REPUBLIC OF KENYA

THE COUNTY GOVERNMENT OF GARISSA
KENYA

Status of Maternal Health and Post Abortion Care Among Women of Reproductive Age in Dadaab Refugee Camp

African Gender and Media Initiative Trust

INUKA FOR COMMUNITY

WE Lead

60 YEARS Kenya Red Cross

NCPD

REPUBLIC OF KENYA

Status of Maternal Health and Post Abortion Care Among Women of Reproductive Age in Dadaab Refugee Camp

African Gender and Media Initiative Trust

Principal Investigator
Gladys Kiio

Co-Investigators
Dr. Jeanne Patrick
Fatuma Issa
Victone Otieno
Dr. Kaendi Munguti

FOREWORD

Female refugees face significant reproductive health challenges due to factors like language barriers, discrimination, and displacement-related stressors. These factors are further exacerbated by limited access to health care such as barriers in accessing prenatal care, contraceptives, and other reproductive health services. As a result, this can lead to increased risk of sexually transmitted diseases, unintended pregnancies, and higher rates of maternal and newborn deaths. This study sought to assess the reproductive health status of women of reproductive age in the Ifo 1 refugee camp in Dadaab and identify interventions that can be put in place to address these issues.

Although global studies have documented the reproductive health issues affecting refugee women, there is a notable lack of recent data specific to the Dadaab refugee camp, particularly regarding reproductive health status and access to post-abortion care (PAC). A maternal death audit conducted by UNHCR in 2010 highlighted key contributors to maternal mortality in Dadaab, including anemia, delays in seeking care, low rates of facility-based deliveries (frequently influenced by cultural preferences for home births), inadequate pre- and postnatal care, and high rates of grand multiparity among young women (UNHCR, 2010). However, no recent audits or comprehensive studies have been undertaken to assess the current sexual and reproductive health conditions of women in the camp.

As a result, this study sought to understand the maternal health situation of women in the Ifo 1 refugee camp in Dadaab. It is expected that the findings will inform policy and guide the development of interventions to improve the provision of reproductive health services in Dadaab and similar settings in Kenya. This study was conducted by GEM Trust in collaboration with the Ministry of Health, National Council for Population and Development, Kenya Red Cross Society, County Government of Garissa, and Inuka Success community-based organization.

Dr. Jeanne Patrick

Senior Deputy Director Medical Services

DRMNCAH - MOH

EXECUTIVE SUMMARY

Existing evidence shows that women in refugee settings face numerous reproductive health challenges (Mukasa et al., 2023; Gebreyesus et al., 2020; West et al., 2017). Some of the barriers identified in limiting women's access to care include high healthcare costs, inadequate infrastructure, and language obstacles (Zeid et al, 2015). Furthermore, access to essential reproductive services such as contraception and skilled birth attendance is often constrained by prevailing social, cultural, and religious norms (Royer et al, 2020; Degni et al, 2006)

Although global studies have documented the reproductive health issues affecting refugee women, there is a notable lack of recent data specific to the Dadaab refugee camp. A maternal death audit conducted by UNHCR in 2010 highlighted key contributors to maternal mortality in Dadaab, including anemia, delays in seeking care, low rates of facility-based deliveries (frequently influenced by cultural preferences for home births), inadequate pre- and postnatal care, and high rates of grand multiparity among young women (UNHCR, 2010). However, no recent audits or comprehensive studies have been undertaken to assess the current sexual and reproductive health conditions of women in the camp.

As a result, this study sought to understand the maternal health status of women in the Ifo 1 refugee camp in Dadaab and post abortion care services. It assessed the maternal health needs and service gaps, including post-abortion care (PAC) services among women of reproductive age. Specifically, the study gathered information on the current status of maternal health with a focus on sexual and reproductive health rights (SRHR) and PAC, and identified critical gaps in service delivery that contribute to poor maternal health outcomes.It is expected that the findings will inform policy and guide the development of interventions to improve the provision of reproductive health services in Dadaab and similar settings in Kenya.

A mixed-methods research design was employed. Quantitative data were collected through a structured survey questionnaire administered to a randomly selected sample of 200 women of reproductive age. Qualitative data were gathered through in-depth interviews with key informants who included health care providers and key community members with knowledge of SRHR and PAC. Focus group discussions were held with selected groups to facilitate in-depth exploration of maternal health by leveraging group dynamics.

Quantitative data was analysed using both bivariate and multivariate statistical techniques, while qualitative data was analysed to provide an in-depth contextual understanding. Study findings are presented using tables, graphs, diagrams, and narrative summaries.

The study findings show that women have some role in decision-making about their pregnancy, with 74% indicating that they wanted to get pregnant during the last pregnancy. In addition, 57% explained that the decision was made jointly with the husband. There were high levels of multipara, with those between 45-49 having 7 children. Use of antenatal (ANC) services is high, with 99% indicating seeking ANC services. Mean visits were 3.8 visits, with 63% of women having delivered at a health facility. **Other key findings were:**

1. Very low contraceptive use at only 3%
2. Information on contraceptives is widely available and shared through various media
3. Post abortion care services are offered to a large extent per National guidelines
4. Child marriage was widely practiced
5. Additional studies are needed on Gender Based Violence (GBV) and female circumcision, and implications for women's health may be needed.

Some of the key recommendations include;

1. Contraceptive choice and educating women on their choices may improve use. More importantly, it may be useful to pitch the use of contraceptives in a culturally and religiously appropriate way – as a means to "child spacing". It was noted that the concept of contraceptive use was "taboo" in the community and had, in some cases, negative connotations – such as leading to unfaithfulness among women.

2. Build on the positive findings that women are already making decisions on pregnancy, using antenatal care, and delivering in health facilities.

3. Girl child empowerment. Work with community leaders to prioritize the education of young girls, especially by ensuring that girls have access to formal education starting at a young age. This is likely to offer social and economic opportunities for many girls and women.

4. Female genital mutilation (FGM). Though not a focus of this study, it emerged that FGM is widely practiced, and this has implications for women's reproductive health and rights. While a better understanding of the current situation is required, partners and donors need to work closely with the community to address it and mitigate its impact on young women.

5. Anecdotal evidence suggests that there is gender-based violence (GBV) in the community. Further studies and interventions are needed to address this and ways in which the community and stakeholders can be engaged.

6. Have a multi-pronged approach to addressing maternal health. SRHR should not work alone, and it needs to be integrated with other social and development issues and have a holistic approach to addressing the health of women and children in the community.

7. Strengthen and create facilities in the health centres that provide privacy for those seeking PAC services to avoid stigma and embarrassment.

8. Provide regular training and refresher courses for health workers, and also ensure the availability of all requisite tools and equipment for PAC.

Gladys Kiio
Executive Director

TABLE OF CONTENTS

Contents

ACKNOWLEDGEMENTS

African Gender and Media Initiative Trust wishes to acknowledge all the study participants. This study goes a long in contributing to the body of knowledge for reproductive health and rights. Further, it provides a basis for action by government and relevant stakeholders to improve maternal health.

Special thanks go to the Ministry of Interior and National coordination through the Deputy County Commissioner's Office and the Department of Refugees Services in Dadaab for their support in community entry during the study.

We would like to thank the study reference group specifically, Ministry of Health - RAMNCAH Division who chaired the reference group, National Council for Population and Development - Garissa Office, County Government of Garissa, Kenya Red Cross Society, Inuka Success CBO, Dr. Kaendi Munguti and Dr. Agneta Mbithi for their technical support.

This publication owes a lot to its technical and financial resources partners HIVOs and Ministry of Foreign Affairs of the Kingdom of the Netherlands.

ACRONYMS

AMREF	Africa Medical Research Foundation
FGM	Female Genital Mutilation
GBV	Gender Based Violence
KDHS	Kenya Demographic Health Survey
PAC	Post Abortion Care
RMNCH	Reproductive, Maternal, Newborn and Child Health
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
UHC	Universal Health Coverage
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization
SUPKEM	Supreme Council of Kenya Muslims

1.0 BACKGROUND

According to the United Nations High Commissioner for Refugees (UNHCR), in 2024, there were 43.7 million refugees worldwide. Refugees are people who are forced to flee their home countries due to, among others, fear of persecution based on their identity, beliefs, or speech, or because of armed conflict, violence, or serious public disorder. Displacement is also increasingly driven by conflict over resources and the growing impacts of climate change. Many refugees flee with little more than the clothes they are wearing, leaving behind homes, possessions, livelihoods, and loved ones. In the process, they may experience human rights violations, suffer physical injuries, or witness the death or assault of family members and friends (UNHCR, 2024).

Based on the World Health Organization (2022) report, refugees and migrants face distinct physical and mental health challenges shaped by their experiences before departure, during migration, and upon arrival in host countries. These challenges are compounded by the policies governing entry, integration, and access to services, as well as by living and working conditions. Such factors heighten their vulnerability to both communicable and non-communicable diseases. In addition, the WHO reports that among refugees and displaced populations, up to one in five women are subjected to sexual violence. For many women, maternity care often serves as the first point of contact with the healthcare system for female refugees and migrants. However, access to adequate care is influenced by broader social determinants of health, including employment, income, education, and housing. For many women and girls, obtaining protection and response services for sexual and gender-based violence remains a significant challenge (WHO, 2022).

In addition, female refugees face significant reproductive health challenges due to factors like language barriers, discrimination, and displacement-related stressors. These factors are further exacerbated by limited access to health care, such as barriers in accessing prenatal care, contraceptives, and other reproductive health services. As a result, this can lead to increased risk of sexually transmitted diseases, unintended pregnancies, and higher rates of maternal and newborn deaths. This study sought to assess the reproductive health status of women of reproductive age in the Ifo 1 refugee camp in Dadaab and identify possible interventions that can be put in place to address these issues.

1.1 Problem Statement

Existing evidence shows that women in refugee settings face numerous reproductive health challenges (Mukasa et al., 2023; Gebreyesus et al., 2020; West et al., 2017). Some of the barriers identified in limiting women's access to care include high healthcare costs, inadequate infrastructure, and language obstacles (Zeid et al, 2015). Furthermore, access to essential reproductive services such as contraception and skilled birth attendance is often constrained by prevailing social, cultural, and religious norms (Royer et al, 2020; Degni et al, 2006)

Although global studies have documented the reproductive health issues affecting refugee women, there is a notable lack of recent data specific to the Dadaab refugee camp, particularly regarding reproductive health status and access to post-abortion care (PAC). A maternal death audit conducted by UNHCR in 2010 highlighted key contributors to maternal mortality in Dadaab, including anemia, delays in seeking care, low rates of facility-based deliveries (frequently influenced by cultural preferences for home births), inadequate pre- and postnatal care, and high rates of grand multiparity among young women (UNHCR, 2010). However, no recent audits or comprehensive studies have been undertaken to assess the current sexual and reproductive health conditions of women in the camp.

