

**DETERMINANTS OF FAMILY PLANNING PRATICE AMONG ETHIOPIAN  
WOMEN REFUGEES LIVING IN KAKUMA CAMP, KENYA**

**BY  
WOINSHET TEGEGNE TESFAW  
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## APPROVAL

This dissertation has been submitted with our approval as the appointed supervisors.

Joseph K.Wang'ombe, B.A, M.A, Ph.D.

Professor, School of Public Health, UoN

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Faith M.Thuita, B.Ed,M.Sc, Ph.D.

Senior Lecturer, School of Public Health, UoN

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This dissertation has been submitted for examination with my approval as the Director,  
School of Public Health.

Mwanthi Mutuku Alexander, BSc, MSEH, Ph.D.

Director, School of Public Health, UoN

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## LIST OF ACRONYMS

<b>CDC:</b>	Centres for Disease Control and Prevention
<b>CMR:</b>	Child Mortality Rate
<b>EDHS:</b>	Ethiopia Demographic and Health Survey
<b>FGM:</b>	Female Genital Mutilation
<b>FP:</b>	Family planning
<b>HIV/AIDS:</b>	Human Immunodeficiency Virus /Acquired Immune deficiency Syndrome
<b>IDPs:</b>	Internally Displaced Persons
<b>IEC:</b>	Information, Education and Communication
<b>IMR:</b>	Infant Mortality Rate
<b>IRC:</b>	International Rescue Committee
<b>KAP:</b>	Knowledge, Attitude and Practice
<b>KDHS:</b>	Kenya Demographic and Health Survey
<b>MDG:</b>	Millennium Development Goals
<b>MMR:</b>	Maternal Mortality Ratio
<b>PRB:</b>	Population Reference Bureau
<b>SPSS:</b>	Statistical Package for the Social Sciences
<b>STI:</b>	Sexually Transmitted Infection
<b>TFR:</b>	Total Fertility Rate
<b>UDHS:</b>	Uganda Demographic and Health Survey
<b>UN:</b>	United Nations
<b>UNFPA:</b>	United Nations Population Fund
<b>UNHCR:</b>	United Nations High Commissioner for Refugees
<b>USCR:</b>	United States Committee for Refugees
<b>WHO:</b>	World Health Organization

## ABSTRACT

Family planning promotion is a unique intervention because of its potential benefits which include reduction of poverty, maternal and child mortality. Access to family planning methods is increasing from time to time. However, unwanted and unplanned pregnancy is still a worldwide problem accounting for 30% of total pregnancies (Choge, 2013). Evidence shows that most of the refugee women live in developing countries which are among the worst in maternal mortality rates y (Krause et al, 2000).

The main objective of this study was to establish determinants of contraceptive use among Ethiopian women refugees living in Kakuma camp. This research used a descriptive cross-sectional study design to examine factors affecting FP practice of Ethiopian refugee women residing in Kakuma camp who are in reproductive age (15-49 years).

Results of the study revealed that although most of the respondents had knowledge on family planning, two-thirds (66.8%) indicated that they were not using any form of contraceptive. The study also found that 56.2% of the respondents have not discussed about contraceptives with their spouses. The study further indicated that 49.9% of the respondents' use of contraceptives decisions was made by their husbands.

The chi-square test showed that current use of family planning is associated with age, marital status, number of children ever born, current place of residence and fear of side effects ( $p$  value  $< 0.05$ ). The study showed that education greatly influences family planning practices among the Ethiopian women refugees living in Kakuma refugee camp. While only one in every four uneducated women used contraceptives, two in every three women with university education use contraceptives.

The study revealed that family planning methods availability in general and availability of the needed methods in particular at the refugee camp health facility were associated with

current use of contraception ( $p < 0.05$ ). This shows that wide range of contraceptive choices and continuous availability of methods enhances high usage of contraceptives.

The study also indicated that women who discussed about family planning with their spouses are more likely to use contraceptives than who did not discuss (46.6% vs 25.9%) and higher contraceptive prevalence (53.1%) is observed among women whose husband's approve family planning as opposed to those who do not approve (24.0%). Thus, there is a significant association between these two proximate determinants.

The study concludes a positive correlation between knowledge, attitude, access and use of contraceptives. This research also identified the gaps and determinants of family planning use among Ethiopian women refugees and came up with appropriate recommendations. It is recommended that health institutions working in Kakuma refugee camp should have a wide range of contraceptive choices and stocks/supplies to meet the FP needs of the refugees on a continuous basis.

For the success of FP programs, male involvement is critical as they play an important role in the decision making process and use of contraceptives. Hence, programs targeting men in general and husbands and partners in particular need to be developed and implemented by Kakuma camp.

Finally, the study recommended that a comparative study be conducted among refugees of different nationalities in Kakuma camp to come up with a comprehensive strategy to improve FP use among refugees.

## DEFINITION OF TERMS

**Family Planning:** Family planning refers to supplies and services which enable individuals and couples to attain and plan for their desired number of children and the spacing and timing of births. Supplies include modern contraceptive methods, such as oral pills, injectable, IUDs, hormone-releasing implants, vaginal barrier methods and male and female condoms. Services include health care, counseling and information and education related to sexual and reproductive health (countdown 2015 Europe, factsheet, 2012).

**Refugee:** Someone who owing to a well-founded fear of being persecuted for reason of race, religion, nationality, membership of a particular group or political opinion, is outside the country of his nationality, and unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (UN, 1951 Article 2).

**Internally Displaced Persons:** Are people or groups of individuals who have been forced to leave their homes or places of habitual residence, who have not crossed international borders (Displaced & Persons, 2008).

**Asylum-seeker:** Are individuals whose applications for asylum or refugee status are pending a final decision (Displaced & Persons, 2008).

**Returnee:** Person who returns to their country or community when conditions permit; the UNHCR encourages voluntary repatriation as soon as conditions are safe and reintegration is viable (USAID, 2008).

**Stateless Individual:** A person who is not considered as a national by any state under the operation of its law (UNHCR, 1954 Article 1).

## CHAPTER ONE

### INTRODUCTION

High fertility rate is a major issue in many developing countries due to its long term effect on social and economic development. Deeply rooted traditional beliefs and values coupled with low level of development and low level of FP use are among the factors that lead to high fertility rate (Kumssa et al, 2013).

Africa which is the world's poorest continent will record the fastest population growth in the world between now and 2050 (PRB, 2013).

The president and chief executive officer of PRB, Wendy Baldwin says "Rapid population growth makes it difficult for economies to create enough jobs to lift large numbers of people out of poverty." Looking at population trends in Africa, the continent's population will grow from the current 1.1 billion people to 2.4 billion people by 2050 (PRB, 2013).

According to PRB (2013), the total fertility rate (TFR or average number of children per woman) worldwide is 2.5 while 4.4 in the poorest countries. TFRs range from as low as 1.2 children in Bosnia-Herzegovina to as high as 7.6 children in Niger. Currently the TFR of Kenyan women is 3.9 (KDHS, 2014).

Many pregnancies and childbearing makes women susceptible in the society to high maternal mortality and morbidity. For instance there are 1,800 and 1000 maternal deaths per 100,000 live births in Sierra Leone and Eritrea respectively (Krause, 2000). Thus, pregnancy can represent a serious health threat for refugee women.

Worldwide over 287,000 women die during pregnancy and delivery yearly. Of these deaths, 99% occur in developing countries. Sub-Saharan Africa accounts for 50% of these deaths while one-third occurs in south Asia (Care, 2013). Conflict and crisis exacerbate this situation. Of those 50 countries ranked lowest on global indicators of maternal and

child health, 30 of these countries have recently experienced armed conflict or host significant number of refugee population (Care, 2013). Among displaced populations around 4% of the total populations are expected to be pregnant (WRC, 2011).

Family planning promotion is a unique intervention because of its potential benefits, which includes reduction of poverty, maternal and child mortality among others. Although family planning methods accessibility and utilization is increasing, unplanned pregnancy is a global problem accounting for almost 30% of all pregnancies (Choge, 2013).

The use of FP methods have increased in the world in the last decades which has given couples the opportunity to limit or space their pregnancy which in turn has been instrumental in life saving (Smith et al, 2009). Abedin (2010) indicated that FP is not only about when to have children but also includes sex education, prevention and management of STIs and infertility as well as preconception counselling.

Thus, identifying and addressing family planning needs and practice of refugee communities requires emphasis. Therefore, this study examined determinants of family planning use among Ethiopian women refugees in Kakuma camp, Turkana County of Kenya.

### **1.1 Background Information**

Due to political, social and economic instability in many countries particularly in Africa, there are considerable numbers of refugees and IDPs worldwide. As of 2008, there were approximately 34.4 million people of concern worldwide composed of refugees, asylum seekers, internally displaced persons, returnees and stateless persons. It is also estimated that in Eastern Africa, some 6 million people of concern to UNHCR, including 1.8 million refugees and more than 3 million internally displaced persons (IDPs), require protection and assistance in the region (UNHCR, 2014).

These refugees are exposed to various health and socio-economic and cultural problems. These health related problems include rape, gender based violence with resulting unintended pregnancies and abortion (Robles et al, 2014).

A number of youth and adolescents are exposed to various reproductive health problems such as unwanted and unplanned pregnancy in refugee situations which affects their health and wellbeing (Okanlawon, 2010). It is recognized that living in refugee situations increases the vulnerability of young people to many sexual and reproductive health risks such as early sexual relation, having unprotected sex and gender based violence especially in the absence of cultural structures and systems (Okanlawon, 2010).

## **1.2. Kakuma Refugee Camp**

This camp located in North-Western Kenya in Turkana County has been hosting refugees from neighboring countries since 1992. The camp was established to accommodate refugees from Sudan but was later expanded and accommodates refugees from Somalia, Ethiopia, Democratic Republic of Congo, Rwanda, Burundi and Uganda (IOM, 2014).

The camp is divided into four parts: Kakuma I, which houses mixed nationalities such as the Ethiopians, Eritreans and Rwandese among others. Kakuma II has a predominantly Somali population while Kakuma III houses mixed nationalities and recently Kakuma IV which is an extension of Kakuma III to accommodate refugees from South Sudan (UNHCR, 2013).

Department for Refugee Affairs (DRA), manages the camp with UNHCR, assisted by other local and international based NGOs, who provide other humanitarian services to refugees and on a smaller scale, to the host Turkana community. IRC and National Council of Churches in Kenya (NCCCK) are among others who are directly involved in providing health care services. The refugees rely mainly on food rations provided by World Food

Program (WFP), while others venture into small scale trading within the camp to supplement their livelihood. Refugees live in semi- permanent shelters which are constructed by NCKK, while Lutheran World Federation (LWF) provides water from drilled bore holes which is pumped to various strategic locations within the camp (Kiura, 2012).

Kakuma refugee camp is in Arid and Semi- Arid environment, with diurnal temperatures ranging between 30 to 40 degrees, making it difficult for arable farming. Movement is also restricted and passes are required for refugees who wished to travel out of Kakuma's environs to any other part of the country (Kiura, 2012).

Family planning services are provided through the camp hospital and clinics. The methods available are limited to oral and injectable contraceptives and condoms. Intrauterine devices are also available in the camp hospital (UNHCR, 2001). UNHCR (2001) also acknowledges the services to respect the rights and traditions of refugees and comprehensive information options and access to FP services. Even though efforts are made by UNHCR and governmental and non-governmental organizations, FP use in the camp women remains low.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Refugee camp is a temporary settlement built to receive refugees undergoing forced migration due to natural disaster, persecution, conflict and human right violation (Wedekind, 2015). In refugee communities' family planning is less prioritized in relation to other lifesaving or immediate needs like food and shelter but it is indicated that women living in crisis environment need FP services. However, the services are not available to meet their demands. (McGinn, et al, 2011).

Wedekind (2015) emphasized that awareness, use and efficiency of family planning remains low in refugee camps. However, refugees in camp settings may have greater needs for family planning due to high rates of sexual violence than the surrounding area.

In a similar study it is indicated that, refugee health has become an issue of public health concern and family planning in relation to refugee health has only recently come in to the picture (Sandesara, 2010).

#### **2.2 Refugees and Family Planning**

A comprehensive multi-country baseline study was conducted by UNHCR and the Women's Refugee Commission, from May 2011 to August 2011 to asses FP knowledge, attitude, practice and level of services among refugees in selected refugee camps.

The findings of the assessment showed that the uptake of family planning methods was low in the refugee settings compared to the host community. Contraceptive prevalence rates for modern methods among refugee populations in each setting were found to be 5.1% in Ali Addeh, Djibouti; 6.8% in Eastleigh, Kenya; 14.6% in Nakivale refugee settlement, Uganda; 21.4% in Amman, Jordan; 34.2% in Kuala Lumpur, Malaysia and

36.9% in Cox's Bazar, Bangladesh. Despite availability of contraceptive services, overall women demonstrated limited awareness regarding the methods (UNHCR, 2011).

