



**Baseline Study: Documenting Knowledge, Attitudes and Practices of
Refugees and the Status of Family Planning Services in UNHCR's Operations in
Nakivale Refugee Settlement, Uganda**

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This report is one of a series of five reports documenting baseline findings and recommendations to improve family planning programming for refugees in Djibouti, Jordan, Kenya, Malaysia and Uganda. The reports have similar objectives, literature reviews, methodology and limitations sections. The studies can be found at <http://www.womensrefugeecommission.org/reports>.

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ACRONYMS AND ABBREVIATIONS

AHA	Africa Humanitarian Action
ANC	Antenatal care
ART	Antiretroviral Therapy
BCC	Behaviour change communication
CDC	Center for Disease Control and Prevention
CHW	Community health worker
CME	Continuing medical education
COC	Combined oral contraceptive pill
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EC	Emergency contraception
FC	Female condom
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HC	Health centre
HH	Household
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IEC	Information, education, communication
IP	Implementing partner
IUD	Intrauterine Device
LAM	Lactational amenorrhea method
MC	Male condom
MTI	Medical Teams International
NGO	Nongovernmental organisation
OJT	On-the-job training
OPM	Office of the Prime Minister
POP	Progestin-only pill
STI	Sexually transmitted infection
TFR	Total fertility rate
TL	Tubal ligation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	Value clarification and transformation
WRA	Women of reproductive age
WRC	Women's Refugee Commission

EXECUTIVE SUMMARY

This report addresses a family planning (FP) study undertaken by the United Nations High Commissioner for Refugees (UNHCR), the Women's Refugee Commission (WRC) and the Centers for Disease Control and Prevention (CDC) primarily among Congolese refugees in Nakivale Refugee Settlement in Southwest Uganda from June to August, 2011. It documents the knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision to improve programming and subsequently increase uptake of good quality FP services among Congolese women, men and adolescents.

Four hundred and seventy women of reproductive age (WRA) were interviewed using an adapted version of CDC's reproductive health assessment toolkit, four health facilities evaluated, six focus group discussions (FGDs) conducted with community adults and adolescent boys and girls, and three in-depth interviews carried out with key informants and refugee leaders in the settlement.

KEY FINDINGS

While an FP programme is in place in the settlement, there are many gaps and barriers at the implementation and resource levels. The contraceptive prevalence rate (CPR) in the settlement was found to be 16.1%, and 14.6% for modern contraceptive methods. The survey further revealed that 7.8% of the population had an unmet need for contraception, and 40% of the women interviewed had ever used some contraceptive method.

Cultural and religious barriers exist within the refugee population. Many families want to have a large number of children to replace those they lost in the war, and families see having many children as a form of wealth. Religious reasons were also given by a number of community members for not being able to use contraception. A number of myths and misconceptions in the community about method use appeared to further discourage people from using contraception.

Girls and boys in the community reportedly become sexually active at a very young age, and girls often exchange sex for money. Adolescents reported buying and selling sex, but not having any FP methods. They were not comfortable with using the health centre (HC) to obtain FP because the services are available only within the maternity wing of the hospital. There are a number of condom dispensers in the community, but they are often empty and not restocked regularly.

The findings from the health facility assessments show that none of the facilities provide long-acting or permanent methods of contraception to clients, nor is there a functioning referral system in place for those who would like to use these methods. Some refugees used long-term methods in their country of origin, but have not been able to attain them since their arrival in the settlement. Facilities also experience frequent stock-outs of short-term methods, such as oral contraceptive pills and condoms, especially when there is a shortage at the regional level. Occasionally, the brands of pills are different, which discourages clients from continued use. In addition, staffing problems exist at the facilities. Most have overstretched staff and the midwives expressed training needs as they have not received any formal training on FP. The infrastructure of all of the facilities is fair, with room for seating, access to water and clean toilets. Sometimes due to the high volume of patients present at one time, ensuring privacy is impossible for the doctor/midwife.

KEY RECOMMENDATIONS

The following recommendations are based on the quantitative and qualitative findings of this study:

IMMEDIATE RECOMMENDATIONS

1) Health implementing partners (IPs) should regularly monitor the condom stock at condom posts and also encourage dual method use at the HCs. A number of condom posts visited were empty, and according to community members had not been refilled for a number of months. Given the high volume of sex work in the community, particularly among adolescents, condoms should be accessible, especially at the condom box located in the youth centre in Base Camp. The only location where the stock is regularly available is at the HCs, where adolescents prefer not to go for FP methods. Further, it was noted that dual method use was not encouraged at the HC except at the STI clinic. Condom use should be promoted at the HC and condoms should be placed on the consultation table.

2) Health IPs should work on developing a functioning referral system for long-term methods and to provide a sufficient stock of temporary methods. The quantitative and qualitative data show that women want FP options and almost 50% of women have heard of a long-term method or have been using them in their countries of origin but cannot access them at the camp. Existing and new partnerships with health providers, NGOs and the regional hospital in Mbarara should be explored in order to develop a functioning referral and transportation system for women who want to use long-term FP methods and increase the availability of female-controlled methods.

To ensure that women have a range of temporary options available to them, the IPs should also explore secondary sources from which they can obtain stocks of oral contraceptive pills and emergency contraception (EC) when there is a stock-out at the regional level. Steps should be taken to ensure that there is a range of combined oral contraceptive pills (COCs) and progestin-only pills (POPs) available, as many women report side effects with the ones currently being supplied at the HC. EC should also be offered as a method outside of response to gender-based violence (GBV) cases and its use should be expanded.

