K4D | Knowledge, evidence and learning for development

Family Planning for Refugees in Camps in Tanzania

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Question

What evidence exists regarding:

- social, cultural and traditional factors that act as a barrier and hinders access to reproductive rights / family planning, among the Burundian and Congolese refugees in refugee camps in East Africa.
- current knowledge and practice about family planning methods either in Burundi or eastern DRC or in camps hosting refugees from these areas

Contents

1. Summary

Refugees have the right and a need to access sexual and reproductive health (SRH) services, including family planning. SRH services saves lives yet access to quality SRH services decreases during humanitarian crises as these services are compromised. In general, they are underfunded and overlooked or deprioritised, even as demand for these services increases with refugees wanting to prevent having children due to their situation and lack of family support, and an increased risk of forced sex, risk-taking behaviours and exposure to high-risk situations. In one study of reproductive health programmes in conflict areas, 30% to 40% of women reported that they did not want a child within two years and an additional 12% to 35% wanted no additional children highlighting a clear need for family planning services in conflict settings. Emergency responders, governments and development actors need to collectively scale-up access to contraception for women and girls affected by crises.

Tanzania hosts around 300,000 refugees mostly from the Democratic Republic of Congo (DRC) and Burundi in three camps, Nyarugusu, Mtendeli and Nduta, located in the Kigoma Region in northwest Tanzania. These camps extend beyond original capacity, having had to cope with a large and rapid influx of Burundians. They offer minimal SRH services and do not provide a safe environment for women and girls who experience sexual violence on the way to/from latrines and showers and whilst collecting water for drinking and washing and firewood for cooking outside the camp, owing to limited camp supplies. There remains therefore opportunity to scale up quality SRH services and improve safety and security related to camp infrastructure and services.

Knowledge of contraceptive methods, STIs and HIV/AIDS are limited in general among refugee, migrant and displaced girls and young women and this group often experiences gender-based and sexual violence and abuse. Access and availability of SRH services are often limited due to distances, costs and stigma. In the Tanzanian refugee camps, factors contributing to teenage pregnancy - education, culture, poverty and unstable family relations – have been found to be exacerbated.

Understanding barriers to family planning uptake in the countries from which the refugees in the Tanzanian camps fled could help understand barriers to be faced in scaling up family planning in these camps where specific evidence is minimal. Barriers preventing uptake of modern contraception among women and men in the DRC include socio-cultural norms (especially the husband's role as primary decision-maker and the desire for a large family), poor spousal communication, fear of side-effects and a lack of knowledge. Many of the women studied though were open to using a modern family planning method in the future offering potential for positive changes in behaviour and perceptions of contraceptive use. Likewise, in Burundi, unmet need for contraception among married women of reproductive age was associated with being poor, rural, no education, living with four, five or six plus children, not visiting a health facility within the past 12 months and lacking access to radio or television messages. Furthermore, availability of modern contraceptives among women of reproductive age in rural Burundi was found not to ensure uptake. A lack of available and trained health professionals to provide contraceptive services; a lack of fit between methods preferred by women and those easily available; a climate of fear surrounding contraceptive use; and provider refusal to offer family planning services have been identified as barriers to uptake.

Evidence shows uptake of SRH services in humanitarian settings if they are of quality. The 2018 Inter-Agency Field Manual (IAFM) on SRH in humanitarian settings places emphasis on human rights, principles and obligations; a new focus on preventing unintended pregnancy and addressing

safe abortion; and provides practical guidance on transitioning from the Minimum Initial Service Package (MISP) to comprehensive SRH services grounded in wider health system strengthening. The manual also highlights the importance in understanding community and cultural beliefs, values and norms around fertility, family planning and contraception. Multiple barriers at multiple levels need to be addressed when providing client-centred services. Examples include, public information campaigns considerate of literacy levels; engaging with influential leaders and adolescents to provide knowledge and understanding of family planning, acceptance and involvement of awareness raising among their community; knowledge and skills training for health professionals and community health workers; strengthening health infrastructure, human resources and providing a sustainable and consistent supply of contraceptives women would like to use; reaching out beyond the health facility through community-based distribution of family planning by community health workers; providing private and respectful services; promoting spousal communication, involving males and providing education.

