



**Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Somali
Refugees and the Status of Family Planning Services in
UNHCR's Ali Addeh Site, Djibouti**

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This report is one of a series of five reports documenting baseline findings and recommendations to improve family planning programming for refugees in Djibouti, Jordan, Kenya, Malaysia and Uganda. The reports have similar objectives, literature reviews, methodology and limitations sections. The studies can be found at <http://www.womensrefugeecommission.org/reports>.

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ACRONYMS AND ABBREVIATIONS

AMDA	Association of Medical Doctors of Asia
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CPR	Contraceptive prevalence rate
EC	Emergency contraception
FGD	Focus group discussion
FGM	Female genital mutilation
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
IUD	Intrauterine device
LAM	Lactational amenorrhea method
MOH	Ministry of Health
NGO	Nongovernmental organisation
PMTCT	Prevention of mother-to-child transmission of HIV
RH	Reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TL	Tubal ligation
UNHCR	United Nations High Commissioner for Refugees
WRA	Women of reproductive age (15-49)
WRC	Women's Refugee Commission

EXECUTIVE SUMMARY

This report addresses a family planning (FP) study undertaken by the United Nations High Commissioner for Refugees (UNHCR), the Women's Refugee Commission (WRC) and the Centers for Disease Control and Prevention (CDC) among Somali refugees in Ali Addeh refugee camp, Djibouti, from July-August 2011. It documents the knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision to improve programming and subsequently increase uptake of good quality FP services among Somali women, men and adolescents. As a result of long-term insecurity and drought in Somalia, the total refugee population of 17,000 in Djibouti may reach 20,800 people by the end of 2011.

The study methodology included a household survey among women between the ages of 15 and 49, along with six focus group discussions, three key informant interviews and a facility assessment at the health centre at the Ali Addeh refugee camp.

KEY FINDINGS

The results from the study indicate a contraceptive prevalence rate (CPR) of 5.6% for any method and 5.1% for modern FP methods among the Somali refugee population. The most commonly used methods are injectables (56.5%) and the oral contraceptive pill (43.5%). Unmet need for FP is at 8.8%. For women who are currently living with a husband/partner and are not using a contraceptive method, the most common reason for not using an FP method was wanting more children (30.4%), followed by currently pregnant (23.3%), breastfeeding (15.2%), lack of knowledge about a method (11.5%) and religious prohibition (6.5%). The proportion of women not currently using an FP method but planning to use a method in the next 12 months was 4.1%. Approximately 11% of the respondents did not know whether or not they would use an FP method in the next 12 months.

The triangulation of findings from the household survey, focus group discussions and key informant interviews reveals that the low CPR, particularly for modern methods is due to religious beliefs that prohibit contraception as an act against "God's will"¹ and cultural norms that favour large families. On the other hand, misconceptions and lack of education and knowledge on reproductive health and FP methods and services also contribute to low contraceptive prevalence. Moreover, absence of knowledge about reproductive health and FP, compounded by the lack of comprehensive FP services at the health centres, constitute important barriers to access and use of FP methods. These challenges need to be addressed through an integration of community outreach programmes and comprehensive FP services, including quality counselling and referrals at the health facility levels.

KEY RECOMMENDATIONS

The following recommendations are based on the quantitative and qualitative findings of this study:

IMMEDIATE RECOMMENDATIONS

1. **Provide in-service training for all health facility personnel on reproductive health, including FP.** The health facility at the refugee camp in Ali Addeh, which currently provides injectables, contraceptive pills and condoms, is able to address only a small part of the contraceptive demand of the refugee women. Not only is access to a wider choice of FP methods limited, but women cannot exercise their right to contraceptive choice because of the absence of complete

¹ Even though only 6.5% mentioned religious prohibition as a reason for not using an FP in the household survey, data from focus group discussions and in-depth interviews indicate that religious beliefs were important reasons for low CPR among the refugees.

and accurate information about the variety of methods available, and the health providers' inability to recommend different contraceptive options if the client experiences side effects. There is therefore an immediate need to conduct training and refresher training courses to all staff involved in FP, including nurses, midwives and traditional birth attendants (TBAs) so that they can provide adequate FP counseling to the community, including providing information and referrals on longer term methods such as implants and IUDs .

2. **Increase correct and timely knowledge about contraceptives, including emergency contraception and the benefits of FP, among women, men and community leaders through clinic- and community-based awareness raising and distribution programmes.** Knowledge among refugee women and adolescents is relatively limited. Of equal importance is knowledge of how to use the selected method correctly and the main side effects. Quality of care is hampered by a lack of trained providers with adequate counselling skills. FP among the refugee population can be improved through better interaction between providers and clients. Trained FP counselors can address sexual and reproductive health needs, and trained outreach community health workers can clarify misconceptions about FP, particularly modern methods, and act as an effective source in distributing contraceptive products among the refugee population. Communication strategies involving the media, drama, sketches and public forums can address cultural barriers and raise awareness by creating a space for public debate on "taboo" topics such as contraception and sexual relations.
3. **Upgrade the health facility at Ali Addeh and supply equipment and supplies.** The facility has limited space for services and counseling on reproductive health and FP. While a new building has been constructed for maternity, it is not currently being used for that purpose. Appropriate measures need to be taken to ensure that the space allows for adequate privacy and is properly used and necessary supplies are purchased and available at the maternity centre.

