International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Barkat AM et al. Int J Reprod Contracept Obstet Gynecol. 2025 Nov;14(11):3691-3699
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20253508

Original Research Article

Family planning barriers and enablers among displaced Somali women in Ali Addeh Camp, Djibouti

Ahmed Mohamed Barkat[1]*, Adesina Oladokun[2], Mache Tsadik Adhana[3]

[1]Reproductive Health Program, Pan African University Life and Earth Sciences Institute (Including Health and Agriculture), Ibadan, Nigeria
[2]Department of Obstetrics and Gynecology, College of Medicine, University of Ibadan / University College Hospital, Ibadan, Nigeria
[3]College of Health Sciences, School of Public Health, Mekelle University, Mek'ele, Tigray, Ethiopia

Received: 12 September 2025
Revised: 11 October 2025
Accepted: 13 October 2025

***Correspondence:**
Dr. Ahmed Mohamed Barkat,
E-mail: ahmed.epi282@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Sexual and reproductive health is essential to human rights, yet displaced populations, particularly women, face numerous barriers to accessing family planning services. This cross-sectional study aimed to explore the barriers and enablers of contraceptive use among Somali refugee women in the Ali Addeh Refugee Camp, Djibouti.
Methods: A qualitative, exploratory design was used, incorporating focus group discussions (FGDs) with Somali refugee women. A total of 49 women participated, organized into seven groups based on marital status and age. Thematic analysis was conducted, focusing on barriers, enablers, and social dynamics related to family planning.
Results: Major barriers cited were religious opposition, misinformation, and sociocultural resistance. Interestingly, 79.6% of the respondents desired large families, 67.3% of whom desired 18 to 35 months of birth spacing. While 40.8% of the women had 1-2 children, 34.7% of the women had five or more children. Contraception was viewed as foreign or religiously prohibited by most women, and 22 women cited religion. Male endorsement of family planning decisions was present, with 27 women reporting that spousal disapproval was a significant deterrent. Privacy concerns were common, with 18 women reporting stigma and fear of judgment among healthcare providers. Despite such barriers, trust in healthcare providers, religious endorsement, and community outreach were reported as facilitators of family planning.
Conclusions: The study underscores the need for men and religious leaders' involvement in family planning. Interventions for displaced women should also prioritize privacy in health facilities, accessible and culturally acceptable family planning services.

Keywords: Ali Addeh Camp, Contraceptive use, Djibouti, Family planning, Reproductive health, Somali refugees

INTRODUCTION

Sexual and reproductive health (SRH) is generally regarded as an essential component of human rights and sustainable development, the cornerstone of the health, agency, and dignity of the individual in any given situation.[1,2] However, in situations of humanitarian crises, the realization of these rights is very uneven.[3-5] Refugees and displaced individuals particularly women and adolescent girls are more vulnerable to negative reproductive health outcomes due to restricted mobility, poverty, compromised health infrastructure, cultural restraints, and restricting gender norms.[6-8] According to Bradshaw et al over 222 million women in their reproductive ages do not wish to become pregnant but are not using safe, modern types of contraception, and the greatest unmet needs are concentrated in low-resource and crisis-affected environments.[9] In such circumstances,

reproductive health activities are usually relegated to secondary in emergency interventions, but the truth is that unplanned pregnancy, unsafe abortion, and maternal death still escalate when family planning is not accessible.[10]