As a result, this study sought to understand the maternal health status of women in the Ifo 1 refugee camp in Dadaab and post abortion care services. It is expected that the findings will inform policy and guide the development of interventions to improve the provision of reproductive health services in Dadaab and similar settings in Kenya.

2.0 LITERATURE REVIEW

2.1 Sexual Reproductive Health and Rights

Sexual and reproductive health and rights (SRHR) are based on the premise that all individuals have the fundamental right to make their own decisions about their sexual and reproductive health, free from discrimination, coercion, and violence. This includes access to comprehensive sexual and reproductive health information, services, and commodities, such as contraception, safe post abortion services, maternal and newborn care, and prevention and treatment of sexually transmitted infections (WHO, 2022). The basic tenets of SRHR:

- **Bodily autonomy and integrity.** SRHR emphasizes that individuals have the right to control their bodies and make decisions about their sexuality and reproductive health without external interference.
- **Access to information and services.** This includes access to accurate, comprehensive, and unbiased information about sexual and reproductive health, as well as access to a range of quality services, such as contraception, prenatal care, and safe delivery services.
- **Informed decision-making.** SRHR ensures that individuals can make informed decisions about their reproductive health based on accurate information and without coercion or pressure.
- **Freedom from discrimination and violence.** SRHR protects individuals from discrimination and violence related to their sexual and reproductive health, including harmful practices like female genital mutilation and forced marriage.
- **Gender equality.** SRHR is closely linked to gender equality, as women and girls are often disproportionately affected by a lack of access to sexual and reproductive health services and information.

SRHR is important as it leads to improved health outcomes for individuals, families, and communities, including reduced maternal mortality and improved reproductive health. It also contributes to economic development by empowering individuals to make informed choices about their reproductive lives, leading to increased participation in education and the workforce. SRHR is a fundamental human right that promotes social justice and equality by ensuring that everyone has the opportunity to make decisions about their bodies and lives.

Some of the challenges to improving and achieving SRHR include social norms and stigma, especially cultural and religious norms, as well as stigma surrounding sexuality and reproductive health, which can limit access to information and services. Additionally, inadequate funding and resources for SRHR programs can hinder the provision of quality services, as can discriminatory laws and policies.

2.2 Reproductive health in Kenya

All reproductive health activities in Kenya, including those in refugee camps, are guided by the National Reproductive Health Policy 2022 – 2032 (Ministry of Health, July 2022). The goal of the policy is to minimize the burden of preventable morbidity and mortality related to reproductive health through achieving universal coverage of quality and comprehensive reproductive health interventions across the country; improving responsiveness to clients' reproductive health needs and strengthening the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaborations. The policy aims at: reducing maternal, perinatal, and neonatal morbidity and mortality; reducing unmet family planning needs; reducing the burden of reproductive tract infections and improving access to, and quality services, among others.

The policy also notes that adolescent health constitutes an ongoing challenge. Childbearing begins early in Kenya, with almost one-quarter of women having given birth by age 18, and half had started childbearing by age 20. Based on the KDHS 2022, the teenage pregnancy rate was 15%. The policy further notes that pregnancies with abortive outcomes, regardless of the cause, method, or rationale, carry a significant risk of morbidity and mortality, and thus the policy seeks to strengthen health systems to mitigate morbidity and mortality from post-abortion complications while minimizing preventable causes of abortion. This policy expands the management of pregnancy to include holistic management and psychosocial support for pregnancies compounded by a crisis. This study was conducted in Ifo 1, Dadaab, against the backdrop of the Ministry of Health policies and focused on improving the health of all women of reproductive age, including those in refugee camps.

The National Reproductive Health Policy defines Post Abortion Care (PAC) as emergency treatment for complications related to spontaneous or induced abortion, including evacuation of residual products of conception, treatment of attendant infections like sepsis, post-traumatic counselling, future conception planning and counselling, provision of contraceptives to prevent unplanned pregnancy (ibid).

2.3 Sexual and Reproductive Health Challenges in Refugee Camps

Literature review shows that women in refugee camps face a myriad of sexual and reproductive health challenges (WHO, 2022, Mungesha et al, 2018; Heslehurst et al 2018; Bhatia et al 2007) Some of the challenges faced include lack of comprehensive access to family planning, safe abortion care, and maternal health services (Chalmiers et al, 2022; Gozzi et al, 2024 and Levesque et al, 2013). The literature identifies the importance of recognizing the heightened vulnerability of refugee women to unintended pregnancies, sexually transmitted infections, and complications during childbirth due to limited access to healthcare and potential experiences of gender-based violence (Marchetti et al, 2023; Mutua et al, 2015).

In a study undertaken in Uganda (Mukasa et al, 2023) in a refugee camp, the researchers found that the factors associated with the utilization of SRHR services among adolescents included gender and marital status. According to the findings, there is a need to pay attention to context specificity as well as gender sensitivity in designing and implementing SRHR interventions in targeting young people in refugee settlements. Their findings also show differences by marriage and gender in influencing SRHR services access and utilization and point to the need to continue emphasizing audience segmentation in design and delivery of SRHR interventions particularly that have social behavioral change activities to facilitate addressing the unique or peculiar needs as well as barriers and enablers to access and utilization of SRHR services by young people in refugee settlements or humanitarian settings.

Some of the factors that have been identified as negatively affecting access to reproductive health care, especially among refugee women, are health care provider attitudes. For example, in a systematic review of qualitative, quantitative, and mixed methods studies of women aged 18 to 64 years and health care providers' perspectives (Davidson et al, 2022) reported that there were many barriers in access to SRH. These include women's low perceived need for preventive care, cultural attitudes and beliefs about family planning, and access to preventive services. In addition, shame surrounding women's access to and use of SRHR care services, discriminatory practices, lack of women's health care providers, culturally competent care, and language barriers limited access to reproductive health care more broadly. The authors also note that many barriers are exacerbated by the refugee context (Kolak et al, 2017; Royer et al., 2020).

Contextual issues such as deficiencies in infrastructure and transport, the costs of transport to access services, and fragmentation of the health care system, especially in refugee camp settings and in poorly resourced resettlement countries, limit women's access to SRHR care and support. Male partners' influences in decision-making about women's SRHR can limit access to contraceptive counselling and other services (Marchetti et al, 2023). Additionally, health provider biases in providing contraception, poor awareness of SRHR services, a lack of privacy

and confidentiality, and respectful and woman-friendly SRHR services were other barriers in many refugee camps. Other studies have also found similar findings Mungesha et al, 2018; Heslehurst et al, 2018; Bhatia et al, 2007).

In addition to the above factors, other literature suggests that a lack of awareness and knowledge can also impact access to reproductive health services in different refugee contexts. In studies looking at Somali refugee women, Khoshnood et al (2011) and Agbemenu et al (2018) note that lack of knowledge and awareness of SRHR in refugee camps can limit access to services, including use of contraceptives. According to their findings, the non-use of contraceptives is influenced by negative beliefs or misperceptions about side effects of contraceptive methods, such as beliefs around inability to conceive after discontinuing contraception and decreased sex drive, and fear that modern contraceptives cause infertility, menstrual irregularities, and mood disorders. As a result, these beliefs limit and, in some cases, discourage women from using contraceptives, thereby exposing women to unwanted pregnancies (Emtel et al, 2019).

Other factors that have been identified in the literature as leading to low use of contraception are mainly due to overburdened health services, cultural pressures regarding fertility, poorly trained service providers, health service disrupted by conflict, distance to service delivery points, cost of transport, religious opposition, language barriers with providers, and provider biases (Tanabe M, et al, 2017). The lack of awareness of the importance of preventive reproductive health services has also been noted as a factor that compromises women's SRHR, especially in refugee camps. Babatunde-Sowole et al (2020) note that for many women, the absence of illness is an indication that one is well, and as such, many do not seek preventive care such as screening for cervical cancer and other preventive care.

In other refugee situations, it has been reported that health care provider discrimination, described as poor communication and perceived lack of care, judgmental approaches, and disrespectful behavior in the provision of contraception, impacted refugee women in low-income country settings in access to care. In a study conducted in Israel, Gebreyesus et al (2020) indicated that poor or second-class treatment occurred due to poor communication, inadequate length of time required to address women's needs, providers' attitudes and fears towards asylum seekers, and gaps in their skills and knowledge in providing care.

The sex/gender of service providers can also be a factor in influencing or limiting access to care. In a study in 2015, Odunukan et al (2015) found that health care provider characteristics, especially concerns about receiving care from male health practitioners, can be a constraint to women seeking SRH care and, in some cases, choosing to forgo care rather than discuss reproductive health topics or undertake cervical screening with a male health care worker. The authors found that Somali women preferred a woman provider for physical examinations.

In addition, sociocultural factors such as family also influence women's utilization of contraception, breast and cervical screening, and other reproductive health services. In the literature review, it was noted that, for example, husbands' resistance to birth control and having the final decision about contraceptive use can limit women's access to care. West et al (2017) note that acceptance by women regarding the dominant role of a male partner in the decision-making, family's interference, as well as deferral to health care providers' decision-making, also impacted non-use of contraceptives across various refugee contexts. Morrison et al (2000) reported that in Thailand, Cambodian women were considered candidates for contraception only after approval from their husbands, despite women wanting to stop or delay childbearing.

Skilled birth attendance is recognized to be the most effective intervention for reducing maternal and newborn deaths, but not all women have access to or choose to use these services for various reasons. It is estimated that 60% percent of preventable maternal mortality and 45% percent of newborn mortality occur in contexts of conflict, displacement, and natural disasters (S. Zeid et al, 2015).

The literature on women and reproductive health also shows that religious opposition to contraception has implications for women's use of contraceptives. In some cultures, it is taboo for a woman to state that she does not want more children or wants to use modern birth control, which may be forbidden by religion. In a multi-country study, Tanabe et al (2017) found that religious teachings actively discouraged modern contraceptive use in five of the six population groups included in the studies (ibid). The importance of marriage and fidelity for Cambodian women in Thailand created a barrier to using contraception (ibid), while in the study amongst Somali women resettling in the US, contraception was more acceptable when framed as temporary assistance for birth spacing, as this is agreed within the tenets of their religion [ibid]. SRHR services differ in each resettlement context. Understanding these contexts and the differences may provide insight into why barriers to access to reproductive health services, including contraception, varied across ethnicity and context (Degni et al, 2006).

Cultural and traditional attitudes towards fertility have been noted to influence modern contraceptive use following displacement. In one qualitative study of Syrian women in Jordan, pressure to marry and begin childbearing early was the main barrier for some (young and unmarried) women but not others (West et al, 2017). In Somali culture, one US study reported that contraception is not discussed with young unmarried women and girls as pre-marital sex is stigmatized and disapproved of, a fact that is likely to expose young women to unplanned pregnancies and the attendant risk (ibid).

