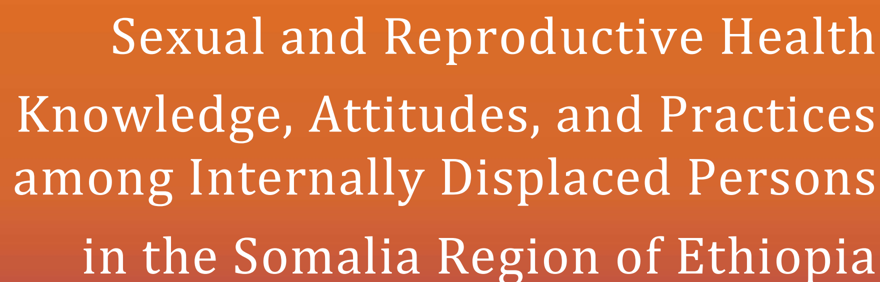

Sexual and Reproductive Health Knowledge, Attitudes, and Practices among Internally Displaced Persons in the Somalia Region of Ethiopia

Baseline Assessment

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for a better life

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Context

Sexual and reproductive health (SRH) is a human right for women and girls around the world, but it is particularly critical for internally displaced persons (IDPs). The sexual and reproductive health and rights (SRHR) of this population require particular considerations. There is a significant need for SRH services in humanitarian settings, but also a severe dearth of rigorous evaluation of the effectiveness of SRHR programming. While SRH services have increased for women in crisis situations broadly, these services have largely failed to reach IDPs.

Photo credit: Rikka Tupaz

IDPs are people who have been forced to leave their homes, but have remained within the borders of their country of origin. Host country governments often lack the ability to serve these IDPs as a result of needing to prioritize the conflict or disaster that has displaced their citizens. Further, as they lack the status of refugees and the associated protections, many multilateral agencies and nongovernmental organizations are unable to offer the same resources that they provide to refugee populations. Additionally, the needs of IDPs differ in meaningful ways from those of the general population. For example, IDPs frequently lack access to SRH services, including specifically contraception and safe abortion care. Similarly, IDPs often lack access to adequate maternal care, which can increase maternal and infant morbidities and mortalities. Further, sexual and gender-based violence (SGBV) is common among IDPs and IDPs are vulnerable to abuse and exploitation—yet SGBV services are often the least developed of services available for women in crisis environments. There is also evidence that the conditions of displacement lend to increased risk of infectious disease, including HIV.

According to the Internal Displacement Monitoring Centre, there are slightly more than two million IDPs in Ethiopia at present, largely due to ethnic conflict, political instability, and scarce environmental resources. IDPs in Ethiopia have a significant unmet need for contraceptive services, including an unmet need for modern contraceptives totaling nearly 50% (Gebrecherkos et al. 2018). This is a critical concern, as the inability to access to modern contraceptives can lead to unplanned pregnancies, poor child spacing, unsafe abortions, and increased prevalence of sexually transmitted infections. Negative attitudes regarding contraception significantly affect utilization in Ethiopia, but targeted education campaigns can decrease negative stereotypes and increase uptake family planning (FP). For example, many Ethiopian women cite religious and cultural beliefs as well as their husbands' desires as reasons for having large families (Davidson et al. 2016). Negative attitudes about long-acting reversible contraception (LARC) have also contributed to low utilization, but focus groups show that implants are more well received than intrauterine devices (Davidson et al. 2016). SGBV is also prevalent among IDPs in Ethiopia, leading to physical and mental health problems (Feseha and Gerbaba 2012).

Project Summary

Project Scope and Objectives

To respond to the critical SRHR needs of IDPs in the Somali region of Ethiopia, EngenderHealth launched a project in the Fafan zone with three key objectives:

1. IDP communities, particularly adolescent girls and women in areas of highest need, have improved access to comprehensive and gender-equitable SRHR information and services.
2. Existing government structures and partners working in humanitarian settings in Ethiopia inform, mobilize, and influence local stakeholders to prioritize SRHR in crisis situations.
3. Evidence exists to address unanswered questions pertaining to the SRHR needs and responses in humanitarian settings, particularly for IDPs.

Project Approach

To achieve our intended objectives, we are working within existing structures, including national and regional government and partner systems, to create urgency around the SRH needs of IDPs, particularly girls and women. Prioritizing the post-crisis stage, we have adapted and are implementing a model of SRHR programming and service delivery that enables IDPs to access a continuum of care for comprehensive SRHR, including particularly contraception, safe abortion care, maternal care, and prevention and clinical management of SGBV. We designed our project activities to create change at the individual, interpersonal, community, institutional, and policy levels to contribute to the ultimate goal that women and girls achieve their rights to gender-equitable SRH services and participate as equal members of society.

