WOMEN'S REFUGEE COMMISSION

Research. Rethink. Resolve.

Global Snapshot of Contraceptive Services across Crisis-Affected Settings

Landscaping Report

January 2021

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

Acknowledgments

This report was authored by Lily Jacobi and Sarah Rich of the Women's Refugee Commission (WRC). Research was conducted by Lily Jacobi, Sara Casey (RAISE Initiative, Columbia University), and Sarah Rich. The report was reviewed by Sara Casey and Sandra Krause, Joanna Kuebler, and Diana Quick of WRC. This report was designed by Erin Worden and Diana Quick of WRC.

In memory of Jennifer Schlecht, who dedicated her career—and her tremendous leadership, commitment, and compassion—to protecting the rights, health, and well-being of girls and women affected by crises around the world.

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Cover photo: Illustration seen in an IRC midwife room in a women-friendly space, Ukhiya refugee camp, Cox's Bazar, Bangladesh, January 2019. © Sara Casey/WRC

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“Because these are humanitarian contexts, many times, we are caught in a debate about whether family planning is lifesaving enough when other health issues are so urgent. But I believe it is. If you ask women in these settings, the same women who have seen their sisters, aunties, or friends die in childbirth, or from unsafe abortion, or struggle through pregnancy during such difficult times, they know sexual and reproductive health services are lifesaving and that the ability to prevent unintended pregnancy is paramount.”

Jennifer Schlecht (1977 - 2019)

From “Women Need and Deserve It” available on Medium

Introduction

Access to contraceptive services is both a fundamental human right and a lifesaving public health intervention.[1] However, the Inter-agency Working Group on Reproductive Health in Crises (IAWG) 2012-2014 Global Evaluation found that the provision of contraceptive services, especially long-acting and permanent methods and emergency contraception, continues to be a gap in humanitarian health funding and programming.[2] For example, contraceptive services made up just 14.9% of sexual and reproductive health (SRH) programming in humanitarian health appeals submitted between 2009 and 2013. In terms of absolute funds received for all SRH components during this period, contraceptive services received the smallest amount.[3]

This inattention not only does a significant disservice to crisis-affected individuals, it undercuts the efficacy of humanitarian assistance across the board. Globally, humanitarian needs are climbing at an unprecedented pace. The United Nations High Commissioner for Refugees (UNHCR) reported that 79.5 million people were forcibly displaced at the end of 2019.[4] In December 2019—prior to the COVID-19 pandemic—the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) estimated that 168 million people would be in need of humanitarian assistance over the course of 2020.[5] Food insecurity is mounting, and the compounding effects of climate change are increasing both the underlying causes of displacement—including natural disasters, resource scarcity, and armed conflict—and vulnerability to shocks.[6] The global COVID-19 pandemic has only amplified the need for humanitarian assistance. It is critical that the international community acts to maximize the impact of humanitarian aid. Investing in contraceptive services fosters resilience, promotes participation in livelihoods and education initiatives, and empowers women and girls to drive recovery efforts in the aftermath of emergencies.

Moreover, providing contraceptive services to crisis-affected communities is a critical opportunity to advance global goals. Numerous sustainable development goals depend on robust, equitable access to comprehensive contraceptive services. Moreover, the goals enumerated by the Family Planning 2020 (FP2020) partnership depend on successfully reaching crisis-affected populations with contraceptive services. As of November 2020, 31 of FP2020's 69 focus countries had UN OCHA humanitarian response plans, flash appeals, or refugee response plans, or were included in regional refugee response plans.[7]

The 2017 Family Planning Summit offered a valuable opportunity for the humanitarian community to make a powerful case for the feasibility and necessity of delivering contraceptive services in crises. Following the summit, a number of actors made significant commitments to accelerate efforts to improve the availability and accessibility of contraceptive services in crises, including the development of the Global Roadmap for Improving Data, Monitoring, and Accountability for Family

1 S. Ahmed, Q. Li, L. Liu, and A.O. Tsui, "Maternal deaths averted by contraceptive use: an analysis of 172 countries," *Lancet*, 2012;380: 111–125. doi:10.1016/S0140-6736(12)60478-4.

2 S.K. Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review," *Conflict and Health*, 2015;9: I1. doi:10.1186/1752-1505-9-S1-I1.

3 M. Tanabe, et al., "Tracking humanitarian funding for reproductive health: a systematic analysis of health and protection proposals from 2002-2013," *Conflict and Health*, 2015;9: S2. doi:10.1186/1752-1505-9-S1-S2.

4 UNHCR, *Global Trends 2019: Forced Displacement in 2019* (2019). https://www.unhcr.org/globaltrends2019/.

5 OCHA, *Global Humanitarian Overview 2020* (2019). https://reliefweb.int/report/world/global-humanitarian-overview-2020-enarfrzh.

6 Lutheran World Relief and IMA World Health, *2019 Early Warning Forecast - Conflict & Climate: Drivers of Disaster* (2019). https://reliefweb.int/report/world/2019-early-warning-forecast-conflict-climate-drivers-disaster.

7 FP2020 focus countries (https://www.familyplanning2020.org/countries) were cross-referenced against plans and appeals at https://reliefweb.int/.

Planning and SRH in Crises and a Bridge Funding Mechanism to facilitate immediate access to supplies at the onset of an emergency.[8]

In 2018, the IAWG released a revision of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, which provides technical and program guidance to field staff, including a revised Minimum Initial Service Package (MISP) for SRH, a minimum set of priority SRH services to be implemented in an emergency.[9] For the first time, the MISP for SRH includes the priority objective of preventing unintended pregnancies, and calls for the availability of a range of contraceptive methods and quality counseling for all affected individuals.

If humanitarian actors are to successfully meet the needs of crisis-affected women and girls—particularly amidst the unprecedented challenge posed by COVID-19—it is critical that stakeholders have access to robust evidence on the state of contraceptive service provision in humanitarian settings, and successful strategies for programming and service delivery.

Accordingly, the Women's Refugee Commission (WRC) undertook a landscaping assessment to evaluate and build the evidence base on barriers, opportunities, and effective strategies to provide the full range of contraceptives, including new contraceptive technologies, to women, girls, and couples affected by crises.

The landscaping assessment comprises a literature review, global contraceptive programming survey of implementing partners in humanitarian settings, key informant interviews (KIIs) with stakeholders across the humanitarian-development nexus, and three case studies in diverse humanitarian settings. This document includes findings from the literature review, contraceptive programming survey, and a series of KIIs to solicit insights on how to sustain and scale contraceptive service delivery programming across transition periods along the preparedness-relief-recovery continuum.

The three case studies were conducted in Cox's Bazar, Bangladesh,[10] Borno State, Nigeria,[11] and Cyclone Idai-affected areas of Mozambique,[12] and findings from each case study are presented in individual reports.

Following the onset of the COVID-19 pandemic, WRC conducted an additional series of KIIs with diverse stakeholders, including representatives of ministries of health and stakeholders in Francophone Africa, to explore the impact of COVID-19 on contraceptive service delivery, and the prioritization of contraceptive and SRH services more broadly in COVID-19 preparedness and response across the humanitarian development nexus. Findings from these KIIs are available in *Disruptions and Adaptations: The Effects of COVID-19 on Contraceptive Services across the Humanitarian-Development Nexus.*[13]

8 Family Planning 2020, *Family Planning Summit 2017 Commitments Summary* (2017). https://www.who.int/pmnch/media/news/2017/fpsummit2017_commitment.pdf.

9 A.M. Foster et al., "The 2018 Inter-agency field manual on reproductive health in humanitarian settings: revising the global standards," *Reproductive Health Matters*, 2017;25: 18–24. doi:10.1080/09688080.2017.1403277.

10 Women's Refugee Commission, *A Clear Case for Need and Demand: Accessing Contraceptive Services for Rohingya Women and Girls in Cox's Bazar* (2019). https://www.womensrefugeecommission.org/research-resources/contraceptive-service-delivery-in-the-refugee-camps-of-cox-s-bazar-bangladesh/.

11 Women's Refugee Commission, *Gap between Supply and Demand for Contraceptive Services in Northeast Nigeria* (2020). https://www.womensrefugeecommission.org/research-resources/contraceptive-services-gap-nigeria/.

12 Women's Refugee Commission, *Opportunities and Challenges for Contraceptive Service Delivery in Cyclone Idai-Affected Areas of Mozambique* (2020). https://www.womensrefugeecommission.org/research-resources/opportunities-challenges-for-contraceptive-service-delivery-in-cyclone-idai-affected-areas-mozambique/.

13 Women's Refugee Commission, *Disruptions and Adaptations: The Effects of COVID-19 on Contraceptive Services across the Humanitarian-Development Nexus* (2020). https://www.womensrefugeecommission.org/research-resources/disruptions-adaptations-effects-covid-19-contraceptive-services-across-humanitarian-development-nexus/.

In November 2020, WRC convened technical stakeholders from a range of settings and organizations to leverage our findings to collaboratively develop actionable recommendations for governments, donors, researchers, advocates, and implementing partners to advance the availability and accessibility of sustainable, good quality contraceptive services across the humanitarian-development nexus.

These recommendations, as well as a synthesis and discussion of key findings from across all components of the landscaping assessment will be available in January 2021.

Literature Review

The first component of the landscaping assessment, the literature review, assesses the current published evidence base for access to, demand for, and need for contraceptives, and contraceptive service delivery in humanitarian settings.

Methods

Researchers searched in peer-reviewed journals and gray literature for quantitative and qualitative data on contraceptive services in humanitarian settings. For the purposes of this literature review, "humanitarian settings" were defined as settings affected by conflict or natural disaster, including protracted crisis settings.

Gray literature was identified using Google and ReliefWeb searches, and by visiting relevant organizations' websites directly. Peer-reviewed literature was identified via the PubMed search engine, using the following search terms:

- Contraceptive (inclusive of contraceptives, contraceptive use, contraceptive services)
- Contraception
- Family planning
- Birth spacing
- Birth limiting
- LARCs (long-acting, reversible contraceptives)
- Removal
- DMPA-SC
- Sayana Press

In combination with the following:

- Humanitarian (inclusive of humanitarian settings, humanitarian emergencies, etc.)
- Displacement
- Crisis
- Conflict
- Disaster

To qualify for inclusion, publications needed to provide data on some aspect of contraceptive services in humanitarian settings, including (but not limited to): the provision and availability of contraceptive services; barriers to contraceptive service delivery; availability of removal services for long-acting reversible contraceptives (LARCs); contraceptive prevalence or use among

affected populations; and specific information on contraceptive service delivery programs and/or interventions. Publications that generally acknowledged the importance of contraceptive or SRH services in humanitarian settings, but lacked specific data on service delivery and/or contraceptive use (e.g., editorials), were excluded. Articles published between 2010 and 2019 were included.

For the purposes of this literature review, researchers categorized the literature as descriptive or programmatic. Programmatic literature included data generated by specific interventions—routine program data, or data generated by program evaluations.

Researchers identified 75 peer-reviewed articles and 22 gray publications for inclusion.

Limitations

Researchers did not systematically assess the quality of the research and/or data; no items were excluded on the basis of quality.

Descriptive literature

Fifty-six peer-reviewed articles and 18 gray publications provided descriptive or qualitative data on contraceptive services in humanitarian settings.

Knowledge and demand

Robust demand for contraceptive services has been documented in diverse humanitarian settings [1–6]. For example, studies in six conflict-affected areas of Sudan, Uganda and the Democratic Republic of the Congo (DRC) found that 43% to 71% of women wanted to delay their next pregnancy or did not want any more children [1]. Moreover, a survey of 420 pregnant Syrian refugee women in Lebanon found that 52.1% did not desire their current pregnancy and nearly three quarters wished to prevent future pregnancies [7]. Surveys conducted in 2014-2015 in four sites hosting refugees and internally displaced persons (IDPs) in Lebanon and Iraq found that 57% of pregnant women and 66.7% of women who delivered in the previous year surveyed reported their pregnancy was unplanned [8].

Knowledge of contraceptive methods varied across settings; researchers working in multiple settings documented a lower knowledge of LARCs as compared to other methods [4,9,10]. Low knowledge or awareness of contraceptive methods can prevent women, and especially adolescent girls, from seeking services in the first place [1,9–16]. Notably, evidence indicates that knowledge of emergency contraception (EC) is extremely low across settings, even where populations reported a reasonably good knowledge of contraceptive methods [2,17–19].

In certain settings researchers have documented generally good knowledge of contraceptive methods [9], particularly where populations had access to SRH services prior to displacement, as in Syria [2,5–7,20,21] or in protracted settings where populations have had at least semi-stable access to health facilities and programming, including outreach and sensitization activities [14]. For example, McGinn et al. reported low knowledge of contraceptive methods in Sudan and DRC, but higher levels of knowledge and use in northern Uganda, where a Marie Stopes International facility had been providing contraceptive services and the country had an overall higher prevalence [1].

In addition to concerns about side effects, misinformation and myths about contraception were commonplace and widespread [2,5,12,16,22–31]. In particular, women and girls reported beliefs that using modern contraceptive methods had the potential to permanently damage their fertility or general health, or compromise the health of babies born after using a modern method.

In some areas, women and girls lacked knowledge about contraception and methods available or were unaware of where to go to obtain these services and accurate information [2,6,11,20,21,32–35].

A 2016 survey of 242 adolescent girls in Bududuram Refugee Camp in Ghana found that although 64.5% had heard of some type of contraceptive method, only 38.5% knew where to obtain a method [32]. When queried about sources of information on contraception, 41.7% cited television, compared to 11.5% who cited health workers.

Adolescents

Multiple studies showed that adolescents coping with the challenges of displacement desired information on sexual health and well-being and preventing pregnancy, and access to SRH services, including contraception[16,22–24,36,37]. In 2012, a comprehensive mapping of SRH programs serving adolescents in humanitarian settings found that despite documenting limited availability of adolescent-focused—or even adolescent-friendly—services, adolescents were enthusiastic contraceptive users, especially when they were able to access contraception in holistic programs that served their diverse needs [36].

Availability

Documented demand notwithstanding, research in diverse settings revealed gaps in the availability of contraceptive services, including adequate method mix. Of 63 health facilities assessed in Burkina Faso (n=28), DRC (n=25), and South Sudan (n=9), only 11 facilities met the quality criteria to be considered functioning contraceptive service delivery points, able to adequately provide intrauterine devices (IUDs), implants, oral contraceptive pills (OCPs), and injectable contraceptives: three hospitals and two health centers in Burkina Faso; one hospital and five health centers in DRC; and none in South Sudan [11]. Providers across settings reported commodity stockouts and lack of training as the main reasons for not providing the service; questionnaires revealed some providers in all countries had negative attitudes toward providing women with contraceptive services without spousal consent.

Of 38 health facilities mandated to provide contraceptive services in six conflict-affected areas in Uganda, Sudan, and DRC, from zero to just over one third had the trained staff, equipment and supplies to provide all mandated methods at the time of the assessment [1].

In 2011 and 2012, an assessment of the state of contraceptive services in refugee sites in Bangladesh, Djibouti, Jordan, Kenya, Malaysia, and Uganda found that facilities in four sites offered at least three short-acting methods (often including condoms), while facilities in Jordan and Uganda did not [9]. Moreover, the facilities in Jordan, Djibouti and Uganda did not provide any long-acting or permanent methods. Failure to ensure that a variety of methods, including LARCs, is available and accessible can deter potential users of contraception. For example, a study conducted with Syrian women in Jordan revealed that women were not using contraception because their preferred method—specifically, the IUD—was not available [7]. In settings where facilities are not able to provide an adequate method mix, referral systems should be in place to link clients with higher-level providers and facilities able to meet their needs. However, evidence indicates that referral systems may not always be in place, or may not function effectively [9].

Emergency contraception (EC)

EC is a critical component of comprehensive contraceptive services, but dedicated EC products continue to be only intermittently available in humanitarian settings. Where it is available, it is often limited to post-rape care [9]. A 2017 assessment in Nakivale Refugee Camp, Uganda, documented inconsistent availability of EC, and another conducted 2010-2011 in Mae Sot, Thailand, found that EC pills (ECPs) were not available in commercial pharmacies or mobile clinics, and that clinics reported inconsistent availability of supplies [18,30]. While EC is a critical component of care for survivors of sexual violence, it is also an important resource for all women and girls seeking to avert unintended pregnancies.

Knowledge of EC was extremely low across settings, even where knowledge of other modern methods was relatively good. Prior knowledge of emergency contraception is essential for its effective use: women and girls must be aware that EC exists, understand the timing in which it can be used after unprotected sex, and know where to obtain it.

Across refugee settings in six countries, awareness of EC was uniformly low, ranging from 0.2% of respondents in Djibouti to 4.7% in Uganda. In terms of availability, only Djibouti and Kenya had EC supplies in stock in all assessed facilities [9].

Because EC is scarce, providers may lack accurate information on its appropriate use. For example, Hobstetter et al. reported that one organization operating in Mae Sot, Thailand, stopped offering ECPs because they were concerned that migrant women were using it too frequently [18]. Organizations feared it would be culturally inappropriate, and some providers expressed concern that it would be misused if it were too "widely available," especially by adolescents.

A research brief on EC provision in contraceptive programs in DRC, Pakistan, Rwanda, Somalia, Syria, and Yemen in 2019 reported a number of provider misconceptions, including about the window of efficacy and the frequency with which it can be used [38]. Per the report, "[the] majority of providers questioned in Pakistan and Somalia believed that EC can lead to promiscuity in society, while the majority of providers in DRC, Rwanda, and Syria disagreed, and providers from Yemen were evenly split." It is critical that improving the availability of dedicated EC products is accompanied by evidence-based training and, where necessary, values clarification exercises.

Sayana Press (DMPA-SC)

Some crisis-affected countries are in the process of registering DMPA-SC, a sub-cutaneous injectable contraceptive method, but nothing specific to delivering DMPA-SC in humanitarian settings has yet been published. Several relevant organizations have indicated in conversation with WRC staff that they intend to begin providing DMPA-SC in selected crisis-affected locations in the near future.

Barriers to contraceptive use

Crisis-affected populations may confront extensive, deeply entrenched obstacles to accessing contraceptive services; this is particularly true for vulnerable populations, including adolescents and persons with disabilities. Notably, many barriers are similar to those women and girls face in stable settings, but they may be exacerbated in emergencies. Although the specific barriers depend on the humanitarian setting in question, several key themes emerged across the literature.