3) Strengthen referral systems in antenatal care (ANC), postnatal care (PNC), voluntary counseling and testing (VCT), antiretroviral therapy (ART) and the sexually transmitted infections (STI) clinic. While it was reported by midwives at all of the assessed health facilities that FP counseling took place in antenatal and postnatal consultations, VCT and STI clinics and ART centres where they existed, there are no FP methods available at the clinics and no system to follow up on referrals to the FP clinic. A more formalized referral system should be developed that would ensure community health workers (CHW) follow up on the referral at the end of a pre-defined duration.

4) Trainings for CHWs and midwives should be organized to enhance provider capacity. HC staff at all of the facilities visited reported training needs in FP methods, side effect management and client-centred care. The staff were found to be using the knowledge they had acquired in their midwifery training and had not participated in any refresher trainings thereafter. Most midwives reported a gap in their ability to manage side effects of injectables and pills, such as excessive bleeding. A continuing medical education (CME) system is present in most of the health facilities, in which any provider who has attended a training shares information with the rest of the staff. This system can be used to further disseminate information taught in FP trainings.

5) CHWs, midwives and key personnel from the community should work directly with community women and men to increase awareness and uptake of FP. Implementing partners should establish additional community education sessions for WRA, men and adolescents about the advantages of using FP, knowledge about methods and correct use, and dispelling myths and misconceptions through the HC, CHWs and the male and female chairpersons present in the community. All such persons are good entry points for gaining access to the population. Community-specific distribution of male and female condoms would also reduce the problem of distance and access reported by some members, and of the condoms being sold or being taken by children. A number of women reported that men are opposed to FP use and that often women use methods without their partner's knowledge. Sensitization of men may help partner support of method use.

6) UNHCR community services department and IPs should work with adolescents in culturally appropriate ways. Adolescents in the community need to be targeted in a culturally appropriate way in order to reduce unwanted pregnancies and STIs. This can be done as part of an overarching health improvement campaign. Information can also be provided at the IP-run youth centre in the community and through a peer education programme in which peer educators can be trained to offer community outreach. A lack of youth-friendly services in the settlement means adolescents have nowhere to go for services and information when they need them.

7) Develop and provide information, education and communication (IEC) materials in local languages. No IEC materials were available at the HCs for clients. Providers expressed a need for IEC materials and posters in pictorial form or in Swahili to post on their clinic walls and to give/show clients, especially while they waited for other services. These messages might also address related concerns, such as consequences of early marriage, the importance of facility-based deliveries and the complications of pregnancy.

LONG-TERM RECOMMENDATIONS

8) Establish additional FP services beyond those available in the maternity unit at the HC. While this is currently a problem due to lack of staff and space, this should eventually be done in order for FP to be prioritized and for FP options to become more accessible to adolescents.

9) Provide long-term FP methods in the settlement. Providing a functioning referral system is a solution in the short term, but there is a need for long-term methods such as implants, intrauterine devices (IUDs) and tubal ligation (TL) to be provided in the settlement.

10) Health IP management should devise a transparent system of accountability for HC staff to manage complaints. There is currently no mechanism to ensure that if patients have a problem with anyone from the HC they have a way to voice their concerns. If a confidential feedback mechanism exists, accountability of providers will increase.

INTRODUCTION

Access to FP services is a human right¹ and neglecting FP can have serious health consequences. Restoring access to safe, effective contraceptives can reduce unwanted pregnancies, unsafe abortion and resulting maternal death and disability. It also provides women and girls the autonomy to determine the number and spacing of their children, access to educational and livelihoods opportunities, and possibilities for families to manage scarce resources more effectively.

The *Statement on Family Planning for Women and Girls as a Life-saving Intervention in Humanitarian Settings*² developed by the Women's Refugee Commission (WRC) 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 further describes methods of service delivery and recommendations for governments, donors and implementing agencies.

While UNHCR has focused on emergency obstetric care, GBV and HIV/AIDS in the past several years, FP activities have not been given sufficient attention to ensure adequate access for refugees and other persons of concern. FP coverage in camp settings has reportedly been low; programmes in the field are often very poor to non-existent.

The purpose of this study is to document knowledge, beliefs, perceptions and practices of refugees as well as the quality of services provided in UNHCR's operations in Nakivale refugee settlement in south-west Uganda to improve programming and subsequently increase uptake of FP services among women, men and adolescents. The study is one of several conducted for a global overview of baseline findings. Finding and recommendations from this study will be used to inform and improve FP programming in the settlement.

Nakivale refugee settlement was established in 1962 for Tutsi refugees from Burundi and became predominantly Rwandese in 1994. This was followed by ongoing rebel activities in Eastern Congo, leading to a large influx of Congolese refugees into Uganda beginning in the late 1990s and continuing through the 2000s. The camp also saw a dramatic increase in the Somali population in the early 1990s. The population of the settlement as of July 1, 2011 was 53,153; of which 27,053 were Congolese, 9,095 Somali, 9,950 Rwandese, 5,281 Burundian and 1281 Eritrean; the remaining were Ethiopian, Kenyan and Sudanese. The settlement is spread over 84 square kilometres, and is divided into 18 zones, which are further subdivided into 69 villages.³

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 Programme 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 A statement on family planning for women and girls as a life-saving intervention in humanitarian settings, Inter-agency Working Group on Reproductive Health in Crises, May 2010.

³ Data from UNHCR sub-office Mbarara.

