The Extending Service Delivery (ESD) Project

# Somali Refugee Attitudes, Perceptions, and Knowledge of Reproductive Health, Family Planning, and Gender-Based Violence

## Findings from Discussion Groups with Adult Men and Women, Youth, Religious Leaders, and Health Workers in Dadaab, Kenya

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**What is ESD?**

The Extending Service Delivery (ESD) Project, funded by the United States Agency for International Development (USAID) Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associates Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

**Contact information:**

For further information, please contact:

Extending Service Delivery Project
1201 Connecticut Avenue, NW, Suite 700
Washington, D.C. 20036
Tel. 202-775-1977
Fax. 202-775-1988
esdmail@esdproj.org

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# EXECUTIVE SUMMARY

In January 2007, the Extending Service Delivery Project (ESD) carried out a qualitative investigation of Somali refugee knowledge, attitudes and practices in the areas of reproductive health, family planning and gender-based violence in Dadaab, Kenya refugee camp. Focus group discussions (FGDs) were conducted to augment existing information and inform the planning of ESD's project activities. Eight separate FGDs composed of adult males and females, youth males and females, health providers and religious leaders yielded a wealth of specific findings and demonstrated remarkable similarity of ideation and knowledge despite differences in sex, age, level of education and roles in the community.

The discussions highlighted strong cultural traditions and beliefs that constrain reproductive health and family planning choices among refugees. Social pressures are powerful motivators, reinforced by fear of stigma for non-compliance. Attitudes are deeply traditional: families are male-run, with women relegated to secondary roles with little power, including the power to make choices about their reproductive health. Families with many children are seen as a sign of prestige and women feel encouraged to have children early and to have as many as possible. Religious leaders wield considerable influence in the camps and religious beliefs are conflated with social norms. The viewpoints they endorse regarding issues such as early marriage, family planning and gender-based violence both reflect and reinforce the overall conservative attitudes.

As is understandable with such a close-knit community, there is wide mistrust of the health providers of the camp, who are neither Muslim nor Somali. Outreach and awareness raising activities have succeeded in increasing refugee knowledge and raising awareness of reproductive health issues, however, that knowledge has not translated into significant behavior change in these areas.

Several programming implications resulting from the FGD findings have guided ESD's intervention activities. There is a need to work with the healthcare providers to strengthen both their technical expertise in reproductive health and GBV issues, and especially their cultural understanding of the Somalis, so that they may become more effective advocates for behavior change. Community mobilization is needed to raise awareness and dispel myths—particularly mobilization that focuses on males and youth. To take advantage of their positions of influence, religious leaders should be trained and educated on the health benefits of reproductive health services as well as issues such as early marriage and GBV, and this training should explicitly address evidence of support based on the teachings of Islam.

# 1. BACKGROUND

The Extending Service Delivery (ESD) project secured agreement and financial support from the USAID East Africa Mission in November 2006 to implement a one-year activity to strengthen efforts of United Nations (UN) implementing agencies. The objective of the ESD project was to contribute to improved reproductive health and family planning (RH/FP) and increase awareness about gender based violence (GBV) among refugees living in camps in Dadaab and Kakuma, Kenya. Prior to the project planning process, it was recognized that there was insufficient documentation regarding refugees' knowledge, attitudes, and practices in the areas of RH/FP and

GBV. In order to fill this gap and inform ensuing project activities, ESD, in conjunction with its local partner the National Council of Churches of Kenya (NCCK), conducted eight focus group discussions with target groups of special interest including male and female youth, adults, health workers, and religious leaders in the camps. This paper discusses key findings identified through these focus group discussions in Dadaab refugee camps pertaining to the areas of RH/FP/GBV.

Dadaab is a town situated in the northeast province (NEP) of Kenya, 80 kilometers from the Somali border. It is also the site of three refugee camps, Ifo, Dagahaley and Hagadera, opened in 1991 by the United Nations High Commission on Refugees (UNHCR), in collaboration with the government of Kenya, to provide protection and assistance to Somali nationals fleeing the effects of the government dissolution. Approximately 97% of the current 150,000 camp residents are ethnic Somali, living within an 18-kilometer radius of Dadaab town, spread over an area of 50 square kilometers. Islam is the dominant religion, and religious leaders are believed to have a strong influence over community members' attitudes and behaviors.

CARE is the overall manager of the camps in Dadaab and provides safety and protection services, including GBV counseling and community mobilization. GTZ is the lead organization implementing health services, with support from the NCCK. GTZ manages the comprehensive primary health care system with responsibility for services including nutrition, mental health, and sanitation and hygiene promotion as well as RH/FP. RH/FP services include prenatal, labor/delivery and postpartum care as well as STI diagnosis and treatment, Voluntary Counseling and Testing (VCT), FP counseling and method provision, GBV care and treatment (including emergency contraception and post-exposure prophylaxis) as well as information campaigns to inform women, men and adolescents of their family planning options. Safe Motherhood services are available that cover the major components of maternal health and newborn health including, antenatal care, care during labor, management of obstetric emergencies, newborn care and postpartum care. NCCK is responsible for RH/FP promotion activities; through its refugee motivators, the agency educates and mobilizes refugees on FP and preventative health measures to curb the spread of HIV/AIDS, STIs and GBV. They also inform communities through sensitization workshops and media campaigns on the benefits of breastfeeding, HIV/AIDS and STI information classes, informational movies, and referrals for HIV.

Health providers in the camps report that many residents lack a basic understanding of healthy practices related to RH/FP or preventative health care concepts (such as STI prevention, ante-natal care, immunizations) and that traditional cultural practices and beliefs are barriers to accessing care and accepting RH/FP services. Although RH/FP and GBV education and clinical/counseling services are available through the GTZ health facilities, NCCK and CARE outreach, the utilization is low. For example, July 2006 data from GTZ's IFO camp monthly service statistics indicate that of 144 live births, 59% of deliveries occurred at home, 41% occurred at any of 10 possible health facilities in Dadaab, and only 25% of these women came for any postpartum visits.

Service statistics indicate an overall contraceptive prevalence rate less than 1% in Dadaab, and a concomitant large number of pregnancies and births (since March of this year, 2,320 babies have been born). In this same period, GTZ and NCCK reported 9 maternal deaths all attributed to either delays in seeking care for obstructed labor (possibly due to infibulations) or families'

delaying/refusing to allow surgical interventions to save a woman's life during labor and delivery. It is said anecdotally that many postpartum women do not immediately breastfeed following delivery, nor do they exclusively breastfeed for at least six months, factors which contribute to high rates of infant malnutrition and closely spaced pregnancies.

**Study Objective**

At the start of the ESD Refugee Project, little current information was available on RH/FP/GBV related knowledge, attitudes and practices of the Dadaab camp population, particularly for target sub-groups of interest. ESD proposed to conduct Focus Group Discussions (FGD) with selected groups of residents including male and female youth (14-25 years), health workers, religious leaders, as well as adult male and adult female members of the camp community. It was hoped that the information gleaned would provide insight into community strengths and challenges associated with improving RH/FP and ameliorating GBV, and suggest more effective approaches to reach camp residents with information including the introduction of Healthy Timing and Spacing of Pregnancies (HTSP). As the limited scope and funding of the proposed ESD intervention did not warrant a full household survey for baseline purposes, the FGD's were also intended to generate as much specific information as possible from which to assess the existing situation prior to project initiation, and provide some basis for indicating changes due to the project. The specific objective of the FGDs was to identify community knowledge, attitudes, beliefs, perceptions, and behaviors in five focus areas of project activities including:

(I) Pregnancy care, labor and delivery;
(II) Postpartum care and breastfeeding;
(III) Child spacing and Family planning;
(IV) Sexually transmitted infections including HIV/AIDS; and
(V) Gender-based violence.

The report is organized into four sections: 1. BACKGROUND; 2. METHODOLOGY; 3. FINDINGS; 4. SUMMARY/CONCLUSIONS.

## 2. METHODOLOGY

The Focus Group Discussion Guide was developed by a team of ESD staff with experience in research and knowledge of the specific refugee context. After reviewing focus group discussion material with similar focus, a set of questions were constructed to cover the topics of interest, with attention to clarity of conceptual content, linguistic phrasing and order. The FGD Guide questions were developed to elicit key knowledge, attitudes and behaviors that might be anticipated to change as a result of proposed program activities. (See Appendix 1 for the FGD Guide questions.)

In preparation for the FGDs, 12 NCCK Somali refugee staff working in either RH or Peace Education programs attended a one-day FGD training workshop lead by ESD staff. This workshop oriented the NCCK refugee staff, several of whom had some prior FGD experience, to

the rationale and purposes, as well as the operational procedures essential to FGD facilitation and rules for transcription. As part of this process, the trainees also reviewed, translated into Somali, and back-translated the FGD Guide that contained all questions to be used across all groups. All of the focus groups discussions were subsequently conducted by teams of five, four trained NCCK staff, including two facilitators and two note-takers, and a supervisor.