Study Objective

The objective of this study is to understand the current SRHR needs and perceptions of IDPs in the Somali region of Ethiopia, in order to inform our programming.

Methodology

Study Context

EngenderHealth identified Gebegebo, Qoloji, and Tule Guleed camps in the Fafan zone of the Somali regional state to serve as study sites. These sites are located southwest of the regional capital city of JigJiga. Operational since 2016, these camps house approximately 150,000 refugees and IDPs. Note, recognizing that these camps are highly restricted zones, refugees and non-refugees commonly intermix in these camps.

Participant Recruitment and Data Collection

EngenderHealth conducted a cross-sectional quantitative study between October and November 2019. Our study population comprised consenting women aged 15 to 49 years from the target camps who either (1) self-identified as a refugee or IDP, (2) had refugee or IDP parents; or (3) lived in informal settlements. Using a convenience and peer-drive recruitment approach, we identified study participants by randomly selecting tents and then inviting one woman in each tent within our target age group to participate in an interview.

Before beginning recruitment efforts, we engaged with the regional health bureau, zonal health departments, district managers, camp managers, and country public health emergency management teams to explain the purpose of the research study and to gain support from these groups for the study. As a result of these engagement efforts, we were able to collaborate with leaders of various refugee associations to identify the study participants.

After obtaining consent for participation in the study, we collected data through in-person interviews in spaces designated for privacy. Our data collectors administered 30- to 45-minute interviews using a paper-based structured survey in local languages (Afan Oromo and Somali). We also provided information about sexual resources to all study participants.

Training

Our study team trained four female research assistants (nurses able to speak Afaan Oromo and Somali) to recruit participants and to administer the survey. The two-day training focused on research methods and ethics, survey administration, and confidentiality. We also worked with these data collectors to review every survey item for clarity and to refine and enhance the relevance of the survey measures for the local context and population.

Sample Size

We calculated our sample size using a single population proportion formula, consisting of: p=0.5; 95% Confidence Interval, 0.05 margin of error, and 10% non-response rate. We interviewed 448 participants. We established three inclusion criteria—participants must: (1) be women between the ages of 15 and 49, (2) identify as IDPs, and (3) be able to communicate in either Afaan Oromo or Somali. We excluded participants with critical illness or who were unable to provide consent for their participation in the study.

Instrument

We based our knowledge, attitude, and practice study questionnaire on other relevant SRHR studies. The questionnaire focused on the following topics: awareness and/or knowledge of contraception, antenatal care (ANC), safe delivery and skilled birth attendance, abortion (including understanding of induced abortion, awareness of the Ethiopian penal code on abortion, and awareness of the availability of abortion services), and SGBV; perceptions related to the acceptability of abortion and health problems associated with abortion and the quality of abortion care services; approval of contraception, ANC, and abortion care; and use of contraceptive methods, ANC, and abortion services and intention to use contraceptive methods.

We developed the questionnaire in English and translated it into local languages. We piloted the entire questionnaire with a sample of 20 respondents, examining internal consistencies and assessing the length required for each interview. Based on this pilot, we adjusted the survey to simplify the phrasing of select questions.

Ethical Considerations

EngenderHealth received approval and a support letter from the Somali Regional Health Bureau to conduct the study. We informed participants of the purpose and procedures of the study, their rights related voluntary participation and confidentiality, and their right to decline or withdraw from the study without penalty. We asked participants to sign consent forms and provided copies of this form

prior to conducting interviews. For participants under 18 years of age, we required consent from the participant as well as permission from an adult family member or guardian.

Results

Sociodemographic Composition

The study utilized information from 445 IDPs in Ethiopia. The mean age of the respondents was 29.26± 6.56 years, and the majority (79.2%) were older than 24 years old. Most were illiterate, had relocated from a rural area, and were married to their current partner (96.7%, 96.5%, and 97.2%, respectively). Few (8.2%) were born in the district. See Table 1 for details.