In addition, women's SRHR rights are further compounded by Gender Based Violence (GBV). For example, in a study conducted in Dadaab on GBV, Muuo et al (2020) found that 60.3% and 66.7% of women had experienced non-partner violence or intimate partner violence in their lifetime, respectively. Other barriers experienced by women in accessing care in Dadaab included stigma by family and the community, fear of further violence from perpetrators, feelings of helplessness and insecurity, and being denied entry to service provision premises by guards. The study concludes that women in the Dadaab refugee camps face violence from intimate partners, family, and other refugees.

As noted above, there are many barriers to accessing SRHR, which are further exacerbated by the refugee context. Deficiencies in infrastructure and transport, costs of transport to access services, and fragmentation of the health care system, especially in refugee camp settings and in poorly resourced resettlement countries, limit women's access to SRHR care and support. More importantly, male partners' influences in decision-making about women's SRHR can limit access to contraceptive counselling and services.

In other studies, health provider biases in providing contraception, poor awareness of SRHR services, a lack of privacy and confidentiality, and respectful and woman-friendly SRHR services were additional barriers in many low- and middle-income resettlement settings. Conversely, enablers to SRHR care identified included accessibility and availability of services, quality of services, affordability, knowledge of services, cultural acceptability, lack of stigma/discrimination, and decision-making autonomy (Davidson, N et al, 2022). The literature review above identifies factors that have been shown to influence women's sexual and reproductive health rights and their impact on women's health.

2.4 Post Abortion Care services and women's reproductive health

Post abortion care remains an area of concern in many countries. A recent report by the Ministry of Health (MOH) in collaboration with the African Population and Health Research Center (APHRC) and the Guttmacher Institute indicates that in 2023, Kenya recorded approximately 792,694 induced abortions (MOH, 2025). One of the major outcomes of abortions (induced or spontaneous) is the post abortion care (PAC), which, if not sought or provided by a qualified provider, can lead to increased mortality among women. In a study on PAC, Mutua et al 2018 estimate that unsafe abortion accounts for 35% of maternal mortality in Kenya. The authors note that unsafe abortion is still a leading cause of maternal death in most sub-Saharan African countries. PAC aims to minimize morbidity and mortality following unsafe abortion, addressing

incomplete abortion by treating complications, and reducing possible future unwanted pregnancies by providing contraceptive advice.

There is evidence to suggest that refugees and internally displaced women are exposed to particularly high levels of sexual violence, and may also need to engage in transactional sex for survival. In addition, they are more likely to have reduced access to contraceptives. As a result, compared with the general population, refugees may more commonly experience unintended pregnancies (Ohren, E and Lewinger S, 2020). The authors note that the lack of appropriate services for refugee and internally displaced women, an estimated 25–50% of maternal deaths in refugee settings are due to complications from unsafe abortion (ibid).

In many countries, policy and legal contexts shape the quality of PAC services provided. These are international, regional, and country-specific in content or implementation. Abortion remains an illegal or highly restricted and emotive issue in most countries globally, including Kenya (Mutua et al, 2018). Limited access to safe abortion, both formally and informally, increases women's recourse to unsafe termination procedures, and negative community and facility-based attitudes limit the effectiveness of interventions to provide quality PAC services. In 2016, changes in law in Kenya led to the registration and inclusion of Misoprostol and Mifepristone as essential drugs for the management of obstetric and gynecological indications, resulting in increased access to these as abortifacients (Mutua et al, 2018). However, many challenges remain in the provision of PAC.

In the above-referenced study on PAC in Kenya, Mutua et al note that quality care requires the continued availability of PAC services, and any service disruption can lead to life-threatening complications or result in lifetime consequences on patients' reproductive and psychological health. They conclude that PAC services in Kenya continue to suffer significant quality drawbacks owing to the legal and policy environment under which both service providers and patients operate, thus impacting access and provision. This study will seek to understand the current situation in terms of access to PAC in Dadaab, should any women require these services.

In addition, fear further fuels discrimination against patients by service providers and community discrimination against service providers. As a result, this leads to delays in seeking care on one hand, and provision of care on the other, which ultimately increases the risks of severe complications among PAC patients (Mutua et al, 2018). Understanding the context of PAC in Dadaab and women's reproductive health will be important in identifying and addressing concerns emerging, especially among the partners providing health care in the camp to these vulnerable populations.

In yet another study on PAC (Mutua et al 2015) looked at factors that may lead to delays in seeking PAC services in Kenya. The researchers found that the socio-demographic and reproductive health characteristics of clients seeking PAC services in Kenya's healthcare facilities in 2012 - over 70 % of the women were aged below 25 years, majority (55 %) of whom were aged between 20 and 24 years. Most women (59 %) reported that their usual residence was rural, while 41 % were from urban areas. Sixty-five percent of these PAC patients reported that they were married or living together with a man as if married. The study suggests that women's characteristics, such as age, educational attainment, and contextual issues such as country policies and provider competency, attitudes, and quality of care for PAC, play an important role in whether or not women delay seeking PAC care and services.

Zulu et al (2018), in a scoping review of published studies, found that because of the restrictions around abortion, various ethical challenges led to the stigmatization of the issue in many settings. The Ethical dilemmas noted by researchers conducting adolescent PAC research included: difficulties in convincing local health providers to permit PAC research; challenges in recruiting and seeking consent due to sensitivity of the subject; effectively protecting confidentiality; managing negative effects of interventions; creating a non-prejudicial atmosphere for research; managing emotional issues among adolescents; and dealing with uncertainty regarding the role of researchers when observing unethical health care practices. To redress these issues, it has

been suggested the use several sources to recruit study participants, using research to facilitate dialogue on abortion, fostering a comprehensive understanding of contextual norms and values, selecting staff with experience working with study populations, and avoiding the collection of personal identifiers.

In summary, based on the literature reviewed, some of the challenges faced by women of reproductive age include limited access to family planning services, hence often a high unmet need for contraception, increasing the risk of unintended pregnancies. In addition, adolescent refugee girls are particularly at risk for child marriage and related reproductive health issues. Other challenges include access challenges and barriers such as language barriers, cultural stigma, limited availability of services within refugee camps, and fear of seeking care due to legal status concerns.

3.0 RESEARCH OBJECTIVES

General Objective

To assess the status of maternal and reproductive health and PAC in Ifo 1 in Dadaab, Garissa County.

Specific objectives of the research:

1. Conduct a comprehensive assessment of the current status of maternal and reproductive health rights and post-abortion care services in Ifo 1, Dadaab Refugee camp.
2. Develop and present evidence-based recommendations aimed at improving maternal health and reproductive health services and post abortion care in Ifo 1, in Dadaab.

Research Questions

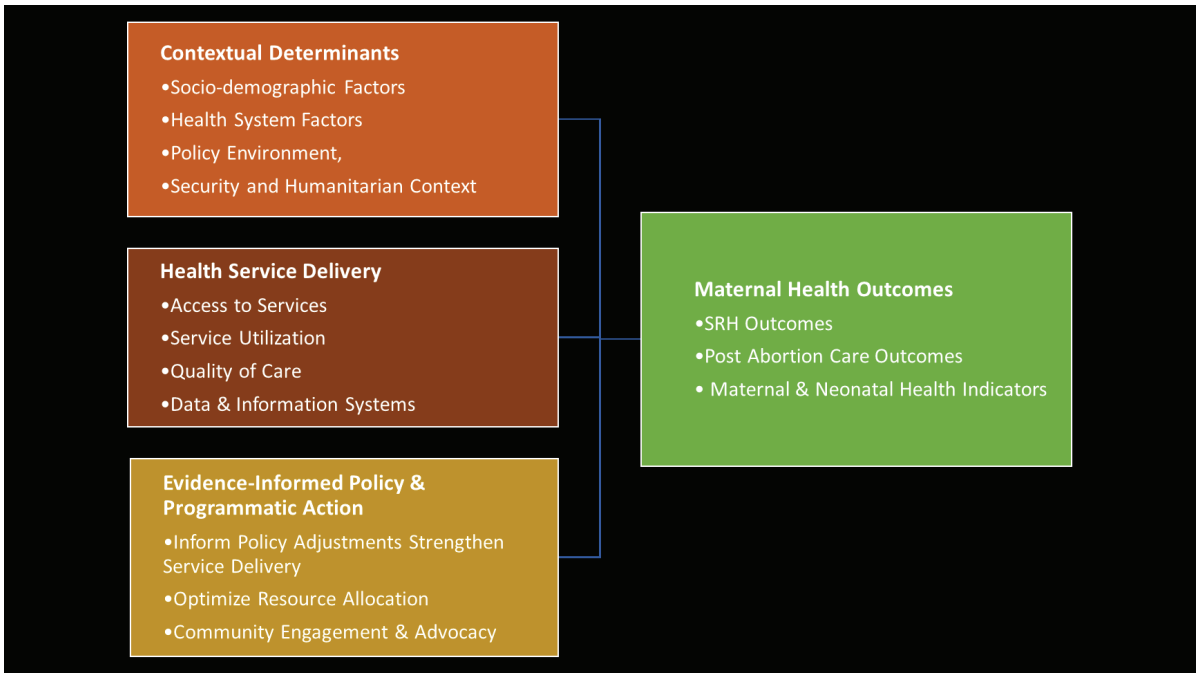
This study sought to address the questions below.

Specific research questions are:

1. What is the current status of maternal, reproductive health rights and post abortion care services in Ifo 1 in Dadaab refugee camp?
2. How can reproductive health rights and post abortion care services be improved in Dadaab refugee camp?

4.0 CONCEPTUAL FRAMEWORK

As mentioned earlier, multiple factors influence sexual and reproductive health rights, as well as access to and use of post-abortion care services. These factors include demographic characteristics, health system and service challenges, and contextual elements, socio-cultural and religious beliefs and practices, the fact that the women live in a refugee camp, national policies, among others. Gaining a deep understanding of the key factors affecting women's reproductive health is essential, as it forms the foundation for evidence-based programs aimed at improving outcomes in this area. Below is a diagrammatic representation of the conceptual framework.



5.0 METHODOLOGY

The study was undertaken in Ifo 1 in Dadaab refugee camp, which is located in Garissa County. Garissa County borders the Republic of Somalia to the east, Lamu County to the south, Tana River County to the west, Isiolo County to the northwest, and Wajir County to the north. It is arid with generally erratic and unreliable rainfall patterns, making it prone to drought and flood emergencies. The Dadaab refugee complex has three camps, namely Dagahaley, Ifo 1, and Ifo 2 (UNHCR, 2025). According to UNHCR, the majority of the refugees in the camp are from Somalia. It is estimated that by January 31, 2025, Dadaab had 419,155 registered refugees and asylum seekers (UNHCR, 2025).

The decision on the study site selection was based on logistical considerations, financial limitations, and the homogeneity of the population; however, the study findings will be generalizable to the larger population in Dadaab refugee camp. A recent population census by the Kenya Red Cross in 2025 estimated the population in Ifo 1 to be 103,914. The population of women of reproductive age 15- 49 years in Ifo 1 is 19,762.

