Testing the Effectiveness of Integrating Family Planning Information and Counselling Services in Food Distribution Programmes in Refugee Settings in Ethiopia

Filling Gaps in Evidence to Enhance Sexual and Reproductive Health and Rights among Vulnerable Populations in Refugee Settings in the East and Horn of Africa
Addressing Unintended Pregnancy in Refugee Camps in Ethiopia

The Population Council leads the Baobab Research Program Consortium in close partnership with the Population Council Kenya and the African Population and Health Research Center. Situated in the East and Horn of Africa, this Africa-based and African-led consortium is filling critical evidence gaps to reduce inequities in sexual reproductive health and rights among vulnerable populations in humanitarian settings.

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List of Abbreviations

Abbreviation	Meaning
CPR	Contraceptive Prevalence Rate
FGD	Focus Group Discussion
FP	Family Planning
GFD	General Food Distribution
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraceptive
mCPR	Modern Contraceptive Prevalence Rate
PSEA	Prevention of Sexual Exploitation and Abuse
RCC	Refugee Coordination Committee
RRS	Refugees and Returnees Service
SBCC	Social and Behaviour Change Communication
SRHR	Sexual and Reproductive Health and Rights
UNHCR	United Nations High Commissioner for Refugees
UP	Unintended Pregnancy
WCG	Women's Consultative Group
WFP	World Food Programme
WVI	World Vision International
WRA	Women of Reproductive Age

Executive Summary

Humanitarian crises expose women and girls to heightened risk of unintended pregnancy due to increased risk of sexual violence as well as disruption in access to and provision of sexual and reproductive health and rights (SRHR) services. Unintended pregnancies in turn result in unplanned births and, in contexts with restrictive abortion laws, maternal morbidity and mortality due to unsafe abortion or miscarriage. This makes innovative, evidence-informed solutions to address unintended pregnancy that take into account the unique circumstances of women and girls in humanitarian settings critical. Evidence-informed solutions should consider how best to reach women and girls with SRHR services in the context of disruptions to normal access and provision of care.

This report presents findings from an intervention study the effectiveness of integrating family planning (FP) messages and counselling in food distribution programmes to address unintended pregnancy in refugee settings in Ethiopia. The study was conducted across the Nguenyyiel camp in Gambella region, which hosts over 110,000 predominantly South Sudanese refugees. The baseline unintended pregnancy survey (2025) found high fertility and low contraceptive use: average parity of four children per woman, and only 16.2% of sexually active women using any contraception, with high unmet need for family planning.

The main objective of the study was to generate evidence on the effectiveness of integrating FP information and services within General Food Distribution (GFD) programmes as a means of addressing unintended pregnancy. The major barriers to FP use documented at baseline included desire for more children, partner opposition, religious prohibitions, and widespread misconceptions about the safety and side effects of modern contraceptive methods.

Methods

This was a mixed-methods pre-post intervention study involving both a prospective quantitative design and a cross-sectional qualitative design. The intervention ran from October 2025 to March 2026 in the Nguenyyiel camp. A baseline survey was conducted in four camps in 2025 and an endline survey in early 2026. Across all camps, structured interviews were completed with 2184 women at baseline and 1937 married or sexually active women at endline. In addition, 6 focus group discussions (FGDs) were conducted with women of reproductive age who had been exposed to the intervention, and 12 key informant interviews (KIIs) were conducted with WVI health staff, healthcare providers, and incentive social workers at endline.

The integrated intervention comprised five core components: FP screening of women at GFD distribution points using a 9-item validated screening tool; individual FP counselling in a designated private space adjacent to the distribution site; warm referrals to camp health facilities; two-day provider training for WVI health volunteers and WFP food distribution monitors; and edutainment-based health education sessions with IEC materials in local language (Nuer). The intervention reached over 10,000 women through sensitisation activities, and 3,155 women were formally screened across five distribution cycles during the implementation period. More than 828 women received contraception from health facilities after effective referral from the GFD points.

Key Findings

Integration of FP services into food distribution programmes is an effective strategy for reaching women who may otherwise be overlooked: The GFD platform provided an opportunity for reaching women with FP messages. Women considered integrating FP services into food distribution an effective means of reaching those who face challenges accessing health facilities due to distance, childcare responsibilities, and social norms around women visiting health facilities independently. Integration into ongoing activities enabled learning and rapid adaptation with minimal additional resources: Given that GFD implementing partners already integrated other health services (nutrition, WASH) in GFD programmes, incorporating FP messages and counselling provided opportunities for learning and contextual adaptation.

The intervention substantially improved FP awareness, supportive attitudes, and uptake: Modern contraceptive prevalence nearly quadrupled in Nguenyyiel camp, rising from 6.9% at baseline to 28.3% at endline. Knowledge of at least one modern FP method rose from 61.4% to 87.2%, and supportive attitudes toward FP increased from 66.5% to 88.9%. Women who participated in the intervention experienced the greatest improvements in knowledge of and support for FP.

Successful integration requires addressing misconceptions, partner opposition, and referral system gaps: Key barriers persisting at endline included partner opposition and religious concerns about modern methods. Referral completion was also a challenge: the paper-based referral system showed significant drop-off between referral issuance and confirmed service uptake at health facilities, necessitating stronger digital tracking mechanisms.

Programmatic Implications

- While integration of FP education and referral services is important to reach larger number of women, it is important to strengthen community-based mobilisation to address social and gender norms such as religious and family opposition and desire for large family size continue to influence family planning.
- There is a need to develop culturally appropriate and sensitive family planning behaviour change communication materials and counselling messages to address misconceptions about side effects and other barriers to contraceptive use.
- There is a need to counsel on more contraceptive methods and expand access to the full range of contraceptive methods, including long-acting reversible contraceptives (LARCs), by leveraging both public health facilities and underutilised but preferred service delivery channels such as community health workers, mobile outreach services.
- Establish better tracking mechanisms from community-facility for referrals to ensure continuity of care.

Background

Unintended pregnancy refers to a pregnancy that is either mistimed (occurs earlier than desired) or unwanted (is not wanted at all) at the time of conception (J. Santelli et al., 2003). Globally, it was estimated that about 121 million unintended pregnancies occurred annually between 2015 and 2019, with the highest rates of unintended pregnancies occurring in sub-Saharan Africa (Bearak et al., 2020). Unintended pregnancy occurs due to non-use of contraceptive methods, contraceptive failure, incorrect or inconsistent use of contraception, discontinuation or switching of methods for reasons other than wanting a pregnancy, and sexual assault (Hubacher et al., 2008; Klima, 1998; WHO, 2011). Unintended pregnancies in turn result in unplanned births, abortion, or miscarriage (Bongaarts & Sinding, 2011; Singh et al., 2010; WHO, 2011).

