would be able to answer the question better, and all were shy to talk about the sexual and reproductive health aspects of the assessment. Conversely, with adult men – a group which typically included the chief – participants were eager to speak at length on all issues of health except those concerning childbirth and newborns. FGDs therefore lasted between a low of 30 minutes to three hours, with the majority falling between one to two hours. All FGDs were conducted in June-July of 2013.

3. LIMITATIONS

The biggest limitation to this research was the lack of any private and enclosed space in which to conduct focus group discussions. Due to this, FGDs were held either outside underneath a tree, or within a public building such as a church or school. As these buildings were made from local materials, they were not soundproof, and this may have restricted the topics people were comfortable talking about. At all times, every effort was made to ensure onlookers were sent away, in order to maintain as much privacy as possible.

Locating and interviewing male youth, of all tribes, was also challenging, as they are rarely around their home in the day, preferring to go out to work or socialise. They also proved particularly unreliable in keeping to previously arranged times to meet, therefore some of these ‘focus groups’ were only conducted with one or two male youth.

4. FINDINGS

Overall, it was notable that different tribes nonetheless had similar beliefs about medicine and health, for example the treatment of Hepatitis with eggs. This also extended to the Dinka host community. As both populations have been highly mobile for years due to the ongoing civil war, and the fact that until very recently there was no international border, cultural exchange and similarity are to be expected, even between different tribal groups. The main difference observed was that Dinka women were less educated than Nuban women, and also less confident, particularly the younger ones. The Dinka also appeared to have a greater lack of knowledge about modern medicine and the facilities available within Yida, likely due to the lesser involvement of NGOs within the host community than within the refugee population. Although some groups of Nuban women seemed more and some less open to sexual and reproductive health interventions, due to the small sample size it is impossible to generalize this to the entire tribal group. The one exception to this was the practice of female circumcision, which it was clearly specific tribal groups still practise, although all Nuban tribes used to do so.

Participants all used both traditional and modern medicine, with no respondent indicating they only used one. The two types of medical practise were not seen as contradictory, but rather complementary, with all respondents, including traditional doctors, also saying they would often seek both types of intervention for the same problem. There was a desire on the part of traditional doctors and traditional birth attendants to have more interaction and exchange with NGOs providing modern medical services, including in some cases requests for basic medical NFIs. One traditional doctor expressed gratitude for being interviewed in this way, saying it was important to make a “bridge” between the NGO doctors and their own doctors. The primary reasons for choosing not to seek modern medical attention were a lack of transport, long waiting queues, and a belief that for specific problems (Hepatitis E, broken bones) they were ineffective.

Diarrhoea and malaria were identified as the primary health problems in the community, a perception which chimes with the medical statistics collected in Yida. In June 2013 there was a crude incidence[2] of 11 (suspected) and 5.4 (confirmed) for malaria, whereas in July the former was 10 and the latter 1.5. Watery diarrhoea had a crude incidence of 33.3 in June, and 20.9 in July. [3]

Although these statistics back up the qualitative data, an interesting departure to note is that upper and lower respiratory tract infections were not mentioned in the focus group discussions, even though these are extremely common diseases in Yida, encompassing 27% of total morbidity in June and 24% in July.

HEPATITIS E

Due to the ongoing epidemic in Yida, one of the main focuses of this research was to learn about people’s knowledge of Hepatitis E.[4] The host community reported that this disease was present in Yida before the refugees came. All respondents indicated that this was an ongoing problem in their community, and that many people, particularly children, were suffering from this at the current time. They also showed a deep lack of understanding of the disease, exemplified by the fact that those respondents who spoke English referred to the disease as ‘yellow fever’ when any mention of yellow eyes was made.

Only two groups mentioned anything related to hygiene as a cause of Hepatitis E, and both mentioned only the role of flies. No mention was made of open defecation as a cause of this disease, although some did mention a ‘dirty environment’ as a cause of diarrhoea. Washing hands with soap was not referred to by any group throughout the research

[2] Number of cases per 1000 of the population
[3] All medical statistics for Yida contained in this report are taken from the Health Information Systems for Yida compiled by UNHCR for June and July 2013.
[4] When speaking to respondents, this was referred to as ‘the disease that make’s people’s eyes go yellow’, rather than ‘Hepatitis E’.

as a cause of any disease, suggesting there is still an urgent need for hygiene promotion explaining the importance of soap. Of the two groups who mentioned the role of flies, one specified that they learnt this because a member of their community had been told this when taken to hospital with AJS.