LONG-TERM RECOMMENDATIONS

4. **Integrate FP into HIV/AIDS national sensitization programmes.** Integrated programmes make better use of limited resources and can reach a wider population. Focus group discussion findings indicated that some adolescents are familiar with contraceptives, such as condoms, as a result of HIV/AIDS sensitization programmes. Adding FP to HIV/AIDS and prevention of mother-to-child transmission (PMTCT) services can better inform people of their choices and risks.
5. **Promote shared responsibility and the active involvement of men in safe and responsible sexual relationships, FP and responsible parenthood.** Findings from this study show that gender issues are important barriers to uptake of FP methods. It is therefore important to ensure men's participation and involvement through community forums and discussions with the participation of informed service providers as well as community and religious leaders.
6. **Reduce knowledge disparities in the provision of FP services.** Access to FP is limited, as is the method mix. They are even more limited to subpopulations such as adolescents. There is a need for developing and implementing provider guidelines and protocols on what services are to be offered, and how the needs of population groups such as adolescents and unmarried women are to be addressed. Efficient, low-cost systems that can assure equitable access to existing FP services, including materials and information, should be developed.

7. **Strategies are needed to help ensure that FP needs of refugees and surrounding host communities are met and sustained over the long term.**
8. **Develop a curriculum on sexual education and FP at refugee schools.** A culturally sensitive curriculum on reproductive health and sexual education that is delivered through educational institutions can serve as a viable means to convey information about FP.

INTRODUCTION

Access to FP services is a human right² and neglecting FP can have serious health consequences. Restoring access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. It also provides women and girls the autonomy to determine the number and spacing of their children, access to educational and livelihoods opportunities, and possibilities for families to manage scarce resources more effectively.

The *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*,³ developed by the Women's Refugee Commission on behalf of partners and endorsed by the steering committee⁴ of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises in May 2010 outlines existing standards on providing contraceptives from the onset of an emergency and throughout protracted crisis and recovery. It further describes methods of service delivery and recommendations for governments, donors and implementing agencies.

The situation in the refugees' country of origin is an important factor influencing expectations, perceived needs and demand for FP. Laws, infrastructure, religious and ethical values and cultural backgrounds and the training of health care providers from the host country also have an important effect on the services that can be offered. While UNHCR has focused on emergency obstetric care, gender-based violence and HIV/AIDS in the past several years, FP activities have not been given sufficient attention to ensure adequate access for refugees and other persons of concern.

Djibouti's predominantly Muslim population is made up of two traditionally nomadic groups – Issa Somalis and Afars – with smaller numbers of Arabs and Europeans. The country has virtually no natural resources to support its own residents, and more than half of the population is unemployed. With a relatively small population (818,000 according to the 2009 census, with an annual growth rate of almost 3%) and sustained economic growth (an average 5-6% a year since 2006), Djibouti recently qualified for lower-middle-income country status. However, it is still considered a least developed, food-deficit country. Rainfall since September 2007 has been less than half the normal average. The current drought has compounded food insecurity, malnutrition and rural-urban migration. In Djibouti, about 15% of the

² Under international law, universal access to family planning is a human right. According to Article 16(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all individuals and couples have the “right to decide on the number, spacing and timing of children”. The Programme of Action from the 1994 International Conference on Population and Development also notes the right of couples and individuals, “to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so” (Article 7.3). Moreover, General Comment No. 14, para. 12 of the Committee on Economic, Social and Cultural Rights states that the right to the highest attainable standard of health includes the “right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning”.

³ Inter-agency Working Group on RH in Crises (2010). *A Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*. Available online at <http://www.iawg.net/fpstatement.html>.

⁴ IAWG on RH in Crises Steering Committee agencies include American Refugee Committee, CARE International, Centers for Disease Control and Prevention; Columbia University School of Public Health, International Medical Corp, International Rescue Committee, Jhpiego, JSI Research and Training Institute, Marie Stopes International, UN High Commissioner for Refugees, UN Population Fund; Women's Refugee Commission, World Health Organisation.

population are already experiencing a crushing lack of food, health care, nutrition support, drinking water and sanitation facilities.⁵

Since 1990, conflicts in Somalia and Ethiopia have caused many refugees to flee across the border into Djibouti. Somalia, with a population of about 10 million people, has been at war since 1991. There have been 14 attempts to establish a government since 1991. The number of Somali refugees in Djibouti remained relatively stable until 2008, before it began to increase again as the result of increased political instability and food insecurity in Somalia. Somali refugees continue to arrive in Djibouti in relatively large numbers as a result of the current drought in the Horn of Africa, although at a lower rate than those going to Ethiopia and Kenya. As of 26 July 2011, there were 17,000 refugees based in Ali Addeh camp, principally of southern/central Somali origin. From January to June 2011, UNHCR registered over 2,600 new arrivals. Monthly arrivals are in the range of 500 refugees. Based on current rates of arrivals, UNHCR expects that the total refugee population in Djibouti may reach 20,800 by the end of 2011. The government of Djibouti has allocated the former refugee site of Hol Hol to UNHCR for rehabilitation in order to decongest the existing Ali Addeh refugee camp and to host the new arrivals.

Ali Addeh refugee camp, 80 kilometres south west of the Djiboutian capital (and 250 kilometres from the Somali border), was established in 1991 for a population of 7,000. Some refugees have been living in Ali Addeh for more than 19 years. Since the camp is located in a rocky and semi-desert area that supports little, if any, crop production, the refugees are wholly dependent on external food support.

OBJECTIVES

Goal

To document knowledge, beliefs perceptions and practices of refugees, as well as the state of service provision in the select UNHCR operation, in order to improve programming and subsequently increase uptake of FP services among women, men and adolescents.

Objectives of the baseline study

- To increase baseline information to guide policy and planning.
- To improve quality of services through training and guiding health and community providers, and improving infrastructure as required.
- To adapt programmes according to barriers, beliefs, fears and perceptions, in terms of information, education and communication efforts, and service delivery.
- To expand access through a broader choice of contraceptive methods, community-based distribution and linkages with national programmes or other in-country initiatives as appropriate.

Study Question

This study aimed to answer the primary question: What are the barriers and challenges at the community and health facility levels that hinder increased uptake of contraceptives among the select refugee communities, and what are the practical ways that the challenges can be addressed?