Trained health cadres (doctors, midwives, clinical officers, community health workers, etc.) exist within nearly every crisis-affected community so effort should be taken to identify them, verify their skills, and mobilise them for service delivery. Engaging local providers will support rapid scale-up of both clinical and community-based contraceptive services and establish more sustainable service delivery models that will more effectively transition to recovery.

This review drew on academic and grey literature, as well as media reports. Literature specific for the Tanzanian refugee camps was less robust. There is minimal peer-reviewed literature on SRH related aspects among refugee, migrant and displaced girls and young women in Africa. Track20 is working with Burundi, DRC and Tanzania, FP2020 pledging countries, to build their capacity to improve the quality of data being collected on SRH and the use of this data to inform regular monitoring and strategic decision-making.

Agencies are working together to provide SRH services in the Tanzanian camps. For example, the United Nations Population Fund (UNFPA) have partnered with Tanzania Red Cross Society, the International Rescue Committee (IRC) and Médecins Sans Frontières (MSF) to support Burundian and Congolese refugees with SRH services including the provision of short and long-term modern contraceptives and providing family planning awareness campaigns.

2. Family planning in humanitarian settings

Access to contraception helps ensure women and girls have the power to make autonomous decisions about their bodies and their futures (IAWG 2018). Access decreases though during humanitarian crises as health systems are compromised. Moreover, there is an increased risk of unintended pregnancy, death or disability during pregnancy and childbirth, and unsafe abortion during flight to safety and in host countries, as the loss of social structure and protective mechanisms during emergencies increase the risk of forced sex, risk-taking behaviours and exposure to high-risk situations (IAWG, 2018). Sexual and reproductive health (SRH) services, including access to family planning, care for pregnancy, miscarriages, unsafe abortions and rape, therefore are especially vital in areas affected by crisis.

SRH services save lives. Family planning is the most proven and cost-effective way to reduce maternal death and disabilities and need for abortion. The availability of these services along with security, water, food, shelter and sanitation is an essential part of any emergency health response with the potential to reach new populations and build back better (IAWG, 2018). An International

Rescue Committee Report (2015) highlights assumptions made by the aid community which have contributed to a lack of funding and political support for family planning in humanitarian crises (International Rescue Committee, 2015). These assumptions include:

- Family planning is neither desired nor possible in certain culture, religious or humanitarian contexts.
- Short-acting contraception satisfies the demand of women and girls.
- Women in emergencies do not want family planning.
- Family planning is too difficult to provide in humanitarian settings.

A systematic review conducted in 2018 explored knowledge, experiences and access to SRH services among refugee, migrant and displaced young women and girls (aged 10-24 years) in Africa (Ivanova, Rai, & Kemigisha, 2018). Available evidence suggests that contraceptive knowledge among this group of young women and girls is limited, they often experience gender-based and sexual violence and abuse, and SRH services often have limited availability due to distances, costs and stigma (Ivanova et al., 2018). The review highlights that peer-reviewed literature on SRH related aspects among refugee, migrant and displaced young women and girls in Africa is minimal and that data should be disaggregated by sex and age in future research in this field (Ivanova et al., 2018). Track20 (http://www.track20.org/) works with FP2020 pledging countries, including Burundi, DRC and Tanzania, to build their capacity to improve the quality of data being collected and how the data is being used to inform regular monitoring and strategic decision-making.

