Refocusing Family Planning in Refugee Settings:

Findings and Recommendations from a Multi-Country Baseline Study

November 2011

Access to family planning services is a human right[1] and neglecting their provision can have serious health consequences. Scaling up access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. Family planning is a critical primary prevention intervention, as up to 40 percent of all maternal deaths can be prevented[2] and newborn deaths can be reduced by more than 50 percent every year if individuals and couples have access to contraceptives.[3] Access to family planning services also provides the autonomy for women to determine the number and spacing of their children, leads to better nutrition for children, improves access to educational and livelihoods opportunities for women and girls, and increases the possibilities for families to manage scarce resources more effectively.[4]

The *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*,[5] developed by the Women's Refugee Commission on behalf of partners and endorsed by the steering committee of the Inter-agency Working Group (IAWG) on Reproductive Health in Crises in May 2010, outlines existing standards on providing contraceptives from the onset of an emergency and throughout protracted crisis and recovery. It describes methods of service delivery and recommendations for governments, donors and implementing agencies.

Methodology

From May to August 2011, the United Nations High Commissioner for Refugees (UNHCR) and the Women's Refugee Commission, with technical assistance from the Centers for Disease Control and Prevention (CDC), undertook a multi-country baseline study to document knowledge of family planning, beliefs and practices of refugees, as well as the state of service provision in select refugee settings in Djibouti, Jordan, Kenya, Malaysia and Uganda. The goal of the baseline study was to support program planning and service delivery, and subsequently increase family planning uptake among women, men and adolescents. The studies employed a multi-method approach consisting of qualitative and quantitative methods: in-depth interviews with community leaders; a household survey among women of reproductive age using the adapted CDC *Reproductive Health Assessment Toolkit for Conflict-Affected Women*;[6] focus group discussions (FGDs) with women, men, adolescent girls and adolescent boys; and facility assessments to examine service quality.

Location	Setting	Country of origin
Ali Addeh, Djibouti	Camp	Somalia
Eastleigh, Nairobi, Kenya	Urban	Somalia
Nakivale, Uganda	Camp	Primarily from DRC
Amman, Jordan	Urban	Iraq
Kuala Lumpur, Malaysia	Urban	Myanmar

[1] Under international law, universal access to family planning is a human right. According to Article 16(1) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all individuals and couples have the "right to decide on the number, spacing and timing of children." The Progarmme of Action from the 1994 International Conference on Population and Development also notes the right of 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" (Article 7.3). Moreover, General Comment No. 14, para. 12, of the Committee on Economic, Social and Cultural Rights states that the right to the highest attainable standard of health includes the "right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning."

[2] Campbell, O.M. and Graham, W.J. (2006). "Strategies for reducing maternal mortality: getting on with what works." *Lancet.* 368: 1284–99.

[3] Guttmacher Institute, *Facts on Investing in Family Planning and Maternal and Newborn Health: Updated November 2010 using new maternal and neonatal mortality data*, November 2010.

[4] For more information, see Inter-agency Working Group (IAWG) on Reproductive Health in Crises, *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*, May 2010. Also Guttmacher Institute, *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, 2009.

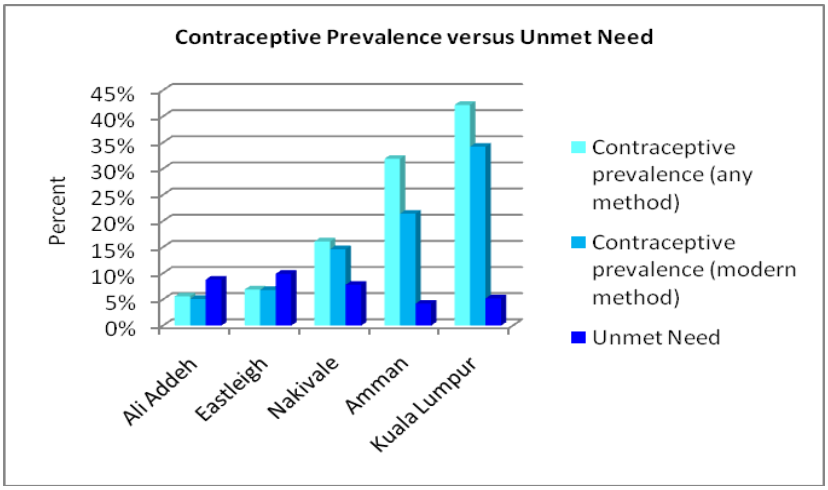
[5] IAWG on RH in Crises, *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*, May 2010.

