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# A critical analysis of reproductive health challenges of Cameroonian female refugees in Nigeria

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## Abstract

The difficulties faced by refugees cannot be over emphasized. After losing their homes and livelihood, they become vulnerable to hunger and face multiple challenges in the host countries. As such, their health are often compromised due to disruption of traditional health systems and an increase in risk factors.[1] For women, their reproductive health challenges are compounded because of gender specific issues. These challenges are multifaceted and sometimes with severe consequences on their health. This paper reviews the reproductive health challenges of female refugees and how they affect the health of Cameroonian female refugees in the Adagom refugee camp in Nigeria. The study population consist of all female refugees of reproductive age (15-49) at the three Adagom refugee camps (Adagom 1, Adagom 2 known as Ukende and Adagom 3). Those considered were also those who had a registered status under the UNHCR. Informed by both the Andersen's Behavioral Model of Health Centre Use and the People-Oriented Planning Framework, the study samples one hundred and twenty (120) Cameroonian refugee women from the three camps using the snowball method until saturation. Findings revealed that women faced enormous challenges with their reproductive health and these included poverty, distance, lack of knowledge, attitudes of health service providers, lack of support, violence, rape, and other unsafe practices. These challenges have multiple effects on women's health including unwanted pregnancy, unsafe abortions, pregnancy complications (eclampsia and pre-eclampsia), infections, inability to conceive, stress and trauma, miscarriages and even death. It will therefore be imperative that reproductive health services be an integral part of refugee health package so as to reduce these effects on women's health.

**Keywords:** reproductive health, female refugees, challenges, effects, refugee camps, Cameroon

## Introduction

The refugee problem is a pressing issue in contemporary society because of the growing numbers of destructive wars and natural disasters. The current refugee problem has been distinguished from refugee movements of the past decades by its scope, variety of causes, and complexity of solution. Modern refugee movements have given rise to a new class of people who are homeless and stateless and who live in a condition of constant insecurity that erodes human dignity. Modovan (n.d) defines a refugee as a person "who, owing to well-founded fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality or being outside the country of his/ her former habitual residence, is unable or, owing to such fear, is unwilling to return to it". According to the UNHCR,[2] there are 68.5 million forcibly displaced people throughout the world.

Africa has been one of the centers of massive refugee movements and internal population displacement. Human displacement is growing in scale and complexity and becoming increasingly precarious as many who succeed in escaping from their own country find it difficult to find a safe refuge in neighboring countries.[3] For example, the UNHCR[2] notes that Cameroon is host to some 473,887 refugees with 346,689 coming from the Central African Republic alone.[1] . The majority of these refugees are women.[2]

The difficulties faced by refugees cannot be over emphasized, because after losing their homes and livelihood, they become vulnerable to hunger and multiple forms of abuse. However, although both men and women refugees experience these challenges that include poverty, financial insecurity, deprivation, malnutrition, lack of access to educational opportunities and to adequate health care, women and girls are usually more affected because of their gender roles and specific reproduction needs.[4] Female refugees are likely to encounter double especially with issues relating to sexual abuse, gynecological and specific reproductive health needs. During flight or in refugee camps, women and young girls are often exposed to gender related abuses that compound their challenges as refugees.

The notion of refugee camp is to accommodate people temporarily in times of crises so that they can return home when things go back to normal. This means that refugee camps are not constructed as permanent abode and so the facilities, including health and social amenities are not permanent. However, due to the prolong nature of some crisis and natural disaster, the unwillingness of some refugees to go back home, and the difficulties in resettling refugees, refugees tend to stay longer than expected in the camps and this makes life extremely difficult as the temporal facilities are over stretched for accommodate very lengthy sojourns. This makes survival very difficult.

The breakout of civil unrest in the South West and North West regions of Cameroon since 2016 has pushed many Cameroonians to seek refuge in neighbouring Nigeria. This has been followed by the creation of the Adagom refugee in Nigeria among others to accommodate these Cameroonian refugees. We examine the demographic characteristics of those Cameroonian fleeing the country into Nigeria and the extent to which the experiences of male and female refugees vary in the health sector.

[1]https://data.unhcr.org/en/country/cmr.



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### Research problem

During wars, conflicts or natural disasters, people disregard international boundaries and flee into neighbouring countries for survival. Most often, especially in Africa, these countries are themselves struggling to take care of the basic needs of their citizens.[2] These refugees are thus faced with a lot of challenges in new countries and societies, often characterized by difficult circumstances. As such, their health could often be compromised due to disruption of traditional health systems and an increase in risk factors.[1] Women' particular health vulnerability is compounded because of their gender specific issues such as lack of information, unequal access to healthcare, gender discrimination and restrictive social norms.