Stigma and negative attitudes

Women and girls in multiple settings reported opposition to contraception. This included religious reasons for not using contraceptive services, particularly modern contraceptive methods [14,22–25,27,39,40]. In many cases, women described opposition by their partner as a barrier to use [2,12,14,16,24,27,28,40]. In several settings, negative attitudes and stigma toward the use of contraceptive services were reported in communities [2,13,16,18,22,27–29,31,36,39]. In focus group discussions with Somali communities in Nairobi, one man reportedly said, "If you decide to use [contraceptive services]…the society will abuse you, you will be stigmatized and they will tell you that you are adopting another culture instead of your own" [25]. Notably, programs designed to engage male partners and religious or community leaders have proven successful in building community support for contraceptive services programming and increasing uptake of services [9,26,40].

Distance, transportation, and cost

In addition to insecurity, [18,31] women and girls who expressed the desire to use contraception

cited prohibitive costs,[2,5–7,13,20,29–31,41] long distances,[7,13,20,24,31,36] and a lack of accessible or affordable transportation [7,20,24,41] as reasons they were not able to do so.

Quality of care

Participants across studies also noted other potentially prohibitive issues with health facilities, including inconvenient hours,[22,24] long wait times,[22,41] poor sanitation,[37,41] and inadequate privacy,[22,24,37] and with the quality of services provided; common concerns about quality of care included inadequate counseling, providers compromising clients' confidentiality, and a lack of staff or insufficient staff to meet the community's needs—leading to long wait times and crowding, and further compromising privacy and confidentiality [22,27,31,37,41]. Language barriers [27,42] as well as a dearth of female providers [20], can also deter women and girls from seeking services.

Crisis-affected individuals in multiple settings reported experiencing poor or discriminatory treatment by health workers due to their nationality, ethnicity, or religion, or their status as a refugee or displaced person [5,7,12,27]. Health workers may also possess negative attitudes toward the provision of contraceptive services, particularly for adolescents, unmarried women and girls, and women seeking contraception without the presence or permission of their partner [6,11,13,18,31,36].

Provider knowledge, attitudes, and skills

Providers may also have incorrect or inaccurate information about modern contraceptive methods, particularly LARCs and EC [18,26,29]. For example, Huber et al. found widespread misinformation and inaccurate beliefs about modern contraceptives among providers in Afghanistan, including beliefs that: "modern contraceptives cause infertility; injectable contraceptives reduce breast milk and should not be used postpartum until menstruation; women who work hard or have six or more children will expel an intrauterine device; and progestin-only pills can be used interchangeably with combined pills" [26].

In many cases providers may possess supportive and positive attitudes toward the provision of contraception but lack the skills and confidence to deliver services. Providers in multiple settings reported receiving infrequent training and expressed the need and desire for additional opportunities to build their skills and confidence [6,22,24,29,37,43]. A lack of skilled providers is particularly detrimental to the availability of LARCs, the provision of which—as previously noted—is imperative to achieve an adequate method mix. Notably, specific searches of both academic and gray literature found no specific data on the availability or accessibility of LARC removal services in humanitarian settings.

Marginalized populations

In outlining the barriers that impede the ability of crisis-affected populations to access contraceptive services, it is critical to note that these challenges are magnified and multiplied for members of marginalized groups, including adolescents and persons with disabilities. Although there is a growing body of research on the SRH needs of adolescents in humanitarian settings, there is little evidence on the needs of persons with disabilities, and even less on programming that can meet those needs. One 2015 article documented very low knowledge of contraceptive methods among persons with disabilities, and of SRH more broadly. Additionally, the authors reported hearing anecdotal reports that persons with disabilities were being forcibly administered contraceptives in Kenya [15].

Supplies and commodities

Finally, challenges with supply chain management and commodity security continue to plague contraceptive services programs in humanitarian settings. Researchers documented insufficient or inconsistent availability of supplies and equipment required to provide contraceptive services in numerous health facilities across settings [1,11,18,22,30,31,36,43]. Stockouts of different contraceptive methods, and of Inter-agency Emergency Reproductive Health kits, were

documented or reported in multiple settings [6,11,24,25,29,36,37]. Poor data collection on supply chains and stocks further impedes the ability of programs to forecast appropriately and procure supplies on a regular and sustainable basis [36]. Supplies-related issues are exacerbated where products are not registered in-country, as is sometimes the case with ECPs [17]. Additionally, Nara et al. documented theft of EC products from facilities by staff [30].

Programmatic literature

There is clear and compelling evidence that women and girls in humanitarian settings demand access to contraceptive services. There is, moreover, substantial documentation of the many factors that complicate or impede this access. However, there is a lack of robust data on effective interventions to implement and improve contraceptive services in these settings. Although this is not unique to contraceptive services, or even SRH services—a 2017 systematic review identified a critical need to expand and strengthen the evidence base for effective humanitarian health interventions—it impedes the ability of organizations to secure funding for contraceptive services programming and scale up service delivery [44].

We identified 22 publications—19 peer-reviewed articles and four gray publications—that present service delivery and/or evaluation data from contraceptive service delivery programs in humanitarian settings.

A number of articles report program data and/or high quality data from comprehensive evaluations of robust, multi-prong contraceptive services programs implemented by service delivery organizations, including CARE, the International Rescue Committee (IRC), and Save the Children, in collaboration with the RAISE Initiative at Columbia University and often in partnership with state actors.

Several articles reported data from contraceptive service delivery programs providing a broad method mix in multiple countries that focused on quality of care [40,45–58].[14] These programs supported primarily Ministries of Health to improve clinical and counseling skills, commodity availability and security, community mobilization, and monitoring and evaluation [59]. Several also addressed post-abortion care (PAC), including post-abortion contraceptive uptake [54,56,57]. Good quality service delivery was essential for securing community buy-in and improving contraceptive uptake. These programs demonstrated that it is feasible to provide good quality contraceptive services, including a range of methods, in crisis-affected settings.

For example, one program in Chad, DRC, Djibouti, Mali, and Pakistan, successfully reached 52,616 new users of modern contraceptive methods between July 2011 and December 2013, 61% of whom selected LARCs [47,48]. Another reported that "contraceptive use and coverage has increased across programs in 13 countries," with the majority of protection attributed to implants (37%) and IUDs (27%) [51]. Fifty-three percent of clients in IRC programs in Chad, Pakistan, DRC, and Myanmar selected LARCs. Even amidst the acute insecurity, active conflict, and targeted attacks on health facilities in Yemen, contraceptive services continued: 44,572 clients started a method from March 2015 to July 2018 [58]. Of these, 57.8% of clients selected OCPs, 18.9% selected injectables, 20.4% selected IUDs, and 2.9% selected implants—compared to 73.5% of clients selecting OCPs prior to the launch of the program.

Robust data collection, monitoring, and evaluation allowed these programs to identify challenges, implement solutions, and document improvements [49,50]. For example, in facilities with low uptake of IUDs, and low uptake of contraception more generally, researchers conducted qualitative research with clients and non-users of contraception to investigate decision-making around method choice, and identified misinformation about IUDs. After implementing program changes, one program found that the average monthly number of clients starting a contraceptive method, per facility increased by 64% [49].

14 J. Bruce, "Fundamental elements of the quality of care: a simple framework," *Stud Fam Plann*. 1990;21: 61–91.

One article reported on the use of mobile outreach teams and health center strengthening to improve contraceptive uptake. Mobile health services can facilitate access to very isolated populations, or populations in transit, and improve service availability in settings with extremely limited infrastructure. Analysis of baseline and endline surveys revealed substantial improvements in contraceptive use from 7.1% at baseline to 22.6% at endline; unmet need for contraceptives decreased 16.4% [53].

Multiple papers documented the efficacy of community- and home-based contraceptive delivery mechanisms, and of engaging communities in program implementation more broadly [26,60–62]. One reported on the use of community health workers to distribute free contraceptives in rural Afghanistan; contraceptive use increased from 16% to 26%; injectables saw the greatest increase [26]. The project addressed widespread misinformation about modern methods of contraception by distributing updated information, education, communication (IEC) materials and engaging religious leaders and women's health committees directly to build community support.

Finally, two publications assessed the efficacy of financial incentives—subsidies and vouchers, respectively. Raheel et al.'s 2012 article evaluated the efficacy of health subsidies on contraceptive uptake among Afghan refugee women residing in Pakistan. The subsidies enabled women to receive a range of health services at no or very low cost, including contraceptive services. The subsidies had a clear and positive impact on knowledge, attitudes, and practices toward contraceptive use: 90% of women who received subsidies reported knowledge of contraception versus 45% in the group who did not receive subsidies, and current contraceptive use among the group of women who received subsidies was 54.5%, compared to 24.9% in the group that did not [63].

Boddam-Whetham et al.'s 2016 article examines the ability of voucher programs to facilitate access to services and increase contraceptive uptake. Between April 2013 and April 2015, approximately 56,000 vouchers were distributed in Yemen. By September of 2015, 12,000 vouchers were redeemed; 1,135 were redeemed for long-acting and permanent methods, 38% higher than projected. In Pakistan, field workers distributed nearly 84,000 vouchers across 13 districts in three provinces; 87% of vouchers distributed were redeemed, and 92% of clients redeeming vouchers selected an IUD. The voucher program supported health facilities to remain operational, provided clinical training opportunities, and ensured they would remain functional moving forward into recovery while facilitating access to contraceptive services [64].

Gaps in the literature

Of the 21 publications providing contraceptive service delivery and/or evaluation data from programs in humanitarian settings, ten mention or discuss training providers on removals of LARCs [40,46–50,52,53,58,64]. One publication did not detail the methods provided [63], and one program did not include LARCs [34]. One additional publication mentioned removals in the context of client concerns regarding LARCs [56]. Notably, Ho and Wheeler 2018 addressed the importance of building information about method removal into counseling to dispel misinformation about the appropriate use of LARCs [49]. However, there is little data available about clients returning to have their methods removed and facilities' ability to effectively meet this need [47].

Global Contraceptive Programming Survey

The global contraceptive programming survey was designed to capture a snapshot of contraceptive service delivery across humanitarian settings.

Methods

The global contraceptive programming survey was administered to service delivery organizations operating in humanitarian settings around the world using the online platform Kobo. Respondents were asked about their provision of contraceptive methods, including IUDs, implants, permanent methods, OCPs, injectables, condoms, and EC. They were also asked to provide information about stockouts in the past three months, and the availability of removal services for LARCs. Respondents were also asked about the accessibility of services for specific populations, including unmarried women and girls and persons with disabilities, and for information on commodities and supply chain management.

Respondents were recruited using purposive sampling, with the goal of achieving as broad a sample as possible. Researchers contacted implementing organizations directly, and information on the survey and how to participate was circulated using list servs for humanitarian health professionals to recruit participants representing additional organizations.

Data collection was from November 2018 through January 2019. Survey data were analyzed using SPSS. Data were stored on secure, password-protected devices. The survey instrument can be reviewed in full in annex A [pg. 43].

Limitations

These data should not be treated as a complete picture of the current state of contraceptive programming in humanitarian settings. It is likely that some organizations providing contraceptive services to crisis-affected populations or in emergencies—especially local and community-based organizations—are not represented in this survey. Additionally, in many cases, respondents were not able to provide complete data on their contraceptive programming.

For the purposes of analysis, the relatively small samples sizes—consider, for example, the three programs in Latin America and the Caribbean—limit the ability to determine statistical significance and/or identify meaningful trends in the data with confidence. It is essential that stakeholders, including donors and implementing partners, continue to invest in robust data collection and research on contraceptive services in humanitarian settings.

Notably, data collection and analysis took place prior to the onset of COVID-19. Given the documentation available thus far on the impact of COVID-19 on humanitarian health programming, including SRH programs, it is likely that the state of contraceptive programming in humanitarian settings has been similarly impacted, and may no longer reflect the data presented.

Profile of survey respondents

The survey received 56 submissions from 20 service delivery organizations implementing contraceptive programming in humanitarian settings—seven international nongovernmental organizations (INGOs), 12 national or regional nongovernmental organizations (NGOs), and one United Nations agency—UNFPA—representing 84 programs across 42 countries and territories. INGO responses were primarily submitted by headquarters staff.

Figure 1: Countries Represented*

*Respondents reported contraceptive programs in countries shaded navy; Tonga is not pictured.

It was possible for one country to include multiple humanitarian settings or sites where programming was being implemented.

Table 1: Type of organization, by region

	East and South Asia/ the Pacific (n=21)	Middle East/ North Africa (n=23)	Sub-saharan Africa (n=37)	Latin America/Caribbean (n=3)	Total (N=84) N (%)
INGO (10)	19 (91%)	11 (48%)	28 (76%)	2	60 (71%)
National/regional INGO (12)	2 (10%)	9 (39%)	0	1	12 (14%)
UNFPA	0	3 (13%)	9 (24%)	0	12 (14%)

The majority of programs across all regions were implemented by INGOs. UNFPA implemented 14% of the programs represented in the survey—13% of programs in the Middle East and North Africa and 24% of programs in Sub-Saharan Africa. National or regional NGOs implemented 14% of programs captured in the survey.

Distribution of programs

Programs were relatively evenly distributed across types of settings, with more programs operating in camp and rural settings: 54% of programs operated in camps versus 39% in non-camp settings, and 67% of programs operated in rural settings versus 54% in urban settings. It is important to note that programs may operate in more than one type of setting in a given country, so percentages do not add up to 100.

Table 2: Programs by type of setting, emergency, and population served (N=84)*

	Total (N=84) n (%)*
Type of setting	
Camp	45 (54%)
Non-camp	33 (39%)
Urban	45 (54%)
Rural	56 (67%)
Type of humanitarian emergency	
Acute emergency	42 (50%)
Post-acute emergency	64 (76%)
Type of populations served	
Refugee	43 (51%)
Internally displaced persons (IDPs)	55 (66%)
Host communities	72 (86%)
Number of health facilities supported/program (*n=79*)	
Fewer than 10	30 (38%)
10-19	19 (24%)
20 or more	30 (38%)

*Respondents could indicate more than one type per country so percentages do not add up to 100. Missing data for five programs.

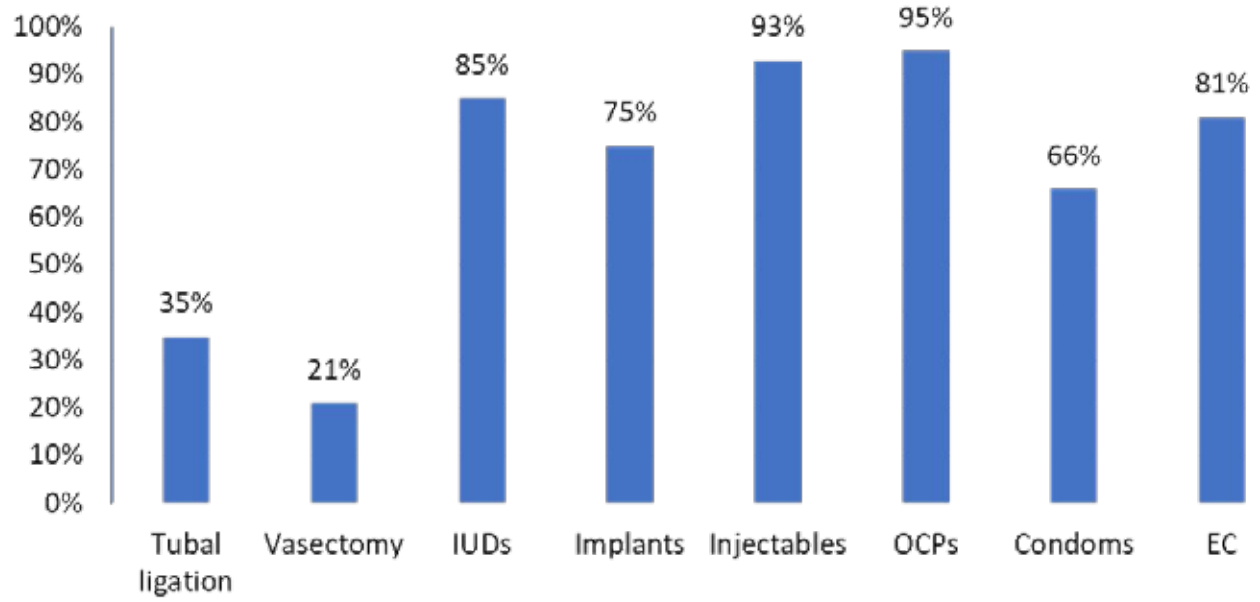
Fifty percent of programs were operating in acute emergencies, and 76% in post-acute emergency settings. Fifty-one percent of programs served refugees, compared to 66% and 86% serving internally displaced persons and host communities, respectively.

The size of programs—in terms of the number of health facilities supported in country—varied. Of the 79 programs that responded to this question, 38% supported fewer than 10 facilities in country, 24% supported 10-19 facilities, and 38% supported 20 facilities or more.

Contraceptive service delivery

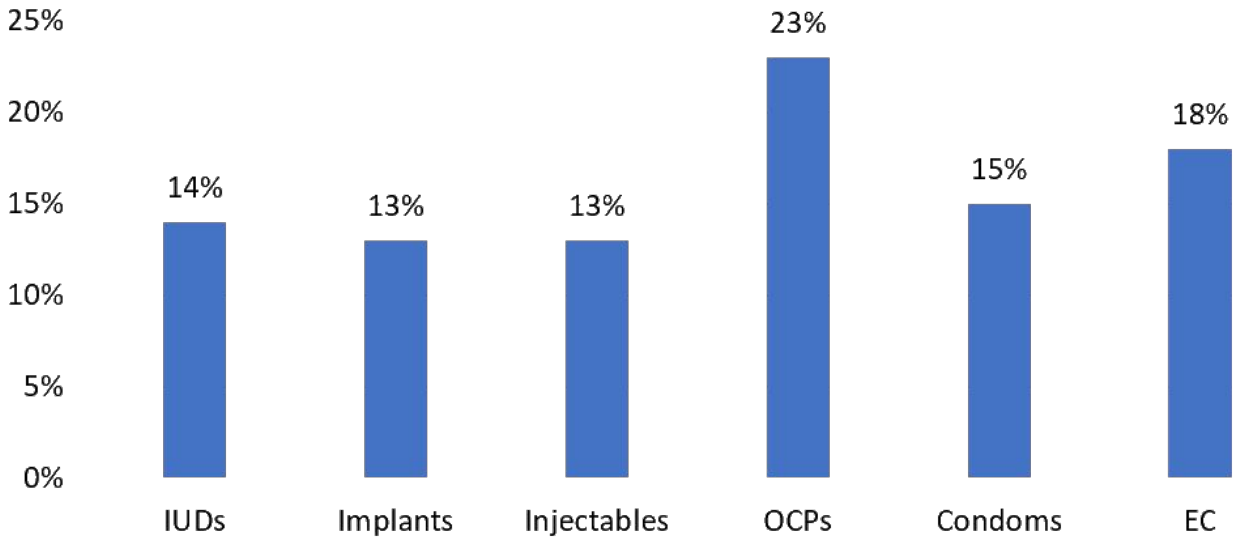
Oral contraceptive pills and injectables were available in more than 90% of programs (Figure 2). IUDs and implants were somewhat less available than these short-acting methods, but still widely available, in 85% and 75% of programs, respectively. Emergency contraceptives were available in 81% of programs, while only 66% of country programs reported providing condoms in all or some service delivery points. Service delivery points (SDPs) included health facilities, mobile health units, etc.