[6] CDC, *Reproductive Health Assessment Toolkit for Conflict-Affected Women*, 2007.

Overarching Findings

While some findings are site-specific and detailed in the respective country reports, cross-cutting and overarching trends can be observed from all five studies. The key findings are:

1. **Contraceptive use is generally lower in refugee camps than in surrounding settlements.** This finding is likely impacted by multiple factors, such as length of stay in the host country (Somali refugees in Nairobi, for example) or improved access to methods once refugees are in a more stable setting. Contraceptive use also appears influenced by religion and marriage status. In Amman, while CPR for any method among all refugee women is 31.9%, among married refugee women the rate is 54.8%. In Kuala Lumpur, CPR for modern or any method varied by religion. Among refugee women who reported current use of modern methods, 36.5 % were Muslim and 62.5% were Christian. Similarly, among refugee women who reported use of any contraceptive method, 32.7% were Muslim and 65.9% were Christian. Despite low CPR in many sites, unmet need[10] was also low, which indicates a need for knowledge and awareness-raising about the life-saving and life-enhancing benefits of family planning services.



	Study Population		Host Country	Country of Origin
Location	CPR[7] (any method)	CPR (modern method)	CPR (modern methods)[8]	CPR (modern methods)[9]
Ali Addeh	5.6%	5.1%	22.5% (WHO 2008)	1.2% married; 3.0% unmarried (WHO 2006)
Eastleigh	6.9%	6.8%	32% WRA (DHS 2008-9)	1.2% married; 3.0% unmarried (WHO 2006)
Nakivale	16.1%	14.6%	18% (DHS 2006)	6% married (DHS 2007)
Amman	31.9%	21.4%	42% married (MoH, 2009)	33% married (UNICEF 2006)
Kuala Lumpur	42.2%	34.2%	34.4% married (UNFPA 2004)	33% married (UNFPA 2010)

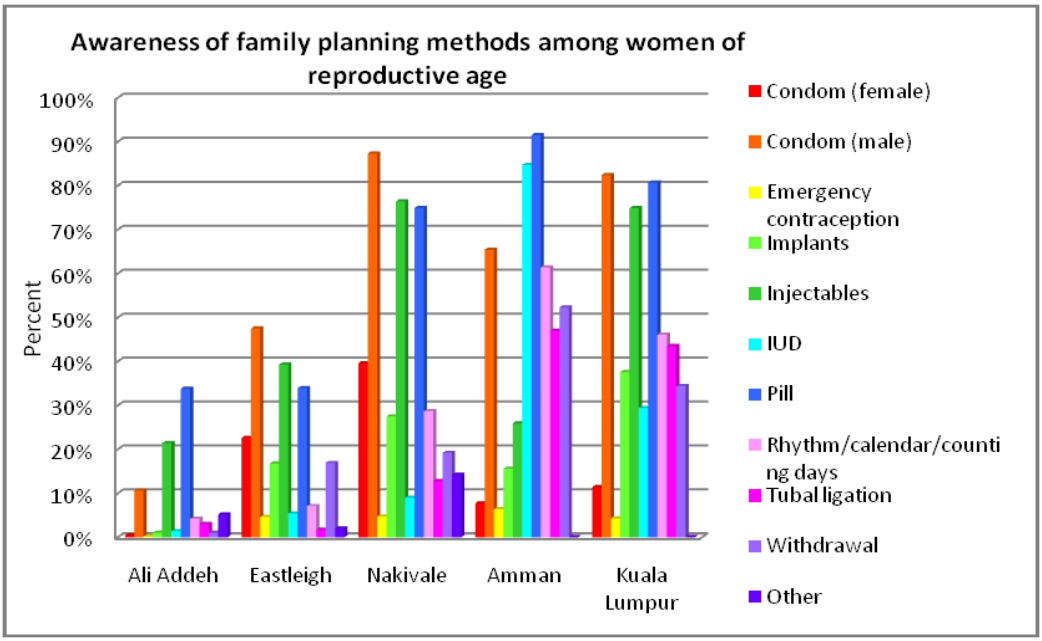
[7] Contraceptive Prevalence Rate (CPR): Women of Reproductive Age (15-49) currently using any method of family planning/ Women of reproductive age. Any method includes modern methods (the pill, intrauterine device, male and female condoms, implants, injectables, emergency contraception, tubal ligation and vasectomy) plus traditional methods (rhythm/calendar method and withdrawal). The denominators includes women who are not at risk for pregnancy or currently pregnant, infecund or have had a hysterectomy.

