COMMENTARY

Socio-Cultural Challenges of Family Planning Initiatives for Displaced Populations in Conflict Situations and Humanitarian Settings

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ABSTRACT

Provision of family planning services for refugee populations in conflict and humanitarian settings has been improving. Availability of services, however, does not translate into acceptability and uptake; understanding socio-cultural settings and barriers is critical to ensure utilization of services. Misconceptions and apprehensions surrounding family planning services are common. Populations may see limiting pregnancies as counterproductive in light of high child mortality or suspicious in the context of ethnic violence; larger family size has the perceived advantage of additional security for the community or ethnic group, assistance with family duties in a subsistence structure, and a social service investment for parents as they age; and there may be religious and moral objections to contraception. Any service planning and implementation must take into account community perceptions and address socio-cultural contextual subtleties. Ongoing community education via local initiatives from within the refugee community, region-wide structural strategies for service implementation and sustainability, and efforts to reconcile reproductive rights and family planning services within the religious and social context are crucial. (*Disaster Med Public Health Preparedness*. 2018;12:670-674)

Key Words: refugees, preventive health services, relief work, health services, community health planning

The number of refugees and internally displaced persons (IDPs) worldwide is estimated to total over 20 million and 38 million, respectively.[1,2] The United Nations High Commission on Refugees (UNHCR) was first organized in the 1950s to support persons displaced in World War II and to provide them assistance in returning home. Since then, the numbers of refugees and IDPs, displaced due to both conflict and natural disasters, has been growing and today has reached record highs. The proportion of displaced persons within the poorest countries has also grown: over 86% of the world's refugees are located in developing countries, compared with 70% a decade ago.[1]

The international health community has gained expertise in providing a wide range of health services to the world's displaced. Initially, medical services focused on addressing basic services including shelter, water and sanitation, food and nutrition, and basic health care; family planning and reproductive health were not prioritized. In response to mounting international attention outside of the refugee context, the 1994 International Conference on Population and Development declared reproductive health a human right and expanded the definition of maternal and child health services to include access to and choice of family planning methods.[3] Soon afterward, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) introduced the Minimum Initial Service Package (MISP) to guide humanitarian response to the immediate needs of people in conflict and emergency settings, and included guidelines for the reduction of HIV and sexually transmitted infections transmission, prevention and management of gender-based violence, prevention of maternal and neonatal mortality and morbidity, and the provision of contraceptives to meet demand.[4]

In many countries affected by conflict and with large refugee populations, high maternal mortality ratios are at least partly attributable to high unmet contraceptive needs.[5] Demand for childbirth timing, spacing, or limiting exists among displaced populations, as in any population.[6,7] Although significant progress has been made to bring reproductive health strategies to refugees and IDPs, most still lack adequate reproductive health services.[8] In addition to inadequate provision of reproductive health services due to poor funding allocation, infrastructural and systems-based barriers,[7,9] complex socio-cultural issues may prevent displaced people from accessing available services. Ensuring the availability of comprehensive reproductive health programs is costly and may redirect resources from other refugee health programs, therefore strategies to address contextual barriers and improve acceptability and uptake are critical. Published accounts of successes and failures in practical

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implementation of these programs highlight a continued unmet need for and limited access to contraception, particularly long-acting or permanent methods.[5,6,10-13] Focused implementation reports and investigations of socio-cultural barriers to acceptability and utilization of family planning services among specific refugee communities are limited.[14-16]

In this perspective piece, through a review of published literature and reflection on personal experience working with IDPs and refugees for the past decades, we aim to provide perspectives on the provision of family planning services among these populations and to expose themes in barriers to acceptance and uptake. We explore community understanding and preferences toward fertility and contraception in the context of conflict; attitudes and acceptability of contraceptive methods; and issues of women's reproductive rights. We will introduce 2 overarching themes that highlight important aspects of our conceptual framework to inform baseline evaluation and programming efforts, and then provide discussion of considerations for successful implementation and sustainability.