⁵ UNICEF (2011). *Humanitarian Action for Children, Building resilience*.

LITERATURE REVIEW

Note: Sections of this literature review are based on those found in the baseline study report among Somalis in Eastleigh, Nairobi, Kenya, written by Erin McCoy.⁶

Reproductive health is a major problem in Somalia, with a maternal mortality ratio of 1,044 per 100,000 live births, placing Somali women among the most high-risk groups in the world. The total fertility rate among the Somali population is between 5.7 and 6.7 across all geographic locations.⁷ The proportion of maternal deaths in Somalia among deaths of females of reproductive age was estimated at 34.5% for 2008, with a lifetime risk estimate of maternal death at 1 in 14. This compares to an estimate⁸ of 6.8% maternal deaths in Djibouti among deaths of females of reproductive age, and a lifetime risk estimate of maternal death at 1 in 93.⁹

While very few reproductive health indicators are available for Somalia, a 2006 World Health Organisation (WHO) survey found that 1.2% of currently married women were using modern contraceptives, with slightly higher use reported among women living in urban areas.¹⁰ In 2008, the CPR in Djibouti was estimated at 22.5%.¹¹ However, this figure conceals a significant discrepancy between urban and rural areas. In rural areas, the contraceptive prevalence is approximately 5%. The discontinuation rate of contraception is very high. In 2007, the continuation rate of modern contraception was 62.5%, though nearly half of the users were new acceptors.¹²

Several qualitative assessments of knowledge, attitudes and behaviour on FP among Somali refugees in camp settings indicate low uptake of contraceptive methods as well as widespread negative attitudes toward FP and contraception. Contraception and, similarly, abortion are perceived as prohibited by Islam, and large families are favoured. Most women fear caesarean section delivery, as it is thought that the surgery may impede subsequent pregnancies.

In 2002, the government of Djibouti initiated health reforms, leading to the development of a strategic health sector plan that prioritised maternal child health. In accordance with its long term commitment to reduce maternal mortality, Djibouti has established a pyramidal system of reproductive health services, guided by the Health Chart.¹³ Since 2006, maternal child health, antenatal care and treatment of anaemia have been provided free of charge to the population, including refugees. The government has made some progress in women and children's health with the adoption of a decentralised health system and the provision of free health care throughout the country. FP services, however, remain weak and the full potential contribution of birth spacing to mortality and morbidity reduction has not been realised to date.

⁶ McCoy, E. (2011). *Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Somali Refugees and the Status of Family Planning Services in UNHCR's Operation in Nairobi, Kenya*. UNHCR and Women's Refugee Commission.

⁷ UNHCR Dadaab Sub-Office (2010). *Report on the Status of Safe Motherhood and Child Spacing Services in Dadaab Refugee Camp: An Assessment of the Health System and the Somali Community's Knowledge, Attitude, and Perception*.

⁸ No accurate data on maternal mortality ratio are currently available.

⁹ WHO (2010). "Trends in maternal mortality: 1990 to 2008", http://www.who.int/gho/maternal_health/countries/en/.

¹⁰ WHO (2006). "Republic of Somalia Country Profile", http://www.who.int/making_pregnancy_safer/countries/som.pdf.

¹¹ In 2006, the contraceptive prevalence rate in Djibouti was estimated at 17.8% and 14.8% for Somalia, <http://apps.who.int/ghodata/>.

¹² WHO (2008). "Djibouti, Reproductive health profile", http://www.emro.who.int/rhrn/countryprofiles_dji.htm.

¹³ Ibid.

METHODOLOGY

The baseline study methodology consisted of four components: a household survey, a facility assessment, in-depth interviews and focus group discussions (FGDs). The study community was located in Ali Addeh refugee camp in Djibouti. The refugee population is predominantly Somali, with a total estimated population of 17,000, and some 500 Ethiopian and Eritrean refugees.

Participants for all activities were informed of the purpose, process, potential risks, use and confidentiality of the information, and their right to refuse to participate, to leave or to refuse to answer at any time. All data were analysed by triangulation and findings verified with other available information.

Household Survey Methodology

The household survey was conducted in July and August 2011, using the adapted CDC *Reproductive Health Assessment Toolkit for Conflict-Affected Women*.¹⁴ The survey was used to gather quantitative data on FP-related knowledge, attitudes and behaviour among women of reproductive age (WRA) between 15 and 49 years.

The refugee camp is divided into eight sections. The number of respondents from each section was determined according to the population size of that section for a total sample size of 512 WRA. Since the camp population resides in tents with no specific address, systematic sampling was used to select the respondents by choosing one respondent from every fourth household. Using a chart, interviewers randomly selected one woman from all WRA in the selected household. If the selected WRA was not home at the time of the first visit, up to two contacts were attempted before being classified as absent.

After obtaining verbal informed consent, pre-tested and piloted structured questionnaires were administered in Somali by trained community data collectors at the respondent's home, in private, where possible. Questions were asked verbatim and rephrased only if a respondent did not understand. On average, the interviews lasted between 15 and 25 minutes.

All interviewers were female and were recruited from the host community. The study coordinator trained the team on how to administer the survey and seek appropriate consent. Review, data cleaning and data entry of the completed questionnaires took place in the field by the study coordinator during the study period. Data entry and analysis were performed using SPSS (version 16) software.

Health Facility Assessment Methodology

The Association of Medical Doctors of Asia (AMDA), a Japanese NGO, has provided health and medical services in Djibouti since 1993 to refugees as an implementing partner of UNHCR. An assessment was conducted at its camp health centre to examine service availability, quality of services and provider opinions.

After obtaining written informed consent from each facility, a provider and a staff member in charge were interviewed using an adapted UNHCR tool about their perceptions of the facility's capacity to

¹⁴ CDC (2009). *Reproductive Health Assessment Toolkit for Conflict-Affected Women*. Available as a PDF document: <http://www.cdc.gov/reproductivehealth/refugee/PDF/AppendixC.pdf>.

provide FP services. The assessment also included an observational checklist. Interviews were undertaken in English and French, and were conducted by the study coordinator.