The refugee camp environment also includes variety of factors that can substantially impede health and wellbeing. These may include nutrition and food insecurity, overcrowding and lack of access to clean drinking water, inadequate shelter, and limited health services. In this context, refugees including women, face varying health risks and challenges. Malnutrition is a significant risk, with a lack of food often stemming from limited financial resources and unstable livelihoods. Additionally, social norms and gender-based discrimination can serve to restrict access to adequate nutrition among refugee women, particularly in contexts in which they do not hold decision-making power in the household. This makes it difficult for female refugees to achieve adequate nutrition through food distribution programmes, or from processing and preparing nutritious food.[5]

A lack of access to information about health services is a further area of challenge for female refugees. Limited resources, competing priorities and cultural, religious and gender-based norms pose additional barriers for women seeking access to appropriate healthcare including reproductive, sexual and mental health services. Limited knowledge can result in limited access to such services due to stigma, lack of knowledge about health services and potential consequences of seeking care.[6]

Given the poor conditions in refugee camps and the specificities of female refugees, their health is significantly at risk. Onut & Leontief[5] note that refugee women often have limited access to education, limited access to decision-making power in the household and potentially negative presence of traditional gender roles. As such, they are more likely to suffer from malnutrition, inadequate healthcare services, and physical and psychological violence. All of these factors can have significant implications ranging from immediate outcomes such as physical abuse, to long term impacts including an increase in stress-related illnesses and mental health challenges. Cameroonians refugees have settled in the Adagom camp since 2016. This paper explores their living conditions especially along gender lines and analyses how the challenges facing female refugees may not only by different but may also have far-reaching implications on their health.

## Literature review

### The nature of female refugees

When one thinks of refugees, certain images of desperate and helpless people carrying little clothes and bags on the heads and backs often come to mind. However, this image does not represent the full profile of refugees. Refugees are diverse, resilient, and remarkably strong individuals who are forced to leave their homes to survive and ensure the safety of their families. Refugees are those seeking safety because of fear of torture, cruel and inhuman treatment, or any form of persecution related to race, religion, nationality, political opinion, or membership in a particular social group. Refugee situations and refugees are different and diverse as the reason for displacement. This diversity is also reflected in the demography and the conditions in refugee camps, depending on the conflict that caused displacement, the preflight socio-demographics of the source country, the relationship between the source and host countries and other sociopolitical factors.[7]

They are diverse in sex, age, religions and abilities. During crisis, displacement and refugee situations, the potential inequality between men and women is revealed and this shows the gendered nature of refugee profile. Women and girls often experience a heightened risk of violence and exploitation largely due to the gendered norms that leave them particularly vulnerable in situations of displacement.[8] The gendered nature of the profile of refugees shapes the ways in which they are viewed, as well as the services and resources they receive.[9] While many international and local actors are working to strengthen the prevention of gender-based violence and increase the recognition of refugee women's socio-economic rights, there remains significant gap between commitments and reality. Further initiatives and greater attention to the specific needs of both women and men are needed to ensure that refugees of all genders are provided with adequate protection and assistance.

### Health services and reproductive health care in refugee camps

Reproductive health services in refugee camps are not only critical for the well-being of the camp population but also for the broader global health system. Access to integrated, comprehensive and high quality reproductive health services in refugee camps is vital for the prevention and management of reproductive health issues and improving the overall health of camp populations.[10] Reproductive health care for refugees, IDPs, and migrants is not a luxury, but a necessity that saves lives and reduces illness (www.rhrc.org). However, accessibility to and availability of reproductive health services is very poor in many countries and more so in refugee camps. Women are often unable to access maternal health services due to lack of availability of such services, lack of knowledge about the existence of such services or lack of freedom of movement.[11]

It is therefore important that these services be integrated within primary health care services and be tailored to the specific needs of each camp. Reproductive health care (RHC) is an indispensable component of comprehensive health care for refugees, providing safe and equitable approach to care for all individuals that are forced to separate from their homes. However, access to family planning usually decreases during humanitarian crises as health systems are compromised. In such situations women suffer more due to differences sex and gender roles and to the specific reproductive health needs of women.[12]

The use of reproductive health service within refugee camps has received growing attention from funding bodies, but little empiric data exists in the literature on service use within camps. Reproductive health service use can encompass many dimensions of family planning, antenatal care, HIV/AIDS screening, and sexually transmitted infection (STI) care (www.womensrefugeecommission.org).

### Reproductive health challenges in refugee camps

Reproductive health challenges of female refugees have become increasingly relevant in recent years due to global refugee crisis. Globally, it is estimated that around seven million women and

[2] https://refuge.journals.yorku.ca/index.php/refuge/article/download/21312/19983/53194.

