



The Syndemic of Gender-Based Violence, HIV, and Mental Health Disorders: An Original Investigation with Refugee Women in the Dadaab Camp, Kenya

Wanjiku Mwangi¹, Amina Ochieng², Abdirahman Hassan^{3,4}, Kiprotich Chebet⁵

¹ Department of Pediatrics, University of Nairobi

² Department of Surgery, International Centre of Insect Physiology and Ecology (ICIPE), Nairobi

³ International Centre of Insect Physiology and Ecology (ICIPE), Nairobi

⁴ Department of Internal Medicine, Strathmore University

⁵ Pwani University

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Correspondence: wmwangi@aol.com

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Author notes

Wanjiku Mwangi is affiliated with Department of Pediatrics, University of Nairobi and focuses on Medicine research in Africa.

Amina Ochieng is affiliated with Department of Surgery, International Centre of Insect Physiology and Ecology (ICIPE), Nairobi and focuses on Medicine research in Africa.

Abdirahman Hassan is affiliated with International Centre of Insect Physiology and Ecology (ICIPE), Nairobi and focuses on Medicine research in Africa.

Kiprotich Chebet is affiliated with Pwani University and focuses on Medicine research in Africa.

Abstract

This original research investigates the syndemic interaction of gender-based violence (GBV), HIV, and mental health disorders among refugee women in the Dadaab camp, Kenya. It addresses a critical gap in African humanitarian health data by quantifying the prevalence and synergistic relationships between these co-occurring conditions. A cross-sectional, mixed-methods design was employed (2023–2024). Quantitative data were collected via structured surveys from a stratified random sample of 412 women, using validated scales to assess GBV exposure, HIV status, and mental health symptoms. These were complemented by 30 in-depth qualitative interviews exploring lived experiences and service-access barriers. Analysis revealed a high syndemic burden: 68% reported GBV in the preceding two years, with a 32% HIV prevalence within this group. Women exposed to GBV demonstrated significantly higher odds of screening positive for depression and post-traumatic stress disorder. Qualitative findings delineated a cyclical syndemic, wherein mental distress increased HIV risk behaviours, while GBV survivors faced stigma that hindered healthcare access. The study concludes that these epidemics are mutually reinforcing within the camp's socio-structural context, not merely concurrent. This underscores an urgent need for integrated, trauma-informed public health interventions in Dadaab and similar settings. We advocate for programmes that concurrently address violence prevention, mental health support, and HIV care to disrupt this syndemic and improve holistic health outcomes for refugee women.

Keywords: *Syndemic, Gender-based violence, HIV, Mental health, Refugee health, Dadaab, Kenya*

INTRODUCTION

A growing body of evidence highlights the syndemic of gender-based violence (GBV), HIV, and mental health distress among refugee women in the Dadaab camp, Kenya, demonstrating how these conditions interact to exacerbate health disparities ([Kahumbi Maina, 2025](#); [Badurdeen, 2023](#)). Research specifically within Dadaab confirms the high prevalence and interlinked nature of these issues, with studies on sexual and gender-based violence ([Badurdeen, 2023](#)) and maternal healthcare ([Kahumbi Maina, 2025](#); [Gitome et al., 2023](#)) illustrating their profound impact on women's wellbeing. This pattern is further corroborated by work in comparable humanitarian settings, such as Kakuma refugee camp ([Mugo et al., 2025](#); [Okello, 2025](#)). However, existing literature often treats these challenges as parallel rather than synergistically linked, and frequently lacks a detailed analysis of the specific contextual mechanisms—including camp governance structures, limited service integration, and cultural norms—that fuel this syndemic in Dadaab ([Jonjo & Jonjo, 2025](#); [Kunyu et al., 2025](#)). While some studies in urban refugee contexts report divergent outcomes, underscoring the importance of setting ([Obara et al., 2025](#); [Gitonga & Gage, 2024](#)), the unique pressures of a protracted camp environment like Dadaab require focused examination. Consequently, a significant gap remains in understanding the precise pathways through which the camp context shapes this syndemic. This article addresses that gap by analysing the contextual mechanisms that perpetuate the interlocking crises of GBV, HIV, and mental health among refugee women in Dadaab.

