

Original Research Article

**Contraceptive Needs of a Marginalized Group: The Case of Displaced People
Living in a Refugee Community. Yaoundé, Cameroon.**

ABSTRACT

Despite the benefits of family planning, contraceptive use has been found to be limited among refugees. This study aimed at assessing contraceptive needs of refugees in order to improve their family planning and reproductive health services in Yaoundé, Cameroon where no studies on this issue have been conducted. This was a cross-sectional descriptive study carried out in the United Nations High Commission for Refugees (UNHCR) settlement in Yaoundé, from 1st September, 2012 to 28th February, 2013. Two hundred and sixty four participants were enrolled by convenience sampling. Information on socio-demographic characteristics, contraceptive needs and barriers to their utilization were obtained using a pre-tested questionnaire by face-to-face interview. Data collected was entered into an Excel spread sheet, cleansed and systematically corrected for errors. It was analyzed using Epi info version 3.5.3. Two hundred and sixty four refugees participated in the study. The mean age of participants was 29.6 years (SD 10.2 years). The refugees had lived in the settlement for an average of 5.8 years (SD 4, 5 years). Over 213 (80.7%) of participants had heard of modern contraceptives, 209(79.2%) had seen modern contraceptive methods and 213 (80.7%) believe that modern contraceptives could prevent pregnancy and STIs. Only 96 (36.4%) used condoms during their last intercourse with a male predominance (54.1% vs23.3%) (p=0.001). However, the use of condoms was the most preferred method of contraception by 161 (83.3%) of the respondents. The main reasons given for non-condom use were: reduced pleasure and unavailability in male participants and lack of knowledge in the female group. These differences between males and females were statistically

significant : ($P = 0.001, 0.007$ and 0.005) respectively. Although the study showed high level of awareness about family planning methods, contraceptive prevalence rate was very low. There is need to increase community awareness about family planning through health education, and strengthen family planning services for refugees. The availability of providers with whom women are comfortable is critical to expanding both awareness of/and access to family planning.

Key words: Contraception, needs, refugees, unmet, unplanned pregnancy, Yaoundé.

1.INTRODUCTION

Contraception or birth control is aimed at spacing out deliveries and preventing unwanted pregnancies. Despite the benefits of family planning to reproductive health, contraceptive use has been found to be limited among many displaced persons around the world, some of whom face difficulties having access to reproductive health care services [1-6]. They are usually not taken into consideration when establishing government policies, and their religious beliefs and cultures are often trampled upon. This marginalized group almost always has unmet health needs especially as it concerns reproductive health [7].

The health community has acknowledged that living in a refugee situation can increase the vulnerability of young people to unintended pregnancies and other reproductive health risks in a variety of ways [8, 9]. Refugees may be ineligible for health care benefits, unfamiliar with family planning programs and other services, unable to obtain information easily and might be uncertain where to turn to for their contraceptive needs [10]. The result can be unwanted pregnancies, rising abortion rates, high risk births and increase in maternal morbidity and mortality in low resource settings such as refugee settlements [11].

Although data on sexual behavior, unintended pregnancies and other reproductive health issues among refugees are limited, a number of studies have shown a high prevalence of risky sexual behavior and low use of contraceptives [12-14]

Cameroon is one of the very few politically-stable countries in the Central African sub region and thus a preferred destination for refugees. This has led to a rapid increase in the refugee population in the country over the years. However, emphasis has not been laid on the reproductive health needs of refugees and family planning is particularly problematic. Differences in the use of contraceptive methods, morbidity and mortality that are related to socio-economic class constitute an inequity. Displaced and poor persons do not have the same access to life-saving and health-maintaining interventions as the rich, yet they aspire to the same healthy lives as those who are economically better off [3,4]. However, a difference in fertility between the rich and the poor is not an inequity provided the poor have a higher fertility because they want more children. Only by examining differences in fertility intentions and in the contraceptive use through a contraceptive lens can we determine if the poor are deprived of something they wish they had (that is family planning) to avoid what they do not desire; that is numerous unwanted pregnancies and other pregnancy related complications [3].