The study design was cross-sectional. Both quantitative and qualitative research methods were used. A questionnaire was used to interview women of reproductive age between the ages of 15-49 years. The sample selected for interviews was based on the availability of resources and also considered women of reproductive age in Ifo 1, as discussed below. In addition, there were 13 Key Informant Interviews (KIIs) and 8 Focus Group Discussions (FGDs).

The KII included staff working at the Ifo health centre and providing various reproductive services and community leaders, such as religious and youth leaders. Discussions were also held with the county leadership, including the Deputy County Commissioner, the Subcounty reproductive health coordinator, and the Department of Refugee Services. The focus group discussions included women and men representing the different ethnicities – Somali, Somali Bantu, Sudanese, and Ethiopian. There were also FGDs of youth, persons living with disabilities and key populations. The information from KII and FGDs was used in creating an in-depth understanding of SRHR and PAC in the Ifo 1 refugee camp.

Sample size

The sample size was calculated using a formula that considers the population size of women of reproductive age at Ifo 1 camp, the desired confidence level, the margin of error, and an estimate of the proportion of pregnant women at Ifo camp, as shown below.

$$\mathbf{n = (N * Z^2 * p * q) / ((N * d^2) + (Z^2 * p * q))}$$

Where:

n = sample size

N = population size

Z = Z-score corresponding to a 95% confidence level

p = estimated prevalence or proportion

q = 1 - p

d = margin of error at 5%

The proportion of pregnant women in the camp is estimated at 10%

$$\mathbf{n} = (19762 * 1.96^2 * 0.10 * 0.90) / ((19762 * 0.05^2) + (1.96^2 * 0.10 * 0.90))$$

$$\mathbf{n = 137}$$

A minimum sample of 137 women of reproductive age was required for the study. Additional participants were sampled to account for potential drop-outs. In total, 200 women were interviewed. The women were randomly selected using available household information of women of reproductive age in the Ifo 1 camp. A recent household census undertaken by the Kenya Redcross Society in 2025 was used to form the sampling frame. The sample was clustered by community of residence within each study area using community units and blocks in Ifo 1.

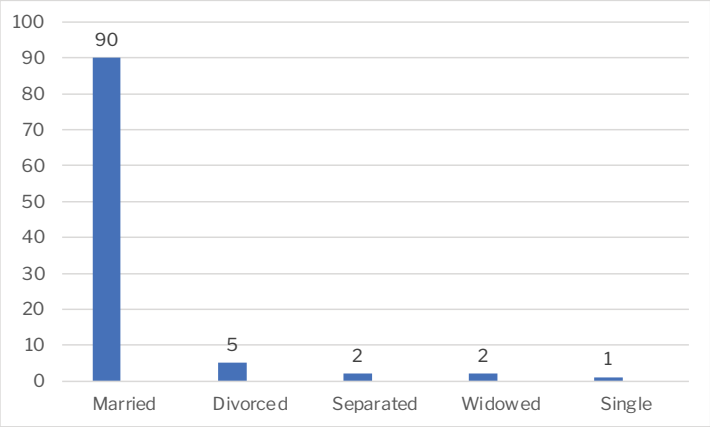
All women of reproductive age (15-49 years) in Ifo 1 were included in the study. The inclusion criteria were an appropriate age bracket and a signed consent to participate in the study before the interviews. For young women under the age of 18 years who are not married or not living in their household, a signed consent form from a parent/guardian was required for these women to be included in the study. All women who did not consent to be interviewed were excluded from the survey.

6.0 STUDY FINDINGS

As noted above, the study collected data from women of reproductive age using a questionnaire in order to understand maternal health status in Ifo 1 - more specifically, it focused on pregnancy, use of health care, contraceptive use, and also use of post abortion care services. In addition, qualitative methods, including focus group discussions, key informant interviews, and dialogue with communities, were also used. This section discusses the main findings.

6.1 Socio-demographic characteristics

Figure 1: Marital status of respondents



A total of 200 women of reproductive age (15-49) years were interviewed in Ifo 1, Dadaab refugee camp. The majority of the women interviewed were married at 90% followed by divorced at 5% and single, separated, and widowed at 2%, 2% and 1 % respectively. ((Figure 1).

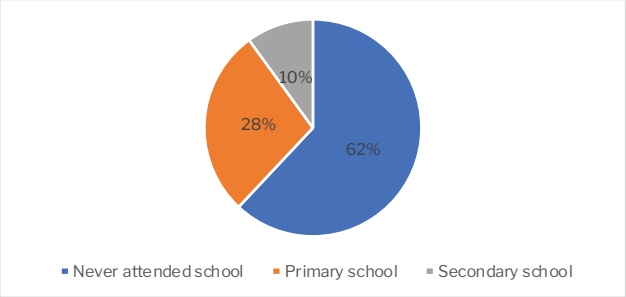
Table 1: Age and Nationality

Age years	**Number**	**%**
15-19	11	5.5
20-24	15	7.5
25-29	34	17
30-34	40	20
35-39	53	26.5
40-44	35	17.5
45-49	12	6
Nationality		
Somali	173	86.5
Ethiopian	10	5
South Sudanese	14	7
Burundi	3	1.5

In terms of the age of the women interviewed, 30% were below 35 years, with the majority (44%) being 35- 44 years. Women from the Somali community formed the largest nationality group (87%), followed by South Sudanese and Ethiopians, respectively (Table 1).

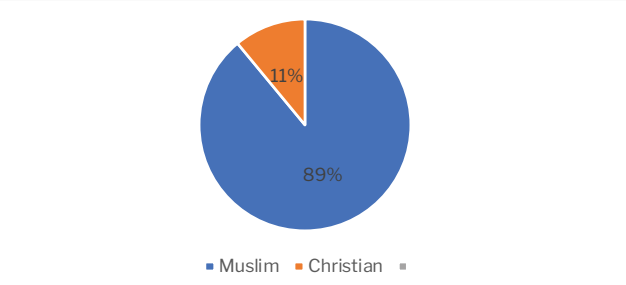
In terms of education, the majority of women (62%) have never attended school. Among those who have an education, 28% had a primary level education and only 10% a secondary or higher education (Figure 2). During focus group discussions with community members, it was noted that many young women, especially in the Somali community, begin their lives by attending *Duksi* (Religious learning of the Quran). However, many of them do not get the opportunity to attend formal schooling, which may explain this finding. This is further compounded by child marriages. Similarly, the living and contextual issues in the camp, such as distances to schools, security, and cultural expectations of young girls to help with household chores, may constrain access to education for many girls and young women.

Figure 2: Educational status



When asked about their religious affiliation, 89% of the women interviewed were Muslim, and the remaining indicated a Christian religious affiliation (Figure 3). Religious affiliation and beliefs can significantly influence attitudes towards reproductive health rights, with various faiths holding diverse perspectives on family planning and contraceptive use and the attendant maternal health-related issues. Some religions, like Catholicism, may oppose modern contraception, while others, such as certain Protestant and Muslim denominations, may allow or even encourage its use for specific purposes like family well-being or spacing births. Social and cultural factors also play a crucial role in shaping decisions about family size and contraception.

Figure 3: Religious affiliation



In terms of sources of livelihood, the majority of women (66%) relied on rations and support from the World Food Program (WFP), while 24% worked as unskilled laborers and 18% were either in small informal businesses or employed in the informal sector. Only 4% relied on "kin remittances" (Figure 4). The average monthly income ranged from Kenya Shillings 1,000-5000 (45%), while 55% had an income of over five thousand shillings a month. The World Food Programme is a humanitarian organization, focused on fighting hunger and promoting food security. It's part of the United Nations and provides food assistance, including emergency relief, and works to build pathways to peace and stability. Based on the findings, many of the refugees in the Ifo refugee camp rely on the WFP for their sustenance. One leader explained that:

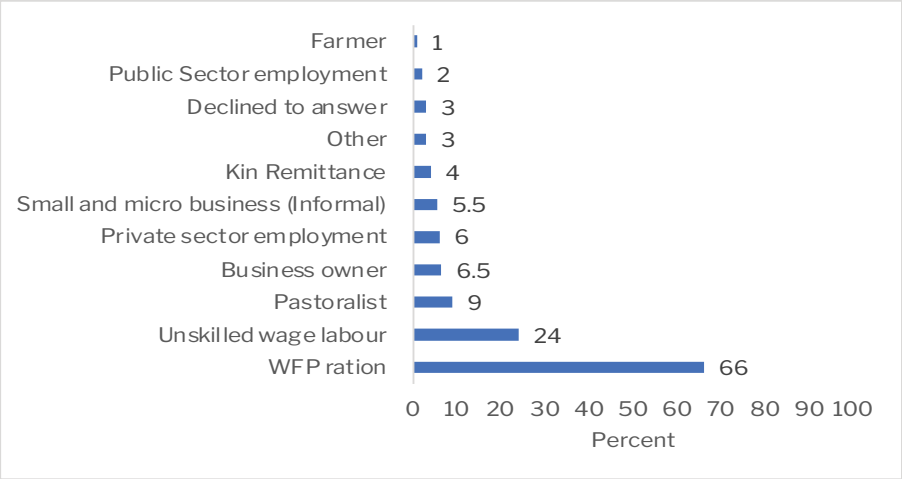
> ***"We arrived in Kenya with hope, seeking stability, and we are grateful that we found peace here. But peace alone is not enough. Many families here are struggling to survive under incredibly difficult conditions. There is a severe lack of access to clean water, adequate health services, and basic living necessities."***

To further underscore the point, they added that:

> ***"We are refugees - displaced people with no land, no resources, and no opportunities. We have come from far, and we have no one else to turn to. As the Somali proverb says,* "ciidna nooma maqno, ceelna nooma qodno," (we have no land to celebrate on, and no well has been dug for us), *to reflect their reality and a sense of helplessness."***

On a positive note, the Kenya Department of Refugee Services in Dadaab indicated that many of the refugees were well settled in the community and were being supported by the Department as needed. In addition, some of the community respondents indicated that the local economy was more vibrant and better with the integration of the refugee community.

Figure 4: Sources of income and livelihood



6.2 Maternal health

This study focused on understanding maternal health, which encompasses the health of women during pregnancy, childbirth, and the postpartum period. It also sought to understand the services offered to women in case of any miscarriages through post abortion care. Effective maternal health care can reduce maternal mortality and morbidity, ensuring the well-being of both mother and child.

Key aspects of maternal health, such as pregnancy, involve prenatal care, which includes monitoring the mother's health and the foetus's development, providing education on healthy behaviours, and addressing potential complications. Access to contraception and reproductive health services is crucial for women to plan their pregnancies and optimize their health. Ensuring maternal health is a fundamental human right, requiring access to quality care for all women, including those in vulnerable situations, such as the Ifo 1 refugee camp.