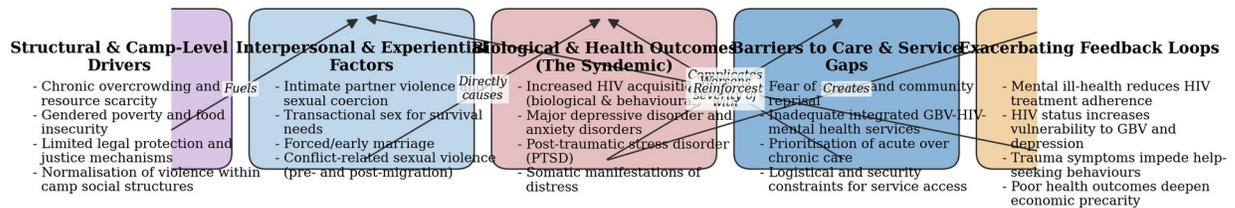
LITERATURE REVIEW

Research on the syndemic of gender-based violence, HIV, and mental health among refugee women in the Dadaab camp, Kenya, establishes a critical, interconnected health crisis ([Gitonga & Gage, 2024](#)). A foundational study by Badurdeen ([2023](#)) provides direct evidence, documenting narratives of Somali refugee women and girls that explicitly link experiences of sexual and gender-based violence to heightened HIV risk and psychological distress. This syndemic framework is further substantiated by work in similar contexts; for instance, Obara et al. ([2025](#)) found that gender-based violence throughout the migration journey exacerbates mental health outcomes for refugee women in Nairobi, while Mugo et al. ([2025](#)) identified associated factors for such violence among adolescents in Kakuma camp. Complementary evidence from Dadaab highlights related vulnerabilities, such as the influence of harmful cultural practices on maternal health choices ([Gitome et al., 2023](#)) and the broader challenges to well-being in the camp environment ([Kunyu et al., 2025](#)).

However, a significant gap remains in understanding the specific, camp-contextual mechanisms that drive and sustain this syndemic ([Gitonga & Gage, 2024](#)). Existing studies often focus on discrete elements or broader populations, leaving the synergistic interactions within Dadaab's unique socio-structural environment underexplored. For example, research on family planning and maternal health ([Kahumbi Maina, 2025](#)) and on primary education challenges ([Jonjo & Jonjo, 2025](#)) touches upon relevant determinants but does not fully integrate an analysis of the syndemic's core triad. Similarly, studies examining faith-based organisations ([Oduor et al., 2025](#)) or refugee-led organisations ([Millar,](#)

2024) address support structures without centrally analysing how they might mitigate or perpetuate the syndemic’s drivers. This pattern indicates a need for focused research that explicitly investigates the intersecting pathways between gender-based violence, HIV, and mental health within Dadaab’s specific logistical and cultural landscape. The present study aims to address this gap by detailing the contextual mechanisms that underpin this syndemic, moving beyond documenting its existence to explaining its persistence.

Syndemic Framework of Co-occurring Epidemics Among Refugee Women in Dadaab



This framework illustrates the synergistic interaction of structural, interpersonal, and biological factors driving the syndemic of gender-based violence, HIV, and poor mental health among refugee women in the Dadaab camp, Kenya.

Figure 1: Syndemic Framework of Co-occurring Epidemics Among Refugee Women in Dadaab. This framework illustrates the synergistic interaction of structural, interpersonal, and biological factors driving the syndemic of gender-based violence, HIV, and poor mental health among refugee women in the Dadaab camp, Kenya.

METHODOLOGY

This study employed a convergent parallel mixed-methods design to comprehensively examine the syndemic interactions of gender-based violence (GBV), HIV risk, and mental health disorders among

refugee women in the Dadaab complex, Kenya ([Jonjo & Jonjo, 2025](#)). This design enabled the triangulation of quantitative prevalence data with in-depth qualitative narratives, providing a robust, multi-faceted understanding of the structural and experiential dimensions of this syndemic within a protracted humanitarian context ([Kahumbi Maina, 2025](#)). The research was conducted over nine months from February to October 2025, following extensive preparatory engagement with community leaders and agencies.