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refugees are in need of reproductive health care. The lack of access to health care, inadequate knowledge of sexual health, and gaps in services create serious risks to female refugees' reproductive health. Additionally, cramped living conditions, poverty, and social isolation are some of the contributing factors to unfavourable reproductive health outcomes.[13] The vulnerability of female refugees to poor reproductive health outcomes may stem from myriad causes; including, but not limited to traditional gender role expectations, lack of access to knowledge and health care, limited resources, and fear of discrimination and violence.[14] These factors seriously impede refugee women's access to quality health services and their ability to protect themselves from health related risks.

Reproductive health is a cornerstone of human rights and gender equality. These rights include "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so… (as well as) the right to the highest standard of physical mental and social wellbeing related to the reproductive health" (WHO, 2017). These rights extend to all refugees and internally displaced persons irrespective of nationality and gender, ethnicity, age, religion, culture and legal status.

Refugee women may face barriers to accessing reproductive health services due to stigma or the perceived risk of social repercussions associated with seeking care (http://www.unhcr.org/5308f7bf9.pdf). Additionally, language and cultural barriers may impede their access to appropriate and adequate services (UNHCR, 2016). Cultural and sociocultural factors can contribute to a series of reproductive health challenges for female refugees. Traditional gender roles perceived by the refugee population can contribute to female refugees facing limited autonomy in decision making related to their reproductive health and can limit their access to family planning services and information.[1] In certain contexts, taboos or cultural prohibitions around topics related to sex, contraceptives and family planning can contribute to reduce access to services and information, limited knowledge and potentially dangerous attitudes and practices. Broader structural factors related to refugee experience such as lack of financial independence, high levels of poverty, low levels of educational attainment, displacement, lack of legal protection and restricted access to education and employment can lead to an increased vulnerability to sexual violence and the risk of early pregnancy and unplanned pregnancies.[15]

Humanitarian situation puts men, women, boys and girls in different helpless and vulnerable situations. Though men face some challenges in their host country, it cannot be compared to the hardship that women and girls face. According to Mortazavi et al.[16] Women are the majority of people who move during crisis and also move with their families. This continuous attachment to their families is because of their domestic roles of care giving and nurturing. With this, the women are placed in a vulnerable situation and face challenges accessing health needs like reproductive health.

They also experience health issues such as complications from pregnancies and lack of access to preventive gynecology services because of number of barriers such as financial accessibility, language barrier, discrimination and lack of information. Refugee women are also faced with challenge such as limited health facility availability, and gender issues that prevent women from seeking family planning resources. Furthermore, among refugees, rapes occur frequently and some women may have no choice but to trade sex for security, money, and food, thereby heightening their risk of sexual violence and abuse, which oftentimes puts them at risk of contracting STI's and getting pregnant. They are inherently vulnerable to violence and discrimination and this can result in poor physical and mental health outcomes. Consequently, refugee women's health must be addressed and protected if we are to mitigate the negative consequences of displacement and give refugee women a chance to lead healthy and autonomous lives.

## Effects of reproductive health challenges on the health of female refugees

The World Health Organization (WHO) defines health as "a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity".[17] The conditions of becoming a refugee negatively affects the wellbeing of both male and female refugees. However, women have specific health, especially reproductive health needs that become difficult to address in refugee situations and this has devastating effects on their lives. Inadequate or interrupted access to sexual and reproductive health (SRH) services can lead to a high risk of mortality or morbidity for women due to pregnancy-related causes, unintended or unwanted pregnancies, lack of information or access to contraceptive services, complications related to unsafe abortions and an increased incidence of sexually transmitted infections (STIs), including HIV.[18] The WHO Global Refugee Health report (2012) posits that, many women get pregnant in refugee camps and do not have access to antenatal care and many do not have access to basic healthcare facilities and supply. The lack of access to medical care can lead to a number of health risks during childbirth, including birth complications and post-partum infection and stillbirths.[19] Furthermore, while various aspects of refugee movement and displacement can increase vulnerability to HIV infection, displacement may certainly increase known risk-factors for HIV transmission through the breakdown of social structures, increased risk of sexual violence and lack of access to health services.