Figure 2: Percentage of programs providing the method in all/some SDPs (N=84)



Stockouts appeared to pose challenges across programs and methods, ranging from 23% of country programs reporting stockouts of OCPs to 13% for implants and injectables (Figure 3).

Figure 3: Percentage of programs reporting a stockout in 3 months preceding survey submission by method



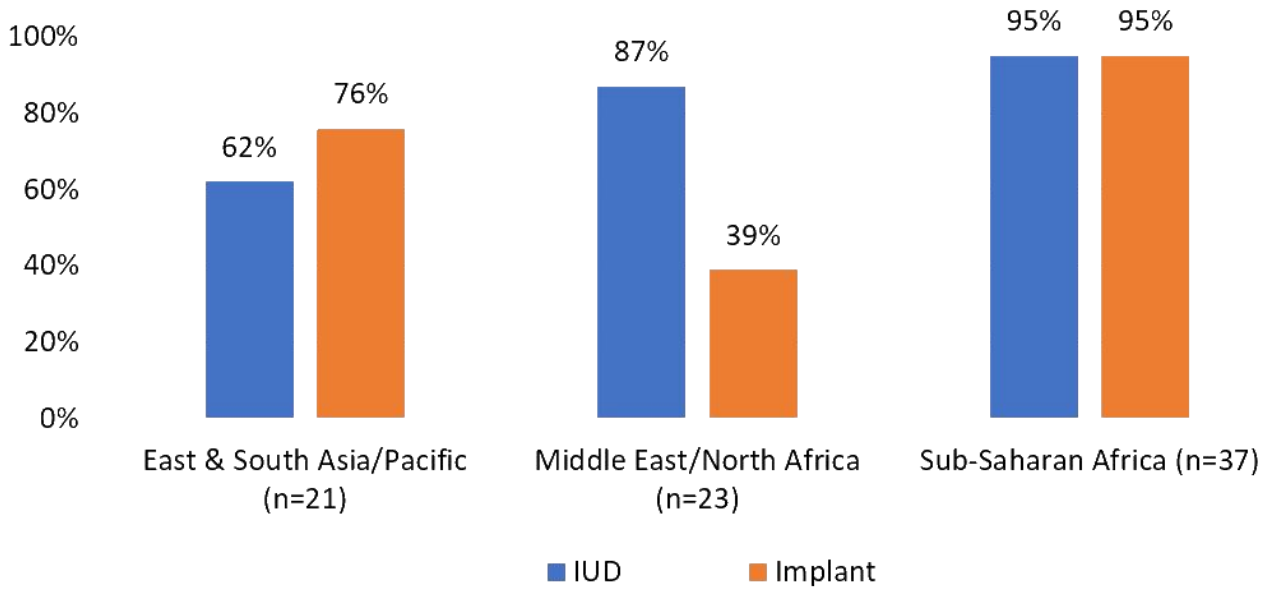
However, it is important to note that many respondents indicated that they did not know about the occurrence of stockouts – ranging from 7% for condoms to 21% for IUDs and 25% for EC. It is therefore possible that the occurrence of stockouts was higher than is reflected in the data.

Contraceptive methods by region

In conducting analysis, we examined data on the availability of methods by region, of humanitarian setting, and type of population served, but did not observe sufficiently significant differences in the data to include methods by type of population served.

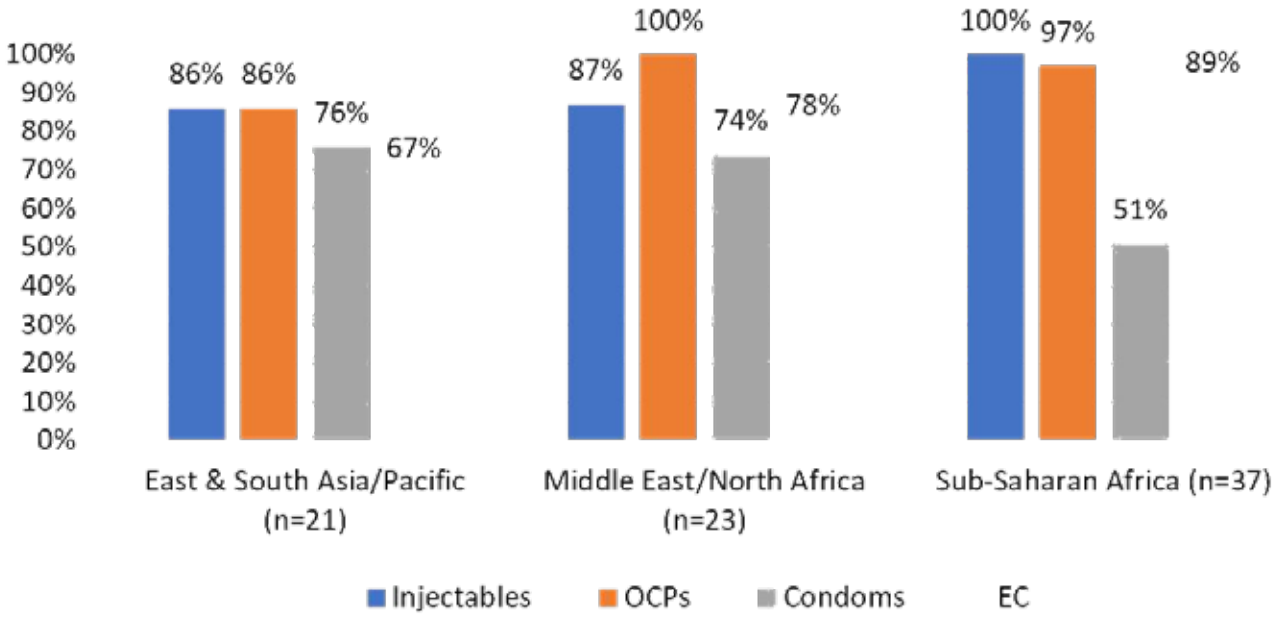
Across regions, the provision of IUDs ranged from 62% of programs in East & South Asia and the Pacific, to 95% in Sub-Saharan Africa (Figure 4). The provision of implants ranged from 39% of programs in the Middle East and North Africa, to 95% in Sub-Saharan Africa. All three programs in Latin America and the Caribbean provided IUDs and implants. Given the small sample size it is not included in this graph. Removals were widely available across programs providing LARCs.

Figure 4: Percentage of programs providing LARCs by region (N=84)



Pills and injectables were widely available across all three regions (Figure 5). The provision of condoms ranged from 51% of programs in Sub-Saharan Africa to 76% in East and South Asia and the Pacific. The provision of EC ranged from 67% of programs in East and South Asia and the Pacific to 89% of programs in Sub-Saharan Africa. All three programs in Latin America and the Caribbean provided all of these short-acting methods.

Figure 5: Percentage of programs providing short-acting methods by region (N=84)

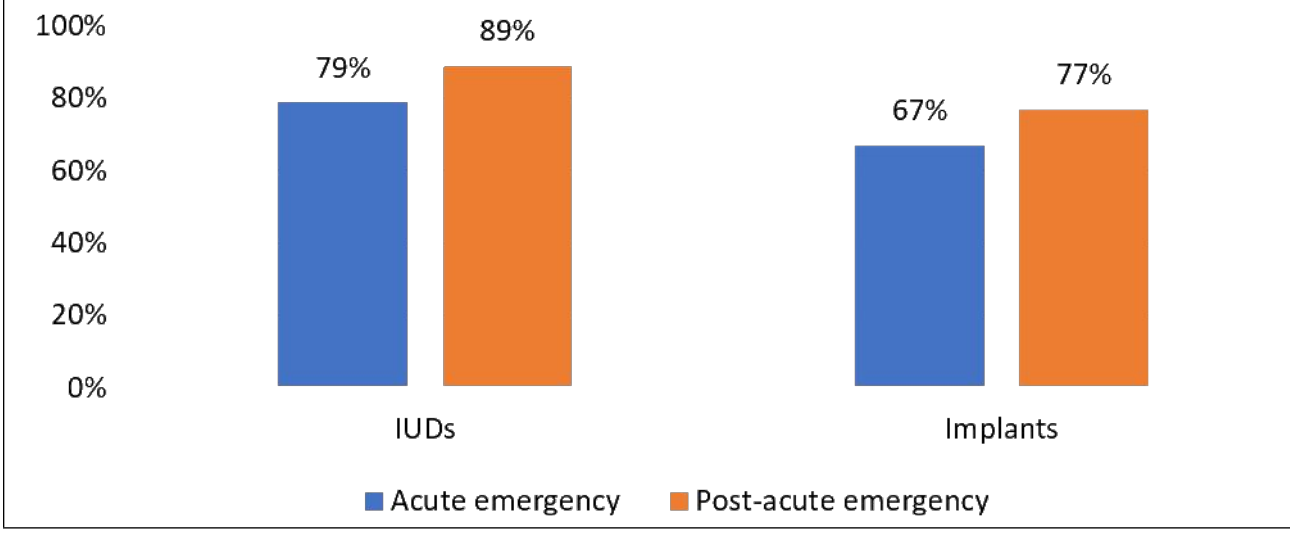


Contraceptive methods by phase of emergency

This section details the availability of methods by phase of emergency—specifically, acute and post-acute settings. Forty-two programs were operating in acute emergency settings, and 64 programs were operating in post-acute settings. Notably, some programs reported they operated in both acute and post-acute areas of the same country.

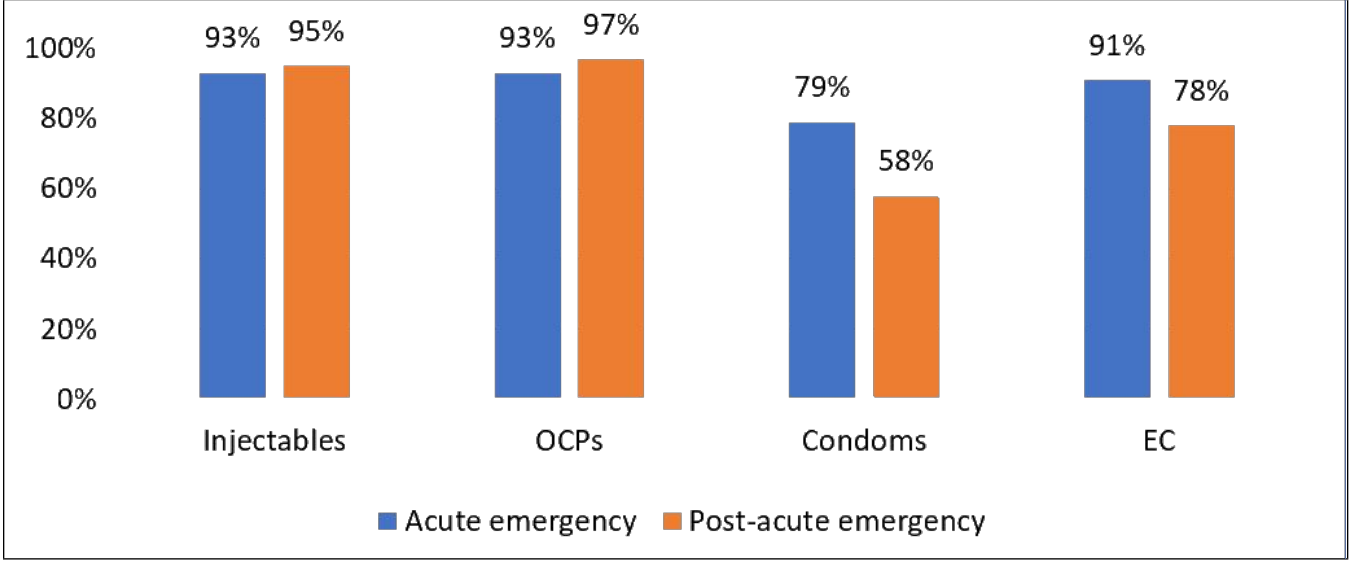
Most (79%) programs operating in acute emergencies provided IUDs, compared to 89% of programs operating in post-acute emergencies (Figure 6). Sixty-seven percent of programs operating in acute emergencies provided implants, compared to 77% in post-acute emergencies. Fewer programs provided permanent methods in acute emergencies (24%) and post-acute emergency settings (42%).

Figure 6: Percentage of programs operating in acute (n=42) and post-acute (n=64) settings providing LARCs



High percentages of programs operating in acute emergencies and in post-acute emergencies provided injectables and OCPs (Figure 7). Seventy-nine percent of programs operating in acute emergencies provided condoms, while 58% provided condoms in post-acute settings. Ninety-one percent provided EC in acute settings and 78% provided EC in post-acute emergencies.

Figure 7: Percentage of programs operating in acute (n=42) and post-acute (n=64) settings providing short-acting methods



Supplies and commodities

This section details how implementing organizations procured contraceptive supplies and commodities by region and by type of humanitarian setting, and common causes of delays by region.

In conducting analysis, researchers examined this data by region, type of humanitarian setting, and type of population served, but did not observe significant differences in the data by type of population, or common causes of delay by type of humanitarian setting or type of population served.

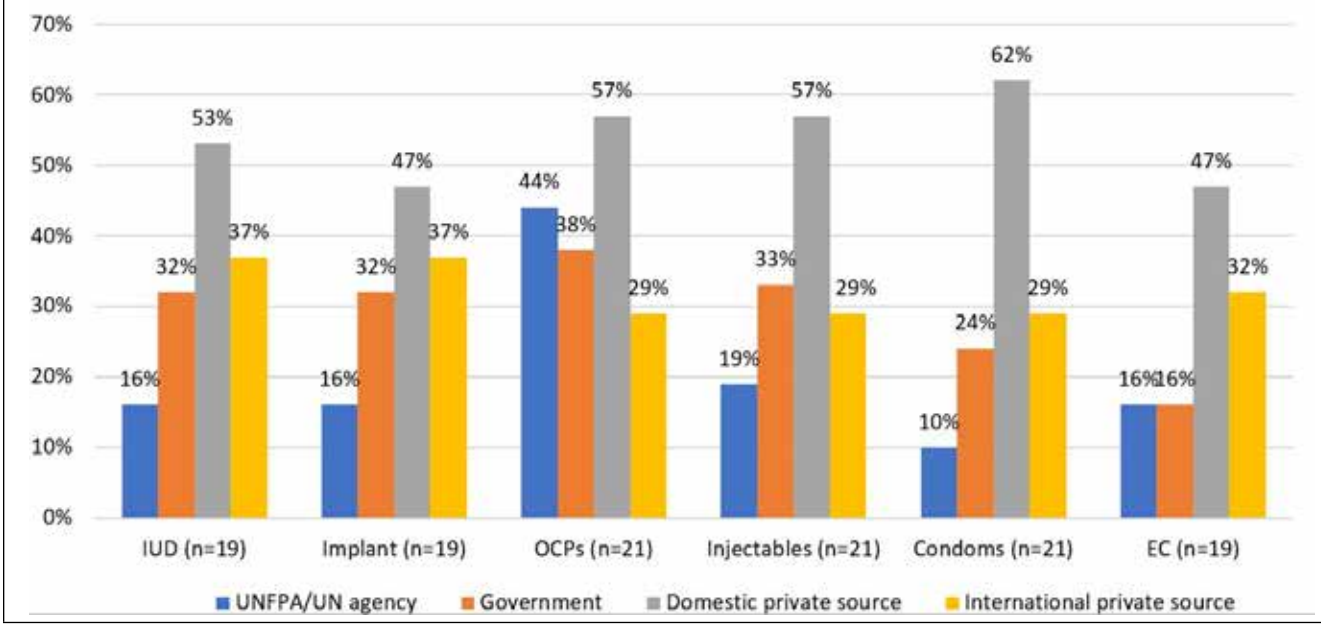
Programs could identify multiple sources for supplies and commodities.

Procurement by region

In the East and South Asia/Pacific region, approximately half of respondents reported that their programs procure contraceptive commodities from domestic private sources—including local pharmacies—ranging from 47% for implants and EC to 62% for condoms (Figure 8). Additionally, around a third of programs reported procuring methods from international private sources.

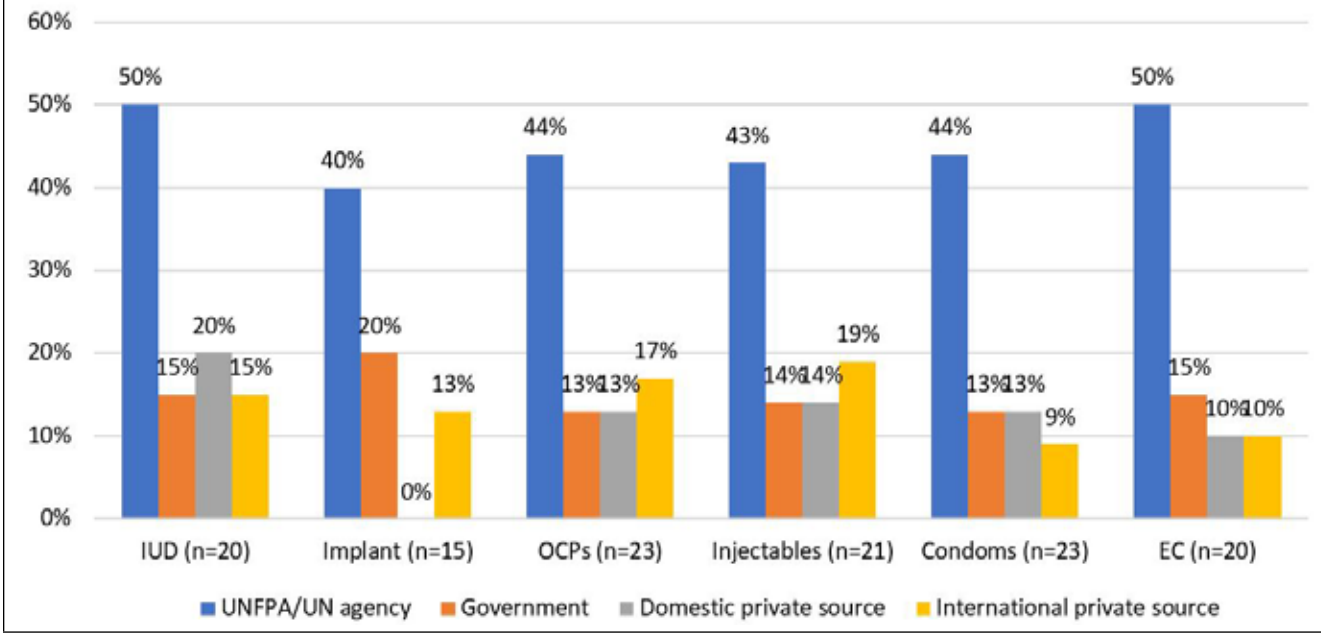
Procurement from the government and UNFPA/UN agencies varied somewhat by method, with 44% reporting UNFPA/UN agencies as the source of OCPs compared to 10-20% for other methods. Approximately one-third of respondents reported procuring IUDs, implants, OCPs, and injectables from the government, but the rates were somewhat lower for condoms and EC.