There is a tripartite agreement with UNHCR, the Government of Uganda and IPs to provide protection and services for the refugees.⁴

OBJECTIVES

Goal

To document knowledge, beliefs, perceptions and practices of refugees, as well as the state of service provision in the select UNHCR operation to improve programming and subsequently increase uptake of FP services among women, men and adolescents.

Objectives

- To increase baseline information to guide policy and planning.
- To improve quality of services through training and guiding health and community providers, and improving infrastructure as required.
- To adapt programmes according to barriers, beliefs, fears and perceptions, in terms of information, education and communication efforts, and service delivery.
- To expand access through a broader choice of contraceptive methods, community-based distribution and linkages with national programmes or other in-country initiatives as appropriate.

Study Question

This study aimed to answer the primary question: What are the barriers and challenges at the community and health facility-levels that hinder increased uptake of contraceptives among the select refugee communities, and what are the practical ways that the challenges can be addressed?

LITERATURE REVIEW

According to the UNHCR health information system (HIS), reproductive health and FP are areas that need to be targeted at Nakivale refugee settlement. The CPR in the community is reported at 3%, and there is a lack of funding for capacity building, lack of IEC materials and a dearth of facility staff.⁵

A 2004 evaluation conducted on the quality, access to and use of reproductive health services for refugees and internally displaced persons in various sites in and around Uganda found that oral contraceptive pills and injectables were the most commonly used method in Nakivale refugee camp. An outreach service operates from the facilities and counseling on FP is provided at antenatal and postnatal visits at the HC. The low CPR was reportedly due to cultural reasons and the need refugees feel to repopulate after the war. There were also many misconceptions held by the community about hormonal FP methods. Overall, FP was found to be a major concern of community adults and adolescents; yet, at the same time, the community has low acceptance and poor education, and a limited range of options are available.⁶

⁴ UNHCR - Inter-agency global evaluation of reproductive health services for refugees and internally displaced persons: Section 3: Evaluation of quality, access to, and use of reproductive health services for refugees and internally displaced persons. (n.d.). UNHCR. Retrieved August 5, 2011, from <http://www.unhcr.org/cgi-bin/texis/vtx/home/opensslPDFViewer.html?docid=41c847b52>.

⁵ 2009 Uganda Factsheet. (n.d.). UNHCR-webHIS. Retrieved August 10, 2011, from <http://his.unhcr.org>.

⁶ UNHCR - Inter-agency global evaluation of reproductive health services for refugees and internally displaced persons: Section 3: Evaluation of quality, access to, and use of reproductive health services for refugees and internally displaced persons. (n.d.). UNHCR. Retrieved August 5, 2011, from <http://www.unhcr.org/cgi-bin/texis/vtx/home/opensslPDFViewer.html?docid=41c847b52>.

The 2006 Demographic and Health Survey (DHS) of Uganda found that the overall CPR in the country is 24%, with 18% CPR for modern methods. The use of modern FP was found to be more than twice as high in urban Uganda as in rural areas. A high discontinuation rate exists among users, especially male users of condoms. The unmet need for FP services in Uganda is 41%.⁷ The 2006 DHS for the Democratic Republic of the Congo (DRC) shows that the CPR for modern methods in the country is 23%, and the male condom is the most widely used method.⁸ The CPR for modern methods in Rwanda is 16%.⁹

The provision of FP and adolescent reproductive health services are an important component of the *Sexual and Reproductive Health Minimum Package for Uganda*.¹⁰ The goal of the health policy is to promote sexual and reproductive health and rights of adolescents, including sex education and life skills to protect against STIs, unwanted pregnancies and unhealthy lifestyles. Studies conducted at the refugee settlements in northern Uganda to expand these programmes to the region have shown that male refugees were vehemently opposed to the use of FP, and many women used methods clandestinely. Men who used condoms only used them occasionally when they had sexual contact with women other than their primary partners.¹¹

METHODOLOGY

This baseline study employed a multi-pronged approach to ensure triangulation of data. It included quantitative data collected through a household (HH) survey and qualitative data gathered through facility assessments, in-depth interviews with key informants and community focus group discussions (FGDs).

Household Survey Methodology

An adapted CDC reproductive health assessment toolkit was used for the HH survey instrument. This survey was used to gather quantitative data from WRA on FP-related knowledge, attitudes and behaviours in the community. A team of six multilingual (Swahili/Kinyarwanda/Somali and English) female community members was trained on administration of the tool. The survey was piloted in 20 HHs before the start of data collection. Because a number of different languages are spoken in the community, the data collectors chose to use an English questionnaire, administering it in the language required. Due to the size of the settlement and logistical difficulties in locating HHs, the sample was drawn using cluster sampling. The settlement is divided into 18 administrative zones, of which the larger zones were subdivided, leading to a total of 22 zones. Approximately 31-32 HH visits in each zone would have been required to draw the sample of 625 households. Due to short working days and long distances in the camp however, the number of zones visited was reduced to 18. Every fourth house was visited within the zone, resulting in 540 completed questionnaires from 600 HHs visited (10% refusal). Seventy completed questionnaires were subsequently removed from the dataset for quality control purposes, with a final sample of 470 completed surveys and a response rate of 78%. The WRA

⁷ Uganda, 2006 - Demographic and Health Survey (DHS). (n.d.). *IHSN*. Retrieved August 14, 2011, from <http://surveynetwork.org/home/index.php?q=activities/catalog/surveys/ihsn/800-2006-001>.

⁸ DRC, 2007 - Demographic and Health Survey (DHS). (n.d.). *IHSN*. Retrieved August 14, 2011, from <http://surveynetwork.org/home/index.php?q=activities/catalog/surveys/ihsn/800-2006-001>.