6.2.1 Marriage and Pregnancy

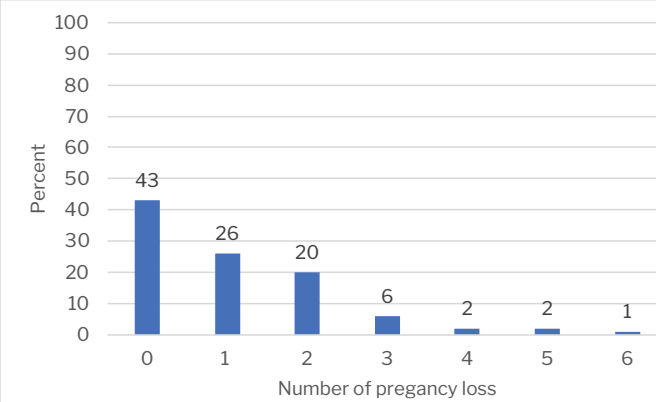
The study sought to understand the pregnancy experiences of the respondents in regards to decisions on when to have a child and when to seek care. As Table 2 below shows, the mean number of children born alive to women aged 15 – 49 years was 5.03, with women aged 40- 44 years having given birth to 7.10 children on average, and 6.5 of these children were still living at the time of the survey.

Table 2: Pregnancy outcomes

Age	Percentage of women with a history of pregnancy	Mean number of children born alive	Mean number of children still alive
15-19	90.9	0.9	0.9
20-24	93.3	2.7	2.6
25-29	100	3.3	3.1
30-34	100	5.1	5.1
35-39	100	5.9	5.8
40-44	100	7.1	6.5
45-49	100	6.1	5.6
Total		5.03	4.88

The study sought to find if the respondents had experienced any pregnancy loss. Nearly half of the women (47%) reported a history of pregnancy loss with one pregnancy and two pregnancies lost by 26% and 20% lost respectively (Figure 7). The mean months of pregnancy loss were 3.5 months. It would be useful for further studies to specifically identify the factors related to loss of pregnancies in this community, as noted earlier, as this study did not seek to address these in detail.

Figure 5: History of pregnancy loss



The study findings show that 5.5% of the women were between 15-19 years of age, and 7.5% were between 20-24 years. Some of these young women were already multipara gravida. While the specific factors leading to pregnancy loss were not identified in this study, there is evidence to suggest that young women under 20 years have higher pregnancy risks due to a combination of factors related to their age and reproductive maturity. For example, younger women may not have reached their full reproductive maturity, which can make them more vulnerable to pregnancy complications. They may also experience complications such as eclampsia, sepsis, and low birth weight babies, all of which can increase the risk of miscarriage or child loss. During discussions with the community members, it was noted that pregnancy loss is seen as "God's work" and as such, not avoidable, and no one is to be blamed for it. Some of the informants noted that female genital mutilation (FGM) may also be a complicating factor.

In addition, studies have shown that younger women may be more likely to experience poverty or other social disadvantages, which can negatively impact pregnancy outcomes. Younger women may be more likely to have certain risk factors like poor nutrition, further increasing the risk of miscarriage. Though not explored in detail in this study, discussions with health practitioners in Ifo 1 revealed that underlying anaemia was one of the leading complications to pregnancy, leading to low-birth-weight babies and miscarriages due to lack or limited access to nutritional foods.

Discussions with health care providers indicated that FGM is widely practiced and depending on type it can interfere with pelvic dilation

Another discussion with youth leaders indicated that FGM must be conducted by 5 years, I was explained that the community believes it reduces a woman's sexual feeling…making them normal.

6.2.2 Child Marriage and reproductive health

As noted above, 13% of the respondents were below the age of 24 years. During discussions with the community members and key informants, it was noted that marriages of young women were commonly practiced and "accepted" in the community. This was attributed in part to religious, cultural, and economic factors. The following were some of the factors identified for child marriages (defined as between ages 12-19 years), especially among the Somali community in the study.

- Cultural norms and practices: The study team learned that one of the main drivers was cultural perceptions of young unmarried women. It was explained that in the Somali community: "*If a girl remains unmarried beyond the age of 25 years, she is labelled Guumays, a term that carries social shame and stigma - making child marriage appear like a safer option for families".* Parents were often said to make marriage decisions on behalf of their daughters, leaving young girls with little or no say in the matter. Similarly, the fear among parents of young women having premarital sex and thus embarrassing the family honour was said to be a concern as the young women grow older.

- Economic vulnerability was also identified as a major contributor to child marriage within the community. Given their refugee status, it was noted that households that have a girl

child at home - with parents who have no income and have financial difficulties - there are cases of young women being married off to someone who is outside country or is going outside country soon (and is perceived/or financially stable) so that he will help support the girl's family financially when he goes to abroad. This was also said to be true among young women married to older men who have financial resources. It was noted that some girls voluntarily opt for child marriage due to societal pressure, lack of educational opportunities, or perceived economic benefits.

- Unequal gender relations were said to lead to some men intentionally seeking out young girls for marriage, believing that younger wives are easier to control and mold according to their expectations. Additionally, some men perceive marrying young girls as a way to "increase fertility" and produce more children for them over time. The importance of having larger families in refugee situations, such as Ifo 1, and increased access to food and other resources (due to resources distribution being based on household size) was also an important factor.

- Technology was also noted to have exacerbated the problem. It was argued that the widespread use of smartphones among adolescents had facilitated relationships between young girls and older men. These relationships were said to lead to unintended pregnancies, prompting families to arrange child marriages to avoid community stigma.

However, in a focus group discussion with Sudanese representatives, it was explained that:

> ***"Child marriage is rarely to be found in our community, but we have more early pregnancies, and this has led to youth being jobless, and they don't have anything to do".***

The group proposed providing youth with opportunities in education and meaningful economic activities to address the problem of early pregnancies. Similarly, it was noted that it is important to ensure that young women are informed about their reproductive health and have options, including contraceptives, to avoid "unwanted pregnancies".

The situation of childhood marriages is further complicated by religious and traditional practices. As noted earlier, we found that many Muslim families prioritize religious learning (*Duksi*) before formal schooling for girls. Children, especially girls, are only sent to school after completing the Qur'an. Additionally, there is a preference for sending boys to school over girls, which further marginalizes young women and reinforces the cycle of child marriage and poverty. Engaging community structures and organizations is vital to reversing this trend and protecting girls' rights.

Equally important is empowering young women through education, economic opportunities, and access to information is crucial for improving their health outcomes. In discussions with the community members, one group noted that:

> ***"Many women do not have the resources or knowledge to prevent unintended pregnancies. Also, there is cultural stigma around discussing reproductive health, and you know this can prevent women from seeking help or advice, leading to child marriages and unsafe practices when they find themselves in difficult situations".***

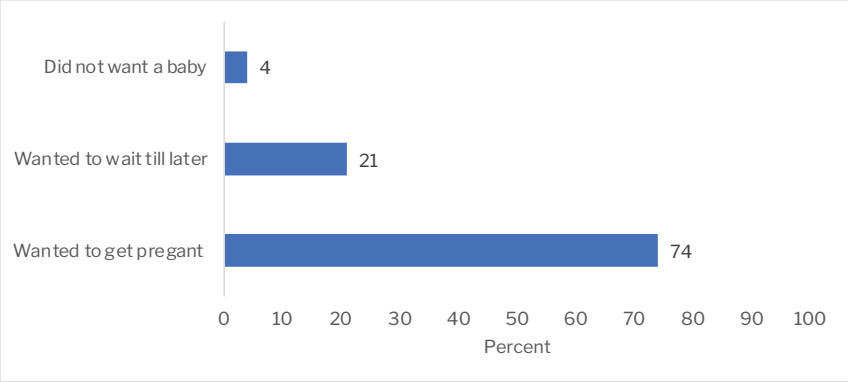
6.2. 3 Decision-making on pregnancy

One of the major aspects of reproductive health rights is for women to have agency over their reproductive rights. Having agency over one's reproductive health is crucial for women's overall well-being, empowerment, and societal progress. It allows women to make informed decisions about their bodies, fertility, and sexual health, leading to improved health outcomes, economic

opportunities, and reduced gender inequality. When women have control over their reproductive lives, they can better pursue education, careers, and overall life goals. According to the World Health Organization, when women have agency, they can make informed decisions about family planning, contraception, and spacing of pregnancies, which are vital for their health and well-being. Promoting women's agency in reproductive health is not just a health issue, but also a human rights issue with profound implications for women's well-being, economic empowerment, and overall societal progress.

In this study, when the respondents were asked about the decision to get pregnant, 74% indicated that they had wanted to get pregnant (Figure 5). However, 21% wanted to delay getting pregnant, while 4% did not want to have another child. For those who wanted to wait, 10% wanted to wait for less than one year, while another 10% wanted to wait for between 1 and 5 years to have another child.

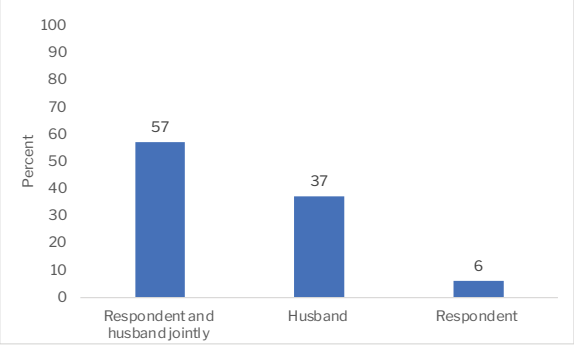
Figure 6: Decision on timing of pregnancy



Fifty-seven percent indicated that the decision to get pregnant was made jointly by both herself and her husband (Figure 6). However, 37% indicated that the husband had made the decision, as compared to only 6% where the woman had been the main decision maker. During dialogues and discussions with community members and individuals, it emerged that, regarding pregnancy, most of the decisions tended to be made by men and that there was "pressure" for women to have many children.

As a result, the study found that many of the women had multiple parities. When asked if they or their spouse was "doing anything to delay getting pregnant," 97 % indicated that they were not. Only 3% of the respondents were using a contraceptive method for birth spacing and to delay getting pregnant. The decision on using a contraceptive method had been made by either the respondent or the spouse. The methods used were the pill and one case of sterilization. However, given that only 6 respondents were using a contraceptive, this number was rather negligible is imperative that the factors that constrain the use of contraceptives/child spacing are identified and addressed. Putting in place structures to address existing gender inequalities may also be necessary.

Figure 7: Decision making on timing of pregnancy



During community discussions and dialogues, it emerged that there were situations where women could not make decisions, even when there were complications that required urgent care, like C-sections. Examples were given of where women may delay pregnancy-related care seeking or lifesaving decisions to get authorization from a spouse who may be out of the country, leading in some cases to adverse health outcomes.

6.2.4 Antenatal care (ANC)

Antenatal care (ANC) is crucial for ensuring a healthy pregnancy and delivery for both the mother and the baby. It involves regular checkups and medical care throughout pregnancy, providing opportunities for early detection and management of potential complications, health education, and support. Regular antenatal visits allow healthcare providers to identify and address potential problems like gestational diabetes, hypertension, and infections early on, reducing the risk of adverse outcomes. Additionally, ANC care provides a platform for educating pregnant women about healthy behaviours during pregnancy, including nutrition, and offers social, emotional, and psychological support. Antenatal care includes discussions about labour and postpartum care, preparing the mother and her family for the birth and the postpartum period, including information and decisions on child spacing and contraceptive use.