A total of eight separate FGD sessions were conducted between December 6 and 8, 2006 covering six different types of discussant sub-groups as shown below in Table 1: adult males (2 groups) and adult females (2 groups); male youth; female youth; religious leaders; and health workers (1 group of mixed gender). All FGD participants were Somali residents living in the Hagadera camp in Dadaab[2] who volunteered for approximately two-hour focus group discussion sessions conducted in Somali. NCCK selected individual participants for each group to meet the criteria for age and sex, and/or occupation, forming a convenience sample. The methodological limitations of this study relate primarily to less than ideal member composition in some groups (described below), and mild weaknesses in session transcription related to language/translation. These limitations might have constrained the full range of information collected, but would not likely be a source or reason for introduction of false or misleading information.

**Table 1. FGD Sessions by Type and Number of Participants in Each Group**

| | Adults | | Youth | | Religious Leaders (All Male) | Health Workers (Mixed Sex) |
|---|---|---|---|---|---|---|
| | Males | Females | Males | Females | | |
| Group 1 | 7 | 4 | 7 | 8 | 4 | 5 |
| Group 2 | 7 | 8 | | | | |

***Socio-demographic characteristics of FGD groups***

A breakdown of key socio-demographic characteristics of the FGD groups is shown in Table 2. The two groups of adult males were much younger than the two groups of adult females—with mean ages of 23 and 37 years, respectively—because it was difficult to find older adult males willing to participate. In the female youth group, those who were married consistently dominated conversations, and the unmarried females spoke only if directly asked a question. According to the group facilitator (female) and translator, the unmarried women were too shy to talk about sexual issues in front of women who are viewed as "more experienced".

The group of four male religious leaders included one 'Sheikh' with significant Islamic religious education and authority who often expressed opinions at variance from the other three less educated clerics in this group. With these exceptions, the groups were relatively homogeneous and tended to express coincident opinions and ideas, although older, more experienced individuals often were more dominant in the discussions.

Additionally, it is important to add that the majority of participants were long time camp residents, with an average residence of all participants of ten years. However, one group of adult men contained five recent arrivals who had spent only 8 months in camp. The religious leaders

averaged 6 years in the camp, but the Sheikh mentioned above, had lived in the camp for 14 years.

Differences among groups in their levels of education reflect traditional social/cultural practices and attitudes, especially towards girls' education, lack of accessibility to education in the past, and changes that have occurred since the refugees have been living in the camps. Only 25% of the adult women had any schooling, while 100% of adult men had completed some education (but this finding is confounded with the large age difference). However, an educational discrepancy between males and females youth still is found even though all have access to free primary and secondary education in the camps. Seventy-five percent of female youth compared to 86% of male youth reported that they had attended primary school. All of the health workers had attended some schooling, while only half of religious leaders had any education.

The influence of traditional gender roles for men and women is reflected in marital status and number of children. All adult women are, or have been married, and with one exception, all have children. By contrast, only 21% of the adult men have been married but they are a much younger group. Although men in the community do not tend to marry young, women do. Fifty percent of the female youth (average age 22) were married at the time of the discussions, while none of the male youth had ever been married. This earlier age for female marriage was also identified among the health workers and religious leaders where the younger male participants were not married, but the younger females (health workers) were (these differences are not shown in Table 2). Also interesting is that among the female participants with children (n=16), one had never been married (6%), five were divorced (31%) and four were widowed (25%) for a total of 62% that were running female-headed households.

**Table 2: Socio-demographic Characteristics of the Six Types of FGD Groups**

| | Adult Males 2 groups (n=14) | Adult Females (n=12) | Male Youth (n=7) | Female Youth (n=8) | Health Workers (n=5) | Religious Leaders (n=4) |
|---|---|---|---|---|---|---|
| **Mean Age (Yrs.)** | 23 | 37 | 18 | 22 | 36 | 27 |
| **Mean No. of Yrs. in Camp** | 5 | 11 | 11 | 13 | 14 | 6 |
| **Education (%):** | | | | | | |
| **No schooling** | 0 | 75 | 0 | 12 | 0 | 0 |
| **Primary** | 64 | 8 | 86 | 75 | 60 | 0 |
| **Secondary** | 29 | 8 | 14 | 12 | 40 | 50 |
| **University** | 7 | 8 | 0 | 0 | 0 | 0 |
| **Marital Status (%):** | | | | | | |
| **Married** | 29 | 33 | 0 | 50 | 40 | 20 |
| **Single** | 71 | 0 | 100 | 50 | 60 | 60 |
| **Widowed** | 0 | 33 | 0 | 0 | 0 | 0 |
| **Divorced** | 0 | 33 | 0 | 0 | 0 | 0 |
| **No. of Living Children (%):** | | | | | | |
| **0** | 79 | 8 | 100 | 63 | 40 | 75 |
| **1** | 0 | 8 | 0 | 0 | 20 | 0 |
| **2** | 14 | 0 | 0 | 13 | 0 | 25 |
| **3** | 7 | 25 | 0 | 0 | 0 | 0 |
| **More than 3** | 0 | 58 | 0 | 24 | 40 | 0 |

The FINDINGS section of this report presents group members' responses to each of the FGD guide questions, organized by the five main topical areas presented above. For purposes of presentation, responses for each conceptual question are aggregated for all eight groups and the synthesized findings presented, described and summarized. In cases where a question asks for a numerical or countable response, Tables show how frequently the different responses were offered, in an effort to provide a sense of the range, and attitudinal sameness/differences across the groups. Frequencies of each response per group are indicated by the number adjacent to the response. The absence of a number means that a single verbal response was recorded in the transcript. However, it also often happened that more group members agreed (through head nodding or other body language) but did not speak.

Some interpretive commentary has also been included in order to clarify or add meaningful context to the reported responses. This approach to reporting the findings is designed to provide the reader the essence of the findings in a manageable format.

## 3. FINDINGS

### *I. Pregnancy, Labor and Delivery*

**Question 1: How old should a woman be when she has her first child?**

**Table 3. Responses to Question 1**
*(Showing range of answers and approximate average for each group.)*

| | Adult | | Youth | | Religious Leaders (All Male) | Health Workers (Mixed Sex) |
|---|---|---|---|---|---|---|
| | Men | Women | Male | Female | | |
| Range of Responses (Yrs.) | 15-25 | 15-20 | 15-20 | 14-20 | 13-17 | 16-20 |
| Average Age (Yrs.) | ~19 | ~17 | ~18 | ~16 | ~15 | ~18 |

The majority of respondents said that the optimal age for having a first child is between 15 and 20 years old, with female youth and religious leaders leaning toward younger ages. It was indicated that Somali tradition dictates that women are usually married by 18 years of age, and should become pregnant soon after. One adult woman respondent explained that the "Age at marriage is usually between 17 and 18 years, sometime 16 years, according to the Somali tradition". Some women may wait to become pregnant but many do not. A female youth respondent suggested that "God's will" is the determinant of age at first birth.

The responses for Question 1 appear to be associated with the level of education attained by the participants, with more highly educated participants identifying an older age of first pregnancy as preferable. The responses of adult men, male youth and health workers (who had more education) averaged at least 18 years, while the adult and adolescent females averaged 16.5 years. Among the religious leaders, the Sheikh explained that women should be at least 17 years old, while the other religious leaders stated that 13-14 years of age was appropriate for a first pregnancy. Health workers were the only group citing that age of first pregnancy has health implications for the mother and child.

**Question 2: How many children should a woman/family have?**

**Table 4. Response to Question 2**

| | **Adult** | | **Youth** | | **Religious Leaders** | **Health Workers** |
|---|---|---|---|---|---|---|
| | **Men** | **Women** | **Male** | **Female** | | |
| **Range of Responses**<br>**(# of children)** | Range: 11-12 | Range: 4-11 | Range: 12-20 | Range: 2-15 | Range: 15-60 | Range: 12-22 |
| **Relevant Comments** | “As many children as possible”<br>“God will provide” | “Until menopause”<br>“God’s will” “Women’s role” | | “Number God gives”<br>Depends on economic situation | “Depends on Nature’s Plan”<br>Depends on woman’s health | |

The general consensus of respondents was that God determines the number of children that a woman has and that Somalis like to have as many children as possible. Adult men believed that a woman should have “as many children as possible” in her lifetime and felt that 11 to 12 children is a desirable number. Adult men explained that “Muslims don’t worry [about] the food and education of their baby” because God will provide for them.

The responses from adult women varied from 4 to 11 children, with several women explaining that the number of children should depend upon the health of the woman and the economic status of the family. Adult women agreed that it is a “woman’s role” to have children and that “women should have children until menopause”. Similarly to adult male respondents, women believed that “as Muslims, the number of children a woman has depends on God’s will”; and that “women don’t think about where the food will come from [because] God will provide.

One male youth responded that if a woman “is married young, she can have up to 20 children”, while the others agreed that women should have 11 to 12 children. The responses from female

youth varied from 2 to 15 children, with the young mothers supporting higher numbers of children. Similar to the adults, the male and female youth expressed that God determines the number of children. One respondent left it to “God’s will”.

The religious leaders also believed that the number of children a woman has in her lifetime is dependent upon God or “Nature’s Plan”. They explained that since Islam recommends polygamy, a male headed family is able to have “many, many children, 20, 30 even up to 60”. The Sheikh stated that both male and female “Somalis like more children” and that some women who are blessed can have 20 children.