Conversely, almost every group, regardless of tribe, stated that Hepatitis E was caused by "too much oil in the body". Some also mentioned eating too much meat or salt, and the Dinka also claimed working in the hot sun was a factor. Perhaps due to this belief, several groups, but especially the Dinka, treat this disease with certain types of food: boiled eggs, chicken soup made without oil, and no salt in the diet.

As well as these food-based treatments, all communities also treat AJS with boiled or burnt tree roots. Another commonly mentioned treatment was to heat up metal needles in a fire, and then to burn the body at various points, including the back of the neck and wrists. Across all groups, Hepatitis E was identified as the main disease which people believe traditional medicine is more effective than modern. Some groups reported that they would go first to the hospital and then afterwards use traditional medicine, however other indicated they avoided going to the hospital entirely. Male youth from the Shatt tribe said that "it is only... [Hepatitis E] that we use traditional doctors, for other diseases we go to the hospital". Across all tribes, at least one group indicated that they would not go to the hospital for this disease. Angolo traditional doctors claimed that this was because "there is no cure for this in the hospital". All respondents claimed that their traditional medicine was very effective in the treatment of Hepatitis E.

SEXUAL AND REPRODUCTIVE HEALTH

The only groups happy to admit their community had sexual diseases were Dinka adults and Nuban traditional doctors. All other Nuban respondents, whether male or female, claimed that there were no sexual diseases present in their community – for example a group of Shatt male youth saying "we have no idea about that". However, Nuban traditional doctors said they were present in the community, and that there were specific doctors who treated these diseases. It was however agreed by all who admitted to the presence of STIs in their community that modern medicine was more effective in treating them. Specific ones mentioned included Syphilis and Gonorrhoea. One Angolo Nuban woman said: "I do not know about these types of diseases in my community, but if someone were to get this they would just go secretly by themselves to the clinic." Given that the prevalence of syndromic STIs amongst under-18s visiting the IRC clinic was 19% in June and 50% in July, and syphilis prevalence was 3.4% amongst OPD patients for both months, the unwillingness to speak about STIs is concerning. When joined with the 0% condom distribution rate seen in both June and July amongst the refugee population, the potential for the spread of disease is clear.

Unsurprisingly therefore, most discussion of contraception centred on pregnancy, rather than protection from disease. People seemed unaware that there was also a disease control aspect of certain types of contraception, articulating their response purely in terms of their desire to have "as many children as possible". Even when questioned regarding young, unmarried girls, it was still seen by adults as better for them to get pregnant rather than use contraception, across all groups. The prevailing attitude was well put by a Dinka woman, who said "If you give us medicine to make us have more babies, this we would take. But not contraception". One woman from the Shatt tribe however, said "contraception is not allowed in our community unless you make an agreement with your husband, but this is not practised regularly". A lack of understanding about conception was demonstrated by one Dinka man, who said "if you do not want to get a woman pregnant, you must avoid sleeping with her while she is menstruating, as this is the time when pregnancy is most likely to occur. The rest of the month it is ok."

Some of the Nuban female and male youth, however, expressed a desire for contraception to prevent pregnancy, again not mentioning disease. The girls expressed fears that contraception would make them infertile in the long term, and were unsure of where they could get it from. They also all said they were very shy to go to an IRC clinic to get these things, with

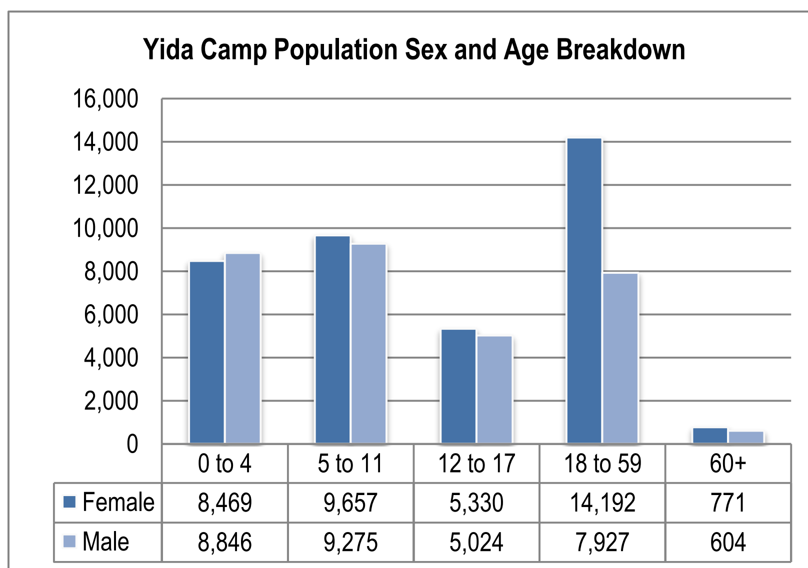
one girl requesting these things to be distributed covertly within the community. Some Nuban girls from the Shatt community, however, said they did not want contraception as they would not have sex before marriage.