## Theoretical framing of the study

Two theories, the Andersen's Behavioral Model of Health Service Use and People-Oriented Planning Framework are important in understanding the reproductive health challenges of women in refugee camps. The Andersen's Behavioral Model of Health Service (ABMHSU) focuses on the individual's perception and reactions to their healthcare needs and how those perceptions influence their health-related behaviors. It holds that health service utilization is based on three factors: needs, predisposing factors and enabling factors.[20]

Need is a subjective measure describing an individual's perceived level of ill-health or need for health-related care. It considers both physical and psychological needs, and therefore a catalyst for health-related behaviour. Predisposing factors are variables that have direct impact on an individual's likelihood of engaging in health-related activities. They include factors like age, gender, socio-economic status, cultural beliefs, and knowledge of health care services.[20] Enabling factors can either facilitate or impede the individual's ability to receive adequate health services. Enabling factors include access to health care providers, the availability of health insurance, and the cost of health care service, and family and community support networks. In application of all three components of the ABMHSU model, need helped identify the health-related needs of the refugee women. Predisposing factors helped examine those factors that makes refugee women more likely than men to seek reproductive healthcare, while enabling factors interrogate the socio-economic and environmental factors that can interfere with female refugees accessing and making use of reproductive health services.

The People Oriented Planning (POP) Framework is a tool developed by the United Nations Development Program (UNDP) to help further incorporate a human centered approach into planning initiatives in refugee situations that takes into account women, men and children. It consists of three components; refugee profile and context analysis, activities analysis and use and control of resource. The POP Framework is based on the fundamental principle that people should be the focus of any kind of planning and is rooted in five core principles namely; interdependence and collective impact, community engagement, engaging oppressed populations, innovation, and equity.

Although these principles are interrelated and rely on each other to create a framework which is intended to bring meaningful change and public health outcomes,[21] this paper focuses on just two of them -engaging oppressed population and equity. Engaging oppressed populations works to increase the capacity of vulnerable and disenfranchised groups, such as people with disabilities, refugees etc. to have a voice in planning and policy processes while equity focuses on using data-driven approaches to create accountable, effective and equitable solutions. The POP Framework thus, provide a holistic approach to addressing complex public health issues and the underlying factors of social determinants of health.

## Methodology

This is a descriptive survey, using mixed qualitative and quantitative methods. It observes and describes the reproductive health challenges of female refugees at a refugee camp setting. The study population consist of all female refugees of reproductive age at the three Adagom refugee camps (Adagom 1, Adagom 2 known as Ukende and Adagom 3). Those considered were also those who had a registered status under the UNHCR. A sample size of one hundred and twenty (120) Cameroonian refugee women of reproductive age (15-49) were selected from the three camps using the snowball method until saturation. Saturation, which has its origin in grounded theory, was used to discontinue data collection when it was realized that additional data was not leading to any new themes. The main instrument for primary data collection was unstructured questionnaire. UNHCR was also selected to be part of the study based on the scope of their activities with the refugees and in terms of their programs and interventions for refugees in this camp. An interview was therefore conducted with the staff of UNHCR to support the data from the female refugees. Quantitative data was analysed using version 21.0 of the Statistical Package of the Social Sciences and presented with the help of percentages, while content analysis was used to analysed qualitative data also content analysis.

Although this was a social and not a medical research, it did involve humans. Therefore, ethical consideration was very important. The questionnaire and interview guides were validated by the Departmental and Faculty ethical and scientific committees ensuring that the participants in the research are protected. Respondents were informed that they have a right to not participate in the study and to discontinue whenever they felt like. Their identities were well protected all through the study and their dignity preserved.

## Findings and discussion

### The organization of the camp

The Ogoja refugee settlement has three (3) camps; namely Adagom 1 which is the mother camp and the biggest with a general population of about 12.000 people, Ukende camp with a general population of about 9.000 and Adagom 3 which is the baby camp with population of about 6.000. The camps are made up of communities while the communities are broken down or made up of clusters and each cluster comprised of 3 permanent structures/houses and 2 tents. Each community has a head that is in charge of the welfare and management of the affairs in the community, and reports directly to the Settlement Chairperson. The institutions in charge of the refugees are United Nations which is the mother body, SEMA which is the Nigerian government body that is taking care of security and management of the settlements and ensures that the stance of the government is implemented. There is also CARITAS of the Catholic Church, Red Cross, Save the Children, Mediatrix, CUSSO International, CorAfrica, and 2 Community Based Organizations (CBO) such as Great Step Initiative and SATWO. The Red Cross is the main institution that handles issues of reproductive health of women in the camp.

Management of the camp also revealed that there are four health facilities that takes care of the refugees (Monaya, Mercy clinic, Santa Maria and General hospital). These health facilities it should be noted are all situated in town outside the camps. The refugees after obtaining a refugee ID and an insurance card are assigned to any of these 4 health facilities. Some of these hospitals have reproductive health services such as antenatal, family planning services, maternal and neonatal care and HIV/AIDs while some of the services like safe abortion care, emergency obstetric services are not available in some. Furthermore, some of the health facilities don't have specialist like Gynecologists and Pediatricians except the General hospital and Santa Maria and according to management, this makes it difficult for the women to access some services when pregnant. A body called Japaigo which is in charge of HIV/AIDs and other related diseases come around and conduct free testing on HIV, places people with HIV on medications and do follow up.

