Abortion service provision and the recording of maternal death in Kakuma refugee camp, Kenya

Introduction

The number of new refugees and internally displaced persons (IDPs) grows around the world each year and shows no sign of slowing.[1] When the United Nations Refugee Agency (UNHCR) began reporting annual numbers of forcibly displaced individuals in 1951, they totaled 2,116,011; at the end of 2020, the number had grown to 89,281,133, an increase of over 4,000%.[2] Between 2015 and 2020 alone, the number grew by 25 million individuals.[2] These numbers are likely underestimates, not overestimates.[3] Not only does the number of forcibly displaced individuals continue to grow, but the causes of displacement are also increasing. The factors accelerating forced displacement globally are well-known. Pre-existing drivers, such as those related to the environment (like drought), society (like lack of opportunity for community members), politics and policy (like corruption), and economy (like poverty), are triggered by immediate events, such as armed attacks or natural disasters, that then force individuals to flee their homes.[4] The most common culprit, however, is political, and may both trigger and protract crises through creation of structural weaknesses and misappropriation of aid.[4]

In 2019, approximately 218 million individuals of childbearing age had an unmet need for modern contraception.[5] This means that these individuals were sexually active, did not want a(nother) child or wanted to space children, and were not using an effective method of contraception. Even with contraceptive use, individuals may become pregnant due to user error or contraceptive failure. A recent comprehensive study including data from 166 countries estimated that from 2015-2019, there were 121 million unintended pregnancies annually, of which 48% were unintended.[6] The same study estimated that 61% of pregnancies between 2015 and 2019 ended in abortion; this amounts to roughly 73 million induced abortions each year.[6]

One in four of the over 89 million forcibly displaced individuals around the world is someone who can become pregnant.[1] These forcibly displaced individuals may have a higher unmet need for high-quality, accessible safe abortion and post-abortion services than the general population due to the constraints of service provision in complex humanitarian emergencies. Health facilities in these settings often experience stock outs of contraceptive methods or may not have the providers or equipment necessary to provide high-quality reproductive health services.[7] This reduced access to commodities and services may increase the number of unintended pregnancies in these populations.[8] Additionally, forcibly displaced individuals are more likely to experience rape, early or forced marriage, intimate partner violence, child sexual abuse, prostitution, sex trafficking, or other forms of sexual violence and exploitation than host communities or individuals in stable settings.[9] In complex humanitarian emergencies, sexual-based violence is committed at an estimated rate of 21.4%[10] compared to about 10% globally.[11] Decreased access to contraception, coupled with increased sexual violence, puts forcibly displaced individuals at a higher risk of unintended pregnancy.

Once individuals become pregnant, they may face barriers to safe abortion care if they wish to end their pregnancy. A scoping review of access to safe abortion care in humanitarian crises found that barriers include those related to the legal environment, context, stigma, economic factors, and service delivery.[12] Potential reasons that forcibly displaced individuals cannot access or do not use comprehensive abortion care include barriers at the policy, community, health facility, interpersonal, or individual level.[13–16]

The most recent data we have to understand the impact of global negligence on refugee and IDPs' reproductive health needs in humanitarian emergencies is this: an estimated 25-50% of maternal deaths in refugee settings are due to unsafe abortion.[17] This number comes from a 1999 annual UNFPA report that does not provide further information about the methodology, such as the estimation technique used or the sample population. Despite these limitations, this estimate is cited across reproductive health literature, from articles in peer-reviewed manuscripts to briefing papers and beyond.[18-21] Meanwhile, global estimates place maternal mortality due to unsafe abortion at 7.9%, meaning the UNFPA estimate for refugees from 24 years ago represents an increased risk of about three to six times.[22]

The purpose of this research is to explore how healthcare workers document maternal deaths in the community and in health facilities in Kakuma refugee camp, Kenya and to understand their attitudes, beliefs, and practices around abortion provision. The study results will contribute to the implementation of successful maternal mortality surveillance activities and measurement refugee camps, in addition to data that can be used to prepare abortion sensitization training for healthcare providers in these populations.

Methods

We will identify potential study participants by working in collaboration with the Health Cluster in Kakuma refugee camp, Kenya. Subjects will be recruited based on their participation in reproductive health service provision and documentation of maternal mortality. Each interview will be conducted in a private room within the participant's linked health facility to ensure privacy and confidentiality. Participants will be consented by a research assistant in English. After they sign the consent form, the research assistant will ask if they may record the interview and will explain what will happen to the recording. The research assistant will also explain that the participant may request to stop the interview at any time and for any reason. At least fifteen healthcare workers in refugee camps will be interviewed, but up to 25, in order to reach code and meaning saturation.

Interview guides will comprise of three sections. The first, "Reproductive health policies/laws" will probe provider perspectives on policies related to women's health. Questions will investigate interviewee knowledge of current laws and how they affect refugees and host populations differently. Section two, "Current practice with unintended pregnancy", will provide context about what happens when a woman living in a refugee camp becomes pregnant and how services are provided in the healthcare worker's workplace. Lastly, section 3, "Maternal death records" will specifically explore how maternal deaths in the community and facility are

documented, the related training that providers receive, and what prevents or facilitates accurate record-keeping.

De-identified transcripts will be analyzed by two independent researchers in MaxQDA using content analysis.[9] We will develop an a priori list codebook deductively, and we will add inductive codes as they arise in the interview transcripts. Interviews will be coded as they are conducted to allow for ascertainment of both code and meaning saturation. Codes will be refined through researcher discussion and inter-coder agreement assessments.

We will review death records in at least five health facilities in Kakuma refugee camp, Kenya. We will extract demographic and cause of death details from the registers to better understand who dies and why in the refugee camp.

Results

This research is currently underway and we expect to present robust qualitative results related to healthcare provider abortion knowledge, attitudes, and practices. We also plan to present detailed information about how maternal death is recorded in Kakuma refugee camp, Kenya. Lastly, we will present detailed descriptive statistics on who dies in Kakuma refugee camp, Kenya, and due to what causes.

Discussion

Maternal mortality due to abortion complications is a pressing issue around the world that is amplified in humanitarian emergencies. The number of refugees and IDPs is accelerating each year and shows no sign of slowing down. This means the number of forcibly displaced individuals of childbearing age is increasing each year, meaning more unintended pregnancies and more unsafe abortions unless issues of access to services are addressed. We cannot rely on an estimate of maternal death from unsafe abortion in refugee settings that was generated almost 25 years ago and for which we have no context. Nor can we assume that the proportion of maternal mortality due to unsafe abortion is the same in stable and humanitarian emergency settings. We cannot rely on extrapolations about access to health services from general populations to humanitarian emergency contexts. We need to be able to more accurately capture maternal deaths in these settings. This lack of research and evidence contributes to the ongoing problem.

In addition, this is a human rights issue: access to these services empowers individuals to make decisions about if, when, and how many children to have. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also called the Maputo Protocol, guarantees women's right to health, and specifically states that signatories should:

> "... Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[23]

This is the first treaty in Africa to recognize abortion as a right.

All individuals should have the means and access to services that allow them to exercise their reproductive rights. Despite immediate circumstances, including complex humanitarian

emergencies, the reproductive rights of all individuals should be upheld. A better understanding of barriers to accurate reporting of maternal death and healthcare provider abortion knowledge, attitudes, and practices are key steps towards empowering forcibly displaced individuals to exercise their human rights.

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