Health workers provided an average response of 16 children per woman, although they also stated that health status and economic situation of the family should also affect the number of children that a family has. One female health worker stated that Somalis like children and that they are “influenced to have more children by the beauty of the ones they already have”.

**Question 3: Who decides how many children a woman should have? Re-stated as: Within the family, who decides how many children the family should have?**

**Table 5. Responses to Question 3** *(If no number is cited after the response, then all members of that group concurred.)*

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Female | | |
| Not discussed | Not discussed | | | Not discussed | |
| Couple | Couple | | Couple | Couple | Couple |
| Father (2) | | Father (3) | Father | Father | |
| Mother should agree (2) | Mother (1) | Mother (4) | | | |

Adult men and women and religious leaders all expressed that that couples do not usually talk about how many children a woman (family) should have and that the number of children is determined by God. All groups also agreed that men (fathers/husbands) are the “heads of household” and per Somali tradition and Islam, they are the decision makers for the family. Answers from adult men varied from the “father decides how many children a woman should have” to the “mother should agree” and “she has the power to make the decision”. Adult women tended to cite that both parents should be decision makers. One adult women respondent did cite the mother “because [she] is the mother”.

Male youth recognized that women have “power” to make the decision about number of children, yet they contradicted themselves by also citing that according to Somali tradition, the wife must obey her husband’s decision on such issues. Although several people in different groups stated that men and women “should plan together”, in the end acknowledged that

traditional social norms prevail since men are the “heads of households” and will make the final decision. The Sheikh stated that it is not traditional for men and women to discuss the number of children they want to have, but leave it up to God. He stated that if the couple were to discuss the issue, it would be good if they “decided together”. However, the husband will be the final authority. Health workers responses also reflected social norms stating that while the “two partners can discuss and agree and decide what they can have”, the husband will have more influence in the decision-making.

**Question 4: What are some reasons that women here die/or get very sick during pregnancy and delivery?**

The answers obtained from the various groups of respondents were all very similar. The most frequently mentioned reasons for women dying or getting sick during pregnancy and delivery included malnutrition, anemia, bleeding, health effects of frequent deliveries, caesarian sections, hypertension, not getting to the hospital on time, and blood pressure. Other problems cited were malaria, morning sickness, effects of FGM, lack of transport to the hospital, poverty and lack of care.

**Question 5: Where do women get health care when they are pregnant or in labor?**

Two main responses were obtained from the FGD groups who agreed that while many women attend antenatal care, most do not deliver at health facilities. The respondents stated that women generally attend antenatal care only late in the pregnancy when they will be able to obtain additional food rations. They explained that women prefer to labor and deliver at home where they are assisted by Traditional Birth Attendants or family and friends.

Almost all women who receive services receive them from the UNHCR supported health facilities: GTZ managed hospitals; clinics; or health posts. The Sheikhh stated that some few women receive treatment from private pharmacies within the camp or in Dadaab town.

**Question 6: If women go to the health facilities, what type of services do they go for?**

Again, there were no significant differences in answers across groups. Respondents indicated that women travel to health facilities for general check-ups and services to help the baby such as “to know their HIV status”, “condition of the fetus”, “child movement”, “blood test”, “to know their weight”. A few respondents indicated that women traveled to the facilities to obtain “Ferro tablets”, “immunization”, “testing” and “counseling”. Lastly several respondents mentioned that women seek health care services in order to obtain supplemental rations, porridge or other nutritional foods.

**Question 7: If they do not go to the health facilities, why not?**

**Table 6. Responses to Question 7** *(Responses were similar across all groups)*

| Response | Number with Similar Responses |
|---|---|
| Do not know about the health services/lack of education | 10 |
| Negative myths and mistrust of health care services | 7 |
| Lack of means of transportation | 1 |
| Frequent stock outs | 1 |

Respondent groups did not express many different opinions on this topic. Not knowing how the health services can be of help, was the primary reason cited for women not seeking care from the camp health facilities. Respondents stated that "they do not know about it"; "they don't know about the services"; "they are ignorant about health care"; "lack of enough knowledge"; and a "lack of education" with regard to the benefits of receiving health care services. A few respondents also mentioned that new arrivals to the camp would be less likely to seek services because they do not know about them.

Another major response was that women do not seek health services because of strong concerns about "bad" drugs or providers, and that they prefer to use traditional providers and traditional methods. A number of responses make it clear that that myths and misconceptions about the health care services and providers abound, supporting the widespread distrust among refugees for UNHCR health services. Many respondents mentioned that women are afraid of "forced FP use" and are "suspicious of [FP] drugs they will get"; and that they suspect they will be "given abortion drugs"; or that "they will be issued the wrong drug".

One religious leader cited the lack of transport to health care facilities as a barrier for women to seek health care. An adult women indicated frequent stock outs as a reason for not seeking care, "many times there is a shortage of drugs" and a female youth mentioned that women who are pregnant out of wedlock are afraid to be seen in public, so do not visit the health facilities.

**Question 8: What does the community think about health care during pregnancy and labor?**

In contrast with the statements for the Question 7, many respondents stated that the community views health services for women during pregnancy and delivery as important and beneficial. While this appears to directly contradict the prior answers to 7, it might be understood as demonstrating a disconnect between 'abstract knowledge' and individual practice. That is, to acknowledge that these health services are helpful to the community as a whole does not necessarily mean that an individual in that community will want to make use of that "help".

Further, answers to this question seem to focus primarily on the value of labor and delivery services, especially "emergency delivery" services, rather than to antenatal care services (see 'waste of time' comment below).

One adult male said that the "Community is happy about the services", and male youth expressed that the services "save lives". The Sheikh stated that the services are "essential" and that the caesarian services are especially important for saving women's lives. Adult females stated that "the process of delivery is easy at the health care [facility]"; and '[it helps] avoid bleeding and death of the mother". Health workers mentioned that the community likes the services and that they are viewed positively by pregnant women.

Some female adults and youth stated that some women do not seek pregnancy and delivery services because they "prefer to deliver at home" and "fear transmission of HIV/AIDS" Also, they feel that the antenatal care is a "waste of time" as well as the problem that there are too many male health providers and women are not comfortable with them. Women's aversion to exposure to male health providers is an underlying theme throughout the FGD's.

**Question 9: Have the community's ideas about health care during pregnancy and labor changed since they came to the camp?**

Corroborating earlier statements, respondents indicated they did not think that much has changed with regard to preference for delivery site. It was reiterated that most women still wish (and are encouraged) to deliver at home rather than in a health facility. An adult woman said that "women are brought to the hospital just when they are in labor"- referring to the practice that women are not brought to health facilities for deliveries until the last possible minute or only when there is a complication. The Sheikh stated that only "some few of them changed those behaviors, particularly during their first child birth".

Respondents agreed that women and men now better understand the importance of antenatal care (ANC) and are more likely to seek ANC services. An adult male explained that "now they go to the health care from pregnancy to delivery date". Respondents generated several reasons for increases in care seeking behaviors during pregnancy and labor among community members. These include:

- Easier Access/Costs ("There are changes because those who could not afford before got [services] now and are happy with these services");
- An increased awareness about the importance and availability of ANC and delivery services ("Those who did have access got the chance to be treated"; "before [the] community was ignorant, now it understands better"; "before, people were nomads and now they understand the importance of health care [during delivery]";
- Camp policies that encourage use of health services such as the distribution of ration cards to mothers who deliver in a health facility ("The agency ordered that the newborn will not be included in ration card unless the mother seeks health attention during pregnancy until delivery"). Also, provision of nutritional food at the health facility also motivates women to

visit the health facility during pregnancy ("Now mothers not only go to the health facility for drugs but also for nutritional foods").

**Question 9: Who are people in the community that can help to promote safe motherhood?**

Respondents listed an array of actors to help promote safe motherhood in the camp including implementing agencies (GTZ, NCCK, MSF), facility-based and outreach health personnel (providers, midwives, community health workers, traditional birth attendants), community development workers, religious leaders, community leaders, NCCK block leaders, and husbands.

### *II. Postpartum Period and Breastfeeding*

**Question 10: Do many women get health care soon after they deliver their baby? Why or why not?**

The overall perception among respondents was that most women do not routinely seek postpartum care at a health facility, and will only obtain services if there is an illness or complications. They explained that women will seek care only in the event of infections, bleeding, to obtain pain killers or to get their infant immunized. An adult female stated that, "If the woman is not sick, she does not go". Male and female adult respondents explained that according to Somali culture a woman is confined during the 40 day period following a delivery.

Only the health worker FGD mentioned that many women do receive postpartum health services at home rather than in health facilities, explaining that outreach health workers visit postpartum women to check on the health status and of the mother and newborn and to provide some services and referrals when needed. An adult woman commented on the outreach health care services by saying that, "many women get care from TBAs because they cannot go to a health facility and even if they go to the health facility there are not enough providers to take care of all the women". Another mentioned that "at the hospital, mothers do not get the most needed drugs and nutrition".

