Study Title: Impact on Reproductive Health Service Delivery in Kakuma and Kalobeyei Camps during Compounded Crises: A Qualitative Study

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Abstract:

The United Nations Refugee Agency (UNHCR) has reported a 4000% increase in forcibly displaced individuals from 1951 to 2020. Crises and its impacts are increasing worldwide, and a growing number of populations are being impacted by multiple events of crises - compounded crises. Populations in compounded crises settings face additional challenges related to accessibility, availability and quality of health services, particularly for women's reproductive health. The purpose of this study was to understand the facilitators and barriers in delivering reproductive health services in compounded crises settings using principles of community-based participatory research and human rights-based approach to health. Our research employs qualitative methodologies, including 4 focused group discussions with health workers (n=28) and 4 health facility assessments in Kakuma and Kalobeyei refugee camps in Kenya. Preliminary findings suggest challenges with battling birth before arrivals, shortages of human resources, stock-outs, use of outdated equipment, limited specialized services, low uptake of family planning and cervical cancer screening, no reporting of maternal mortality, and cultural rigidity in uptake of reproductive health services. We hope the insights from our findings could lead to improvements in reproductive health of refugees in Kenya and guide policy makers to plan for compounded crises management.

Background

The number of new refugees and internally displaced persons (IDPs) grows around the world each year. When the United Nations Refugee Agency (UNHCR) began reporting annual numbers of forcibly displaced individuals in 1951, they totaled 2,116,011. At the end of 2020, the number had grown to 89,281,133, an increase of over 4,000%.[3] Between 2015 and 2020 alone, the number grew by 25 million individuals.[4] These numbers are likely underestimates, not overestimates. Not only does the number of forcibly displaced individuals continue to grow, but the causes of displacement are also increasing. Crises and its impacts are increasing worldwide. In the last three years, the pandemic alone disrupted essential health services in 92 percent of countries.[5]

Crises often pose a great threat to the general public health due to collapsed or damaged health systems, lack of medication and supplies, and absence of trained medical staff.[6] Women and girls' reproductive health is particularly vulnerable due to increased sexual and domestic violence, complications with maternal and newborn health, increased unsafe abortions, and anemia or compromised nutrition due to food insecurity.[7] Countries with the poorest reproductive

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[3] UNHCR - Refugee Statistics. UNHCR. Published 2023. Accessed at <https://www.unhcr.org/refugee-statistics/>
[4] Ibid.
[5] Dr. Kumah and Dr. Ameh. "Improving maternal and newborn healthcare access in humanitarian settings: Is it Time to Rethink Our Strategy?" Plos One Global Public Health. July 2023.
[6] UNHCR Website. "South Sudan Refugee Crisis." United Nations, Geneva. 2022. Accessed at <https://www.unrefugees.org/emergencies/south-sudan/>
[7] Aderanti Adepoju. "Migration dynamics, refugees, and internally displaced persons in Africa." Human Resource Development Center, Nigeria. United Nations Website.

health indicators, particularly maternal mortality, are currently impacted by humanitarian crises.[8] Women's reproductive health needs do not stop or diminish during crises. In fact, they only become greater and vary throughout their reproductive life cycle.[9] Previous studies in humanitarian settings have shown reduced access to reproductive health and mental health services resulting in higher rates of unintended pregnancies, unsafe abortions, pregnancy complications, miscarriage, maternal and infant mortality among other serious health outcomes.[10]

Compounded crises increase the barriers for women to access health services and impact their health outcomes. Compounded crises 'is the occurrence of two or more dependent or independent events of crises affecting a population at a given time, that unveils the complex interactions of those events of crises to disproportionately impact populations, reducing their ability to cope.' A study conducted in the humanitarian settings in Democratic Republic of Congo (DRC), concluded that the emergence of the COVID-19 pandemic (an added event of crisis or compounded crisis) further threatened the health system and caused increased incidences of gender-based violence, and unintended pregnancies.[11] This study highlights, "in humanitarian settings, where health systems struggle to deliver health services to populations already affected by violence, natural disaster, or political instability, the emergence of COVID-19 further threatens the delivery, quality, accessibility, and availability of vital care to those communities. In those settings, Sexual and Reproductive Health (SRH) services are often the first to get deprioritized. Access, and use of sexual and reproductive health services among women and girls is hence limited, even when services are available."[12] During the 2014 Ebola outbreak in Africa, SRH programming was given limited attention in the outbreak response, leading to sharp declines in service utilization, consequently leading to excess maternal and neonatal deaths which were more than the number of deaths from Ebola.[13] A study conducted in South Sudan reported increased unintended pregnancies and induced abortions during the recent conflict in 2020.[14] Due to the war, people's situations had changed leading to increased instability and poverty, increased transactional sex and rape, disruption of marital norms, and low contraceptive use.[15]

Substantial measures have been taken for the issuance of reproductive health in humanitarian settings, however implementation has lagged.[16] Health service delivery during the event of one crisis has been fragmented and there are no existing provisions for populations facing compounded crises. The existing standards on reproductive health delivery in humanitarian settings are often not context-bound and lack empirical evidence in their guidance.[17] The purpose