Abedin (2010) conducted a study on family planning in Oslo, Norway among South Asian immigrant women regarding their knowledge, attitude and practice. According to this study 58.6% of the respondents lack FP Knowledge while 41.4% of the respondents have average knowledge. The majority of the respondents (62.5%) source of family planning information were family members and friends while (33%) received sex education in the schools. Similarly 84.2% of the respondents indicated discussing FP with unmarried women is embarrassing in their society while FP methods use was 68.9% (Abedin, 2010).

In 1999, UNFPA conducted an evaluative study on reproductive health services among Somali refugees in Eastern Ethiopia. The study showed that FP services were neglected in favor of activities on eradication of FGM. The study recommended the recruitment and engagement of literate Somali speakers is critical in FP awareness raising and service delivery (UNFPA, 1999).

A study was also conducted in Tanzania refugee camp, Nyarugusu about men's involvement in family planning. Findings from 454 research participants showed that 35.2% of refugee men reported that they or their wives had never used family planning method while in the camp and condom use as a family planning method stood 4.4% among respondents. Out of these respondents, 83.3% said they would be upset if their wives were using family planning methods without their knowledge, and another 64.8 % were unwilling to accompany their wives to the family planning clinic. On the other hand, the research indicated that 71.4% of respondents would like to be more involved in family planning decision with their wives and 82.2% said that they saw benefits to men's

involvement in family planning. Regarding family planning knowledge, it is indicated that the majority had claimed to have heard about family planning from the main health dispensary and most were familiar with methods such as injections, pills and condoms (Sandesara, 2010).

Findings of a study conducted in Northwest Nigeria, Oru refugee camp on 208 refugee youth regarding their knowledge, perception, and attitudes towards contraceptive use revealed that 60% of the refugees have a challenge to access modern contraceptives as well as do not know source of contraceptive supplies closer to the camp (Okanlawon, 2010).

Another study was conducted in 2011 in Malaysia refugee camp to examine the extent to which Burmese refugees use family planning services in Kuala Lumpur. From this study they were able to know that most people were aware of family planning including the health benefits of the mother and economic benefit of raising fewer children but they do not know different methods. From the study, 42.2% of women of reproductive age were using contraceptive methods, the most commonly used methods were oral contraceptive pill, withdrawal and male condom (WRC, 2011).

A similar study was conducted in Western Uganda, Kyaka refugee camp on the factors influencing contraceptive use by refugee women. From the study the researcher indicated 91.9% of refugee women were aware of at least one modern FP methods but use of FP services was 18.2%. Injectables (51.1%) and condom (29.6%) were the most used contraceptive methods (Orach et al, 2007). The national contraceptive prevalence in 2006 was 24% (UDHS, 2006).

### **2.3 Barriers to Use Family Planning Methods**

In different studies several reasons were indicated for low utilization of FP services by refugees. In 2007, USAID 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, refugee camp, Kenya. 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.

The study highlighted male dominance in the family, low empowerment of women and related traditional attitudes influence women to have informed decisions on family planning. In the society, children are considered as a sign of prestige and women feel encouraged to have as many children as possible (Leader et al, 2008). One of the main reasons cited for not using modern contraceptive methods were misinformation as evidenced by 42.9% of the respondents (Okanlawon, 2010).

In different studies participants cited that fear of side effects like excessive bleeding, permanent infertility, unpredictable or irregular menstrual cycle, stomach-ache, and weight fluctuation as side effects which have scared off potential users (Sandesara, 2010; Orach et al, 2007; Kiura, 2012).

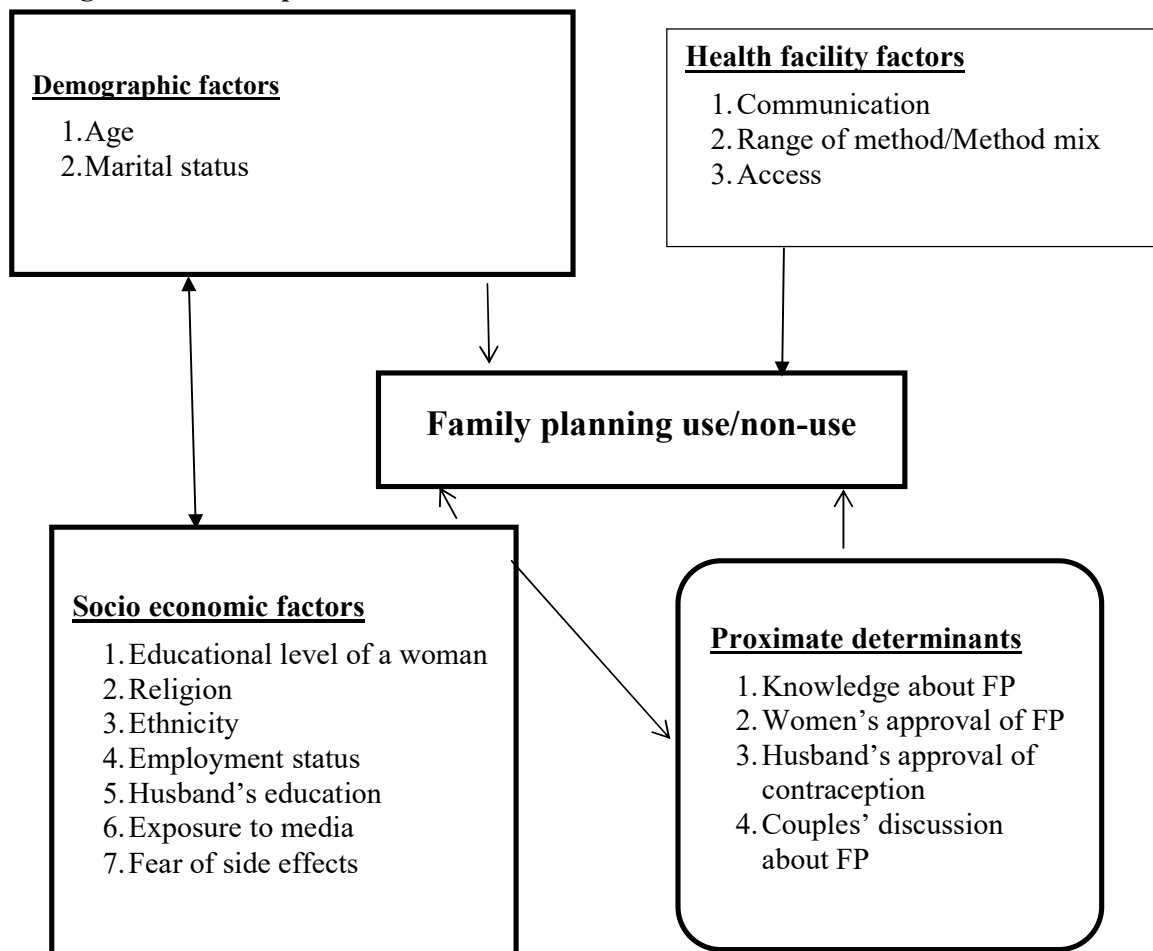
Lack of knowledge, low level of education, level of earnings, sex preference, limited option for privacy, lack of support of male partners, strong religious and cultural believes, opposition to use are indicated as the barriers to use family planning methods ( Orach et al, 2007; Sandesara, 2010; Kiura, 2012).

## 2.4 Conceptual Framework

The figure below shows the conceptual framework which depicts dependent and independent variables affecting family planning use among Ethiopian refugee women. The dependent variable for this study is FP use and the independent variables, which influence FP use of women, are divided in to four groups. Demographic and socio economic factors are the first and second variables respectively.

The third variables are health facility related factors and the fourth group of variables that influence the family planning practice of women are the proximate determinants (knowledge, attitude of women and approval of husband / partner about FP).

**Figure 2.1: Conceptual framework for FP use**



### **2.4.1 Narrative of the Conceptual Framework**

The socio economic and demographic factors that may affect family planning use include level of education of women and spouse, employment status, exposure to the media and fear of side effects. Women with low level of education tend to start giving birth at early age because the period they would have been in school will now be used for conception and deliveries (Agbo et al, 2013). Women who attain higher educational level are more likely to acquire knowledge of what/how to safeguard their own health than those who attain lower educational level.

The perceived fear of side effects result from using contraception and need for many children as a social security further hinder their family planning use (Okanlawon, 2010). Lack of male involvement and limited decision power by women also affect family planning use (Sandesara, 2010). Moreover, health service factors such as lack of FP supplies, lack of effective communication and limited range of method mix during health provider and client's contact influences FP use (Okanlawon, 2010).

Geographical access to health facilities (distance and cost of transport) has impact on use of contraceptive services. Proximate determinants such as lack of women and men knowledge about family planning, lack of open and free discussion about family planning affects their use of family planning method (Mekonnen, 2011).

### **2.5 Summary**

In summary, this chapter reviewed pertinent literature in relation to family planning practices and refugees. Although refugee camps hosts thousands of refugees from neighbouring countries and despite the recognized importance of family planning, no adequate research is done in the area of family planning and its practice among refugees.

There is a need to understand the reasons for use and non-use of contraceptives among refugees through research. This is especially true in Kakuma Refugee Camp which hosts refugees from eleven countries with limited literature except some studies on Somali women refugees. The researcher also found that a number of studies focused only on married couples, hence leaving a gap in family planning needs and practices among single women and adolescents. There is knowledge gap in family planning among refugees in general and Ethiopian women refugees in particular which is the focus of this study. This research will facilitate better interventions on contraceptives use to contribute to the improvement of refugee women's health.

## CHAPTER THREE

### STATEMENT OF THE PROBLEM

Kenya has seen a large-scale influx of refugees, mostly triggered by the protracted humanitarian crises in neighbouring countries. Currently Kenya hosts 625,250 refugees from neighbouring countries of South Sudan, Somalia, Ethiopia, Eretria and other countries. The Kakuma camp population was 147,612 women, men and children refugees. Out of these total refugees 7,458 are registered as Ethiopian refugees (UNHCR Fact Sheet, March 2014).

Over the last two decades, increased attention has been given to the necessities of reproductive health services in refugee settings. As a result, humanitarian and governmental organizations have made family planning programs available within refugee camps. However, despite these efforts women and girls suffer from unintended pregnancies and unsafe abortion in refugee settings (Abedin, 2010 and Robles et al, 2014).

The Director of UN women highlighted insecurity issues women and girls come across in Kenya refugee settlements which includes gender based violence in their homes and on the streets. Moreover, due to lack of shelter newly arrived refugees sleep on the open outside the camp which exposes them to other related risks (Xinhua, 2011). The Director further noted that due to their low level of education and restricted movement outside the camp, a number of women refugees are unemployed (Xinha, 2011).

In a variety of refugee settings, women become pregnant without their choice due to unavailability of contraceptives or limited methods. More over women also don't use available contraceptives due to culture or the thinking that those lost in conflict should be replaced (O'Heir, 2004).



As indicated by UNHCR, poor quality of information, negative attitude to women and girls, insufficient knowledge, loss of traditional information sources and the tendency to focus attention on immediate life-saving measures are cited as reasons for low use of family planning services in the Kakuma refugee camp (UNHCR, 2001).

Ethiopian women refugees who reside in Kakuma camp came from many different ethnic groups and educational level, with their own native language and culture. These and other related factors could be additional barriers to their contraceptive practice. Thus the research focused to determine factors associated with family planning practices of Ethiopian women refugees residing in Kakuma camp.

### **3.1 Rationale**

Family planning is one of the key development achievements of public health in the last decade. It has been instrumental in improving maternal and child health and in fertility decline as well as in breaking the poverty cycle. Today, 63 % of women use FP methods compared to 10% in the 1960's (Mane, 2011).

Leaders et al (2008) concluded that family planning is cost-effective interventions that has impact on maternal mortality in developing countries. Family planning among refugees is also an important in relation to achieving Millennium Development Goals (MDGs). Successive family planning initiatives have the potential to reduce maternal, infant and child mortality rates (Sandesara, 2010).

It has been proven that the economic burden in poor families can be reduced by having fewer, healthy children who can be cared for, educated, as opposed to having many children, where quality of life can be compromised. Smaller families allow for scarce resources such as food, housing and health to be better managed, and it allows couples to engage freely in income- generating activities (Leaders et al, 2008).

Bongaarts et.al (2011) indicated the health, human rights and poverty reduction benefits of FP and stressed the need to allocate resources to the program as part of the economic and human development agenda.

### **3.2 Significance of the Study**

This study aims to establish determinants of family planning use among Ethiopian women refugees living in Kakuma refugee camp. Results of this research will contribute to the development of appropriate planning and making of informed decisions by those concerned organizations and institutions in promoting family planning services and mitigating the observed difficulties faced by refugee women. This in turn enhances and improves the wellbeing of those living in the refugee setting. Furthermore this study will serve as a reference material for those scholars interested in the field of family planning programs and services especially in the refugee settings.