⁹ Rwanda, 2004- Demographic and Health Survey (DHS). (n.d.). *IHSN*. Retrieved August 27, 2011, from <http://surveynetwork.org/home/index.php?q=activities/catalog/surveys/ihsn/800-2006-001>.

¹⁰ The 1995 burden of disease study indicated that sexual and reproductive health and its complications contribute tremendously to the disease burden of Uganda. Subsequently, a technical committee was appointed to formulate the SRH minimum package to be disseminated in all districts for guidance. The package provides a national guide for operationalization of the reproductive health policy with an overall output of increased accessibility and utilization of services. (Mulumba, 2010.)

¹¹ Mulumba, D. (2010). *Women refugees in Uganda: gender relations, livelihood security, and reproductive health*. Kampala: Fountain.

interviewed were Congolese, Rwandese, Somali and a minority from other nationalities, with Congolese refugees forming the majority. After an HH was selected for the survey, a locator form was used to select the WRA within the HH to ensure each woman had an equal chance of being chosen. The data collected through this tool was entered by the study coordinator and analyzed using SPSS.

Health Facility Assessment Methodology

Health facility assessments were carried out using an adapted UNHCR tool to examine service availability, quality of service and provider opinions. Four secondary level health facilities exist in the settlement and are run by three different IPs: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Africa Humanitarian Action (AHA) and Medical Teams International (MTI). Assessments, consisting of a health facility checklist, a short interview with the provider and an observation of FP consultations, were carried out at all locations. Since IP staff are predominantly Ugandan and speak English, a translator was not required for this exercise.

In-depth Interview Methodology

In-depth interviews with community leaders and key informants were conducted to learn about challenges and barriers to increasing contraceptive uptake in the refugee community. Three interviews were conducted with a refugee leader of a Congolese zone, a female chairperson of a Congolese zone and a community health worker. All interviews were recorded and then transcribed for analysis. Two of the interviews were conducted in English and one in Swahili; the latter was translated at the time of transcription.

Focus Group Discussion Methodology

FGDs were carried out with community women, men, adolescent girls and adolescent boys to gather qualitative data on attitudes and barriers. Two male and two female community members were trained to conduct FGDs. Each session consisted of a facilitator and a note-taker, and the sex of the facilitator conducting the session was matched with that of the group. The FGDs were conducted in Swahili and were recorded. Later they were translated and transcribed. Two sessions were conducted among women, two among adolescent girls, one among men and one among adolescent boys. More FGDs with male participants could not be conducted because of time constraints. The data collection team mobilized FGD participants in different zones within the settlement to diversify the participants. Each group consisted of eight participants. The adolescent groups consisted of boys and girls between the ages of 15 and 19.

Ethical Considerations

The data collection team received training on the ethical issues that relate to working with refugee populations. Informed consent was obtained from participants of the HH survey, FGDs, facility assessments and interviews. All participants were informed about the procedures and the voluntary nature of their participation; assured confidentiality; and informed that no adverse consequences would arise if they declined participation. No identifying markers were listed on any of the HH survey questionnaires, and the names of the FGD participants were not recorded. The data collected was stored securely by the UNHCR country office and will be destroyed after five years if no further analysis is required.

PRESENTATION OF FINDINGS

Household Survey

The results of the HH survey (tables in Annex A, page 17) show that the CPR in the settlement is 16.1%. The CPR for modern methods is 14.6%. Both figures are significantly higher than the UNHCR HIS-reported CPR of 3%.¹² Furthermore, almost 40% of WRA interviewed reported having *ever* used an FP method. The reported unmet need for contraception is also low, at 7.8%. While not currently users, 21.4% of women reported that they planned to use a FP method in the next 12 months. Knowledge of FP methods was also high, with 75% of WRA being aware of the oral contraceptive pill and injectables, and 87% knowing about male condoms. Knowledge of the female condom was lower, at 40%. The following is a breakdown of the methods being used by women who are currently using an FP method:

Table FP-6: Family planning method being used among women who are currently using any family planning method, Uganda, 2011 {N=76}	
Method	% (n) women*
Pill	10.5% (8)
IUD	2.6% (2)
Male condom	13.2% (10)
Female condom	0.0% (0)
Implants	3.9% (3)
Injectables	63.2% (48)
Emergency contraception	0.0% (0)
Tubal ligation	6.6% (5)
Vasectomy	0.0% (0)
Lactational amenorrhea	1.3% (1)
Rhythm/calendar/counting days	3.9% (3)
Withdrawal	3.9% (3)
Periodic abstinence	5.3% (4)
Other	0.0% (0)

The main problems reported by women who had heard of each method were method-related reasons, especially for pills and injectables; with fear of side effects being the most commonly reported problem (Table FP-4).

Health Facility Assessments

Access to Health Facilities. There are four health facilities operating in the settlement, each catering to a catchment area of up to 20 square km. There is no public transportation available in the community; therefore most clients walk to the facility or travel by bicycle if available. Many women tend to their crops during the day; access to the facility for FP was challenging since consultation hours were typically over by the time they finished their chores. This was one of the reasons some women reported going to pharmacies and private health facilities for their FP needs. Of the four facilities assessed, all provide FP services, but only one is administering FP methods in the evenings and on weekends. An ambulance was

¹² 2009 Uganda Factsheet. (n.d.). *UNHCR-webHIS*. Retrieved August 10, 2011, from <http://his.unhcr.org>.

available at each of the facilities to transport patients from their homes in emergency situations, but transportation was not available to and from the health facility for those seeking FP services.