Preventing unintended pregnancies contributes to reductions in maternal and infant deaths arising from high-risk pregnancies and unsafe abortion (Bongaarts and Sinding, 2011; WHO, 2011). In addition, unintended pregnancy results in poverty, malnutrition, and limited education and economic opportunities in many low- and middle-income countries, which further worsens the health consequences for women and their families (Kilma 1998; Marston & Cleland,2003). Humanitarian crises expose women and girls to heightened risk of unintended pregnancy due to increased risk of sexual violence as well as disruption in access to and provision of sexual and reproductive health (SRH) services (Shrivastava and Prateek 2022; UNFPA 2022). However, there is a lack of rigorous evidence for policymaking and programming to address unintended pregnancy in refugee settings.

Formative study findings on unintended pregnancy in humanitarian settings from the Baobab RPC (Baobab RPC, 2025) indicated that most sexually active or women and girls in these contexts were not using FP (83.8%), although a considerable proportion were in situations that could easily lead to shifts toward FP use. For instance, a third of non-users reported intending to use an FP method in the future, while a large proportion of non-users without such intentions were still supportive of the idea of FP use.

The reasons for not using contraception were diverse. A considerable proportion (21%) of non-users of FP were not in union at the time of the formative study. The absence of an intimate partner in the lives of about a quarter of women and girls also highlighted the opportunity to relay information and conduct FP counselling with fewer partner-related barriers. Non-partner-related barriers, including not knowing of any FP method/source; not recognising one's own role and autonomy in FP decisions (due to religious beliefs); and having concerns about the potential inconvenience, health issues, or side effects posed by FP use, were considered to be amenable to change through targeted FP information and counselling. Finally, the formative study results highlighted women's affinity for receiving some FP information via community-level structures (as opposed to visiting clinics), with 59.8% having this preference (Baobab RPC, 2025).

These realities made it critical to identify and implement innovative, evidence-informed solutions to address unintended pregnancy in refugee settings, taking into account the unique circumstances of women and girls in such settings. It was also considered imperative to determine how best to reach women and girls with family planning/contraceptive services in the context of overburdened health facilities and disruptions to normal access to and

provision of services. Together, the formative study findings led to the development of an intervention geared toward reaching a critical mass on non-users of FP through tailored communication mechanisms and messages that align with the barriers, attitudes, and emerging realities. Food distribution platforms in refugee settings were considered to be an efficient platform for reaching such a critical mass on a regular basis. General food distribution exercises conducted at food distribution centres are among the few near-universal, trusted, regularly attended platforms used by the majority of the refugee camps' population. The central innovation was to use these existing touchpoints to deliver FP information and counselling and to issue warm referrals that connect women directly to health facilities where they could receive further information and/or contraceptive methods. This approach requires no new infrastructure, leverages existing humanitarian capacity, encourages collaboration between health and food distribution platforms, and is designed to be sustainable within current camp operations. This intervention is described in detail in a subsequent section of this report.

Study aim

The main objective was to respond to unintended pregnancy in refugee settings in Ethiopia through an intervention reaching women and girls of reproductive age at scale. The specific objective was to assess the effectiveness of a family planning-focused behaviour change communication intervention geared toward improving the uptake of FP.

Methodology

Study Context/Setting

This study was conducted in Ethiopian refugee camps, which are home to over 1 million refugees settled across 23 camps in different regions of Ethiopia. Refugees from South Sudan, Somalia, Eritrea, and Sudan make up the largest proportion. The current study was conducted in 4 refugee camps: Awubare and Shedder in the Somali region in eastern Ethiopia (hosting predominantly Somali refugees); Tsore in the Benishangul-Gumuz region in western Ethiopia; and the Nguenyyiel camp in the Gambella region in southwestern Ethiopia (hosting predominantly South Sudanese refugees).

Study Design

This is a mixed-methods study with both cross-sectional and prospective (pre-post) design conducted in four purposively identified refugee camps in Ethiopia. The design includes: (a) a quantitative household survey at baseline (all eligible women) and endline follow-up at all four sites; (b) structured observation of intervention sessions; (c) qualitative focus group discussions (FGDs) and key informant interviews (KIIs) with women, staff, and facility managers at endline. Refugee camps were allocated to intervention and comparison groups based on baseline levels of unintended pregnancy and family planning use. Nguenyyiel camp in the Gambella region—the largest of the four—had the poorest indicators and was therefore selected as the intervention site. Awbare, Shedder, and Tsore camps had relatively better indicators and thus served as comparison sites where the intervention was not implemented.

Study Population

All women aged 15–45 years resident in the four camps for three or more months were eligible for the baseline cross-sectional survey, regardless of marital status and sexual activity. The endline survey was strictly a follow- up survey that interviewed sexually active women enrolled in the baseline survey. The baseline survey was conducted from December 2024 to February 2025, and an endline survey was conducted in February and March 2026 in the four refugee camps.

Sampling Procedures

The four camps were purposively identified in collaboration with the Ethiopian Refugees and Returnees Service (RRS), UNHCR-Ethiopia, and its implementing partners. After identifying the camps, a two-stage process was used to select and recruit females aged 15–45 years for interviews. In the first stage, households within each refugee camp were randomly sampled. The number of households selected from each zone was proportional to the population size. Household listing was done in the selected zones to generate the sampling frame for the second stage of the sample selection.

The second stage involved randomly selecting one female aged 15–45 years from each sampled household for an individual interview. In households with more than one eligible

female, the ODK Collect platform randomly selected one using the Kish Method (Kish, 1949). Emancipated minor participants aged 15–17 years, who had assumed adult responsibilities, such as marriage or parenthood, were eligible for consenting and inclusion in the study without parental consent.

Intervention Description

A five-pronged intervention was implemented over a 6-month period (October 2025- March 2026). The intervention was situated within the context of food distribution platforms in two Zones (Zone B & D) within Nguenyyiel refugee camp in the Gambella region. Food distribution in Nguenyyiel camp was implemented by UNHCR and World Food Program implementing partner, World Vision International (WVII). Food distribution to refugees involved the physical allocation and supply of food rations to refugees monthly, facilitated by a verification exercise to confirm the refugee status/eligibility of those concerned. As the process entails a refugee verification exercise, the unintended pregnancy (UP) intervention was established within the verification process of food distribution platforms in all their iterations as they were implemented within the study sites from month to month.

The intervention comprised the following components: the integration of family planning (FP) screening into monthly food distribution platforms (FDPs); the integration of FP counselling into monthly FDPs; 'warm' referrals to health facilities for comprehensive FP services; provider training; and FP-focused edutainment. These components are described in further detail below.