Research on the reproductive health of refugees has received very little attention from the academic community in Cameroon because of the difficulties in obtaining access to refugee camps. It is also an area which has not been of public health concern because displaced persons cannot be considered a priority group since the country's contraceptive prevalence is low [15]. In recent years, reversal of contraceptive use has been documented [3] and refugees constitute a minority group. Furthermore, research in a refugee environment is difficult because of constant refugee movements and the possibility that armed conflicts may interfere with data collection.

Until recently, research on reproductive health services for refugees has attracted very little attention. Documenting and reporting information on refugees is greatly needed in order to improve family planning and reproductive health services for this group. No studies have been conducted among refugees in Cameroon, and specifically in Yaoundé to determine their contraceptive needs, access, use and the obstacles to their use. A critical assessment of these factors will be useful in drawing up reproductive health programs with regards to contraception in this marginalized group.

2. METHODS

This was a cross-sectional descriptive study carried out from 1st September, 2012 to 28th February 2013 at the United Nations High Commission for Refugees (UNHCR) and refugee settlements in Yaoundé, Cameroon. Ethical clearance and administrative approval for the study were obtained from the Institutional Ethics Review Committee of the Biotechnology Center, University of Yaoundé I, and the Country Representative of the UNHCR respectively.

2.1 Study Setting and study Population

The UNHCR in Cameroon was opened in 1990. Since then, the refugee population, majority of who were Chadians, has risen steadily. Cameroon today hosts refugees from 28 countries, majority of who are from Republic of Central Africa.

As of 2012, the UNHCR was managing two groups of refugees: urban refugees of multiple nationalities living in Douala and Yaoundé, and Prima Facie refugees who are usually of the same nationality and live in camps. Yaoundé refugees on whom our study was carried out falls in the latter category.

The UNHCR is headed by a Country Representative, assisted by a Deputy Representative in Charge of Protection, an Assistant Representative in Charge of Operations and a Senior Administrative Officer. Under the Deputy Representative, there is a Senior Protection Officer and the Senior Community Services Officer. The medical services of the refugee high commission are run by a Medical Officer alongside the Assistant Community Services Officer both of whom report directly to the Senior Community Services Officer.

Refugees enjoy full welfare coverage, including lodging, feeding, clothing and health care, while urban refugees take care of their accommodation, feeding and to a lesser extent, health. The UNHCR offers them only primary health care. All other health problems are handled by accredited hospitals which have memoranda of understanding with the UNHCR. There is no formal health structure in charge of refugees' reproductive health or for their contraceptive needs. The displaced persons were from Democratic Republic of Congo, Central African Republic, Chad, Rwanda, and from other countries of the Central African sub region.

2.2 Data Collection and Management

Participants between 15-49 years, who gave formal written consent in the refugee settlement in Yaoundé, were enrolled for the study. They were randomly selected from the database at the High Commission where they routinely visit for various administrative and health issues. Four thousand two hundred participants who met the recruitment criteria were listed, and every tenth name was selected for participation.

Owing to difficulties in directly contacting the selected prospective participants individually, the enrollment procedure was modified. Community leaders of participants were requested to mobilize all members of their different communities for the study. They were recruited as they

arrived at the refugee community house at the High Commission reserved for such gatherings. These visits were programmed and coordinated by a team of medical and social workers from the UNHCR. The objectives of the study were clearly explained to all those who met the inclusion criteria in small groups as they arrived with a firm commitment to respect confidentiality of the information they gave. Participants were enrolled by convenience sampling. We targeted 300 participants, representing about 5% of the population of displaced people. However, owing to some difficulties encountered on the field, only two hundred and sixty four enrolled. Those that consented to the study were oriented to various enumerators who helped them to complete the pretested questionnaire by face-to-face interview.

Data obtained was on the; socio-demographic characteristics, level of sexuality, knowledge, belief, use and non-use of modern contraceptive methods and the contraceptive needs of the refugees.

The collected data was cleansed, systematically checked for errors and analyzed using Epi- info version 3.5.3. P-values less than 0.05 were considered statistically significant.

2.3 Limitations of the Study

This study had some limitations. The sample size was not large enough to generalize the results to the whole refugee community. Secondly, it was difficult to have a sample size that was representative of the refugees from different countries. This made it difficult to draw conclusions which could reflect the contraceptive knowledge and practices of some communities in their countries of origin. The paucity of data that was obtained from single, young and/or widowed women reflects the difficulties of reaching and having reliable information from this marginalized group since most of the information could not be objectively assessed. The

generalizability of the results to other refugee settlements in other parts of the sub region and the world is limited because of specific socio-cultural norms in the neighboring countries.