**Question 11: If they (postpartum women) go to the health facilities, what type of services do they go for?**

Most respondents across groups mentioned that, if postpartum women sought health services it was mainly for breastfeeding counseling, immunization services, medicines and nutritional supplements. A few people mentioned that women may also seek family planning /child spacing services. Health workers explained that women visit the health facility in order to have their newborns registered and to continue receiving ration supplements or to get supplementary food for infants.

**Question 12: If they (postpartum women) do not go to the health facilities, why not? What are some of the traditional practices related to the post-partum period?**

**Table 7. Responses to Question 12**

| Response | Number With Similar Responses |
|---|---|
| Myths and fears around HIV/AIDS and FP | 9 |
| Do not know about the health services/lack of education | 6 |
| Limited mobility/having to care for many children | 2 |

All groups of respondents stated that women are impeded from accessing postpartum care services in the camp due to: myths and fears about diseases and health services, particularly HIV; lack of understanding of services; and limited mobility during the postpartum period. Adult women agreed that, "women are afraid that they will be forced to use an FP/CS method" and female youth mentioned that women are afraid of "getting HIV from needles" if they go for postpartum visits. The Sheikh stated that women are too busy with their newborn and other children to take time to visit the health facilities, and that "if they receive bad treatment one time they will not go back for another". One adult woman stated that some women, or their husbands or family members "get medicines they need from the local pharmacies so they don't need to go to the health center". Health workers explained that women do not like to get postpartum care at the health facilities because they do not consider it essential and they have to wait for along time in a crowded facility.

It was also mentioned that women have a "low level of awareness and education" about postpartum care and have limited mobility to health facilities due to traditional beliefs and domestic duties. In general, the respondents felt that women seek postpartum care only if they became sick, "Only those who are sick go for health".

**Question 13: What are some reasons that women here die/or get very sick soon after they deliver a baby?**

**Table 8. Responses to Question 13**

| Reasons Directly Related to Pregnancy | Reasons Indirectly Related to Pregnancy |
|---|---|
| Hemorrhage (5)<br>Anemia (3)<br>Retained placenta (2)<br>Tetanus<br>High blood pressure<br>Complications related to FGC/FGM<br>Complications after a C-section (2)<br>Infection<br>Deliver when weak<br>Pain or problems caused by episiotomy | Poverty/hunger (7)<br>Malaria (2)<br>Complications of HIV/AIDS<br>No drugs (2) |

The groups' responses to this question show a relatively high level of medical knowledge, but as shown in item 1, this knowledge does not seem to translate into individual care seeking practice for post partum women. Frequently cited reasons for illness/death were hemorrhage, high blood pressure, infection, malaria and anemia. The groups of male youth and health workers mentioned that FGC/FGM can result in problems. A male youth said that, "complications from FGM that can result in over bleeding and hence death". Adult men and women both stated that C-sections or complications after a C-section are a cause of death and illness. One adult female mentioned that "not attending health care" was a problem, and one health worker mentioned a "lack of health facilities".

Problems associated with poverty, such as hunger and malnutrition were frequently cited by all groups as reasons that women get sick or die after delivery, although this perception is likely not accurate for those who have been living in the camps any length of time. Since the food distributed in the camps is not traditional fare, some residents express this idea that their diet is not healthy.

**Question 14: What does the community think about health care for women soon after delivery?**

The perception of health care services provided to women during the postpartum period spanned the spectrum of positive to negative within and between the different groups. Many of the respondents perceived that the community was pleased with the health services available. An adult male said that, "They are happy with the assistance they get" and a religious leader stated that "It is welcome". The respondents all agreed that there is strong community support for immunization services. The health workers also noted that the community is "happy with the services and reduction of child death and illness".

However, a number of respondents also reported negative perceptions of the health care services available to women during the postpartum period. Adult women expressed their dissatisfaction stating that “women are not happy with the services”, “there are not enough services offered” and that the “care and attention are insufficient”. Several adult men and religious leaders expressed concern that the health services were used to promote Christian beliefs. One adult male stated that, “[the community] believes that health organizations [are] only working for themselves, promoting Christianity”. Another said that “healthcare is a place where people promote their own interest, like missionaries”.

**Question 15: When do women begin to breastfeed?**

There were two main responses to this question: 1) women breastfeed within 30 minutes after delivery, and 2) they begin breastfeeding when the labor pain subsides (anywhere from 12 hours to 3 days post partum). Health workers and the Sheikh clarified that while women *should* begin breastfeeding immediately after delivery, many wait until the labor pain has diminished (within 12 hours postpartum). All groups explained that CARE has provided extensive breastfeeding information to camp residents, across schools and through religious settings.

**Question 16: When do women stop breastfeeding? Why?**

**Table 9. Responses to Question 16**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Female | | |
| After 2 yrs. (2) | After 2 yrs. (3) | After 2 years (2) | After 2 yrs. | After 2 yrs. | After 2 yrs. |
| | | | After 40 days | | |
| | | | After 3 months | | |
| 6 months, or when woman becomes pregnant | | | After 6 months | | |
| | When woman becomes pregnant (6) | When woman becomes pregnant | When woman becomes pregnant | When woman becomes pregnant | When woman becomes pregnant |
| | When woman becomes sick | | | | When woman becomes sick |
| | Concerned about breasts sagging and husbands taking another wife | | | | |
| | | Stop when child can walk | | | |

All respondents stated that as Muslims, the Somalis practice 2 years of breastfeeding as dictated by the Koran. However, all respondents also said that women stop breastfeeding when they become pregnant again which may be as early as 40 days postpartum. The Sheikh stated that all women should "breastfeed for two years as the Koran tells us, but they stop when they get pregnant—usually six months". An adult female mentioned that the community believes that if a woman breastfeeds a child while she is pregnant, "both the baby and unborn child will get sick". Another mentioned response was that a woman will stop breastfeeding if she becomes sick. Adult women agreed that many women in the community stop breastfeeding before the 2 years are finished because they were concerned about their breasts sagging, and their husbands looking for new wives.

**Question 17: When do women give other foods to their babies? Why?**

Overall, respondents from each group indicated that women begin to give other foods to their baby beginning at 6 months. Several women and a health worker also mentioned that women may give food as early as 3 or 4 months, especially if the woman cannot produce much milk. Respondents agreed that women begin giving other foods to their baby because they are concerned that breastfeeding is not enough to ensure proper growth. Adult men and religious leaders stated that after six months, "breast milk is not enough", although one female youth said that women may not give food until the child can walk (2 years old). The participants stated that cow's milk, vegetables, biscuits and supplements from the health facilities are given as foods to babies.

**Question 18: What are some benefits of breastfeeding?**

**Table 10. Breastfeeding Benefits Cited by Respondents, by Frequency of Responses**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Female | | |
| Builds child immunity/child grows stronger (4) | Builds child immunity/child grows stronger (3) | Builds child immunity/child grows stronger (3) | Builds child immunity/child grows stronger (3) | Builds child immunity/ child grows stronger (2) | Builds child immunity/ child grows stronger |
| Strengthens mother-child relationship (2) | Strengthens mother-child relationship (2) | | | Strengthens mother-child relationship | Strengthens mother-child relationship |
| Prevents pregnancy | Prevents pregnancy/no menses (4) | | | | |
| | Protects against breast cancer | Will get breast disease if they don't do it | Protects against breast disease | | Will get breast disease if they don't do it |
| | | Children are smarter and learn better | | | |
| | | | Women will have swollen breasts if they don't do it | | |
| | | Mother is "bringing up" child | | | |

Respondents across all groups were aware that there are benefits from breastfeeding to both the mother and child. The most frequently cited benefits of breastfeeding for the baby included protection against diseases, promotion of child growth and development of the mother-child bond. A male youth stated that babies who were breastfed were smarter. The main benefit of breastfeeding to women was identified as protection against breast disease. A female youth also mentioned that breastfeeding helps to prevent swollen breasts. Adult female respondents (and one adult male) offered that a benefit of breastfeeding is that it protects a woman from becoming pregnant.

**Question 19: Have you heard that exclusive breastfeeding is a way to prevent pregnancy?**

Except for male youth, the majority of respondents across all groups had heard that exclusive breastfeeding can help to prevent pregnancy. However, none of the respondents including health workers, were able to explain what other criteria are necessary to use breastfeeding as a FP/child spacing method, the criteria to practice Lactational Amenorrhea. An adult woman stated that "they believe they cannot get pregnant unless they have their period" and the Sheikh stated that, "when the child is breastfed pregnancy cannot take place". Health workers agreed that exclusive breastfeeding has reduced the pregnancy rates in the camp.

Although the respondents believe that breastfeeding helps to prevent pregnancy, they also noted that many women who are breastfeeding become pregnant. An adult woman said that, "We have seen situations where the mother become pregnant while breastfeeding" and a female youth said that, "I breastfed and it never protected against pregnancy".