Figure 8: Procurement by method in East and South Asia/Pacific



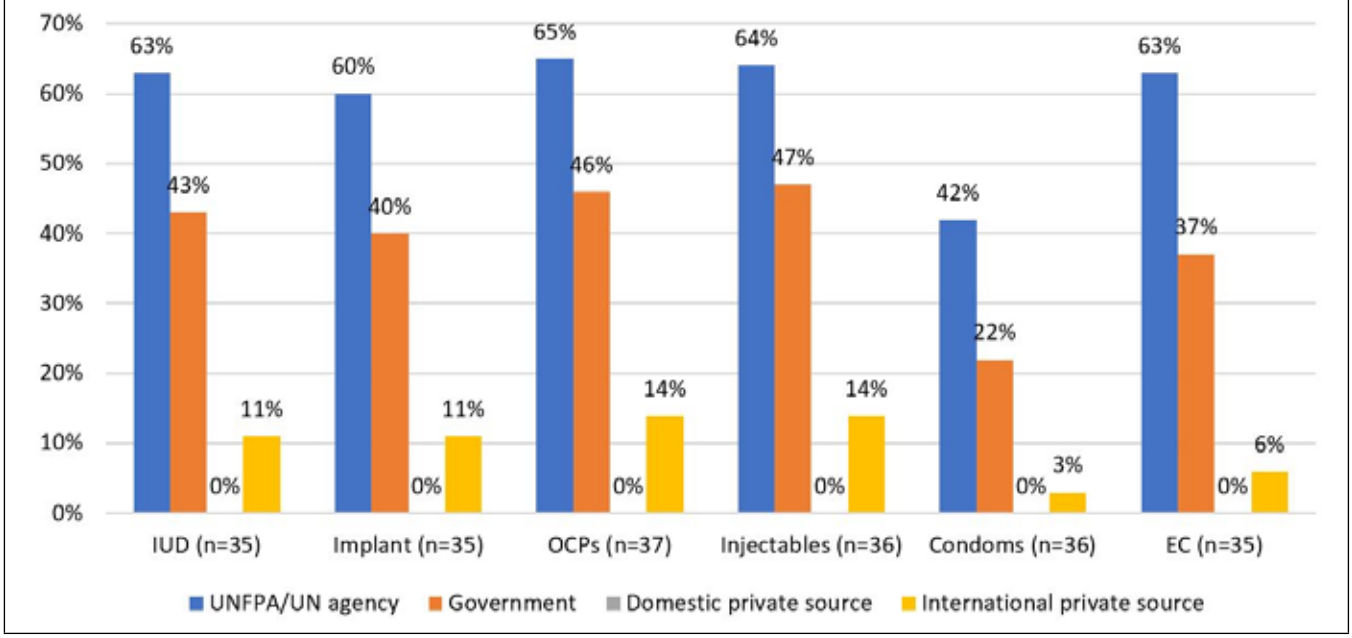
In the Middle East/North Africa region, respondents reported procuring all methods most frequently from UNFPA/UN agencies (Figure 9). The proportion of respondents whose programs procure contraceptive commodities from the government ranged from 13% (OCPs and condoms) to 20% (implants). Procurement from private sources (domestic and international combined) was highest for IUDs (35%) and lowest for implants (13%).

Figure 9: Procurement by method in the Middle East/North Africa



In the Sub-Saharan Africa region, more than half of respondents reported procuring contraceptive commodities, except condoms, from UNFPA/UN agencies (Figure 10). The government was the next most common source of procurement in Sub-Saharan Africa across all methods, ranging from 22% for condoms to 47% for injectables. No respondents reported procuring any contraceptive commodities from domestic private sources in sub-Saharan Africa.

Figure 10: Procurement by method in Sub-Saharan Africa



Latin America and the Caribbean (n=3)

While the sample size for the LAC region was small (n=3), programs reporting procurement of all methods across domestic private sources, government, and UNFPA/UN agencies. Only IUDs and condoms were procured from international private sources.

Procurement of contraceptive methods by Inter-Agency Reproductive Health Kits by region

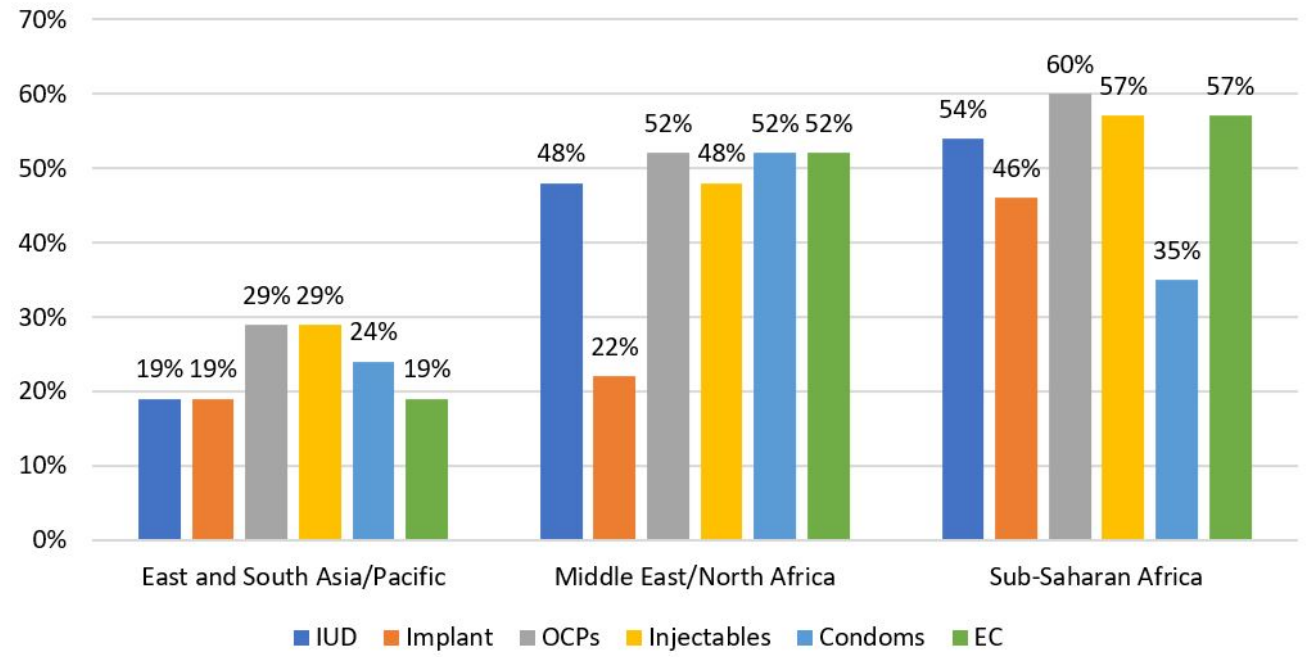
The Inter-Agency Reproductive Health (IARH) Kits are prepackaged kits, managed by UNFPA, designed to be used to implement the MISP for SRH at the onset of an emergency. Programs were asked to indicate if they used IARH kits to obtain the needed supplies and commodities to provide the contraceptive methods offered in their program.

With the exception of condoms (35%), programs in Sub-Saharan Africa reported the highest frequency of using IARH kits (46–60%) to procure the supplies and commodities required to provide IUDs, implants, OCPs, injectables, and EC (Figure 11).

Programs in the Middle East and North America reported a similarly high frequency (48–52%) of procuring contraceptive commodities and supplies via IARH kits, excepting implants at 22%.

Across methods, programs in South and East Asia and the Pacific reported procuring supplies and commodities via IARH kit at much lower frequencies (19–24%).

Figure 11: Procument methods in IARH kits by region



In Latin America and the Caribbean, one of three programs reported obtaining all methods through IARH kits.

Common delays by region

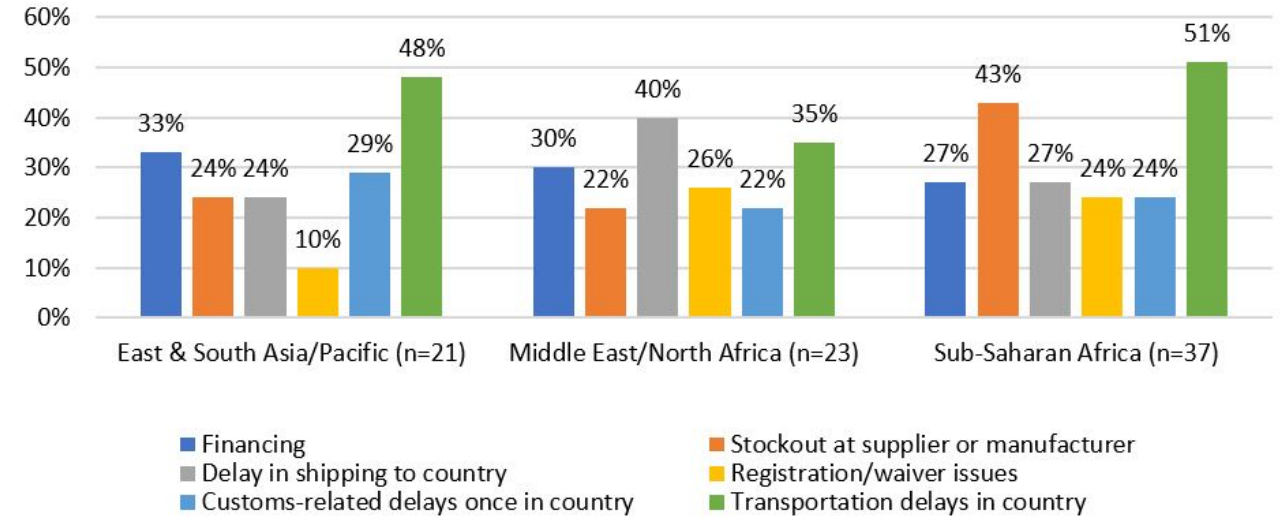
Respondents also reported the common sources of delays in the supply chain they experienced in their programs; programs could select multiple sources of delays (Figure 12).

In East and South Asia and the Pacific, the most frequently reported cause of delay was transportation delays in country (48%), followed by delays related to financing (33%).

In the Middle East and North Africa, the most commonly reported delay was delays in shipping products to the country (40%), followed by challenges due to transportation delays in country (35%) and delays due to financing (30%).

Among programs in Sub-Saharan Africa, the most frequently reported challenge was due to transportation delays in country (51%), followed by stockouts at the supplier or manufacturer (43%).

Figure 12: Common delays in obtaining supplies by region



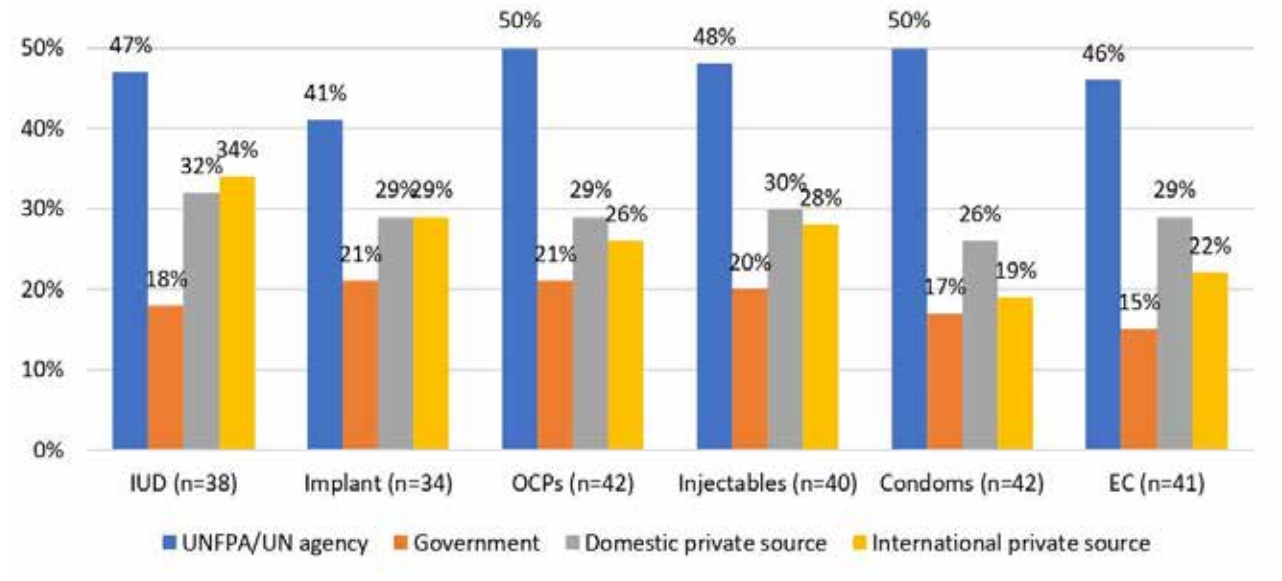
In Latin America and the Caribbean (n=3), each program reported different delays, including financing, stockout at the supplier or manufacturer, issues with product registrations or waivers, and transportation delays in country.

Procurement by phase of emergency

The survey also included questions on how programs obtained contraceptive supplies and commodities by phase of emergency.

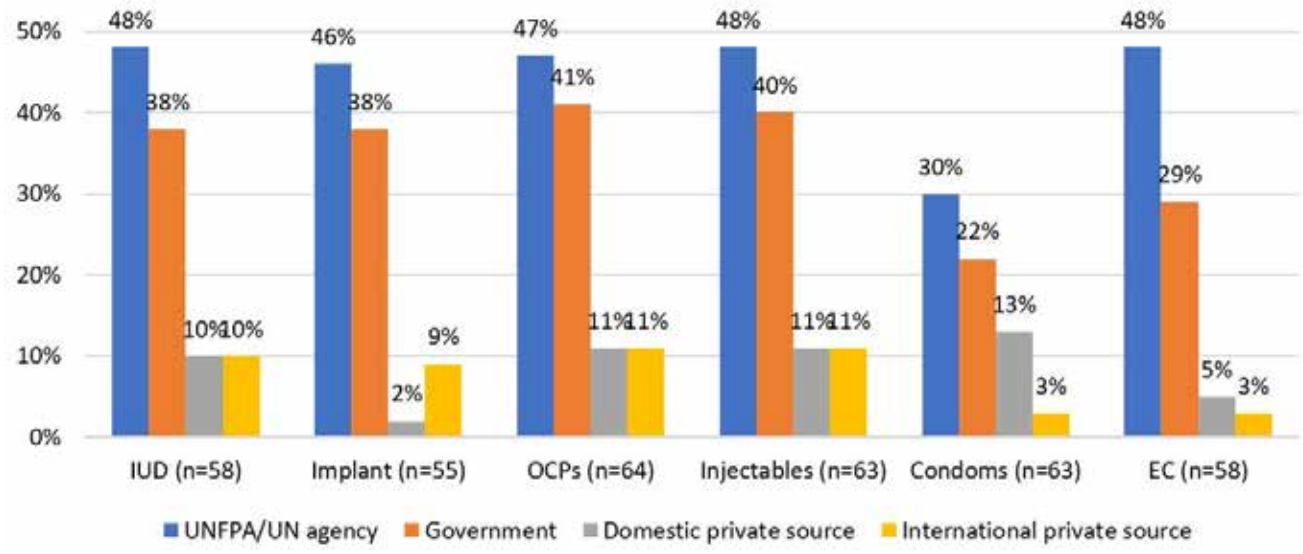
In acute emergency settings, across all methods, a plurality of programs reported procurement of contraceptive commodities from UNFPA/UN agencies, ranging from 41% for implants to 50% for OCPs and condoms (Figure 13). Private sources—both domestic and international—were also used across methods. Programs report procuring from governments in acute emergencies at the lowest rates across all methods, ranging from 15% for EC to 21% for implants and OCPs.

Figure 13: Procurement by method in acute settings



In post-acute settings, nearly half of respondents reported procurement of all methods except condoms from UNFPA/UN agencies (Figure 14). A greater proportion of respondents reported procurement of methods from the government than in acute settings, ranging from 22% for condoms to 41% for OCPs, while a smaller proportion of respondents reported procuring methods from the private sector, ranging from 11% for implants to 22% for OCPs and injectables when domestic and international private sources are combined.

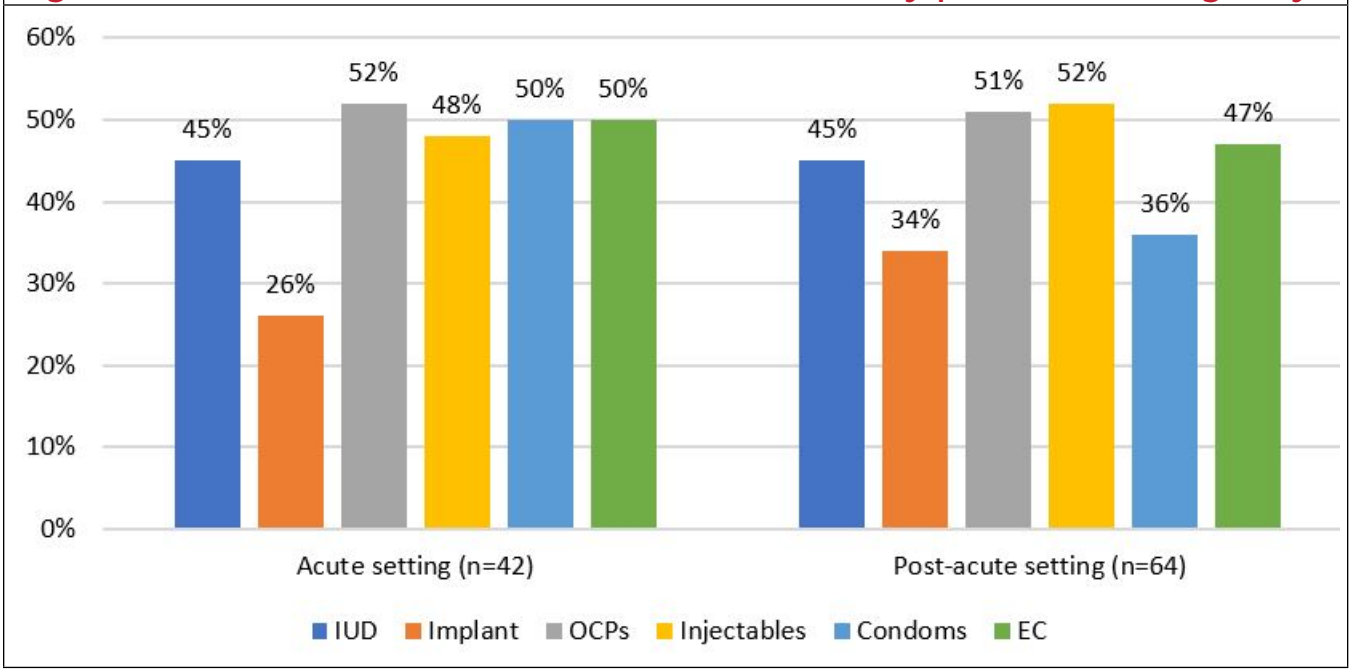
Figure 14: Procurement by method in post-acute settings



Procurement of contraceptive methods by Inter-Agency Reproductive Health Kits by phase of emergency

Little difference was observed in use of the IARH kits across the phases of the emergency (Figure 15). In both acute and post-acute settings, approximately half of contraceptive commodities across most methods were obtained from the IARH Kits, reflecting long-term use of the kits to obtain contraceptive commodities. Implants were somewhat less likely to be obtained from the kits in both types of settings. In post-acute settings, a smaller proportion of respondents reported obtaining condoms from the kits as compared to acute settings.