In-depth Interview Methodology

Three in-depth interviews with key informants, one male and two female refugee leaders, were used to learn about challenges and barriers to increasing contraceptive uptake within the refugee community. Respondents were selected using purposeful sampling by UNHCR staff and the study coordinator.

After obtaining written informed consent, each respondent was asked a set of pre-structured questions, developed by UNHCR and the WRC. All interviews were conducted in Somali through an interpreter.

Focus Group Discussion Methodology

Focus group discussions were held with women, men, adolescent girls and adolescent boys to gather further qualitative information on attitudes and barriers to contraceptive uptake, using the focus group discussion tool developed by UNHCR and the WRC.

Convenience sampling was used to select participants, with the help of UNHCR staff. Six focus groups were convened at Ali Addeh camp. One group consisted of men age 40 and above, another group of men aged 19 to 25, two groups of women aged 17 to 25, and two groups of women age 28 and above. The total number of participants was 34. All of the participants were Somali refugees.

The facilitators consisted of one of the female interviewers, and one male interpreter. All focus group discussions were audio-taped. The male facilitator and another male interpreter transcribed the audio recordings. Oral consent was obtained for both participation and permission to record the discussion.

Ethical Considerations

The study was approved by UNHCR-Geneva. Appropriate approvals were sought with the local authorities to conduct the study at the camp site. All data collectors were trained in study ethics adapted from Family Health International curriculum.¹⁵ Oral consent was secured from all respondents prior to the administration of the questionnaires, and no identifying characteristics of respondents were recorded during data collection. All audio recordings of focus group discussions were destroyed after the data were transcribed.

PRESENTATION OF FINDINGS

Household Survey

Demographics. The sample size was 512 women between the ages of 15 and 49. The response rate was 97.7%, with 500 completed questionnaires. The majority (96.8%) of refugees were of Somali origin, and 3% were Ethiopian.¹⁶ The mean age was 30.9 (standard deviation, SD=8.3). The mean number of years spent at Ali Addeh refugee camp was 13.2 (SD= 8.3 years). About three-quarters of the respondents (72.2%) had never attended school.

The majority of the women (87.2%) had ever been married. The mean age of first marriage among the refugees was 18 (SD=3). Among those who had ever been married, about 86% were currently married,

¹⁵ Family Health International. (2011). Research Ethics Training Curricula. From www.fhi.org/en/RH/Training/trainmat/ethicscurr/RETCCREn/.

¹⁶ One person (0.2%) was a local resident.

5% were divorced or separated, 6% were widowed and 1% reported to be single. A small percentage of women (11%) reported their husband had more than one wife.

The majority of the women (85%) had ever been pregnant. The mean number of children alive was 3.9 (SD=2.2). Among women that had ever been pregnant,¹⁷ 7.6% reported to have had stillborns. The mean number of stillborns was 1.8 (SD=1). About 23% had lost a child due to spontaneous or induced abortions. The mean number of children lost to spontaneous or induced abortion was 2 (SD=1.1).

Knowledge and Ever Use of Contraception. The majority of the women (82.4%) had heard of some form of FP method. The most widely known methods included the pill (33.8%), followed by injectables (21.6%) and male condom (10.6%). These were, in fact, the only contraceptive methods that were available at the health centre in the camp. The least known FP methods included the female condom (0.4%) and emergency contraception (0.2%). Table 1 shows these findings.

More than 40% of the women who had ever heard of FP methods had been instructed on how to use a contraceptive method. The proportion of women who had ever used a contraceptive method (irrespective of whether or not they were current users) was 30.8%. These findings are presented in Table 2.

Among women who reported ever having heard of a method, the most common response to what they believed was the main problem with using the specific method was “I don’t know” or no response (70%). The second most common response reported was “no problems” (15.3%), followed by a method-related reason (15%). The least common responses had to do “opposition to use” (0.7%). None of the respondents reported lack of access as a problem for not using contraceptives. See Table 3.

Current Use of Contraception. The proportion of women (irrespective of being pregnant, infecund or having had a hysterectomy) who had ever heard of any FP methods and were currently using a contraceptive method was 5.6%, and the proportion of those using modern methods, such as the pill, intrauterine device (IUD), male and female condoms, implants, injectables, emergency contraception, tubal ligation and vasectomy, was slightly lower, at 5.1%. Of the 23 women who reported using at least one method, the majority were using a modern method: 56.5% were using injectables and 43.5% were using the pill.¹⁸ Only a small percentage (8.7%) reported using lactational amenorrhea method (LAM) as a contraceptive method. The results for current and ever use of contraception are shown in Table 4, and the results of type of contraceptives used by current users are presented in Table 5.

Among women who were currently living with a husband/partner and were not using a contraceptive method, the most common reason for not using an FP method was wanting more children (30.4%), followed by currently pregnant (23.3%), breastfeeding (15.2%), lack of knowledge about a method (11.5%) and religious reasons (6.5%). Around 4% were not using any contraceptive methods because of no sex or infrequent sex. The results are presented in Table 6.

Differences in Contraception Use. Among those who reported currently using a method, 24% were aged 15 to 24, 32% were 25 to 34 and 36% were 35 to 49. The majority (82.6%) were currently living with a husband or partner. The majority of current users (43.5%) had had more than four pregnancies. Less than one-half (47.8%) of the women currently using an FP method had been sexually active within the

¹⁷ Excluding those who were currently pregnant for the first time.

¹⁸ Two persons reported using both the pill and the injectables.

past month. Table 7 shows the results of demographic characteristics of women currently using an FP method.