[8] Ali Addeh: World Health Organization (WHO), *Djibouti, Reproductive Health Profile*, 2010; Eastleigh: Kenya National Bureau of Statistics, *Kenya Demographic and Health Survey* (DHS), 2008-09; Nakivale: *Uganda DHS*, 2006; Amman: Department of Statistics Jordan and ICF Macro, *Jordan Population and Family Health Survey*, 2009; Kuala Lumpur: United Nations Population Fund (UNFPA), *Status of Family Planning in Malaysia*. Unpublished report, 2010.

[9] Ali Addeh: WHO, *Republic of Somalia Country Profile*, 2006; Eastleigh: WHO, *Republic of Somalia Country Profile*, 2006; Nakivale: *DRC DHS*, 2007; Amman: UNICEF et al., *Iraq Multiple Indicator Cluster Survey*, 2006; Kuala Lumpur: UNFPA, *State of World Population*, 2010.

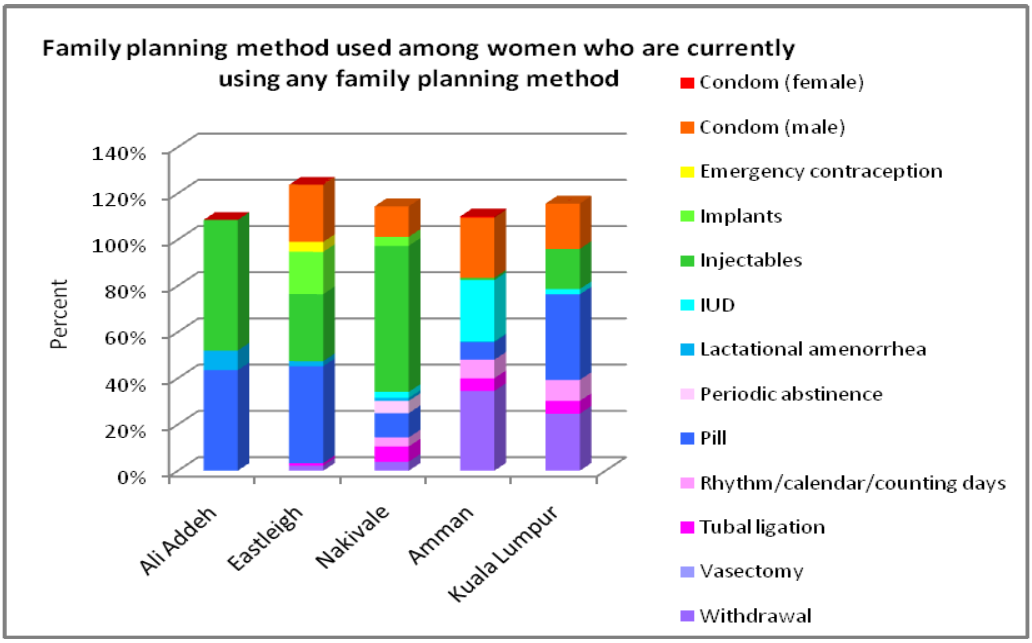
[10] Unmet need is defined as the proportion of women who are at risk for pregnancy, desire to stop or delay childbearing, and are not using family planning among women of reproductive age. Women who are at risk for pregnancy are defined as women who report being fecund, sexually active, not pregnant and not postpartum.

2. **Awareness of family planning methods remains low.** Awareness of family planning methods is considered the first step towards adopting a method. Although family planning services are available to varying degrees in many of the locations surveyed, when women were asked which methods of family planning they had heard of, they demonstrated limited awareness regarding the different methods overall, particularly the Somali refugees in Ali Addeh and Eastleigh. Oral contraceptive pills (OCPs) were relatively known across all sites; in Kuala Lumpur and Nakivale, women further indicated awareness of the male condom and injectable contraceptives. In Amman, awareness of the intrauterine device (IUD) was much higher than in the other sites.



*Percentages add up to more than 100% as respondents gave more than one response.