Somali women refugees are among the most vulnerable populations within this global arena. Decades of war and environmental deterioration have yielded prolonged displacement, placing thousands of Somali families in long-term encampment outside regional boundaries.[11] They reside in refugee camps where amenities are basic, educational opportunities are limited, and entrenched patriarchy continues to affect reproductive behavior and decision-making.[12,13] Earlier research work among Somali refugee populations in Kenya, Ethiopia, and Uganda all found high fertility aspirations, low contraceptive use, and male control over fertility decisions.[14,15] Big families are typically socially desired, religiously virtuous, and economically wealthy, while family planning is seen as foreign, harmful, or even religiously prohibited.[16,17] Studies such as those by Pfeil et al and Zhang et al.[17,18] have outlined how misinformation ranging from infertility and cancer fears to fears over implants "moving in the body" continues to deter women from using modern contraceptive technology.[17,18] The same misbeliefs are often complemented by informal social circles, limited literacy, and erratic action by health systems.[14] Further, reproductive decision-making tends to be dominated by the male head of the household in the majority of Somali households, and women are expected to conform to the prevailing norms of high fertility.[19,20] While such dynamics have been very well researched in large, well-known camps like Dadaab or Kakuma, there is significant evidence lacuna in small, lesser-known refugee camps like Ali Addeh in Djibouti. Located in a relatively low-resource environment and home to a large Somali refugee population for over thirty years, Ali Addeh provides a specific social and institutional environment in which reproduction may be shaped by local cultural and systemic factors. Although it is a priority sector, little research exists on the reproductive health behaviors of Somali women in this camp, and no study has comprehensively explored their contraceptive knowledge, attitudes, access to, and use as related to male participation and structural health system factors. Addressing this gap is important for understanding women' lived experiences and unserved reproductive needs in protracted displacement. The study for this research is guided by four general research questions: i) What are the barriers to the use of modern contraceptive among Somali refugee women in Ali Addeh Camp? ii) What are the facilitators that can shape their contraceptive decision-making? The ultimate objective is to develop a context-specific model of contraceptive dynamics among this refugee population through the integration of qualitative and quantitative methods to inform responsive, culturally sensitive interventions. Through this effort, the study aims to share empirical evidence to assist policymakers, humanitarian actors, and reproductive health planners in developing more effective and equitable family planning programs for displaced Somali women.

METHODS

Study design

This study employed a qualitative, exploratory design to investigate the factors influencing contraceptive use among Somali refugee women in the Ali Addeh Refugee Camp, Djibouti. The primary data collection method was through focus group discussions (FGDs) among seven groups, each constituted by seven women. This design was applied for their effectiveness in exploring the social, cultural, and personal experiences related to reproductive health within a group dynamic. Data integration occurred at the interpretational level to facilitate triangulation and ensure validity of the findings.

Study setting

The research was conducted in Ali Addeh Refugee Camp, located in the southeast Ali Sabieh province of Djibouti from August to December 2024. Ali Addeh Refugee Camp was established in 1991 and hosts approximately 15,000 Somali refugees. The camp is characterized by primitive infrastructure, including water points and community health centres, which are largely managed by humanitarian agencies such as UNHCR and the International Rescue Committee. This setting provides a critical context for the examination of reproductive health and family planning decisions in displaced populations (Figure 1).

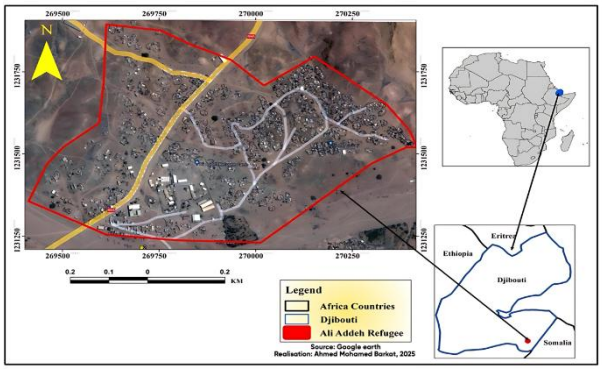

Figure 1: Map of the study area.

Participants and sampling

Participants were sampled through purposive sampling to obtain a representative and diverse sample from different residential zones of the camp. Women aged 18-49 years, self-identified Somali, residing in the Ali Addeh camp, and speaking Somali as their primary language were eligible for inclusion. Voluntary participation and willingness to provide informed consent was also required. Forty-nine women were enrolled and distributed into seven FGDs of seven participants each.

To facilitate open and free conversation, groups were organized according to marital status, and the elderly women were organized in a separate group to reduce fear or inhibition among the young women. Each group was structured to foster confidence and acquaintance among members. The process started by identifying three women from each section of the camps who were known to be intimate friends. These initial participants were then asked to name four additional women from their personal networks with whom they would feel comfortable engaging in open discussion with one another present. Where insufficient rapport or mutual understanding existed between any suggested participants, stand-ins were introduced to maintain the group as safe and open as possible. Age and life stage were also considered to achieve a broad range of perspectives.

Data collection

Data were collected using semi-structured focus group discussions (FGDs) using an interview protocol developed for the sake of this study. The protocol contained open-ended questions to determine the participants' knowledge, attitude, practices, and barriers and enablers of contraceptive use. The topics discussed were personal experience of using contraception, cultural beliefs, religious opinions, male involvement, and availability of family planning services.

The FGDs lasted for 45 to 60 minutes each and were conducted in a secluded place in the camp to ensure confidentiality. Audio recording, with the permission of the participants, was used to capture the discussion verbatim. An additional note-taker also recorded non-verbal reactions and contextual observations, which provided a better insight into the dynamics of the group.