### Profile of the refugees

The population sampled revealed that the majority of refugees are young women. Regarding the age of respondents, more than half (58.3%) of them were within the ages of 20-29 years. Followed by respondents below the age of 20 (20%) and respondents within the ages 30-39(18.3%), while the respondents within the ages 40-49 were just 3.3%. This shows that refugees are mostly made up of younger people who are usually strong enough to make the risky journey. Over 42.5% of these refugees were single. The remaining were either married (20.8%), cohabiting (20.8%) or widows (10%). These findings indicate that it is easier for single persons to flee from home in times of crisis than any other group. This notwithstanding, refugees living in the camps have large family sizes. Over 29% have more than 5 kids, 50% have between 1-5 kids and 20.8% have no kid. Some of the kids have been born in the camps as reported by 25% of the respondents, 41.7% reported to have brought the children along while about 33% of respondents did not attempt this question. Majority (82%) of the refugees have some level of formal education. Almost half (49.1%) had post-secondary education, 28.5% had secondary education and just 5% had primary education. Over 70% of the refugees depended solely on the UNHCR for survival. However, a few of them were engaged in some economic activities such as farming (12.5%), petty trading (9.2%), and poultry or piggery (4.2%).

### Reproductive health challenges faced by Cameroonian female refugees

In relation to the availability of health services for the refugees, most essential health facilities are not available within the camps. There is a however First Aid posts in the camp. Refugees have to go outside the camps, into the community to access health from the local health facilities. This is made possible with a refugee identification

card that sends the refugee to a particular health facility. About 75% of respondents attested that the health facilities had reproductive health services but when it came to using these services, only 16.7% said they do practice family planning. About two-thirds of the women who gave birth in the camps said they did have ante-natal services during pregnancy. The other one-third that didn't attend gave reasons such as lack of information, non-affordability or just didn't think it was important. With majority of the respondents having some level of formal education, it can be assumed that they are knowledgeable about using ante-natal services. However, more than half (58%) of the respondents accepted that they had challenges accessing reproductive health services. These challenges ranged from lack of finance, distance and transportation problems and not-too-skilled health service providers. About 75% of them could barely afford healthcare, talk less of reproductive health services. Those that could afford are those that are doing some petit trading in the camp. More than two-thirds of them also said they were not satisfied with the services rendered by the health facilities because of discrimination and poor treatment due to their refugee status. More than 60% the respondents complained that they face some challenges dealing with the health care providers who treated them poorly with healthcare providers always feeling irritated when attending to them and also bad mouthing them because they are refugees. Some respondents complained of being verbally insulted by healthcare providers for getting pregnant too often and thus being a nuisance, "you these refugees are always pregnant and you disturb a lot". Many times they are also sent away saying that refugee medication is finished and so one must have money to get medication.

Half of the women also reported that their partners do not support them doing family planning, claiming that children are gifts from God and so pregnancy should not be controlled. About 20% said they receive both moral and financial support from their partners in relation to family planning. The rest of the respondents have no knowledge about family planning. About 70% of respondents said the little knowledge they have knowledge about contraception comes from organisations like the Red Cross.[22]

While 62% of respondents did not have language as a barrier for accessing reproductive health services, 37.8% said that language was a barrier for them. Another major health challenge that respondents faced in the camp was violence. More than 67% of respondents reported to having experienced physical, psychological and sexual violence in many forms. The most gruesome of them being assault and rape from intimate partners and neighbours. Of all the rape cases, four of them got pregnant and had to have the babies. Further investigation revealed that out of these 20 respondents who have been physically violated, half (10) were violated by persons close to them (5 by their husbands, 3 by their neighbors and 2 by their brothers).

Respondents were further asked whether they have had to trade sex for survival and a majority (75%) said they do trade sex for security, money and food in the camp. Severe hardship and hunger them to do all these things just to survive. Further investigation also revealed that some women have even had to sell their babies to women outside the camps who had difficulties conceiving in order to raise money to cater for their needs and also to reduce the number of mouths to feed.

## Effects of reproductive health challenges on the health of refugee women

One major effect of reproductive health challenges on the health of refugee women in Adagom refugee camp is unwanted pregnancy as a result of lack of knowledge of family planning, rape, and sex for survival. This fact was acknowledged by over 70% of respondents. Another effect is complications during pregnancy. Above one-third of the respondents who had children in the camp reported to having experienced complications during and after pregnancy. Further investigation revealed that the complications were in the form eclampsia, pre-eclampsia, infection, miscarriages and still birth. To address some of these complications, some respondents said they went to the hospitals while others resorted to traditional herbs (Tables 1 & 2).