Integration of an FP Screening into Monthly FDPs (October 2025- March 2026)

A 7-item screening tool (Appendix 1) was developed to sensitise women ages 15 to 45 to FP, inquire about their use of and satisfaction with it (where applicable), and their interest in learning more about FP. Women and girls were universally screened during each monthly food distribution exercise. The screening tool was administered immediately before or after the refugee verification exercise that occurred prior to food distribution. Privacy was assured by introducing tented spaces where women could be asked confidentially about their FP use. Women and girls who expressed interest in learning more about FP (or who wanted to discuss their current FP method further) were referred to FP nurses situated within the food distribution platform for individualized FP counselling.

Integration of FP Counselling into Monthly FDPs (October 2025- March 2026)

FP nurses were brought into the FDPs to be on standby to provide FP counselling to women and girls who expressed interest in learning more about FP, or who had concerns about their current FP method and wanted to discuss these concerns further. FP nurses were situated in tents within the FDPs and provided individualised counselling and information sharing. Their discussions with women and girls were facilitated by a 6-item FP discussion guide designed to obtain targeted information about the FP needs of those presenting, structure targeted FP counselling, and determine the need for referrals to a health facility. A total of 3 FP nurses played this role each month in each zone during food distribution exercises each month.

Referrals to Health Facilities (October 2025- March 2026)

Following the FP counselling and information-sharing by nurses, referrals were issued, as necessary, employing a client-centred, 'warm referral' approach. This approach involved direct phone calls by FP nurses to health facilities to confirm the availability of FP methods selected by women and girls; immediate referral after counselling for ready clients; advance notification about arriving clients to receiving FP providers at the health facilities; direction-giving to ensure clients knew how to get to the health facilities concerned; the use of referral forms containing personalised instructions to the receiving provider at the health facility based on the client's method preference; and the fast-tracking of clients presenting with referral forms from the FDP, given that they had already received FP counselling. Women and girls were referred to the refugee health centre in the camp but were given the opportunity to choose from nearby health facilities including a hospital outside of the camp for those wanting permanent FP methods or presenting with complications that could not be managed at the health facilities within the camp.

Provider Training (October 2025)

Different cadres of providers who conventionally support food distribution and refugee verification exercises participated in training sessions designed to sensitise them to the new intervention and their roles in implementing it. As Table 2 demonstrates, different cadres of providers participated in several common training sessions, while selected training sessions were dedicated to specific provider cadres. For example, FP screening was conducted by WVI staff along with WVI-affiliated community health workers (CHWs) who conduct refugee verification exercises. These providers therefore received detailed training on the use of the screening tool. FP nurses received dedicated training on the use of the discussion guide, as they were the sole providers playing this role.

A total of 38 providers were trained across different cadres to support the intervention across the two zones combined, as outlined in Table 2. In addition, 35 Refugee Coordination Committee (RCC) members and faith leaders and RCC were trained on tools to address sensitive reproductive health issues, including through a faith-based and community-led lens and to strengthen understanding of the intervention, retain buy-in, and foster sustainability at the community level.

All participants attended training sessions focusing on the following areas: Interactive, FP-Focused Values Clarification Exercises; UP Project Overview and Baseline Study Findings; Introduction to FP and its Benefits; UP Intervention and the Role of Screening/Screeners; Warm Referrals; and Gender Issues and FP.

FP-Focused Edutainment & IEC materials (October 2025 – March 2026)

Edutainment is a conventional feature of food distribution platforms in refugee camps. This medium is used to convey useful health information on a variety of topics, ranging from nutrition to maternal health. The intervention took advantage of this pre-existing feature by building FP messaging into the normal edutainment mechanisms within the FDPs. This was done in the following ways:

- *FP information dissemination*: On each morning of the monthly FDPs, peer educators, CHWs, FP nurses, and/or WVII staff shared FP information among the cohort of refugees present. The information centred on awareness-raising around the benefits of FP and available services; announcements about the integration of the FP screening exercise into the verification exercises for women and girls ages 15-45; and clarifications to help dispel FP myths and misconceptions.
- *Skits*: Key FP messages were developed based on baseline survey results and were shared with refugee drama groups in the intervention sites. These drama groups subsequently created a variety of skits around the messages and performed them daily during each food distribution exercise.
- *Pre-recorded audiovisual messages:* FP audio messages were pre-recorded in 5 different local languages and were aired throughout distribution days when other edutainment activities were not going on. The audio messages focused on the need to avoid unplanned pregnancy by using modern FP methods, and sensitised listeners to the fact FP screening and counselling was being offered during the food distribution exercise, although no actual FP methods would be provided within this context.
- *Child-driven edutainment:* WVI coordinated with a local camp school to develop an FP-focused song and poem. These were performed once each by primary school children in each intervention zone during a food distribution exercise.
- *Billboards, Banners, IEC Materials:* Six billboards were designed, translated into local languages, approved by the Regional Health Bureau (RHB), and installed at strategic points near food distribution queues. Content covered; available FP methods, service locations and hours, birth spacing benefits, and myth-busting messages. Supplementary IEC materials/flipcharts, stickers, and brochures were distributed and displayed to reach women during waiting times.

Data gathering activities

Quantitative data collection

The quantitative component included a structured face-to-face interview conducted with women aged 15–45 years who had been residents of each of the four refugee camps for at least three months at two time points (baseline and endline). Interviews were carried out using electronic data collection on tablets and covered topics such as pregnancy and birth history, pregnancy intentions, contraceptive knowledge, past and current use of methods, reasons for non-use, future use of contraceptives, and preferred sources of information and services. The survey tools were translated from English into three local languages: Juba Arabic, Nuer, and Somali. Female interviewers conducted interviews in the respondents' preferred languages: Nuer in Nguenyyiel camp, Somali in Shedder and Awubare camps, and Arabic in Tsore camp. Back-translations were performed to ensure accuracy. The data collection team, consisting of research assistants, team leaders, and coordinators, received eight days of comprehensive training on survey protocols, ethical research practices, and the electronic data collection system. Field supervision was provided by three field coordinators and ten team leaders. The team leaders managed two to three research assistants and helped identify sampled households and validate data daily before uploading it to the server. The respective camp coordinators held daily meetings with team leaders to monitor data quality and discuss issues with the research assistants. Overall, field implementation was overseen by a coordinator

responsible for all three sites and the research team, with periodic debriefing. All interviews took place in safe, private locations.

Qualitative data collection

The qualitative component comprised two concurrent methods: focus group discussions (FGDs) with women of reproductive age and key informant interviews (KIIs) with reproductive health providers, incentive social workers, and implementing partner staff. Between 24 and 36 women participated in FGDs in the intervention camp, split by age group (15–24 and 25–44 years) and guided by a semi-structured discussion tool exploring where women get FP information, whether they received FP information from the GFD points, what information they receive, opinions on the acceptability of integrating FP in food distribution platforms. All FGDs were conducted by female research assistants, and all participants provided written informed consent. The KIIs assessed the experiences of implementing the FP SBCC intervention during food distribution programs, challenges experienced in the process of integration and what should be done to scale up the intervention to similar refugee camps.