Figure 15: Procurement of methods in IARH its by phase of emergency



Accessibility and availability

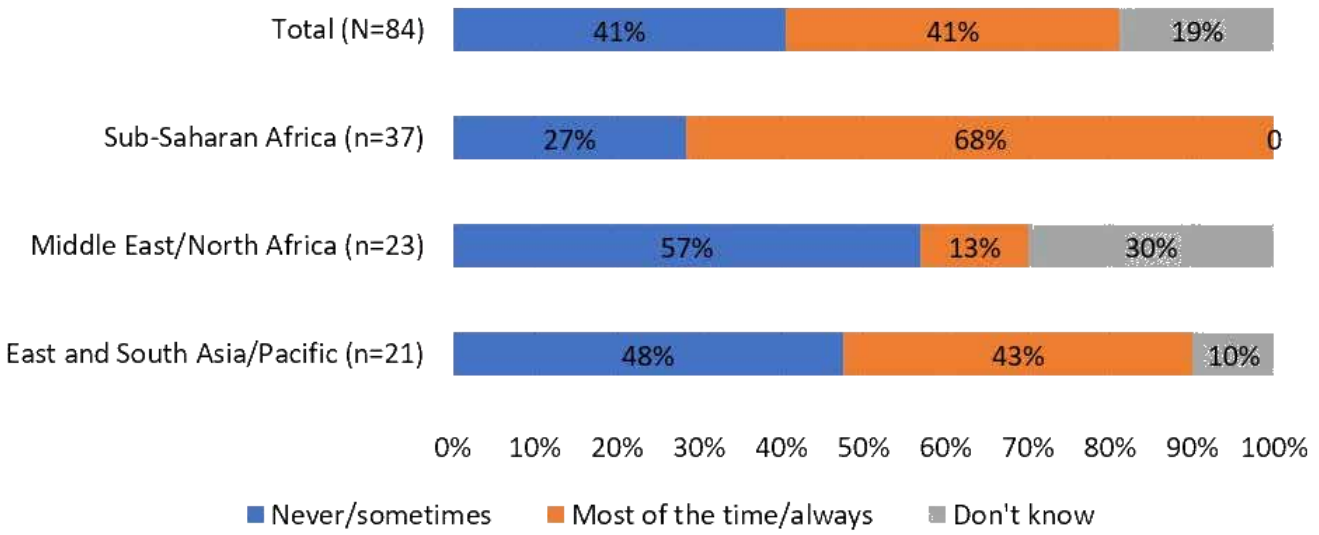
Survey respondents were asked to assess the accessibility and availability of contraceptive services to specific populations in the settings where their programs operated: never/sometimes or most of the time/always.

Unmarried adolescent girls

Across all regions, 41% of programs reported that contraceptive services were never/sometimes available for unmarried adolescent girls, and 41% reported most of the time/always (Figure 16).

There was regional variation. Sixty-eight percent of respondents in Sub-Saharan Africa reported contraceptive services to be available to unmarried adolescent girls most of the time/always compared to 13% of respondents in the Middle East and North Africa and 42% in East and South Asia and the Pacific. In Latin America and the Caribbean, one reported never/sometimes and two reported most of the time/always.

Figure 16: Contraceptive services are accessible and available to unmarried adolescent girls.

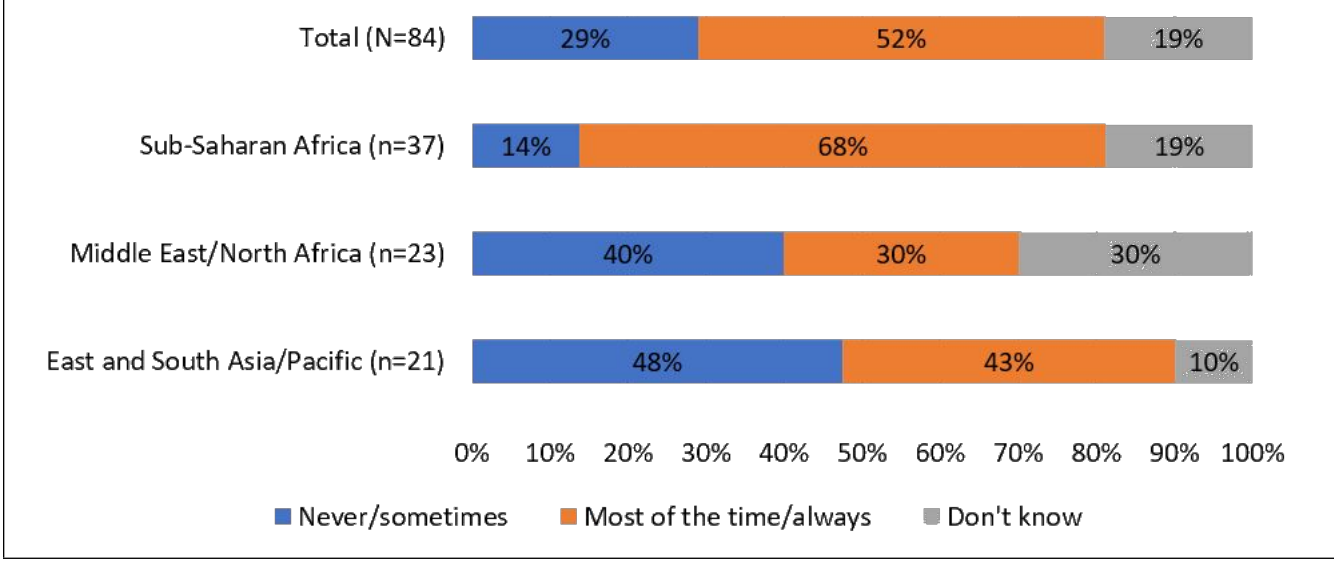


Unmarried women

Across regions, 29% reported contraceptive services were never/sometimes accessible and available to unmarried women and girls, compared to 52% reporting most of the time/always (Figure 17).

In the Middle East and North Africa and East and South Asia and the Pacific, 30% and 43%, respectively, reported contraceptive services are accessible and available to unmarried women most of the time/always. This percentage was greater in Sub-Saharan Africa at 68%; in Latin America and the Caribbean, three (n=3) reported most of the time/always.

Figure 17: Contraceptive services are accessible and available to unmarried women.

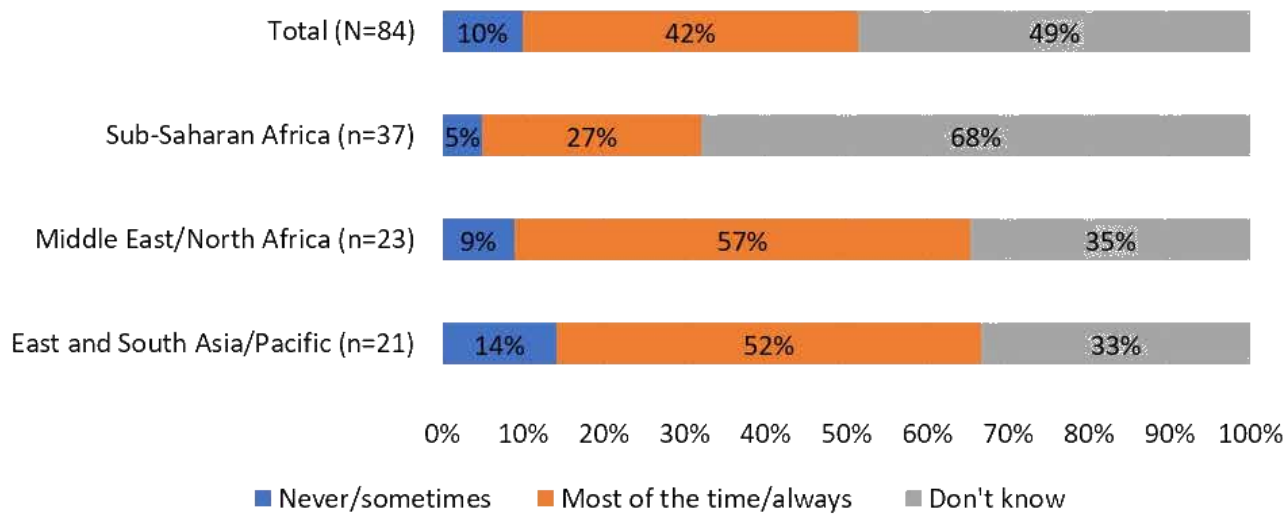


Persons with disabilities

Notably, across regions, higher percentages reported not knowing about the accessibility and availability of contraceptive services for persons with disabilities as compared to unmarried women and adolescent girls: 68% in Sub-Saharan Africa, 35% in the Middle East and North Africa, 33% in East and South Asia and the Pacific, and one program in Latin America and the Caribbean (Figure 18).

However, also across regions, higher percentages reported contraceptive services to be accessible and available to persons with disabilities most of the time/always ranging from 57% in the Middle East and North Africa to 27% in Sub-Saharan Africa. In Latin America and the Caribbean (n=3), one reported never/sometimes and one reported most of the time/always.

Figure 18: Contraceptive services are accessible and available to persons with disabilities.

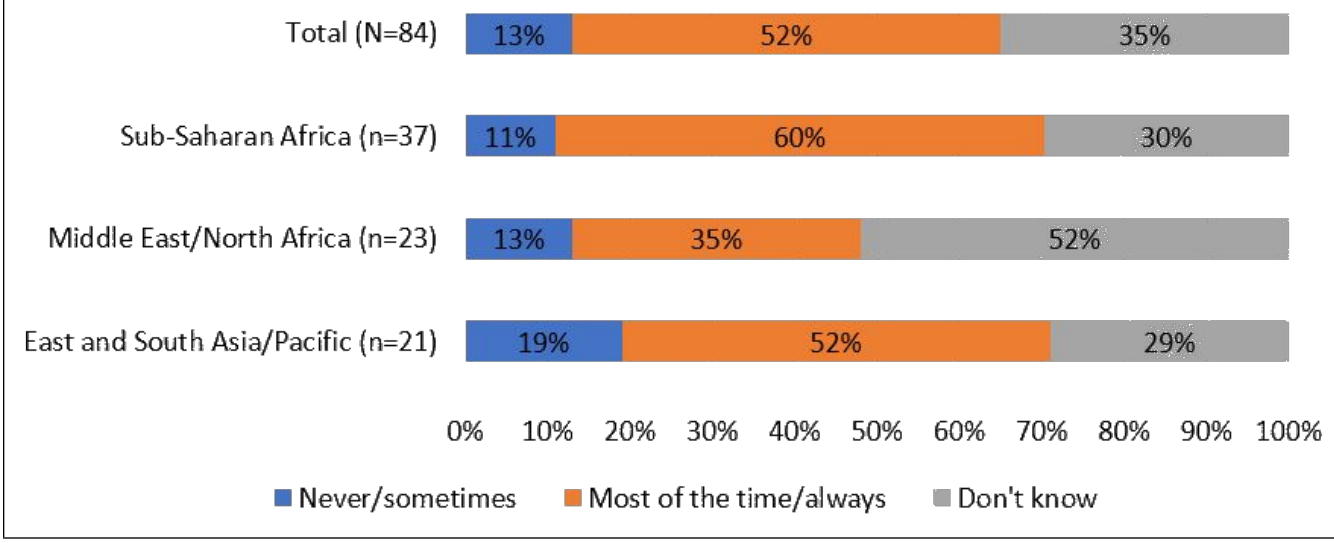


Persons engaging in transactional sex

Higher percentages also reported not knowing about the accessibility and availability of contraceptive services for persons engaging in transactional sex, ranging from 52% in the Middle East and North Africa to 29% in East and South Asia and the Pacific (Figure 19).

Across regions, higher percentages reported contraceptive services were accessible and available most of the time/always for persons engaged in transactional sex, ranging from 60% in Sub-Saharan Africa to 35% in the Middle East and North Africa. In Latin America and the Caribbean, three (n=3) reported most of the time/always.

Figure 19: Contraceptive services are accessible and available to persons engaging in transactional sex

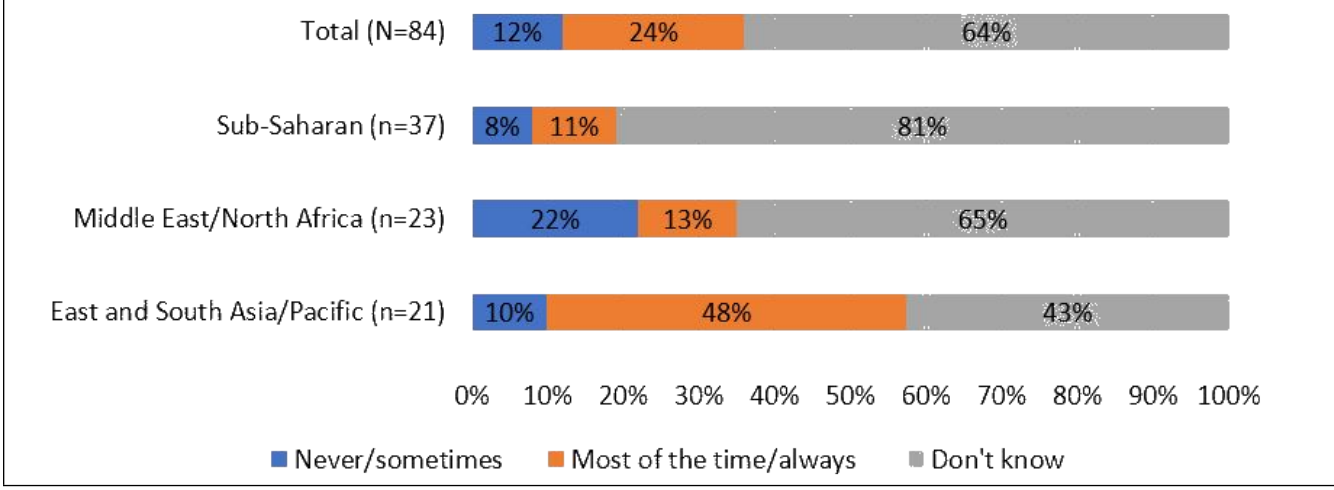


Lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) and gender non-conforming people

Finally, high percentages of programs across regions also reported not knowing about the accessibility availability of contraceptive services for LGBTQI and gender non-conforming people, with a total of 64% of programs reporting to not know (Figure 20).

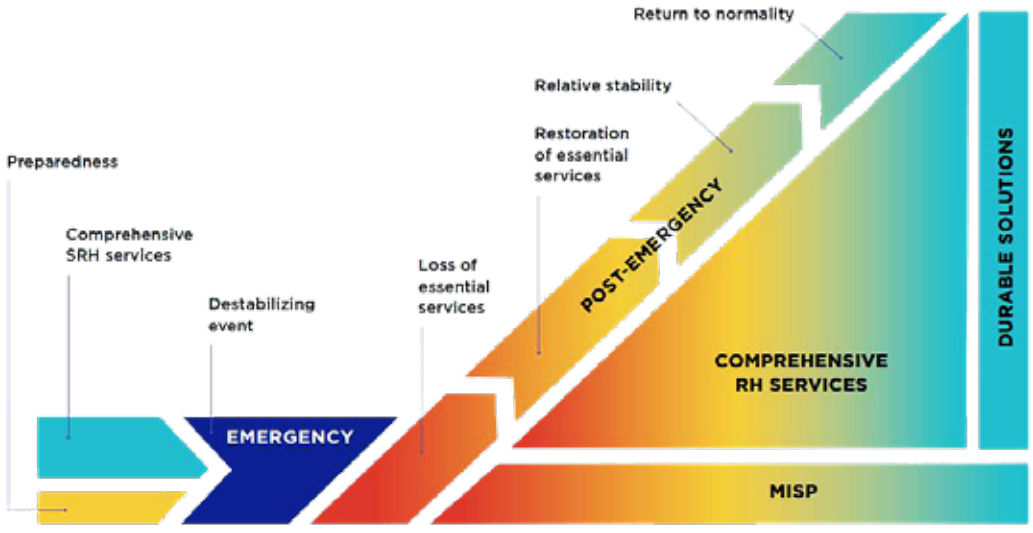
Across all regions, 12% reported that contraceptive services were never/sometimes available to LGBTQI and gender non-conforming people, and 24% reported most of the time/always. Percentages reporting that contraceptive services were never/sometimes available ranged from 8% in Sub-Saharan Africa to 22% in the Middle East and North Africa. Percentages reporting that services were available most of the time/always ranged from 11% in Sub-Saharan Africa to 48% in East and South Asia and the Pacific; all three programs in Latin America and the Caribbean indicated that contraceptive services are available most of the time/always for LGBTQI and gender non-conforming people.

Figure 20: Contraceptive services are accessible and available to persons LGTBQI and gender non-conforming persons.



Key Informant Interviews

Based on input from key stakeholders, the key informant interviews (KIIs) were designed to elicit more information about contraceptive programming in transition periods across the preparedness to relief to recovery continuum, including challenges and strategies to successfully scale and transition programs as situations stabilize or evolve.



Graphic Credit: Family Planning 2020, (2020), "A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies" adapted from IAWG (2018), Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.

Transition periods include (1) the onset of an acute emergency, when a humanitarian response is launched and (2) the transition to an ongoing, or protracted, situation or recovery following stabilization. These periods, particularly the transition to protracted or recovering settings, often pose challenges for partners implementing contraceptive service delivery programs, and consequently can threaten the availability of services and access for affected populations.