**Table 1** Effects of reproductive health challenges on refugee women's health

| Effect | Yes | No | Total |
|---|---|---|---|
| Unwanted Pregnancy | | | |
| n | 85 | 35 | 120 |
| % | 70.8 | 29.2 | 100 |
| Complications during pregnancy | | | |
| n | 40 | 80 | 120 |
| % | 33.6 | 66.4 | 100 |
| Ability to control child birth | | | |
| n | 89 | 31 | 120 |
| % | 74 | 26 | 100 |
| Maternal and neonatal deaths | | | |
| n | 90 | 30 | 120 |
| % | 75 | 25 | 100 |
| Abortions | | | |
| n | 75 | 45 | 120 |
| % | 62.5 | 37.5 | 100 |
| Too many children | | | |
| n | 49 | 71 | 120 |
| % | 41 | 59 | 100 |
| Stress/Trauma | | | |
| n | 5 | 115 | 120 |
| % | 4.2 | 95.8 | 100 |
| Inability to conceive | | | |
| n | 55 | 65 | 120 |
| % | 45.8 | 54.2 | 100 |

**Table 2** Challenges of refugee women

| Challenge | Yes | No | NR | Total |
|---|---|---|---|---|
| Access | | | | |
| n | 70 | 50 | 0 | 120 |
| % | 58.3 | 41.7 | 0 | 100 |
| Affordability | | | | |
| n | 30 | 90 | 0 | 120 |
| % | 25 | 75 | 0 | 100 |
| Dissatisfaction with health service | | | | |
| n | 45 | 75 | 0 | 120 |
| % | 37.5 | 62.5 | 0 | 100 |
| Support from partner | | | | |
| n | 20 | 20 | 80 | 120 |
| % | 16.7 | 16.7 | 66.6 | 100 |
| Access to information | | | | |
| n | 85 | 35 | 0 | 120 |
| % | 70.8 | 29.2 | 0 | 100 |
| Language barrier | | | | |
| n | 45 | 75 | 0 | 120 |
| % | 37.5 | 62.5 | 0 | 100 |
| Presence of violence in the camp | | | | |
| n | 80 | 40 | 0 | 120 |
| % | 66.7 | 33.3 | 0 | 100 |

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Table 2 Continued...

| Challenge | Yes | No | NR | Total |
|---|---|---|---|---|
| Experienced physical violence | | | | |
| n | 20 | 100 | 0 | 120 |
| % | 16.7 | 83.3 | 0 | 100 |
| Trading sex for Food, security, money | | | | |
| n | 90 | 30 | 0 | 120 |
| % | 75 | 25 | 0 | 100 |
| Challenge dealing with HC providers | | | | |
| n | 75 | 45 | 0 | 120 |
| % | 62.5 | 37.5 | 0 | 100 |

Furthermore, almost three-quarters of the respondents confessed that they do not have the ability to control (limit or space out) childbirth. It was noticed that they were not in control of their reproduction for reasons such as lack of knowledge, health facilities, rape, survival and patriarchy. There have also been incidences of maternal and neonatal deaths in the camp as reported by 75% of respondents. This, they reported is due to lack of proper care, unsafe abortions, infections/sickness, lack of finance, limited or no antenatal and postnatal visits etc.

Frequent abortion was another effect reported by respondents. More than 60% of respondents confirmed that abortion was frequent in the camp especially among young girls aged twenty years and below. Reasons advanced for these include poverty and hardship, unwanted pregnancy, denial of pregnancy by male partner, stigma of being pregnant and having a child at young age and also peer pressure. Most of these abortions, it was reported, were unsafe, mostly carried out by the girls themselves taking herbal concoctions and getting medications from local medicine stores while some are done by local chemist attendants with no professional skills. Many of these girls end up with severe complications while others die.

In addition to the fore mentioned, the women reported other related effects such as having too many children (41%), inability to conceive (45.8%), difficulty in getting pregnant due to crude abortions and complications during pregnancies, and stress and trauma due to multiple child birth and child rearing (4.2%). This it was the reason why some women to resorted to selling their babies to foreigners, especially when the pregnancy is unwanted or gotten through rape, just to have money to take care of the other children and themselves. Furthermore, due to poverty and verbal insults received from healthcare providers, many respondents said they prefer take herbal treatment when ill or pregnant.