Source of Modern Methods among Current Users. Among women who reported current use of a modern FP method, 95.7% last obtained it from a health centre and 4.5% from the pharmacy. The pharmacy is located at the health centre in the camp. The majority (92.8%) of women who had heard of modern FP methods¹⁹ also reported the health centre as a place where contraceptives could be obtained, while 2.5% mentioned the pharmacy. Less than 1% of those who had ever heard of modern FP methods reported private clinics as the location for obtaining contraceptives. Table 8 shows the distribution of locations reported by women who had ever heard of modern contraceptives, and Table 9 presents the results for where the method was reported to have been last obtained by current users.

Barriers to FP. Unmet need for FP is defined here as the proportion of women at risk for pregnancy who wish to space their next birth or stop childbearing entirely but are not using contraception. Unmet need for FP was 8.8% (44).²⁰ See Table 10.

Intention to Use a Method. The proportion of women not currently using an FP method but reporting that they were planning to use a method in the next 12 months was 4.1%. Table 11 shows the results.

Facility Assessment

AMDA's main activities in the refugee camp include medical checkups, maternal and child health services, nutrition, health and sanitation education. It also provides referral services, in which AMDA transports patients who need treatment outside of the camp for more detailed medical tests to medical centres with better medical facilities and techniques in Ali Sabieh (about 20 kilometres away) and Djibouti (130 kilometres away).

Normal working hours at the facility are between 7 a.m. and 2 p.m. The maternity ward is open 24 hours, and after normal hours, the emergency night duty midwife provides services. One nurse was also on duty for nonmaternal care. The facility is located in a safe area. The distance between the health centre and the farthest sections of the camp is approximately 2 kilometres. The health centre's environment was adequately clean. Waiting times were not always perceived as acceptable by the clients. In fact, during the focus group discussions, some participants noted that they had to get to the centre by 4:00 a.m. in order to obtain a number to see the doctor at the official opening hour. The head nurse however, noted that the clients of the maternity ward did not need to receive numbers and could be at the clinic at any time during the day to receive counselling.

The consultation room was part of the delivery room at the maternity clinic. There was no privacy during consultation or during delivery. There was also insufficient lighting and no ventilation. A sink, covered with cardboard, served as a bed/crib to place the newborn. There were only two beds for post-delivery, with no sheets. Women would often bring their own sheets or blankets to the clinic at the time of delivery.

¹⁹ Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception, tubal ligation and vasectomy. The number of women who had heard of modern methods was 359.

²⁰ 44 out of 500 met the following criteria: were not currently using FP methods; were not pregnant; were not postpartum; and were fertile (i.e., could get pregnant); were married. Those who mentioned breastfeeding as a reason for not using FP methods are also included in the nominator.

The facility provided only temporary FP methods, such as injectables, oral contraceptives and condoms. An acceptable mix was available in stock at the time of the assessment, including male condoms, oral contraceptives and injectables. Counselling services to inform clients of permanent and longer-term methods were not available. There were no educational posters or printed material on any FP method.

The health centre had one doctor (male), five nurses (all male), one assistance nurse (male), one TBA (female) and one midwife who had undergone FP training more than two years ago. The midwife provided FP services and counselling along with her other duties. She was also available throughout the evenings on weekends. While the facility had counselling and a test centre for sexually transmitted infections (STIs), HIV and PMTCT, there was no system for follow-up.

At the time of the visit, the doctor was on leave and only the head nurse and the midwife were available. The head nurse had not undergone any FP training. The midwife reported her confidence in the facility's ability to provide comprehensive FP services to the community as 30%. She also described the clients' satisfaction with the services as 30%. She expressed the desire for follow-up FP training, as well as the need for additional qualified staff to assist her in providing FP services to clients.

The head nurse reported a negative attitude towards FP in the community, and attributed low FP uptake to religious and traditional beliefs, fear of opposition and misconceptions about the use of modern contraceptives on a woman's fertility. Furthermore, the facility reported to have no use of FP services among unmarried adolescents, given the cultural stigma associated with sexual activity among unmarried women in the population.

Focus Group Discussions

The general consensus among the adult male (40 and above) respondents regarding the woman's age for her first pregnancy was between 16 and 25 years. The women (28 and above), on the other hand, believed that a woman should have her first pregnancy between the ages of 15 and 18. Both adult male and female groups agreed that a woman is expected to become pregnant as soon as she marries, which is between 15 and 18.

There was a difference of opinion between the adult males and females regarding the number of children. While the men agreed on six or seven children (with the exception of one person who said 14), the women believed that the ideal number was between 13 and 15. One woman mentioned that the number of children a woman can have depends on her health, since she can have as many children as she wishes up to menopause.

Some women indicated that it was usually the husband who decided on the number of children, but the woman also had to agree. In the 28 and over female group, one participant noted, "It is good for women to give birth often," and another said, "We women have a limited time, so if we practice child spacing, we will not be happy since in the Somali culture we want many children."²¹ In general, both women and men agreed that the number of children depended on "God's will" and as many as "Allah would give". One male participant acknowledged that multiple pregnancies for a woman could lead to economic difficulties as the woman/mother would not be able to work.

²¹ Focus Group Discussion (28 and above), Ali Addeh, 31 July 2011.

Overall, the men were more knowledgeable and vocal about contraceptive methods than the women. While the men mentioned the pill, male condoms, injectables, the calendar method,²² IUD²³ and breastfeeding, the women only mentioned breastfeeding and male condoms. Younger men²⁴ believed that the younger generation was more aware of contraceptives as a result of HIV/AIDS awareness. Most women, however, acknowledged that they knew little about modern contraceptives. None of the younger women were able to mention any contraceptive methods. For the most part, younger females regarded male condoms as a means to prevent STIs and HIV/AIDS rather than an FP method.