### **3.3 Objectives**

#### **3.3.1 General Objective**

The ultimate objective of this study was to establish determinants of contraceptive use among Ethiopian women refugees living in Kakuma camp, Kenya.

#### **3.3.2 Specific Objectives**

Specifically, the study was aiming at:

1. Determining prevalence of contraceptive use among Ethiopian women refugees.
2. Identifying socioeconomic and demographic factors influencing the use of family planning among Ethiopian women refugees.
3. Establishing the attitude of Ethiopian women refugees living in Kakuma camp towards use of various family planning methods.
4. Describing the knowledge of family planning among Ethiopian women refugees.

5. Determining access to FP services and availability of family planning method choice.

### **3.3.3 Research Questions**

1. Do Ethiopian women in Kakuma refugee camp practice family planning?
2. What are the factors that influence use of family planning among Ethiopian women refugees living in Kakuma refugee camp?
3. Does knowledge on FP influence use of FP among Ethiopian women refugees living in Kakuma refugee camp?
4. Does perception on FP influence use of FP among Ethiopian women refugees living in Kakuma refugee camp?

### **3.4 Research Hypotheses**

The following hypotheses were developed for this research.

1. Accessibility of family planning services is associated with high use of contraceptive methods
2. Availability of a good range of family planning methods increases use of contraceptives
3. Adequate knowledge among women about family planning is associated with high use of contraceptive methods.
4. Positive perception of women towards family planning increases use of contraceptive methods.

## **CHAPTER FOUR**

### **RESEARCH METHODOLOGY**

#### **4.1 Introduction**

This chapter discusses the research design and methods used to conduct the study. It further describes the population of the study, data collection methods, sampling techniques, sampling frame and methods employed for data analysis as well as ethical considerations.

The methodology used for this research was quantitative, which is designed to answer specific questions for the purpose of assessing factors influencing use of family planning methods among Ethiopian women refugee in the Kakuma refugee camp.

#### **4.2 Study Design**

This research used a descriptive cross sectional study design to examine factors affecting FP practice of Ethiopian women refugees residing in Kakuma camp.

The study focused on FP survey to gather information regarding practice, attitude, knowledge and interrelationship of variables through administration of structured questionnaire.

#### **4.3 Variables**

The variables for this research are divided in to two categories, the dependent and independent variables.

##### **4.3.1 Dependent Variable**

The variable which is dependent on other factors (independent variables) is family planning use.

### **4.3.2. Independent Variables**

Independent variables which are related to the dependent variables are divided in to four categories; demographic variables, socio economic variables, health facility variables and proximate determinants.

#### **4.3.2.1 Demographic Variables**

1. Age - age of the respondents
2. Marital status –married, unmarried, living together but not legally married, divorced, widowed

#### **4.3.2.2 Socio Economic Variables**

1. Educational level of a woman – primary, secondary, university, no education
2. Religion – Orthodox, Muslim, Protestant, Catholic, other
3. Ethnicity – Amhara, Oromo, Tigre, Sidama, other
4. Work status – employed, un employed, student
5. Husband’s education - primary, secondary, university, no education
6. Exposure to media – radio, TV, newspaper, literature, pamphlets, none of them

#### **4.3.2.3 Health Facility Variables**

1. Availability/supply – always available, sometimes available, not available
2. Lack of effective communication – have good communication, no communication
3. Range of methods/method mix – range of choice, limited choice, no choice
4. Access – geographical access

#### **4.3.2.4 Proximate Determinants**

- Knowledge about FP – no knowledge, has knowledge
- Women’s approval of FP – approve, disapprove
- Husband’s approval of contraception – approve, disapprove
- Couples’ discussion about FP – never, once or twice or more often

#### **4.4 Study Area**

The study area for this research was Kakuma Refugee Camp which is located in Turkana County of the north western region of Kenya, 120 kilometers from Lodwar District and 814 kms from Nairobi city.

Kakuma Refugee Camp is administered by the Department for Refugee Affairs and UNHCR serves refugees displaced from their home countries. The camp was established in 1992 for Sudanese refugees but over time it was expanded to accommodate other refugees from Somalia, Ethiopia, Burundi, Democratic Republic of Congo, Eritrea, Uganda and Rwanda.

#### **4.5 Study Population and Sampling Frame**

The target population for this research was Ethiopian refugee women residing in Kakuma camp who are in reproductive age (15-49 years). The sampling frame for this study was the households of Ethiopian women refugee in the reproductive age (15-49) in Kakuma refugee camp.

#### **4.6 Inclusion Criteria**

1. Ethiopian refugee women in the reproductive age (15- 49)
2. Ethiopian refugee women who live in Kakuma camp
3. Ethiopian refugee women registered by UNHCR Office
4. Ethiopian refugee women who will give consent

#### **4.7 Exclusion Criteria**

1. Refugee and non- refugee women who are not in the reproductive age (15-49)
2. Refugee women in the reproductive age (15-49) who are not Ethiopian
3. Ethiopian refugee women who are not registered in UNHCR Office
4. Ethiopian refugee women who did not give consent

## 4.8 Sampling Technique

### 4.8.1 Sample Size

Considering women in the reproductive age in the camp as the main attributes, sample size should have a minimal number of women to support good estimation of the parameters of the population. It is in this respect that the following Cochran's formula is used (Andrew et al, 1991).

$$n = \frac{Z^2 p q}{e^2} = \frac{(1.96)^2 (0.192) (1-0.192)}{(0.05)^2}$$

$$n = 238$$

**10% for the possible non-response rate**

$$\text{Hence, } n = 238 + 10\% (238) = 262$$

Where:

**n** is the desired sample size

**z** is the standard normal Deviation at the required confidence interval set at 95 % (1.96)

**p** is contraceptive prevalence rate of refugee at Kakuma camp (19.2%) (Choge, 2013)

**q** is the proportion of the target population estimated not to have the characteristics being measured ( $q = 1 - p$ ) (80.8%)

**e** is the level of precision set at 5% (0.05)

10% non-response rate was added

Hence, the estimated sample was 262 women of reproductive age.

### 4.8.2 Probability Sampling Method

The researcher used probability sampling, specifically systematic sampling technique.

With the list of women in the reproductive age bracket, the next step was to choose the specific women to be included in the study. The following steps were followed:

1. Total number of Ethiopian refugees' living in Kakuma camp (UNHCR, Sept,2015) 8,000
2. Average family size of Ethiopian refugee family in Kakuma is 5, then to estimate the total number of Ethiopian refugee women in the reproductive age (15-49) ,  $8000/5= 1600$
3. Target population (N) = 1600
4. Sample size (using Cochran's formula)  $n=262$
5. A Sampling Interval (i) was determined. This was done by dividing the total number of Ethiopian women in the refugee camp by the sample size:

$$i = \frac{N}{n} \quad (1600/262)$$

Where: i =sampling interval (6)

N = number of Ethiopian women refugee in the refugee camp (1600)

Hence the sampling frame for this study was households of Ethiopian women refugees in the reproductive age (15-49) in Kakuma refugee camp.

n = sample size (262)

6. The starting point K was selected randomly by lottery method between the number 1 and i (the sample interval). Note that K which in this case was 4 became the first woman to be chosen.
7. Then select successive women for inclusion in the sample by moving at the interval  $K+i$ ;  $K+2i$ ;  $K+3i$ ;  $K+4i$ ;  $K+5i$ ; etc until the required sample size reaches (GPRAHIC,2014)
8. During data collection process where more than one woman in the reproductive age (15-49) were found in a house hold, the data collectors applied lottery method to choose among them.



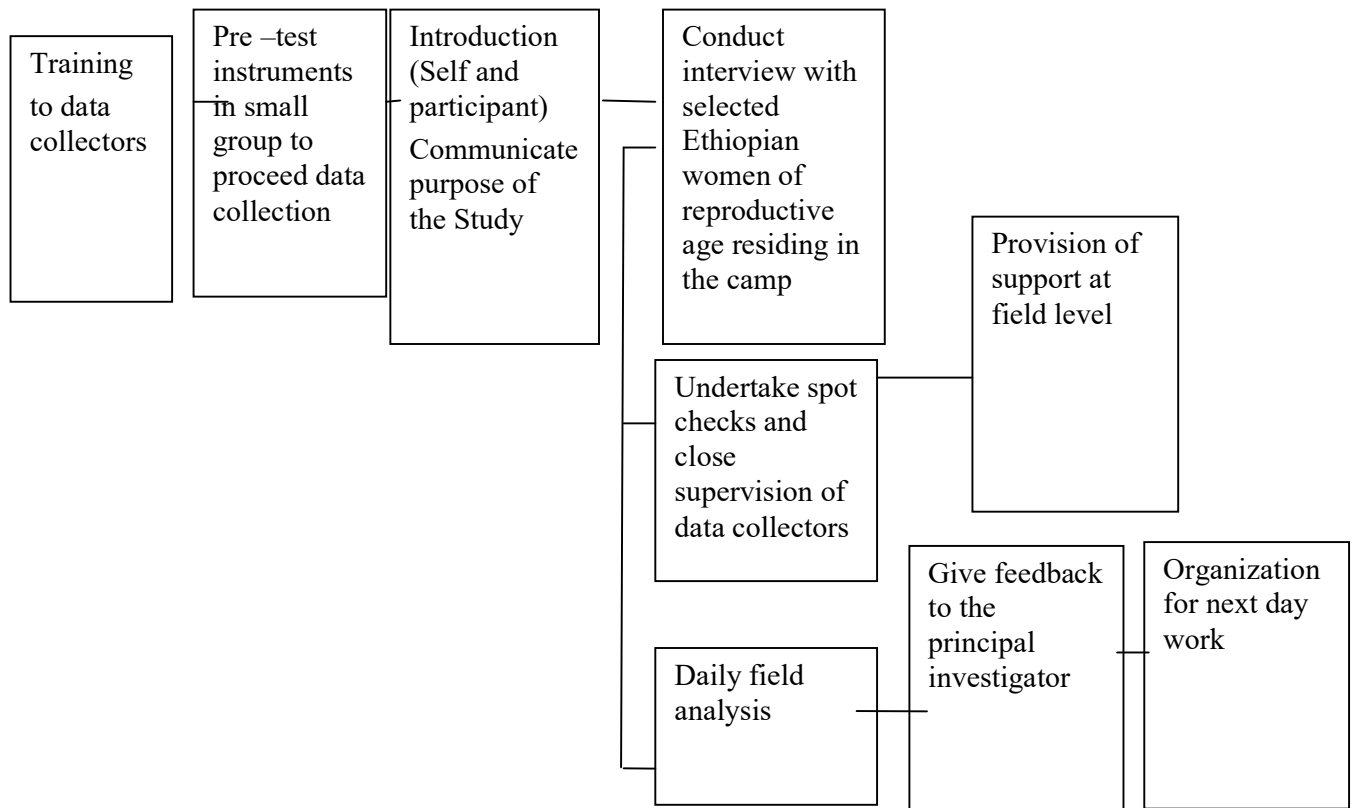
#### **4.9 Data Collection Methods**

Primary data (quantitative) was collected from sample of target group using structured interview technique and a cross-sectional survey was employed. Structured questionnaire was adapted from CDC tool kit for conflict affected women and used to collect from a representative sample of women residing in the camp.

The questionnaires were coded and pilot tested in Kakuma camp for accuracy and clarity and the necessary corrections were made. Data collectors were recruited from Ethiopian refugees living in Kakuma camp in consultation with the International Rescue Committee (IRC) and trained in the administration of the questionnaires. Data collectors and supervisors were chosen based on criteria that they speak the refugee community languages and that they have good interpersonal communication ability. The training included classroom discussions, mock interview and field practice in filling out the questionnaires. The classroom discussion focused on data collection techniques, explanation of terms and concepts that were used in the questionnaire, and elaboration of the content of each questionnaire and other issues.

After the training and a pilot test, data collectors and supervisors collected the data. Data collectors recorded all answers on printed questionnaires. Supervisors were in the data collection sites to ensure data collectors follow the procedures of data collection and for quality assurance. At the end of every day, data collectors returned the completed questionnaires to supervisors for further checks and logging.

The steps taken to conduct the data collection are shown below (Figure 4.1).



**Figure 4. 1: Chart of Major Field Activities**

#### **4.10 Pre-Testing and Quality Control**

The researcher conducted preliminary test of data collection tools before the actual data collection with small group of respondents to eliminate, identify, adjust and correct changes before collecting data from the study population.

#### **4.11 Data Analysis**

The researcher developed appropriate templates for data entry and storage. Information collected were entered in to database and checked to identify inconsistencies. SPSS (20.0 version) was used for the data analysis of this study. The analysis begun with descriptive analysis to assess the status of core indicators such as levels of knowledge, attitude, perceptions and beliefs regarding family planning. The Bi-variate analysis considered

associations between demographic factors (e.g., age, education, marital status, sex, religion and others) and knowledge, behavior and exposure to basic FP services. Where Bi-variate associations were statistically significant, further multivariate analysis were conducted to examine the relationship between variables and to measure the degrees of relationship between variables.