FP Method Availability. A summary of the FP method availability at the HCs can be found in the summary facility assessment table (Annex B). EC is available at three of the four facilities and is only used for sexual assault cases. Two of the four facilities had COCs and POPs; one facility only had POPs, while the fourth had no oral contraceptive pills due to a stock-out. When there is a stock-out of a method at a facility, clients are referred to one of the other health facilities in the settlement. It is unclear whether or not the referrals are completed due to transportation challenges and distance from one facility to another. Condoms are provided at the HC at consultations, and IPs maintain around 25 male condom dispensers in the settlement, including at the youth and health centres. Condom use, however, was not widely promoted at the HCs as an FP method due to the prevalent idea that people do not like condoms. Long-term and permanent methods such as IUDs, implants, TL and vasectomies were not available at any of the HCs and there is no functioning referral system in place for clients who would prefer to use these methods. Traditional methods, including the calendar method, cycle beads and withdrawal, are not promoted at any of the facilities as, according to the providers, clients do not use these methods correctly, leading to a high failure rate. All facilities reported that midwives and counselors make FP referrals to the FP clinic at ANC and PNC visits, as well as at VCT and ART centres, where they exist. However, there is no mechanism to follow up with clients about these referrals.

Staffing and Training. Midwives and nurse-midwives are responsible for providing FP at each of the facilities visited. The staff at the HCs generally had an extremely high caseload and were overstretched, particularly midwives who dealt with ANC, PNC, FP and deliveries. While there is no specific on-the-job training (OJT) at any of the facilities, a CME system is available where providers who have attended trainings share information with their colleagues on a weekly or biweekly basis. All providers reported that they have gaps in their skills and would like refresher trainings, as well as trainings on long-term FP methods and developments in contraceptive technology. They often found that they were unable to effectively treat the side effects, such as excessive bleeding, that brought women back to the facility, and this was one of the most common reasons for discontinuation.

Quality of Services Provided. Providers were respectful towards clients and presented them with FP options where they were available, although in most cases observed, clients already knew which method they wanted to use. It was noted that providers encouraged the use of injectables more than other FP methods because many women would forget to take pills daily.¹³ Client visits were generally kept very short and not much time was spent talking about side effects and instructions for use. Special measures were not taken to ensure confidentiality and privacy. Follow-up dates were set during the visit.

A number of reasons were given for low uptake in the community, including cultural and religious reasons, lack of information, partner opposition and a desire to replace those lost in the war. All providers interviewed agreed that the facility did not provide youth-friendly services since FP operated from within the maternity wing. As one midwife commented: "If a young person is seen in the maternity wing, people will assume they are pregnant and that is not acceptable in the community. Mostly, they will catch me while I'm outside and tell me they need to speak to me in private or that they are in trouble."¹⁴

¹³ HC assessment, GIZ Nakivale, Uganda, July 12, 2011.

¹⁴ Midwife, GIZ Nakivale HC, Uganda, July 12, 2011.

All interviewed providers also expressed an urgent need to set up a referral system for the provision of long-term FP methods. They reported having clients who had used implants or IUDs in their country of origin, but had no place for referrals. The HCs work with the community through CHWs and mobile outreach, and providers felt having IEC materials to distribute at these informational sessions would be beneficial.

IEC Materials. All facilities visited had almost no IEC materials on FP methods. All providers expressed a need for IEC materials in either pictorial form or in local languages. The national FP choices flipchart was only present at the MTI facility. Syndromic management of STI chart for providers was available at one of the two GIZ HCs.

Record Keeping. Weekly, quarterly and monthly reports were available in the facilities and providers are efficient at recording and reporting. Uptake statistics were not displayed in the facility. The mechanism for recording follow-up appointment dates, however, was not very efficient as the date was only given to the client but not kept with the provider. The provider therefore had no record of when the client previously visited and her history.

Infrastructure and Equipment. All assessed facilities are located in fairly safe areas in the settlement. Facilities are generally clean and have access to running water, toilets/latrines and all of the required infection prevention equipment. Light source was a problem in the health facilities: staff often conducted deliveries at night with lamps and lanterns in the absence of light bulbs. Space was also a problem as FP services are provided in the maternity ward of the HC, and often the delivery room doubles as a consultation room. There is sufficient room for clients to wait outside and inside the facility, and waiting times are not long unless the midwife on call is conducting a delivery. An examination table was present in the consultation room of only one facility (GIZ), but because long-term methods are not provided at the facilities, providers generally do not perform physical exams unless there is a complication.

Good Practice: CHWs conducted health awareness sessions in the mornings with community members while they were waiting in the waiting area for their various consultations. The CHWs made use of the opportunity to disseminate information on a number of health topics, which also included information about the benefits of FP and the importance of maternal child health care.

Qualitative Findings

Cultural Barriers. One of the main reasons identified for low uptake of FP services in the settlement was that refugee populations needed to repopulate after losing many people in the war. Another recurrent comment from the focus groups was, “Africans like big families so someone can carry on our legacy when we’re gone.”¹⁵ In the settlement, having many children was also seen as a blessing because each child brings extra food and non-food items to the refugee family. The average age of marriage was reportedly between 13 and 15 years. Men were seen as the main decision-makers within the family on family size and number of children. Community leaders, men, women and adolescents all identified a number of reasons that FP should be practiced, including for the health of the mother and child, and the livelihood of the family. They also thought that three to five years was an appropriate age gap between children. Women in the community were seen to have a general unmet need for FP due to cultural constraints: “All these years I just kept reproducing because my husband wanted me to, and because he

¹⁵ FGD Participant, Base Camp men’s group, Uganda, July 21, 2011.

didn't like me using FP, and now I have told my daughter to never make the mistake I made by having ten children when I could have stopped."¹⁶

Many women and girls in the community also said they would like to use long-term methods such as IUDs because they do not require partner cooperation. Among short-term methods, injectables were preferred because women often used these methods without the knowledge of their partner, and they were less conspicuous than the pill.