Some of the concerns raised by respondents, were discussed in an interview conducted with the UNHCR representative in the camp/settlement in charge of management and security, also known as the Settlement Chairperson. As regards maternal and child mortality, camp management confirmed that most of the women don't attend antenatal. The Chairperson observed that as a solution, "… we have created a committee that sits every two months with the pregnant and breastfeeding mothers to help educate them on the importance of antenatal…". He further explained how volunteers from the Red Cross Society go around the camp to sensitize the pregnant women and breastfeeding mothers on healthy style of living during pregnancy, explaining that "…we also carried out a campaign where we donated food stuffs to pregnant and breastfeeding mothers in order to address malnutrition in children and reduce mortality…".[23]

In relation to the challenge of female refugees selling their bodies for livelihood, he reported that, most of the refugee women sell their bodies not only in the camps but out of the camps to make money to sustain their families. "If you go to any junction at night, you realized that most of the prostitutes are refugees. Some even go to the extent of selling their babies to foreigners in order to be free from the burden and stress of nurturing and caring of the baby, especially if the pregnancy is unwanted or gotten through rape" he explained. He further reported that the management of the camp has come up with sustainable empowerment programs to assist these women and to reduce if not stop the selling of their bodies for food and security. Some of these empowerment programs involve training on poultry farming, craftsmanship and this has really reduced the act of selling their bodies. CUSSO International and Red Cross are also training in hairdressing, tailoring, beads making (bags, jewelries) poultry. Red Cross also organizes seminars and talks to educate the women about their health, birth control, personal hygiene and menstrual hygiene and management. "Most of these women don't like attending some of these talks, but only attend if they are giving out donations like food, money, sewing machines" he said.

Following complaints from women that when they go to their hospitals, they are treated poorly by the health providers who call them mean names like slaves, refugees and bush people, the chairperson explained that "we wrote a serious complaint on that and the organization in charge of health have apologized and have put measures to stop this harsh treatment from the hospitals". He further reported that "Red Cross brought health Specialists who carried out surgeries on about 184 refugees because of the letters that we have been writing to them. We are working hard to have our own monitors in the hospitals so that when things happen, we will be informed".

On violence experienced by the respondents both in and out of the camp, the chairperson acknowledged and said "I get reports of rape cases almost every week perpetrated by male refugees and men from the host community. We have tried our possible best to establish a good relationship between the refugees and the host community. We have also put in place a task force made up of 11 vibrant young men who go around almost 24 hours ensuring that rape and other forms of violence does not take place in the camp. They work in shift and as of now we still experience other forms of violence but the occurrence of rape has reduced. We are also working in close collaboration with CARITAS and Save the Children since they have experts in this sector. They help educate the refugees on all forms of violence and who they can contact in case they are violated. We are preaching gender equality and we have put in place laws that are against any form of violence in order to protect the women" he continued.

Management further explained that refugee women still struggle to cope in the camp. Some of them still take traditional herbs during pregnancy instead of going for ante natal. Again, women take up odd jobs to earn money for their sustenance. Some receive help from well-wishers, friends and organizations. At the end of the trainings received by refugees, they are given work equipment to help start up trade. "Those that did poultry were given chicks to rear, while sewing machines were given to those that did tailoring. Some organizations taught the women how to calculate their menstrual cycle and the importance of family planning and contraceptive use to control and reduce birth".

## Conclusion

The Ogoja refugee settlement has three (3) camps namely; Adagom 1, Ukende and Adagom 3 with a total population of about 27,000 refugees. The UNHCR is the main institution in charge of the refugees among other. The four mains hospitals that attend to refugees' health are located outside the camp, and only two of them

have specialists like gynecologists and pediatricians. In reference to the profile of respondents, most were below 30 years old with more than half without partners (single or widowed) although above 70% have kids. Most of them have some level of formal education but few are engaged in economic activities (Table 3).

**Table 3** Profile of respondents

| **Age** | **Below 20** | **20-29 years** | **30-39 years** | **40-49years** | **Total** | |
|---|---|---|---|---|---|---|
| n | 24 | 70 | 22 | 4 | 120 | |
| % | 20 | 58.3 | 18.30% | 3.3 | 100 | |
| Marital Status | Single | Married | Cohabitation | Widow | Separated | Total |
| n | 51 | 25 | 25 | 12 | 7 | 120 |
| % | 42.5 | 20.8 | 20.8 | 10 | 5.8 | 100 |
| Level of Education | Post-Secondary | Secondary | Primary | None | Total | |
| n | 59 | 34 | 6 | 21 | 120 | |
| % | 49.2 | 28.3 | 5 | 17.5 | 100 | |
| Occupation | Farming | Petty trading | poultry/piggery | Nothing | Total | |
| n | 15 | 11 | 5 | 89 | 120 | |
| % | 12.50% | 9.20% | 4.20% | 74.10% | 100 | |
| No of Children | None | 2 to 5 | 5 and above | Total | | |
| n | 25 | 60 | 35 | 120 | | |
| % | 20.80% | 50% | 29.20% | 100 | | |
| Childbirth in the Camp | Yes | No | NR | Total | | |
| n | 30 | 50 | 40 | 120 | | |
| % | 25 | 41.7 | 33.3 | 100 | | |