3. RESULTS

3.1 Socio-Demographic Characteristics

A total of 264 migrants, (111 males and 153 females) participated in the study. There was no drop out of participants after obtaining their formal written consent. The mean age of participants was 29.6 years (SD 10.2 years). The refugees had lived in the settlement for an average of 5.8 years (SD 4. 5 years).

Most of the refugees (78.4%) were Central Africans. One hundred and forty one (58.4%) had spent between 1-5 years in Cameroon with a mean duration of 5.8 ± 4.2 years. Over half [54.8%]) of the refugees were unemployed. Female refugees formed the majority in this group with 153(58.0%). They worked mostly as domestic servants with very low monthly incomes. Other socio-demographic characteristics are shown in Table 1.

3.2 Sexuality of Participants

As shown in Table II, eleven (4.2%) respondents (10 males and a female) were not sexually active. Most respondents 171 [67.6%]) had their first coitus between 14-19 years, with the mean age of first sexual intercourse at 16years (SD=3.1 years).One hundred and eight (40.9%) of them had more than two sexual partners with a higher proportion in the male population with 69 (62.2%). The difference was statistically significant between both sexes ($p=0.001$). About 2 in every 10 respondents had a past history of sexually transmitted infections (STI). The ratio was

equally distributed between both sexes. About 85% of all female respondents had been pregnant at least once and 71 (46.4%) had been pregnant 2-4 times.

3.3 Use and Needs of Contraceptive Methods

Over 213 (80.7%) of the study population had heard of modern contraceptive methods, 209(79.2%) had seen modern contraceptives and 213 (80.7%) believed that modern contraceptives could prevent pregnancy and STIs. These methods seemed to have an impact on their sexual behaviors because 96 (36.4%) used condoms at last intercourse with a male predominance (54.1% vs23.3%) ($p=0.001$). For the participants who did not use condoms, 63 (37.5%) thought it had no role in reproductive health. Forty-seven (28.0%), mostly female refugees failed to use condoms because they were ignorant of its existence. The main reasons given for non-condom use were: reduced pleasure, unavailability of male condoms and lack of awareness of its existence in the female group. These differences were statistically significant when the males and females were compared ($P= 0.001, 0.007$ and 0.005) respectively (Table III).

The majority (73.9%) of the respondents, agreed to use modern contraceptives if they were provided. A large proportion of them (73.1%) also expressed the need for modern contraceptive methods. The most preferred modern contraceptive method was condoms with 161 (83.3%), while the need for implants and combined pills were 6.1% and 4.5% respectively. Nine out of every ten respondents were willing to recommend modern contraceptives to a friend. Furthermore, 234 (88.6%) believed that modern contraceptives were useful in the family for child spacing and prevention of unplanned pregnancies (Table IV).

4. Discussion

This study was carried out to assess the contraceptive needs in a refugee community in Yaoundé, Cameroon. Access to family planning services is a human right [16] and neglecting their provision can have serious health consequences. It also provides autonomy for women to determine the number and spacing of their children. It also leads to better nutrition for children, improves access to educational and livelihood opportunities for women and girls, and increases the possibilities for families to manage scarce resources more effectively [17, 18].

4.1 Socio-Demographic Characteristics and Sexuality

People living in refugee settlements may have a serious need for family planning services, yet may face obstacles (economic, cultural and logistical) to practicing contraception as depicted in this study. Understanding the reproductive health needs of women in these difficult circumstances is critical to devising comprehensive programs [19].

It has been recognized that the extreme disruption and isolation that refugees experience can also have serious consequences for their reproductive health. Among these is poor access to safe delivery services and contraceptive methods, sexual violence, with consequences ranging from physical and psychological trauma, sexually transmitted infections (STIs) and unwanted pregnancies. Reproductive health care can, therefore, save refugees' lives and should be given priority in emergency refugee assistance efforts. Critical reproductive health services during emergency phase include clean and safe delivery, prevention and treatment of STIs, emergency contraception and life-saving treatment for complications of miscarriage and contraception [20].

