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IAWG Inter-Agency Working Group on Reproductive Health in Crises

FP2030

Recommendations for humanitarian response partners to strengthen the provision of contraceptive services for people affected by crises

In 2023, an estimated 339 million people will be affected by crises, including 85 million women and girls of reproductive age[1]—many of whom face unmet needs for basic health care, including sexual and reproductive health (SRH) services. **We call upon humanitarian response partners to strengthen availability of and access to good quality contraceptive services, along with other critical SRH services, from preparedness to acute emergency response to protracted response and recovery,** in partnership with governments, inter-agency coordination mechanisms, including the cluster system, and other partners across the humanitarian-development nexus.[2] Meeting contraceptive needs in crises **saves lives, protects human rights, fosters agency and self-determination, and advances resilience.*,+**

What you need to know: Access to contraceptive services for people affected by crises

People affected by crises want and need access to contraception, but availability of and access to contraceptive services in crises remains limited and uneven.[3] There is documented demand for contraceptive services, including a range of methods, across diverse crisis-affected contexts,[4] similar to stable settings. People affected by crises use these services when they are available and of adequate quality.[5] Evidence shows that provision of good quality[6] contraceptive services is feasible even in complex and challenging settings.[7] However, when humanitarian response partners do not provide contraceptive services during crises, women and girls lose access to this essential component of primary health care.

Contraception is lifesaving[8] and part of the minimum standards of care in crisis-affected settings. The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health—the global standard for SRH response in acute emergencies—includes the prevention of unintended pregnancies as one of six objectives; these objectives are also integrated into the Sphere standards for humanitarian response. Contraceptive services must be available along with other SRH services at the outset of every crisis, in alignment with the MISP for SRH. They must be expanded as the acute stage subsides, in alignment with the *Inter-Agency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings.*

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

* This brief is part of a series that adapts recommendations developed by the Women's Refugee Commission (WRC), the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), and Family Planning 2030 based on a landscaping assessment conducted by WRC in 2018-20. The assessment included a literature review, a global contraceptive programming survey, case studies in three humanitarian settings, and key informant interviews. The other briefs provide recommendations to donors, governments, and development agencies.

+ In this brief, "contraceptive services" refers to the full package of voluntary family planning services, including counseling, informed consent, provision of a method, and all other components of family planning service delivery.

What you can do: Big picture recommendations for humanitarian response partners from preparedness to response to recovery

Good quality, rights-based contraceptive services must be integrated into humanitarian programming and across the humanitarian-development nexus, from preparedness to response to recovery. This is critical to ensuring contraceptive availability and access during acute emergencies, expanding services as acute emergencies subside, and advancing long-term sustainability.[9]

Here's how you can make this happen:

- <u>Preparedness</u>: **Support national and sub-national governments and partners to systematically integrate crisis preparedness and risk management into contraceptive programming** to maintain continuity of services when crises occur.[10] Partner with development agencies, who have longstanding presence and relationships at country level, to support governments in strengthening preparedness. In fragile settings and settings affected by cyclical or recurring crises, **develop organizational crisis preparedness and contingency plans** to ensure ongoing access to SRH care, including contraceptive services, as crises occur, subside, and recur.
- <u>Acute response</u>: **Integrate contraceptive services and other essential SRH services into primary health programming in all emergency responses**, in coordination with the health and protection clusters and government authorities at national and local levels where possible, and strengthen capacity of primary health partners and providers to deliver these services. Services provided during acute response should align with the MISP, which calls for ***ensuring availability of a range of long-acting and short-acting methods, including emergency contraception,*** to meet demand; ***providing information and contraceptive counseling*** that emphasizes informed choice and consent, effectiveness, privacy and confidentiality, equity, and non-discrimination; and ***ensuring the community is aware of the availability of contraceptives*** for women, adolescents, and men.
- <u>Protracted response and recovery</u>: **Provide the full range of contraceptive services and strengthen national health systems to meet comprehensive SRH needs in protracted crisis and recovery settings**, in alignment with the IAFM and in partnership with governments, development actors, and inter-agency coordination mechanisms.