It is critical to gain a more robust understanding of how these transitions unfold, how implementing partners operate therein to transition their programming, challenges faced, and strategies for success that may inform peer organizations and other key stakeholders, including donors and governments.

These transition periods also offer a potential window for humanitarian and development actors to work together and strengthen coordination across the nexus, particularly to support a setting to move more quickly into sustainable recovery. Accordingly, we included a number of questions focused on challenges and successes in coordinating and collaborating across the humanitarian-development nexus.

Methods

Researchers conducted 14 interviews with 17 respondents from eight organizations: one United Nations agency, six international NGOs, and one national NGO. Eight respondents were based in the field, and nine were headquarters staff. Ten respondents represented humanitarian organizations or humanitarian teams at dual function organizations (organizations that conduct both humanitarian and development programming). Seven respondents represented development organizations or teams.

Respondents were identified using purposive and, subsequently, snowballing sampling. All organizations and respondents included were delivering or supporting the availability and accessibility of SRH, including contraceptive, services in some capacity in the setting(s) where they worked. Upon securing verbal informed consent, interviews were recorded; recordings were deleted after transcription, and all identifying information removed. All materials were stored on secure, password-protected devices. Transcripts were coded and analyzed using NVivo 12 Plus.

The format of the interview varied by the respondent, their role, and their organization. Many respondents were asked to provide specific examples of settings and programs in which transitions were particularly successful, and particularly challenging.

Limitations

Researchers did not attempt to reach saturation, and findings may not be representative of all organizations' experiences providing or supporting contraceptive programming in transition periods across the preparedness to relief to recovery continuum.

Factors affecting contraceptive programs in transitions between stability and emergency

Over the course of interviews, a number of themes emerged around the factors that affect the processes and outcomes of transition periods across the preparedness to relief to recovery continuum.

Context or setting in which the emergency occurs

First, respondents emphasized that contextual factors—namely, the existing strengths, capacities, and structures in-country—significantly impact transitions into and out of an acute humanitarian response.

The strength of a country's health system, its resources, and its existing national capacity—including preparedness planning—have a significant impact on the success of a humanitarian response and its ability to move along the continuum of relief to recovery.

When queried about settings in which transitions have been particularly successful, multiple respondents cited the Rohingya response in Bangladesh, pointing to the existence of a national preparedness plan and the government's active role in the response. Another respondent cited Colombia's strong health infrastructure and well-established civil society organizations and local partners as facilitating their successful response for Venezuelan refugees. Other organizations attributed success in these countries to ongoing development programming in-country that facilitated their ability to respond quickly when crises erupted, and transition to providing a comprehensive package of SRH services at scale.

One organization working in refugee camps in Rwanda attributed its successful scale-up of a complete package of quality SRH services to the strong national health system, the government's investment in monitoring and supervision, and its national family planning policy. The health facilities in the camp are under the authority of the Ministry of Health (MOH), and the health response is led by government authorities, with support from humanitarian actors. In the immediate aftermath of the refugee influx in Rwanda in April 2015, SRH services were limited to obstetric care. However, the respondent's organization successfully integrated family planning in its SRH and primary health services and conducted targeted community outreach, reaching a reported contraceptive

prevalence of 30% among the refugee population. The organization addressed initial difficulties with consistent supplies by integrating into the national supply chain.

Respondents cited particular challenges in areas with cyclical and protracted violence where national capacity and infrastructure, including in the health system, have been compromised. In these cases, organizations must expend more time and resources to establish basic service provision, and may be forced to establish independent or parallel systems. It is, for example, more challenging to scale up a program, expand the available services, and increase the number of supported service delivery points in the absence of a functioning national supply chain.

Coordination among partners in a response

Multiple respondents spoke about the existence of an effective coordination mechanism for health actors as critical to successful transitions. Respondents described successful coordination mechanisms as those that met regularly, engaged local authorities and partners, and supported implementing partners to coordinate their programming to maximize the efficacy of the response.

One respondent provided an example from DRC in which the MOH and partners established a permanent, multisectoral committee at the provincial level to coordinate service provision and advocacy activities for contraception. The committee supports actors to identify gaps in service delivery and leverage capacity; for example, identifying trained providers to facilitate trainings for other organizations. The committee also successfully advocated for the inclusion of a dedicated line item for contraceptive services in the annual provincial budget. The respondent anticipates that this committee will support the continuation of contraceptive programming, even after international actors have left the area.

Strong coordination across sectors was also cited by one respondent as being critical to her organization's ability to continue providing contraceptive services in a development program in an increasingly insecure environment. In that environment, armed groups were hostile to actors addressing SRH. By coordinating with partners from different sectors, including nutrition and agriculture, and developing innovative service delivery mechanisms, the program was able to continue providing contraceptive services while minimizing the risk to women and providers.

Coordination was also discussed in relation to capacity strengthening for local actors, and to collaboration between humanitarian and development actors (see below).

Funding

Funding was cited in all key informant interviews as a determining factor in the success or failure of a program to effectively transition across different points in the humanitarian response cycle. Sustained, long-term funding, or dedicated funding for the transition phase, was instrumental to successful program transitions in diverse settings. Respondents cited the success and benefit of longer funding cycles, and having funding earmarked for phasing out and handing over programs to local partners.

Challenges

Multi-year funding: Multiple respondents emphasized the importance of multi-year funding cycles, particularly in settings with longstanding conflict, noting that one- to two-year funding cycles do not reflect geopolitical realities in many countries, where some degree of instability and insecurity persist for long periods of time. Another respondent cautioned that in these settings, short-term

funding cycles also risk greater inefficiency: "When the humanitarian funding dried up, [humanitarian organizations] closed shop and left…they sold all the assets…[and then] four months or six months down the line, they had to come back because the emergency happened again. All the assets were gone. You have to start from scratch, and this costs more money…[it is important] to think long-term, instead of short-term only."

One respondent stated that a multi-year funding cycle ensured that high quality family planning services were available because "…you need at least two years to…roll out a family planning package with all the interventions so that when you leave after two years, it can be sustained. [That] includes training healthcare providers, addressing gender and social norms, working on the supply chain, and working on data collection." Another respondent described a setting with protracted conflict as "a testament to the difference that sustained funding can make," noting that the organization had seen significant increases in contraceptive prevalence in the areas where they are working, despite major instability.

Notably, one informant expressed that more stable countries have an advantage when securing funding as compared to their fragile counterparts. Donors may feel more comfortable making long-term investments in a historically stable setting, and these countries may be eligible for additional funding mechanisms.

One respondent referenced a setting in which the organization received dedicated funding for the phase-out period of a project; during this time, the organization will hand over responsibility for program activities to local government and other local partners.

Funding cessations: Conversely, multiple respondents reported abrupt closures of programming when funding ended. Across humanitarian settings and sectors, actors struggle with funding in the long term—it is well documented that in the immediate aftermath of a crisis, funding floods in, but tends to subsequently taper off. Funding for SRH services is no exception. Respondents described a number of negative outcomes, ranging from the complete cessation of program activities to reduced hours, reduced services, or closing of some health facilities. The implications for affected populations are serious, with multiple respondents expressing frustration that programs create demand and reliance on services that are then not guaranteed.

One respondent reported struggling to impress upon donors the importance of funding the phase-out and handover period of a project, and to secure funding extensions when needed to do so. Multiple respondents mentioned incidents in which shifts in donor priorities negatively impacted programming or forced the cessation of program activities.

Even in cases in which additional funding is anticipated, there are often lags between when grants are awarded and funding is available. One respondent noted that these funding gaps can force cuts to the program.

Finally, several respondents described challenges that arise when donor classifications or definitions—namely, whether or not a setting qualifies as a humanitarian setting—conflicts with what implementing partners see on the ground; one respondent reported that a country program would be closing in the future due to a loss in funding for this reason.

Solutions

Respondents discussed a range of strategies to secure and sustain funding.

Shifting funds at the onset of a new crisis: Depending on the size and structure of the organization, respondents reported that organizations may shift funds internally in the event of a shortfall.

In certain settings and circumstances, respondents from dual-function organizations described country offices shifting funding from ongoing or development programming to a humanitarian response in the event of an emergency. Respondents were clear that this was not true of all funds, and that it may require approval from a donor. One respondent from a dual-function organization reported that, in at least some crisis-prone countries, standard operating guidelines permitted country directors to redirect funding within the country office in the event of an emergency, at least until larger humanitarian funding mechanisms were activated. No respondents discussed shifting funds from humanitarian programming to development programming.

Appealing to donor priorities: Respondents representing diverse organizations described efforts to appeal to or work directly with donors. Respondents discussed designing or adapting programs to be attractive to donors, including by prioritizing efficiency to stretch funding, and to be competitive in proposals. However, one respondent expressed concerns that, at a certain point, efforts to cut costs run the risk of compromising the ability of a program to meet the needs of the affected population.

Advocating for funding in protracted crises: Respondents discussed conducting advocacy on an ongoing basis to maintain funding, even as international interest in the emergency waned. It was widely acknowledged that funding for humanitarian action is driven by international attention, exacerbating the challenges faced by organizations operating in protracted settings that do not receive regular media attention but still have high needs.

Diversifying funding sources: Multiple respondents discussed the importance of diversifying funding sources, both for individual organizations and programs, and for the humanitarian field. At the organizational level, respondents discussed applying for both humanitarian and development funding streams, and seeking new funding sources for their organizations, like private foundations or corporate initiatives; this strategy was reported to be more challenging for smaller organizations who may be less well known to donors. Moreover, the process of securing additional funding can be time intensive.

More broadly, even as the global scale of humanitarian needs rise, funding has not kept pace. One respondent stated that in order to increase the funding available for humanitarian assistance at the global level, humanitarian partners must consider identifying different funding sources, including entrepreneurial funds, new financial institutions, alternative funding models and financing options, including cash-based aid, vouchers, and cost recovery options in appropriate programs and settings.

Internal or organization-specific factors affecting program transitions

Pre-existing programming

When asked about factors, policies, and practices specific to their organization and their successes and challenges, multiple respondents acknowledged that particularly successful transitions had benefited in cases in which their organization had ongoing development programming in country, or even ongoing humanitarian programming in a different part of the country. In these cases, organizations were able to react very quickly at the onset of a crisis, mobilize supplies and personnel, and leverage their existing situational knowledge and relationships to react quickly. These factors were also advantageous when programming transitioned to a more stable response.

Organizational preparedness

When queried about preparedness activities, one respondent with a development organization operating in a fragile setting, including stock at the facility level, in advance of the country's hurricane season, described partnering with the MOH to conduct evaluations of the supply chain. Another respondent reported that their organization benefited from internal preparedness activities, particularly with teams in countries prone to or at risk of crises. These preparedness activities included both burnishing technical and clinical skills as well as advocacy skills to ensure SRH and contraception were addressed in a response. However, high staff turnover is a persistent challenge. Notably, one respondent from a development organization reported that their organization did not routinely develop preparedness plans for programs.

Internal barriers to SRH programming

Notably, respondents from a number of organizations described internal barriers to prioritizing SRH programming, particularly family planning, over the course of the humanitarian response cycle. To address this challenge, one respondent described internal advocacy campaigns targeting, in particular, senior, non-technical members of management. Another respondent reported the success of engaging midwives in emergency health response teams to ensure an advocate for the importance of providing contraception from the outset of a response.

One respondent from a dual-function organization noted that the decision whether or not to continue humanitarian contraceptive service delivery programs in stabilizing settings was also whether or not that setting was in one of the organization's priority countries, and if there was capacity within the organization's non-humanitarian teams, including in country, to continue programming.

Organizational strategies for promoting and managing program transitions

In addition to discussing external and internal factors affecting contraceptive service programs in transition periods, respondents were asked about their organizations' strategies for managing these transitions.

Capacity and systems strengthening with local partners

The most widely cited strategy for transitioning programs successfully is developing partnerships with local actors, and conducting capacity- and systems-strengthening activities to ensure the program can be sustained after the organization is no longer operating and responsibility has shifted entirely to local actors and authorities. Respondents discussed a range of capacity-strengthening activities, including clinical training, supervision, and supply chain management, activities that are particularly important in settings with weak health systems.

However, one respondent emphasized that while operating in protracted settings requires systems thinking, it is critical to pay attention to context: it is not enough to establish basic services, and strengthen the capacity of service providers. Organizations must also address the policy environment, engage communities, and strengthen the evidence base for effective SRH service provision in that context to build the necessary foundation for successful SRH programming.

Supporting the local health system also improves efficiency, and reduces the risk of a program being scaled to such an extent that it cannot feasibly be maintained in the absence of external implementing

partners or funding. One respondent described a setting in which their organization was handing off several health facilities to the MOH. If the facilities were to remain operational, the MOH would need to find the funding to staff, stock, and manage them. The respondent considered this to be a significant burden, and believed that if they had instead supported existing MOH facilities from the beginning, they would have maximized their investment in the community in the long term.

Another respondent reported that in some settings, their organization's staff operate out of the local government's health office, which facilitates collaboration and local ownership of the program from its outset. The respondent anticipates that this will facilitate smooth transitions when their organization is no longer directly involved in implementation.

Exit planning

In addition to conducting capacity strengthening activities with local partners, multiple respondents believed that robust exit planning is instrumental to a successful transition when working with local partners. By proactively planning for its eventual exit, an organization can ensure that the eventual handover of a program will be as smooth as possible. In one example, a respondent described how, in anticipation of its exit, an organization gradually handed over responsibility for monthly supervision visits of facilities to the local government, providing support and constructive feedback throughout the process.

Respondents discussed developing work plans and timelines with local partners, and handing over program tools, including registers and monitoring and evaluation frameworks. One respondent described working with the local government to ensure the program activities were integrated into its workplans.

One respondent also mentioned that their organization provided a local partner with a buffer stock of certain supplies and equipment to mitigate any challenges that could arise after the partner assumed sole responsibility for supply chain management, particularly considering the relative weakness of the national supply chain in that setting. The organization also worked with the partner to implement cost recovery measures—a small fee for clients—to maintain the stock that was initially provided.

Data collection and data-driven decision making

Multiple respondents discussed robust data collection as being key to successful programming and good quality service delivery; capacity strengthening activities with local partners—discussed above—frequently included strengthening systems for data collection and use.

More broadly, respondents discussed the critical importance of publishing program data, and evaluation findings to build the evidence base and support peer organizations to learn from one another. Respondents recommended increased funding for robust monitoring and evaluation, and for publication of data and findings.

Remote management

One respondent described their organization's efforts to remotely manage programs in partnership with local partners and authorities in highly insecure environments with ongoing conflict, and fragile contexts that transition in and out of acute emergencies. The nature of the organization's remote management depends in large part on the context. In settings with intermittent conflict, interspersed with periods of relative stability, their organization is able to conduct normal programming, and be engaged on the ground with local partners, up to the point that the crisis escalates. At that time, the

organization shifts over to remote management, and works with and through partners to ensure programming continues. While the specifics of the remote management model depend on the setting, the goals are the same: determine if and ensure services are available, and of good quality, when the organization's staff cannot access the service delivery points supported by a program.

Coordination between humanitarian and development teams at dual-function organizations

As previously mentioned, key informants included representatives from both humanitarian and development teams at dual-function organizations. We were particularly interested in learning more about how dual-function organizations operate in transitioning settings, particularly if, when, and how development teams are engaged in programming in stabilizing or recovering settings.

One respondent reported their organization, which is relatively small, makes determinations about which team will manage programming based on the security in the setting. If the security is relatively good, they will shift responsibility to their more development-oriented staff, even if the programming is still part of a humanitarian response. This allows their humanitarian team, which is small and quite specialized, to respond to other crises if required. However, the respondent did not discuss if or how they engaged donors in this decision-making process.

Several respondents represented organizations that operate through country offices, in which the majority of programming for a given country is managed. In most cases, the organization does not maintain separate humanitarian and development teams in country offices. Instead, the organization will adapt the programming conducted in country in response to the onset or escalation of an emergency, or to stabilization and recovery. Existing staff will launch emergency response programming when appropriate, and receive additional external support when necessary, depending on the needs. In a large emergency like the 2017 Rohingya response in Bangladesh, an organization may experience a surge of international staff who essentially established a humanitarian response team. Over time, responsibility for managing those programs shifted to national staff, and emergency response programming became integrated into the country office's standard operations.

One respondent noted that her organization was reportedly considering reducing the number of positions across the humanitarian and development teams at the headquarters level, and merging the teams, and exploring how to provide direct support and technical expertise through positions at country or regional offices.

The respondent did note that humanitarian staff at her organization were advocating for maintaining at least a baseline number of humanitarian-focused roles at the headquarters level to preserve the flexibility and speed required to respond at the onset of an emergency. Similarly, a humanitarian respondent at a different dual-function organization felt it was important for her organization to maintain a dedicated humanitarian response team given the special expertise required.

Notably, when queried about protocols for internal shifts in responsibility between humanitarian and development teams in dual-function organizations, many respondents reported that their organization did not have a formal or standard protocol for determining if, when, or how to shift responsibility for program management. More broadly, many respondents reported that humanitarian and development teams within their organizations tended to be siloed, and that this impeded the efficacy of their work in transitioning environments. Respondents reported that these silos were compounded by vertical funding streams.

However, many respondents felt that organizations could benefit, and program transitions would

be stronger, if they had a more systematic approach to working across teams. Respondents recommended that organizations develop guidelines for engaging development teams in transitioning settings, and protocols for determining when and how to shift responsibility for program management. Respondents also recommended organizations undertake preparedness activities with development teams to build their comfort and capacity to operate in fragile and humanitarian settings.

Coordination across the humanitarian-development nexus

In many ways, the internal challenges between humanitarian and development teams reflect the larger coordination challenges faced by actors across the humanitarian-development nexus related to their different ways of working.

Respondents from humanitarian organizations and teams reported their perception that development organizations and programs struggle to operate with the speed and agility required in a humanitarian response at the onset of an emergency, and their perception that many development staff do not have the experience or training required to operate in these environments. Others mentioned differences in standard operating procedures, including how to operate in insecure environments. Notably, development respondents noted that the systems and the associated costs of operating in insecure environments can prevent development actors from remaining or operating in some settings.

Humanitarian-oriented respondents also felt this affected handover in stabilizing or recovering settings, with one respondent noting that these environments are a different "starting point" from standard development settings and therefore a challenge for development actors.

Respondents noted that development and humanitarian organizations may not be funded to work in the same settings, compromising their ability to work in partnership where collaboration would be most effective. Respondents also cited hesitation on the part of traditional donors to invest in fragile or humanitarian contexts as contributing to these silos.

One development respondent also discussed the differences in timelines and procedures for applying for and receiving development funding as compared to humanitarian funding. He noted that the time required for development actors to receive funding could delay their ability to engage in a protracted or recovering setting, potentially exacerbating the challenges humanitarian and development actors face when trying to work together in one setting.