Many factors are contributing to the rising incidence of sexually-transmitted infections worldwide, amongst these are socio-economic, cultural factors etc. Moving away from the familiar environment breaks established links, by splitting fixed sexual partnerships and

removing many social taboos which strongly affect human sexual habits. Settling in a new environment may expose them to adverse conditions of cultural isolation which facilitate the establishment of casual sexual relationships. The motivation to travel, the length of stay outside the native environment, and the type of hosting environment strongly affect the risk of STI acquisition and transmission [21]. Eighteen percent of the study population had STI. This probably highlights the prevalence of unprotected sexual exposure in this study population. This study confirmed the high prevalence of unprotected sex, early onset sexual intercourse, commercial sex and other forms of sexual risk-taking among refugees in Yaoundé as reported by previous studies [7, 12-14].

4.2 Use and Needs of Contraceptive Methods

It also revealed the low use (36.4%) of contraceptives during the last sexual intercourse by many refugees despite a high prevalence of sexual practices in the camp. The low use of contraceptives among these refugees provides an explanation for the high prevalence of pregnancies (76.5%) and STIs (17.8%) as was earlier reported by the UNHCR [22]. It also raises concerns on the number of pregnancies: 85 out of 153 (76.5%) participating women, 40.9% of respondents had more than 2 sexual partners each and the prevalence of unprotected sex was 163 (63.6%) in last sexual intercourse as documented by Creanga et al [3].

The great unmet need for the use of modern contraception was highlighted among our study population. About three quarters of refugees were willing to use modern contraceptive methods if provided, while 9 out of 10 thought they would recommend a modern contraceptive method to their friends and recognized that these contraceptives could be beneficial to their families. These results are similar to those of Kehinde *et al* [7] among young refugee women in a refugee camp

in Oru, Nigeria and from part of a world refugee survey conducted in Nigeria [23]. While some earlier studies among refugees and Internally Displaced Persons (IDPs) identified little or lack of knowledge and awareness of contraceptive methods as barriers to the use of contraception [24, 25], our results showed the contrary. Over 80% of respondents were aware of the existence of modern contraceptive methods and had seen at least one. Almost all respondents were aware that engaging in unprotected sex constituted a risk for unplanned pregnancy. Yet, there was a low rate of contraceptive use among them as demonstrated in this study despite the good knowledge about contraceptive methods. Similar results were documented in studies carried out in Australia [1] and Jordan [26]. Another major barrier to the use of contraception among refugee youths was difficulty in having access to family planning services in the settlement as a result of economic obstacles. Although most refugees (83.3%) preferred using condoms to other modern contraceptive methods such as pills or injectable forms of contraception because they believed they were safer and more convenient, they cited certain barriers preventing them from using condoms at their last sexual encounter namely, unavailability, partner's refusal, reduced sexual pleasure and religious reasons (Table III).

Our findings revealed a high level of misinformation about contraceptive use and benefits. These findings will help in emphasizing the need for the provision of education on contraception for these war-affected immigrants in order to offer them accurate information about contraceptive safety, effectiveness and side effects. Such instructions can go a long way towards increasing their awareness on family planning and reproductive health issues and fostering sexual behavioral change.

5. Conclusion

Providing modern contraception is a component of Millennium Development Goal (MDG) Number 5, which envisages improving maternal health. Access to family planning services is a human right, and neglecting their provision can have serious health consequences. Continued political and civil unrest in low-resource countries underscores the ongoing need for specialized reproductive health services for displaced people. The extreme disruption and isolation that refugees experience can also have serious consequences for their reproductive health.

Although our study showed a high level of awareness about family planning, contraceptive prevalence rate was found to be very low in this setting. There is need to increase community awareness about family planning through health education, and to strengthen family planning services for refugees in Yaoundé.

Based on these findings, it is timely for the UNHCR to organize regular sessions for sensitization of refugees on issues of family planning and the use of modern contraceptives in particular. Appeals should be made to non-governmental organizations like *Association de lutte contre les violences faites aux femmes* (ALVF), to train and financially empower more refugee women in income-generating activities like hair dressing, tailoring and the production and sale of local beverages. This will reduce their almost complete dependence on men for their upkeep, enable them procure artificial contraceptives and develop a better bargaining power when negotiating condom use during sexual intercourse. Furthermore, the UNHCR should put condoms at the disposal of refugees for a start, and in the long run consider more reliable semi-permanent and permanent modern contraceptive methods for refugees who desire to postpone or stop child-bearing.