Ethical considerations

Ethical approval for the study was given by the University of Ibadan/University College Hospital Ethical Committee (Ref: UI/EC/24/0304) Informed consent was given by all the respondents, to whom the objective of the study, their rights, and the voluntary basis of the study were explained. Because of the nature of the topic, all the respondents were assured of confidentiality of their answers and of the right to withdraw from the study at any point without any penalty.

Data analysis and management

The thematic analysis approach, which is described by Braun and Clarke (2006), was used to analyse the qualitative data. FGD recordings were all verbatim transcribed and subsequently translated into English by bilingual research assistants. To ensure accuracy, transcripts were cross-checked to ascertain completeness and adherence to the original discussions.

Data were examined through an inductive coding process, whereby themes were drawn directly from participants' accounts. Two researchers coded separately from one another to search for patterns and themes within data. Disagreements about coding were resolved through discussion and consensus. An inductive strategy was adopted through coding, and prominent themes were found directly from the data.[21] The inductive themes were categorized into four broad themes: sociocultural norms, individual knowledge and beliefs, and factors of the health system. The occurrence number of the sub-themes was counted to identify the prevalence and consistency of each theme in FGDs. Member checking was also conducted to enhance the validity of the findings such that a subset of participants reviewed the interpreted results to ensure they represented their views accurately. In addition, peer debriefing was done with study team researchers to challenge assumptions and ensure rigor in analysis.

RESULTS

Demographic and social characteristics of respondents

The majority of the 49 refugee women interviewed (65.30%) had no formal education, followed by those with only a primary education (24.48%), and a smaller percentage with either a secondary education (4.08%) or a college degree (6.12%) (Table 1). Of the participants, 14.29% were single and 85.71% were married. The majority of women (79.59%) had no job. According to the age distribution, 40.81% of those surveyed was 35 years of age or older, 32.65% was between 25 and 34, and 26.53% was between 15 and 24. In terms of reproductive health, 34.69% of the women had five or more pregnancies (high gravidity), while 44.89% had three to four pregnancies (medium gravidity). In terms of parity, 40.82% had between 1 and 2 children, 26.53% had 3 to 4 children, and 32.65% had 5 or more children. The majority of women (40.81%) had moderate birth spacing (18-35 months), with short intervals of less than 18 months (34.69%) coming in second. The majority (79.59%) of respondents said they would like to have five or more children, and 67.34% said they would prefer a moderate future birth spacing of 18 to 35 months.

Thematic analysis of the focus group discussions (FGDs) showed ten recurrent themes, organized into four overarching domains: individual knowledge and beliefs, sociocultural norms, health system factors, NGO/Foreign Influence. These themes collectively illuminate the social, informational, and structural dynamics shaping contraceptive use in the refugee context.

Knowledge, misinformation, and perceived benefits influencing contraceptive use among Somali refugee women in Ali Addeh Camp, Djibouti (2025)

Basic awareness of contemporary contraceptive methods such as pills, injections, and implants was observed across all FGDs, and 20 women reported awareness. This was

largely derived from clinic attendance or outreach community groups. Misinformation was, nonetheless, rampant and was mentioned by 29 participants (Figure 2). The common myths were infertility concerns, cancer, and devices "moving" in the body. A woman related, *"They say the implant moves in your body"*, to which another contributed, *"But fear stays with us. Some say the implant moves in your body, or the injection causes permanent infertility."*. Despite these concerns, 17 women reported the positive impact of birth spacing on child and maternal health. *"After using the injection, I had two years before my next child. I was healthier, stronger. My baby breastfed better."*. These testimonies reveal greater acceptance of contraception when framed in the context of physical recovery and family health.

Table 1: Socio-demographic and reproductive health characteristics of participants.

Variable	Category	Frequency (N)	Percentage (%)
Education	No formal education	32	65.30
	Primary education	12	24.48
	Secondary education	2	4.08
	College and above	3	6.12
Marital status	Married	42	85.71
	Single	7	14.29
Occupation	Unemployed	39	79.59
	Employed	10	20.40
Age (years)	15-24	13	26.53
	25-34	16	32.65
	35 and above	20	40.81
Duration in refugee camp (years)	0-4	5	10.20
	5-9	14	28.57
	10+	30	61.22
Duration of marriage (years in union)	Single	7	14.29
	11-15	8	16.32
	16-20	19	38.77
	21-25	12	24.48
	26 and above	3	6.12
Gravidity	1-2 (low)	10	20.40
	3-4 (medium)	22	44.89
	5+ (high)	17	34.69
Parity	0-2 (low)	20	40.82
	3-4 (medium)	13	26.53
	5+ (high)	16	32.65
Birth spacing	Short (<18 months)	17	34.69
	Moderate (18-35 months)	20	40.81
	Long (36+ months)	5	10.20
Desired number of children	0-2 (low)	1	2.04
	3-4 (moderate)	9	18.37
	5+ (high)	39	79.59
Desired future birth spacing	Less than years	2	2.04
	Short (1year to 18 months)	9	18.37
	Moderate (18-35 months)	33	67.34
	Long (36+ months)	5	10.20