In this study, the majority of the women (89%) reported seeking antenatal/medical advice during their last pregnancy. Almost all the women who sought care went to a health facility (99%), with the remaining using community-based care. The mean months when the women started ANC visits were at 3.5 months, with a mean number of ANC visits during the pregnancy being 3.8 visits in total. The majority of the women sought care in the health centers near their homes in health posts, while 20% used the main health facility in Ifo 1 (Figure 8). This is an important and positive finding as it shows that pregnant women and their families are aware of the importance of ANC care for a healthy pregnancy outcome. These should be encouraged factors that may constrain the other women in seeking care, identified and addressed.

Those with primary and secondary levels of education were more likely to seek services at 96% and 97 per cent respectively, as were those whose monthly income was above 5000 shillings (96%).

Figure 8: Where women sought ANC care

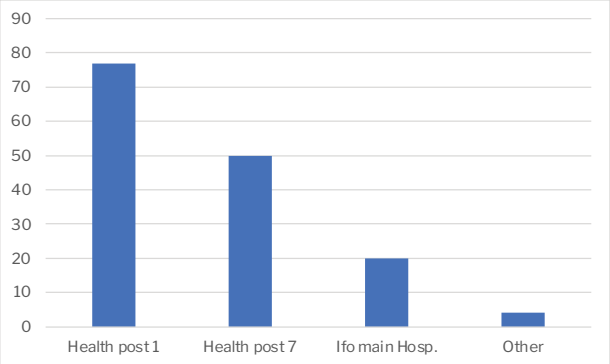
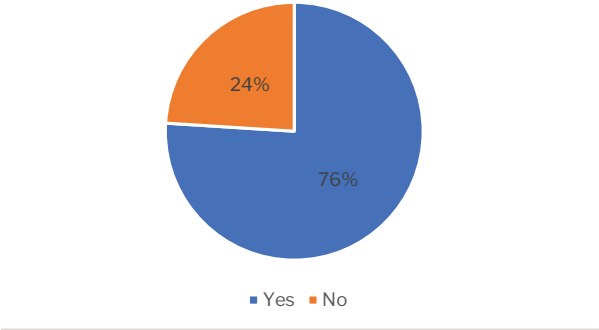


Figure 9: If pregnancy made it to term



The majority (76%) of the respondents indicated that the last pregnancy had made it to term; however, 24% had lost the last pregnancy (Figure 9). Given that the majority of the respondents had earlier indicated that they desired to get pregnant, the loss of pregnancy despite the use of ANC services raises a concern and is an area that needs further study to understand and address any related issues.

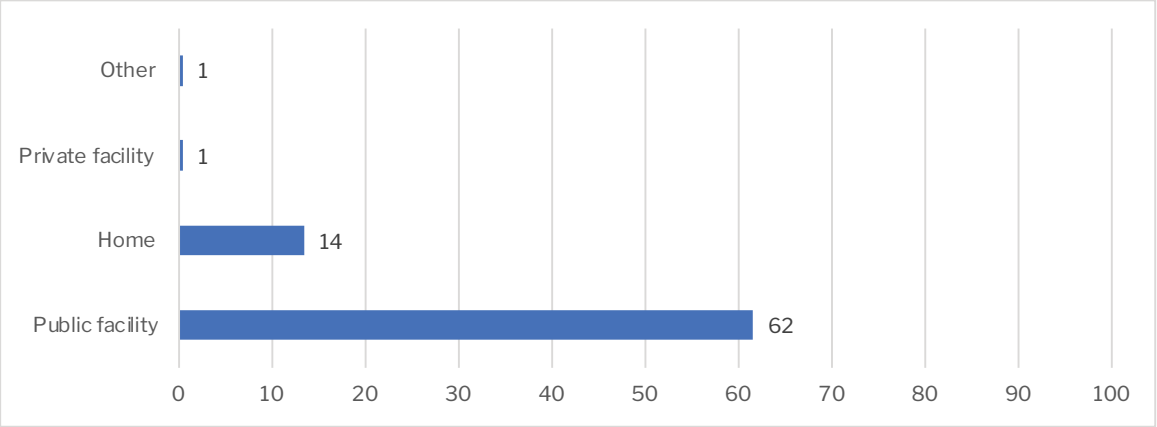
6. 2.5 Safe Delivery

Delivering a baby in a health care setting is generally considered safer due to the availability of skilled medical professionals, access to emergency equipment and interventions, and the ability to manage potential complications promptly. These factors significantly reduce the risks of both maternal and infant mortality and morbidity. Studies consistently show that facility-based deliveries are associated with lower rates of maternal mortality and morbidity compared to home deliveries (WHO,2022).

Findings from this study show that the majority of the women delivered in a health facility (63%), with home deliveries at 14 percent (Figure 10). However, while a majority were delivered at a health facility, the 14% that were not is still a high number. Since studies elsewhere have shown

that many women in refugee communities such as Dadaab may not deliver at a health facility due to social, religious, and cultural practices, this positive finding indicates the need to continue to advocate and encourage women to use health facilities during their pregnancies and to deliver at a health facility. This can be achieved by creating enabling environments to deliver with a skilled attendant in a health facility.

Figure 10: Place of delivery during last pregnancy



Experiences with care can influence decisions to seek or not seek care. In general, based on discussions with key informants, it appeared that the delivery of care services offered in the existing facilities and the main Ifo 1 health center were appreciated by the community and served the needs of the community.

6. 2.6 Reproductive health and contraceptive use

Contraceptives are essential for family planning, enabling individuals to control their reproductive health and achieve their desired number of children and spacing between pregnancies. Contraceptives play a vital role in preventing unintended pregnancies, which can reduce maternal and infant mortality rates and improve the overall health and well-being of families and communities.

In terms of family planning and reproductive health, contraceptives empower individuals to make informed decisions about their reproductive health, allowing them to plan for the number and spacing of their children. They help reduce the number of unintended pregnancies, which are a major contributor to maternal and infant mortality, especially among young girls and older women. By preventing unintended pregnancies, contraception also reduces the need for unsafe abortions.

In terms of social and economic benefits, family planning through contraception enables women to pursue education and employment opportunities, leading to greater social and economic empowerment. By reducing the burden of unintended pregnancies and childcare, contraception can improve the quality of life for families and contribute to the overall development of communities. As such, contraceptives can be a crucial tool for promoting individual autonomy, improving health outcomes, and fostering social and economic development.

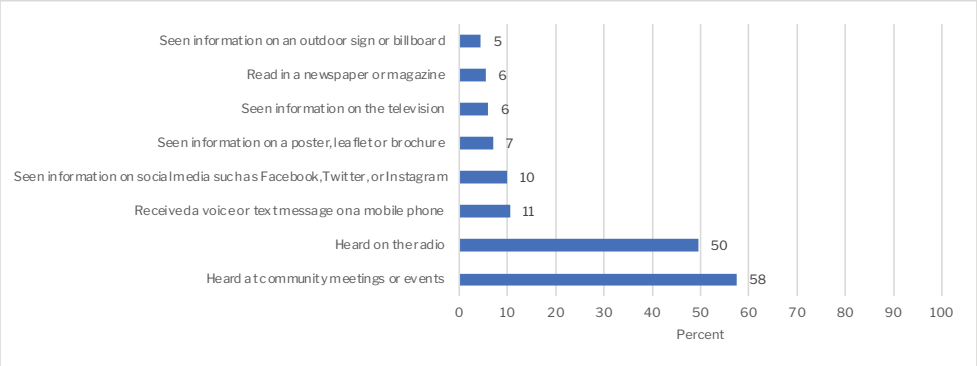
Findings in this study show that the use of contraceptives was minimal, with only six women (3%) of all those interviewed reporting to be currently using any contraceptive. The contraceptive methods used by these women were female sterilization, injectables/implants, and the pill. Counselling was provided for four of the women by a health professional. The decision on contraception was made by both the respondent and husband (five women), and the other by the husband alone.

As noted above, social, cultural, and religious factors contribute to the low use of contraceptives. From a religious perspective, the use of contraceptives by women is often viewed as unacceptable. This belief limits many women from accessing or using family planning methods. Qualitative

information garnered during the study showed that there is a strong cultural expectation that a woman should breastfeed her child for two full years and that this would act as a "contraceptive"/ child spacing. This belief may in part influence decisions around spacing of children and may impact the uptake of certain contraceptive methods, as it is believed that women who are breastfeeding are less likely to get pregnant.

Despite the low use of contraceptives, various efforts have been made to create awareness in the community about the importance of contraceptives and child spacing. When asked if they had heard or received any information on contraceptives, 57.5% indicated that they had information on family planning through community events, 49.5% through the radio, and 22% through social media forums (Figure 11). Based on these findings, the low use of contraceptives is not linked to a lack of awareness rather to other broader social and cultural factors.

Figure 11: Sources of information on contraceptives

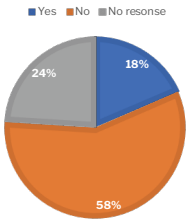


As Figure 11 shows lack of information on contraceptives is not the major hurdle or factor in non-contraceptive use. As such, new approaches and strategies must be put in place to address this issue. The research team learned that in Hagadera refugee camp, health communication efforts involving women and community leaders had led to an increase in child spacing/family planning and contraceptive use. The feasibility and appropriateness of this approach in Ifo 1 need to be explored and implemented.

6.3 Miscarriages, abortion, and post abortion care

Before conducting this study, anecdotal evidence suggested that there was a high number of abortions in Ifo 1. It was estimated that there were between 4-6 cases needing post abortion care each month. This was in part attributed to the low use of contraceptives and the high parity, especially among older women, who may not desire to have additional children. While the question of abortions was not asked directly to the respondents, the respondents were asked if they had lost a pregnancy to either a miscarriage or abortion, or any other reason, over the last three years. Of the 152 women who answered this question, 18% said that they had lost a pregnancy over the last three years (Figure 12).

Figure 12: If lost a pregnancy in the last 3 years



Because of the low contraceptive use in the community, there was information to suggest that some women who had more than five children were likely to seek to terminate a pregnancy (if they unintentionally found themselves pregnant) as a way of delaying having a child. The most commonly used way to terminate a pregnancy was the use of misoprostol, which is sometimes available in private outlets.

For women who lose a pregnancy either spontaneously or induced, post-abortion care (PAC) may be required to ensure a healthy outcome for the woman. PAC encompasses medical and psychological support provided to women after an abortion. It includes treatment for any complications, counselling, and access to contraception to prevent future unintended pregnancies. PAC is crucial for ensuring women's physical and emotional well-being following

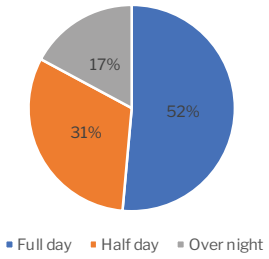
an abortion, regardless of whether the abortion was spontaneous or induced.