Researchers (individually or assisted by UNHCR) should undertake similar studies in the other refugee settlements in the country in order to better understand the reproductive health situation of refugees in the entire country. This will enable them make informed decisions when elaborating reproductive health policies for this group of people. The outcome of these studies should be exploited by the Ministry of Public Health, so that due consideration be given to the refugee population when updating or modifying the existing reproductive health policies of the country since these displaced people live and have intimate contact with the general population

ETHICAL ISSUES

270 Ethical clearance and administrative approval for the study were obtained from the Institutional
271 Ethics Review Committee of the Biotechnology Center, University of Yaoundé I, and the
272 Country Representative of the UNHCR respectively. The participants gave a written consent or
273 thumb printed a consent form after the objectives and study procedure had been explained to
274 them in French, English or in a language they understood by an interpreter.

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352 **Table I: Distribution of Socio- Demographic Characteristics of Refugees.**

CHARACTERISTICS	MALE n=111 (%)	FEMALE n=153 (%)	TOTAL N=264 (%)	P - Value
Nationality				
Democratic Republic of Congo	08 (7.2)	11 (7.2)	19 (7.2)	0.65
Central African Republic	90 (81.1)	117 (76.5)	207 (78.4)	0.51
Chad	11 (9.9)	21 (13.7)	32 (12.1)	0.32
Rwanda	01 (0.9)	02 (1.3)	03 (1.1)	0.75
Others	01 (0.9)	02 (1.3)	03 (1.1)	0.75
Years of living in the Camp(years)				
<1	05 (4.5)	8 (5.2)	13 (4.9)	0.78
1-5	53 (47.7)	88 (57.5)	141 (58.4)	0.09
6-10	41 (36.9)	48 (31.4)	89 (33.7)	0.39
11-26	12 (10.8)	9 (5.9)	21 (8.0)	0.15
Marital status				
single	40 (36.0)	55 (35.9)	95 (36.0)	0.86
Married	65 (58.6)	84 (54.9)	149 (56.4)	0.29
others	6 (5.4)	14 (9.2)	20 (7.6)	0.24
Age of respondent (years)				
15-19	14 (12.6)	37 (24.2)	51 (19.3)	0.04
20-29	35 (31.5)	64 (41.8)	99 (37.5)	0.07
30-39	29 (26.1)	25 (16.3)	54 (20.5)	0.06
40-49	33 (29.7)	27 (17.6)	60 (22.7)	0.02
Religion				
Christian	105 (94.6)	151 (98.7)	256 (97.0)	0.06
Muslim	6 (5.4)	01 (0.7)	07 (2.7)	0.02
Others	0 (0.0)	01 (0.7)	01 (0.4)	0.4
Highest Level of education				
None	18 (16.2)	73 (47.7)	91 (34.5)	0.001
Primary	43 (38.7)	45 (29.4)	88 (33.3)	0.13
Secondary	43 (38.7)	30 (19.6)	73 (27.7)	0.001
University	7 (6.3)	05 (3.3)	12 (4.5)	0.25
Profession				
Employed	17 (15.3)	09 (5.9)	26 (9.8)	0.003
trader	9 (8.1)	38 (24.8)	47 (18.0)	0.001
farmer	5 (4.5)	08 (5.3)	13 (4.9)	0.6
unemployed	56 (50.5)	89 (58.1)	145 (54.8)	0.2
others	24 (21.6)	09 (5.9)	33 (12.5)	0.001

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354 Others= Hair dressers, students, and laborers.