Sociocultural resistance and religious beliefs influencing contraceptive use among Somali refugee women in Ali Addeh Camp, Djibouti (2025)

There was cultural resistance to contraception, which was a theme in six of the seven FGDs from 19 participants (Figure 2). Family planning was widely viewed as being foreign and un-Somali. As one woman explained, *"Honestly, I see it as something brought from outside. In the past, our mothers had many children and didn't use any of these methods."*. One of them said, "Before the NGOs came, no one spoke about injections or pills. Our mothers had many children. It was just the way life was.".

Religious concerns were brought up by 22 women, often supplementing cultural opposition. Contraception was

viewed by many as contrary to Islamic law. *"Why would you stop what God has planned? I believe it's haram."* was the view of one participant. Others noted that family planning had been supported by some religious leaders on health grounds. Fifteen participants cited the potential role for religious leaders, saying that their support could turn female and male attitudes in favour. Spousal opposition was the most prevalent obstacle to contraceptive use, reported by 27 participants. Women indicated that they had to hide contraceptive use or risk disapproval, conflict, or even violence. As one participant indicated, *"Her husband beat her when he found out. He said she disrespected him by making decisions without him."*. Other women resisted contraception even if their husbands supported it, out of fear of divine retribution.

Table 2: Themes influencing contraceptive use among Somali refugee women in Ali Addeh Camp, Djibouti.

Domain	Theme	Sub-theme
Individual knowledge and beliefs	Knowledge of contraception	Awareness of contraceptive methods Sources of information
	Misinformation and myths	Health risks - Cultural myths
	Perceived maternal health benefits	Physical recovery and wellbeing Spacing pregnancies for better health outcomes
	Infant health improvement	Breastfeeding benefits - Fewer health risks to babies
	Economic motivation	Financial benefits of smaller families
Sociocultural norms	Cultural resistance	Perceived foreignness of contraception Social pressure for large families
	Religious belief as a barrier	Perception of contraception as 'haram' Religious leaders' stance
	Spousal opposition	Male authority in reproductive decisions Fear of marital conflict or violence
	Community influence	Peer pressure and gossip Support from women's groups or networks
	Fear/social judgment	Stigma associated with contraceptive use Judgment from other women
	Religious leader influence	Religious endorsement or condemnation Education by religious leaders
	Conflicting religious messages	Varying interpretations of Islamic teachings
	Male involvement needed	Importance of male education on contraception
	Positive shift in attitudes	Increasing acceptance of contraception Role of younger generations in challenging traditional views
Health system factors	Trust in healthcare providers	Reliability of healthcare professionals Quality of counseling
	Privacy concerns	Fear of public exposure Lack of confidential spaces in healthcare facilities
	Secrecy and stigma	Fear of being judged Avoiding public attention
	Provider safety concerns	Fear of adverse side effects Lack of informed consent
	Access issues	Distance to clinics Availability of contraception
	Outreach/education needed	Increased community-based education Educational programs in community spaces
NGO/foreign influence	Perception of external imposition	Perception of foreign NGOs promoting contraception
	Positive NGO involvement	Positive role of NGOs in providing essential healthcare services and information

Health system determinants of contraceptive use: trust, access, and privacy among Somali refugee women in Ali Addeh Camp, Djibouti (2025)

The behaviours of contraception were most directly affected by trust of healthcare professionals. Fifteen participants chose providers as their primary source of information. *"The nurses explain things. Also, the outreach teams that come house to house they give out information."*. Still, there were structural and social obstacles that remained. Eighteen participants complained of clinic privacy, concerning judgment by others in

society. As one participant said, *"Privacy is important". If someone catches you at the family planning room, they may go and gossip."*. Nine of the participants mentioned access-related limitations in the nature of stockouts and distance to clinics. *"I live far from the clinic. It's hard to go without transport. And my husband won't come with me."* said one woman. Such constraints further complicated the provision of family planning services on a regular and safe basis for the women.