Men and women agreed that child spacing was beneficial to the health and growth of the child and would also allow the mother to recover and regain her strength and health. The general consensus for child spacing was two years as prescribed in Islam, and breastfeeding was the most commonly practiced form of FP within the community. One male respondent mentioned withdrawal as an FP method, and one which is also sanctioned by Islam.

For the most part, attitudes towards modern methods were negative, but some mentioned that it was a personal choice. One woman indicated, "We don't want to use them [modern contraceptives] because they are not part of our tradition and if we want child spacing, we will use natural methods."²⁵ The majority believed that modern contraceptives had negative side effects, such as excessive bleeding and other complications. Some men (in the 40 and above group) said that since instructions on the use of contraceptive products are not always adequately explained, their use can lead to health problems.

The general belief was that sexual relationships between unmarried boys and girls were inappropriate and against cultural norms, and marriage was the best way to prevent pregnancy out of wedlock. The older female participants felt that giving information to young girls and boys about contraceptives could encourage sexual relationships before marriage. While younger men said that it was not uncommon for young girls and boys to have sex before marriage, younger girls believed that most girls avoided sexual relationships before marriage due to the social stigma associated with pregnancy out of wedlock. One male respondent explained, "Ali Addeh used to be a homogenous community with the majority of Somalis from Somaliland, but with the arrival of newcomers from South Somalia, who are a bit different culturally, the community is no longer homogeneous. In the south, sex is more frequent. Before, there were just Somalis from Somaliland and Ethiopians, who are very limited in number."²⁶

Most of the younger women and men said that they seek advice from a doctor at the health centre or hospitals when they have a health problem. All respondents agreed that the best place to get information and services on contraceptives was the health centre, since the staff were more aware of the quality of the products and able to give advice on their use.

With respect to problems or challenges community members experienced in obtaining FP services, one male respondent noted that although FP services and information were available at the health centre, they were not "quite enough or public enough" because of people's attitudes and beliefs. Other male participants indicated that they would like to be able to purchase condoms at shops in the Somali sections as they could in the Ethiopian section. They believed that if condoms were made more publicly available, people would not be afraid or ashamed to buy and use them. Both younger males and females

²² One male mentioned that both men and women should know the calendar method (Male Focus Group 19 to 25), Ali Addeh, 30 July 2011.

²³ Referred to as "the loop" by the respondents.

²⁴ Men in the 19 to 25 year focus group, Ali Addeh, 30 July 2011.

²⁵ Woman in the 28 and above focus group, Ali-Addeh 31 July 2011.

²⁶ Male in the focus group 19 to 25, Ali Addeh, 30 July 2011.

expressed a desire for greater sensitisation, health education and more “open discussions” on contraceptives and STIs. Some suggested awareness raising strategies, including sketches and dramas, songs and poems, to attract people to FP services. One male participant (in the 19 to 25 group) also suggested education and sensitisation on female genital mutilation.

The majority of the respondents agreed that counsellors, community health workers (CHWs), midwives, TBAs and the medical staff were the best people to raise awareness about child spacing and FP in the community. Some also mentioned community leaders, mothers and women’s committees. None of the respondents felt the community Sheik or the Imam to be the most qualified person to promote FP since he never talked about it.

The common view was that the health centre was too small and could not accommodate many people at the same time. Some mentioned that there was no privacy at the prenatal/delivery centre, and not enough beds for post-delivery care. Others complained about lack of staff, particularly midwives and TBAs, for outreach activities. One male participant noted that the midwives need to be qualified and professional, and the TBAs should receive more training even if they cannot go to school.

In-depth Interviews

In response to the question of what the community thinks about getting health care for pregnancy and childbirth, the key informants mentioned more staff, particularly, midwives, a more suitable space for delivery and counselling services on FP, as well as antenatal and postnatal care and more equipment. Overall, the key informants did not perceive pregnancy and delivering a baby as a risky situation for the mother and noted that maternal mortality was relatively low in the camp. The more immediate concerns were lack of nutrition and follow-up by skilled staff. While referral systems for complicated pregnancies are in place and women with complications are referred to the hospital in Djibouti, the community’s concern is with delays in treatment. Two of the key informants noted that some counselling on contraception was available at the health centre, but the third respondent observed, “There are no counselling services because there are no counsellors”.²⁷

The consensus was that the average age of marriage for girls was 17 or 18. While, the actual number of children a family would have depended on “God’s will,” respondents believed that, on average, the minimum number was between five and six, and the maximum between nine and ten. Another key informant stated, “In this camp, Somalis want large families. A family with few children has a low social status”.²⁸

The general view by the key informants was that most family matters, including the number of children, were decided by the man. On the other hand, one of the female key informants noted that if women were more sensitised through health education, they would have a better understanding of FP, and would be able to make more informed decisions regarding the number of children.

A recurring theme was the women’s inability to access modern FP services publicly and openly. As one informant mentioned, “The services are not openly provided and the women do not openly approach the centre to get family planning services. Of course that also depends on whether or not you have connections at the centre”.²⁹ Accordingly, at times, it appears to be more convenient for the husband to

²⁷ Key informant interview (female), Ali Addeh, 31 July 2011.

²⁸ Ibid.

²⁹ Key informant interview, Ali Addeh, 31 July 2011.

obtain contraceptives (such as the pill) for his wife from the health centre/pharmacy than for the woman to go there herself. The key informants, however, stated that there has been some change in the community's attitude towards FP as a result of sensitisation, outreach services and mothers' meetings.

In-depth interview respondents emphasized that awareness-raising and FP services needed to be made more readily available to adolescents since they made up a large portion of the camp's population. The recommendations for encouraging FP in the community included meetings with section leaders (i.e., the elders), adolescents and women leaders, and greater interaction and cooperation between CHWs and the community. It was agreed that the health centre/hospital and the school would be the most appropriate sites to educate the community on child spacing.