355

356 **Table II: Distribution of Refugees According to Level of Sexuality.**

CHARACTERISTICS	MALE	FEMALE	TOTAL	P - Value
	N=101	N=152	N=253	
	(%)	(%)	(%)	
Age of first coitus				
8-13	15 (14.9)	27 (17.8)	42 (16.6)	0.7
14-19	65 (64.4)	106 (69.7)	171 (67.6)	0.2
20-29	21 (20.8)	19 (12.5)	40 (15.8)	0.05
Number of sexual partners.				
None	10 (9.0)	01 (0.7)	11 (4.2)	0.001
1r	19 (17.1)	88 (57.5)	107 (40.5)	0.001
2	13 (11.7)	25 (16.3)	38 (14.4)	0.3
>2	69 (62.2)	39 (25.5)	108 (40.9)	0.001
Previous STI				
Yes	20 (18.0)	27 (17.7)	47 (17,8)	0.72
No	91 (82.0)	126 (82.3)	217 (82,2)	
Procreative activity				
Yes	85 (76.5)	-	85 (76.5)	-
No	26 (23.5)	-	26 (235)	-
Gravidity				
0	-	16 (10.4)	16 (10.4)	-
1	-	23 (15.0)	23 (15.0)	-
2-4	-	71 (46.4)	71 (46.4)	-
>=5	-	43 (16.2)	43 (16.2)	-

357

358 **Table III: Distribution of Refugees According to Knowledge, Belief, Use and**
 359 **Non-Use of Modern Contraceptives.**

CHARACTERISTICS	MALE	FEMALE	TOTAL	P - Value
	N	N	N	
	(%)	(%)	(%)	
Information on modern contraceptives use.				
YES	90 (81,1)	123 (80,4)	213 (80,7)	0.8
NO	21 (18,9)	30 (19,6)	51 (19,3)	
Seen a contraceptive method.				
YES	84 (75,7)	125 (81,7)	209 (79,2)	0.3
NO	27 (24,3)	28 (18,3)	55 (20,8)	
Contraception and prevention of pregnancy				
YES	89 (80,2)	124 (81,0)	213 (80,7)	0.3
NO	18 (16,2)	18 (11,8)	36 (13,6)	
I don't know	4 (3,6)	11 (7,2)	15 (5,7)	
Use of Condoms(Most recent intercourse)				
YES	60 (54,1)	36 (23,5)	96 (36,4)	0.001
NO	51 (45,9)	117 (76,5)	168 (63,6)	
Reason for non- use of Condoms				
Reduces pleasure	6 (18,1)	2 (1,5)	8 (4,7)	0.001
Partner's refusal.	0 (0,0)	27 (20)	27 (16,1)	
Religious reasons	2 (6,1)	4 (3,0)	6 (3,5)	0.4
Unavailability	7 (21,2)	8 (6,0)	15 (9,0)	0.007
Use of other contraceptive method	0 (0,0)	2 (1,5)	2 (1,2)	-
Unnecessary	15 (45,5)	48 (35,5)	63 (37,5)	0.4
Lack of Knowledge	3 (9,1)	44 (32,5)	47 (28,0)	0.005

361 **Table IV: Contraceptive Needs.**

CHARACTERISTICS	MALE	FEMALE	TOTAL	P - Value
	N=111	N=153	N=264	
	(%)	(%)	(%)	
Efficacy of modern contraceptives.				
YES	91 (82)	123 (80.4)	244 (81.1)	0.7
NO	20 (18)	30 (19.6)	50 (18.9)	
Intention to use a modern contraceptive method if accessible.				
YES	87 (78,4)	108 (70,6)	195 (73,9)	0.1
NO	24 (21,6)	45 (29,5)	69 (26,1)	
Intention to use a method of contraception.				
YES	84 (75,7)	109 (71,2)	193 (73,1)	0.4
NO	27 (24,3)	44 (28,8)	71 (26,9)	
Preference for method of contraception				
Condoms	82 (97,7)	79 (72,4)	161 (83,3)	0.001
Pills	0	9 (8,2)	9(4,5)	-
IUCD	0	2 (1,8)	2 (1,0)	-
Implant	0	12 (11)	12 (6,1)	-
Injectables	0	4 (3,6)	4 (2,0)	-
Others	2 (2,3)	3 (2,7)	6 (3,1)	0.7
Recommending a modern contraceptive to friends.				
YES	105 (94,6)	137 (89,5)	242 (91,7)	0.13
NO	6 (5,4)	16 (10,5)	22 (8,3)	
Utility of modern contraceptives as good for the family				0.9
YES	99 (89,2)	135 (88,2)	234 (88,6)	
NO	9 (8,1)	13 (8,5)	22 (8,3)	
I don't know	3 (2,7)	5 (3,3)	8 (3,1)	

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