All communities interviewed said that they practised male circumcision. This was mostly done at home, by members of their community, although a few said they took boys to the hospital to be circumcised. One group said that there was a specific medicine for children who had been circumcised available at pharmacies in the market,[5] and that they used this instead of going to hospital.

All communities also said that female circumcision occurs within Yida, although only one group, of Shatt women, said they practised this themselves. Other Nuban groups indicated they had previously practised this, but no longer did, in part due to difficulties in childbirth following the operation. Dinka people said this had never been a cultural practise of theirs.

PREGNANCY AND CHILDBIRTH

In 2008, the last year for which there are country-wide statistics, South Sudan had a birth rate of 30, whereas Sudan had one of 34 for the same year, and 32 for 2011.[6] In comparison, Yida had a monthly crude birth rate of 4.1 in June and 3.7 in July, averaging out to 49.2 and 44.4 per year respectively. This high rate may be due to the low prevalence of men in Yida, as shown by the below graph, taken from UNHCR registration statistics for Yida, August 2013.



	0 to 4	5 to 11	12 to 17	18 to 59	60+
Female	8,469	9,657	5,330	14,192	771
Male	8,846	9,275	5,024	7,927	604

In addition to the higher percentage of women in Yida, both Dinka and Nuban culture also places a high importance on children and childbirth, which was evidenced in all focus group discussions. All communities said that it is preferable for women to give birth in a hospital, with some members of the Kadugli community even saying they no longer had any TBAs, as all women went to IRC to give birth. In other tribes, however, Traditional Birth Attendants (TBAs) are still present and attend at births. All communities said that women give birth at home when it is not possible to get them to a clinic: for example if the labour onset is very fast. Overall, the percentage of known births in Yida attended by a trained health professional (not including TBAs) was 89% in June and 91% in July 2013, confirming that most women would prefer to give birth in a clinic.

The Dinka TBAs spoken with requested that an NGO help them with some basic supplies for their work. Specifically, medical gloves and soap were requested, with one woman exclaiming “last week I delivered twins, and I don’t even have soap!” Although all agreed that the ideal situation was for women to give birth at a clinic, they nonetheless felt that for those times when this was not possible, it would be beneficial to have more NGO support given to TBAs.

All Nuban communities interviewed said that a newly born child should not be washed with water, for a time which changes between communities, but is between one day and two weeks. During this period, the child is cleaned using oil,

[5] They referred to this medicine as ‘khamsulan’
[6] Live births per 1000 of the population per year, World Bank.

which is taken from the ration. This is done because it "protects the child from disease". This was collaborated by a doctor working in Yida, who indicated he had noted newborns were often unwashed.

Breastfeeding practices varied between communities, although all said that they breastfed the child for the first four to six months of life. Some communities however said that they also gave their children water, especially if the mother could not produce enough milk. Water mixed with a little salt was also mentioned in discussions with Dinka, Kadugli and Shatt women. Dinka said that this was used as a substitute if the mother could not produce enough milk, whereas the Nubans said this was something they gave to the child once they stopped relying solely on breastmilk. Dinka women also indicated they stopped breastfeeding at four months, then moving onto sorghum porridge with sugar.

TRADITIONAL VERSUS MODERN MEDICINE

All communities reported that they had traditional doctors, and all but one that they had TBAs. Traditional doctors tended to specialise in one specific area of medicine, such as broken bones or STIs, although people would still seek their help for other ailments. Traditional doctors all expressed a positive view of modern medicine, although they were also keen to emphasise their cultural role and expertise.

Respondents in all communities appeared to feel that modern and traditional medicine were not exclusionary of one another. Thus, most respondents reported that after going to a modern hospital they might then also go to a traditional doctor afterwards, especially if they felt they had not improved. Traditional doctors also indicated they would recommend a seriously ill patient to go to the hospital if they felt they could not treat them. Nuban traditional doctors spoke of a need to "build a bridge" between NGO and traditional doctors, so that both could understand the other.