Table 1. Sociodemographic Characteristics of Respondents

	n	%
Current age (n=422)	-	-
15–19 years	16	3.6
20–24 years	76	17.2
25–40 years	323	73.1
41–49 years	27	6.1
Illiterate (n=426)	412	96.7
Born in the district (n=415)	34	8.2
Living area prior to displacement/relocation (n=425)	-	-
Urban	4	0.9
Semi-urban	11	2.6
Rural	410	96.5
Marital status (n=428)	-	-
Currently married	416	97.2
Widowed	10	2.3

Fertility Experiences and Preferences

The majority (95.9%) of respondents had delivered a live birth, and the average age at first birth was 17.62 ±1.74 years. More than half had given birth to five or more children and now had five or more living children (60.7% and 56.6%. respectively). Nearly two-thirds (64.9%) of the respondents had given birth within 12 months prior to the survey; the majority of these had either delivered in a health center (40.9%) or at home (35.5%). Respondents who delivered at home cited the lack of formal healthcare, prohibitive distance to healthcare, lack of transportation, or personal preference as the reason. The majority of the respondents (78.3%) attended antenatal care for their last pregnancy and nearly all (98.2%) would recommend antenatal care to others. Those who did not attend antenatal care cited the lack of formal healthcare, prohibitive distance to healthcare, lack of transportation, or lack

of perceived necessity as their reason. Approximately half of the women who had given birth in the past year or who were currently pregnant had planned for their child (49.1% and 44.6%, respectively). Most respondents (72.3%) reported jointly deciding with their husband as to the number of children the family would have and similarly most (59.1%) believed that their husband wanted the same number of children as them. See Table 2 for more information.

Table 2. Fertility Experiences and Preferences

	n	%
Ever given birth (n=441)	435	98.6
Children ever born (n=435)		
< 2 children	66	15.2
2–4 children	105	24.1
≥ 5 children	264	60.7
Number of living children (n=429)	-	-
< 2 children	72	16.8
2–4 children	114	26.6
≥ 5 children	243	56.6
Given birth within the past 12 months (n=428)	279	65.2
Location of the last birth (n=279)	-	-
Health post	63	22.6
Health center	114	40.9
Hospital (by referral)	3	1.1
Home / tent	99	35.5
Received antenatal care (n=437)	342	78.3
Currently pregnant (n=434)		
Yes	92	21.2
No	336	77.4
Unsure	6	1.4
Gave birth in the last year and had planned for the child (n=277)	-	-
Yes	136	49.1
Wanted a child later	137	49.5
Did not want more children	4	1.4
Currently pregnant and had planned for the child (n=92)	-	-
Yes	41	44.6
Wanted a child later	44	47.8
Did not want more children	7	7.6

Primary decision-maker for determining the number of children (n=405)	-	-
Self	14	3.5
Husband	68	16.8
Self plus husband jointly	293	72.3
Parents	3	0.7
Health workers	12	3.0
Religious leaders	1	0.2
Other	14	3.5
Perceptions of husbands' desires to have the same number of children (n=432)	-	-
Same	257	59.1
More	146	33.6
Fewer	4	0.9
Unsure	28	6.4

SRHR Awareness, Attitudes, and Practices

A total of 87.7% of respondents reported ever hearing about SRHR and 71.8% reported receiving family planning information within the past 12 months. The majority of respondents cited either health workers (58.2%) or health extension workers (28.1%) as their primary source of SRHR information. However, 64.0% did not know where SRHR services were available. Most respondents (76.1%) approved of the use of family planning; however, the majority had not previously used and were not currently using any family planning method (85.1% and 91.3%, respectively). The primary reasons for not using family planning included a desire to conceive, active breastfeeding, or a current pregnancy. See Table 3 for additional details.

Table 3. SRHR Awareness, Attitudes, and Practices

	n	%
Ever heard of SRHR services (n=423)	371	87.7
Knowledge of where to obtain SRHR services (n=25)	153	36
Sources of SRHR information accessed in the past 12 months (n=416)		
Radio	33	7.9
Television	11	2.7
Family and friends	3	0.7
Health workers	242	58.2
Health extension workers	117	28.1
Community events	8	1.9
Other	2	0.5

Received family planning messages in past 12 months (n=433)	311	71.8
Approved of family planning use (n=435)	331	76.1
Reason for disapproving of family planning use (n=435)	-	-
Currently pregnant	84	20.4
Wants to conceive	144	34.9
Currently breastfeeding	133	32.2
Postpartum amenorrhea	16	3.88
In-fecund or sub-fecund	1	0.24
Menopausal	1	0.24
Not engaging in sexual intercourse	4	0.97
Unaware of family planning methods	3	0.73
Afraid of side effects	9	2.2
Religious prohibition	3	0.71
Other	14	3.4
All respondents currently using a family planning method (n=436)	38	8.7
Married respondents currently using a family planning method (n=408)	37	9.1
Family planning method currently in use (n=53)	-	-
Lactation amenorrhea	17	68.0
Injectable contraceptives	4	16.0
Implants	2	8.0
Oral contraceptives	2	8.0
Previously used a family planning method (n=437)	65	14.9
First family planning method used (n=53)	-	-
Lactation amenorrhea	40	75.5
Injectable contraceptives	2	3.8
Implants	1	1.9
Oral contraceptives	9	17.0
Other	1	1.9
Married respondents' reasons for not using a family planning method (n=405)	-	-
Currently pregnant	80	20.8
Wants to conceive	133	34.5
Currently breastfeeding	128	33.2
Postpartum amenorrhea	16	4.2