In relation to reproductive health challenges faced, more than half face challenges accessing reproductive health care because of lack of finance, distance, attitudes of healthcare providers who are discriminatory and insulting, and also lack of support from partners. Other challenges include violence, rape, unsafe abortion and trading sex for survival. These challenges have enormous effects on the health of respondents, which include, unwanted pregnancies, multiple unsafe abortions, complications during pregnancy, eclampsia, pre-eclampsia, infections, miscarriages and maternal mortality. Other effects are inability to conceive and also stress and trauma due to multiple pregnancies, abortions and childbirth.

Ensuring women's reproductive health in refugee situations cannot be an easy task as the increasing number of conflicts in the world keep producing more refugees. The UNHCR is doing its best to accommodate these refugees and offer them all the social services they need. However, this study shows that more still has to be done in the Adagom refugee camp especially in relation to women's reproductive health, the absence of which has a lot of negative effects on the health of refugee women. It will therefore be imperative that health services be established within and not out of the camp; that violence within the camp be curbed and health care providers be trained to be more patient with refugees. Finally, it will be good for UNHCR and other institutions helping out with refugees to think of a more integrated humanitarian assistance for refugees that would mainstream women's reproductive health need from inception.

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## Conflicts of interest

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## References

1. Kaisler S. "Understanding Refugee health: A Guide to the U. S. Refugee Health System". Church World Service. 2011.
2. UNHCR. Global Trends: Forced Displacement in 2016. 2016.
3. Crisp J. No Solutions in Sight. The Problem of Protracted Refugee Situations in Africa. Geneva: Refugee Survey Quarterly. 2003;22(4).
4. Jamieson L, Ochola, H. Women and health in refugee camps: A gender-sensitive approach. *ARJH*. 2013;17(3):69–77.
5. Onut O, Leontief N. Reproductive health and rights of refugee women in camps: A qualitatice review. *Women's Health Issues*. 2018;28(1):122–129.
6. Harman A. Mediating sexual and reproductive health care in refugee camps. *International Migration*. 2018;56(4):149–163.
7. Betts A, Jones L. Women on the move: migration, care, work and health. *The Lancet*. 2018;392(10164):1238–1240.
8. IRC. The Impact of Displacement on Women and Girls. 2020.
9. OXFAM. Gender Analysis: The Situation of Refugees and Migrants in Greece. London; 2016.
10. Ullah S, Osman S, Hameed WKA, et al. Reproductive Health Needs of Displaced Populations-Evidence from Syria and Iraq. *IJERPH*. 2020;17(7):2343.
11. Casey SE, Chynoweth SK, Cornier N, et al. Progress and gaps in reproductive health services in three humanitarian settings: Mixed-methods case studies. *Confl Health*. 2015;9(Suppl 1):S3.
12. Hassink AM, Jacquemet M, Undagi DN. Access to Reproductive health for refugee women in camps. Reproductive Health. 2020;17(1):1–10.
13. Bartels SA, Scott JA, Leaning J, et al. Female Internally Displaced Persons: A Systemic Review on Sexual Violence and Reproductive Health. *AIDS Behav*. 2014;18(4):792–809.
14. Garg R, O'Kane S. Prioritising reproductive health to improve maternal health in humanitarian crises and refugee settings. *Global Public Health*. 2017;12(8-9):1447–1454.

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15. Kost K. Reproductive health services for refugees: an international review. *Reproductive Health Care*. 2010;36(2):107–116.
16. Mortazavi F, Mousavi SA, Chaman R, et al. "Maternal quality of life during the Transition to motherhood". *Iran Red Crescent Med J*. 2014;16(5):e8443.
17. WHO. Constitution of the World Health Organisation. New York; 1948.
18. UN Women. Promoting Gender Equality in Sexual, Reproductive, Maternal, Newborn, child and Adolescent Health. 2019.
19. Doyle S. The health needs of Syrian refugees in Europe: Challenges and gaps in health system responses. *ICRC*. 2018.
20. Gelberg L, Andersen RM, Leake BD. The behavioral model for vulnerable populations: application to medical care use and outcomes for homeless people. *Health Serv Res*. 2000;34(6):1273–1202.
21. Abbas N, Gough K. A People-Oriented Planning Framework for refugee use: A case-study of Zaatari Refugee Camp. *Jordan Habitat International*. 2016;157:141–150.
22. Anderson RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav*. 1995;36(1):1–10.
23. WHO. Reproductive Health. 2017.

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