3. Refugee camps in Tanzania

Tanzania hosts around 300,000 refugees mostly from DRC and Burundi in three camps, Nyarugusu, Mtendeli and Nduta, located in the Kigoma Region in northwest Tanzania. The Nyarugusu Refugee Camp opened in 1996 to host persons fleeing conflicts in DRC. Prior to April 2015, the camp hosted 65,000 Congolese and 2,400 Burundians (UN Country Team in Tanzania, 31 July 2018). Between April and October 2015, 84,961 Burundians entered the camp forcing the UNHCR to open two new refugee camps in Tanzania to accommodate them. 40,000 Burundian refugees were relocated to Nduta and Mtendeli refugee camps between October 2015 and February 2016. The population of the Nyarugusu refugee camp as of July 2018 was 153,024 of which 29% are women aged between 12 and 59 years old (UN Country Team in Tanzania, 31 July 2018). The camp has one hospital, 2 health centres, 5 health posts and 2 women centres (UN Country Team in Tanzania, 31 July 2018). The demand for reproductive health services is captured in an article which discusses the opening of a clinic in the Nyarugusu refugee camp in July 2015 (Kim, 26 September, 2015). The article quotes a widowed mother "*many of us don't have relatives to help us with children*" explaining some of the demand for family planning (Kim, 26 September, 2015).

Asylum Aid's *Women's Asylum News* reports on a safety mapping exercise conducted by Refugees International at the Nyarugusu refugee camp (Women's Asylum News, February/March 2016). Several women and girls spoke of sexual violence occurring on the way to/from latrines, and/or showers (Women's Asylum News, February/March 2016). Some women and girls were having to walk beyond the camp to a river because of limited water supplies for drinking and washing, and to a forest, in search of firewood, where women suffered rape or sexual assault committed by both fellow refugees and members of the host population (Women's Asylum News,

February/March 2016). Even when women travelled in groups or with male family members, they were still at risk of sexual violence with one man quoted as saying "*some of us encounter larger groups of Tanzanian men and we cannot fight them*" (Women's Asylum News, February/March 2016). Refugees International have raised concerns that the humanitarian community in Nyagurusu has not met minimum standards to prevent gender-based violence in this humanitarian setting (Women's Asylum News, February/March 2016). However, Refugees International acknowledge that this camp faces enormous challenges in responding to the influx of refugees in Tanzania but there remains opportunity to improve the situation by "prioritizing the distribution of core relief items that address the dignity and safety of women and girls, and engaging this vulnerable group in consultation to improve safety and security related to camp infrastructure and services" (Women's Asylum News, February/March 2016).

4. Barriers to family planning amongst Burundian and Congolese

This section looks at current knowledge and practice about family planning methods in DRC and Burundi. Understanding barriers to family planning uptake in the countries from which the refugees in the Tanzanian camps fled could help understand barriers to be faced in scaling up family planning in these camps where specific evidence is minimal. All women who want to delay pregnancy (spacing) or do not want more children (limiting) should have equal access to the contraceptives of their choice and to quality services. Yet data on contraceptive prevalence and the unmet need for family planning (key indicators for measuring improvement in access to reproductive health) for married or in-union women aged 15-49 years in Burundi and DRC highlights family planning requirements in these women are not being met. For Burundi (data taken from 2016 Demographic Health Survey): contraceptive prevalence (for any method) was 28.5%, contraceptive prevalence (for any modern method) was 22.9%, unmet need for family planning (total) was 29.7% (United Nations, 2018). For DRC (data taken from 2013-2014 Demographic Health Survey): contraceptive prevalence (for any method) was 20.4%, contraceptive prevalence (for any modern method) was 7.5%, unmet need for family planning (total) was 27.7%, unmet need for family planning (spacing) was 20.7%, unmet need for family planning (limiting) was 6.9% (United Nations, 2018). "Unmet need" includes a rights-based approach as captures not only the woman's use of contraception but also her fertility preferences.