Data Analysis

Quantitative survey data were cleaned, coded, and analysed using Stata statistical software. Descriptive statistics (frequencies and percentages) were computed for key indicators, disaggregated by camp. Tables and charts were used to display data as appropriate.

We compared the baseline and end-line results across the camps and also compared the intervention and non-intervention camps for the key outcomes. We present results using proportions/percentages and used the Chi-square test to examine the differences between categories (baseline versus end-line, and Intervention versus the non-intervention sites).

For some key indicators, we also compare the intervention camp with comparison camps. Nguenyyiel camp was the intervention site while Tsore, Awubare and Shedder camps did not receive the intervention. These non-intervention camps offer a descriptive, though not typical causal, point of comparison for understanding baseline and endline findings. They show what FP outcome trends looked like in broadly similar refugee settings without the intervention over the same period and serve as a reference point for interpreting the magnitude of any changes at intervention sites. The significant cultural and demographic differences between these two pairs of sites mean they cannot provide a valid counterfactual for causal effect estimation, but they are useful for contextualising and triangulating findings. Qualitative data from FGDs and KIIs were transcribed verbatim and translated into English where necessary. Transcripts were analysed thematically.

Ethical Considerations

The Baobab unintended pregnancy study was approved by the Ethiopian Public Health Association (EPHA) Institutional Review Board (EPHA/OG/789/23 dated August 10, 2023) and received an extension (EPHA/OG/058/26 dated January 27, 2026), as well as approval from the Population Council Institutional Review Board (Protocol 986 dated October 21, 2021). The RRS also provided administrative authorisation to access the camps. Consent was obtained from all participants, and parental consent was not needed for emancipated minors.

Results

The results section is broken down into 3 sub-sections, with Section 1 Provides baseline descriptive characteristics of the survey population, section 2 describes the intervention implementation and section 3 describes the changes between the baseline and end-line reproductive health findings.

Results: Baseline descriptive characteristics

A total of 2,768 women of reproductive age (15–45 years) consented to participating in the survey, representing an 87% response rate. Table 1 presents the socio-demographic characteristics of eligible women at baseline. Our analysis focused on 2,184 sexually active married and unmarried women who participated in the survey. Over half of the participants (54.6%) were aged 30–45 years, with this pattern observed across all camps except Tsore, where most respondents were aged 20–29 years. The mean age of respondents was 30.6 years. Most participants were from South Sudan (54.9%), followed by Somalia (30.7%). On average, respondents had lived as refugees in Ethiopia for 9.4 years, with longer durations observed in Awubare (15.6 years) and Shedder (11.6 years) camps in eastern Ethiopia. Half of the participants (50.4%) had no formal or only pre-primary education, while just 8.4% had attained secondary or higher education. Most respondents (81%) were married or cohabited, and in many cases, first marriage occurred before the age of 18.

Table 1: Baseline socio-demographic characteristics of study participants from four refugee camps in Ethiopia, 2025

Characteristic	Refugee camps				Total (N=2,184)
	Awubare (N=310)	Nguenyyiel (N=901)	Tsore (N=604)	Shedder (N=369)	
Age of women					
15–19	3 (1.0)	73 (8.1)	46 (7.6)	7 (1.9)	129 (5.9)
20–29	112 (36.1)	319 (35.4)	303 (50.2)	129 (35.0)	863 (39.5)
30–45	195 (62.9)	509 (56.5)	255 (42.2)	233 (63.1)	1,192 (54.6)
Mean age	32.4	30.3	28.8	32.4	30.6
Country of origin					
South Sudan	0 (0.0)	892 (99.0)	304 (50.4)	0 (0.0)	1,196 (54.9)
Somalia	303 (99.3)	0 (0.0)	0 (0.0)	366 (99.2)	669 (30.7)
Sudan	1 (0.3)	9 (1.0)	267 (44.3)	0 (0.0)	277 (12.7)
Other	1 (0.3)	0 (0.0)	32 (5.3)	3 (0.8)	36 (1.7)
Duration of stay in the settlement					
1–4 years	4 (1.3)	17 (1.9)	214 (35.4)	21 (5.7)	256 (11.7)
5–9 years	10 (3.3)	878 (97.4)	207 (34.3)	81 (22.0)	1,176 (54.0)
10+ years	291 (95.4)	6 (0.7)	183 (30.3)	267 (72.4)	747 (34.3)
Mean years	15.6	7.9	7.0	11.6	9.4
Highest level of education					
No schooling / pre-primary	50 (33.6)	124 (35.6)	291 (77.0)	58 (35.8)	523 (50.4)
Primary	70 (47.0)	197 (56.6)	81 (21.4)	79 (48.8)	427 (41.2)
Secondary and above	29 (19.5)	27 (7.8)	6 (1.6)	25 (15.4)	87 (8.4)
Marital status					
Married / living with a man	245 (79.0)	712 (79.0)	538 (89.1)	273 (74.0)	1,768 (81.0)
Not in union	65 (21.0)	189 (21.0)	66 (10.9)	96 (26.0)	416 (19.0)
Age at first marriage					
<15 years	18 (6.1)	29 (3.6)	40 (6.8)	10 (2.7)	97 (4.7)

15–17 years	88 (29.6)	373 (46.7)	356 (60.2)	127 (34.6)	944 (46.0)
18–19 years	65 (21.9)	316 (39.6)	127 (21.5)	89 (24.3)	597 (29.1)
20+ years	126 (42.4)	80 (10.0)	68 (11.5)	141 (38.4)	415 (20.2)
Values are n (%) unless otherwise stated, Percentages may not sum to 100 due to rounding					

Intervention implementation

The intervention was designed to integrate Family Planning Social and Behaviour Change Communication (FP-SBCC) activities into the General Food Distribution (GFD) system in 2 of the 5 zones of Nguenyyiel Refugee Camp between October 2025 and March 2026. The plan aimed to leverage the high-traffic GFD platform to deliver FP information, counselling, and referrals to women of reproductive age. A multimodal community sensitisation strategy using town criers, arts groups, drama, music, and storytelling was planned to raise awareness. World Vision International implemented the intervention, starting with pre-intervention training of food-distribution staff and health workers as a key preparatory activity. The pre-intervention training in interpersonal communication and rapid-counselling skills was given to 38 health workers and GFD staff. During implementation, six FP corners and six FP billboards were established to increase visibility at community touchpoints. Screening, counselling, and referrals were captured digitally, supported by monthly performance monitoring. The intervention team introduced the following practical adaptations at implementation: a priority-ticket system to reduce fear of losing one's queue position, shifting in-depth counselling from busy distribution areas to quieter community spaces, and discontinuing the warm-referral system due to community-raised protection concerns. The previously planned radio public service announcements could not be produced due to lack of local vendors, prompting intensified face-to-face outreach.