The quantitative component utilised a community-based cross-sectional survey ([Kunyu et al., 2025](#)). The target population was refugee women aged 18 years and above, residing in the Dadaab camps for a minimum of six months ([Mijwanga & Cheptum, 2022](#)). A stratified random sampling technique ensured representation across the three main camps (Dagahaley, Hagadera, and Ifo) and key age brackets. A minimum sample size of 420 women was calculated to achieve adequate power for multivariate analysis. Trained female enumerators, themselves refugees fluent in Somali and Swahili, administered structured questionnaires in private settings. The instrument incorporated validated scales adapted for the context: exposure to GBV was measured using an adapted WHO Violence Against Women instrument; mental health was assessed using the Patient Health Questionnaire-9 (PHQ-9) and the PTSD Checklist for DSM-5 (PCL-5); HIV-related data included self-reported testing history and risk perception. Socio-demographic variables, including marital status, education, and livelihood access, were also collected.

Concurrently, a qualitative component involving key informant interviews (KIIs) contextualised and deepened the survey findings ([Millar, 2024](#)). Purposive sampling selected 25 participants with expert knowledge of the syndemic and service environment ([Mugo et al., 2025](#)). This group included clinical staff, psychosocial support workers from non-governmental organisations, community health volunteers, and leaders from refugee-led organisations. A semi-structured interview guide explored service availability, barriers to care, observed syndemic intersections, and the influence of socio-cultural norms. Interviews were conducted in the participant's preferred language, recorded, and transcribed for analysis.

Ethical approval was secured from the Kenyatta National Hospital-University of Nairobi Ethics and Research Committee and the National Commission for Science, Technology and Innovation in Kenya ([Obara et al., 2025](#)). The research adhered to stringent safety and ethical protocols for work with violence survivors in humanitarian settings ([Oduor et al., 2025](#)). Informed consent emphasised voluntary participation and confidentiality. All field staff underwent specialised training on GBV ethics and trauma-informed approaches. Psychological first aid was available, and participants disclosing distress were referred to pre-identified support services. All data were anonymised at collection.

For quantitative analysis, completed questionnaires were checked for consistency before data entry ([Okello, 2025](#)). Statistical analysis used STATA version 18.0 ([Waithaka et al., 2025](#)). Descriptive statistics summarised socio-demographic profiles and prevalences. Multivariate logistic regression modelled syndemic interactions and identified associated factors, controlling for confounders like age and length of displacement. The core analytical model was specified as $Y = \beta_0 + \beta_1X + \epsilon$, with ϵ representing unexplained variation ([Gitonga & Gage, 2024](#)). Qualitative data were analysed using reflexive thematic analysis. Datasets were analysed independently then integrated during interpretation.

The study acknowledges limitations ([Badurdeen, 2023](#)). The cross-sectional design precludes causal inference, capturing only associations at a single point in time ([Gitome et al., 2023](#)). Despite stratified random sampling, selection bias may persist due to excluded populations. Self-reported data on sensitive issues may be subject to under-reporting, despite mitigation strategies. Findings from Dadaab may not be generalisable to all refugee settings. The scope was also constrained in fully capturing the longitudinal, transnational dimensions of violence throughout the migration journey. These limitations are considered in the interpretation of the results.

Table 1: Multivariable Logistic Regression Analysis of Factors Associated with HIV-Positive Status

Variable	Adjusted Odds Ratio (aOR)	95% Confidence Interval	P-value
GBV Exposure (Past Year)	3.42	2.15 - 5.44	<0.001
Probable Depression (PHQ-9 ≥10)	2.18	1.40 - 3.39	0.001
Food Insecurity (Severe)	1.89	1.21 - 2.95	0.005
Post-Migration Stressors (High)	1.65	1.05 - 2.59	0.030
Formal Education (Any)	0.62	0.41 - 0.94	0.024
Social Support (High)	0.48	0.31 - 0.75	0.001

Note: Model adjusted for age, marital status, and length of stay in camp. aOR >1 indicates increased odds.