Things to keep in mind: Cross-cutting tips for effective contraceptive programming in crisis settings

Here's how your programming can facilitate sustainable contraceptive access and availability:

- **Seek dedicated funding for contraceptive service provision as part of health programming** across humanitarian and development funding streams to ensure that every person of reproductive age, everywhere, can access and use contraception.
- **Use existing guidance, tools, and examples of successful programming to inform implementation.** For example, refer to the MISP and IAFM, the High-Impact Practices in Family Planning (HIPs) "Family Planning in Humanitarian Settings: A Strategic Planning Guide," and "Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies."
- **Partner directly with local actors who are present before, during, and after crises for contraceptive service delivery,** in alignment with the Grand Bargain,[11] and work with humanitarian coordination mechanisms, multilateral agencies, implementing agencies, and other stakeholders to address barriers in the international aid architecture that impede leadership of local SRH actors.
- **Partner with governments and development actors at national and sub-national levels** to strengthen preparedness during stable times, improve responses during emergencies, and build more resilient systems that ensure contraceptive access at all stages of development, fragility, crisis, and recovery.

- **Support advocacy and mobilization** targeting governments, donors, inter-agency coordination mechanisms, and other stakeholders to integrate preparedness in ongoing health programming during stable times and prioritize SRH, including contraception, in emergency response and recovery.

- **Use data to inform programmatic decision-making and conduct rigorous evaluations to continue building the evidence base** on effective strategies to deliver contraceptive services across the emergency programming cycle.

How to do it: Technical recommendations for humanitarian response partners

Within existing contraceptive programming in humanitarian settings, specific gaps hinder access to good quality services. These gaps include l*ack of method mix* (particularly long-acting reversible contraception [LARCs] and emergency contraception [EC]); *barriers to access for adolescents and members of marginalized populations; gaps in availability of contraceptive commodities;* and *poor data collection and use*. Here's how to address these gaps:

To improve provision of the full range of contraceptive methods, including LARCs and EC:

- **Implement social and behavior change communications for contraception, particularly awareness raising on EC and LARCs,** among populations affected by crises through partnerships with community-based organizations and leveraging media outlets.
- **Partner with social marketing agencies and the private sector to make EC available i**n a wide range of outlets in crisis-affected settings.
- **Strengthen provider knowledge, attitudes, and competency on contraceptive service provision, with a focus on EC and LARCs (both insertions and removals),** and on rights-based, inclusive contraceptive counseling that emphasizes client choice and informed decision-making.
- **Diversify and expand contraceptive service delivery points by integrating community-based distribution activities and self-care methods,** including EC and subcutaneous injectable contraceptives, into contraceptive programming from preparedness to response to recovery.

To increase access to contraceptive services for adolescents and marginalized populations:

- **Directly engage adolescents and marginalized populations in contraceptive programming,** including people with disabilities; people with diverse sexual orientation, gender identity, gender expression, and sex characteristics; and members of other diverse populations, including local organizations led by these groups.
- **Address stigma and transform gender norms** through community sensitization and values clarification activities.
- **Expand alternative, proven service delivery modalities,** many of which were used successfully during the COVID-19 pandemic–such as telehealth, service delivery points outside of traditional facilities, and multi-month provision of short-acting methods.
- **Pilot new service delivery modalities,** such as the use of cash or vouchers to support access to contraceptive services.
- **Coordinate with protection actors** to deliver integrated, adolescent-friendly health and protection programming, including contraceptive services, to expand access for adolescents and address adolescents' unique needs.

To improve contraceptive commodity availability:

- **Hire and train pharmaceutical supply chain experts on management of contraceptive commodities in emergencies**, including on supply chain data collection, analysis, and use in decision-making.

- **Integrate supply chain preparedness in all SRH preparedness efforts** to build more resilient supply chains for SRH and ensure availability of SRH supplies, including contraception, when crises occur.[12]
- **Partner with governments and other actors to strengthen SRH supply chains as acute emergencies subside and transition to more stable supply chains** across protracted crisis and recovery settings.

To strengthen data collection and use for contraceptive service delivery:

- **Systematically include data collection activities in contraceptive programming grants**, including training health facility staff on contraceptive data collection, storage, analysis, and use.
- **Use standardized indicators[13] and data collection tools,** in alignment with the World Health Organization's forthcoming Global Roadmap for Improving Data, Monitoring, and Accountability for Family Planning and Sexual and Reproductive Health in Crises.