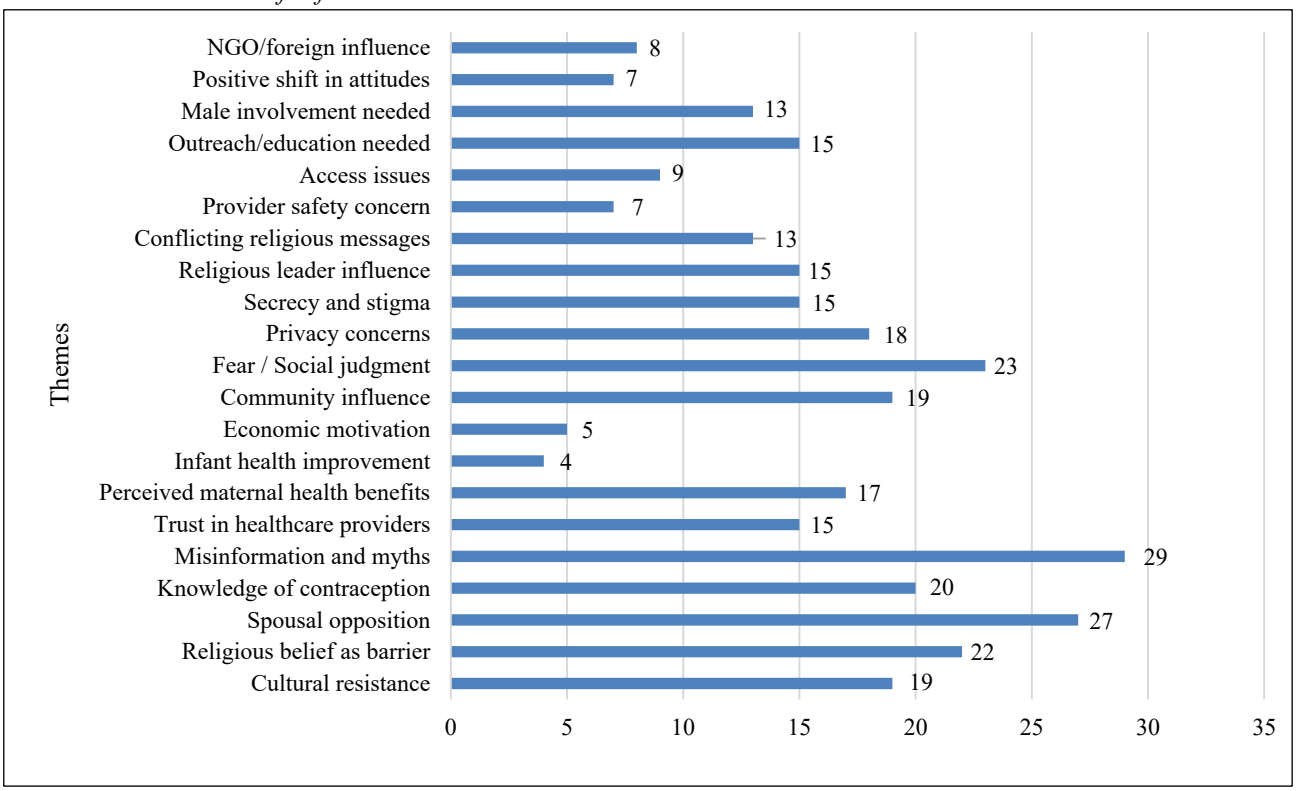

Figure 2: Thematic frequencies on contraceptive use among Somali refugee women in Ali Addeh Camp (2025 FGDs).

Community-identified solutions and suggestions to improve contraceptive use among Somali refugee women in Ali Addeh Camp, Djibouti (2025)

Participants not only shared barriers but also proposed culturally grounded solutions to improve contraceptive uptake and reproductive health outcomes. A major theme was the need to involve trusted religious leaders in family planning advocacy. Many women expressed confidence that Islamic endorsement would ease community resistance. *"If a husband hears from a sheikh that it's okay, he might allow it."* one participant remarked. Another added, *"If you hear it from a trusted religious person, it's more powerful than from a nurse."*. Women widely agreed that clear religious guidance could align contraception with local moral frameworks.

A second recurring recommendation was to directly educate men. Several participants emphasized that male partners often act as gatekeepers to women's health decisions. *"Men need education. Most of the time, it's the husband who says no"*, one woman explained. Others suggested that men should be included in clinic-based or mosque-based awareness sessions: *"I wish there were sessions for men too. Let them hear from the doctors. Maybe things would change"*.