Recommendations to support program transitions and improve collaboration across the nexus

Recommendations to donors

Across the board, respondents recommended that donors extend funding cycles to reflect the needs of protracted settings, and dedicate funding for transition periods and activities. More broadly, diverse respondents discussed the challenges engendered by siloed development and humanitarian funding streams. Respondents felt there would be tremendous value in dedicating funding for settings undergoing transition to ensure availability of funds, and funding that was designed to meet the specific needs and challenges in these environments.

Respondents noted that long-term funding, and dedicated funding for transition periods, also supports organizations to develop meaningful partnerships with local actors and invest in capacity building—a key strategy for successful transitions and sustained programming (see below).

Respondents also expressed enthusiasm about the possibility of diverse donors working together to generate innovative approaches to funding fragile, protracted, or recovery settings and ensuring that funding remains available as these settings move along the continuum and humanitarian funding is no longer appropriate or available.

When asked about key actions to improve and support coordination and collaboration across the nexus, respondents discussed the importance of data and evidence on effective models, strong coordination mechanisms, and identifying and engaging diverse stakeholders, including development partners, early in a response. Respondents also discussed the key tenets of quality SRH service delivery as being an effective starting place from which development and humanitarian implementing organizations can build working relationships, and the broader importance of localization and investing in local partners to ensure the sustainability of any intervention, be it humanitarian or development.

Building the evidence base

Respondents expressed an appetite for program evaluation data demonstrating successful transitions, and engagement of both development and humanitarian partners. Respondents emphasized the need for a robust evidence base documenting successful strategies in these environments, as well as experiences and lessons learned from collaborative efforts across the nexus.

Identifying common ground

In this vein, one humanitarian respondent reflected on the importance of finding common ground between development and humanitarian activities to facilitate cooperation. Indeed, there are clear parallels between contraceptive service delivery programming across all settings, including building partnerships with government authorities and other local partners, supporting supply chain management, and conducting clinical skills training. The respondent reviewed the fundamental tenets of good quality contraceptive service delivery and program management, and emphasized her belief that focusing on this common ground has the potential to motivate diverse stakeholders to find ways to navigate conflicting standard operating procedures to partner on essential work.

Building capacity and coordination mechanisms

Across the board, respondents emphasized the importance of strong coordination mechanisms. Respondents felt it would be important for development partners to participate in preparedness activities, and engage in humanitarian coordination mechanisms to build the necessary foundation to work with humanitarian actors to transition programming in stabilizing, protracted, and recovering settings.

One respondent from a development organization with experience operating in protracted and recovering states reported that participation in coordination mechanisms allowed them to benefit from the security information and systems provided by their humanitarian counterparts, and ensured they were able to safely continue operations and remain engaged over the course of the emergency.

Localization

Multiple respondents emphasized the importance of localization, defined by one respondent as "a way of doing business that empowers local organizations to take the leadership of a response."

Respondents cited examples of local organizations and communities playing a critical role in immediate response, and many discussed the importance of proactively identifying diverse

stakeholders in country when an emergency strikes, including actors that are not traditionally associated with SRH—for example, Red Cross and Red Crescent societies. One respondent lamented, "This is something we overlook as implementing partners or international organizations. We think that the first response to a humanitarian crisis is what we provide, what we bring....No. When people are fleeing, when people have been displaced, the first response is not coming from international organizations. Not even [from] the government. The first response is coming from local communities, coming from local organizations."

One respondent noted that in many cases, diverse actors, including national NGOs and community-based and civil society organizations, have longstanding operations in country. Although these organizations may not have prior experience participating in a humanitarian response or implementing SRH programming, the respondent noted there is tremendous value in engaging these actors in preparedness activities to increase the number of SRH advocates and implementing partners and ensure that gains achieved over the course of a response are sustained. These organizations are first responders, and will remain on the ground after international organizations have departed.

Respondents perceived localization to support efficient and sustainable humanitarian responses across the board, and collaboration across the nexus. However, respondents acknowledged that localization efforts are hampered by the current humanitarian funding apparatus in which humanitarian funding largely flows to and through large international organizations. Respondents emphasized the importance of investing in national and local organizations, including in the operational elements required to ensure organizations are equipped to manage larger-scale programs.

Conclusion

The literature review shows a robust evidence base that consistently demonstrates high demand for contraception across diverse humanitarian settings and populations, and that women will use contraceptive services when they are available. However, there are gaps in the availability of contraceptive services, including adequate method availability, and particular barriers for adolescents and other marginalized groups. The evidence base is limited with respect to the effectiveness of specific interventions on access to contraception in humanitarian settings, but there is programmatic evidence supporting multi-prong contraceptive services programs designed to improve method mix, provider capacity, commodity availability and security, and monitoring and evaluation; community-based service delivery mechanisms; contraception as part of post-abortion care; and vouchers and subsidies.

The contraceptive programming survey, representing 84 humanitarian programs across 42 countries/territories, found that OCPs and injectables were widely provided at service delivery points. Long-acting reversible methods, including IUDs and implants, were also available in a majority of programs; however, there were regional variations, with nearly all programs in Sub-Saharan Africa providing both methods but somewhat lower proportions of programs in the East and South Asia and the Pacific region and Middle East and North Africa region providing these methods. Notably, implants were available in less than half of programs in the Middle East and North Africa. Stockouts appeared to pose challenges across programs and methods, ranging from 23% of country programs reporting stockouts of OCPs to 13% for implants and injectables.

The key informant interviews explored contraceptive programming during transition periods across the preparedness to relief to recovery continuum, including at the onset of a crisis, and as situations stabilize or evolve. Several themes emerged related to factors that affect these transitions, including contextual factors, coordination mechanisms, and funding. Respondents emphasized that contextual factors—namely, the existing strengths, capacities, and structures in-country—significantly impact transitions, and cited particular challenges in areas with cyclical and protracted violence, and emphasized the importance of robust coordination mechanisms. Notably, the most widely cited strategy for transitioning programs successfully was conducting capacity- and systems-strengthening activities over the course of a program, underscoring the critical importance of local ownership and leadership for sustaining and scaling programs. Respondents across contexts discussed localization as foundational to ensuring effective, sustainable response and recovery.

Funding was cited in all KIIs as a determining factor in the success of a program to effectively transition across different points in the humanitarian response cycle. Many respondents described frustrations and challenges posed by the siloed nature of funding streams, including a lack of dedicated funding for transitional or fragile settings, and all respondents cited siloed funding streams as an obstacle to collaboration across the humanitarian-development nexus. Sustained, long-term funding, or dedicated funding for the transition phase, was instrumental to successful program transitions in diverse settings; across the board, respondents recommended that donors extend funding cycles to reflect the needs of protracted settings.

With regard to coordination across the nexus, one of the most frequently discussed challenges was a lack of cross-sectoral communication. Both humanitarian and development respondents were nearly unanimous in citing the importance of strong, formal coordination mechanisms that proactively engaged stakeholders across the nexus to share information, build partnerships and capacity, and set the stage for future transitions.

Together, the literature review, contraceptive programming survey, and key informant interviews suggest that women and girls want access to contraception in humanitarian settings and will use it. Ultimately, it is clear that contraceptive service delivery is underway in humanitarian settings, but that availability of the full range of methods is mixed across settings, and marginalized populations—including adolescents—face greater barriers to accessing services that meet their unique needs. While contraceptive service delivery programs face clear challenges during transition periods across the preparedness to relief to recovery continuum, these periods also provide an opportunity that should be leveraged by stakeholders across the humanitarian development nexus to strengthen preparedness, collaboration, and resilient health systems that are equipped to deliver contraceptive services to all who want and need them—no matter who they are, or where they live.

Abbreviations

DRC	Democratic Republic of the Congo
EC	Emergency contraception
ECPs	Emergency contraception pills
FP2020	Family Planning 2020
IARH	Inter-Agency Reproductive Health (Kits)
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IDPs	Internally displaced persons
IEC	Information, education, communication
INGO	International nongovernmental organization
IRC	International Rescue Committee
IUD	Intrauterine device
KIIs	Key informant interviews
LARCs	Long-acting, reversible contraceptives
LGBTQI	Lesbian, gay, bisexual, transgender, queer, intersex
MISP	Minimum Initial Service Package (for SRH)
MOH	Ministry of Health
NGO	Nongovernmental organization
OCHA	(UN) Office for the Coordination of Humanitarian Affairs
OCPs	Oral contraceptive pills
PAC	Post-abortion care
SRH	Sexual and reproductive health
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WRC	Women's Refugee Commission

References: Literature Review

1. McGinn T, Austin J, Anfinson K, Amsalu R, Casey SE, Fadulalmula SI, et al. *Family planning in conflict: results of cross-sectional baseline surveys in three African countries*. Conflict and Health. 2011;5: 11. doi:10.1186/1752-1505-5-11.
2. Cherri Z, Gil Cuesta J, Rodriguez-Llanes MJ, Guha-Sapir D. *Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study.* International Journal of Environmental Research and Public Health. 2017;14. doi:10.3390/ijerph14080836.
3. Davidson AS, Fabiyi C, Demissie S, Getachew H, Gilliam ML. *Is LARC for Everyone? A Qualitative Study of Sociocultural Perceptions of Family Planning and Contraception Among Refugees in Ethiopia.* Maternal and child health journal. 2016; 1–7. doi:10.1007/s10995-016-2018-9.
4. Gedeon J, Hsue SN, Walsh M, Sietstra C, MarSan H, Foster AM. *Assessing the experiences of intra-uterine device users in a long-term conflict setting: a qualitative study on the Thailand-Burma border.* Conflict and Health. 2015;9: 6. doi:10.1186/s13031-015-0034-9.
5. Kabakian-Khasholian T, Mourtada R, Bashour H, Kak FE, Zurayk H. *Perspectives of displaced Syrian women and service providers on fertility behaviour and available services in West Bekaa, Lebanon.* Reproductive Health Matters. 2017;25: 75–86. doi:10.1080/09688080.2017.1378532.
6. Krause S, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. *Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. Conflict and Health.* 2015;9: S4. doi:10.1186/1752-1505-9-S1-S4.
7. Benage M, Greenough PG, Vinck P, Omeira N, Pham P. *An assessment of antenatal care among Syrian refugees in Lebanon. Conflict and Health.* 2015;9: 8. doi:10.1186/s13031-015-0035-8.
8. Balinska MA, Nesbitt R, Ghantous Z, Ciglenecki I, Staderini N. *Reproductive health in humanitarian settings in Lebanon and Iraq: results from four cross-sectional studies, 2014-2015.* Confl Health. 2019;13: 24. doi:10.1186/s13031-019-0210-4.
9. Tanabe M, Myers A, Bhandari P, Cornier N, Doraiswamy S, Krause S. *Family planning in refugee settings: findings and actions from a multi-country study. Conflict and Health*. 2017;11: 9. doi:10.1186/s13031-017-0112-2.
10. *Refocusing Family Planning in Refugee Settings: Findings and Recommendations from a Multi-Country Study*. Women's Refugee Commission; UNHCR; 2011 Nov. Available: https://www.unhcr.org/4ee6142a9.pdf.
11. Casey SE, Chynoweth SK, Cornier N, Gallagher MC, Wheeler EE. *Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies*. Conflict and Health. 2015;9: S3. doi:10.1186/1752-1505-9-S1-S3.
12. Ackerson K, Zielinski R. *Factors influencing use of family planning in women living in crisis affected areas of Sub-Saharan Africa: A review of the literature*. Midwifery. 2017;54: 35–60. doi:10.1016/j.midw.2017.07.021.
13. Ivanova O, Rai M, Kemigisha E. *A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa*. International Journal of Environmental Research and Public Health. 2018;15: 1583. doi:10.3390/ijerph15081583.
14. Kisindja RM, Kimona C, Etoy M, Dorme F, Benfield N. *Family planning knowledge and use among women in camps for internally displaced people in the Democratic Republic of the Congo*. International Journal of Gynecology & Obstetrics. 2017;138: 256–260. doi:10.1002/ijgo.12220.
15. Tanabe M, Nagujjah Y, Rimal N, Bukania F, Krause S. I*ntersecting Sexual and Reproductive Health and Disability in Humanitarian Settings: Risks, Needs, and Capacities of Refugees with Disabilities in Kenya, Nepal, and Uganda.* Sex Disabil. 2015;33: 411–427. doi:10.1007/s11195-015-9419-3.
16. Mulumba D. *Encampment of Communities in War-Affected Areas and its Effect on their Livelihood Security and Reproductive Health: The Case Of Northern Uganda.* Eastern Africa Social Science Research Review. 2011;27: 107–129. doi:10.1353/eas.2011.0002.
17. Gure F, Dahir MK, Yusuf M, Foster AM. *Emergency Contraception in Post-Conflict Somalia: An Assessment of Awareness and Perceptions of Need. Studies in Family Planning*. 2016;47: 69–81. doi:10.1111/j.1728-4465.2016.00047.x.
18. Hobstetter M, Sietstra C, Walsh M, Leigh J, Foster AM. *"In rape cases we can use this pill": A multimethods assessment of emergency contraception knowledge, access, and needs on the Thailand – Burma border*. International Journal of Gynecology & Obstetrics. 130: E37–E41. doi:10.1016/j.ijgo.2015.05.008.
19. Lathrop E, Telemaque Y, Haddad L, Stephenson R, Goedken P, Cwiak C, et al. *Knowledge and use of and opportunities for emergency contraception in Northern Haiti*. International Journal of Gynecology & Obstetrics. 2013;121: 60–63. doi:10.1016/j.ijgo.2012.11.013.
20. Reese Masterson A, Usta J, Gupta J, Ettinger AS. *Assessment of reproductive health and violence against women among displaced Syrians in Lebanon*. BMC Women's Health. 2014;14: 25. doi:10.1186/1472-6874-14-25.

21. West L, Isotta-Day H, Ba-Break M, Morgan R. *Factors in use of family planning services by Syrian women in a refugee camp in Jordan*. Journal of Family Planning and Reproductive Health Care. 2017;43: 96–102. doi:10.1136/jfprhc-2014-101026.
22. *Baseline Study: Documenting Knowledge, Attitudes and Behaviors of Somali Refugees and the Status of Family Planning Services in UNHCR's Ali Addeh Site, Djibouti.* Women's Refugee Commission; UNHCR; 2011 Aug. Available: www.unhcr.org/4e8c0b589.pdf.
23. *Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Burmese Refugees and the Status of Family Planning Services in UNHCR's Operation in Kuala Lumpur, Malaysia*. Women's Refugee Commission; UNHCR; 2011 Aug. Available: http://www.unhcr.org/4e8c0d1c9.pdf.
24. *Baseline Study: Documenting Knowledge, Attitudes and Practices of Refugees and the Status of Family Planning Services in UNHCR's Operations in Nakivale Refugee Settlement, Uganda.* Women's Refugee Commission; UNHCR; 2011 Aug. Available: http://www.unhcr.org/4e8c0da49.pdf.
25. *Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Somali Refugees and the Status of Family Planning Services in UNHCR's Operation in Nairobi, Kenya*. Women's Refugee Commission; UNHCR; 2011 Aug. Available: http://www.unhcr.org/4e8c0cbe9.pdf.
26. Huber D, Saeedi N, Samadi AK. *Achieving success with family planning in rural Afghanistan*. Bulletin of the World Health Organization. 2010;88: 227–231. doi:10.2471/BLT.08.059410.
27. Kiura AW. *Constrained Agency on Contraceptive Use among Somali Refugee Women in the Kakuma Refugee Camp in Kenya.* Gender, Technology and Development. 2014;18: 147–161. doi:10.1177/0971852413515321.
28. Okanlawon K, Reeves M, Agbaje OF. *Contraceptive Use: Knowledge, Perceptions and Attitudes of Refugee Youths in Oru Refugee Camp, Nigeria.* African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. 2010;14: 16–25.
29. *Priority Reproductive Health Activities in Haiti.* CARE; International Planned Parenthood Federation; Save the Children; and Women's Refugee Commission; 2011 Feb. Available: https://www.womensrefugeecommission.org/resources/document/696-priority-reproductive-health-activities-in-haiti-2011.
30. Nara R, Banura A, Foster AM. *Assessing the availability and accessibility of emergency contraceptive pills in Uganda: A multi-methods study with Congolese refugees. Contraception*. 2019 [cited 14 Jan 2020]. doi:10.1016/j.contraception.2019.09.008.
31. Hobstetter M, Walsh M, Leigh J, Lee CI, Sietstra C, Foster AM. *An assessment of reproductive health on the Thailand-Burma border*. : 51.
32. Ganle JK, Amoako D, Baatiema L, Ibrahim M. *Risky sexual behaviour and contraceptive use in contexts of displacement: insights from a cross-sectional survey of female adolescent refugees in Ghana*. Int J Equity Health. 2019;18: 127. doi:10.1186/s12939-019-1031-1.
33. Truppa C, Leresche E, Fuller AF, Marnicio AS, Abisaab J, El Hayek N, et al. *Utilization of primary health care services among Syrian refugee and Lebanese women targeted by the ICRC program in Lebanon: a cross-sectional study*. Confl Health. 2019;13: 7. doi:10.1186/s13031-019-0190-4.
34. Behrman JA, Weitzman A. *Effects of the 2010 Haiti Earthquake on Women's Reproductive Health*. Studies in Family Planning. 2016;47: 3–17.
35. Seyife A, Fisseha G, Yebyo H, Gidey G, Gerensea H. *Utilization of modern contraceptives and predictors among women in Shimelba refugee camp, Northern Ethiopia*. PLoS ONE. 2019;14: e0212262. doi:10.1371/journal.pone.0212262.
36. *Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-Depth Look at Family Planning Services*. Women's Refugee Commission; Save the Children; UNHCR; and UNFPA; Available: https://www.womensrefugeecommission.org/resources/901.
37. *Baseline Study: Documenting Knowledge, Attitudes and Behaviours of Rohingya Refugees and the Status of Family Planning Services in UNHCR's Operation in Cox's Bazar, Bangladesh*. Women's Refugee Commission; UNHCR; 2012 Dec. Available: http://iawg.net/wp-content/uploads/2016/08/family_planning_baseline_study_coxs_bazar_final_report-1.pdf.
38. *Emergency Contraception in Reproductive Health Programs in Humanitarian Settings*. Save the Children; 2019.
39. Gee S, Vargas J, Foster AM. *"The more children you have, the more praise you get from the community": exploring the role of sociocultural context and perceptions of care on maternal and newborn health among Somali refugees in UNHCR supported camps in Kenya.* Confl Health. 2019;13: 11. doi:10.1186/s13031-019-0195-z.
40. Castle S, Schroffel H, Nzau Mvuezolo JJ, Mupenda B, Mumbere J, Shapiro R. *Successful programmatic approaches to facilitating IUD uptake: CARE's experience in DRC*. BMC Womens Health. 2019;19: 104. doi:10.1186/s12905-019-0793-3.
41. *Baseline Study: Documenting Knowledge, Attitudes and Practices of Iraqi Refugees and the Status of Family Planning Services in UNHCR's Operations in Amman, Jordan*. Women's Refugee Commission; UNHCR; 2011 Aug. Available:

http://www.unhcr.org/afr/4e8c0c419.pdf.
42. Srikanok S, Parker DM, Parker AL, Lee T, Min AM, Ontuwong P, et al. *Empirical lessons regarding contraception in a protracted refugee setting: A descriptive study from Maela camp on the Thai-Myanmar border 1996 – 2015.* Foster AM, editor. PLOS ONE. 2017;12: e0172007. doi:10.1371/journal.pone.0172007.
43. Casey SE, Mitchell KT, Amisi IM, Haliza MM, Aveledi B, Kalenga P, et al. *Use of facility assessment data to improve reproductive health service delivery in the Democratic Republic of the Congo.* Confl Health. 2009;3: 12. doi:10.1186/1752-1505-3-12.
44. Blanchet K, Ramesh A, Frison S, Warren E, Hossain M, Smith J, et al. *Evidence on public health interventions in humanitarian crises.* The Lancet. 2017;390: 2287–2296. doi:10.1016/S0140-6736(16)30768-1.
45. Casey SE, Cannon A, Mushagalusa Balikubirhi B, Muyisa J-B, Amsalu R, Tsolka M. *Twelve-month contraceptive continuation among women initiating short- and long-acting reversible contraceptives in North Kivu, Democratic Republic of the Congo.* PloS one. 2017;12: e0182744. doi:10.1371/journal.pone.0182744.
46. Casey SE, Tshipamba M. *Contraceptive availability leads to increase in use in conflict-affected Democratic Republic of the Congo: evidence from cross-sectional cluster surveys, facility assessments and service statistics.* Conflict and health. 2017;11: 2. doi:10.1186/s13031-017-0104-2.
47. Curry DW, Rattan J, Nzau JJ, Giri K. *Delivering High-Quality Family Planning Services in Crisis-Affected Settings I: Program Implementation*. Global Health: Science and Practice. 2015;3: 14–24. doi:10.9745/GHSP-D-14-00164.
48. Curry DW, Rattan J, Huang S, Noznesky E. *Delivering High-Quality Family Planning Services in Crisis-Affected Settings II: Results.* Global Health: Science and Practice. 2015;3: 25–33. doi:10.9745/GHSP-D-14-00112.
49. Ho LS, Wheeler E. *Using Program Data to Improve Access to Family Planning and Enhance the Method Mix in Conflict-Affected Areas of the Democratic Republic of the Congo.* Glob Health Sci Pract. 2018;6: 161–177. doi:10.9745/GHSP-D-17-00365.
50. Rattan J, Noznesky E, Curry DW, Galavotti C, Hwang S, Rodriguez M. *Rapid Contraceptive Uptake and Changing Method Mix With High Use of Long-Acting Reversible Contraceptives in Crisis-Affected Populations in Chad and the Democratic Republic of the Congo.* Global Health: Science and Practice. 2016;4: S5–S20. doi:10.9745/GHSP-D-15-00315.
51. *Impossible Nowhere: Family Planning for Women and Girls in Crises*. International Rescue Committee; 2015 Nov. Available: https://www.rescue.org/report/impossible-nowhere-family-planning-women-and-girls-crises.
52. Abdelhadi E, Spilotros N, Hesel K. *Family planning and post-abortion care in emergency response - IRC's experience in Yemen. International Rescue Committee*; 2014 May pp. 11–13. Available: https://odihpn.org/magazine/family-planning-and-post-abortion-care-in-emergency-response-irc%c2%92s-experience-in-yemen/.
53. Casey SE, McNab SE, Tanton C, Odong J, Testa AC, Lee-Jones L. *Availability of long-acting and permanent family-planning methods leads to increase in use in conflict-affected northern Uganda: Evidence from cross-sectional baseline and endline cluster surveys.* Global Public Health. 2013;8: 284–297. doi:10.1080/17441692.2012.758302.
54. Chukwumalu K, Gallagher MC, Baunach S, Cannon A. *Uptake of postabortion care services and acceptance of post-abortion contraception in Puntland, Somalia.* Reproductive Health Matters. 2017;25: 48–57. doi:10.1080/09688080.2017.1402670.
55. Casey SE, Gallagher MC, Dumas EF, Kakesa J, Katsongo JM, Muselemu J-B. *Meeting the demand of women affected by ongoing crisis: Increasing contraceptive prevalence in North and South Kivu, Democratic Republic of the Congo.* PLoS ONE. 2019;14: e0219990. doi:10.1371/journal.pone.0219990.
56. Deitch J, Amisi JP, Martinez S, Meyers J, Muselemu J-B, Nzau JJ, et al. *"They Love Their Patients": Client Perceptions of Quality of Postabortion Care in North and South Kivu, the Democratic Republic of the Congo.* Glob Health Sci Pract. 2019;7: S285–S298. doi:10.9745/GHSP-D-18-00368.
57. Gallagher M, Morris C, Aldogani M, Eldred C, Shire AH, Monaghan E, et al. *Postabortion Care in Humanitarian Emergencies: Improving Treatment and Reducing Recurrence*. Glob Health Sci Pract. 2019;7: S231–S246. doi:10.9745/GHSP-D-18-00400.
58. Morris CN, Lopes K, Gallagher MC, Ashraf S, Ibrahim S. *When political solutions for acute conflict in Yemen seem distant, demand for reproductive health services is immediate: a programme model for resilient family planning and post-abortion care services.* Sexual and Reproductive Health Matters. 2019;27: 100–111. doi:10.1080/26410397.2019.1610279.
59. Adam IF. *Evidence from cluster surveys on the association between home-based counseling and use of family planning in conflict-affected Darfur*. International Journal of Gynecology & Obstetrics. 2016;133: 221–225. doi:10.1016/j.ijgo.2015.09.023.
60. Mullany LC, Lee TJ, Yone L, Lee CI, Teela KC, Paw P, et al. *Impact of Community-Based Maternal Health Workers on Coverage of Essential Maternal Health Interventions among Internally Displaced Communities in Eastern Burma: The MOM Project.* PLoS Med. 2010;7. doi:10.1371/journal.pmed.1000317.
61. Viswanathan K, Hansen PM, Rahman MH, Steinhardt L, Edward A, Arwal SH, et al. *Can community health workers in-*

crease coverage of reproductive health services? J Epidemiol Community Health. 2012;66: 894–900. doi:10.1136/jech-2011-200275.

62. Raheel H, Karim MS, Saleem S, Bharwani S. *Knowledge, Attitudes and Practices of Contraception among Afghan Refugee Women in Pakistan: A Cross-Sectional Study*. PLOS ONE. 2012;7: e48760. doi:10.1371/journal.pone.0048760.
63. Boddam-Whetham L, Gul X, Al-Kobati E, Gorter AC. *Vouchers in Fragile States: Reducing Barriers to Long-Acting Reversible Contraception in Yemen and Pakistan.* Global Health: Science and Practice. 2016;4: S94–S108. doi:10.9745/GHSP-D-15-00308.

Annex A

Contraceptive Programming Survey

Section 1: Introduction

The Women's Refugee Commission (WRC) is conducting an assessment of contraceptive services in humanitarian settings, including a coverage study, for the Bill & Melinda Gates Foundation. As a part of this assessment, we are asking you to provide information on the countries where your organization supports the provision of contraceptive services.

Data will be aggregated across organizations. No data will be presented by organization without your permission. We are asking for your contact information only for follow-up purposes if necessary.

Please note: you must fill out separate survey forms for each region in which your organization provides contraceptive services in humanitarian settings. This survey asks for the number of countries in which you support contraceptive services. You must complete all of the questions for each country. **After starting this form, you will not be able to save your progress until you complete all information.** If you do not wish to provide this information for all countries in a given region in one sitting, or if you wish to have multiple members of your organization provide information, you may submit multiple forms for one region. **Please only enter the number of countries for which you will be providing information in a given form** (you may go back and change the number of countries if you realize you do not have time to complete the form for all in one sitting). We will combine the data as appropriate.

If you have any questions, please contact Lily Jacobi at lilyj@wrcommission.org.

No.	Questions	Response/coding categories	Skip to
Q1	Please enter your name:	*text*	
Q2	Please enter your email address: *Please note: this information will only be used to follow up with you if we have further questions and will not be reported or shared.*	*text*	
Q3	Please select your organization: *Please note that no results will be reported by organization without your explicit prior approval.*	*Dropdown list provided. Select one.*	
Q4	What is your title and/or professional role?	*text*	

Q5	Globally, in how many countries does your organization provide health services in humanitarian settings? *Enter in the format "01"*	*2-digit number*	
Q6	Globally, in how many countries does your organization provide contraceptive services in humanitarian settings? *Enter in the format "01"* *Please note: this number should be a sub-set of the countries counted in your response to the previous question.*	*2-digit number* *Constraint: 006 must be < 005*	
Q7a	In which Region does your institution provide contraceptive services in humanitarian settings? *Please complete a form for each region.*	*Select one* East Asia and the Pacific 1 Europe and Central Asia 2 Latin America and the Caribbean 3 Middle East and North Africa 4 South Asia 5 Sub-Saharan Africa 6	
Q7b	In which countries does your institution provide contraceptive services in humanitarian settings?	Dropdown list of countries attached *Select multiple*	

Instructions: Please complete the following question set for EACH country listed in your response to Question 7b.

Please note: the form will take you through all of the questions for one country before showing the same questions for the next country.

No.	Questions	Response/coding categories	Skip to
Q101a	In how many areas of COUNTRY do you provide voluntary contraceptive services (provinces, camps, etc.)? *2-digit number*	*2-digit number* *Then text box with the option to add multiple responses (can be one box)*	
Q101b	Please list the areas in which you provide contraceptive services. *Please add a semi-colon between each response—e.g. North Kivu; Kasai*	*Text*	
Q102	Type of settings where you provide contraceptive services in COUNTRY: *Please select all that apply:*	*Select multiple* Camp 1 Non-camp 2 Urban 3 Rural 4 Other (specify) _____ 5	
Q103	State of humanitarian emergency in COUNTRY (you may select both if different parts of the country are in different states)	*Select multiple* Acute emergency 1 Post-acute emergency 2	
Q104	Type(s) of populations served in COUNTRY: *Please select all that apply:*	*Select multiple* Refugees 1 Internally displaced populations (IDPs) 2 Host communities 3 Other (specify) _____ 4	
Q105	Number of beneficiaries served in COUNTRY: *Please give your best estimate if you don't have the exact number. 6-digit number*	*6-digit number*	
Q106	Number of health facilities supported in COUNTRY: *2-digit number*	*2-digit number*	

Q107a	Number of service delivery points (SDP) supported in COUNTRY: *If you do not support any other type of service delivery points, please enter 00* *2-digit number*	*2-digit number* Number___ ____ Type: *text*	
Q107b	Type of other service delivery points (SDP) supported in COUNTRY (e.g., mobile clinics, etc.): *Please add a semi-colon between each response*	*Please add a semi-colon between each response* *text*	

Section 2: Questions on contraceptive methods and services provided:

No.	Questions	Response/coding categories	Skip to
Q201	Do service delivery sites in COUNTRY provide intrauterine devices (IUDs)?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q206 ➔ Q203 ➔ Q206
Q202	How many health facilities or SDPs in COUNTRY provide IUDs? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q203	What types of IUDs are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* Copper bearing IUD 1 Levonorgestrel IUD (LNG-IUS) 2 Other (specify) ➔ *text* 3	
Q204	Do service delivery sites in COUNTRY provide removal services for IUDs?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q206 ➔ Q206 ➔ Q206

Q205	How many health facilities or SDPs in COUNTRY provide removal services for IUDs? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q206	Do service delivery sites in COUNTRY provide contraceptive implants?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q211 ➔ Q208 ➔ Q211
Q207	How many health facilities or SDPs in COUNTRY provide contraceptive implants? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q209	Do service delivery sites in COUNTRY provide removal services for contraceptive implants?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q211 ➔ Q211 ➔ Q211
Q210	How many health facilities or SDPs in COUNTRY provide removal services for contraceptive implants? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q211	Do service delivery sites in COUNTRY provide permanent methods of contraception?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q214 ➔ Q213 ➔ Q214

Q212	How many health facilities or SDPs in COUNTRY provide permanent methods of contraception? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q213	What types of permanent contraceptive methods are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* Tubal ligation 1 Vasectomy 2 Other (specify) → *text* 5	
Q214	Do service delivery sites in COUNTRY provide oral contraceptive pills (OCPs)?	No 0 → Q217 Yes, in all supported health facilities and SDPs 1 → Q216 Yes, but only in certain health facilities and SDPs 2 → Q217 I do not know 8	
Q215	How many health facilities or SDPs in COUNTRY provide OCPs? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q216	What types of OCPs are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* Combined oral contraceptives (estrogen/progestin) 1 Progestin-only pills (mini-pill) 2 Not sure which kind we have 3	

Q217	Do service delivery sites in COUNTRY provide injectable contraceptives?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q221 ➔ Q219 ➔ Q221
Q218	How many health facilities or SDPs in COUNTRY provide injectable contraceptives? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q219	What types of injectable contraceptives are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* DMPA-IM (e.g., Depo-Provera) 1 DMPA-SC (e.g., Sayana Press) 2 Other (specify) ➔ *text* 3	 ➔Q221 ➔Q221
Q220	Who administers DMPA-SC in COUNTRY? Please select all that apply.	*Select multiple* Health workers (e.g., doctors, nurses, midwives) 1 Community health workers (CHWs) 2 Women can self-inject 3 Other (specify) ➔ *text* 4	
Q221	Do service delivery sites in COUNTRY provide condoms?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q224 ➔ Q223 ➔ Q224
Q222	How many health facilities or SDPs in COUNTRY provide condoms? *2-digit number* *Please give your best estimate.*	*2-digit number*	

Q223	What types of condoms are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* Male condoms 1 Female condoms 2	
Q224	Do service delivery sites in COUNTRY provide emergency contraception?	No 0 Yes, in all supported health facilities and SDPs 1 Yes, but only in certain health facilities and SDPs 2 I do not know 8	➔ Q227 ➔ Q226 ➔ Q227
Q225	How many health facilities or SDPs in COUNTRY provide emergency contraception (EC)? *2-digit number* *Please give your best estimate.*	*2-digit number*	
Q226	Which methods of emergency contraception (EC) are provided by service delivery sites in COUNTRY? Please select all that apply.	*Select multiple* Dedicated EC product 1 Oral contraceptive pills used for EC 3 Copper bearing IUD 4 Other (specify) ➔ *text* 5	
Q227	Please list any other modern contraceptive methods (e.g., the ring, the patch) provided by service delivery sites in COUNTRY.	*Text box*	

Section 3: Accessibility

No.	Questions	Response/coding categories	Skip to
Q301	Do unmarried adolescent girls in COUNTRY require parental consent to access contraceptive services?	Yes, by law and/or by policy 1 No, but providers usually require it 2 No 3 I do not know 8	
Q302	Do married women and girls in COUNTRY require spousal consent to access contraceptive services?	Yes, by law and/or by policy 1 No, but providers usually require it 2 No 3 I do not know 8	

Instructions: Please indicate to the best of your knowledge the extent of access each of these groups has to contraceptive services:

No.	In COUNTRY contraceptive services are accessible and available to...	Never	Sometimes	Most of the time	Always	Don't know
Q303	Unmarried adolescent girls	1	2	3	4	8
Q304	Unmarried women	1	2	3	4	8
Q305	Persons with disabilities	1	2	3	4	8
Q306	Persons engaging in transactional sex	1	2	3	4	8
Q307	Lesbian, gay, bisexual, transgender, queer, intersex, and gender non-conforming people	1	2	3	4	8

Section 4: Logistics and contraceptive supplies

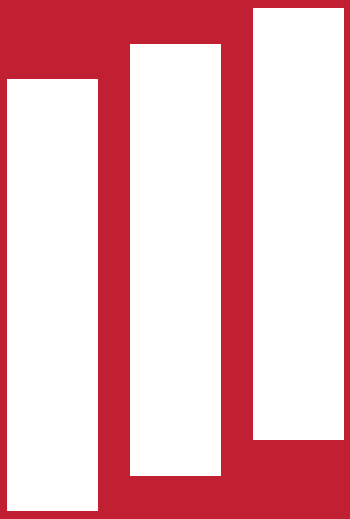
No.	Questions	Response/coding categories	Skip to
Q401	In the last three months, how has your institution obtained intrauterine devices (IUDs) for use in COUNTRY? Please select all that apply.	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q404

Q402	In the last three months, where has your institution procured IUDs for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	
Q403	Has there been a stock-out of IUDs at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	
Q404	In the last three months, how has your institution obtained contraceptive implants for use in COUNTRY?	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q407
Q405	In the last three months, where has your institution procured implants for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	
Q406	Has there been a stock-out of implants at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	

Q407	In the last three months, how has your institution obtained oral contraceptive pills (OCPs) for use in COUNTRY? Please select all that apply.	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q410
Q408	In the last three months, where has your institution procured OCPs for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	
Q409	Has there been a stock-out of OCPs at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	
Q410	In the last three months, how has your institution obtained injectable contraceptives for use in COUNTRY? Please select all that apply.	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q413
Q411	In the last three months, where has your institution procured injectables for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	

Q412	Has there been a stock-out of injectables at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	
Q413	In the last three months, how has your institution obtained condoms for use in COUNTRY? Please select all that apply.	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q416
Q414	In the last three months, where has your institution procured condoms for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	
Q415	Has there been a stock-out of condoms at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	
Q416	In the last three months, how has your institution obtained emergency contraception for use in COUNTRY? Please select all that apply.	*Select multiple* Inter-agency Emergency RH kits 1 Government supplier 2 My institution does not provide this method in COUNTRY 3 Other (specify) 4	➔ Q419

Q417	In the last three months, where has your institution procured emergency contraception for use in COUNTRY? Please select all that apply.	*Select multiple* UNFPA or other UN agency 1 Government 2 Parastatal supplier 3 Domestic private source 4 International private source 5 Other (specify) 6	
Q418	Has there been a stock-out of emergency contraception at any point within the past three months at a supported facility in COUNTRY?	No 0 Yes 1 I do not know 2	
Q419	What are the most common delays in obtaining contraceptive supplies in COUNTRY? Please select all that apply.	*Select multiple* Financing 1 Stockout at the supplier or manufacturer 2 Delay in shipping to country 3 Registration/waiver issues 4 Customs-related delays once in country 5 Transportation delay in-country 6 Other (specify) 7	



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