Reasons for choosing to only visit traditional doctors were largely about access to medical care: long walks and long waiting times were identified by all groups as their primary reasons for not seeking modern medical care. Some respondents indicated there had been times when they had gone to an NGO clinic, but the waiting time was so long they had given up and gone to a traditional doctor instead. As discussed above, respondents also felt that for the treatment of Hepatitis E, traditional medicine was more effective than modern, although many did report using both. The other area in which modern medicine was perceived as lacking was in the treatment of broken bones. In both Dinka and all Nuban communities, traditional doctors were seen as extremely effective at mending broken bones, and the doctors themselves indicated they were better than the NGO doctors at this. The treatment for broken bones involves using ceartain leaves to wrap the limb and/or weighing down the hand or foot with a heavy lump of clay. This process often involves rebreaking a partially healed bone, and Dinka traditional doctors therefore requested that NGOs could provide them with painkillers for their patients.

Traditional doctors primarily referred to their treatment methods as being based on the use of certain plants, such as the bark show on the front cover, which is used to stem bleeding. Some treatment claims were wildly exaggerated, such as the claim that one doctor could take the bones from sheep and goats and use it to replace a bone which was too badly broken to heal. Doctors also referred to the religious aspect of their role, with some saying they had been "called" to the profession by god. One Dinka doctor explained: "When I was young I broke my hip bone very badly. So badly that I died. Then I came back to life, and this is how I became a doctor for healing bones." The same man also referred to his use of the power of god and spirits in his practise.

CONCLUSIONS

- Traditional doctors and birth attendants are not opposed to modern medical intervention, but all see the benefits (with the exception of broken bones and Hepatitis E). They are also happy to refer their own patients to seek modern medical care instead of or in addition to their own treatment, and this willingness could be capitalised on to ensure there is an effective system of referral for serious cases in the camp. Working with traditional medical leaders within the community would offer a way of reaching the community through their own networks rather than imposing new structures, which are likely to be less effective.

- The only links between sanitation and hygiene and Hepatitis E mentioned by participants were a dirty environment and the fact that flies move from excrement to the house spreading diseases. Neither of these were expressed with any sense of their own agency to control the spread of the epidemic, giving a somewhat fatalistic picture. As this information was received at the hospital rather than from the hygiene promoters working in the field, hospital staff should be encouraged to give more positive and active options for controlling the disease, such as hand washing. Hygiene promoters should speak to hospital staff in order to ensure the same messages regarding hygiene are spread in the community and at the point of care.

- Female circumcision is still prevalent within the camp. This is an immensely complex and difficult issue for outsiders to address, made particularly challenging within the large and temporary nature of Yida as a settlement. However within the smaller and more permanent community of Ajuong Thok this is perhaps an issue which can be looked into by protection partners to identify in greater detail the cultural beliefs driving this practice and possible options for ensuring girls are not forced into a dangerous and painful procedure that may negatively impact their future ability to engage in sexual activity and/or reproduce.

- Engaging with TBAs, particularly within the host community, could both reduce the number of mothers giving birth outside of the clinic, and improve the long-term sustainability of maternal health after the refugees have left. Providing TBAs with basic training on hygiene and midwifery, coupled with emphasis that in all possible cases mothers should be referred to the clinic using the existing donkey-cart ambulance would be highly beneficial. As it is likely all clinics will leave Yida once the refugees have left the area, this would also ensure a higher level of skill for attendance at births within the community in preparation for this eventuality.

- Practices surrounding the washing and feeding of newborns are potentially problematic, although these differ between different communities. Better education on care of newborns could help to improve their health and to set up better awareness of hygiene throughout childhood.

- There is still a deep unwillingness within the Nuban community to speak about sexual health issues, in comparison to Dinka adults of both genders, who were happy to discuss. However, there were some women who hinted they would like to access these services, only being concerned it would be anonymous and private.

- No community of refugees identified malnutrition as a serious concern in their community, demonstrating the improvement in nutrition in Yida since it first opened.

- The main reasons for choosing traditional over modern medicine (with the exceptions of the cases mentioned above) were long distances to walk and/or long waiting times at the hospitals.

ANNEX: TOOLS

NB all tools were developed in conjunction with health partners in Yida, who were asked for input and feedback. The below tools were used as a starting point for a flexible discussion, rather than getting simple and direct answers to these and nothing else.