Women also called for increased privacy in service delivery, noting that social judgment deterred many from visiting clinics. *"If it were private and no one knew, many women would go. It's the shame and the fear of being judged"*. Enhancing confidentiality through private consultation areas, discreet outreach visits, and coded appointment systems were perceived as important enablers.

Lastly, the respondents expressed a need for consistent supply and accessible services. Travel distance and stockout were mentioned most frequently as practical barriers. A woman suggested, *"If the clinic runs out or is far, maybe bring the services closer like mobile teams or community days"*. Such community-based delivery mechanisms were understood as being closer to people, especially when accompanied by familiar outreach workers.

DISCUSSION

This study was conducted to analyze the determinants of contraceptive use among Somali refugee women living in the Ali Addeh Camp, Djibouti. It intended to analyze how individual knowledge, sociocultural norms, religious

beliefs, and factors in the health system determined the use of contraceptives in this setting. The results revealed a dynamic interplay of cultural, individual, and structural determinants of contraceptive use.

Myths and cultural resistance were found to be significant obstacles to the adoption of new contraceptive methods, even though participants' awareness of them had improved. This paradox, in which high awareness does not result in widespread use, is consistent with patterns observed in other refugee contexts.[15,22] As revealed by Tadesse et al and Kiura et al, Somali refugee societies are often caught between acquaintance with family planning and deep-rooted myths about its safety and effectiveness.[14,19]

Somali women in the Ali Addeh Camp, Djibouti were typically predisposed toward large families, with nearly all women desiring five or more children, the majority of participants (67.34%) also had a preference for 2-3 years of birth spacing. This underscores a greater appreciation of the health benefit of spacing births for the health of children and mothers. The coexistence of wishes for large families and an appreciation of the necessity for birth spacing was also reported by Cox et al and Maina et al.[20,23] Additionally, cultural resistance, and specifically the perception that contraception is foreign and counter to Somali culture, remains another key barrier. This aligns with previous report in other refugee settings.[17,24]

Religious beliefs played also an important role in contraceptive attitudes. The study further revealed that the majority of the women found contraception to be "haram" (forbidden) based on religious grounds, which was similar to experiences documented by Degni et al and Freeman et al for the Somali and other Muslim communities.[25,26] However, some women acknowledged the fact that endorsement by religious leaders could redefine the attitudes regarding contraception, implying the need for religious leaders to redefine contraception in Islamic perspective. This finding is in line with the works of Azmat et al and Marshall et al, which emphasized the role of religious leaders in enhancing family planning acceptance among refugee and immigrant groups.[27,28]

Male involvement in family planning choice was another important determinant of contraceptive use in the Ali Addeh Camp. Most women indicated that their husbands had the last word in matters of reproductive health, while others were afraid of conflict or violence in marriage if they used contraception without their husband's consent. These results resonate with those of Zhang et al, where male dominance of reproductive health decisions severely constrained women's autonomy in family planning.[18] Participants in this research proposed increased education for men, emphasizing that male involvement in family planning would improve the use of contraceptives, as also proposed by Azmat et al and Marshall et al to engage men in reproductive health discussions.[27,28]

Privacy concerns were another significant barrier to the use of contraceptives. The majority of women feared being judged and gossiped about if they were caught traveling for family planning services. Such social stigmatization fear was reported by Logie et al when conducting a study among refugee populations in Uganda, where contraceptive-related stigma discouraged women from seeking reproductive health services.[29] The participants in the current study proposed enhancing privacy through the utilization of confidential consultation rooms, mobile clinics, and outreach services, which would enhance the stigma and push more women to utilize family planning services.

Contraceptive service access was also a major hindrance. Women reported difficulties accessing family planning services due to traveling distances to the clinic and stockouts. The above structural barriers are consistent with findings in other refugee contexts, for instance, Kiura et al, where logistical issues and health access limitations were significant obstacles to the use of contraceptives.[19] Participants also recommended mobile clinics and outreach services at the community level to increase availability of contraceptives among women in refugee camps, just as Gitonga et al recommend to improve access in urban settings.[15]

In response to these issues, respondents offered a variety of culturally acceptable solutions to increasing contraceptive use. These included appealing to religious leaders in family planning promotion, educating men about using contraceptives, and improving the privacy and availability of reproductive health services. These recommendations are aligned with more general calls for culturally acceptable, community-centered interventions to address social as well as structural impediments to family planning among refugee populations.[17,22]

There were a number of important limitations that could have been confounding this study's conclusions. Self-reported measures are at risk of social desirability and biased recall, particularly in a setting where contraceptive use is culturally sensitive and even taboo. The fact that the study relied on a single refugee camp (Ali Addeh) means that the results cannot be generalized to other Somali refugee populations or other humanitarian contexts. Also, the study did not discuss the quality of family planning services like counseling or client-provider relationship that can be a good determinant of acceptability and accessibility of contraceptive technologies.