3. **Among women who are currently using any family planning method, results vary in terms of the most commonly used method**. In Ali Addeh and Nakivale, injectables are the most commonly used option. Withdrawal comprises a larger proportion noticeably higher among the Iraqi population in Amman than in the other sites.



*Percentages add up to more than 100% as respondents gave more than one response.

4. **Among those not using a family planning method, women most reported fertility-related reasons, followed by lack of knowledge and opposition to use, as key reasons for not using a method.** Women in the survey expressed not using contraceptives when wanting more children or if they were currently pregnant. Women, particularly in Ali Addeh, reported breastfeeding as a reason for not using contraceptives, although it is unclear whether they understood that it was only protective if exclusive for the first six months and before menses returns (i.e., lactational amenorrhea). Opposition to use, particularly due to religious reasons, was commonly or often described as a barrier to using modern methods, except in Amman. Among the Somalis in Eastleigh and Ali Addeh, the Muslim and Christian Burmese in Kuala Lampur, and the Muslim, Catholic and Pentecostal communities in Nakivale, religious teaching was cited as a major factor discouraging the use of modern family planning methods. Somalis in Eastleigh, however, noted that exclusive breastfeeding and other natural methods of child spacing are, in fact, encouraged by religious teaching. The Burmese acknowledged that their religion allowed for the use of contraceptives to protect the health of the mother and to adapt to the challenging circumstances of displacement. Common method-related reasons for non-use included misconceptions and fear of side effects. Misinformation that was raised among the Burmese and Congolese was that modern methods can cause birth defects in future children and infertility in women after they stopped use.

5. **Access to information and services is particularly difficult for adolescents**. In all sites assessed, adolescents reported difficultly accessing services, as premarital sex is disapproved of, particularly among Iraqis, the Burmese and Somalis. In Nakivale, adolescents were hesitant to seek contraceptives from the health facility, as family planning consultations take place in the maternity ward. Adolescents in Nakivale also reported exchanging sex for money, but with very little in way of protective strategies. The condom dispensers in the camps—which allow for confidential use—were reportedly often empty.

6. **Emergency contraception (EC) is only available in the context of post-rape care**. As in most countries, awareness of EC as a family planning method is low in comparison to other methods. While existing sexual and gender-based violence (SGBV) programs in the assessed sites offer EC to survivors of sexual assault, family planning providers, especially in Uganda, reportedly disapprove of making EC available for non-sexual assault cases, citing that it could promote promiscuity, particularly among adolescents. EC is not available in the assessed health facilities providing family planning services in Kuala Lumpur—although they are available through prescriptions at pharmacies—or in UNHCR's implementing partner health facilities in Amman.

	Ali Addeh	Eastleigh	Nakivale	Amman	Kuala Lumpur
Number of facilities accessed by refugees assessed	1	2	4	7	3
Are at least three short-term methods offered in all facilities?	Yes	Yes	No	No	Yes
Is there at least one facility offering at least one long-term method?	No	Yes	No	Yes	Yes
Is there at least one facility offering at least one permanent method?	No	Yes	No	Yes	Yes
Is EC available in all facilities?	Yes	Yes	No	No	No

7. **Service quality limited the willingness of women to access services.** Women noted the lack of adherence to standard precautions, lack of cleanliness, long wait times or limited options for privacy as factors that impacted their willingness to obtain contraceptives from health facilities. In Amman, more than 40 percent of women are accessing contraceptives from pharmacies rather than for free from public health facilities, reportedly due to long wait times and problematic hygiene practices. In Eastleigh, the lack of privacy and long wait times are noted barriers, while in Nakivale, consultation times are inconvenient for women doing chores and too short for adequate counseling. In Kuala Lumpur, while the quality of services is good, costs of services and concerns of being detained, especially for unregistered refugees, are major barriers in refugees' ability to seek services.

8. **Limited availability of long-term and permanent methods is compounded by the general weakness of referral systems for unstocked or longer-term and permanent methods**. Long-term and permanent methods of contraceptives are not always available in facilities with the infrastructure and capacity to offer these methods. The strength of referral systems, however, varied per site. Especially in Amman, where UNHCR's implementing partners do not offer contraceptives, referrals are critical, but were found to be limited, particularly at one partner facility. In all sites, formal and institutionalized mechanisms for follow-up are lacking for long-term and permanent methods.