Barriers in DRC

Research from DRC has shown that over a quarter of women have an unmet need for family planning (M. Muanda, Gahungu Ndongo, Taub, & Bertrand, 2016). Despite reasonable physical access to health facilities across Kinshasa only one in five married women uses modern contraception (M. Muanda et al., 2016) but this is still three times higher among urban than rural women (M. F. Muanda, Ndongo, Messina, & Bertrand, 2017). Through focus group discussions among women and their husbands, Muanda and colleagues tried to identify barriers to modern contraceptive use for those living in Kinshasa (M. Muanda et al., 2016) and in rural areas in DRC (M. F. Muanda et al., 2017). Key barriers that emerged were:

In Kinshasa:

1. Socio-cultural norms (especially the dominant position of the male in family decision-making)

"I am the man, I am the master of the family, it is I who manages everyone. The woman should not make decisions for me." (Husband in non-user union, Kalamu II)

2. Fear of side effects (especially sterility)

   "I have learned that people who use these methods have complications such as cancer, [and] sterility, so I cannot use these methods." (Female/traditional method user, Bumbu)

3. Lack of information/misinformation

   "Me, I have not used these [modern] methods in the past because I did not know them, only now I learn that these methods exist and can help prevent children." (Husband in non-user union, Bumbu)

4. Costs of the method

   "I cannot go to the health center because $20 is asked for the implant [which] is the money I need for sales." (Female/non-user, Bumbu)

5. Pressure from family members to avoid modern contraception

   "My husband told me: if you get an injection, you will become unfaithful, you will start dating other men because you know that you will not fall pregnant." (Female/non-user, Kalamu II)

In rural areas in DRC:

1. Socio-cultural norms (especially the husband's role as primary decision-maker including deciding on the desired number of children)

   "Children are wealth to Africans. Each family must have many children because these children are able to help work in the fields." (Female, non-user/Mutoto)

2. Fear of side-effects

   "Men say that these methods will cause diseases, others say that these methods will burn our organs. For now we put all these comments into the hands of God, who is our only refuge." (Female/modern method user, Kampene)

3. Lack of knowledge

   "We want to use these methods but we do not have enough information to reassure us. There is no counselling and it surprises us when we are told to go to the health centre to take these methods." (Female/non-user, Bosobolo)

4. Poor spousal communication

   "No, we don't need to discuss the number of children; it is the man who makes the decision, he is the head of the family and it is he who pays the dowry." (Husband in a non-user union, Bosobolo)

Common barriers exist in urban and rural settings. Yet despite these barriers, many women in the studies indicated that they were open to adopting a modern family planning method in the future. These findings imply that programming should train and ensure that family planning workers counsel future clients, men and women, to allow informed decision-making and trigger positive changes in behaviour and perceptions relating to contraceptive use (M. F. Muanda et al., 2017).

As part of the Inter-Agency Working Group (IAWG) second 2012 to 2014 global evaluation of SRH in humanitarian settings, a cross-sectional, mixed methods case study in Burkina Faso, South Sudan and the DRC (the Masisi Health Zone in North Kivu Province) was conducted to document the availability, quality, utilisation of and access barriers to Reproductive Health (RH) services (Casey, Chynoweth, Cornier, Gallagher, & Wheeler, 2015). Although RH services were provided, the quality was inconsistent. Essential provider knowledge and skills were often lacking. Knowledge of available RH services was limited and socio-cultural barriers existed in accessing

these services (Casey et al., 2015). Recommendations from the study were that “commodity management and security must be prioritised to ensure consistent availability of essential supplies. It is critical to improve the attitudes, managerial and technical capacity of providers to ensure that RH services are delivered respectfully and efficiently” (Casey et al., 2015).