CONCLUSION

The study identified core obstacles to the use of contraceptives among Somali refugee women in the Ali Addeh Refugee Camp, Djibouti, which were grouped into four dominant areas: individual beliefs and knowledge, sociocultural norms, health system factors, and NGO/foreign influence. Despite overall awareness of contraceptive methods, cultural resistance,

misinformation, and religious beliefs constituted significant obstacles. The majority of women desired large families and viewed contraceptives as foreign or religiously prohibited, and male involvement in reproductive matters and privacy issues also served to deter use. Structural obstacles such as limited access to services and stockouts of condoms contributed to the situation. However, some enablers were discovered in these regions to boost the use of contraceptives. Training women and men, mobilizing religious leaders to accept contraception, and improving privacy in the health care facility were important enablers suggested by the interviewed. In addition, improving access through mobile clinics and outreach within communities had to be addressed. This study brings to the fore the need for culturally sensitive family planning programs aimed at social, informational, and structural barriers in these regions and help improve reproductive health outcomes for Somali refugee women in Ali Addeh Camp and similar settings.

ACKNOWLEDGEMENTS

Authors would like to thank the African Union Commission through the Pan African University Life and Earth Sciences Institute, including Health and Agriculture (PAULESI) for their financial support during study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the University of Ibadan/University College Hospital Ethical Committee (Ref: UI/EC/24/0304)

REFERENCES

1. Sedgh G, Singh S, Taqi I, Wittenberg J. Sexual and reproductive health and rights and global development. Stud Fam Plann. 2025;56(2):232-42.
2. Hassan A, Golub S. Sexual and reproductive health goals and the 2030 global agenda for sustainable development: progress, prospects, and challenges. J Pediatr Adolesc Gynecol. 2025;38(1):13-7.
3. Balinska MA, Nesbitt R, Ghantous Z, Ciglenecki I, Staderini N. Reproductive health in humanitarian settings in Lebanon and Iraq: results from four cross-sectional studies, 2014-2015. Conflict Health. 2019;13(1):24.
4. Khosla R, Krause S, Tanabe M. Addressing the Rights of Women in Conflict and Humanitarian Settings. In: The Health of Refugees: Public Health Perspectives from Crisis to Settlement; Allotey P, Reidpath D, Eds.. Oxford University Press; 2019.
5. Amiri M, El-Mowafi IM, Chahien T, Yousef H, Kobeissi LH. An overview of the sexual and reproductive health status and service delivery among Syrian refugees in Jordan, nine years since the crisis: a systematic literature review. Reproduct Heal. 2020;17(1):166.
6. Ivanova O, Rai M, Kemigisha E. A systematic review of sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women in Africa. Int J Environm Res Publ Heal. 2018;15(8):1583.
7. Jain R, Davison CM, Michael S, Durand MA, Bartels SA. A qualitative analysis of knowledge, attitudes, and perceptions of family planning among Syrian refugees in Lebanon. Curr Opin Gynecol Obstetr. 2019:346-53.
8. Soeiro RE, de Siqueira Guida JP, da-Costa-Santos J, Costa ML. Sexual and reproductive health (SRH) needs for forcibly displaced adolescent girls and young women (10–24 years old) in humanitarian settings: a mixed-methods systematic review. Reproduct Heal. 2023;20(1):174.
9. Bradshaw CJ, Perry C, Judge MA, Saraswati CM, Heyworth J, Le Souëf PN. Lower infant mortality, higher household size, and more access to contraception reduce fertility in low-and middle-income nations. Plos one. 2023;18(2):e0280260.
10. Askew I, Khosla R, Daniels U, Krause S, Lofthouse C, Say L, et al. Sexual and reproductive health and rights in emergencies. Bull W Heal Org. 2016;94(5):311.
11. Hammond L. History, overview, trends and issues in major Somali refugee displacements in the near region (Djibouti, Ethiopia, Kenya, Uganda and Yemen). Bildhaan An Int J Somali Stud. 2014;13(1):7.
12. Muhumad AA, Jaji R. Somali refugees, informality, and self-initiative at local integration in Ethiopia and Kenya. J Migrat Human Secur. 2023;11(1):75-88.
13. Agaba DK. Analysing the implementation of refugee laws and policies in relation to women and girls: A case of Kampala, Uganda. African Human Rights Law Journal. 2024;24(2):684-719.
14. Tadesse K, Seifu W. Why refugee women didn't use modern contraceptives? lesson from women in shedder refugee camp, Ethiopian Somali Regional State, Eastern Ethiopia; 2014. Gynecol Obstet. 2017;7(03):3-8.
15. Gitonga E, Gage AJ. Modern contraceptive prevalence and its predictors among non-refugee and refugee Somali women in Nairobi city, Kenya; a comparative view. Frontiers in Global Women's Health. 2024;5:1328612.
16. Davidson AS, Fabiyi C, Demissie S, Getachew H, Gilliam ML. Is LARC for everyone? A qualitative study of sociocultural perceptions of family planning and contraception among refugees in Ethiopia. Mater Chil Heal J. 2017;21(9):1699-705.
17. Pfeil S, Crouthamel B, Chalmiers MA, Ghebrendrias S, Kully G, Mody S. Exploring contraception attitudes, beliefs, and practices among refugee women [A41]. Obstetr Gynecol. 2022;139:12S-3S.
18. Zhang Y, McCoy EE, Scego R, Phillips W, Godfrey E. A qualitative exploration of Somali refugee women's experiences with family planning in the US. J Immigr Minority Heal. 2020;22(1):66-73.