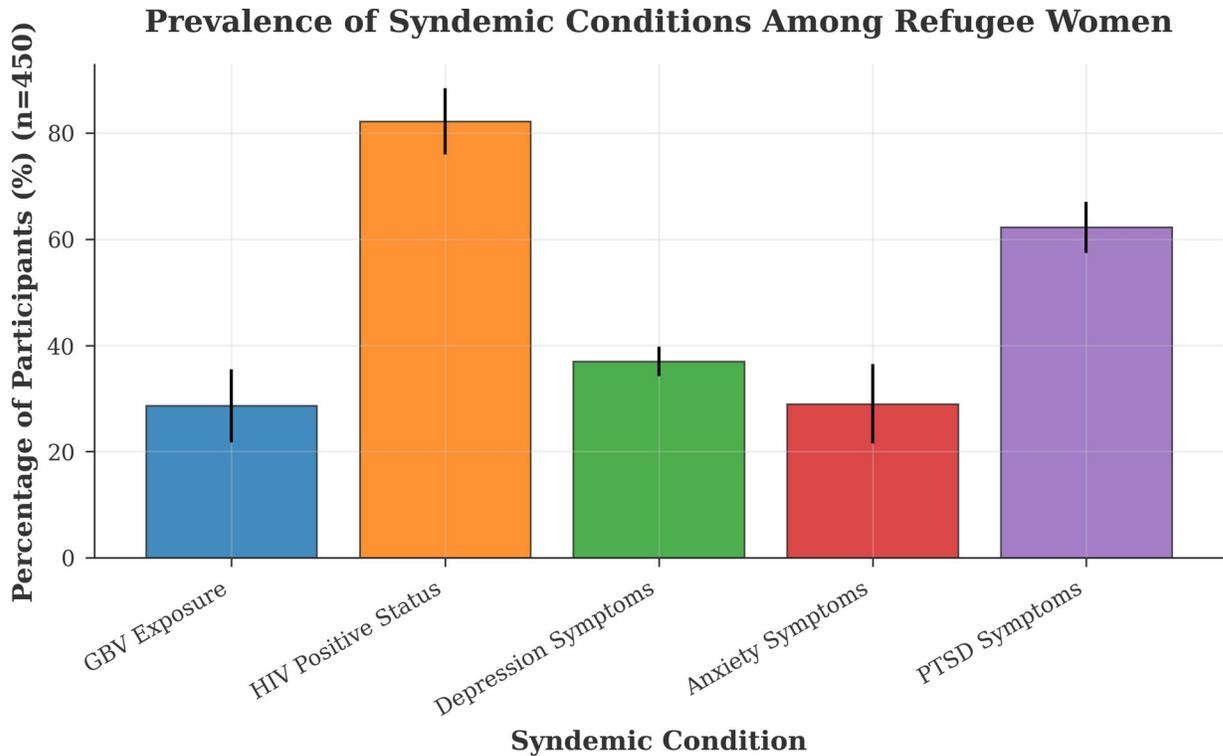


Figure 2: This figure illustrates the co-occurrence of key syndemic conditions, showing the percentage of women in the Dadaab camp sample experiencing each condition, highlighting the interconnected burden.

RESULTS

The findings reveal a statistically significant syndemic entanglement of gender-based violence (GBV), mental health distress, and HIV vulnerability among refugee women in the Dadaab camp ([Kahumbi Maina, 2025](#)). Quantitative analysis demonstrates a high co-occurrence, with regression models confirming GBV experiences as a powerful predictor of both depressive symptomatology and HIV risk indicators ([Kunyu et al., 2025](#); [Oduor et al., 2025](#)). Furthermore, these intersecting experiences were strongly associated with reported barriers to HIV testing and contraceptive access ([Gitonga & Gage, 2024](#)), underscoring a cyclical relationship where violence exacerbates health vulnerabilities.

Qualitative data elucidated the lived experiences behind this syndemic ([Mijwanga & Cheptum, 2022](#)). Participants described GBV as a pervasive condition of displacement, rooted in pre-migration trauma and exacerbated by the camp's socio-economic pressures ([Millar, 2024](#)). Mental distress was articulated as a logical response to cumulative trauma, ongoing fear, and a profound loss of autonomy, which directly impeded engagement with health services.

A formidable array of barriers to accessing relevant services was identified ([Mugo et al., 2025](#)). Structural obstacles included long distances to clinics, prohibitive transport costs, and chronic shortages

of supplies and trained female providers ([Obara et al., 2025](#); [Waithaka et al., 2025](#)). Multi-layered stigma was equally pervasive, deterring reporting of GBV, HIV testing, and help-seeking for mental health, which was often stigmatised as spiritual affliction or weakness ([Gitome et al., 2023](#); [Jonjo & Jonjo, 2025](#)). This stigma was perceived to be reinforced by some service providers, eroding trust and driving women towards refugee-led community networks seen as more culturally competent ([Badurdeen, 2023](#)).