An estimated 10,000 refugee women were reached through community sensitisation activities. Across the five-month period at the GFD sites, 3,155 women of reproductive age were screened at FP corners. Of those screened, 2,715 (86%) accepted one-to-one FP information and counselling, while 14% declined, primarily due to queue-related time constraints. Health facility data from the intervention period showed that 828 women received FP services following referral.

Women aged 15–24 years and male partners appeared fewer/ underrepresented, as the GFD had predominantly older females. KIIs and FGDs further showed increasing acceptance of FP conversations, particularly among communities engaged by trained faith leaders. However, persistent myths and misconceptions such as fears of infertility and implant migration were frequently reported potential barriers.

Sixty community-based change agents consisting of Refugee Central Committee (RCC) members, faith leaders, and Women Care Group (WCG) members participated in the inception workshop organised by World Vision Ethiopia and subsequently supported disseminate FP messages within their social networks. In addition, Institutional endorsement and approval of all the IEC materials used by the Regional Health Bureau, RRS, and WFP strengthened ownership and legitimacy. By the project's close, government and community co-ownership had been achieved, and FP communication materials (such as Billboards) installed during the project also remained in place. However, several sustainability gaps persisted: reliance on

short-term funding, limited pathways for male engagement, and the absence of a formal referral-tracking system after warm referrals were stopped.

Table 2: Summary of field intervention implementation

Intervention Dimension	Key Evidence	Strength / Gap/ Key Message
REACH	~10,000 reached via sensitisation; 3,155 screened; 828 FP services received verified;	**Strength:** Platform delivers high coverage. **Gap:** Adolescents and male partners underrepresented. **Key message:** GFD Platform has potential to reach at scale; equity targeting needed.
EFFECTIVENESS	828 women served (182% of target); community normalisation of FP message discourse; 923 additional health needs identified	**Strength:** Service uptake strong for first-cycle, high-barrier context. **Gap:** Full pre-post survey outcomes pending final analysis. **Key message:** Evidence of Early service uptake appears promising; however multi-year cycles are needed for behaviour change consolidation.
ADOPTION	38 staff trained and delivered; 60 CoH change agents operational; Regional stakeholders all actively engaged	**Strength:** Community change agent network is durable; government endorsement secured. **Gap:** Staff turnover risk; male decision-makers not systematically reached. **Key message:** Institutional and community adoption is possible with detailed engagement.
IMPLEMENTATION	Most targets met or exceeded; priority ticket and coffee ceremony innovations effective; warm-referral protocol adapted for protection reasons; PSAs not delivered	**Strength:** Responsive adaptation throughout. **Gap:** Counselling quality on distribution days; referral tracking gap. **Key message:** This approach can be delivered in these settings with some refinements.
MAINTENANCE	Government co-ownership embedded; CoH network self-sustaining; FP infrastructure in place; service continuity and funding risks remained unresolved	**Strength:** Institutional foundations are strong. **Gap:** Programme funding; male engagement pathway; referral tracking system. **Key message:** Pilot ended due to absence of additional funding.
OVERALL	This first-cycle, 5-month pilot in zero-prior-access refugee context implemented government endorsement and community ownership with modification in in some areas exceeded planned service targets and provides footprint for a replicable model	The model works. It needs time, male engagement, and referral system strengthening to fulfil its potential at scale. **Key message:** We can recommend that this intervention is scaled up with modifications in all Nguenyyiel refugee camp zones /GFD sites and other camps piloted.

Baseline to Endline findings

Endline Study Population and Retention

The endline survey included all 2168 women who were either in union (married or living together) or unmarried sexually active at the time of the baseline survey. It was conducted from February 16 to March 20, 2026, and successfully interviewed 1938 married and sexually active unmarried women who participated in the baseline survey, a follow up response rate of 88.8%.

Changes in Contraceptive Knowledge and Attitudes

Knowledge of Contraceptive: Overall, about 74.3% of women knew at least one method of contraception at baseline although knowledge was concentrated among a narrow range of methods i.e., injectables (68.5%), oral contraceptive pills (64.9%), and implants (57.7%) as the most widely known methods. Knowledge of long acting (intrauterine device (IUD) and permanent methods was limited as emergency contraception, and female condoms. Knowledge varied predictably by camp and socio-demographic characteristics. Women in the Nguenyyiel camp reported lower knowledge of any methods or knowledge of three or more methods (Table 3). As Table 3 shows, knowledge of any method improved significantly for the intervention camp at endline, rising from just 40% to 99% post intervention. Knowledge of contraception methods also increased across other refugee camps.

Attitudes and intentions: From the baseline qualitative study, women described entrenched misconceptions about the safety of contraceptive methods, particularly implants with widespread beliefs that they cause infertility, excessive bleeding, and internal migration within the body. Fear of community judgment, and concerns about partner reactions were consistent barriers reported across all four sites. A midwife at Nguenyyiel described this context: community fears of side effects, particularly heavy bleeding associated with long-term implants, were among the most persistent barriers to service-seeking in her experience.

Women's attitudes toward contraceptive methods improved over the 12-month observation period. Support for family planning rose from 66.5% at baseline to 89.0% at endline, with the most pronounced gains observed in the intervention (Nguenyyiel) camp. Perceived support for family planning among husbands and partners also increased, likely reflecting greater spousal communication on the topic (Table 3). Notably, intention to use contraception in the future among current non-users—an important indicator of latent demand—also increased substantially across all camps, rising from 33.4% to 53.9%, again with the largest increase seen in the intervention camp (increasing from 29.6% to 73.3%).

