



Family planning in refugee settings

“All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.”

Programme of Action, International Conference on Population and Development, Cairo, September 1994

More than 120 million women say they want to space or to limit their families, but currently do not have accessible, affordable, or appropriate means of doing so. This problem is most evident in refugee settings where a high number of women are struggling with unwanted, unplanned, and poorly spaced pregnancies - hazardous for them and their children.

Given the choice, many refugee women would prefer not to become pregnant and face the difficulties of childrearing in a camp setting. However, many do not have the choice since contraceptive services are often unavailable. Even where services do exist, women are often constrained from using them by cultural mores, or political pressure to rebuild the population. Unwanted pregnancies, and the attendant increase in unsafe abortions are also by-products of a breakdown in social order which allows rape and prostitution to flourish.

Increasing access to safe, effective contraception saves the lives of women and children. Family planning plays a crucial role in helping women remain healthy by preventing unwanted or untimely pregnancies. Many contraceptives have added health benefits. For example, the pill can protect against certain cancers, while condoms provide protection against HIV/AIDS and other sexually transmitted infections. The best guarantee of infant survival is to ensure the survival of the mother.

Hence, family planning and birth spacing increase the chance that children will grow up healthy.

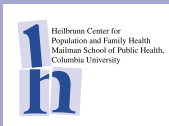
Family planning also has positive long-term benefits for the entire refugee community. Smaller families allow women and couples to care for their children more effectively, manage scarce resources for health, education, food and housing, and undertake a greater range of income-generating activities.

Case study

Internal displacement of people due to civil unrest and war has been a critical phenomenon in Sri Lanka since the 1980s. It has been estimated that over one million people have been displaced during this period.

Research commissioned by Marie Stopes International (MSI) examined the reproductive health status of internally displaced people in six districts. Results indicate that IDPs are at increased risk of reproductive ill health. For example, findings showed that:

- 42% of families have four or more children
- 4% of pregnant women used family planning methods before their first pregnancy
- 8% of sexually active adolescents use condoms
- 36% of adolescents had no knowledge of family planning.



The statistics clearly indicate a lack of access to family planning services and education in the IDP camps and resettlement villages. Access to family planning services and education is key to reversing poor reproductive health indicators.

Key facts

- 350 million women - nearly one third of all women of reproductive age in developing countries - still do not have access to a range of modern, safe and acceptable methods of family planning; 120 million more women would use family planning now if it were more widely available¹
- of the nearly 175 million pregnancies each year, as many as half are unwanted or ill-timed²
- family planning can prevent 25-30% of all maternal deaths.³



What can be done?

Refugees must be involved in defining their own reproductive needs and in designing and delivering appropriate family planning services.

Providers should ensure that women and men have safe and affordable access to family planning services in settings, which are culturally appropriate and convenient.

Family planning must be part of an integrated package of services that are not simply technical interventions to control family size or limit population growth, but which improve the lives of women, men and children.

Provision of contraceptive services should be based on the needs and demands of women and men. The quality and coverage of contraceptive options in refugee situations needs to be improved and expanded to include methods that appeal to both women and men.

Staff should be trained and sensitive to the special needs of refugee women.

Family planning services should be introduced as part of a co-ordinated approach by all non-government and international agencies working in refugee settings.

Technical resources

Contraceptive Guidelines for Refugee Settings, John Snow International, 1996

Five Day Training Program for Health Personnel, Reproductive Health Programming in Refugee Settings, CARE on behalf of the RHR Consortium, April 1998

One Day Awareness Building Module Intro to Reproductive Health for Refugee Settings, CARE on behalf of the RHR Consortium, April 1998

Refugee Reproductive Health: Needs Assessment Field Tools, RHR Consortium, 1997

The Reproductive Health Kit for Emergency Situations, UNFPA, 1998

Reproductive Health in Refugee Settings: An Inter-Agency Field Manual, UNHCR/UNFPA, 1999

Setting Priorities in International Reproductive Health Programmes: A Practical Framework, Columbia School of Public Health, 1996

Further reading

Health Benefits of Family Planning, WHO/FHE/FPP/95.11

Improving Access to Quality Care in Family Planning, WHO/FRH/FPP/96.9

References

¹ The State of World Population, UNFPA, 1999

² Ibid

³ Family Planning Saves Lives, Population Reference Bureau, 1991

Note: The term 'refugee' officially describes a person who has crossed an international border, while an 'internally displaced person' (IDP) has had to leave her home but has remained in her own country. For the purposes of this factsheet, 'refugee' is used here to refer to both groups.

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