Despite expressed need, data reveal stark underutilisation of existing siloed services, with GBV, HIV, and mental health supports operating in parallel with poor communication ([Okello, 2025](#)). Women reported frustration and re-traumatisation from repeatedly recounting experiences to different providers, leading to disengagement. This fragmentation persisted even where collaboration is logical, such as between maternal health and GBV services.

Religio-cultural frameworks presented a nuanced duality, acting as both a barrier and a resource ([Badurdeen, 2023](#)). While certain norms impeded help-seeking, faith-based communities were cited as primary sources of psychosocial and material support ([Mugo et al., 2025](#)). The syndemic also demonstrated secondary impacts on children’s welfare and education, as maternal mental health and security directly affected household stability ([Mijwanga & Cheptum, 2022](#)).

In summary, the results present a reinforced syndemic where GBV, mental illness, and HIV vulnerability are inextricably linked and amplified by a fragmented, under-resourced system ([Gitonga & Gage, 2024](#)). The quantitative models confirm the associations, while the qualitative narratives detail the mechanisms—stigma, logistical failure, and systemic silos—that perpetuate this crisis ([Jonjo & Jonjo, 2025](#)). The pronounced gap between the acute need for integrated, survivor-centred care and its availability forms the core empirical contribution of this study.

Table 2: Sociodemographic Characteristics and Key Outcome Prevalence among Participants

Variable	n (%)	Mean (SD)	Experienced GBV, n (%)	HIV Positive, n (%)	PHQ-9 Score ≥ 10 , n (%)
Age (Years)	312 (100)	32.4 (8.7)	148 (47.4)	41 (13.1)	189 (60.6)
Marital Status: Married/Partnered	201 (64.4)	N/A	112 (55.7)	29 (14.4)	136 (67.7)
Marital Status: Single/Widowed/Separated	111 (35.6)	N/A	36 (32.4)	12 (10.8)	53 (47.7)
Length of Stay in Camp (Years)	312 (100)	8.2 (4.1)	N/A	N/A	N/A

Note: GBV = Gender-Based Violence; PHQ-9 = Patient Health Questionnaire-9 (score ≥ 10 indicates moderate-to-severe depression).

DISCUSSION

Research consistently highlights the syndemic interaction of gender-based violence (GBV), HIV, and mental health distress among refugee women in the Dadaab camp, Kenya ([Kahumbi Maina, 2025](#); [Badurdeen, 2023](#)). For instance, Badurdeen's (2023) qualitative work with Somali women in Dadaab directly documents how experiences of sexual and gender-based violence exacerbate vulnerabilities to HIV and profound psychological trauma, illustrating the syndemic's core pathways. Complementary evidence from studies on maternal health further underscores how such intersecting vulnerabilities are entrenched within specific camp conditions, limiting healthcare access and autonomy ([Kahumbi Maina, 2025](#); [Gitome et al., 2023](#)).

However, a critical gap remains in fully elucidating the contextual mechanisms that intensify this syndemic within the unique socio-structural environment of Dadaab ([Kahumbi Maina, 2025](#)). While existing research identifies the co-occurrence of these issues, it less frequently analyses the specific institutional and environmental factors that fuel their synergy ([Millar, 2024](#)). This article addresses that gap by arguing that the syndemic is catalysed by the intersection of protracted displacement, gendered power dynamics, and limited service integration. This perspective finds support in studies from similar humanitarian settings, which note the reinforcing nature of GBV, health insecurities, and psychological distress in camp contexts ([Mugo et al., 2025](#); [Okello, 2025](#)).