In-fecund or sub-fecund	1	0.3
Menopausal	1	0.3
Not engaging in sexual intercourse	2	0.5
Unaware of family planning methods	3	0.8
Afraid of side effects	9	2.3
Religious prohibition	2	0.5
Other	10	2.6

Abortion Awareness, Attitudes, and Practices

Few respondents had heard of abortion (20.5%) or knew where to access abortion services (19.8%). Very few respondents (7.1%) would approve of abortion in any circumstances, largely due to religious values. Similarly, very few (2.8%) were aware of a family member or friend who had terminated a pregnancy and few respondents (18.2%) would advise a family member or friend wishing to terminate a pregnancy. Additionally, the vast majority of respondents believed that terminating a pregnancy at least sometimes if not always results in complications and only a few (10.6%) believed that their nearest health center would have sufficient equipment and supplies to perform safe abortion services.

Table 4. Abortion Awareness, Attitudes, and Practices

	n	%
Ever heard of abortion (n=429)	88	20.5
Knew where to access abortion services (n=86)	17	19.8
Knew a family member or friend who had terminated a pregnancy (n=435)	12	2.8
Likelihood of advising a family member or friend who may wish to terminate a pregnancy (n=88)	-	-
Would advise	16	18.2
Would not advise	69	78.4
Unsure	3	3.4
Believes abortion is acceptable	31	7.1
Reasons for not accepting abortion (n=396)	-	-
Personal values	22	5.6
Religious values	368	92.9
Spousal or familial pressure	4	1.0
Other	2	0.5
Perceived likelihood of the nearest health center having sufficient equipment and supplies to safely terminate a pregnancy (n=425)	-	-
Yes	45	10.6

No	134	31.5
Do not know / unsure	246	57.9
Perceived likelihood of experiencing complications associated with terminating a pregnancy at a health center or hospital (n=426)	-	-
Always experiences complication(s)	137	32.2
Sometimes experiences complication(s)	242	56.8
Never experiences complication(s)	36	8.5
Unsure	11	2.6
Perceived likelihood of experiencing complications associated with terminating a pregnancy at places other than a health center or hospital (n=443)	-	-
Always experiences complication(s)	255	57.6
Sometimes experiences complication(s)	157	35.4
Never experiences complication(s)	23	5.2
Unsure	8	1.8
Perceived reasons for terminating a pregnancy (n=427)	-	-
Rape	23	5.4
Incest	93	21.8
Pregnancy posing a health risk for the mother	107	25.1
Pregnant mother is mentally ill	96	22.5
Pregnant mother is under age (under 18 years old)	3	0.7
Unsure	105	24.6

Sexual and Gender-Based Violence Awareness

Few respondents (12.9%) were aware of where survivors of sexual and gender-based violence could seek support.

Table 5. Sexual and Gender-Based Violence Awareness

	n	%
Knew where sexual and gender-based violence survivors can seek support (n=427)	55	12.9

Key Learnings and Recommendations

Based on the data collected through our study, we have identified several key learnings and related recommendations for future programming.

Table 5. Key Learnings and Recommendations

Learning	Recommendation
Most of the IDPs surveyed were illiterate.	Outreach messaging must be delivered in ways that illiterate audiences can understand. Approaches might include community theater skits, radio programming, and printed materials using pictures or other visual design elements to convey key messages.
Nearly all respondents had given birth. Nearly half had five or more living children and more than half had given live birth within the past 12 months.	Recognizing high fertility rates among IDPs, comprehensive programming along the continuum of care is crucial—this includes contraceptive and abortion care; antenatal, safe delivery, and postnatal care; as well as infant and child healthcare.
While most participants were aware of SRHR and approved of family planning, very few were using or had previously used any family planning method.	Generating awareness around the importance of and options for accessing contraception is critical for increasing demand for services. Programs must also ensure such services are readily available to IDPs to respond to the potential increase in demand.
The majority of respondents were unfamiliar with abortion (including being unaware of where to access abortion services and unaware of family members or friends who had accessed abortion services) and were unaccepting of abortion.	Increasing acceptance for abortion care will require generating awareness as well as addressing key barriers. Engaging and educating religious leaders may be one approach to destigmatizing abortion, particularly in cases in which pregnancy and/or childbirth poses a risk to the mother or child's physical and/or mental well-being.
Despite documented high incidence of sexual and gender-based violence among IDPs overall, few respondents knew where to access support for sexual and gender-based violence.	While awareness is a clear gap, further analysis is needed to understand prevailing attitudes, beliefs, and behaviors in order to inform the scale and scope of programming needed to address sexual and gender-based violence within IDP groups. Additional tracking of sexual and gender-based violence is also necessary to determine prevalence of the issue and guide appropriate responses or referrals.