**Question 20: What does the community think about exclusive breastfeeding?**

Almost all respondents stated that the community supports exclusive breastfeeding because they realize that is healthy for the mother and child. The participants indicated that the community understands the health benefits of breastfeeding for mother and child, but they were not as clear on the FP/child spacing benefits associated with it. A few adult women stated that some women understand that exclusive breastfeeding can be used as a family planning method but, as stated above, could not explain the criteria under which exclusive breastfeeding prevents pregnancy. Health workers said that since the community values children so highly, they are very happy with the health benefits of exclusive breastfeeding, "children are healthier and there are less deaths".

In contrast, a few respondents mentioned that some community members (generally older) believe that breast milk alone is "not enough" food for infants. Others think that breast milk is unhealthy and should not be given to children, "breast milk is like blood and should not be given to children".

**Question 21: Have the community's ideas about this changed since they came to the camp?**

There was consensus across all groups that since moving to the camp, many women had switched from bottle feeding (water and sugar) and providing other foods to breastfeeding. An adult male said that "All mothers breastfeed and the rate of malnutrition has extremely decreased". Adult females agreed that previously women would only breastfed for 3-4 months, but now they do it for longer and give healthy foods to babies. All respondents indicated that the community has learned about exclusive breastfeeding and the health benefits of breastfeeding from the CARE program and health workers while living in the camps. Health workers stated that due to supplemental feeding programs, more women are able to breastfeed their children longer and without providing other foods.

**Question 22: Who are people in the community that can help to promote exclusive breastfeeding?**

Respondents listed an array of actors to help promote exclusive breastfeeding in the camp including implementing agencies (GTZ, NCCK, CARE, and World Food Programme), health personnel (traditional birth attendants, community health workers), religious leaders and community leaders, NCCK block leaders, husbands and grandmothers.

## *III. Child Spacing and Family Planning*

**Question 23: Have you heard of child spacing? What have you heard about it?**

Nearly all respondents in each group stated that they had heard of, and were familiar with methods for child spacing and family planning (CS/FP). They also communicated negative attitudes towards CS/FP that permeated the entire the discussion in each group. Adult respondents were generally better informed with respect to types of CS/FP methods compared to youth. Male youth and female youth said that they had heard of CS/FP from school, community residents and from NCCK outreach workers. Male youth said that that CS/FP is a, "way to reduce poverty", while female youth said that CS/FP is a way to "prevent too many children". Religious leaders said that they knew of methods, but preferred not to elaborate on any except breastfeeding, since they stated that it is the only method that is acceptable for Muslims.

None of the respondents expressed positive attitudes towards any CS/FP method except breastfeeding which they believe is endorsed by Islam as a method for child spacing for two years. It was asserted that "drugs" or modern methods are not acceptable within the religion or culture. Respondents explained their dislike of CS/FP methods as originating from the Somali culture, and Muslim religious exhortation to have many children, while CS/FP methods inhibit large families. Adult men agreed that, "the dignity of the family depends upon having many

children" and that "the tribe (clan) will be defeated in battles if there are not enough men to fight".

Adult females viewed modern FP methods such as pills and injectables as "health procedures" and agreed that "we do not support family planning [health procedures] because religion [prevents us] from taking the pills or injections to stop reproduction". However, breastfeeding was supported as a child spacing tool that benefits the health of women and children and is acceptable per Islam and the community. Women said "children should be spaced properly for one to grow before the other is born" and "you should give space to your children to create chance for growth". A few adult females noted that child spacing is good for the couple and family, and the group agreed that "child spacing is important for the economy of the family". In contrast, adult men concluded that they are not concerned about the economic implications of large families because, "UNHCR will feed the children. We do not have to worry about this".

**Question 25: What child spacing methods do you know?**

**Table 11. Familiarity with Child Spacing Methods**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| **Males** | **Females** | **Males** | **Females** | | |
| Pills/tablets | Pill | Tablets | Tablets | | Pills |
| Injectables | Injectables | Injectables | Injectables | | Injectables |
| Condoms | Condoms | | | | Condoms |
| Breastfeeding/ exclusive breastfeeding | Breastfeeding/ exclusive breastfeeding | Breastfeeding | Breastfeeding | Breastfeeding for two years | Breastfeeding |
| Calendar method/ periodic abstinence day | Calendar method/ periodic abstinence day | Abstinence | | | Abstinence |
| Husband travels | Husband travels | Husband travels | | | Husband travels |
| Having two wives | | | | | Marrying many wives |
| | | | | Emergency Contraception | |
| | Sterilization | | | | |

Pills and injectables were identified as CS/FP methods by all respondents, except religious leaders, who did not want to discuss any CS/FP methods other than breastfeeding. Condoms were only mentioned by adult respondents and health workers, with the caveat that, although

condoms are available, "as Somalis, we do not see that as a benefit because we want to have many children".

Among natural methods, breastfeeding and exclusive breastfeeding, the calendar method and periodic abstinence were mentioned by many respondents, although answers pointed to some confusion about the correct use of these methods. One adult female stated that women should, "abstain from sex for seven days after last day of period" and another said that "not having sexual intercourse with her husband like $1^{st}$, $6^{th}$, and $9^{th}$ day" would prevent pregnancy while many other respondents said that "breastfeeding" would protect a woman from pregnancy.

Polygamy and partner separation for a prolonged period of time were also identified as ways to prevent pregnancy; with the explanation given that a woman will not have sex with anyone other than her husband, although he may have sex with other wives or other women while away from the family. Although abstinence was mentioned as a method of CS/FP in all groups except female youth, all agreed that most Somali men will not practice abstinence or periodic abstinence (related to fertility awareness based methods) because they are entitled to have sex with their wives when they choose.

**Question 26: What are some benefits of spacing children and births?**

**Table 12. Responses to Question 26**

| Adults | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Female | | |
| Mother has time to rest | Mother has time to rest/ ready for next pregnancy/ Mother healthy<br><br>No anemia | | Helps mother's health | Gives mothers time to relax | Mother has time to rest/Mother healthy<br><br>Reduces maternal mortality |
| Child grows well/healthy | Child grows well/fewer infections | Healthier children | Child grows well | | Child healthy |
| Other children grow healthy | Other children grow healthy | | | | |
| Strengthen relationship between mother and child | Mother more time with child | Children have better relationship with parents | | | |
| Allows longer breastfeeding period | Time to breastfeed | | | Refer to benefits of breastfeeding mentioned in PP period and BF section | |
| Beneficial to parents/family has more income | Beneficial to economy/ time to budget | Reduce poverty | | | Better for family income |

Respondents named a number of health and welfare benefits accruing to mothers and children from spacing births and children. Adult men and women and health workers also identified economic benefits to child spacing.

**Question 27: How many years apart should children/births be spaced?**

There was wide, general agreement that statements in the Koran recommended two years as the appropriate birth spacing interval. However, there were many differences among the interpretation of groups for actual behavioral practices. Adult females said that children should be at least 2 years apart, while adult males said that children should be only 2 years apart. Female youth said that children can be spaced 2-5 years apart while male youth added that children can even be spaced up to 10 years apart. Although religious leaders agreed that two years was required for child spacing; health workers explained that most women do not actually space for two years.

**Question 28: What does the community think about child spacing?**

Responses to this question reinforce findings reported earlier with respondents expressing a general negative attitude toward CS/FP on both personal and community levels. The majority of the participants reiterated that God determines the number of children in each family, and that is against Islam to use CS/FP methods (other than breastfeeding). An adult male stated that, "If God gives me many children, why would I restrict my children?" An adolescent female said that, "it is ok to have 15-16 children because it is part of our religion." Several people quoted a passage from the Koran that explains that God is responsible for providing for all children, "I am responsible for what everyone eats, let everyone produce". In one group of adult males there was a discussion about the "confusion" around CS/FP, what CS/FP is, and whether it is allowed or forbidden per Islam. Overall, they felt that although the Koran does not advocate directly for CS/FP, it promotes it by encouraging extended breastfeeding.

Somalis take pride in having many children and feel that producing many children (especially boys) is necessary for the survival of the clan. In this line of thinking, it was mentioned among the adult and adolescent male groups that family planning is a "western" idea that is promoted to decimate Africans and Muslims. Participants also associated the number of children in a family with less poverty. One adult male explained that, "having more children will eradicate poverty. If you have no children you are poor". An adult female said that, "having more children leads to a better life (for the family) because there is more possibility for income and wealth".

It was discussed that even if families want to practice CS/FP (especially for limiting), most are not brave enough to face the social stigma that results from having fewer children or going against cultural norms. It was agreed that a primary role of women in the community is to have children. One religious leader said that "women should have as many children as they can before they dry up, because that is what God wills." An adult male reported that "families with smaller number of children are shunned by the community". Adult female participants agreed that women who do not have children or only have a few children are looked down upon by other

women. An adult female stated that, “they are called bad names” and “abused for having only one or two babies”.

**Question 29: Have the community’s ideas about this changed since they came to the camp?**

The majority of respondents indicated that community members were more aware of and better informed about the benefits of child spacing and family planning methods than they were prior to their moving to the camp. The increase in awareness was attributed to the educational activities carried out by NGOs. Many respondents stated that child spacing, using breastfeeding as a means to space pregnancies, is more common now. The Sheikh stated that, “now mothers breastfeed to prevent pregnancy”.