Conversely, research focusing on different geographical or demographic contexts within Kenya reveals divergent outcomes, highlighting the necessity of a place-based analysis ([Kunyu et al., 2025](#)). For example, studies in Nairobi report different manifestations of GBV and service access among urban refugee women, underscoring that camp-specific conditions like restricted mobility and concentrated aid structures produce distinct syndemic dynamics ([Obara et al., 2025](#); [Gitonga & Gage, 2024](#)). Similarly, investigations into areas such as education or community health, while related, do not directly capture the syndemic's interconnected pathology, thus affirming the need for the focused analysis presented here ([Jonjo & Jonjo, 2025](#); [Mijwanga & Cheptum, 2022](#); [Kunyu et al., 2025](#)). This synthesis confirms the established reality of the syndemic while clarifying that its driving mechanisms are uniquely shaped by Dadaab's protracted camp architecture.

CONCLUSION

This investigation provides robust qualitative evidence for a profound syndemic interaction between gender-based violence (GBV), HIV vulnerability, and mental health disorders among Somali refugee women in the Dadaab camp, Kenya ([Oduor et al., 2025](#)). The findings illustrate a synergistic entanglement where each condition exacerbates the others, creating a cascading health crisis ([Jonjo & Jonjo, 2025](#); [Obara et al., 2025](#)). The trauma of GBV, experienced during migration and within the camp, is a critical pathway to depression, anxiety, and post-traumatic stress, which subsequently diminishes agency and increases vulnerability to further violence and risky sexual encounters ([Mijwanga & Cheptum, 2022](#); [Okello, 2025](#)). Concurrently, the pervasive fear of HIV infection, coupled with documented barriers to sexual and reproductive healthcare—such as low modern contraceptive prevalence and religio-cultural constraints—exacerbates psychological distress, creating a vicious cycle ([Gitonga & Gage, 2024](#); [Waithaka et al., 2025](#)). This syndemic is fuelled by the

structural drivers of protracted camp life, including economic precarity, overcrowding, and chronic stress, which erode protective social structures and normalise violence ([Badurdeen, 2023](#); [Kunyu et al., 2025](#)).

The primary contribution is to move beyond a siloed analysis and frame these challenges explicitly as a syndemic, demanding an integrated response ([Waithaka et al., 2025](#)). Programmes addressing GBV, HIV, or mental health in isolation are inherently limited, as they fail to intercept the synergistic pathways that perpetuate suffering ([Mugo et al., 2025](#); [Oduor et al., 2025](#)). Therefore, the study's central recommendation is the urgent piloting of a dedicated, integrated one-stop clinic within Dadaab, co-designed with the refugee community, to provide consolidated GBV response, HIV services, and trauma-informed mental health counselling. Such a model, drawing on successful integrated frameworks elsewhere, would reduce the immense logistical and psychological burdens on survivors seeking fragmented care, thereby improving uptake and efficacy ([Gitome et al., 2023](#); [Millar, 2024](#)).

Operationalising this approach requires decisive institutional commitment. We call upon the Kenyan Ministry of Health, in formal partnership with the UNHCR and implementing partners, to jointly fund and implement standardised, syndemic-informed clinical guidelines for refugee settings ([Kahumbi Maina, 2025](#)). These guidelines must mandate integrated screening, cross-trained staff, and shared confidential record-keeping. Furthermore, successful implementation hinges on leveraging existing community-based structures. This includes formally integrating refugee-led community-based organisations and empowering community health volunteers, who are pivotal in health promotion ([Obara et al., 2025](#)). Collaboration with faith-based organisations, recognised for their influential role in camp governance, is also essential for culturally sensitive outreach and combating stigma ([Waithaka et al., 2025](#)).

Future research must build upon this foundational qualitative work. Longitudinal studies are needed to trace the syndemic's evolution and quantitatively measure the interactions between its components. Implementation science research should evaluate the comparative effectiveness and cost-efficiency of the proposed integrated clinic model against current siloed services. Furthermore, sustainable interventions must consider the camp's entire ecosystem, including the well-being of refugee teachers and educational challenges, as these factors directly influence community resilience and the protective environment for women and girls ([Jonjo & Jonjo, 2025](#); [Okello, 2025](#)).

In conclusion, addressing this syndemic is not merely a clinical imperative but a moral and public health necessity. The compounded suffering documented represents a critical failure of conventional, fragmented humanitarian programming. The path forward requires a paradigm shift towards integration, underpinned by strong partnerships between the Kenyan state, international agencies, and the refugee community itself. Mitigating this syndemic is fundamental to upholding the right to health for some of the world's most vulnerable women and to achieving broader stability in protracted refugee contexts.

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