Religious Barriers. Religious barriers were present within the Muslim, Catholic and Pentecostal populations. As a community members noted: "The bible says to be fruitful and multiply, and to keep producing till we fill the earth. Knowing this I can't practice FP."¹⁷ Some churches also reportedly forbid the use of FP to the extent that if a member of a woman's congregation saw her at the HC obtaining contraceptives, she was at risk of being removed from her church.

Health Facility-related Barriers. FGD participants reported having to walk up to two hours to reach the nearest health facility where they could access FP services. The hours of the facilities were not flexible and by the time they finished their housework, the FP consultation hours were over. They also noted that FP services were typically not seen as a priority at the HC. Midwives would often have to interrupt client visits to tend to deliveries and other maternity-related issues. Women who had been to the facilities for FP services further stated that they would have liked for the provider to spend more time with them to obtain their history, conduct a physical exam and explain possible side effects.

Absence of and the Need for Youth-friendly Services. Sex work was found to be rampant in the community, with girls starting to sell sex for money by age 10 in some instances. One adolescent boy noted, "If a girl doesn't have food, and a boy or man is in a position to buy it for her, why would she not have sex with him?"¹⁸ An adolescent girl further noted: "Many girls in the community have babies but don't know who the fathers are. Men don't want to use condoms and we don't have access to the family planning methods we want so it just happens."¹⁹

Adolescents reported that while adults did not care about whether or not adolescents were using contraception, it was still not appropriate to be seen in the maternity wing of a health facility, as that implied they were pregnant or had impregnated someone. Some girls who engaged in sex work also found that condom dispensers were empty and had not been refilled for days.²⁰ Almost none of the adolescents in the discussions knew about EC. The secondary school in the settlement apparently provided some reproductive health education to students, which meant that many adolescents were aware of FP methods, STIs and the benefits of child spacing, but could not obtain the methods. One FGD participant noted: "I was told at school that there is an ABC of sex: abstinence or be faithful and use condoms."²¹

Women in the community reported that they did not know how to talk to their young daughters about using contraception, because they thought talking about it might lead to encouraging sexual intercourse. They mentioned, however, that they would be comfortable knowing that their daughters had a place they could access information and services for them to be safe.

¹⁶ FGD Participant, Base Camp women's group, Uganda, July 22, 2011.

¹⁷ FGD participant, Base Camp men's group, Uganda, July 21, 2011.

¹⁸ FGD participant, Base Camp boys group, Uganda, July 21, 2011.

¹⁹ FGD participant, Base Camp girls group, Uganda, July 22, 2011.

²⁰ Ibid.

²¹ FGD participant, Base Camp boys group, Uganda, July 21, 2011.

Myths and Misconceptions. Community men and women reported that they had heard that implants lead to cancer, and that using injectables over a long period leads to infertility. Another common misconception was that a child born after several years of using a method is often sick and weak.²² Adolescent boys reported that sometimes young girls would not allow their partner to use condoms because they were afraid of the condom getting stuck inside them during intercourse.

DISCUSSION

The low uptake of and demand for FP in the community are the result of a combination of factors. A strong fear of side effects, and myths and misconceptions associated with use of FP methods appear to be major barriers. Perceived or real religious opposition to the use of FP and the idea that a large family is a “form of wealth” are also impediments. Lack of buy-in from partners is another obstacle for women. Surprisingly, access and availability issues were reported by only a very small percentage of the respondents in the quantitative data, as opposed to the qualitative data that showed that they were key barriers.

The discrepancy between the CPR of the HIS and that calculated through this study is also noteworthy. One reason for this discrepancy may be that while record keeping at health facilities is generally efficient, it is possible that not every FP consultation is recorded by the health facilities due to the large influx of patients; another reason is that all women who use contraception do not obtain their methods from the health facilities in the settlement. It was found that less than 60% of current users of modern FP methods had reported obtaining their methods at the health facility. Some women accessed their methods from private health clinics, the regional town or pharmacies, or had obtained a long-term method from their countries of origin. While the sample size for the HH survey was not very large, the calculated CPR was assumed to be a modest estimate of the actual CPR due to some participants possibly concealing FP use during their interviews.

Through an analysis of the FGDs and in-depth interviews, despite uptake of contraceptives being low in the community, community members are very aware of the benefits of child spacing and its importance to them. The high volume of sex work in the community was also a recurring issue that was discussed at each FGD, making it clear that there is a demand for some form of FP method that can be accessed easily by adolescents.

Facility-level barriers are also significant hurdles. Because FP provision is provided in a section of the maternity ward, midwives are often forced to prioritize maternal health over FP provision and transfer (human) resources to address the extremely heavy caseload of deliveries and ANC and PNC consultations. Midwives have also not undergone any recent training on FP and they identified the gaps in their own skills. Lack of space and resources in the HCs to keep FP separate from the maternity ward is also a barrier, especially for adolescents who find visiting the maternity section unacceptable. Another problem was with the temporary methods that were available at the facilities. Some of the HCs reported frequent stock-outs of POPs and COCs or only having one form of the pill, which women preferred not to use. The lack of supplies was often due to a stock-out at the regional level. Lastly, the absence of a functioning referral system for the provision of long-term and permanent methods drastically reduced the choices available to women when they visited the HC.