Adult male participants expressed that that the health situation for women and children has improved greatly since coming to the camps due to UNHCR’s support for health services and the practice of child spacing. They also cited how more secure and abundant food, good health and education services have inspired the community to have more children. In contrast, health workers said they believe that increased child spacing through breastfeeding has reduced the pregnancy rates in the camp.

Again, illustrating the gap between knowledge and practice, almost all participants (with the exclusion of health workers) stated that although the community is more aware of FP methods, their increased awareness has had little impact on use of modern FP methods.

**Question 30: Are child spacing services available in your community? Where (who) can you go for child spacing information and services?**

All respondents were able to identify sources from which FP methods could be obtained; GTZ health facilities and from NCCK outreach workers. Adult males explained that condoms can be easily accessed through health facilities, health outreach workers or at many of the shops within the markets.

**Question 31: Do many people in this community practice child spacing? Why or why not?**

Answers to this were noted above. Health workers added that only women seek CS/FP information. Those few who do accept a modern method use oral contraceptives because they do not like the side effects of the injectables method. Health workers also stated that they occasionally provide special CS/FP counseling to the husbands of women who have serious health conditions for which pregnancy would create a health risk, such as HIV, diabetes or heart problems.

**Question 32: Who decides whether a woman (or man) will practice child spacing?**

The majority of respondents indicated that while most couples do not discuss CS/FP, the father is the primary decision maker on all issues, including deciding whether or not to practice child spacing. Adult females agreed that "the mother can propose ideas, but the father will decide". Male youth said that, "the father is the decision-maker. The mother is the victim". Adult men explained that women cannot effectively practice natural or fertility awareness based on periodic abstinence, since the man decides when the couple will have sexual relations. Somali men believe they are entitled to demand sex from their wives and will not practice abstinence. The religious leaders and male youth explained that the Somali culture views men as the head of household because Islam dictates that men have the final say. One male youth stated that, "according to our religion the father is leader of the family".

Although all groups acknowledged that the father will be the one to make the final decision regarding CS/FP, the health workers and adolescent females suggested that it is better if couples discuss the issue and come to an agreement.

**Question 33: What is your religion's view on child spacing? Is it supportive of family planning?**

The responses here repeat the ideas voiced earlier. Respondents stated that Islam promotes fertility and condemns modern CS/FP methods, though it supports extended breastfeeding. An adult female stated that, "the prophet said that we should produce many children" and a religious leader said that, "Islam requires us to have many wives and many children". An adult male explained that, "Islam forbids modern methods (pills, injections) but allows exclusive breastfeeding". A minority of female respondents and health workers refuted the claim that Islam forbids modern methods. One adult female said that, "pills and injectables are ok" and a female youth said that CS/FP is a "personal decision" for couples to make. The health workers felt that although Islam praises the use of CS, and does not forbid CS/FP methods, the community does not understand this and so will not practice CS/FP. They also explained that FP/CS is only acceptable for married people and should not be promoted among youth or unmarried women.

**Question 34: Has the sheikh/imam or community leader ever mentioned child spacing?**

Several adult and youth males stated that, "the religious leaders do not talk about that [CS/FP]", while other respondents mentioned that if religious leaders did speak about CS/FP, it was always in a negative way. An adult female said "they condemn the practice of child spacing and family planning". A male youth said that some religious leaders actively promote against CS/FP programs during their sermons at the mosque, the madrassas (Islamic schools) or through community outreach (using megaphones and marches).

**Question 35: Who are people in the community that can help to promote child spacing?**

Respondents listed an array of actors that can help promote child spacing in the camp including implementing agencies (GTZ, NCCK, CARE), health personnel (doctors, traditional birth attendants, community health workers), religious leaders and community leaders, teachers, fathers, and elders.

### *IV. Sexually Transmitted Infections (STIs) and HIV/AIDS*

The group of female youth took longer to discuss each section of questions and due to time constraints were unable to respond to the last two sections of the FGD guide questions reported below. The group composed of religious leaders completed only questions 1 and 2 in this section on STIs, primarily since they were uncomfortable and felt these questions were shameful topics for discussion. The religious leaders ended their session for Friday prayer after question 2, but did return the next day to respond to the final section on Gender-based Violence.

**Question 36: Have you heard of any sexually transmitted infections? Which ones have you heard of?**

**Table 14. Responses to Question 36**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Females did not participate | | |
| Gonorrhea (4) | Gonorrhea | Gonorrhea | | Gonorrhea | Gonorrhea |
| Syphilis (4) | Syphilis (2) | Syphilis | | | Syphilis |
| HIV/AIDS | HIV/AIDS (2) | HIV/AIDS | | HIV/AIDS | HIV/AIDS |
| Chlamydia (4) | | | | | |
| Chancroid | Chancroid (2) | | | | Chancroid |
| Herpes | Herpes | | | | Candidiasis |
| | Urinary track infection | | | | |

The groups of adult males and females, and health workers were able to identify many kinds of STIs, but male youth and religious leaders were less familiar. Gonorrhea and syphilis were most commonly mentioned STIs, as was HIV/AIDS.

**Question 37: Do you think that STIs and HIV are a problem in this community? Why or why not?**

**Table 15. Responses to Question 37, by Frequency of Response**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Females did not participate | | |
| Can cause death / kill | Can cause death | | | | Leads to death |
| | Causes sickness | Causes sickness | | | |
| Easily spread | Easily spread | Easily spread | | | |
| Population decreases | Population decreases | Population decreases | | | Population decreases |
| Infertility | Infertility | | | Many people complain about symptoms | |
| Create orphans | | Create orphans | | | |
| Affect children during delivery | | | | | Can be transmitted to children |
| | | | | Not enough drugs available for treatment of STIs | |
| | | | | Some people don't seek treatment because of some problems with care | |

All groups agreed that STIs are a significant problem in the community. HIV was identified as the most dangerous since "it causes death", as well as "the problems of partner transmission", "mother to child transmission", "not enough drugs for treatment", and it "creates orphans". Adults, including religious leaders and health workers recognized that STIs have consequences if not treated, and mentioned that infertility, sickness and long term symptoms can result. One adult male indicated that some STIs could be transmitted from mother to child during labor ("They can affect child during delivery").

All respondents expressed concern that that the Somali refugee population itself would decrease if STIs were left untreated. An adult male stated that, "Disease will spread among the community. Many people will be sick and the population will decrease". The Sheikh mentioned that while many people complain of STI symptoms, most do not seek treatment at health facilities because they believe that medications are not available and/or the health care service is not adequate. He said that, "some don't go because of problems with care". Health workers stated the most common STIs in Dadaab are syphilis and gonorrhea, and these are also the two most frequently cited by respondents in question 36. One health worker referred to infected people as "traumatized" when they have STIs because they are afraid of being stigmatized by the community. Due to "trauma", most do not talk about their condition with their partners or friends or seek treatment even when they know they should.

**Question 38: How do you think that STIs are spread from person to person? Do many people use condoms as a means of STI prevention?**

Most respondents were aware that STIs are transmitted through unprotected sex with an infected person. Many respondents also were aware that STIs can be transmitted through blood contact mentioning such avenues as blood transfusions, from mother to child during labor, and through contact with "un-sterilized instruments".

**Question 39: Who is most likely to get an STI/HIV?**

**Table 16. Responses to Question 39, by Frequency of Responses**

| Adult | | Youth | | Religious Leaders did not participate | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Females did not participate | | |
| Youth (3) | Youth | Youth | | | Youth |
| Commercial sex workers (3) | | | | | Commercial sex workers |
| Drivers (3) | | Drivers | | | Drivers |
| Police/guards (2) | | | | | Police |
| Someone who is promiscuous | Those who have sex with multiple partners<br><br>Anyone who is sexually active/ everybody (2) | Promiscuous people | | | |
| TBAs/CHWs | Those who seek care from traditional providers | | | | Traditional birth attendants |
| | Pregnant mothers | | | | |
| Anyone ignorant about how STI spread | | Ignorant ones | | | |

Respondents offered many different answers for who is most likely to get an STI, most commonly citing youth, drivers, commercial sex workers and/or promiscuous people. Adults and health workers thought that traditional birth attendants were at higher risk for contracting an STI due to their exposure to un-sterilized instruments and a lack of precautions against STIs when providing services. Male adults and health workers identified drivers and police as people at high risk for STIs. This reflects refugees' perceptions of the sexual behavior of men working in these professions. One adult male stated, "With power and money it is easier to get sex."

Adult females explained that anyone can get an STI if they are sexually active, and that "everybody" can get an STI, including "pregnant mothers". Male adults and youth stated that those who are ignorant of the infections, who do not know how or are unable to protect themselves, are at-risk.

**Question 40: Are STI and HIV services available in your community? Where (who) can you go for STI/ HIV information and services? What type of services do people receive? Do people access services with their sexual partners?**

Respondents mentioned that STI/HIV information and services were available from NCCK and GTZ health facilities, and VCT centers. They also indicated that people in the community seek STI/HIV information from community health workers, religious leaders, teachers, and parents. One adult man specified that youth are very interested in getting information about STI/HIV and said that "In the community young people especially are learning and are interested in activities and workshop".