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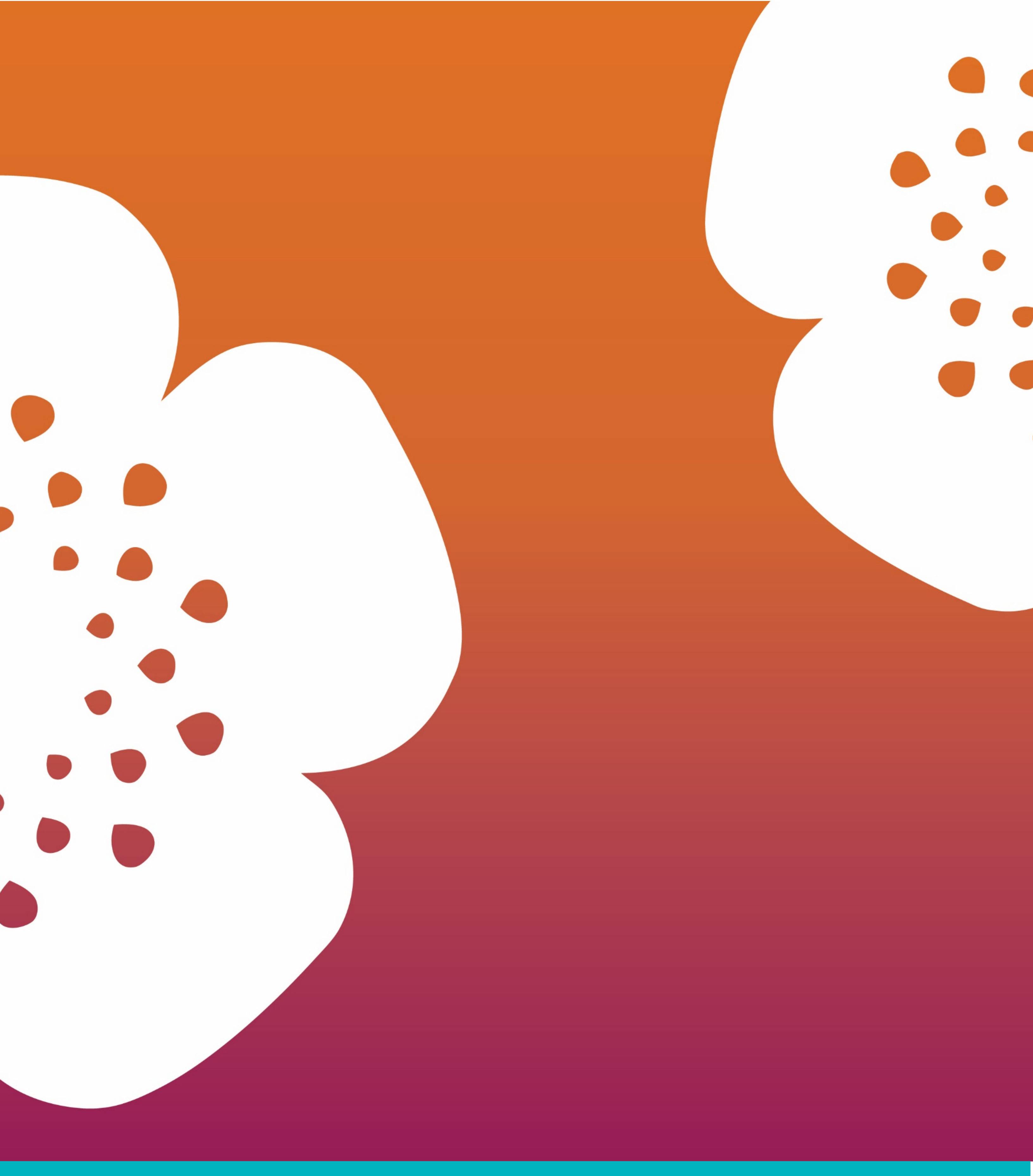

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