A 2011 study found that knowledge and use of modern contraceptive methods was low among married or in-union women of reproductive age in six reproductive health programmes in conflict areas (including a site in Eastern DRC) relative to other sub-Saharan African countries (McGinn et al., 2011). Despite a clear need for family planning services, with 30% to 40% of women reporting that they did not want a child within two years, and an additional 12% to 35% wanting no additional children, at most, only one-third of health facilities mandated to provide family planning had the necessary staff, equipment and supplies to do so adequately. In some areas, none of the facilities were prepared to offer such services. Hence, it was found that there was a demand for family planning services in crises settings, yet services were rarely adequate to meet this demand. The authors recommended that refugee and internally displaced women must be included in national and donors’ plans to improve family planning in Africa (McGinn et al., 2011).

The DRC National Multisectoral Strategic Plan for Family Planning: 2014-2020 sets a goal of achieving a modern contraceptive prevalence rate (mCPR) of 19% by 2020 (Kwete et al., 2018). This is ambitious considering the mCPR was only 7.8% at the national level as of 2013-14 (Kwete et al., 2018). Yet there is momentum for family planning in the DRC with strong political will, increasing donor support, a growing number of implementing organisations, innovative family planning programming and a cohesive family planning stakeholder group (Kwete et al., 2018). And promising initiatives including improving the supply and quality of services and generating demand for family planning through, for example, social marketing of subsidised contraceptives at both traditional and non-traditional channels. However, formidable challenges remain. These include “uncertainty over the political situation, difficulties of ensuring access to family planning services in a vast country with a weak transportation infrastructure, funding shortfalls for procuring adequate quantities of contraceptives, weak contraceptive logistics and supply chain management, strong cultural norms that favour large families, and low capacity of the population to pay for contraceptive services” (Kwete et al., 2018). The desire for a large family remains in DRC, with couples undeterred by their inability to provide materially for their children or by women’s participation in the labour force. Improvements in women’s education and urbanisation unusually have failed to reduce the number of children a woman desires. Having many children is a sign of social status for both men and women. Congolese law makes women subordinate to their husbands giving them less power in their relationship. The husband’s family may believe that his wife owes them many children in exchange for the dowry they paid and may encourage the husband to marry another if she does not provide the desired number of children (Kwete et al., 2018). Kwete et al. (2018) highlight that “progress in family planning made in the DRC should not be compared with sub-Saharan African countries with high mCPR and mature programmes, but rather with those starting from much further behind” (Kwete et al., 2018).

Barriers in Burundi

A cross-sectional study was carried out in 2010 to determine the demographic, socio-economic and other factors underlying the unmet need for contraception among married women aged 15-49 years in Burundi. Results suggested that women with unmet need for spacing were primarily younger, poor, rural, with no education, desired six plus children, ignored their husband’s fertility preferences, and were not exposed to radio and television messages. Women with unmet need

for limiting were older (35 years plus), desiring zero to three children, had six plus children, had experienced the death of a child, or had not visited a health facility during the 12 months preceding the survey (Nzokirishaka & Itua, 2018). The authors suggested interventions at multiple levels including male involvement, promoting spousal communication, client-centred services and information, increasing the use of media and designing and creating an enabling environment based on the promotion of women education, urbanisation and pro-poor policies (Nzokirishaka & Itua, 2018).

Ndayizigiye et al. (2017) conducted a mixed-methods study investigating uptake of modern contraceptives and barriers to contraceptive use among women of reproductive age (15-49 years) in two rural health districts of Burundi (Ndayizigiye, Fawzi, Lively, & Ware, 2017). Of the 39 health clinics studied, uptake of family planning averaged only 2.96% despite contraceptives being generally available (at least one long term and one short term method available 99% of the time). Higher uptake was "positively associated with the number of health professionals engaged and trained in family planning service provision, and with the number of different types of contraceptives available. Four uptake barriers were identified through individual interviews with facility managers and community leaders and through focus group discussions with pregnant women, non-pregnant women, and men: (1) lack of health professionals available and trained to provide contraceptive services; (2) lack of fit between the methods preferred by women and those easily available; (3) a climate of fear surrounding contraceptive use; and (4) provider refusal to offer family planning services" (Ndayizigiye et al., 2017). The authors suggest that the "climate of fear" around family planning use could, at least in part, be rooted in conservative Christian religious beliefs in this rural Burundian region. The authors conclude that availability of modern contraceptives alone will not ensure uptake. Simultaneously addressing multiple barriers to contraceptive use is likely to be the most effective way of improving access to family planning. In rural Burundi, examples include community-based distribution of family planning by community health workers to reach out beyond clinical-settings, public information campaigns considering illiteracy levels, improved training for health professionals and community health workers, and strengthening of the health infrastructure including a private space for provision of family planning services. Ndayizigiye et al. (2017) highlight that an understudied area is how best to provide family planning services to rural youth in resource-limited settings (Ndayizigiye et al., 2017).