COMMUNITY AND INDIVIDUAL FERTILITY PREFERENCES AND UNDERSTANDING OF FAMILY PLANNING GOALS

In rural low-resource settings, from which many refugee and IDP populations originate, subsistence and herding families may value multiple children as a financial and social investment in the family's livelihood. A populous family and community means more human resources to protect land and livestock against intruders and natural threats. As such, larger families are appealing as a means to ensure both familial and community prosperity, security and safety.[17-19] High rates of child mortality may further drive fertility preferences, especially where health care is inadequate, health literacy is low, and child mortality is high.[18-22] The financial and social incentives to increase fertility among populations from poor and remote areas often supersede the notion that limiting childbearing may allow for better distribution of scarce resources.[22] Such fundamental socio-cultural preferences are in stark contrast to the predominant views among humanitarian staff from largely high-income societies where limiting childbearing and family size is encouraged for direct maternal and child health benefits.

For some refugee communities, humanitarian aid programs may be their first contact with family planning services and prior health and reproductive education may be very limited.[15,23] In the authors' personal experience doing qualitative assessments and focus groups in Central Asia and sub-Saharan Africa in the context of political and/or ethnic violence (unpublished data), many female and male community leaders believed contraception to be useful to prevent recurrent pregnancy during breastfeeding (ie, birth spacing), to reduce miscarriages or prevent pregnancy complications for the promotion of overall maternal and child health. Fertility control and limiting family size, however, was not a significant motivator for contraceptive demand, especially in the context of ethnic violence in Sub-Saharan Africa, where preserving ethnic group size and identity was perceived as crucial for survival. Others have shown that original preferences or practices in family planning and reproductive health may shift in response to experiences of violence and displacement.[22,24] Others have documented populations who have been motivated to use family planning for birth spacing and limiting family size, desired only birth spacing, or perceived no need for contraception or family planning.[5,15,23] A clear distinction between different motives for family planning services and the understanding of community, family and individual preferences for birth spacing and/or family size may be difficult but critical to successfully address the reproductive needs of a population through education and programming.[22,25,26]

ACCEPTABILITY AND ATTITUDES TOWARD CONTRACEPTION AND REPRODUCTIVE RIGHTS

The role of cultural norms and religion cannot be underestimated when introducing contraceptive services to displaced communities. Despite an understanding of ultimate or intended benefits of contraception and proper knowledge, the use of contraception may be confounded by issues of morality and religiosity, negatively or positively. Contraception may be perceived as either a sign of, or a risk factor for promiscuity, thereby generating contradiction between the moral views, perceived rights to reproductive choice, and actual sexual behavior or forced experiences of women, particularly adolescents and those vulnerable to rape, young sexual debut, and age-discrepant marriages.[23,27,28] As religious figures are highly respected and given authority over health issues in many such communities, women may experience a strong conflict between the implicit health benefits of contraception and explicit restrictions from religious leaders and the community itself to avoid family planning altogether. From the authors' experience working in the Sub-Saharan and Central Asian conflict zones, even if societally permitted, a woman's right to choose contraception for herself may be a contentious issue. Women and their male partners may be divided in their beliefs regarding reproductive rights; contraceptive choice ultimately may be, at best, a choice made by the partners together.[29,30]

An informed decision to consider family planning and to select an available contraception method requires proper education for both women and their partners to understand the mechanisms of different methods and to be familiar with individual and societal implications of family planning overall. Although community education may be seen as a proper means to improve understanding and thus increase rates of informed use of contraception, there are limitations on the effect of education alone in view of familial and community needs, preferences and beliefs. Spiritual, religious,

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and secular leaders who often act as the principal voice of education among refugee communities may be an effective and even essential element in reconciling societal ethics, morality, and faith with family planning services.