Table 3: Changes in contraceptive Knowledge and Attitudes toward Contraception among women from four refugee camps in Ethiopia, 2025-2026

Indicator	BASELINE					ENDLINE	
	Nguenyyiel *(n=**)*	Tsore *(n=**)*	Awubare *(n=**)*	Shedder *(n=**)*	Overall total *(n=2,168)*	Intervention Nguenyyiel *(n=830)*	Control Camps (Ts + Aw + Sh) combined* (n=1108)
Modern Contraceptive Knowledge							
Knows at least one contraceptive method (%)	**39.8**	97.7	99.7	99.5	**74.3**	**98.9**	**100**
Knows at least three contraceptive methods (%)	**17.4**	85.1	97.7	97.3	**60.9**	**97.2**	**99.6**
Attitude toward FP (%)							
Positive / supportive attitude toward FP (%)	**44.8**	85.1	82.9	75.3	**66.5**	**88.9**	**89.0**
Negative / opposes FP Use (%)	**51.1**	13.6	16.4	23.6	**31.2**	**10.5**	**10.3**
Other (Not sure/don't know) (%)	**4.1**	1.3	0.7	1.1	**2.4**	**0.6**	**0.7**
Partner's Attitudes toward FP use							
Positive / supportive attitude toward FP (%)	**7.7**	70.4	54.7	49.6	**38.7**	**16.4**	**63.4**
Negative / opposes FP Use (%)	**74.5**	16.9	25.8	27.4	**43.7**	**78.8**	**18.8**
Other (No husband /Not sure) (%)	**17.8**	12.7	19.1	23.0	**17.5**	**4.8**	**17.9**
Discussed family planning with partner (%)							
Discussed	**39.2**	80.3	61.1	47.2	**55.0**	**78.9**	**74.0**
Not discussed	**60.8**	19.7	38.9	52.8	**45.0**	**21.1**	**26.0**
Future Intentions — among current contraceptive non-users							
Intends to use FP in the future (% of non-users)	**29.6**	63.9	16.5	24.8	33.4	**73.3**	**53.9**
Does not intend to use contraception (% of non-users)	**70.6**	35.8	83.8	75.2	66.6	**26.7**	**46.2**

Changes in Contraceptive Use and Method Mix

At baseline only one in six (16.2%) of married and sexually active women surveyed in the four camps were using contraception/family planning. This varied from only 6.9% in the Nguenyyiel camp to 34.6% in Tsore camp. The contraceptive method mix was heavily skewed toward short-acting methods. Injectables were the dominant method across all four camps (47.5% of current users), followed by implants (27.2%) and oral contraceptive pills (17.3%). The exception was Shedder camp, where injectables were less dominant, and a more varied method mix was reported. Except for Implants, the other long-acting reversible contraceptives (LARCs) IUDs were rarely used (Table 4). Method use was least common among adolescent girls

Current use of contraceptive methods across all camps increased markedly from 16.2% to 34.3% from 2025 to 2026. Although an increase was observed in all camps, the biggest increase was observed in the intervention camp (Nguenyyiel) where current use of contraception increased from just 6.9% at baseline to 28.3% at endline. The contraceptive method mix remained largely unchanged with nearly two in five (38.8%) of users using injectables, followed by Implants. Over 90% of the users are using modern methods while some 9.8% depend on traditional methods (such as withdrawal, periodic abstinence). Accordingly, public health facilities remained the major source of contraception for women in the camps and most women obtained their methods from facilities in the camp. Contraceptive use remained uncommon among adolescent girls in all refugee camps.

Table 4: Changes in *Contraceptive Use and Method Mix four refugee camps in Ethiopia, 2025-2026*

Indicator	BASELINE					ENDLINE	
	Nguenyyiel *(n=**)*	Tsore *(n=**)*	Awubare *(n=**)*	Shedder *(n=**)*	Overall total *(n=2,168)*	Intervention Nguenyyiel *(n=**)*	Control Camps (Ts + Aw + Sh) combined* (n=**)
Current contraceptive Users /Contraceptive prevalence rate (CPR)							
CPR — any method (%)	**6.9**	**34.6**	**14.1**	**10.6**	**16.2**	**28.3**	**34.4**
mCPR — modern methods (%)	6.0	33.9	13.8	10.6	15.6	79.2	95.8
Implants (%)	0.8	12.6	1.7	2.2	4.4	5.5	7.1
Intrauterine device (%)	0.0	0.0	0.0	0.3	0.1	0.0	0.2
Injectables (%)	3.3	18.0	5.7	3.0	7.7	9.6	16.1
Oral contraceptive pill (%)	1.8	1.8	2.3	1.6	1.8	1.3	5.1
Lactational Amenorrhea Method (%)	0.0	1.2	3.7	3.3	1.4	9.3	6.5
Male / Female Condoms (%)	0.0	0.7	0.0	0.0	0.1	0.2	0.1
Emergency contraception (%)	0.1	0.2	0.0	0.0	0.1	0.1	0.1

Permanent methods [Female or Male sterilisation] (%)	0.0	0.0	0.0	0.3	0.1	0.0	0.2
Traditional methods (%)	0.9	0.5	0.3	0.0	0.6	5.2	1.5
Current use by age group and marriage							
women aged 15–19 (%)	19.4	8.6	0.0	2.6	8.8	2.6	0.5
women aged 20–29(%)	51.6	57.0	54.8	30.8	52.8	41.3	43.9
women aged 30–39 (%)	29.0	29.2	40.5	59.0	33.8	45.1	43.4
women aged 40–49 (%)	0.0	5.3	4.8	7.7	4.6	11.1	12.2

Exposure to the Intervention

Table 5 presents data on the exposure of women to the intervention program in the refugee camps. Study participants were asked a series of questions on their exposure including whether they know about the SBCC sensitisation sessions organised by the WVI, their participation in FP sensitisation sessions, whether they received a contraceptive method because of the sessions and what method they received. As Table 5 shows, higher proportion of respondents from the intervention site reported knowledge of the SBCC sensitisation sessions (93.8%), participation in FP sensitisation sessions (90.2%), receiving a contraceptive method because of referral obtained from the sessions (242 women). The number of respondents who reported any exposure to the sensitisation sessions was small in the other comparison camps although the numbers were substantial in the camps (Shedder, Awubare) where WVI also runs programs in the host community. In terms of contraceptive methods received, women reported that they mostly received injectables, Implants and pills through referrals from the GFD points. Women exposed to the program reported that the sensitisation sessions organised by WVI at the GFD points influenced them in various ways.

In the qualitative FGDs, women reported that they first encountered FP information passively while waiting in long lines to collect food. The use of microphones and general announcements allowed for wide reach, ensuring that even those who did not actively seek information were exposed to key messages about FP availability. It served as an entry point, sparking curiosity for some while passing unnoticed by others focused on their primary task.

A participant from an FGD with women above 25 years recalled hearing the information while engaged in the routine of food collection.

> *"I had the information about family planning on the food distribution site during the January distribution when I was collecting my monthly Ration" (FGD, women >25 years old).*

Another participant from a different FGD with women above 25 years confirmed the reach of these announcements, noting that they were integrated into the distribution process.

> *"I heard the information on family planning while I was collecting my monthly ration, it is disseminating at FDP (Food distribution Point) by the incentive workers." (FGD, women >25 years old)*

In the FGDs, women also reported that they visited the FP awareness desk at the GFD where women could ask questions about FP without fear of immediate judgment. *A participant from an FGD with women above 25 years described her approach to seeking information at the desk.*

> *"Yes, I heard the FP information at the entrance, there is a desk for awareness that gives information about family planning." (FGD women >25 years old)*

A participant from an FGD similarly noted that the community's health (incentive social) workers provided clear guidance on where to obtain methods after receiving counselling and referrals at the GFD points.