DISCUSSION

Findings indicate a higher CPR among the Somali refugees in Ali Addeh than had been documented in previous studies³⁰ of Somalis in their home country (5.6% versus 1.2%). While traditional beliefs contribute to a large extent to the negative attitudes towards modern FP methods, misconceptions due to lack of education on child spacing also play a role in low prevalence rates of FP methods among the refugees. The community's acceptance of breastfeeding presents an important opportunity in educating the population on LAM as one FP method.

The results from the household survey, the focus group discussions and key informant interviews indicate that most people have low knowledge of contraceptive methods. They also point to the fact that education and instructions on FP, including information on the availability of different types of contraceptives, have been inadequate. Sensitisation and awareness-raising efforts should target both adults and adolescent boys and girls, and promote public debate.

This study suggests that absence of knowledge about reproductive health, compounded with lack of comprehensive FP services at the health centres, constitute important barriers to access and use of FP methods. The challenges need to be addressed through integration of community outreach programmes and quality FP services, including counselling on both short and long term FP methods, and referrals on long term FP methods that are unavailable at Ali Addeh.

LIMITATIONS

The most important limitation for the household survey was the self-reported nature of the information and the sensitive character of some of the questions. Social desirability biases may have been introduced, given that the use of contraceptives is not socially sanctioned among Somalis. Social desirability biases also made it difficult to calculate some of the indicators, such as unmet need, by using more straightforward variables such as, "Have you had sexual intercourse in the last 30 days," due to inconsistencies in results.

As part of the study took place during the first three days of Ramadan, respondent and interviewer fatigue may have contributed to some random errors. While the interviewers were trained on the

³⁰ "Republic of Somalia Country Profile," 2006, http://www.who.int/making_pregnancy_safer/countries/som.pdf.

questionnaire and the questionnaire was piloted, reporting biases may also have occurred due to lack of consistent coaching of the interviewers due to time constraints.

Sampling bias may have been introduced based on the selection of people who were available and/or willing to participate in the study. Moreover, since the tents/households were not necessarily set up in a geometric order, the randomness of the systematic sampling may have been affected.

Selection bias of focus group respondents also constitutes a further limitation, as they were selected by the UNHCR staff according to their availability at the time of the sessions.

Limitations for facility assessments included time constraints, which meant that family planning consults were not observed at the facility.

APPENDICES

APPENDIX I: HOUSEHOLD SURVEY DATA TABLES

TABLE 1: Awareness of Family Planning Methods among Women of Reproductive Age (Wra), Ali Addeh, Djibouti, 2011 {N = 500}	
Method	Ever Heard of Method % (n) women
Pill	33.8% (169)
IUD	1.4% (7)
Male condom	10.6% (53)
Female condom	0.4%(2)
Implants	1.0% (5)
Injectables	21.4% (107)
Emergency contraception	0.2% (1)
Tubal ligation	3.0% (15)
Rhythm/calendar/counting days	4.2% (21)
Withdrawal	1.0% (5)
Other*	5.2% (26)
TOTAL**	82.4% (412)

* 5.2% (26) of the respondents mentioned breastfeeding and 0.4% (2) mentioned "herbs". Those who mentioned "herbs" are excluded from the analysis.

** Respondent may give more than 1 response.

TABLE 2: Proportion of Women Who Have Ever Used a Family Planning Method among Women Who Have Ever Heard of Any Family Planning Method, Ali Addeh, Djibouti, 2011 {N = 412}		
Method	Ever Instructed Method % (n) women	Ever Used Method % (n) women
Pill	12.4% (62)	9.6% (48)
IUD	0.4% (2)	0% (0)
Male condom	0.6% (3)	0.2% (1)
Female condom	0.2% (1)	0% (0)
Implants	0.2% (1)	0% (0)
Injectables	9.0% (45)	5.4% (27)
Emergency contraception	0.2% (1)	0.2% (1)
Tubal ligation	1.0% (5)	0.2% (1)
Rhythm/calendar/counting days	3.6% (18)	4.0% (20)
Withdrawal	0.6% (3)	0.6% (3)
Other*	5.2% (26)	5.2% (26)
TOTAL**	40.5% (167)	30.8% (127)

* 5.2% (26) of the respondents mentioned breastfeeding and 0.4% (2) mentioned "herbs". Those who mentioned "herbs" are excluded from the analysis.

** Respondent may give more than 1 response.

Ever Heard of Method	Lack of access % (n) women	Opposition to use % (n) women	Method- related % (n) women	No problem % (n) women	Don't know/No response % (n) women
Pill (n=169)	0% (0)	0.2% (1)	3.2% (13)	7.3% (30)	30.1% (124)
IUD (n=7)	0% (0)	0% (0)	0% (0)	0% (0)	1.7% (7)
Male condom (n=53)	0% (0)	0% (0)	0.2% (1)	0.2% (1)	12.4% (51)
Female condom (n=2)	0% (0)	0% (0)	0% (0)	0.2% (1)	0.2% (1)
Implants (n=5)	0% (0)	0% (0)	0% (0)	0% (0)	1.2% (5)
Injectables (n=108)	0% (0)	0.5% (2)	3.6% (15)	6.1% (25)	16% (66)
Emergency contraception (n=1)	0% (0)	0% (0)	0% (0)	0% (0)	0.2% (1)
Tubal ligation (n=15)	0% (0)	0% (0)	0% (0)	0.5% (2)	3.2% (13)
Rhythm/calendar/counting days (n=21)	0% (0)	0% (0)	3.4% (14)	0.2% (1)	1.5% (6)
Withdrawal (n=5)	0% (0)	0% (0)	0.7% (3)	0.2% (1)	0.2% (1)
Other (n=26)	0% (0)	0% (0)	3.9% (16)	0.5% (2)	2.2% (9)
TOTAL**	0% (0)	0.7% (3)	15% (62)	15.3% (63)	68.9% (284)

*N = number of women who ever heard of at least one contraceptive method.