#### **4.12 Ethical Consideration**

The participants did not risk psychological, legal or social harm during the study as the study did not have any clinical trial that could harm their health status. Additionally, the respondents participated in this study following explanation of the purpose, the risks and benefits of the study and also by ensuring them that they had the right to be interviewed or not interviewed or to stop at any point during the interview.

##### **4.12.1 Ethical Clearance**

The researcher secured ethical clearance from the Kenyatta National Hospital and University of Nairobi Ethical Review Committee. Additionally permission was obtained from UNHCR Nairobi Office and Kakuma Sub Office as well as from IRC Nairobi Head Office and Kakuma Sub Office to conduct the research in Kakuma refugee camp. Moreover, a written consent form for respondents was prepared and used. The principal investigator also ensured that every respondent had the right to refuse or accept to be interviewed either at the beginning or any time during the interview.

##### **4.12.2 Privacy and Confidentiality**

The interview was conducted with each respondent taking in to account confidentiality and privacy as well as in a way the respondents were able to talk freely. The researcher did take confidentiality of any information related to respondent's answers to the highest care. The data collectors never discussed the respondents' answer with anyone, except the

supervisor as required. Moreover as the respondents name did not appear on the questionnaire, there is no mechanism to link specific answer to a specific respondent.

#### **4.12.3 Benefits of the Study to Participants**

Participants may not directly benefit from the study. However, the findings of the study could influence different governmental and non-governmental organizations that are working in the area of FP to understand more on the family planning needs and challenges of refugee women and to come up with appropriate interventions both at policy and service delivery levels to address those constraints as well as to improve the health status of the refugee women.

#### **4.12.4 Risks to Participants**

In this study participants were involved voluntarily with their full prior consent to and they were also having the right to withdraw the interview any time. Regarding the privacy of the study participants, the data collectors conducted the interview in a manner that is comfortable to the participants in a private room and in such a way that no other people hear the interview and the researcher also protects the confidentiality of data given by the participants. Moreover all the participants did not risk any psychological, legal or social harm during the study. One way of ensuring confidentiality was that participants were not required to write their name and filled in questionnaire were kept private in a locked file and the data stored in the computer using SPSS was not shared with the general public and only the researcher has access to the data.

Additionally, in the analysis and report writing, the findings were not linked to any single respondent.

#### **4.12.5 Illiterate Participants**

The participants were interviewed by trained data collectors and hence those illiterate participants were able to participate in this study without any problem. Additionally as the data collectors speak the local languages of respondents, they helped to clarify the questionnaires and to get the right responses.

## **CHAPTER FIVE**

### **RESULTS**

#### **5.1 Introduction**

This section on results analysis interprets and presents the study findings. The total sample size was 262. However, 6 questionnaires were excluded as they were incomplete.

The general objective of the study was to establish determinants of contraceptive use among Ethiopian women refugees living in Kakuma camp, Kenya. The study was guided by four research questions. Do Ethiopian women in Kakuma refugee camp practice family planning? What are the factors that influence use of family planning among Ethiopian women refugees living in Kakuma refugee camp? Does knowledge on FP influence use of FP among Ethiopian women refugees living in Kakuma refugee camp? Does perception on FP influence use of FP among Ethiopian women refugees living in Kakuma refugee camp?

This section presents background characteristics of the respondents and findings in line with the specific research questions.

#### **5.2 Response Rate**

The study had a sample size of 262. The study achieved a 97.71% response rate. Six questionnaires which were more than 50% incomplete were excluded. Thus the analysis is based on 256 respondents.

#### **5.3 Respondents Background Characteristics**

According to the findings of the study 24.7% of the respondents were in the age range between 25 and 29 years followed by those aged between 20 and 24 years (24.3%). Those aged 30 to 34 years were 18.4%; those aged 15 to 19 years were 14.1%; those aged 35 to

39 years were 11.4%; 40 to 44 years were 5.1% while those aged 45 to 49 years were 2.0%. This distribution shows that most of the respondents (81.5%) were below 35 years.

Sixty eight percent of the respondents were from the Oromo ethnic group; 11.7% from the Amhara; 7% from the Tigre; 4.7% from Sidama; and other ethnic groups comprised 8.6% of the respondents.

Table 5.1 further shows that majority of the respondents (35.3%) were primary school drop outs; 32.2% had no education while 28.2% had secondary education and only 4.3% had university education. Finally, Table 5.1 indicates that 72.7% of the respondents were unemployed; 18.0% employed while 9.4% were students.

**Table 5.1: Background Characteristics (Age/Ethnicity/Education/Employment)**

Background Characteristics	Category	n=193 Kakuma 1	n=63 Kakuma 3	Total Frequency	Total Percent (%)
Age	15-19	34 (17.7%)	2(3.2%)	36	14.1%
	20-24	41(21.4%)	21(33.3%)	62	24.3%
	25-29	47 (24.5%)	16 (25.4%)	63	24.7%
	30-34	31 (16.1%)	16 (25.4%)	47	18.4%
	35-39	24 (12.5%)	5 (7.9%)	29	11.4%
	40-44	10 (5.2%)	3 (4.8%)	13	5.1%
	45-49	5 (2.6%)	0 (0.0%)	5	2.0%
	Total	192 (100.0%)	63 (100.0%)	255	100.0%
Ethnicity	Amhara	30 (15.5%)	0 (0.0%)	30	11.7%
	Oromo	114 (59.1%)	60 (95.2%)	174	68.0%
	Tigre	17 (8.8%)	1 (1.6%)	18	7.0%
	Sidama	12 (6.2%)	0 (0.0%)	12	4.7%
	Others	20 (10.4%)	2 (3.2%)	22	8.6%
	Total	193 (100%)	63 (100%)	256	100.0%
Education Level	Primary	73 (38.0%)	17 (27.0%)	90	35.3%
	Secondary	65 (33.9%)	7 (11.1%)	72	28.2%
	University or higher	10 (5.2%)	1 (1.6%)	11	4.3%
	No education	44 (22.9%)	38 (60.3%)	82	32.2%
	Total	192 (100.0%)	63 (100.0%)	255	100.0%
Employment Status	Employed	43 (22.3%)	3 (4.8%)	46	18.0
	Unemployed	127 (65.8%)	59 (93.7%)	186	72.7
	Student	23 (11.9%)	1 (1.6%)	24	9.4
	Total	193 (100.0%)	63 (100.0%)	256	100.0

Table 5.2 shows that 63.1% of the respondents were currently married; 19% unmarried; 9.9% divorced; 4.4% living together but not legally married yet and 3.6% were widowed.

Table 5.2 also indicates that majority of the respondents were Muslims (57.3%), followed

by Orthodox (18.8%); Protestants (17.6%); Catholics (3.9%); and others (2.4%). The respondents were then asked to indicate their husbands' level of education. Thirty six point four indicated that their husbands had secondary education, 28.7% were primary school drop outs, and 23.1% of their husbands had no education while 11.8% indicated that their husbands had university education.

**Table 5.2: Background Characteristics (Marriage/ Religion/Husband's Education)**

Background Characteristics	Category	Kakuma 1	Kakuma 3	Total Frequency	Total Percent (%)
Marital Status	Currently married	105 (55.3%)	54 (87.1%)	159	63.1%
	Unmarried	47 (24.7%)	1 (1.6%)	48	19.0%
	Living together but not legally married	11 (5.8%)	0 (0.0%)	11	4.4%
	Divorced	20 (10.5%)	5 (8.1%)	25	9.9%
	Widowed	7 (3.7%)	2 (3.2%)	9	3.6%
	Total	190 (100.0%)	62 (100.0%)	252	100.0%
Religion	Orthodox	48 (25.0%)	0 (0.0%)	48	18.8%
	Protestant	40 (20.8%)	5 (7.9%)	45	17.6%
	Muslim	88 (45.8%)	58 (92.1%)	146	57.3%
	Catholic	10 (5.2%)	0 (0.0%)	10	3.9%
	Others	6 (3.1%)	0 (0.0%)	6	2.4%
	Total	192 (100.0%)	63 (100.0%)	255	100.0%
Husbands Education Level	Primary	39 (28.1%)	17 (30.4%)	56	28.7%
	Secondary	56 (40.3%)	15 (26.8%)	71	36.4%
	University or higher education	20 (14.4%)	3 (5.4%)	23	11.8%
	No education	24 (17.3%)	21 (37.5%)	45	23.1%
	Total	139 (100.0%)	56 (100.0%)	195	100.0%

#### 5.4 Knowledge about Family Planning

The study sought to establish knowledge of Ethiopian women living in Kakuma refugee camp about family planning. Cross tabulation and chi square tests were done using age; marital status and respondent's education level as independent variables. Table 5.3 shows that when evaluating knowledge of modern family planning methods, majority (81%) had heard about the pills; followed by injectable (76%); Implant (58%); IUD (51%); male condoms (43%); female condoms (26%), emergency contraceptive (18%); Vasectomy (7%); and female sterilization/tubaligation (4%). Knowledge of traditional methods was low with 21% indicating that they know about lactational amenorrhea; 20% calendar



method and 5% periodic abstinence. The Chi square results in Table 5.3 indicated that any observable difference was due to chance and are not statistically significant except for knowledge on male condoms and vasectomy ( $p < 0.05$ ). The other findings are homogenous and are generalized to the entire population.

A close look at of Table 5.3 shows that knowledge of male condoms decreases as age increases. For example, when minors (15-19 years) are excluded, 60% of those aged 20-24 years knew about male condoms; this decreased to 44% for those aged 25-29%; then to 36% for those aged 30-34 years; 31% for those aged 35-39%; 23% for those aged 40-44 years and finally 20% for those aged 45-59 years.

**Table 5.3: Distribution of respondents' knowledge on methods by age**

Contraceptive method	Age (%)							Total (n=255)	Inferential	
	15-19 (n=36)	20-24 (n=62)	25-29 (n=63)	30-34 (n=47)	35-39 (n=29)	40-44 (n=13)	45-49 (n=5)		Chi square	p-value
<b>Any modern method</b>										
Female sterilization	0 (0%)	4 (7%)	0 (0%)	3 (6%)	2 (7%)	1 (8%)	0 (0%)	10 (4%)	7.226	0.300
Female condom	12 (33%)	22 (36%)	12 (19%)	10 (21%)	5 (17%)	3 (23%)	1 (20.0%)	65 (26%)	7.401	0.285
Male Condom	14 (39%)	37 (60%)	28 (44%)	17 (36%)	9 (31%)	3 (23%)	1 (20%)	109 (43%)	13.123	<b>0.041</b>
Pill	26 (72%)	49 (79%)	52 (83%)	37 (79%)	24 (83%)	13 (100%)	5 (100%)	206 (81%)	6.431	0.377
IUD	23 (64%)	32 (52%)	30 (48%)	26 (55%)	14 (48%)	4 (31%)	2 (40%)	131 (51%)	5.487	0.483
Injectable	23 (64%)	48 (77%)	52 (83%)	35 (75%)	22 (76%)	11 (85%)	3 (60%)	194 (76%)	5.744	0.452
Implant	20 (56%)	37 (60%)	34 (54%)	26 (57%)	19 (66%)	10 (77%)	2 (40%)	148 (58%)	3.870	0.694
Emergency contraceptive	11 (31%)	13 (21%)	7 (11%)	7 (15%)	4 (14%)	2 (15%)	1 (20%)	45 (18%)	7.056	0.316
Vasectomy	0 (0%)	6 (10%)	1 (2%)	7 (15%)	2 (7%)	0 (0%)	0 (0%)	16 (7%)	13.46	<b>0.041</b>
<b>Any traditional method</b>										
Lactation	2 (6%)	12 (20%)	1 (18%)	16 (34%)	8 (28%)	2 (15%)	1 (20%)	52 (21%)	11.72	0.069
Amenorrhea	6 (17%)	10 (16%)	10 (16%)	10 (21%)	11 (38%)	2 (15%)	1 (20%)	50 (20%)	7.638	0.266
Calendar method	0 (0%)	5 (8%)	3 (5%)	2 (4%)	3 (10%)	0 (0%)	0 (0%)	13 (5%)	5.762	0.45
Periodic Abstinence	0 (0%)	5 (8%)	3 (5%)	2 (4%)	3 (10%)	0 (0%)	0 (0%)	13 (5%)	5.762	0.45

However, knowledge about vasectomy is limited to only four age groups. That is, ages 30-34 years (15%); 20 to 24 years (10%); 35 to 39 (7%) and 25 to 29 years (2%).