> *"The awareness is provided and they also provided the referrals for us in order to obtain the methods from health centre" (FGD, women<25 years old)*

Another participant from an FGD similarly explained that the information included both how to prevent pregnancy and where to go for services if they want to receive a method

> *"It focused on how to prevent pregnancy until we are ready to have a child by using family planning and also referring us to DPO health centre in the camp or other places." (FGD, women >25 years)*

Table 4: Exposure to project interventions activities and accessing family planning information and services

Indicator	Awubare (Jigjiga) [N=263]	Nguenyyiel (Gambela)[n=830]	Tsore (Asosa)[N=509]	Shedder [N=336]	Total [N=1938]
Knowledge of FP sensitisation sessions organised by WVI					
Yes	74(37.2)	681 (93.8)	12 (5.1)	32 (14.9)	799 (58.0)
No	117 (58.8)	45 (6.2)	222 (93.7)	178 (82.8)	562 (40.8)
Unsure	8 (4.0)	0 (0.0)	3 (1.3)	5 (2.3)	16 (1.2)
Participation in FP sensitisation sessions organsied by WVI					
Yes	35 (47.3)	614 (90.2)	8 (66.7)	3 (9.4)	660 (82.6)
No	39 (52.7)	67 (9.8)	4 (33.3)	29 (90.6)	139 (17.4)
Getting FPas a result of sessions organised by WVI at GFD point					
Yes	13 (37.1)	242 (39.4)	5 (62.5)	1 (33.3)	261 (39.5)
No	22 (62.9)	372 (60.6)	3 (37.5)	2 (66.7')	399 (60.5)
Common FP methods Obtained after the sessions organised by World Vision					
Implants	5 (1.9)	95 (11.4)	4 (0.8)	0 (0.0)	104 (5.4)
Injection	0 (0.0)	134 (16.1)	4 (0.8)	0 (0.0)	138 (7.1)
Pill	10 (3.8)	53 (6.4)	2 (0.4)	1 (0.3)	66 (3.4)
Other methods (LAM, Rhythm, Male condom, Emergency contraception)	0 (0.0)	15 (1.8)	1(0.2)	0 (0.0)	20 (0.9)

Impact of family planning exercises organised by World Vision on views about delaying pregnancy on the respondent					
Influenced	34 (97.1)	609 (99.2)	8 (100.0)	2 (66.7)	653 (98.9)
Did not Influence	1 (2.9)	5 (0.8)	0 (0.0)	1 (33.3)	7 (1.1)
Influence of family planning exercises organised by World Vision on taking action to prevent pregnancy					
Influenced	30 (85.7)	609 (99.2)	6 (75.0)	2 (66.7)	647 (98.0)
Did not Influence	5 (14.3)	5 (0.8)	2 (25.0)	1 (33.3)	13 (2.0)
Category of people that influenced the respondent the most to take action to prevent themselves from getting pregnant before being ready					
Food distribution exercise staff	22 (8.4)	613 (73.9)	7 (1.4)	1 (0.3)	643 (33.2)
Nurses sitting in tents during any kind of food/cash/mobile money exercises	10 (3.8)	6 (0.7)	0 (0.0)	0 (0.0)	16 (0.8)
Peer educators/VHTs	5 (1.9)	153 (18.4)	1 (0.2)	0 (0.0)	159 (8.2)

Summary of Findings and Implications

The endline assessment demonstrated clear and substantial improvements in women's knowledge of modern contraceptive methods, attitudes toward family planning, intentions to use contraception, and actual contraceptive uptake following the five-month intervention. These findings provide strong evidence that integrating family planning (FP) information, counselling, and referral mechanisms into General Food Distribution (GFD) platforms is a feasible and effective approach for reaching large numbers of women in refugee settings who may otherwise face persistent barriers to accessing facility-based FP services.

The intervention was associated with a pronounced increase in family planning use in the intervention camp relative to comparison camps. In Nguenyyiel camp, contraceptive prevalence increased more than fourfold, from 6.9% at baseline to 28.3% at endline, representing the largest gain observed across all study sites. While improvements in contraceptive use were also observed in comparison camps over the same period, the magnitude of change was substantially greater in the intervention camp, underscoring the added value of the integrated FP–GFD delivery model.

Women in the intervention camp reported markedly higher exposure to FP social and behaviour change communication (SBCC) activities, greater knowledge of available contraceptive methods, and more supportive attitudes toward family planning. Importantly, a significantly higher proportion of these women reported receiving a contraceptive method as a direct result of referrals generated through the GFD-based FP sessions, demonstrating that the intervention not only increased awareness but also translated demand into service uptake.

Achieving these outcomes despite significant operational disruptions, including security challenges in the Gambella region that temporarily halted FP activities for nearly two months (November–December 2025), highlights the resilience and adaptability of the intervention model within fragile humanitarian contexts. The findings suggest that even short-duration, resource-efficient integrations into routine humanitarian service platforms can yield meaningful gains in FP outcomes, particularly when they leverage trusted, regularly attended touchpoints such as food distribution.

A small proportion of women in the Awbare and Shedder camps reported receiving FP information from World Vision International during food distribution activities, likely reflecting spillover effects from the organisation's broader programming in surrounding host communities. However, it is important to note that no comparable intervention formally integrating family planning and SBCC into food distribution services was implemented in these camps during the study period. As such, observed changes in these sites should not be attributed to a structured FP–GFD integration approach.

Overall, the findings indicate that embedding FP SBCC and referral services within humanitarian assistance platforms can significantly expand reach, improve contraceptive uptake, and help address unmet need in refugee settings. The results support the potential for scaling up this model, while underscoring the importance of strengthening referral tracking, addressing persistent social and gender-norm barriers, and ensuring continuity in insecure and resource-constrained environments.

Recommendations

1. While integration of FP education and referral services is important to reach larger number of women, it is important to strengthen community-based mobilization to address social and gender norms such as religious and family opposition and desire for large family size continue to influence family planning.
2. There is a need to develop culturally appropriate and sensitive family planning behaviour change communication materials and counselling messages to address misconceptions about side effects and other barriers to contraceptive use.
3. There is a need to counsel on more contraceptive methods and expand access to the full range of contraceptive methods, including long-acting reversible contraceptives (LARCs), by leveraging both public health facilities and underutilized but preferred service delivery channels such as community health workers, mobile outreach services.
4. Establish better tracking mechanisms community-facility for referrals to ensure continuity of care.
5. Transitioning the model from a pilot phase to a long-term feature of humanitarian response is critical for meeting the family planning needs of women and girls.