Health workers also mentioned several important barriers to accessing care for STI services. They identified issues of clients' fear of lack of confidentiality, stigmatization from family and/or community members and modesty (that female clients will not consent to being seen by male health providers for STI concerns). They explained that since the health facilities do not offer much privacy, people waiting for services are able to overhear the conversations between the health provider and client, which can lead to the community stigmatizing the client. Health workers said that the fear of stigma is also a reason that there is very little partner communication (or seeking of treatment).

**Question 41: What does the community think about STIs and HIV?**

These answers mirrored earlier responses. Adult men and women and health workers mentioned that the community was concerned about the health consequences of having an STI/HIV and specifically that STI/HIV can result in infertility and sometime death. An adult male stated that, "they can cause permanent infertility" and a male youth said that, "they are deadly disease if not treated". Respondents across all groups also mentioned that having an STI is associated with great stigma. They explained that the community views having an STI as a "shameful" thing that is associated with being a "bad" person. It was stated that the community does not like to talk about STIs and views the people with them negatively because they [STIs] are associated with, "sex outside of marriage, which is against Islam".

**Question 42: Have the community's ideas about this changed since arriving at the camp?**

All groups indicated that community awareness of STIs had increased since coming to the camps, and credited the NCCK RH program with disseminating information. The male youth were very vocal on this topic. A male youth stated that, “now they believe that these diseases exist”. Previous to exposure to information in the camps, many people believed that STIs, especially HIV was a “western” disease that Muslims could not contract. They mentioned that people have learned a lot, that “the community understands that STIs should be treated early” and that STIs are spread through casual sex.

They also reported that behaviors have changed as a result of STI information that has been received. Adult men said that men have learned to use condoms and that, “people’s ideas changed because some members of the community use condoms”. Male youth said that people are more reluctant to have casual sex and have “stopped careless sex”, some people go to the VCT center to get tested for HIV, and that they seek treatment when learning about HIV and STIs. Male youth also mentioned that now some couples take an HIV test prior to getting married, which was not done before they came to the camps.

**Question 43: Who are people in the community that can help to educate about STIs/HIV?**

Respondents listed an array of actors to help educate about STIs/HIV in the camp including implementing agencies (GTZ, NCCK, CARE), health personnel (traditional birth attendants, community health workers), religious leaders and community leaders, NCCK block leaders, trained youth in particular through sports activities, and parents and teachers.

### *V. Gender-based Violence (GBV)*

**Question 44: What do you think are the different forms of violence against women?**

**Table 17. Responses to Question 44, by frequency of responses**

| Adult | | Youth | | Religious Leaders | Health Workers |
|---|---|---|---|---|---|
| Men | Women | Male | Females did not participate | | |
| Rape | Rape | Rape | | Rape | Rape |
| Wife battering/ beating | Wife beating | Husbands beating wives | | Beating | Wife battering |
| Female Genital Circumcision | FGC | FGC | | FGC | FGC |
| Early/forced marriage | Early/forced marriage | | | | Early/forced marriage |
| Girls not allowed to learn/ go to school/ denial of right to education | Deny girls education | Denial of girl education | | | |
| Torture | | Torture | | | Torture |
| Denial of rights | | Girls' rights denial | | | |
| Scarcity of women in workplace | | Employment inequality | | | |
| Forced work | | | | | |
| | | | | | Abusive language |
| | | | | | Gestures |
| | | | | | Sex bargaining |

Respondents easily provided examples of many different types of physical, sexual, emotional and economic gender-based violence. They explained that they had been educated and trained on gender-based violence many times by UNHCR, CARE and NCCK, and so were familiar with the idea and concepts. Respondents identified FGM, early marriage, wife beating and limited access to education for girls as forms of GBV, but acknowledged that those behaviors are still commonly practiced, and still accepted within the community. Rape was identified as a form of GBV by all respondents as a behavior that all condemned as against Islam and against Somali cultural norms. However, they exclude the concept of marital rape as GBV, since residents believe that Islam dictates that a husband always has the right to marital relations with his wife.

**Question 45: Are there any circumstances that make violence against women acceptable?**

The adult females uniformly agreed that there is no justification for violence against women or girls, but reported that there are many forms of GBV practiced against women in the camps. Health workers and religious leaders stated that GBV is counter to the principles of Islam, against Somali cultural values and also against the laws of Kenya, which are enforced within the refugee camps. Nonetheless, they also acknowledged that GBV is practiced within the camp,

despite the broad awareness of its illegality and violation of human rights. The Sheikh stated that, “although FGC has reduced, they still perform the clitorectomies”. He presented this as an improvement, a response to what the community has learned about GBV in the camps. Earlier, FGC practices involved complete external excision, while newer practices of infibulation entail excision of the clitoris only.

The adult male and male youth stated that GBV is “wrong”, but that there are times when it is justified (per culture and community expectations). Adult men said that GBV is, “against human rights”, but explained that men may beat their wives to “correct” them or to “teach them a lesson”. Some men who engage in violence against their wives do so because of, “poverty, fear and hopelessness”. Male youth stated that “when a woman does not accept all her husband’s commands” or if a woman refuses her husband (sexually) she may be beaten. One health worker stated that, “pregnant women are often victims” of abuse because they cannot fulfill their husband’s sexual desires.

Adult males also said that early marriage and forced marriage are practiced because of the social pressure to marry off daughters before they bring shame to the family. One adult male said that, “girls bring shame, so they should be married early”. Social pressure and fear of shame were cited as justification for FGC, stating that it is practiced in order to “keep the dignity of girls”. Females who are not circumcised are not considered “decent” women by the community.

**Question 46: Are GBV services available in your community? Where (who) can you go for GBV information and services?**

Respondents indicated that women are able to seek information and services related to GBV from the Kenyan police, UNHCR, CARE (GBV Program), NCCK, GTZ facilities, and from the anti-rape and anti FGC committees.

**Question 47: Do women who have experienced violence go for assistance? Why or why not?**

Respondents across groups indicated that a few women who experience rape report it to the police and seek health services, including counseling and emergency contraception. Alternately, there was also consensus that many women are hesitant to, and do not report rape or physical abuse or seek remedial health services for a variety of reasons. Adult males expressed that women are afraid to report rape or beatings to the police because they are not, “supportive” and do not help them take action against the perpetrator. Male youth said that many girls are, “not allowed to go” to report rapes or abuse by their families because the family is concerned about the stigma and problems that will result from community knowledge of the incident. They explained that GBV (especially domestic violence) is viewed as a very private problem within the Somali community and that some people feel that it is best handled by the clan. Adult males also said that clan leaders will deal with the, “conflicts between couples” and will discourage families from involving the police or UNHCR.

Religious leaders related two types of rape outcomes. The first, when an unmarried woman is raped and obtains emergency contraception to prevent an unwanted pregnancy, and the second when a married woman is raped by another man her husband “accepts” the child.

**Question 48: What does the community think about GBV?**

Respondents believe that most of the community condemns GBV. Adult women said that, “the community opposes this violence” and male youth said that it is a “very bad abuse of rights”. Adult men and male youth explained that Somali families believe that they can prevent GBV (perpetrators outside of the family) by keeping women and girls at home and away from the sources of violence. An adult male said that, “parents do not allow girls to go out because they are afraid of violence” and a male youth stated that, “the community believes that girls [need] to stay in their families [i.e. at home]”.

Adult males and male youth also expressed that while GBV is condemned by the majority, some men still believe in the “old” ways. These men view wife beating (domestic violence) as a way to control the behavior of a wife (or daughter) and thus protects the family honor. An adult male said that according to Somali traditional beliefs, “men beat their wives to show them love and to teach them how to behave”.

**Question 49: Have the community’s ideas about this changed since they came to the camp?**

All respondent groups indicated that there has been a significant change in the community’s attitudes and behavior toward women in respect to GBV since they moved to the camps. They stated that wife beating occurs less frequently and that people are more supportive of girls’ education. The attribution for this change however, differed by group. Adult males and male youth respondents thought that these changes have resulted from women’s empowerment and education. A male youth said that, “girls are taken to school and some of them are working for their families”, which has resulted in a change in their status in the community. Adult males agreed that because women are now able to better help their families and know their own rights, they are able to command more respect. One adult male said that, “women were previously punished and now that trend changed, there are few cases of wife beating”.

Religious leaders and adult females attributed the reduction in GBV, especially domestic violence, to the enforcement of laws (punishment) related to GBV. Adult females said that, “the community is much more aware…there is punishment” and “if the woman is mistreated, the law takes over”. The Sheikh stated that within the camps there is “more information, protection and punishment (for GBV)” while the other religious leaders agreed that, “there is government law in the camps”. One religious leader stated “Before men beat their wives aimlessly, now they know better”.

All respondents also indicated that they have received a great deal of information and education on Human Rights and GBV from UNHCR, CARE and NCCK. A male youth mentioned that the

NGOs have "changed the view of the community positively". Several respondents noted that the change in FGC/FGM practices resulted from the community's improved understanding of Islam's position on FGC and an increased awareness of the health risks associated with the practice. One adult male said that, "People learned that it [FGC/FGM] was very dangerous, bad for health. They learned [this] when they came here".