Table 5.4 shows that there is statistically significant evidence to show that knowledge about female condoms, emergency contraceptives and lactation amenorrhea vary with marital status ( $p < 0.05$ ). The findings demonstrate that knowledge about female condoms is least among widowed (11%), followed by divorced women (16%); married women (22%); unmarried women (39.6%) and women living in unions but not legally married (46%). Similarly, there was statistically significant ( $p < 0.05$ ) difference in knowledge about emergency contraceptives. While no single widow (0%) indicated knowledge of emergency contraceptives, 46% of those living in non-formalized unions, 35% unmarried, 24% of divorced and 10% of currently married women expressed knowledge of the same.

**Table 5.4: Distribution of respondents' knowledge on contraceptive methods by marital status**

Contraceptive	Currently married women (n=159)	Unmarried women (n=48)	Living Union (n=11)	in Divorced (n=25)	Widowed (n=9)	Total (n=252)	Chi square	p-value
<b>Modern Methods</b>								
Female sterilization	6(4%)	1(2%)	1(9%)	2(8%)	0(0%)	10(4%)	2.659	0.616
Female condom	39(22%)	19(40%)	5(46%)	4(16%)	1(11%)	64(25%)	10.530	<b>0.032</b>
Male Condom	69(43%)	25(52%)	5(46%)	8(32%)	0(0%)	107(43%)	9.678	0.046
Pill	130(82%)	39(81%)	8(73%)	20(80%)	7(78%)	204(81%)	6.26	0.920
IUD	84(53%)	28(58%)	6(55%)	9(36%)	2(22%)	129(51%)	6.532	0.153
Injectable	129(81%)	33(69%)	7(64%)	16(64%)	6(67%)	191(76%)	6.598	0.138
Implant	93(59%)	28(58%)	5(46%)	15(60%)	4(44%)	145(58%)	1.473	0.831
Emergency contraceptive	16(10%)	17(35%)	5(46%)	6(24%)	0(0%)	44(18%)	25.404	<b>0.00</b>
Vasectomy	12(8%)	3(6%)	0(0%)	2(8%)	0(0%)	17(7%)	1.690	0.792
<b>Traditional methods</b>								
Lactation Amenorrhea	42(27)%	1(2%)	0(0%)	7(28%)	1(11%)	51(20%)	17.875	<b>0.001</b>
Calendar method	28(18%)	8(17%)	4(36%)	7(28%)	1(11%)	48(19%)	4.196	0.380
Periodic Abstinence	6(4%)	3(6%)	2(18%)	3(12%)	0(0%)	14(6%)	6.857	0.144

Table 5.5 shows that knowledge about female condoms; IUD, emergency contraceptives, and calendar method vary with education level. Table 5.5 demonstrates that compared to other educational levels, women without education are least aware about female condoms

(11%). Awareness about female condoms also increases with advancement in education. Similarly, awareness about IUD also increases with education level. Only 39% of women without education were aware of the IUD, while this is 51% for primary school drop outs, and 67% for those with secondary education.

Knowledge about emergency contraceptives was least among the uneducated (6%) followed by primary school drop outs (18%); secondary school leavers (30%) and university/higher education (27%). Finally knowledge about calendar method also increases with education level which is no education (9%); primary (21%); secondary (28%) and higher education (36%).

**Table 5.5: Distribution of respondents’ knowledge on contraceptive methods by education level**

Contraceptive	Primary (n=90)	Secondary (n=72)	University or higher education (n=11)	No education (n=82)	Total (n=255)	Chi square	p-value
<b>Modern Methods</b>							
Female sterilization	2(2%)	5(7%)	2(18%)	1(1%)	10(4%)	9.962	0.019
Female condom	25(28%)	27(38%)	4(36%)	9(11%)	65(26%)	15.496	<b>0.001</b>
Male Condom	38(42%)	33(46%)	4(36%)	24(42%)	109(43%)	0.529	0.913
Pill	71(79%)	58(81%)	8(73%)	69(84%)	206(81%)	1.268	0.737
IUD	46(51%)	48(67%)	5(46%)	32(39%)	131(51%)	11.903	<b>0.008</b>
Injectable	68(76%)	55(76%)	6(55%)	64(78%)	193(76%)	2.94	0.401
Implant	55(61%)	42(59%)	4(36%)	46(56%)	147(58%)	2.628	0.453
Emergency contraceptive	16(18%)	21(29%)	3(27%)	5(6%)	45(18%)	14.803	<b>0.002</b>
Vasectomy	4(4%)	6(8%)	2(18%)	4(5%)	16(6%)	3.955	0.266
<b>Traditional methods</b>							
Lactation Amenorrhea	18(20%)	11(15%)	1(9%)	21(26%)	51(20%)	3.588	0.310
Calendar method	19(21%)	20(28%)	4(36%)	7(9%)	50(20%)	11.513	<b>0.009</b>
Periodic Abstinence	5(6%)	6(8%)	1(9%)	2(2%)	14(6%)	2.868	0.412

The respondents were then asked to indicate their first source of information about family planning. Majority (58.2%) indicated that they first heard about family planning from the camp clinic; 41% from other health facilities outside the camp; 34.4% from the social media; 32% from school; 19.5% from friends; and 6.3% from the parents. This shows that health facilities play the major role in disseminating information about family planning. It

also shows that very little information about family planning is shared among community members. Very few indicated that they first received the information from parents and friends. Interestingly social media is becoming an important source of information as evidenced by 34.4% of the respondents.

**Table 5.6: Distribution of women by first sources of information about family planning**

Response Category	Place of Residence(current residence)		Total (n=256)
	Kakuma 1 (n=193)	Kakuma 3 (n=63)	
Parents	12(6.2%)	4(6.3%)	16(6.3%)
Health facility other than camp clinic	64(33.2%)	41(65.1%)	105(41.0%)
In the camp clinic	98(50.8%)	51(81.0%)	149(58.2%)
School	64(33.2%)	18(28.6%)	82(32.0%)
Friends	43(22.3%)	7(11.1%)	50(19.5%)
Social media	82(42.5%)	6(9.5%)	88(34.4%)

## 5.5 Family Planning Practices

The study sought to establish family planning practices among the Ethiopian women refugees living in the Kakuma refugee camps. Table 5.7 indicates that modern contraceptives are mostly used by women aged 25 to 29 years (46%) followed by those aged 30 to 34 years (42.6%); 20 to 24 years (29%); 35 to 39 (24.1%); 40 to 44 years (23.1%); 15 to 19 years (16.7%) and 45 to 49 years (20%). This distribution shows that contraceptives are mostly used by young women in their reproductive ages (20 to 34 years).

Table 5.7 also shows that in terms of ethnic group 41.7% of Sidama; 40% of Amhara and 36.2% of Oromo women use modern contraceptives. This compares unfavorably with only 16.7% of Tigre and 4.5% of women from other ethnic groups. Table 5.7 further indicates that only 25.6% of women without education use modern contraceptives compared to 34.4% with primary education; 33.3% with secondary education and 63.6% with higher

education. This shows that utilization of FP methods is influenced by the level of education where those with higher education level tend to use modern contraceptives more.

**Table 5.7: Distribution of women who are currently using modern contraceptive methods by background characteristics (Age/Ethnicity/Education level)**

	Users		Non Users		Total	
	Number	%	Number	%	Number	%
<b>Age in years</b>						
15-19	6	16.7%	30	83.3%	36	100%
20-24	18	29%	44	71.0%	62	100%
25-29	29	46%	34	54.0%	63	100%
30-34	20	42.6%	27	57.4%	47	100%
35-39	7	24.1%	22	75.9%	29	100%
40-44	3	23.1%	10	76.9%	13	100%
45-49	1	20%	4	80.0%	5	100%
Total	84	32.9%	67.15	171	255	100%
<b>Ethnicity</b>						
Amhara	12	40%	18	60.0%	30	100%
Oromo	63	36.2%	111	63.8%	174	100%
Tigre	3	16.7%	15	83.3%	18	100%
Sidama	5	41.7%	7	58.3%	12	100%
Others	1	4.5%	21	95.5%	22	100%
Total	84	32.8%	172	67.2%	256	100%
<b>Education Level</b>						
Primary	31	34.4%	59	65.6%	90	100%
Secondary	24	33.3%	48	66.7%	72	100%
Higher education	7	63.6%	4	36.4%	11	100%
No education	21	25.6%	61	74.4%	82	100%
Total	83	32.5%	172	67.5%	255	100%

Table 5.8 illustrates that majority of the women in employment (41.3%) use modern contraceptives compared to 30.1% of those unemployed and 37.5% of the students. Additionally the table indicates the use of modern contraceptive methods is high among those with 1 to 3 children (50.9%) followed by those women having 4 to 7 children (41.4%) and those having no children (27.5%) and those with more than 8 children (14.3%). The fact that few women with more than 8 children (14.3%) use modern

contraceptive would point to the fact that most of them probably passed their menopause and only few could still be reproductively active.

**Table 5.8: Distribution of women who are currently using modern contraceptive methods by background characteristics (Employment/Children)**

	Users		Non Users		Total	
	Frequency	%	Frequency	%	Frequency	%
<b>Employment Status</b>						
Employed	19	41.3%	27	58.7%	46	100%
Unemployed	56	30.1%	130	69.9%	186	100%
Student	9	37.5%	15	62.5%	24	100%
Total	84	32.8%	172	67.2%	256	100%
<b>Number of Children</b>						
0	19	27.5%	50	72.5%	69	100%
1-3	57	50.9%	55	49.1.5%	112	100%
4-7	24	41.4%	34	58.6%	58	100%
8-11	1	14.3%	6	85.7%	7	100%
Total	101	46.3%	145	53.7%	246	100%

Findings in Table 5.9 illustrates that women aged 15 to 19 years mainly use Pills (33.3%) followed by IUD; calendar method and abstinence at 16.7% each. Women aged 20 to 24 mainly use injectable (44.4%); and Pills (33.3%). Similarly those aged 25 to 29 years use injectable (44.8%); Pills (27.6%); and implants (10.3%).

On the other hand, women aged 30 to 34 years use injectable (35%) followed by implant (20%) and Pills (15%). Likewise those aged 35 to 39 (71.4%) and 40 to 44 years (33.3%) also use injectable.

**Table 5.9: Distribution of women who are currently using contraceptives by type of method and age**

Contraceptive Method	Age							Total
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Pill	2	6	8	3	1	0	0	20
	33.3%	33.3%	27.6%	15.0%	14.3%	0.0%	0.0%	23.8%
Injectable	0	8	13	7	5	1	0	34
	0.0%	44.4%	44.8%	35.0%	71.4%	33.3%	0.0%	40.5%
IUD	1	0	2	2	1	1	0	7
	16.7%	0.0%	6.9%	10.0%	14.3%	33.3%	0.0%	8.3%
Implant	1	1	3	4	0	1	0	10
	16.7%	5.6%	10.3%	20.0%	0.0%	33.3%	0.0%	11.9%
Emergency contraceptives	0	1	1	0	0	0	0	2
	0.0%	5.6%	3.4%	0.0%	0.0%	0.0%	0.0%	2.4%
lactational amenorrhea	0	1	1	1	0	0	0	3
	0.0%	5.6%	3.4%	5.0%	0.0%	0.0%	0.0%	3.6%
calendar method	1	1	1	3	0	0	0	6
	16.7%	5.6%	3.4%	15.0%	0.0%	0.0%	0.0%	7.1%
Periodic abstinence	1	0	0	0	0	0	1	2
	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	2.4%
Total Count	6	18	29	20	7	3	1	84

Comparatively, Table 5.10 indicates that currently injectable is used by most women. Regardless of educational level, injectable was ranked as the most used family planning method followed by pills.

**Table 5.10: Distribution of women who are currently using contraceptives by type of method and education level**

Contraceptive Methods	Educational level				Total
	Primary	Secondary	Higher education	No education	
Pill	9	2	2	7	20
	29.0%	8.3%	28.6%	33.3%	24.1%
Injectable	12	8	2	11	33
	38.7%	33.3%	28.6%	52.4%	39.8%
IUD	3	2	0	2	7
	9.7%	8.3%	0.0%	9.5%	8.4%
Implant	4	5	1	0	10
	12.9%	20.8%	14.3%	0.0%	12.0%
Emergency contraceptives	0	2	0	0	2
	0.0%	8.3%	0.0%	0.0%	2.4%
Lactational amenorrhea	2	1	0	0	3
	6.5%	4.2%	0.0%	0.0%	3.6%
Calendar method	1	3	1	1	6
	3.2%	12.5%	14.3%	4.8%	7.2%
Periodic abstinence	0	1	1	0	2
	0.0%	4.2%	14.3%	0.0%	2.4%
Total	31	24	7	21	83
	100.0%	100.0%	100.0%	100.0%	100.0%

As indicated in Table 5.9 and 5.10, injectable was ranked highest among women regardless of marital status. Table 5.11 indicates that half of divorced and widowed women use pills followed by unmarried women (40%); women living together but not legally married (37.5%) and married women (19%). One eighth of women living together but not legally married and 9.5% of married women use IUD. The table further shows that majority of married women (49.2%) use injectable followed by 25% of the divorced; 20% of the unmarried and 12.5% of those living in unofficial unions. However, half of widowed women, 25% of divorced and 12.5% of women living in unofficial unions use implants.