CONSIDERATIONS FOR IMPLEMENTING REPRODUCTIVE HEALTH EDUCATION AND FAMILY PLANNING SERVICES IN THE DISPLACED SETTINGS

Over the past decade, significant progress has been made in the recognition of a need for and efforts to systematically provide reproductive health services for refugees in conflict areas. However, ensuring the availability of contraceptive services alone does not translate into acceptability, access, and uptake. There are myriad reasons that displaced communities may not consistently and effectively utilize family planning services and these need to be systematically evaluated and addressed before implementation.[31] Structural, environmental, developmental, and community-wide barriers ought to be addressed through both vertical and community-level horizontal approaches that take into account the context of specific refugee communities, the individual challenges faced by women, and other fundamental obstacles such as general lack of formal education, health literacy, and access to health care.[32,33]

Educating communities about the risks and benefits of contraception in ways that acknowledge contextual factors and socio-cultural and economic priorities may improve uptake in communities that often and significantly lack security, civil society structure, and health care and health literacy. Implementing reproductive health education programs and increasing awareness of family planning methods likely translate into higher contraceptive use and can improve family planning uptake.[12,13] Proven educational approaches plus consistent availability of methods could translate into effective family planning programs with careful consideration of historical contexts, religious beliefs, infrastructural constraints and resources, and community order and norms.[32,34] However, ongoing community education via local initiatives from within the refugee community, region-wide structural and environmental strategies, and efforts tailored toward specific refugee communities to reconcile family planning services with faith or belief systems are crucial.[15] Religious leaders can be influential in disseminating thorough and accurate information as they often carry authority over community health issues. Radio programs, word of mouth, and both secular and religious venues can reinforce this information by recounting stories of people's experiences and benefits from different family planning methods.

Considerations of fertility preferences and reproductive health needs require particular attention in refugee settings. Women's fertility preferences may shift and thus their contraceptive needs may diverge from trends among the local population and even among their own community of origin.[35] Whereas large family size as an economic and functional means to promoting long-term family and community livelihood may be a priority in the original community, once displaced, women and families may desire to delay fertility in the face of an unstable socio-political situation.[36] Although direct assessments of knowledge, attitudes, and practices of refugee women are scarce,[15] prior implementation studies have suggested a high level of continued unmet need for family planning services by demonstrating a trend of increasing monthly contraceptive uptake over multiple years and across multiple crisis settings.[37] On the other hand, in conflict areas where violent ethnic and racial atrocities have been perpetrated, there may be additional barriers to overcome. It has been suggested that communities may be suspicious of contraception services delivered by foreign humanitarian organizations, perceiving them as attempts to limit their population in the wake of devastating ethnic-based violence, which is consistent with the authors' own experience in Darfur. While this may not be a common or dominant barrier in the majority of displaced settings, family planning programs must ensure trust, support, and participation from community leaders in both planning and implementation phases to reduce such misconceptions.[31] Whether or not individual or community fertility preferences will present a high or low demand for family planning during the acute crisis setting and beyond ought to be assessed before program planning and implementation. Reproductive health programs planned and implemented by refugees themselves have been relatively successful in increasing acceptability and uptake despite challenges such as sustaining funding and technical assistance.[38]

Most health services provided in displaced settings are designed as temporary interventions despite the fact that the majority of refugee circumstances and their consequences persist for years or even decades.[39] However, the health needs of displaced populations, including their reproductive health needs, continue long after the acute phase of relocation. Thus, establishing strong foundations is essential to transition successfully from immediate service availability to sustainable and effective programs.[31] Reproductive health research and programs in refugee settings often focus on immediate access without consideration of fundamental social and economic factors within populations where resources are scarce and external funding is likely temporary. Understanding specific conflict-related factors, external aid availability and sustainability, and the opportunity costs associated with any intervention in a setting of finite resources is critical to ensuring appropriate allocation of funding and acceptability of services.

CONCLUSIONS

We aimed to explore themes in reproductive health preferences, barriers to uptake of services, and challenges to implementing effective family planning programs in conflict-related refugee and displaced contexts. Prior to

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implementation of reproductive health programming in these settings, planning should aim to understand and address socio-cultural contextual preferences and constraints. Ongoing general education and reproductive health teaching via local initiatives from within the refugee communities, robust community involvement to support efforts to reconcile family planning services with faith or belief systems, regional structural strategies, and consideration of both short- and long-term needs and resources are critical components of successful and sustainable family planning interventions among displaced populations.

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