[8] Ibid.
[9] Sneha Barot. "In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Settings." Guttmacher Institute. February 2017. Accessed at <https://www.guttmacher.org/gpr/2017/02/state-crisis-meeting-sexual-and-reproductive-health-needs-women-humanitarian-situations >
[10] Ho, L.S., Bertone, M.P., Mansour, W. et al. "Health system resilience during COVID-19 understanding SRH service adaptation in North Kivu." Reproductive Health, BMC. June 2022. DOI: https://doi.org/10.1186/s12978-022-01443-5.
[11] Ibid.
Ibid.
[12] Ibid.
[13] Ibid.
[14] Sara E Casey, et al. "Community perceptions of the impact of war on unintended pregnancy and induced abortion in Protection of Civilian sites in Juba, South Sudan." Taylor and Francis Online. 2020. DOI: https://doi.org/10.1080/17441692.2021.1959939.
[15] Ibid.
[16] Sneha Barot. "In a State of Crisis: Meeting the Sexual and Reproductive Health Needs of Women in Humanitarian Settings." Guttmacher Institute. February 2017. Accessed at <https://www.guttmacher.org/gpr/2017/02/state-crisis-meeting-sexual-and-reproductive-health-needs-women-humanitarian-situations >
[17] UNHCR - Refugee Statistics. UNHCR. Published 2023. Accessed at <https://www.unhcr.org/refugee-statistics/>

of this study was to understand the facilitators and barriers in delivering reproductive health services in compounded crises settings using principles of community-based participatory research and human rights-based approach to health. Through first-hand experiences of healthcare workers in Kakuma and Kalobeyei refugee camps, we seek to comprehend the differences in service delivery during compounded crises.

Methodology

Our research employs qualitative methodologies, including focused group discussions (FGDs), and health facility assessments to learn more about the availability, accessibility, acceptability, and quality of services delivered. The team of researchers was formed and trained. The team had a facilitator and a note taker. All interactions were audio recorded upon consent. FGDs were conducted in English. The interactions lasted 90-120 minutes. The data was collected from 14 to 28th February 2024.

Study Participants:

The target population selected for this study included health workers in Kakuma and Kalobeyei that were affiliated with a public or private health system and were actively in service, providing reproductive health service to refugee women.

Sampling and Recruitment:

The geographical location was selected based on the definition of compounded crises and interest in the local community to collaborate on the research topic. Convenience sampling was used to select the camp sites for the study. Upon identification of campsites, homogenous sampling was used by partner organizations to identify humanitarian agencies and other organizations working on delivering health services in the camps. Participants were also recruited through phone calls, messages, and study flyers. Recruitment was stopped upon reaching the sample size of 6-8 participants per FGD. The overall study design employed a maximum variation approach to include different groups of health workers by age, nationality, health service delivery experiences, and location (camps). Purposive sampling was used to identify the health facilities for assessment.

Training:

A three-day training was conducted with the enumerators to familiarize them with the study and pilot test the tools. The topics of the training included human subjects research, reproductive health, compounded crises, qualitative research, study overview, conducting FGDs, note-taking, consent process, ethical handling, team communication and troubleshooting. Mock practice and consent seeking sessions were also held. English FGD guides were tested for contextualization and appropriation. Extra enumerators were trained for bench strength and emergencies. Trained enumerators pilot tested the guides. FGD guides were revised based on the feedback from the pilot testing.

Debriefs:

Daily debriefs were held with the enumerators. In the morning debriefs, the teams went through the checklists, finalized their field movement plan, and received their audio recorders. In the evening debriefs, the team reported on sample completion, note taking, troubleshooted, and returned the audio recorders.

Informed Consent:

When approached, all participants were verbally informed of the project's goals and methods. Unsigned consent was given by all participants of the study. Consent form provided an overview

of the study, explained confidentiality, voluntary participation, risks, and benefits of the research. During data collection, no personal identifiers were collected.

Ethical Approvals:

The study received approval from the Committee of protection of Human Subjects at the University of California, Berkeley (CPHS #2023-10-16754), and Kenyan National Commission for Science, Technology, and Innovation (NACOSTI Licence #NACOSTI/P/24/32807). Additionally, approvals from the Commissioner of Refugee Affairs, Department of Refugee Services, Ministry of Internal and National Affairs, Kenya was also granted for this research.

Findings[18]

In total, 4 focused groups were conducted: one each with private health providers, safe motherhood promoters, community health volunteers, and reproductive health staff and doctors from a public hospital. 28 health workers from Kakuma and Kalobeyei participated in the study. Of whom, 50 percent (n=14) participants were between the age of 20-29, 32.1 percent (n=9) were between 30-39, 10.7 percent (n=3) were between 40-49, and 7.1 percent (n=2) were between 50-59 years. Of the 28 participants, half of them (n=14) identified as women and half (n=14) as men. In total, 4 health facility assessments were conducted, one each in public hospitals in Kalobeyei and Kakuma, one at a reception center, and one at a public clinic in Kalobeyei.

Preliminary findings suggest challenges with battling birth before arrivals, shortages of human resources, stockouts, use of outdated equipment, limited specialized services, low uptake of family planning and cervical cancer screening, no reporting of maternal mortality, and cultural rigidity in uptake of reproductive health services.

Data analysis is being conducted on MaxQDA version 24 and Microsoft Excel 16.80. Transcripts were cleaned and checked for accuracy. A codebook with preliminary themes and categories was designed. Qualitative data is being coded using an analytic inductive and deductive approach. Research assistants with prior experience in qualitative research are supporting coding to ensure inter—coder reliability.

Conclusion[19]

This paper highlights the importance and urgency of using a compounded crises orientation while developing and implementing policies and programs that recognize the complex interplay of multiple crises and the layered impact on affected populations. Efforts placed in compounded crises settings should ensure all stakeholders provide a holistic and integrated response to affected populations.

Insights from our findings could lead to improvements in reproductive health of refugees in Kenya and guide policy makers to plan for compounded crises management. When humanitarian organizations understand and anticipate the complexities of compounded crises and can provide coordinated aid, forcibly displaced populations can benefit from continued health services to achieve better health outcomes.

[18] The data analysis for this study is ongoing and findings are preliminary. Please do not cite, circulate, or publish these findings of this paper.
[19] The conclusion will change based on the revised findings and discussion section of the paper.