**Table 5.11: Distribution of women who are currently using contraceptives by type of method and marital status**

Contraceptive methods	Marital status					Total
	Currently married	Unmarried	Living together but not legally married	Divorced	Widowed	
Pill	12	2	3	2	1	20
	19.0%	40.0%	37.5%	50.0%	50.0%	24.4%
Injectable	31	1	1	1	0	34
	49.2%	20.0%	12.5%	25.0%	0.0%	41.5%
IUD	6	0	1	0	0	7
	9.5%	0.0%	12.5%	0.0%	0.0%	8.5%
Implant	6	0	1	1	1	9
	9.5%	0.0%	12.5%	25.0%	50.0%	11.0%
Emergency contraceptives	1	0	1	0	0	2
	1.6%	0.0%	12.5%	0.0%	0.0%	2.4%
Lactational amenorrhea	2	0	0	0	0	2
	3.2%	0.0%	0.0%	0.0%	0.0%	2.4%
Calendar method	4	1	1	0	0	6
	6.3%	20.0%	12.5%	0.0%	0.0%	7.3%
Periodic abstinence	1	1	0	0	0	2
	1.6%	20.0%	0.0%	0.0%	0.0%	2.4%
Total	63	5	8	4	2	82
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Use of different contraceptives was then cross tabulated with the number of children. Table 5.12 indicates that regardless of the number of children, injectable is highly used contraceptive method.



**Table 5.12: Distribution of women who are currently using contraceptives by type of method and number of children**

Contraceptive	1-3 children (n=112)	4-7 children (n=58)	8-11 children (n=7)	Total
<b>Modern Methods</b>				
Pill	45(40.2%)	12(20.8%)	0(0.0%)	57(32.2%)
IUD	13(11.6%)	7(12.5%)	0(0.0%)	20(11.3%)
Injectable	70(62.5%)	28(45.8%)	7(100.0%)	105(59.3%)
Implant	22(19.6%)	7(12.5%)	0(0.0%)	29(16.4%)
Emergency contraceptive	3(2.7%)	0(0.0%)	0(0.0%)	3(1.7%)
<b>Traditional methods</b>				
Lactation Amenorrhea	6(5.4%)	2(4.2%)	0(0.0%)	8(4.5%)
Calendar method	19(17%)	0(0.0%)	0(0.0%)	19(10.7%)
Periodic Abstinence	3(2.6%)	2(4.2%)	0(0.0%)	5(2.8%)
Total count	181	51	7	246(100%)

The study sought to assess level of contraceptive use in Kakuma1 and Kakuma 3. Table 5.13 shows that there is statistically significant ( $p<0.05$ ) difference on the family planning practices between Kakuma 1 and Kakuma 3. While more than half (52.4%) of women in Kakuma 3 use contraceptives, less than one third (26.9%) of women in Kakuma 1 use contraceptives. This difference might be attributable to the ethnic composition of these camps. For example Kakuma 3 is predominantly composed of Sidama and Oromo ethnic groups which Table 5.7 indicated had a higher percentage use of contraceptives.

**Table 5.13: Distribution of women who are currently using contraceptives by type of Residence**

Family planning practice	Residence		Total	Chi-square	p-value
	Kakuma 1	Kakuma 3			
Yes	52 (26.9%)	33(52.4%)	85(33.2%)	13.858	0.000
No	141(73.1%)	30 (47.6%)	171 (66.8%)		
Total	193 (100.0%)	63 (100.0%)	256 (100.0%)		

Those women who were not using any contraceptive method were requested to indicate the reasons for not using any FP method. Thirty six percent indicated not having sex while 27.6% indicated breast feeding; 12.5% indicated pregnancy; 6.6% cited religious prohibition; 6.6% need to have more children; 3.9% feared side effects and 2.6% indicated inconvenience of use.

**Table 5.14: Reasons for not using contraceptive methods by place of residence**

Response Category	Kakuma 1	Kakuma 3	Total frequency	Total Percentage
Currently pregnant	12 (11.7%)	7 (14.3%)	19	12.5%
Religious prohibition	8 (7.8%)	2 (4.1%)	10	6.6%
Not having sex	45 (43.7%)	10 (20.4%)	55	36.2%
Breast feeding	15 (14.6%)	27 (55.1%)	42	27.6%
Wants more children	9 (8.7%)	1 (2.0%)	10	6.6%
Respondents opposed	1 (1.0%)	0 (0.0%)	1	0.7%
Husband/partner opposed	2 (1.9%)	0 (0.0%)	2	1.3%
Knows no method	0 (0.0%)	1 (2.0%)	1	0.7%
Knows no source	2 (1.9%)	0 (0.0%)	2	1.3%
Fear of side effect	5 (4.9%)	1 (2.0%)	6	3.9%
Inconvenient to use	4 (3.9%)	0 (0.0%)	4	2.6%
Total	103 (100.0%)	49 (100.0%)	152	100%

As illustrated in Table 5.15, majority of women who indicated that they want more children in the future also indicated that they use family planning (32.6%). Similarly, majority of those who indicated that they don't want more children also use family planning but at a higher percentage (67.4%). This means that even though one wants children in the future does not mean that they want children now, hence use of contraceptives.

**Table 5.15: Distribution of women who do not want to have a child in the future but not using contraceptive method (unmet need)**

Want to have a baby in the future	Using any method to delay or avoid pregnancy	
	Yes	No
Yes	76 (32.6%)	9 (27.3%)
No	147 (67.4%)	24 (72.7%)
Total	233 (100%)	33 (100%)

Majority of the women who wanted another child at a later date but who indicated that they don't use contraceptives cited not having sex (28.6%) and breast feeding (21.4%) as the main reason they were not using contraceptives. On the other hand, half of those who did not want another child at a later date but who indicated that they don't use contraceptives indicated that they are opposed to use of contraceptives while the other half indicated that their partners opposed.

**Table 5.16: Distribution of women by reasons for not using for not using contraceptives**

Reasons	Wants another child later	Wants no more children	No response	Total
Currently pregnant	2 (14.3%)	0 (0.0%)	1 (2.6%)	3 (5.6%)
Religious prohibition	2 (14.3%)	0 (0%)	3 (7.9%)	5 (9.3%)
Not having sex	4 (28.6%)	0 (0%)	13 (34.2%)	17(31.5%)
Breast feeding	3 (21.4%)	0 (0%)	19 (50.0%)	22(40.7%)
Wants more children	1(7.1%)	0 (0%)	0 (0%)	1(1.9%)
Respondents opposed	0 (0%)	1 (50.0%)	0 (0%)	1(1.9%)
husband/partner opposed	0 (0%)	1 (50.0%)	0 (0%)	1(1.9%)
Knows no method	0 (0%)	0 (0%)	1 (2.6%)	1(1.9%)
Fear of side effects	2 (14.3%)	0 (0.0%)	0 (0.0%)	2 (3.7%)
Inconvenient ways	0 (0.0%)	0 (0.0%)	1 (2.6%)	1 (1.9%)
Total count	14	2	38	54(100%)

The respondents were asked to indicate their main source of contraceptives. Table 5.17 shows that the main source of contraceptives were camp health center (70%) and private clinics (17.2%). Only 13.4% of the women indicated their source of contraceptives are pharmacies.

**Table 5.17: Distribution of women using contraceptive methods by source of supply**

Sources	Contraceptive method					Total women
	Pill	Injectable	IUD	Emergency	Implant	
In camp Health center	17 (85%)	27 (82%)	5 (8%)	2 (3.4%)	6 (10.3%)	57 (70%)
Private clinic	3 (14%)	5(15%)	1 (7.1%)	1 (7.1%)	4 (28.6%)	14 (17.2%)
Pharmacy	1 (5%)	1 (30%)	7 (8.3%)	2 (2.4%)	0 (0%)	11 (13.4%)
Total	21	33	13	5	20	82 (100%)

Lastly, the respondents were asked to indicate challenges associated with access to family planning. Only 36% and 9% of the respondents in Kakuma 1 and Kakuma 3 respectively indicated that family planning methods are always available. On the other hand, while 44% of the respondents in Kakuma 1 indicated family planning methods are sometimes available while it is 77% in Kakuma 3. Additionally 21% from kakuma 1 and 14 %from Kakuma 3 indicated that family planning method are not available.

Table 5.18 shows that most women (62.2%) indicated that they have limited range of family planning methods while 28% accessed a range of family planning choice. Nine point eight percent of the respondents did not have a variety of choices. Further, 50.4% reported that they do not face language barriers while accessing family planning methods. Only 17.9% have ever faced language barriers. Ninety seven point four percent of the respondents reported that they travel less than 5 km to access family planning services; while 2.6% travel more than 10 km. Thirty seven point six percent reported that they access family planning methods from the camp health facility.

**Table 5.18: Challenges to Access FP**

Response Category	Residence		Total
	Kakuma 1	Kakuma 3	
<b>Availability/supply of contraceptives at the health facilities</b>			
Always available	44 (35.5%)	5 (8.9%)	49 (27.2%)
Sometimes available	54 (43.5%)	43 (76.8%)	97 (53.9%)
Not available	26 (21.0%)	8 (14.3%)	34 (18.9%)
Total	124 (100.0%)	56 (100.0%)	180 (100.0%)
<b>Range of method/Method mix</b>			
There is a range of choice	44 (41.1%)	2 (3.5%)	46 (28.0%)
Limited choice	56 (52.3%)	46 (80.7%)	102 (62.2%)
No choice	7 (6.5%)	9 (15.8%)	16 (9.8%)
Total	107 (100.0%)	57 (100.0%)	164 (100.0%)
<b>Communication with service providers</b>			
Have good communication	110 (63.2%)	8 (13.3%)	118 (50.4%)
No communication	29 (16.7%)	13 (21.7%)	42 (17.9%)
Don't know	35 (20.1%)	39 (65.0%)	74 (31.6%)
<b>Access – Geographical access</b>			
More than 10 km	3 (3.6%)	0 (0.0%)	3 (2.6%)
5-10 km	0 (0.0%)	0 (0.0%)	0 (0.0%)
Less than 5 km	81 (96.4%)	30 (100.0%)	111 (97.4%)
Total	84 (100.0%)	30 (100.0%)	114 (100.0%)
<b>Access – FP service access</b>			
Yes	71 (40.8%)	17 (28.3%)	88 (37.6%)
No	11 (6.3%)	2 (3.3%)	13 (5.6%)
Don't know	92 (52.9%)	41 (68.3%)	133 (56.8%)
Total	174 (100.0%)	60 (100.0%)	234 100.0%

Table 5.19 shows that 29.8% of the respondents had never received counseling on how to use contraceptives; 21.8% had received once or twice while 48.4% of the respondents more often received counseling.

**Table 5.19 Method counseling**

Counseling	Kakuma 1 (Yes)	Kakuma 3 (Yes)	Total Yes (%)
Never	64 (33.9%)	11 (17.5%)	75 (29.8%)
Once or twice	41 (21.7%)	14 (22.2%)	55 (21.8%)
More often	84 (44.4%)	38 (60.3%)	122 (48.4%)
Total	189 (100.0%)	63 (100.0%)	252 (100.0%)

Cross tabulation result in Table 5.20 shows that those women who don't discuss family planning issues with their partners are more likely (74.1%) not to use family planning. Similarly, women whose husbands are not involved in the approval of contraceptives are possibly (76%) not to use a method. This implies that women should be encouraged to discuss more with their partners about family planning issues and there should be programs targeting men. On the other hand, women who don't partake in the approval of family planning methods are also more likely (68.9%) not to practice family planning. Interestingly, 60.3% of the women who make decision about family planning don't use family planning.

**Table 5.20: Cross tabulation (Proximate determinants versus family planning practice)**

Proximate determinants		Are you using any method to delay or avoid pregnancy		Total
		Yes	No	
Discussion with Partner about FP	Yes	48 (46.6%)	55 (53.4%)	103
	No	35 (25.9%)	100 (74.1%)	135
Partner makes decision about FP	Yes	43 (53.1%)	38 (46.9%)	81
	No	42 (24%)	133 (76.0%)	175
Women makes decision about FP	Yes	25 (39.7%)	38 (60.3%)	63
	No	60 (31.1%)	133 (68.9%)	193

## 5.6 Attitude of Women towards family planning

Table 5.21 indicates that attitude influences family planning practices. It should be noted that although the respondents were 256, the nature of the question provides respondents with one or more than one responses. The table shows that majority of women who had negative attitudes towards family planning are possibly not to use contraceptive methods. For those who indicated that FP is trouble to use, 61.9% don't use family planning and for those who don't like FP, 66.7% don't use family planning. Similarly of those who indicated that FP is against religion, 85.7% of them don't use FP while 55.6% of the respondents indicated they use FP without problems. Moreover, 40.5% of the respondents use FP even with problems.

