UNHCR
The UN Refugee Agency

FIELD BRIEF
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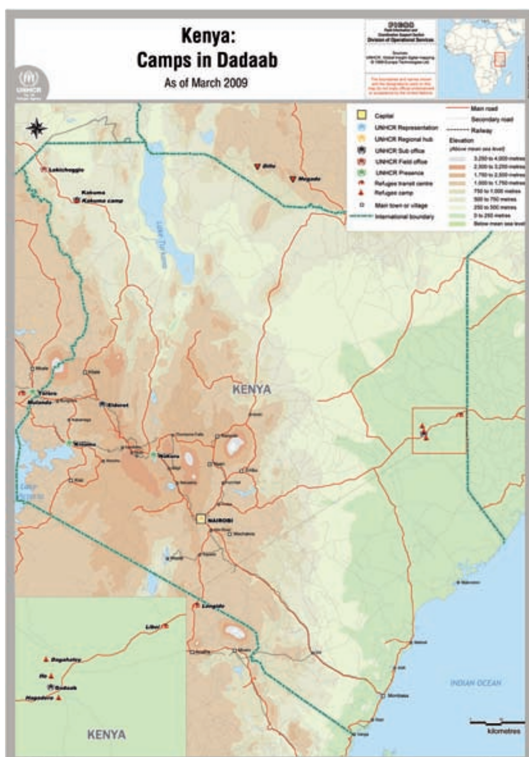
Improving Maternal Care in Dadaab Refugee camps, Kenya

Context

Dadaab is located in the Garissa district in the North Eastern Province of Kenya and is home to approximately 300,000 refugees, primarily (97%) from Somalia.



From 2007, Dadaab refugee camp has experienced a huge influx which doubled the population in less than two years. UNHCR continues to receive and register new arrivals even though the capacity of the camps is completely overstretched. Since the beginning of 2009, more than 72,500 new arrivals have been registered in the three adjacent refugee sites (10 – 15 km apart) that make up the Dadaab camp complex – Hagadera, Ifo and Dagahaley. Camps designed almost two decades ago to accommodate a total of 90,000 people now host 3 times that number with new arrivals settling at the periphery and encroaching to the surrounding areas which are far from the established infrastructure such as hospitals and health centres.

In early 2008, the Kenyan government closed the Kenya-Somali border and recent arrivals spontaneously entered the camps without an opportunity for early screening and orientation on where and how to access health services in the refugee camps.

The camps are located in insecure areas and public transport to reach health services is not available for refugees to use at night. In addition, the health agencies vehicles have experienced several attacks and, therefore, do not operate at night.

Over half the new arrivals to the camp are women and children. Nearly 20% of the total population in the camps is women of reproductive age with more than 8,000 recorded deliveries (both home and facility based) in 2008. Due to cultural issues, many Somali women opt to deliver at home and are reluctant to consent to an emergency caesarian section even when critically indicated.

The above complex situation has severely impacted the ability of humanitarian agencies to improve obstetric care for refugee populations in the camps.

Actions for Change

In 2008, UNHCR along with GTZ (German Technical Cooperation), the main health implementing partner (IP) in Dadaab, introduced strategies to reduce maternal morbidity and mortality in the camps.

UNHCR introduced a maternal death audit system in which every case of maternal death was investigated by a team comprised of medical personnel from the IP, UNHCR, refugee health committee leaders, the Ministry of Health (MoH), the report was then shared with the UNHCR Regional Office for review and to inform intervention strategies for countries with similar refugee populations. An important aspect of this strategy was awareness raising among the local community. The community was sensitised to report any cases of women who died at home during childbirth.

A first review of all maternal deaths took place during the annual public health regional workshop in November 2008, bringing to light risks factors and possible strategies to address them. A three-day workshop was then organized by UNHCR in January 2009 to review every case of maternal mortality in order to identify missed opportunities which led to the deaths. The review focused on the three levels of delays: the delay in seeking care, the delay in reaching care and the delay in receveiving care; in addition medical conditions and professional and cultural factors that contributed in any way to the deaths were examined.

Kenya / Somali refugees / The Maternity Ward. Dagahaley Camp. Dadaab. / Photo: © Australia for UNHCR / T. Mukoya / October 2009

A total of 22 maternal deaths were reported in 2008. From these reviewed cases several risk factors were identified to focus intervention efforts.

- Anaemia
- Delay in care-seeking and surgical intervention
- Low rates of health facility deliveries (high rates of home delivery)
- Poor quality care and facilities
- Low rates of pre and post natal care
- Grand-multiparity in relatively young women

Anaemia was found as a risk factor in 55% (12 out of 22) of the cases. Delay in seeking care and giving consent for Caesarean sections were other contributing factors. Delivery in health facilities was low as was the number of qualified midwives to provide quality obstetric care. The health facilities that were constructed during the 1991 emergency phase have since deteriorated and the low quality services further contributed to pregnant women not presenting for delivery. The reviews found that perinatal care was poor and post-natal care was low due to cultural practices where Somali women remain in-doors for 40 days after delivery. Many of the cases of maternal deaths have been pregnant often with short intervalls and given birth to many children.