The importance of life histories to "engage with and understand the life experiences, transformations and social concerns of people affected by conflict before, during and after the conflict" is highlighted in an article by Ssali and Theobald (2016). Learning how experiences and challenges to well-being, health and health care seeking changes through time helps focus on the "software of health systems – on building holistic, responsive and accessible health care systems that go beyond a focus on the physical rebuilding of health infrastructure" in post-conflict health care reconstruction (Ssali & Theobald, 2016).

A qualitative study conducted within two Burundian refugee camps in Tanzania, Nduta and Kanembwa, investigated reasons for a higher prevalence of teenage pregnancy and its implications within a refugee setting (Roxberg, 2007). Factors contributing to teenage pregnancy – education, culture, poverty and unstable family relations – were found to be more extreme in the camps than in other settings potentially contributing to the higher prevalence of teenage pregnancy (Roxberg, 2007). The author suggests that "more efforts needs to be made in promoting the inclusion of women into educational and vocational activities" to realise their SRH rights and reduce the teenage fertility rate in refugee camps (Roxberg, 2007).

5. Scaling up family planning in Tanzania's refugee camps

A systematic review by Casey (2015) found that SRH programmes can be implemented in humanitarian settings, and women and men will use these services when they are of reasonable quality (Casey, 2015). However, despite increased attention to SRH service provision in these challenging settings, provision of adolescent SRH services was found to be minimal and safe abortion was not even assessed (Casey, 2015).

Provision of SRH services in humanitarian settings

There are internationally agreed standards for SRH services in acute crises, as well as global goals and specific UK commitments. The IAWG on Reproductive Health in Crises is a broad-based, highly collaborative coalition of non-governmental organisations and United Nations agencies to expand and strengthen access to quality SRH services for people in humanitarian settings. The third and latest edition of the Inter-Agency Field Manual (IAFM) on SRH in humanitarian settings (along with supplementary materials, including detailed clinical guidelines, decision aids and templates) was published by IAWG in 2018 (IAWG, 2018). Foster et al. describe the collaborative and intersectoral revision process and highlight major changes in this 2018 version (Foster et al., 2017).

In the 2018 IAFM, prevention of unintended pregnancy is a newly listed standalone objective (Foster et al., 2017). The identified priority activities are to:

1. Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including condoms and emergency contraception) at primary healthcare facilities to meet demand.
2. Provide information, including information, education and communication materials, and ensure contraceptive counselling that emphasises informed choice, effectiveness and supports client privacy and confidentiality.
3. Ensure the community is aware of the availability of contraceptives for women, adolescents and men.

The 2018 IAFM also strengthens guidance on transitioning from the Minimum Initial Service Package (MISP) to comprehensive SRH services (Foster et al., 2017). The manual includes a logistics chapter, in response to feedback from users in the field, which maps the key stakeholders and processes that are essential to effective SRH supply chains; provides recommendations on transitioning from emergency to ongoing supply chains; outlines key steps including forecasting, procurement, transportation, and last-mile distribution; and identifies staff roles and responsibilities for effective supply chain management (Foster et al., 2017).