**Table 5.21: Attitude towards family planning**

Attitude	FP practice		Total
	Use FP	Don't use FP	
Use FP methods without problem	25 (55.6%)	20 (44.4%)	45 (100%)
Use contraceptives even with problems	15 (40.5%)	22 (59.5%)	37 (100%)
Its trouble to use	8 (38.1%)	13 (61.9%)	21 (100%)
Has side effects	23 (53.5%)	20 (46.5%)	43 (100%)
FP is against nature	10 (55.6%)	8 (44.5%)	18 (100%)
Don't like FP	6(33.3%)	12(66.7%)	18 (100%)
Never use	11 (14.9%)	63 (85.1%)	74 (100%)
Against Religion	1 (14.3%)	6 (85.7%)	7 (100%)
Other	4 (17.4%)	19 (82.6%)	23 (100%)

The findings were cross tabulated against education level and status of employment so as to understand whether education or economic status influenced attitude towards family planning. The findings are expressed in Table 5.22. The findings show a relationship between approval of FP and level of education. It shows an increase in disapproval with low level education. That is, less educated women tend to disapprove of FP. The summated scale shows that 38% of those who did not approve of FP did not have any kind

of formal education while 35% and 25% had primary and secondary education respectively but only 3% with higher education. This clearly demonstrates the influence of education on FP approval.

Similarly, the table shows that majority (76%) of those women who disapproved of FP were unemployed while 15% were employed and 9% were students. Probably, there is a link between employment and education level. There is a likelihood that those who were not employed have limited education, hence the high level of disapproval of FP.

**Table 5.22: Attitude towards FP versus Education and Economic Status**

	Education Level					Economic Status			
	No school	Primary	Secondary	University	Total	Employed	Unemployed	Student	Total
Its trouble to use	10 (48%)	6 (27%)	5 (24%)	0 (0%)	21 (100%)	5 (24%)	14 (67%)	2 (10%)	21 (100%)
Has side effects	19 (44%)	16 (37%)	7 (16%)	1 (2%)	43 (100%)	4 (9%)	36 (84%)	3 (7%)	43 (100%)
FP is against nature	8 (44%)	7 (39%)	3 (17%)	0 (0%)	18 (100%)	3 (17%)	14 (78%)	1 (6%)	18 (100%)
Don't like FP	5 (28%)	9 (50%)	2 (11%)	2 (11%)	18 (100%)	4 (22%)	12 (67%)	2 (11%)	18 (100%)
Never use	24 (32%)	22 (30%)	26 (35%)	2 (3%)	74 (100%)	10 (14%)	56 (76%)	8 (11%)	74 (100%)
<b>Total</b>	<b>66 (38%)</b>	<b>60 (34%)</b>	<b>43 (25%)</b>	<b>5 (3%)</b>	<b>174 (100%)</b>	<b>26 (15%)</b>	<b>132 (76%)</b>	<b>16 (9%)</b>	<b>174 (100%)</b>

### 5.7 Limitations of the Study

The study focused only on Ethiopian women refugees due to time and resource constraints. Hence this is one of the limitations of the study as refugees from other nationalities living in Kakuma camp were not covered. Therefore generalizing this result findings to other nationalities residing in Kakuma refugee camp is limited.

Additionally the researcher used quantitative methods of data collection to get the necessary information about the respondents. Thus lacks qualitative information that would have enriched more the findings of the study.

## **CHAPTER SIX**

### **DISCUSSION, CONCLUSION AND RECOMENDATION**

#### **6.1 Introduction**

This chapter presents discussions, conclusions and recommendations aligned to the research objectives. These are; to determine the prevalence of contraceptive use among Ethiopian women refugees in Kakuma camp; to identify socioeconomic and demographic factors influencing the use of family planning among Ethiopian women refugees living in Kakuma camp; to establish the attitude of Ethiopian women refugees towards use of FP; to describe the knowledge of family planning among Ethiopian women refugees living in Kakuma, to determine access to FP services and availability of family planning method mix.

#### **6.2 Discussion**

##### **6.2.1 Prevalence of contraceptive use among Ethiopian women refugees living in Kakuma camp**

In general, the study established that only one third of the Ethiopian women refugees living in Kakuma refugee camp use contraceptives. The uptake of contraceptives was higher among women aged 25 to 29 years. The study also showed that family planning practice increases from age 15 to 19 (one in every six) and peaks at 29 years (one in every 2.1) before decreasing as age advances. This could be attributed to a woman's reproductive cycle. Generally as girls reach puberty, their sexual activities increase as they move into marriage and desire to have children. The increased sexual activity influences use of contraceptives for women who intend to control births. This however decreases as age advances towards menopause. Hence, the decline in use of contraceptives to a low of one in every five for women aged 45 to 49 years.



Injectable was identified as the most used contraceptive method followed by pills, implant and IUD. Women aged 20 to 24 mainly use injectable and pills. Similarly those aged 25 to 29 years prefer injectable; pills; and implants. On the other hand, women aged 30 to 34 years use injectable more followed by implant and Pills. Likewise, those aged 35 to 39 and 40 to 44 years also use injectable more. Regardless of education level, marital status and number of children, injectable was ranked as the most used family planning method.

## **6.2.2 Factors influencing the use of FP among Ethiopian women refugees living in Kakuma refugee camp**

### **6.2. 2.1 Health Facility Factors**

The study sought to establish the health facility related challenges that influence family planning practices among Ethiopian women refugees living in Kakuma refugee camp. The health facility variables studied were, availability of FP methods; availability of range/choice of FP methods; language barrier; and distance to health facility.

The study established that only one in eight respondents indicated that family planning methods are not available. However, when asked to indicate accessibility to various methods of family planning, two in three indicated that access to choice of methods of family planning is limited. Further, half of the women reported that they do not face language barriers while accessing family planning methods. Ninety seven point four percent reported that they travel less than 5 km to access family planning services. Thirty seven point six percent reported that they access family planning methods from the camp health facility.

The above findings show that availability and choice of family planning methods limits family planning practices.

The study showed that distance not to be a major hindrance to family planning as most refugee women can access health facilities less than 5 km.

#### **6.2.2.2 Socio Economic Factors**

The study sought to identify the influence of women's education level; religion; ethnicity; husband's education level; employment status; and number of children on family planning use. The study showed that comparatively, use of contraceptives was more prevalent among Sidama, Amhara and Oromo ethnic groups (at least one in every two). However, the prevalence was very low for Tigre (one in every six) and other ethnic groups (one in every twenty two).

The study further showed that education greatly influences family planning practices among the Ethiopian women refugees living in Kakuma refugee camp. While only one in every four uneducated women used contraceptives, two in every three women with university education use contraceptives. This clearly shows that education plays a key role in creating awareness about family planning and its use. This is in line with Abedin (2010) who argued that education plays an important role in FP awareness and practice. Korra (2002) also indicated that compared to educated women, illiterate or little educated women have more unmet need for FP.

Furthermore, the research showed that prevalence of family planning was high among employed women, women having less than 3 children followed by those women having 4 to 7 children and those having no children and those with more than 8 children. The fact that few women with more than 8 children use modern contraceptive would point to the

fact that most of them probably passed their menopause and only few could still be reproductively active.

### **6.2.2.3 Proximate Factors**

The study evaluated the influence of three proximate factors (instruction on how to use family planning method; discussion with the partner; and family planning decision maker) on family planning practices. The study established that close to one third of the respondents had never received any counseling on how to use family planning methods. This lack of knowledge limits awareness and utilization of services. Furthermore, the study showed that discussion with partners, husband's and women's approval of contraceptive influences family planning practices among Ethiopian women refugees living in Kakuma refugee camp. Women who don't discuss family planning issues with their partners are more likely not to use family planning methods. This supports arguments by Sandesara (2010) that the main provider- related barriers to men's involvement in family planning included the lack of pertinent men targeting campaign. This would imply that to increase use of family planning, women should be encouraged to discuss more with their partners about contraceptives issues. Finally, women who don't partake in the approval of family planning also are more likely not to practice contraceptives.

### **6.2.3 Attitude of Ethiopian women refugees in Kakuma camp towards use of family planning**

The study sought to establish how the attitude of Ethiopian women refugees living in Kakuma influence family planning practices. The study established that negative attitude towards family planning negatively influences use of family planning methods. For example those who indicated that FP is trouble to use; that they don't like FP; that FP is against religion are less likely to use family planning. However, those who had positive

attitudes demonstrated higher likelihood of using FP methods. For example, most of those who indicated that they use FP without problems; and that they use FP even with problems also indicated that they use family planning. This supports findings by Orach et al, (2007) that pointed out constraints to use family planning among others include low level of awareness, misperception and lack of male involvement.

#### **6.2.4 Knowledge of family planning among Ethiopian women refugees in Kakuma camp**

The study sought to establish knowledge of Ethiopian women refugees living in Kakuma refugee camp about family planning. The study established that knowledge about pill was the highest (five in every six respondents). More than half had heard about injectable, Implant and IUD. Knowledge about male condoms was at 43% while less than one quarter had heard about female condoms, emergency contraceptive; Vasectomy and female sterilization/tuba ligation. Knowledge of traditional methods was low with less than one in every five respondents having heard about lactational amenorrhea; calendar method and periodic abstinence (5%).

The study demonstrated that knowledge about female condoms is least among widowed, followed by divorced women; married women; unmarried women and women living in unions but not legally married. The study showed that knowledge about female condoms; IUD, emergency contraceptives, and calendar method vary with education level. Compared to other education levels, women without education are least aware about female condoms. Awareness about female condoms also increases with advancement in education. Similarly, awareness about IUD also increases with education level. Only 39% of women without education were aware of the IUD while it was 51% for primary school drop outs and 66.7% for those with secondary education.

Knowledge about emergency contraceptives was least among the un-educated followed by primary school drop outs; secondary school leavers and university/higher education. Finally knowledge about calendar methods also increases with education level. The study further established that majority of the respondents first heard about family planning from the camp clinic. The other important sources were other health facilities outside the camp, social media and schools but only about 3.3% heard from the parents. This shows that health facilities play the major role in disseminating information about family planning. It also shows that very little information about family planning is shared among community members.

#### **6.2.5 Access to FP services and availability of family planning method mix for Ethiopian women refugees in Kakuma camp**

The study established that availability of family planning methods influences family planning use. That is, limitations on the method choice negatively influence family planning practices. Distance has been established not to be a major hindrance to family planning.

### **6.3 Conclusions**

The study draws the following conclusions.

First respondents' knowledge about family planning is generally high as evidenced that over 90% have ever heard about family planning. However, the contraceptive prevalence rate is 32.5% which is low among Ethiopian women refugees living in Kakuma refugee camp.

Second, limited family planning method choice and non-continuous availability of methods/supplies at the camp health facility negatively influences family planning practices. Distance has been established not to be a major hindrance to family planning

among the Ethiopian women refugees. Thus, the study concludes that to enhance family planning use it is important to diversify contraceptive methods and ensure continuous availability/supplies.

Third, the study further showed that education greatly influences family planning practices among the Ethiopian women refugees living in Kakuma refugee camp. While only one in every four uneducated women used contraceptives, two in every three women with university education use contraceptives. Moreover, the study showed that prevalence of family planning was high among employed women. This clearly shows that education and employment plays key role in creating awareness and use of FP methods.

Fourth, the study showed that women who don't discuss family planning issues with their partners are more likely not to use family planning. Similarly, women whose husbands are not involved in the approval of family planning practices are possibly not to use contraceptives.

Fifth, women who don't approve family planning are also more probably not to use contraceptives. Therefore, the study concludes that husband's involvement and discussion as well as empowering women in decision making has a positive influence on family planning use.

Finally, health facilities play major roles in disseminating and creating knowledge and use of family planning among the Ethiopian women refugees living in Kakuma camp.

## **6.4 Recommendations**

Based on the findings of the study, the following recommendations are made towards improving family planning practice among Ethiopian women refugees living in Kakuma refugee camp.