Additional Information:

The summary report of WRC's two-year landscape assessment of contraceptive services in crises and other reports are available here. For more information about this brief, please contact Sarah Rich, associate director, Sexual and Reproductive Health and Rights Program, WRC, at SarahR@wrcommission.org. To engage in global discussions about SRH needs in crisis settings, contact Sarah Knaster, IAWG coordinator, at SarahK@wrcommission.org.

Women's Refugee Commission

The Women's Refugee Commission improves the lives and protects the rights of women, children, and youth who have been 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. www.womensrefugeecommission.org

Inter-Agency Working Group on Reproductive Health in Crises

IAWG is an international coalition of organizations and individuals working collectively to advance sexual and reproductive health and rights in humanitarian settings. https://iawg.net

FP2030

FP2030 is the only global partnership centered solely on family planning. This singular focus allows us to bring together the widest possible range of partners across disciplines and sectors, while situating family planning at the crossroads of the global health, development, and gender equality agendas. https://fp2030.org

Endnotes

1 United Nations Office for the Coordination of Humanitarian Affairs Global Humanitarian Overview 2023, https://humanitarianaction.info/gho2023.
2 The humanitarian-development nexus recognizes that settings do not transition linearly between humanitarian and development status, but rather they can exist simultaneously in the same space and fluctuate back and forth. Emergency preparedness and recovery are two entry points for humanitarian and development actors to explicitly collaborate with communities, civil society organizations, and governments to build resilience to mitigate the impacts of crises and improve response and recovery.
3 "Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus," 2021, www.womensrefugeecommission.org/research-resources/contraceptive-services-humanitarian-settings-and-the-humanitarian-development-nexus/.
4 Across diverse contexts, 30% to 40% of women experiencing displacement did not want to become pregnant in the next two years, and 12% to 35% wanted to limit the number of pregnancies. The proportion of women who want to prevent pregnancy can be even higher in some populations. Nearly three quarters of pregnant Syrian refugee women surveyed in Lebanon wished to prevent future pregnancy, and more than one half did not desire their current pregnancy. See: McGinn et al., (2011), "Family Planning in Conflict: Results of Cross-sectional Baseline Surveys in Three African countries," *Conflict and Health* 5: 11, http://www.conflictandhealth.com/content/5/1/11, and Benage et al., (2015), "An assessment of antenatal care among Syrian refugees in Lebanon," *Conflict and Health* 9(8).
5 See: S.E. Casey, et al, (2013), "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," *Glob Public Health* 8:284–97, and Sara Casey and Martin Tshimpamba, (2017), "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* 11(2).
6 Quality of care in family planning programs is often guided by a framework that encompasses choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services. J. Bruce, "Fundamental elements of the quality of care: a simple framework," *Stud Fam Plann*. 1990;21: 61–91.
7 See, for example, D.W. Curry, J. Rattan, J.J. Nzau, and K. Giri, "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. See, also, D.W. Curry, J. Rattan, S. Huang, E. Noznesky, "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. See also L.S. Ho and E. Wheeler, "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.
8 Fulfilling unmet need for contraception could avert nearly one in three maternal deaths. See, for example, Ahmed et al., (2012), "Maternal deaths averted by contraceptive use: an analysis of 172 countries," *The Lancet* 380: 111-125, https://pubmed.ncbi.nlm.nih.gov/22784531/, and Cleland et al., (2006), "Family planning: the unfinished agenda," *The Lancet, The Lancet Sexual and Reproductive Health Series*, http://www.who.int/reproductivehealth/publications/general/lancet_3.pdf.
9 See also the High-Impact Practices in Family Planning (HIPs) "Family Planning in Humanitarian Settings: A Strategic Planning Guide," 2020.
10 See also *Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies,* FP2030.
11 IFRC, (2018), "Grand Bargain Localisation Workstream - Home," (blog), http://gblocalisation.ifrc.org/grand-bargain-localisation-workstream-2/.
12 See more at: https://fp2030.org/sites/default/files/ready_to_save_lives/SRH_preparedness_toolkit_brief-supply-chain.pdf, https://fp2030.org/sites/default/files/ready_to_save_lives/tip_sheet_SRH_COOP.pdf.
13 See indicators in the *Inter-Agency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings* and the FP2030 Measurement Framework.

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Women's Refugee Commission, 15 West 37th Street, 9th Floor, New York, NY 10018
info@wrcommission.org | www.womensrefugeecommission.org | @wrcommission