** Respondent may give more than 1 response.

Indicator	% (n) women
Proportion of women who have ever used any family planning method	30.8% (127)
Proportion of women who are currently using a modern* family planning method (Contraceptive prevalence – Modern Methods)	5.1%** (21)
Proportion of women who are currently using any family planning method (Contraceptive prevalence – Any Method)	5.6%** (23)

*Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, emergency hormonal contraception, tubal ligation and vasectomy.

**The denominator may include women who are not at risk for pregnancy because they are currently pregnant, infecund or have had a hysterectomy.

TABLE 5: Family Planning Method Being Used among Women of Reproductive Age Who Are Currently Using Any Family Planning Method, Ali Addeh, Djibouti, 2011 {N = 23}*	
Method	% (n) women
Pill	43.5% (10)
IUD	0% (0)
Male condom	0% (0)
Female condom	0% (0)
Implants	0% (0)
Injectables	56.5% (13)
Emergency contraception	0% (0)
Tubal ligation	0% (0)
Vasectomy	0% (0)
Lactational amenorrhea	8.5% (2)
Rhythm/calendar/counting days	0% (0)
Withdrawal	0% (0)
Periodic abstinence	0% (0)

*Percentages may add up to greater than 100% as respondent may give more than 1 response

TABLE 6: Demographic Characteristics of Women Who Are Currently Using Any Family Planning Method, Ali Addeh, Djibouti, 2011 {N = 23}	
Characteristic	% (n) women
Age	
15-24	24% (6)
25-34	32% (8)
35-49	36% (9)
Relationship Status	
Living with a husband/partner	82.6% (19)
Not living with husband/partner	13% (3)
Total pregnancies	
0	8.7% (2)
1-2	13% (3)
3-4	34.8% (8)
>4	43.5% (10)
Sexually active in last 30 days	
Yes	47.8% (11)
No	52.2% (12)

TABLE 7: Reasons Mentioned for Not Using a Method among Women Who Are Currently Not Using a Method and Are Currently Living with a Husband/Partner, Ali Addeh, Djibouti, 2011 {N = 333}*	
Barriers to family planning	% (n) women
Wants more children now	30.4% (98)
Currently pregnant	23.3% (75)
Breastfeeding	15.2% (49)
Knows no method	11.5% (37)
Religious prohibition	6.5% (21)
No sex/infrequent sex response	4.3% (14)
Postpartum	3.7% (12)
Partner opposed	2.2% (7)
Hysterectomy	1.2% (4)
Difficulty in getting pregnant	1.2% (4)
Others oppose	0.9% (3)
Knows no source	0.6% (2)
Afraid of side effects	0.6% (2)
Respondent opposes	0.3% (1)
Too far/Method not available	0% (0)
Method expensive	0% (0)
No response	1.2% (4)

** Percentages may add up to greater than 100% as respondent may give more than 1 response.*

Ever Heard of Method	Health Centre % (n) Women	Private Clinic % (n) Women	Pharmacy % (n) Women	Don't Know/No Response % (n) Women
Pill (n=169)	95.3% (161)	0% (0)	0% (0)	3.6% (6)
IUD (n=7)	71.4% (5)	0% (0)	14.3% (1)	14.3% (1)
Male condom (n=53)	77.4% (41)	3.8% (2)	13.2% (7)	5.7% (3)
Female condom (n=2)	100% (2)	0% (0)	0% (0)	0% (0)
Implants (n=5)	80% (5)	0% (0)	0% (0)	20% (1)
Injectables (n=108)	99.1% (106)	0% (0)	0% (0)	0.9% (1)
EC (n=1)	0% (0)	0% (0)	100% (1)	0% (0)
Tubal ligation (n=15)	86.7% (13)	0% (0)	0% (0)	13.3% (2)
TOTAL**	80.8% (333)	0.5% (2)	2.2% (9)	3.4% (14)

*Percentages may add up to greater than 100% as respondent may give more than 1 response.

Currently using method	Health Centre % (n) women	Pharmacy % (n) women
Pill	39.1% (9)	4.5% (1)
Injectables	56.5% (13)	0% (0)
TOTAL	95.7 (22)	4.5% (1)

TABLE 10: Proportion of Women of Reproductive Age Who Desire to Stop or Delay Childbearing, Who Are Not Currently Pregnant and Not Postpartum, Who Are Sexually Active, Are Fecund and Not Currently Using Contraceptives, Ali Addeh, Djibouti, 2011 {N=500}	
Indicator	% (n) women
Unmet need	8.8% (44) ³¹

TABLE 11: Proportion of Women Who are Not Currently Using a Family Planning Method, But Plan to in the Next 12 Months, Ali Addeh, Djibouti, 2011 {N = 463}	
Indicator	% (n) women
Future intent to use family planning in next 12 months	4.1% (19)

³¹ 44 out of 500 met the following criteria: were not currently using FP methods; were not pregnant; were not postpartum; and were fertile (i.e., could get pregnant); and were married. Those who mentioned breastfeeding (25) as a reason for not using FP methods are also included in the nominator.

ANNEX II: HEALTH FACILITY ASSESSMENT SUMMARY

1	Staffing	# of doctors or clinical officers providing any FP method	1
		# of midwives, nurse-midwives or nurses providing any FP method	1
2	Training	Proportion of doctors or clinical officers trained in FP among all doctors and clinical officers providing FP	100%
		Proportion of midwives, nurse-midwives or nurses trained in FP among all midwives, nurse-midwives or nurses providing FP	100%
3	Method Mix	# of temporary methods available	3
		# of long-acting methods available	0
		# of permanent methods available	0
		# of traditional methods promoted	0
		Is EC available?	Yes
4	Relative Score of Quality Measure	Score (Out of 15)	10
5	Capacity to meet infection prevention standards	Score (Out of 15)	15