1. It is recommended that IRC and UNHCR in collaboration with the Turkana County Ministry of Health should ensure that the health institutions working in Kakuma camp have a wide range of contraceptive choices and stocks/supplies to meet the FP needs of the refugees on a continuous basis. Moreover, FP method counseling needs to be done by service providers for all refugees seeking and using contraceptives to enhance regular use of methods. As private clinics and pharmacies play a role as source of contraceptives for refugees, UNHCR and IRC in collaboration with Turkana County Ministry of Health should create mechanisms to engage these private clinics and pharmacies such as through trainings.
2. There is a need to strengthen behavioral change communication by the camp health institutions with a focus on family planning in order to enhance knowledge and contraceptive use. These should include benefits of FP, wide range of contraceptive methods available and how to use.
3. It is recommended that for the success of FP programs, male involvement and discussion of both partners is critical in the decision making process and contraceptive use. Hence FP programs targeting men in general and husbands and partners in particular need to be developed and implemented by IRC in collaboration with the Ministry of Health of Turkana County.
4. The study recommends that a comparative study be conducted on family planning using both qualitative and quantitative methods among refugees of different

nationalities in Kakuma camp to come up with a comprehensive strategy to improve FP use among refugees.



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### **Unpublished Articles**

- Family planning saves lives & improves health - Countdown 2015...  
[www.countdown2015europe.org/wp-content/uploads/.../IPPF\\_FactSheet-4\\_Health.p...](http://www.countdown2015europe.org/wp-content/uploads/.../IPPF_FactSheet-4_Health.p...)
- GPRHCS\_2014\_Survey\_Sampling\_Methodology\_Guide\_ENGLISH ...  
[countryoffice.unfpa.org/.../GPRHCS\\_2014\\_Survey\\_Sampling\\_Methodology\\_Guide](http://countryoffice.unfpa.org/.../GPRHCS_2014_Survey_Sampling_Methodology_Guide)

## APPENDICES

### APPENDIX 1: CONSENT EXPLANATION FORM.

#### 1.1 STUDY TITLE:DETERMINANTS OF FAMILY PLANNING PRATICE

AMONG ETHIOPIAN WOMEN REFUGEE SLIVING IN KAKUMA CAMP,  
KENYA.

#### 1.2 INVESTIGATOR: WOINSHET TEGEGNE TESFAW

POSTGRADUATE STUDENT  
SCHOOL OF PUBLIC HEALTH  
UNIVERSITY OF NAIROBI

My name is Woinshet Tegegne Masters Student in the field of Public Health, College of Health Sciences; university of Nairobi, at Kenyatta National Hospital .I wish to conduct a research study about determinants of family planning practice among Ethiopian women refugees. I would like to invite you to participate in this study. Your opinion is very important for me as a researcher. Please note the following principles in this study.

- Participation is voluntary and you may withdraw from the study at any time.
- Refusal to participate will involve no penalty of benefits to which you are entitled at this camp.
- After you read/ listen to the explanation, please feel free to ask any questions that will allow you to clearly understand the nature of the study.
- All information obtained from this study will remain confidential and your privacy will be upheld. Identification will be by number only; no names will be used in this study or in its future publications.

### **1.3 BACKGROUND INFORMATION**

Women in various refugee settlements encounter different reproductive health problems which in turn affects their health and development. Among others these includes vulnerability of refugee women and girls to unplanned pregnancies, HIV/AIDS, STI, gender based violence and related sexual and reproductive health problems. The breakdown of traditional structures and systems also contributes to this problem (Okanlawon, 2010). As such it is considerable public health problem which needs to be addressed.

### **1.4 AIM OF THE STUDY**

The purpose of the survey is to investigate the family planning practice among Ethiopian refugee women in the Kakuma camp.

### **1.5 PROCEDURES**

In this research, you will be asked about your knowledge, attitude and practice of FP methods. You will also be asked about the sources of contraceptives. As the questionnaire is anonymous, you will not be asked your name and identification number.

### **1.6 RISKS**

There may be inconveniences due to the length of the interview time, discussion of sensitive personal issues.

### **1.7 BENEFITS**

The study finding may result to implementation of better family planning interventions and comprehensive care for mothers and children.

## 1.8 COMPENSATION

There will be no payment for taking part in this study.

## 1.9 DATA STORAGE

The written data of this study will be stored and secured in private locked file cabinet.

After the data collection is completed, the data will be transferred to computer data storage and will be locked by password. Thus only the principal investigator can have access to the data (password protected access only).

For any concern about this project, you may call woinshet Tegegne, at +254 736 473 488 or for any enquiry, please contact the Secretary of KNH/UON Ethical and Research Committee:

P.O. Box 20723-0020, Nairobi

Tel 020726300-9.

## APPENDIX 2: CONSENT FORM

### Consent form

I hereby confirm that, after receiving the above information, I agree to participate in the determinants of family planning practice survey. My information will only be used only for research purposes and informed that participation is voluntary and that I can withdraw my participation at any time.

Signature or mark of participant----- Date-----

Signature of interviewer /investigator ----- Date-----

### APPENDIX 3: QUESTIONNAIRE

The following questioners were adapted form CDC Reproductive Health Assessment toolkit for Conflict-Affected Women (Tobergte et al, 2013)

#### Section1. Back ground characteristics of respondent's

Please tick as appropriate

1. How old are you (or what was your age when you celebrated last birthday)? \_\_\_\_\_  
years

2. What is your Ethnic group?

- 1. Amhara
- 2. Oromo
- 3. Tigre
- 4. Sidama
- 5. other

3. What is your educational level?

- 1. Primary
- 2. Secondary
- 3. University or higher education
- 4. No education

4. What is your employment status?

- 1. Employed
- 2. Unemployed
- 3. Student

5. What is your marital status?



1. Currently Married
2. Unmarried
3. Living together but not legally married
4. Divorced
5. Widowed

6. What is your Religion?

1. Orthodox
2. Protestant
3. Muslim
4. Catholic
5. Other

7. What is the highest level of school that your husband attended?

- 1 Primary
- 2 Secondary
- 3 University or higher education
- 4 No education

## **Section 2 .Knowledge about family planning**

8. Have you ever heard about family planning?

1. Yes
2. No

9. If yes where did you get your First Family Planning Information?

1. Parents
2. Health institutions other than camp health center
3. In the camp health center

4. School
5. Friends
6. Mass media

10. Which method of contraceptives have you heard about?

1. Pill
2. Female Condom
3. Male condom
4. Injectable
5. IUD
6. Implants
7. Emergency contraceptive
8. Female sterilization/tuba ligation
9. vasectomy
10. Lactational amenorrhea
11. Calendar method/counting days
12. Periodic abstinence

11. Have you ever been taught or instructed on how the method works?

1. Never
2. Once or twice
3. More often

### **Section 3 Attitude about family planning**

13. Have you ever discussed with your spouse/partner family planning issues?

1. Yes
2. No

13. What is your opinion when you discussed with your husband about contraceptive method?

- 1. Embarrassing/avoid to discuss
- 2. Positive/ we are enjoying discussions
- 3. I never discuss

14. What is your view about contraceptive methods?

- 1. I have used contraceptives without any problems
- 2. I have used contraceptives in spite of problems
- 3. It troubles to use
- 4. It has side effects
- 5. It is against nature
- 6. I don't like to use
- 7. I never used
- 8. It is against religion
- 9. Other (specify) \_\_\_\_\_

15. Who makes decisions regarding FP?

- 1. Husband/partner
- 2. Myself
- 3. Other specify \_\_\_\_\_

**Section 4. Practice of family planning**

16. Do you have any children?

- 1. Yes
- 2. No

17. If yes, How many children do you have? \_\_\_\_\_ children

18. Do you want to have a baby in the future

1. Yes

2. No

19. If yes when do you want to have your next baby?

1. Within the next 12 months

2. Within one to two years

3. After two years

4. unknown

20. If no, are you using any method to delay or avoid pregnancy?

1. Yes

2. No

21. If yes which method are you currently using?

4. Pill

5. Female Condom

6. Injectable

7. IUD

8. Implants

9. Emergency contraceptive

10. Female sterilization/tuba ligation

11. Lactational amenorrhea

12. Calendar method/counting day

13. Periodic abstinence

22. If no please indicate the reasons why you are not using a method to delay or avoid getting pregnant?

1. Currently pregnant
2. Religious prohibition
3. Not having sex
4. Breast feeding
5. Wants more children
6. Postpartum(6 weeks after birth)
7. Respondents opposed
8. Husband/partner opposed
9. Knows no method
10. Knows no source
11. Fear of side effect
12. Inconvenient to use
13. Methods not available
14. Expensive

23. Where would you go to get your contraceptive choices?

1. In camp health centre
2. Private clinic
3. Pharmacy
4. Supermarket/market

24. Are you using the method because you want to have another child later or because you want no more children at all?

1. Wants another child later
2. Wants no more children

3. No Response

25. In your opinion what is the main problem, if any with using (method)?

1. Cannot obtain method

2. Husband / partner will not permit

3. Religious reasons

4. Stops my period

5. Increases / irregular periods

6. Cannot afford

7. Does not work

8. No problems

9. Don't Know

10. No response

26. In your opinion what is the main problem, if any with availability (method)?

1. Always available

2. Sometimes available

3. Not available

27. In your opinion what is the main problem, if any with range (method)?

1. There is a range of choice

2. Limited choice

3. No choice

28. Have you ever felt language barrier when you seek family planning services?

1. Yes

2. No

3. Don't know

29. How far do you go to get family planning service -----kms?

30. Do you get the FP services you need in the camp health facility?

1. Yes

2. No

3. Don't

APPENDIX 4: MAP OF KAKUMA REFUGEE CAMP



Source: [www.Behance.net](http://www.Behance.net)



## APPENDIX 5: KNH/UON-ERC APPROVAL LETTER



UNIVERSITY OF NAIROBI  
COLLEGE OF HEALTH SCIENCES  
P O BOX 19676 Code 00202  
Telegrams: varsity  
(254-020) 2726300 Ext 44355



KNH/UON-ERC  
Email: [uonknh\\_erc@uonbi.ac.ke](mailto:uonknh_erc@uonbi.ac.ke)  
Website: <http://erc.uonbi.ac.ke>  
Facebook: <https://www.facebook.com/uonknh.erc>  
Twitter: @UONKNH\_ERC [https://twitter.com/UONKNH\\_ERC](https://twitter.com/UONKNH_ERC)



KENYATTA NATIONAL HOSPITAL  
P O BOX 20723 Code 00202  
Tel: 726300-9  
Fax: 725272  
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/323

22<sup>nd</sup> July 2015

Woinchet Tegegne Tesfaw  
ID H57/79577/2012  
School of Public Health  
College of Health Sciences  
University of Nairobi

Dear Woinchet

**RESEARCH PROPOSAL – DETERMINANTS OF FAMILY PLANNING PRACTICE AMONG ETHIOPIAN WOMEN  
REFUGEES LIVING IN KAKUMA CAMP, KENYA (P115/03/2015)**

This is to inform you that the KNH/UoN-Ethics & Research Committee (KNH/UoN-ERC) has reviewed and **approved** your above proposal. The approval periods are 22<sup>nd</sup> July 2015 – 21<sup>st</sup> July 2016.

This approval is subject to compliance with the following requirements:

- a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
- b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH/UoN ERC before implementation.
- c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH/UoN ERC within 72 hours of notification.
- d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH/UoN ERC within 72 hours.
- e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
- f) Clearance for export of biological specimens must be obtained from KNH/UoN-Ethics & Research Committee for each batch of shipment.
- g) Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

For more details consult the KNH/UoN ERC website [www.erc.uonbi.ac.ke](http://www.erc.uonbi.ac.ke)

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## APPENDIX 6: SCHOOL OF PUBLIC HEALTH SUPPORT LETTER



# UNIVERSITY OF NAIROBI

## College of Health Sciences

### School of Public Health

Kenyatta National Hospital  
P.O. BOX 19676-00202,  
NAIROBI, KENYA.

Tel: Nairobi 2726300 Ext. 43481  
Telegrams: 22095, Medken Nairobi  
Direct line: 2724639/020 4915044  
Fax: 2724639

Date: 4<sup>th</sup> August, 2015

UNHCR Kakuma Refugee  
Camp Office  
Kenya

Dear Sir/Madam,

**RE: LETTER OF SUPPORT – MS. WOINSHET TEGEGNE – H57/79577/2012**

This is to confirm that Ms. Woinshet Tegegne is a postgraduate student pursuing a Masters of Public Health degree at the School of Public Health.

She has an approval from KNH/UON-ERC to conduct a study on: "Determinants of Family Planning Practice among Ethiopian Women Refugees Living in Kakuma Camp, Kenya". I wish to confirm that the study is purely academic driven and the data collected will not be used for any other purposes.

Please accord her the necessary assistance.

  
**Dr. Dismas Ongore**  
DIRECTOR  
SCHOOL OF PUBLIC HEALTH



DO/jwm

## APPENDIX 7: UNHCR PERMISSION LETTER

13/9/2015

[John Wagacha Burton <burtonj@unhcr.org>](mailto:burtonj@unhcr.org)

Dear Woinshet,

As earlier communicated to you by UNHCR Head of Sub-Office Kakuma, I write to confirm our support for you to undertake Post Graduate thesis study in Kakuma refugee camp.

Regards

Dr Burton Wagacha  
Health Coordinator  
UNHCR, Kenya