MALE YOUTH AND ADULTS

1. What are the biggest health problems that affect your community? What do you think is the cause of these?
2. What do you think is the best method of prevention of these?
3. What do you think is the best method of treatment of these?
4. Sometimes some people in Yida have a disease where their eyes go yellow[7]. What do people in your community think causes this disease, and what do people do when they get this? Why?
5. Do you think there are ever times in Yida where children and adults get sick because they are not eating enough food, or the food is not good enough quality? If so, what do people do when this happens?
6. What are the biggest problems your community faces in terms of sexual health? What do you think are the causes of this? What do you think are the best ways to prevent/treat this? Are there any difficulties in pursuing these options?
7. When a woman is pregnant what are the dangers to her health and/or to the baby's health? If your wife was pregnant, what would you want her to do to ensure her and the baby were healthy?
8. Are there any people in your community who want or use contraception? Why? What type and where do they get this from?
9. When a baby is newly born, are there any special things that you do to keep the child healthy and safe? Are there any things that are dangerous for newly-born babies?
10. In Yida there are both traditional doctors and NGO doctors. What do you think about these two types of doctors? When do you choose to go to a traditional doctor? When do you choose to go to an NGO doctor?
11. In Yida there are both mobile clinics and OPDs. Which do you prefer? Why? If you have a health problem, how serious does it have to be for you to consider going to the OPD?

FEMALE YOUTH AND ADULTS

1. What are the biggest health problems that affect your community? What do you think is the cause of these?
2. What do you think is the best method of prevention of these?
3. What do you think is the best method of treatment of these?
4. Sometimes some people in Yida have a disease where their eyes go yellow. What do people in your community think causes this disease, and what do people do when they get this? Why?
5. Do you think there are ever times in Yida where children and adults get sick because they are not eating enough food, or the food is not good enough quality? If so, what do people do when this happens?
6. Sometimes here, people in Yida get special food because they are sick, or because they are pregnant or breastfeeding. What do you think of this food? What do you do with it, and who eats it?
7. What are the biggest problems your community faces in terms of sexual health? What do you think are the causes of this? What do you think are the best ways to prevent/treat this? Are there any difficulties in pursuing these options?

[7] NB although there are other causes of jaundice this question is aimed at HEV, this research is not mentioning it by name because it has been noted some members of the community refer to the disease where people have jaundice as 'Yellow Fever', thus naming 'Hepatitis' could cause confusion.

8. Sometimes unmarried women will still have a need for sexual health services. In your community, is this difficult for any reason? Why?
9. People in different cultures have different cultural practices – some people decorate their heads with scars, and some people circumcise boys and/or girls. Do people in your community practice any of these things here? If so, can you explain to me how this is done? Are there ever any health problems associated with this cutting, and if so, what do people do to treat the person?
10. When a woman is pregnant what are the dangers to her health and/or to the baby's health? If you were pregnant, what would you do to take care of yourself and the baby?
11. Are there any people in your community who want or use contraception? Why? What type and where do they get this from? Are there any barriers to you accessing these services?
12. When a baby is newly born, are there any special things that you do to keep the child healthy and safe? Are there any things that are dangerous for newly-born babies?
13. In Yida there are both traditional doctors and NGO doctors. What do you think about these two types of doctors? When do you choose to go to a traditional doctor? When do you choose to go to an NGO doctor?
14. In Yida there are both mobile clinics and OPDs. Which do you prefer? Why? If you have a health problem, how serious does it have to be for you to consider going to the OPD?

TRADITIONAL DOCTORS

1. What are the biggest health problems that affect your community? What do you think is the cause of these?
2. What do you think is the best method of prevention of these? (if say NGO clinic ask how they treat these)
3. What do you think is the best method of treatment of these? (if say NGO clinic ask how they treat these)
4. Sometimes some people in Yida have a disease where their eyes go yellow. What do people in your community think causes this disease, and what do people do when they get this? Why?
5. What are the biggest problems your community faces in terms of sexual health? What do you think are the causes of this? How do you treat these?
6. Are there any traditional methods of contraception that you know about? Can you explain these to me? How many people come to you asking for these? Are there any people you would refuse to give these?
7. When a baby is newly born, are there any special things that you do to keep the child healthy and safe? Are there any things that are dangerous for newly-born babies?
8. As traditional doctors, what is your opinion of the NGO clinics in Yida? Do you think they offer a good service for your community? Why?
9. Are there any things the NGO clinics do that you think are dangerous?
10. When do members of your community choose to see you and when do they choose to go to an NGO clinic?
11. Are there ever any times when you would tell a patient that they should visit an NGO clinic? Are there ever any times when you would tell a patient they should avoid going to an NGO clinic? Why?