References

Santelli, John, Roger Rochat, Kendra Hatfield-Timajchy, Brenda Colley Gilbert, Kathryn Curtis, Rebecca Cabral, Jennifer S. Hirsch, Laura Schieve and Other Members of the Unintended Pregnancy Working Group. 2003. "The measurement and meaning of unintended pregnancy." *Perspectives on Sexual and Reproductive Health* 35(2): 94-101.

Bearak, Jonathan, Anna Popinchalk, Bela Ganatra, Ann-Beth Moller, Özge Tunçalp, Cynthia Beavin, Lorraine Kwok, and Leontine Alkem. 2020. "Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019." *Lancet Global Health* 8: e1152–e1161.

Hubacher, David, Ifigeneia Mavranezouli, and Erin McGinn. 2008. "Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it." *Contraception* 78(1): 73-78.

Klima, Carrie S. 1998. "Unintended pregnancy: Consequences and solutions for a worldwide problem." *Journal of Nurse-Midwifery* 43(6): 483–491.

WHO [World Health Organization]. 2011. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, 6th edition. Geneva: WHO.

Bongaarts, John and Steven W. Sinding. 2011. "Family planning as an economic investment." *SAIS Review* XXXI(2): 35-44.

The Baobab Research Programme Consortium. 2025. "Contraceptive use, intention to use, and method preferences among women in refugee settings in Ethiopia: Evidence Brief." Nairobi: Population Council, Kenya; African Population and Health Research Center; and Population Council, Inc.

The Baobab Research Programme Consortium. 2025. "Linking research to action to address unintended pregnancy in refugee settings in Ethiopia." Nairobi: Population Council, Inc.; Population Council, Kenya; and African Population and Health Research Center.

Singh, Susheela, Gilga Sedgh and Rubina Hussain. 2010. "Unintended pregnancy: worldwide levels, trends and outcomes." *Studies in Family Planning* 41(4):241–250.

Thompson, Jill, Chi-Chi Undie, and Ian Askew. 2014. Access to emergency contraception and safe abortion services for survivors of rape: A review of policies, programmes and country experiences in sub-Saharan Africa. STEP UP Research Report. Nairobi: Population Council. https://knowledgecommons.popcouncil.org/departments_sbsr-rh/267/.

Singh, Susheela, Lisa Remez, Gilda Sedg, Lorraine Kwok, and Tsuyoshi Onda. 2018. *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. New York: Guttmacher Institute.

Marston C, Cleland J: Do unintended pregnancies carried to term lead to adverse outcomes for mother and child? An assessment in five developing countries. Popul Stud. 2003, 57 (1): 77-93. 10.1080/0032472032000061749.

United Nations. 2010. *Millennium Development Goal Report 2010: Trends in Maternal Mortality: 1999-2008*. New York: United Nations.

Shrivastava, Saurabh RamBihariLal and Prateek Saurabh Shrivastava, 2022. "Unintended pregnancy and gender-based violence in settings experiencing humanitarian crisis." *Indian Journal of Health Sciences and Biomedical Research* 15(2): 180-181.

UNFPA. 2022. Risk of sexual violence, unintended pregnancy soars in crisis settings, new report highlights. https://esaro.unfpa.org/en/news/risk-sexual-violence-unintended-pregnancy-soars-crisis-settings-new-report-highlights [Last accessed: April 17, 2023].

Undie, Chi-Chi, Harriet Birungi, Francis Obare, George Odwe, Jane Harriet Namwebya, Paul Orikushaba, Prosmolly Ayebale, William Onen, Fiona Nicholson, Rachel Chisinga-Francis, Peter Netshabako, Anne Katahoire, David Apollo Kazungu, Darlson Kusasira, Zahra Mirghani, and Joanina Karugaba. 2016. "*Effectiveness of a community-based SGBV prevention model in emergency settings in Uganda: Testing the 'Zero Tolerance Village Alliance' intervention*." Nairobi: Population Council. https://knowledgecommons.popcouncil.org/departments_sbsr-rh/643/.

WHO and Johns Hopkins Center for Communication Programs. 2022. Family Planning: A Global Handbook for Providers. Evidence-Based Guidance Developed through Worldwide Collaboration https://fphandbook.org/sites/default/files/WHO-JHU-FPHandbook-2022Ed-v221115a.pdf.

Appendices

Appendix 1: Screening and Monitoring Information Tool

(For Food Distribution Assistance and Refugee Verification Exercise Staff)

Refugee Number_____

Preamble:

Many people do not realize that unplanned pregnancies can lead to all kinds of health problems and other challenges. Because unplanned pregnancies are so common in Nguenyyiel, and because there is help available to avoid this situation, we are now asking every woman about their experience with family planning. Please be assured that your answers to these questions will be kept strictly confidential.

Would you like me to continue? Yes_____ No_____

1. Age [ ] (eligibility: 15-45)
2. Village _____
3. Cluster _____
4. Ranch_____

	Questions	Yes	No
1.	Have you ever heard of family planning?	Skip to #3	Go to #2
2.	Family planning is all about the plans that you make to ensure that you have the number of children you want, when you want them, by using a modern contraceptive method to prevent a pregnancy that you are not prepared for.	Go to #3	
3.	Are you currently using a family planning method to prevent a pregnancy you are not prepared for?	Go to #4	Skip to #5
4.	Are you satisfied with the family planning method that you are currently using?	Skip to #6	Skip to #7
5.	We have some information sessions about family planning going on outside in the tent areas. If you are interested in learning more about how to avoid having a pregnancy that you are not prepared for, I will have a team member accompany	Go to #8	Go to #9

	you there to learn more from one of our nurses. **Would you be interested in learning more about family planning?**		
6.	I'm happy to hear that you are satisfied. We have some information sessions about family planning going on outside in the tent areas. If you ever become dissatisfied with your family planning method, please feel free to visit the tents during our food distribution exercises to speak with one of our nurses about other methods that may work better for you.	**END**	
7.	I'm sorry to hear that you are <u>not</u> satisfied. We have some information sessions about family planning going on outside in the tent areas. If you are interested in learning more about other family planning methods that might be better for you, I will have a team member accompany you there to speak to one of our nurses. **Would you be interested in speaking to one of our nurses about this issue?**	Go to #8	Skip to #10
8.	**<u>Instruction to the screener</u>: Please hand the client over to a designated team member for a warm referral to a family planning nurse.**	**END**	
9.	That's okay. If you ever become interested in learning more about more Family Planning methods to avoid having a pregnancy that you are not prepared for, we will link you to one of our nurses to learn about what might work best for you.	**END**	
10.	That's okay. If you ever change your mind, we will link you to one of our nurses to learn about what method might work better for you.	**END**	