It is newly noted in the 2018 IAFM to ensure that safe abortion care is available to the full extent of the law in health centres and hospital facilities (Foster et al., 2017). Although reliable data on abortion in refugee crisis, conflict and emergency settings is lacking, unsafe abortion is a leading cause of maternal death worldwide. The evidence base is still very limited with a need for more implementation research and programme evaluations to measure their effectiveness (Casey, 2015).

Chapter 6 of 2018 IAFM is dedicated to adolescent SRH. Adolescents are "resilient, resourceful and energetic" and can play an integral role in humanitarian programmes. For example, they can "assist health providers as volunteers and community-based distributors; they can expand access

to quality SRH services for the wider community as well as for their peers at the community level; and they can play a critical role in coordination mechanisms to ensure that adolescent needs are considered from the outset of emergencies" (IAWG, 2018).

Greater emphasis is placed on human rights in the 2018 IAFM edition laying out a "survivor-centred, rights-based approach" through fundamental principles in humanitarian settings (Foster et al., 2017). This includes gender-based violence. The manual also highlights the importance in understanding community and cultural beliefs, values and norms around fertility, family planning, and contraception (IAWG, 2018).

The 2018 IAFM includes a series of examples of implementation of SRH programming in different humanitarian settings with case studies exploring a range of challenges that are routinely experienced by those in the field (Foster et al., 2017). Three programme examples are given in Chapter 7 Contraception. (1) A programme run by CARE in Northern Syria, to provide static and mobile SRH clinics integrated into primary health care. Lessons learned are that pre-crisis, oral contraceptive pills were the contraceptive of choice compared to the crisis where intrauterine devices were the preferred method due to increased access to comprehensive contraceptive services and supplies. (2) A programme run by IRC in Nigeria, to establish SRH service delivery and initiate MISP services. Lessons learned demonstrate a capacity to rapidly scale contraceptive services in a fragile context with low contraceptive prevalence. Low numbers of skilled health staff available, long lead times for procurement and recruitment, and low priority for SRH are to be expected. Therefore, more skilled staff including procurement staff should be budgeted for and prepare data and evidence to share with local authorities and in the health cluster to prioritise SRH. (3) A programme run by IRC in Chad, to provide awareness-raising and training for influential religious leaders on the importance of contraception. Lessons learned were that religious leaders are often considered as a barrier to contraception in humanitarian settings. Yet once people are well informed and quality services are in place, even in a traditional and religious context, contraception is accepted (IAWG, 2018). Additional sensitisation though is needed to expand access for vulnerable groups as contraceptive use among adolescent girls and unwed women is still taboo.

Provision of SRH services in Tanzania's refugee camps

IrishAid is helping UNHCR facilitate awareness campaigns on family planning methods and their benefits in the Nyarugusu camp (Millimouno & Munuo, 19 June 2018). Women attending these campaigns are then volunteering as peer counsellors on family planning methods for other women and girls at the camp. Family planning acceptance rates are currently low at 30% (Millimouno & Munuo, 19 June 2018).

UNFPA partnered with the Tanzania Red Cross Society and the IRC Tanzania to support 315,681 Burundian and Congolese refugees between July 2016 and June 2017 with essential SRH services (UNFPA Tanzania, 2017). UNFPA supplied 242 RH Kits to all three refugee camps with distribution support from Médecins Sans Frontières (MSF) at Nduta camp. UNFPA supplied 21,628 injectable contraceptives, 36,045 cycles of oral contraceptive pills, 122 intrauterine devices, and 807 contraceptive implants to the camps. This supply of contraceptives averted an estimated 2,927 unintended pregnancies; avoided 8 maternal deaths; and prevented 658 unsafe abortions (UNFPA Tanzania, 2017). To build awareness and demand for contraceptives the IRC conducted a family planning awareness raising campaign in Mtdendi and Nyarugusu camps reaching 7,740 people and resulting in the distribution of 6,073 condoms (UNFPA Tanzania, 2017).

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