Overarching recommendations

1. **Conduct global advocacy to ensure a full range of family planning methods, including EC and long-term and permanent methods, are available in settings of displacement.** Given the evidence around the safety and effectiveness of modern family planning methods, and specifically of EC over the past 30 years,[11] EC should be made more widely available, and over-the-counter, to prevent unwanted pregnancy and reduce unsafe abortions.

2. **Enhance information and acceptance of family planning methods among community members.** Efforts should include:
    - Strengthen information, education and communication (IEC) efforts on the benefits of family planning and where to seek services, including among adolescents, and sensitize community leaders and influential persons. Traditional birth attendants and religious/community leaders are often extremely influential over community perceptions on the use of family planning services. Reaching out to such key persons may be pivotal in catalyzing change in community attitudes and demand.
    - Develop messages that consider cultural/religious teaching, and take advantage of acceptable natural methods, with concurrent messaging on the use of EC for method failure. Engaging communities on the lactational amenorrhea method (LAM), calendar method and withdrawal (referred to as "'Azi" in the Koran) offer opportunities to familiarize them to the concept of family planning, for further promotion of modern methods. Information on dual protection as well as EC will be critical, however, to ensure back-up options.
    - Build knowledge for long-term and permanent methods, and highly effective and reversible methods to increase demand for these methods. This may include emphasizing the promotion of implants and IUDs in the context of post-placental and post-abortion care. Studies show that women can be more willing to accept a long-term method immediately

[11] International Consortium on Emergency Contraception. Emergency Contraception Fast Facts. Accessed November 2, 2011 from http://www.cecinfo.org/media/ecFF.htm.

after delivery or induced abortion.[12] Men can also be more open to accepting family planning post-partum; male involvement is critical to enhancing uptake.

3. **Improve service delivery: quality and availability**
    - Raise the profile of EC beyond post-rape care and ensure its availability in health centers, dispensaries and pharmacies. EC should be made available, including through provider training, for use following unprotected sex, even among adolescents and unmarried persons.
    - Enhance methods of service delivery to include outreach. Community-based distribution (CBD) approaches have been widely promoted in development contexts and the World Health Organization has approved the community-based provision of injectable contraceptives as safe, effective and acceptable to users.[13] Such approaches may be promising with a focus on dual method promotion.
    - Increase privacy, confidentiality of counseling and non-judgmental and friendly services, in particular for adolescents and unmarried women.
    - Provide training/follow-up training for health workers that would improve quality and uptake, and strengthen supervision of community health workers (CHWs), taking into account possible turnover due to resettlement and mobility. While CHWs and health workers expressed need for training, training and supervision alone have not been effective in increasing service uptake. Creative solutions are necessary to ensure sustained service quality and enhanced uptake.
    - Strengthen referral systems and mechanisms for follow-up. Affordable, clear referral systems to ensure access to a full range of family planning services should be established and made known to refugees at all health facilities, including where they are not provided due to religious reasons.

Findings and recommendations from the baseline studies will be applied to improve UNHCR's programs, as well as for global advocacy to enhance family planning services for crisis-affected populations. More information on each country is accessible from the country-specific report available at www.womensrefugeecommission.org/reports and www.unhr.org.

Limitations

Despite efforts to ensure the highest quality of data was collected, field realities introduce limits to data collection. One key limiting factor during this study was time, and as a result, not all teams were able to implement the suggested 12 FGDs to reach saturation, or visit all tertiary care facilities accessed by the refugees. Survey sampling posed challenges, especially in urban settings, due to limited accuracy of registration lists and recorded cell phone numbers. The self-reported nature of the survey is a recognized limitation. Further, method switching and discontinuation were not captured in the survey. Social desirability bias of respondents, particularly among unmarried women and adolescent girls, was perceived to exist, especially in Amman, Ali Addeh and Eastleigh. Translation error was likely, as, while the data collectors were conversant in local languages and efforts were made to ensure appropriate translations, they were not always comfortable reading in their language and preferred to verbally translate from another language.

[12] Population Council, *Advances and Challenges in Postabortion Care Operations Research: Summary Report of a Global Meeting*, 1998. See also Curtis C, Huber D, Moss-Knight T. "Postabortion family planning: addressing the cycle of repeat unintended pregnancy and abortion." *International Perspectives on Sexual and Reproductive Health*. 2010 Mar;36(1):44-8.

[13] WHO, *Community-based health workers can safely and effectively administer injectable contraceptives,* 2009. Available from http://www.who.int/reproductivehealth/publications/family_planning/WHO_CBD_brief/en/.

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