²² FGD participant, Kiretwa women’s group, Uganda, 22 July 2011.

LIMITATIONS

The size of the camp led to changes in the sampling strategy, from random to cluster, which made the sample less representative. Additionally, the number of completed questionnaires was reduced to preserve data quality, which decreased the generalisability of the findings.

Security issues in the settlement, as well as a 24-hour workweek for the assessment team due to the distance of the settlement from the regional town, meant the time for data collection was limited. This impacted the number of zones covered for the HH survey, and the number of FGDs that could be conducted. FGDs with boys and men were only conducted in Base Camp, which may have led to a lack of saturation in the data collected. The decision was made to reduce the number of male groups rather than female, given that the women's groups were presumed to better inform and contextualize the findings from the HH survey.

Due to the multilingual nature of the settlement, the data collectors decided to use the survey tool in English and translated it according to the language of the randomly selected participant. It is possible that this may have affected the consistency of the questions asked in the HH survey.

While it was made clear to the participants of the HH survey that there would be no gains from participating, it appeared some participants hid their contraceptive use and knowledge hoping to receive supplies from the data collectors. Additionally, despite data collectors' attempts to ensure privacy when administering the survey, some women hid their use of FP because their partners were not aware and they were in the vicinity when the survey was being conducted. The data collectors came to this conclusion because of occasional logical inconsistencies in responses across different sections of the survey.

APPENDICES

APPENDIX I: HOUSEHOLD SURVEY DATA TABLES

Table FP-1: Awareness of family planning methods among women of reproductive age, Uganda, 2011 (N = 470)	
Method	% (n) women*
Pill	74.9% (352)
IUD	9% (42)
Male condom	87.3% (410)
Female condom	39.6% (186)
Implants	27.5% (129)
Injectables	76.4% (359)
Emergency contraception	4.7% (22)
Tubal ligation	12.8% (60)
Rhythm/calendar/counting days	28.7% (135)
Withdrawal	19.2% (90)
Other	14.2% (67)

*Percentages may add up to more than 100% as respondent may give more than 1 response.

Key Indicator FP-A: Proportion of women who have ever used any family planning method among women of reproductive age, Uganda, 2011 (N=470)	
Indicator	% (n) women
Ever used family planning method	39.4% (186)

Table FP-2: Proportion of women who have been instructed how to use or have ever used family planning methods among women of reproductive age,* Uganda, 2011 (N = 470)		
Method	Instructed how to use method % (n) women	Ever used % (n) women
Pill	26.6% (125)	14.5% (68)
IUD	4.5% (21)	0.9% (4)
Male condom	39% (183)	14.4% (68)
Female condom	16.9% (79)	0.8% (4)
Implants	12.5% (59)	2.7% (13)
Injectables	50% (235)	31.7% (149)
Emergency contraception	1.4% (7)	4.7% (22)
Tubal ligation	6.6% (31)	2.6% (12)
Rhythm/calendar/counting days	19.8% (93)	20.2% (95)
Withdrawal	14.6% (69)	9.9% (47)
Other	12.3% (58)	9.1% (43)

*Percentages may add up to more than 100% as respondent may give more than 1 response.

Table FP–3: Knowledge of where to get modern* family planning methods among women of reproductive age,† Uganda, 2011 (N = 470)

Method	Health Centre % (n) women	Private clinic % (n) women	Market % (n) women	Friends/ relatives % (n) women	Pharmacy % (n) women	Don't Know % (n) women
Pill	61% (286)	0.0% (0)	0.0% (0)	0.0% (0)	0.5% (3)	8.8% (41)
IUD	5.8% (27)	1.8% (8)	0.0% (0)	0.0% (0)	0.0% (0)	1.3% (6)
Male condom	62.7% (295)	0.2% (1)	6.8% (32)	0.0% (0)	2.2% (10)	11% (51)
Female condom	20% (94)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	6.3% (30)
Implants	19.6% (92)	3.5% (16)	0.0% (0)	0.0% (0)	2.5% (12)	0.4% (2)
Injectables	69.9% (329)	0.3% (2)	0.0% (0)	0.0% (0)	1.1% (5)	4.3% (20)
Emergency contraception	3.8% (18)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.9% (4)
Tubal ligation	8.8% (41)	2.6% (12)	0.0% (0)	0.0% (0)	0.0% (0)	0.4% (2)

*Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, EC, tubal ligation and vasectomy.

†Percentages may add up to more than 100% as respondent may give more than 1 response.

Table FP–4: Main problem reported with using specific family planning methods among women who have ever heard of that method, Uganda, 2011

Method	Lack of access % (n) women	Opposition to use % (n) women	Method- related % (n) women	No problem % (n) women
Pill {N=352}	2.8% (10)	7% (25)	34% (120)	11.3% (40)
IUD {N=42}	0.0% (0)	0.0% (0)	19% (8)	10% (4)
Male condom {N=410}	2.4% (10)	1.7% (7)	11.4% (47)	28.5% (117)
Female condom {N=186}	0.0% (0)	8% (15)	8% (15)	21.5% (40)
Implants {N=129}	7.7% (10)	4.6% (6)	11.6% (15)	17% (22)
Injectables {N=359}	3.8% (14)	3.3% (12)	39.2% (141)	17.5% (63)
Emergency contraception {N=22}	0.0% (0)	0.0% (0)	0.0% (0)	22.7% (5)
Tubal ligation {N=60}	0.0% (0)	0.0% (0)	16.6% (10)	25% (15)
Rhythm/calendar/counting days {N=135}	0.0% (0)	5.9% (8)	42.2% (57)	37% (50)
Withdrawal {N=90}	0.0% (0)	10% (9)	4.4% (4)	65.5% (59)
Other {N=67}	0.0% (0)	0.0% (0)	7.4% (5)	53.7% (36)

Key Indicator: FP-B): Proportion of women who are currently using a modern* family planning method among women of reproductive age, Uganda, 2011 (N=470†)

Indicator	% (n) women
Contraceptive prevalence (modern methods)	14.6% (69)

*Modern family planning methods include the pill, IUD, male and female condoms, implants, injectables, EC, tubal ligation and vasectomy.