Key aspects of post-abortion care may include treatment of complications involving procedures to ensure the uterus is completely empty, treatment of infections or injuries, and management of any other complications like haemorrhage or uterine perforation. In addition, preventative care, especially providing information and access to various contraceptive methods to prevent future unintended pregnancies, is also part of the process.

This study sought to find out if PAC services were available for women who had a miscarriage or had lost a pregnancy. Of those who had lost a pregnancy, 78% indicated that they had used a health facility (public and private) to get care, while the remaining had either not sought care or used a traditional birth attendant. It was noted that, in the health facilities, pregnancy loss tended to be reported as postpartum hemorrhage (PPH), and as such, the cause of the miscarriage or abortion is not clear and is unlikely to be reported. As such, it is not possible to indicate the number or proportion of miscarriages that were induced.

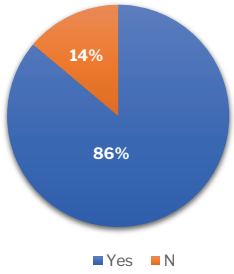
Of the 35 respondents who responded to the question on time spent at the health facility, 52% had spent the whole day (Figure 13). Regarding the specific type of treatment offered, 73% indicated that they had been provided care through the use of vacuum aspiration, while 19% had received misoprostol.

Figure 13: Time spent seeking post abortion care



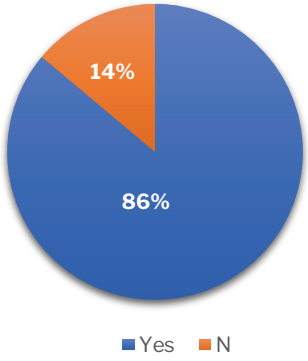
In line with globally recommended PAC guidelines, 89% of those who received post abortion care services indicated that they had received counselling services (Figure 14).

Figure 14: If counselling was offered as part of PAC



In post abortion care counselling, discussion and information on contraceptives is essential in ensuring that women can make choices and decisions on future pregnancies. As required by international standards and practice, 86% of those receiving PAC services received counselling on contraceptive use as a way of spacing children and delaying unwanted pregnancies (Figure 15). This finding is commendable as it clearly shows that the health workers in Ifo 1 are well-trained in PAC counseling and are following protocols.

Figure 15: If contraceptive counselling was offered as part of PAC



The study findings showed that training and refresher skills for health workers were needed. It was also noted that there are health facility-related factors that may lead to non-use of services. For example, PAC services were generally provided at the maternity section, as there was no specific section set aside for PAC. In one of the health facilities, this was said to be an appropriate practice as many of the health workers could easily provide the PAC services. However, in Ifo 1, this was said to create anxiety and fear of stigma, especially for women requiring PAC services. Being in the maternity section and not being pregnant may stigmatize them, and they are likely to be the gossip in the community. As such, some women may decide not to seek health care in cases of abortion.

6.3.1 Access to health services

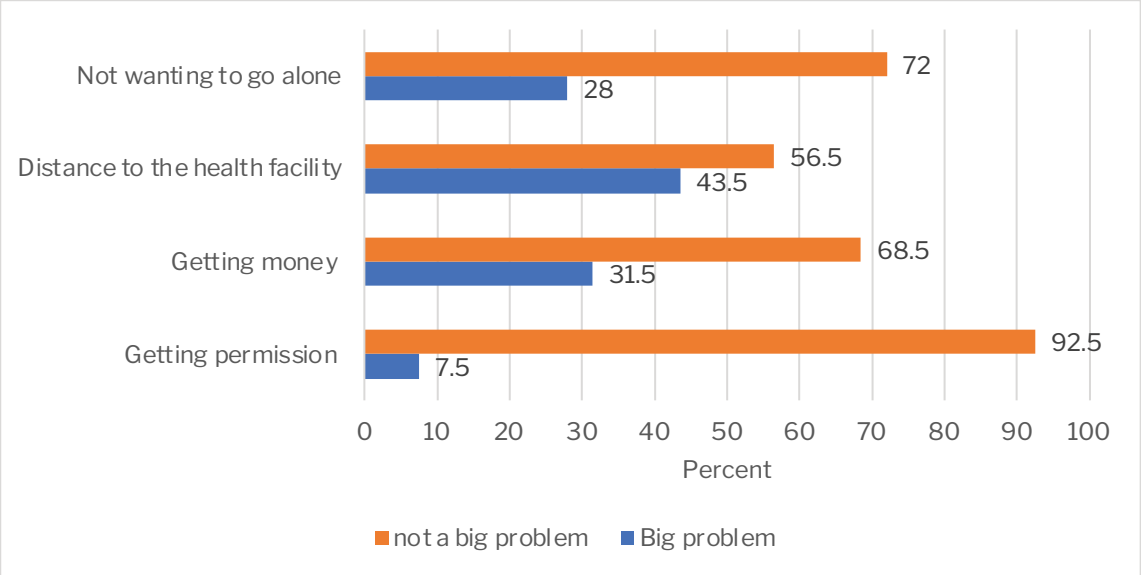
Over 40% of the respondents indicated that the health services offered in Ifo 1 were satisfactory. Among those who had concerns, these included long distances to access care, especially where health posts had been closed, lack of medications, and other related health service issues.

Although in general many of the respondents were able to access health care easily, it was also pointed out that there are some who do not live near a health facility. In a community dialogue, it was noted that:

> ***"Currently, distance is a problem as our Block is far from the health facility. Previously, there was an ambulance that was always available to pick up the sick, but currently, there is none. In addition, there are insecurity issues, making it difficult for a mother to go to the health facility alone. There's also a lack of transportation."***

The women's perception of some factors affecting seeking care. Distance to the health facility (44%) and getting money (32%) were seen as a big problem by the women interviewed (Figure 16).

Figure 16: Factors affecting seeking medical advice or treatment



7.0 DISCUSSION AND RECOMMENDATIONS

7.1 Community living situation

The study findings show that many of the people in Ifo 1 live in a challenging socio-economic context, with many of them relying on the WFP for their own and their families' livelihoods. Many of those interviewed did not have an education and reported low monthly income levels. While community dialogue revealed that the community appreciated the peace prevailing in their camp and the support of the Kenyan Government, donors, and partners, community leaders expressed concerns over the worsening living situation, which also has implications for maternal health, their families, and life in general.

It is well established (WHO 2022) that refugees often face significant economic challenges stemming from limited access to resources, employment, and markets, alongside restrictions on movement and potential exploitation. These challenges are further compounded by factors like inadequate infrastructure, lack of financial inclusion, and social and cultural barriers to integration.

Refugees often face high unemployment rates or are forced to take on low-paying, informal jobs (UNHCR, 2020). In some cases, refugees may be restricted from certain types of work or face bureaucratic hurdles in accessing employment opportunities. Refugee camps or settlements may experience price fluctuations for essential goods, making it difficult for refugees to budget and manage their limited resources. In the recent past, humanitarian aid to refugee populations has decreased, leaving refugees more reliant on their own resources and potentially exacerbating economic hardship. Indeed, in discussions with community members and leaders in Ifo 1, it was noted that food rations and decreased significantly – putting individuals and families at risk,

During the entire study period, various community members and leaders noted in specific terms how the pulling out of donors such as USAID and others has also had a negative effect on the services they are offered. Despite the efforts of the government and humanitarian organizations, support has declined significantly, and as a result, it was noted that families are suffering in silence, facing extreme poverty and daily struggles inside their households. As one key informant explained, "children go without food, women cannot access proper health care, and many people live without any certainty about tomorrow". There is a need to review the current situation and for leaders to develop new approaches that address the current gaps in resources and services.

7.2 Maternal health in Ifo 1

As noted above, the average number of children from the respondents in this study was 6.1. The findings showed that many women had experienced the loss of a child during a pregnancy. While this study did not seek to find out the main causes of pregnancy loss, further studies working with the local health institutions may be required to identify the key drivers of miscarriages and ways to address these.

74% of the women indicated that they had wanted to get pregnant the last time, and 57% noted that this decision had been made by the woman and her spouse. This is a positive finding and can be used as a basis for messaging on the importance of women having agency over their pregnancies and partner involvement in such decisions. The study also found that many women had used antenatal care an average of 3.8 times and that 60% of the women had delivered at a health facility. For the 14% who had delivered at home, distance to health facilities was one of the factors identified. However, discussions with community members also emphasised that sometimes women choose to deliver at home as delivery is seen as a natural event. The fact that a majority of women were delivering at the health facility is a positive finding, and partners and donors can reinforce this. It was also noted that, given their refugee status, some women were keen to have their children registered through the health facility processes as per the Ministry of Health.

The findings and anecdotal evidence suggest that child marriages (girls between 15-19 years) were very common despite widespread recognition that childbearing in the adolescent years is harmful to both mother and child. Child marriages endanger the health of the girls, as they are not physically suited to give birth. According to the United Nations (2004), girls younger than 15 years are five times more likely to die in childbirth than women in their 20s, and pregnancy is the leading cause of death worldwide for women ages 15 to 19 years.

As noted earlier, child marriages are also associated with lower levels of education. The importance of girl child education cannot be gainsaid. Evidence suggests that educating girls creates positive outcomes for economic development by improving income-earning potential and also addressing poverty. It was noted that there was a recent initiative in the community that sought to ensure access to education among young married women. This is important and should be further explored and strengthened as an option for the young women who are already married.

One interesting finding in conversations with the community revealed that, though divorce was rare and scorned upon, there were a few women who had broken this mould, and many were socially and economically empowered. Called *garoob* in Somali – these women seemed to be respected for the freedoms and economic achievements - an indication of how societal norms and perceptions may shift when women are empowered.

Recommendations

1. Work with community leaders to address the issues of child marriages.

2. Build on the positive findings that women are already making decisions on pregnancy, using antenatal care, and delivering in health facilities.

3. Girl child empowerment. Work with community leaders to prioritize the education of young girls, especially by ensuring that girls have access to formal education starting at a young age. This is likely to offer social and economic opportunities for many girls and women.

4. Female genital mutilation (FGM). Though not a focus of this study, it emerged that FGM is widely practiced, and this has implications for women's reproductive health and rights. While a better understanding of the current situation is required, partners and donors need to work closely with the community to address it and mitigate its impact on young women.

5. Anecdotal evidence suggests that there is gender-based violence (GBV) in the community. Further studies and interventions are needed to address this and ways in which the community and stakeholders can be engaged.

7.3 Reproductive health and contraceptive use

As the study findings show, only 3% of those interviewed were using contraceptives. The importance of contraceptives in delaying pregnancy and women's empowerment is well articulated in various studies. According to the WHO, contraceptive use empowers women and gives them choices. As noted earlier, social, religious, and economic factors contribute to the low use of contraceptives in Ifo 1. It is important to increase the use of contraceptives as an option for child spacing.