19. Kiura AW. Constrained agency on contraceptive use among Somali refugee women in the Kakuma refugee camp in Kenya. Gend Technol Develop. 2014;18(1):147-61.
20. Cox CM, Ahmed F, Mitchell A, Ganey A, Kahin A, Kahin A. Decision making and communication about child spacing among Somali couples in Minnesota. Perspect Sex Reproduct Heal. 2019;51(2):63-9.
21. Kvale S. InterViews : Learning the Craft of Qualitative Research Interviewing. Los Angeles: Sage Publications; 2009:354.
22. Gele AA, Musse FK, Shrestha M, Qureshi S. Barriers and facilitators to contraceptive use among Somali immigrant women in Oslo: A qualitative study. PloS one. 2020;15(3):e0229916.
23. Maina NK, Gitome J, Bagelman J, Mainah M, Kituku JM, Mwoma T, et al. Family planning as a determining factor in preference to Traditional Birth Attendants (TBAs) among Somali community in Dadaab Refugee Camps, Kenya. Euro J Human Soci Sci. 2021;1(6):1-5.
24. Achola R, Atuyambe L, Nabiwemba E, Nyashanu M, Garimoi Orach C. Barriers to contraceptive use in humanitarian settings: Experiences of South Sudanese refugee women living in Adjumani district, Uganda; an exploratory qualitative study. Plos one. 2024;19(3):e0278731.
25. Degni F, Mazengo C, Vaskilampi T, Essén B. Religious beliefs prevailing among Somali men living in Finland regarding the use of the condom by men and that of other forms of contraception by women. Euro J Contracep Reproduct Heal Care. 2008;13(3):298-303.
26. Clarkson Freeman PA, Penney DS, Bettmann JE, Lecy N. The intersection of health beliefs and religion among Somali refugees: a qualitative study. J Relig Spirit Soci Work: Soci Thought. 2013;32(1):1-3.
27. Azmat SK. Mobilizing male opinion leaders' support for family planning to improve maternal health: a theory-based qualitative study from Pakistan. J multidisci health. 2011;4:421-31.
28. Marshall K, Soetendorp RA, Soetendorp J. G20 Policy Makers Should Support Wider Religious Roles in Refugee Resettlement, 2017. Available at: https://www.g20interfaith.org/app/uploads/2019/06/App-Item-7-G20-Policy-Brief_Refugee-Resettlement-2018.11.18.pdf. Accessed 01 June 2025.
29. Logie CH, MacKenzie F, Malama K, Lorimer N, Lad A, Zhao M, et al. Sexual and reproductive health among forcibly displaced persons in urban environments in low and middle-income countries: scoping review findings. Reproduct Heal. 2024;21(1):51.

Cite this article as: Barkat AM, Oladokun A, Adhana MT. Family planning barriers and enablers among displaced Somali women in Ali Addeh Camp, Djibouti. Int J Reprod Contracept Obstet Gynecol 2025;14:3691-9.