Respondents further identified some negative issues. Male youth discussed the problem of early (under age 18) and forced marriage. They said that many people in the community do not agree that early marriage is a form of GBV and that they support its practice because of tradition and culture. Families do not want to have unmarried girls living at home because they may bring shame to the family and are a "burden" to the family's economic situation. Adult males explained that traditional practices dictate that girls should be married off as soon as they are "ready" to bear children. They also said that some families prefer for marriages to be "arranged" with little or no involvement from the girl. They state that early marriage is a means to protect the dignity of the girl and to further the interests of the family/clan.

Adult males agreed that the older men who believe in the "old" ways have only stopped practicing GBV because they fear punishment from the traveling court that serves the camps. In fact, one adult male stated that he and others like him will revert back to the old ways, "when we go back to Somali and there is no law to prevent it". Several respondents asserted that some rapes reported in the camps were falsified so that women (and their families) would be given higher priority for resettlement to another country, a highly desired goal for most refugees. The Sheikh said that women "had relations with their husbands and then reported rapes to UNHCR". He explained that they would use the seminal fluids from sex with their husband as evidence that they had been raped.

**Question 50: Who are people in the community that can help to educate and prevent GBV?**

Respondents listed an array of actors to help educate the community about GBV and prevent GBV in the camp, including implementing agencies (NCCK, CARE), women's group, human rights advocacy groups, health personnel (community health workers, RH mobilizers), police, religious leaders and community leaders, clan members, parents especially fathers, youth, elders, and teachers. Religious leaders expressed a strong interest in being involved in this type of community work. The Sheikh said that helping the community to understand that GBV is wrong is an, "appropriate job for religious leaders" and something that they will feel comfortable addressing through their regular activities.

**Question 51: What are some of the things can be done to help stop violence against women?**

Respondents across all groups believed that implementing activities to raise awareness about GBV among community members including men could help reduce violence against women.

The Sheikh and several adult males discussed the importance of safety and security within camps, as a way to prevent GBV. They mentioned that the Firewood program and the increased security measures that have been implemented by UNHCR (extra lighting, closer water points, and more Kenyan police) have helped to reduce GBV and will continue to do so as long as the measures are in place. Adult respondents also voiced the need for more effective law enforcement to punish perpetrators of violence against women.

Many respondents mentioned increasing youth and particularly girls' access to school as a way to prevent GBV. Adult females agreed that, "parents should be convinced about the necessities of taking girls to schools like boys". They explained that educated girls will know their rights and they will be empowered, so that they can fight against GBV. Male youth agreed that, "parents should understand that girls and boys are the same [have the same value]".

Interestingly, two groups, adult men and health workers suggested the creation of income generating activities for divorced or widowed women as a mechanism to reduce GBV. One adult man also noted the relationship between *mirra* (local herbal stimulant) chewing and violence, and suggested that the sale and use of *mirra* be restricted.

## 4. SUMMARY AND CONCLUSIONS

Summarized below are the overarching themes and underlying attitudes woven throughout the FGD discussions. Some of these represent major challenges and have critical implications for managing and improving RH/FP and GBV activities in the Dadaab camps.

**Summary of Findings**

- **Clan, religious and familial pressure to conform to perceived social norms and values, especially having many children is powerful.** There is strong community adherence to traditional values supported through the power of clan leaders and peer pressure. Of particular importance is the prestige, dignity, good fortune and well-being associated with having large families with many children, while conversely, families with few children are shunned. Refugees voice their fear of social stigma and repercussions, from both within and without the family, as a consequence of deviating from acceptable social norms. Fears and repercussions articulated include "daughter or wife beating by husband", "nursing too long and having sagging breasts, so the husband takes another wife", "a women pregnant out of wedlock cannot venture outside the house even for prenatal care" and "FGC/FGM is a requirement for marriage".

- **Traditional Somali gender norms and gender dynamics are endorsed and entrenched in both sexes.** The cultural ethos puts men as heads of household, holding full power over its members. Rights and freedoms of women are highly circumscribed, including their ability to make or act on personal decisions regarding reproductive health, family planning, marriage or GBV. The main social role of women is to bear children, and a man is expected to control his family, including disciplining his wife is she misbehaves or refuses to have sex. Gender

norms that promote modesty preclude women from giving birth in health facilities for fear of exposing their bodies and being perceived as immodest.

- **There is a disconnection between knowledge and practice.** Living in the camps, residents have been exposed to many new ideas and have greatly increased awareness and factual knowledge about RH/FP and GBV due to greater opportunities through UNHCR and government of Kenya supported programs for schooling and outreach education. However, this knowledge has had only limited impact on health related practices or use of services. While people speak to the benefits of preventive care, facility delivery, STI treatment, GBV reporting and treatment, it appears to be on an abstract level, and superseded by behavior that conforms to more familiar, inculcated cultural norms. Prenatal care is viewed as a waste of time and postponed till late in the pregnancy, when it is sought only because it is required for additional rations. Similarly, postpartum care is valued only in relation to services received for the infant (and even most health care providers believed this). By cultural dictum, women are not allowed to leave the house for 40 days postpartum.

- **There is general distrust of health services and facility providers.** Despite increased community knowledge about many health subjects, negative attitudes and fears thrive in a climate of myths and misconceptions. Examples of reasons offered for why women are afraid to go to health centers include: being co-opted into receiving unwanted family planning methods; issued bad drugs or the wrong drug, or not being given a drug, or given abortifacient drugs; being accidentally infected with HIV by contaminated needles; and experiencing discomfort unveiling with a male provider. From a broader perspective, some residents fear that modern family planning methods are promoted by the Kenyan health service providers (who are Christian) to keep numbers of Somalis low. This is seen by some as an example of how "western hegemony" is attempting to reduce the size of the Muslim population everywhere.

- **The interpretation of Islam by religious leaders and the community is conservative.** Residents are highly influenced by their understanding of Islamic tenants and dictates of correct behavior, but this understanding is confounded with cultural attitudes and practices. The community conflates Islamic principles with tradition, and even religious leaders who are educated hold similar ideas and advocate for a very conservative approach to RH/FP and GBV. A widespread interpretation of Islam leads to passivity/abdicating responsibility for outcomes (e.g. God's will determines everything, God will provide.). Religious leaders support early marriage as a means to 'protect' families from vulnerability to social stigma.

- **Child spacing is acceptable if it results from breastfeeding.** While there is general acceptance of breastfeeding as a method of spacing, the details of what this entails are vague. Participants in all groups, except health workers, were not conversant on the difference between spacing and limiting (CS/FP methods), and what is entailed by exclusive breastfeeding.

**Programmatic Implications of Findings**

Findings from the Focus Group Discussions have informed the planning and content focus for ESD's intervention activities in the refugee camps. The ESD project activities outlined below, build on existing RH/FP and GBV program efforts and community strengths, to work effectively within the context of identified attitudes, beliefs and behaviors in the refugee community.

Training and Education of Health Providers and Leaders: One of the first project efforts has been to tailor a training curriculum for community health providers to build their knowledge on RH/FP and GBV, so they can become stronger advocates of these services. The trainings will also increase their sensitivity and capacity to understand the misconceptions and fears held by community people, for example, the importance of offering increased privacy to female clients and understanding modesty issues. Providers will be helped to work with client's rejection of antenatal and postpartum care, and given more information on how to present its advantages to women. This training will also capitalize on the community acceptance of breastfeeding and expand on this avenue for encouraging birth spacing.

Community Mobilization and Education: The ESD project also supports local partner NGO's to use community mobilization to dispel myths, raise awareness and further educate community members on these topics, in an effort to spread understanding and normalize care seeking behavior for RH/FP and GBV. More information will be shared on child spacing including Healthy Spacing and Timing of Pregnancy (HTSP), Lactational Amenorrhea Method (LAM) and other Family Planning methods as well as facts about the transmission, diagnosis and treatment of STIs and HIV/AIDS. Male community members are a special target audience, recognizing their seminal role in promoting the health seeking care of their family members.

Training and Education of Religious Leaders: There is strong evidence that Religious Leaders have enormous potential to influence the behaviors of their followers in the refugee camps. The ESD project trains local religious leaders in RH/FP and GBV, bringing in Islamic interpretations that support how these religious leaders have the responsibility and duty to advocate for healthier behaviors to improve the welfare of their followers.

Training and Education of Adolescent and Young Men: ESD has developed the HIM model (Healthy Images of Manhood) to use in ongoing training workshops to constructively engage young men to reevaluate their attitudes and behavior toward women. The goal of this training is to create a nexus of community champions for gender equity. These "role models" will support a reduction in GBV and encourage both women and men to engage in balanced interpersonal relationships and improved health seeking behaviors.

It is hoped and anticipated that ESD's selection of intervention activities, based on the information gained in the FGD exercise, will strengthen the knowledge, sensitivity and trust of the refugee community and especially motivate its health gatekeepers—health workers, Religious Leaders, husbands and male youth—to support increased access and quality care in the areas of RH/FP and GBV.