Recommendations

1. Need to engage men in addressing reproductive health issues. It was suggested that this may require partnering with religious organizations such as the Supreme Council of Kenya Muslims (SUPKEM). Based on a previous intervention, it was noted that working with the religious body to campaign for child spacing had increased contraceptive use.

It was noted that the Muslim faith encourages breastfeeding as a way of child spacing at least every two years. Similarly, these religious organizations can also be a partner in discussing the dangers of FGM and child marriages.

2. Ensure availability of a wide range of contraceptive methods. For example, it was noted that in some cases implants and injectables were the preferred type of contraceptive due to their effectiveness, long-lasting protection, and convenience, as they do not require daily use and can be removed in case of desired pregnancy. However, these were not always available. Additionally, to increase use, communication should focus on the importance of quality family planning services and the compelling evidence that access to and use of contraception improves the health and socioeconomic status of women.

3. Contraceptive choice and educating women on their choices may improve use. More importantly, it may be useful to pitch the use of contraceptives in a culturally and religiously appropriate way – as a means to "child spacing". It was noted that the concept of contraceptive use was "taboo" in the community and had, in some cases, negative connotations – such as leading to unfaithfulness among women.

4. Build the capacity of the community health promoters (CHPs) to provide some of the commodities at the community level, such as the cycle beads. This was proposed as a way to increase contraceptive use. The CHPs may also be able to provide culturally appropriate and sensitive information to women in their communities to encourage child spacing. In addition, it is important to continue to work with the community health promoters in each Block to create awareness on women's reproductive health, including dangers of FGM, GBV, and child marriages.

5. Involve community level leaders - it was noted that each Block leader, section, and youth leaders, among others, should be involved in addressing community health-related issues such as child marriages, FGM, and contraceptive use, among others. It was noted that, in the past, there was a non-governmental organization that worked with communities to discourage child marriages and to mobilize on important issues. However, the organization has since closed – but their interventions and approach were said to have been impactful. It may be useful to learn about this group and work with the community leaders to champion and address these issues with them as an integral part of the solution.

6. Incorporate strategies that promote women's empowerment into efforts to improve sexual, reproductive, and maternal health. This will include prioritizing policies, interventions, and programmes that empower and strengthen the agency of adolescents and young women through working with religious and community leaders to address the issue of child marriages. Similarly, it is important to tailor policies and delivery platforms for adolescent girls and young women to their specific needs and preferences.

7. Have a multi-pronged approach to addressing maternal health. SRHR should not work alone, and it needs to be integrated with other social and development issues and have a holistic approach to addressing the health of women and children in the community.

7.4 Post abortion care

As the study results show, 24% of the respondents noted that they had lost a pregnancy in the last three years either spontaneously or induced. The study sought to find out if post abortion care was available, and 92 % indicated that they had sought care. It emerged during discussions with community members, health workers, and others that it was likely that women who had multiple pregnancies and multiparas may seek to terminate a pregnancy instead of having an unplanned pregnancy/child. It was also noted that abortions are unlikely to occur among younger married women (unless spontaneous), as many of them are married and are expected to have children. The study found that some social stigma and practices may discourage those in need of PAC services from seeking care. These include a lack of privacy, where the care is provided (especially in the maternity ward). Similarly, a lack of appropriate tools and skills among service providers was also identified as a constraint.

Recommendations

1. Engage the community and encourage the use of contraceptives as a way of child-spacing and delaying unwanted pregnancy to forestall the need to terminate pregnancy as a “family planning option” - especially among older married women.

2. Strengthen and create facilities in the health centres that provide privacy for those seeking PAC services to avoid stigma and embarrassment.

3. Provide regular training and refresher courses for health workers, and also ensure the availability of all requisite tools and equipment for PAC.

8.0 REFERENCES

Agbemenu K, Volpe EM, Dyer E. Reproductive health decision-making among US-dwelling Somali Bantu refugee women: a qualitative study. J Clin Nurs. 2018;27(17–18):3355–62.

Babatunde-Sowole OO, Power T, Davidson PM, DiGiacomo M, Jackson D. Health screening and preventative health care in refugee women: a qualitative analysis. Contemp Nurse. 2020:1–30.

Bhatia R, Wallace P. Experiences of refugees and asylum seekers in general practice: a qualitative study. BMC Fam Pract. 2007;8:48.

Chalmiers M. et al Refugee women's experiences with contraceptive care after resettlement in high-income countries: A critical interpretive synthesis, Contraception, Vol 108, April 2022 pages 7-18

Davidson N., Karin Hammarberg, Lorena Romero and Jane Fisher , Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: a systematic review https://doi.org/10.1186/s12889-022-12576-4

Degni F, Koivusilta L, Ojanlatva A. Attitudes towards and perceptions about contraceptive use among married refugee women of Somali descent living in Finland. European Journal of Contraception & Reproductive Health Care. 2006;11(3):190–6

Emtell et al Contraceptive use among migrant, second-generation migrant and non-migrant women seeking abortion care: a descriptive cross-sectional study conducted in Sweden. BMJ Sexual & Reproductive Health. 2019;21:21.

Gebreyesus T, Gottlieb N, Sultan Z, Ghebrezghiabher HM, Tol W, Winch PJ, et al. Barriers to contraceptive care seeking: the experience of Eritrean asylum-seeking women in Israel. Ethn Health. 2020;25(2):255–72.

Gozzi P et al, Contraceptive access and use among women with migratory experience living in high-income countries: a scoping review, BMC Public Health (2024) 24:2569

Gurnah K, Khoshnood K, Bradley E, Yuan C. Lost in translation: reproductive health care experiences of Somali Bantu women in Hartford, Connecticut. J Midwifery Women's Health. 2011;56(4):340–6

Heslehurst N, Brown H, Pemu A, Coleman H, Rankin J. Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. BMC Med. 2018;16(1):89

Joseph M. Zulu1, Joseph Ali, Kristina Hallez, Nancy Kass,, Charles Michelo and Adnan A. Hyder, Ethics challenges and guidance related to research involving adolescent post-abortion care: a scoping review Reproductive Health (2018) 15:71 https://doi.org/10.1186/s12978-018-0515-6.

Kenya Demographic and Health Survey, 2014, Kenya National Bureau of Statistics, Kenya.

Kolak et al Midwives' experiences of providing contraception counselling to immigrant women. Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives. 2017;12:100–6.

Levesque JF et al. Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. International journal for equity in health. 2013; 12:18.

Mengesha ZB, Perz J, Dune T, Ussher J. Preparedness of health care professionals for delivering sexual and reproductive health care to refugee and migrant women: a mixed methods study. Int J Environ Res Public, Health. 2018;15:174

Marchetti F et al. Health needs and perception of health care quality among Asylum Seekers and Refugees in an Italian local health authority: A qualitative study. Front. 2023; 11:1125125.

Michael Mbithi Mutua, Lenore Manderson, Eustasius Musenge, Thomas Noel Ochieng Achia, Policy, law and post-abortion care services in Kenya, PLOS ONE | https://doi.org/10.1371/journal.pone.0204240 September 21, 2018.

Michael M. Mutua, Beatrice W. Maina, Thomas O. Achia and Chimaraoke O. Izugbara, Factors associated with delays in seeking post abortion care among women in Kenya. BMC Pregnancy and Childbirth (2015) 15:241 DOI 10.1186/s12884-015-0660-7.

Ministry of Health, Incidence of induced abortions and severity of related complications in Kenya, April 2025

Ministry of Health, The National Reproductive Health Policy 2022 - 2032, Government of Kenya, July 2022.

Morrison V. Contraceptive need among Cambodian refugees in Khao Phlu camp. Int Fam Plan Perspect. 2000;26(4):188–92.

Odunukan OW, Abdulai RM, Hagi Salaad MF, Lahr BD, Flynn PM, Wieland ML. Provider, and interpreter preferences among Somali women in a primary care setting. J Prim Care Community Health. 2015;6(2):105–10. 73.

Ohren, E and Lewinger S, 2020 Refugee and Internally Displaced Women's Abortion Knowledge, Attitudes and Practices: Addressing the Lack of Research in Low- and Middle-Income Countries, International Perspectives on Sexual and Reproductive Health , 2020, Vol. 46, No. Supplement 1, Focus on Abortion (2020), pp. 77-81

Paul Mukisa Wako Bukuluki, Peter Kisaakye, Symon Peter Wandiembe, Victor Kiwujja, Christine Kajungu, Wilberforce Mugwanya, Shakira Nabakooza, Cyprian Anyii and Fiona Kaikai,al Utilization of sexual and reproductive health services among young people in refugee settings in Uganda, Reprod. Health 5:1077761. doi: 10.3389/frph.2023.1077761

Royer PA et al. "In Africa, There Was No Family Planning. Every Year You Just Give Birth: Family Planning Knowledge, Attitudes, and Practices Among Somali and Congolese Refugee Women After Resettlement to the United States. Qual Health Res. 2020;30(3):391–408.

Sheru Muuo, Stella Kagwiria Muthuri, Martin Kavao Mutua, Alys McAlpine, Loraine J. Bacchus, Hope Ogego, Martin Bangha, Mazeda Hossain & Chimaraoke Izugbara, Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex, https://doi.org/10.1080/26410397.2020.1722404

Tanabe M, Myers A, Bhandari P, Cornier N, Doraiswamy S, Krause S. Family planning in refugee settings: findings and actions from a multi country study. Conflict and Health. 2017; 11:9.

United Nations High Commissioner for Refugees. What is a refugee? Geneva. 2020 https://www.unhcr.org/en-au/what-is-a-refugee.html. Accessed 11 Nov 2021.

United Nations High Commissioner for Refugees. Global trends forced displacement. Geneva: UNHCR; 2019. https://www.unhcr.org/60b63 8e37/unhcr-global-trends-2020.html Accessed 11 Nov 2021

United Nations Population Fund and the University of Aberdeen (2004). Maternal Mortality Update 2004: Delivering Into Good Hands. UNFPA: New York).

UNHCR, GOK Registered refugees and asylum-seekers, 2025

UNHCR, Improving Maternal Care in Dadaab Refugee camps, Kenya. 2010.

West L, Isotta-Day H, Ba-Break M, Morgan R. Factors in use of family planning services by Syrian women in a refugee camp in Jordan. J Fam Plann Reprod Health Care. 2017;43(2):96–102.

WHO, Refugee and Migrant Health, Fact Sheet, 2 May 2022

WHO global action plan on promoting the health of refugees and migrants, 2019–2023 to 2030, WHO, 2019.

Zeid S. et al 2015, For every woman, every child, everywhere: a universal agenda for health of women, children and adolescents, The Lancet, Vol. 385, 9981, P1919-1920

with support from the Embassy of the Kingdom of Netherlands

Kingdom of the Netherlands

3rd Ngong Avenue,Upper Hill Garden Apt# E-06,
P.O.BOX 50429 00200 Nairobi.
Office Tel: +254 - 20-211-3093 I 4
Email: info@gem.or.ke
Web: www.gem.or.ke

African Gender& Media Initiative Trust
@GEM_Africa