†The denominator may include women who are not at risk for pregnancy because they are currently pregnant, infecund or have had a hysterectomy.

Key Indicator: FP-C): Proportion of women who are currently using any family planning method among women of reproductive age, Uganda, 2011 (N = 470*)	
Indicator	% (n) women
Contraceptive prevalence (any method)	16.1% (76)

**The denominator may include women who are not at risk for pregnancy because they are currently pregnant, infecund or have had a hysterectomy.*

Table FP-5: Demographic characteristics of women who are currently using any family planning method, Uganda, 2011 (N=76)	
Characteristic	% (n) women
Age	
15-24	19.5% (15)
25-34	37.6% (29)
35-49	37.6% (29)
Relationship Status	
Living with a husband/partner	84.4% (64)
Not living with husband/partner	15.6% (12)
Total pregnancies	
0	5.2% (4)
1-2	15.58% (12)
3-4	28.57% (22)
>4	53.42% (41)
Sexually active in last 30 days	
Yes	76.6% (58)
No	20.8% (16)

Table FP-7: Location where family planning method was last obtained among women who are currently using a modern* family planning method, Uganda, 2011 (N=69)	
Method	% (n) women
Health Centre	58.7% (41)
Hospital	20% (14)
Supermarket/Market	0.0% (0)
Pharmacy	12% (8)

**Modern methods include the pill, IUD, female and male condoms, implants, injectables, emergency hormonal contraception (EC), tubal ligation and vasectomy*

Key Indicator FP-D: 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, Uganda, 2011 (N = 470)	
Indicator	% (n) women
Unmet need*	7.8% (37)

**Women who are at risk for pregnancy are women who report being fecund, sexually, active, NOT pregnant and NOT postpartum.*

Table FP-8: Barriers to family planning among women who are at risk for pregnancy, desire to stop or delay childbearing and are not using family planning, Uganda, 2011 (N=37)	
Barriers to family planning	% (n) women*
Fertility-related reasons	78.9% (29)
Opposition to use	13.2% (5)
Lack of knowledge	26.3% (10)
Method-related reasons	15.8% (6)
Lack of access	7.9% (3)
Other	0.0% (0)

*Percentages may add up to more than 100% as respondent may give more than 1 response.

Table FP-9: Demographic characteristics of women who reported barriers to family planning among women who are at risk for pregnancy, desire to stop or delay childbearing and are not using family planning, Uganda, 2011					
Characteristic	Fertility-related % (n) women	Opposition to use % (n) women	Lack of knowledge % (n) women	Method related % (n) women	Lack of access % (n) women
Age					
15-24	10% (3)	20% (1)	0% (0)	0% (0)	0% (0)
25-34	60% (18)	80% (4)	50% (5)	66.6% (4)	33.3% (1)
35-49	30% (8)	0% (0)	50% (5)	33.3% (2)	66.6% (2)
Relationship Status					
Living with a husband/partner	100% (29)	100% (5)	100% (10)	100% (6)	100% (3)
Not living with a husband/partner	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Total pregnancies					
0	3.4% (1)	0% (0)	10% (1)	0% (0)	33.3% (1)
1-2	23.3% (7)	20% (1)	20% (2)	0% (0)	0% (0)
3-4	10% (3)	20% (1)	40% (4)	16.7% (1)	0% (0)
>4	63.3% (18)	60% (3)	30% (3)	83.3% (5)	66.6% (2)
Sexually active in last 30 days					
Yes	100% (29)	100% (5)	100% (10)	100% (6)	100% (3)
No	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)

Key Indicator FP-E: Proportion of women who are not currently using a family planning method, but plan to in the next 12 months, Uganda, 2011 (N = 395)	
Indicator	% (n) women
Future intent to use family planning in next 12 months	21.4% (85)

APPENDIX II: HEALTH FACILITY ASSESSMENT SUMMARY

	Topic	Indicator	GIZ HC1	MTI HC	GIZ HC2	AHA HC
1	Staffing	# of doctors or clinical officers providing any FP method	0	0	0	0
		# of midwives, nurse-midwives or nurses providing any FP method	3	4	6	3
2	Training	Proportion of doctors or clinical officers trained in FP among all doctors and clinical officers providing FP	0	0	0	0
		Proportion of midwives, nurse-midwives or nurses trained in FP among all midwives, nurse-midwives or nurses providing FP	0	0	0	0
3	Method Mix	# of temporary methods available	6	2	6	3
		# of long-acting methods available	0	0	0	0
		# of permanent methods available	0	0	0	0
		# of traditional methods promoted	1	1	1	1
		Is EC available?	Yes	No	Yes	Yes
4	Relative Score of Quality Measure	Score (Out of 15)	13	12	13	12
5	Capacity to meet infection prevention standards	Score (Out of 15)	14	15	14	15