Interventions and Positive Outcomes

In February 2009, UNHCR brought together all health partners in Dadaab to review the maternal deaths audit reports and the entire health programme. The workshop generated a number of recommendations to improve safe motherhood. Delivery in the health facilities by newly qualified personnel increased significantly. The following interventions were incorporated to address the problem:

a) Maternal Death Audits

Maternal death audits that started in January 2008 have enabled stakeholders to better understand the risk factors that led to deaths or near deaths. UNHCR worked with IPs to ensure a very honest and open review to identify all forms of delays and risk factors. In Feb 2009, UNHCR conducted a workshop to review all audit reports and at the same time, discuss ways of addressing the identified factors. These events have increased consciousness among health workers and refugee leaders on the need to prevent future maternal deaths.

b) Improvement of infrastructure

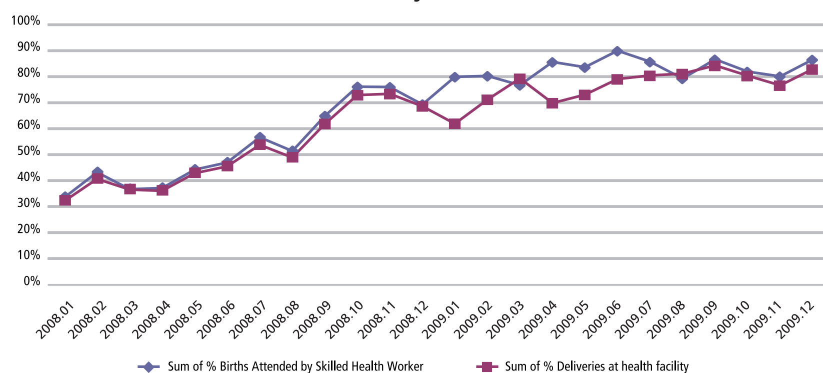
Construction of a new maternity hospital in Hagadera camp, together with appropriate trained staff, led to an increase in the number of women delivering in this new facility from 28% annually before construction to 49% annually after. Similar trends were noted in Dagahaley and Ifo after renovating the maternity wards. The Hagadera and Dadaab Health Centres were equipped to provide timely emergency and neo-natal obstetric care instead of referring cases to Garissa hospital which is 80km away through rough terrain.

c) Staffing

Additional female midwives were recruited to work in the maternity room which further improved and scaled up services. Additional doctors were also hired to ensure 24 hour timely emergency obstetric and neonatal care (EmONC) when necessary. The recruitment of extra service providers was gender sensitive to ensure that at least 50% of maternity room staff are female, especially among doctors, nurses and midwives.

d) Community sensitisation

Some of the major challenges affecting safe-motherhood related to community beliefs and practices. There is a belief that Somali men prefer a woman who have as many children as possible, and this has negatively affected family planning uptake and the ability to secure consent for caesarean sections, as women understand that several ceasarean sections will eventually limit the number of children they can deliver. As such, women were opting to give birth at home and only present to health facilities in serious condition. UNHCR and it's partners targeted and worked with community and religious leaders as agents of change as well as with others that have the power of influencing opinion towards improving safe-motherhood. In Dagahaley camp, the chairman (an elected representative of the refugees) sensitised the community and as a result, the improvement was greatest in that camp. Additionally, health education on reproductive health issues was intensified in all the three camps by the IPs.



e) Improved transportation

Dadaab camps are located in a phase III security situation and UN Agency vehicles are escorted by armed police to and from camps. Agency transportation from the refugee houses to hospitals is not possible at night. Consequently, many pregnant refugee women who may otherwise seek care in a health facility continue to deliver at home because of lack of means to access health care.

Kenya / Somali refugees / The Maternity Ward. Dagahaley Camp. Dadaab. / Photo: © Australia for UNHCR / T. Mukoya / October 2009

To overcome this challenge, UNHCR and its health partners introduced community taxis "Mama Taxi" which are hired from the local community. Drivers' mobile cell numbers are distributed to the block leaders for any emergency occuring during the evening and nights.

The emphasis is put on referral for emergency obsetric and neonatal care although transport services are also available for other emergencies. This has greatly reduced delay in accessing care and increased the number of women seeking hospital care at night. In addition, women who are in full-term and go to the health posts are encouraged to remain at the hospital in order to deliver there, even though labour may not yet have started.

f) Physical presence of health staff in the camps

Agency staff had been operating from Dadaab centre which is 5-15 kilometres away from the hospital, depending on the camp location. However, since the beginning of 2009, technical agency staff relocated to live near the hospitals, and this has improved 24 hour coverage and timely response to obstetric emergencies.

g) Mother incentives

Mothers delivering in hospitals are given a baby package that includes a bar of soap and a basin. In addition, those who deliver their babies in hospitals are provided with a birth notification that enables them to register the baby within one week.

h) Supplies

Availability of blood from a central blood bank has boosted capacity to respond to anti and post-partum hemorrhage as well as severe anaemia in pregnancy.

Conclusions

As a result of the initiatives conducted by UNHCR and partners, maternal death audits have enabled key factors to be identified for improved maternal care in complex and protracted refugee settings such as Dadaab refugee camp. The two main factors that appear to have prompted women to deliver in health centres were the improvement of health infrastructure and increasing the number of qualified health staff sensitive to the needs of refugee women. Community sensitisation and participation was an essential aspect of improving safe maternal care in the camps.