




Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus: Summary of Gaps and Recommendations from a State-of-the-Field Landscaping Assessment

March 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.

The **Inter-Agency Working Group on Reproductive Health in Crises** (IAWG) is a coalition of international nongovernmental organizations, national agencies, and UN agencies working together to advance sexual and reproductive health and rights in humanitarian settings.

Family Planning 2030 (FP2030) (formerly FP2020) is a global partnership to empower women and girls by investing in rights-based family planning. Founded at the London Family Planning Summit in 2012, the platform FP2030 has built is resilient, inclusive, and effective.

Acknowledgments

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Cover photo: Contraceptives seen in a private dispensary at a market in Kutupalong camp, Cox's Bazar, Bangladesh. © Rumana Akter/WRC

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EXECUTIVE SUMMARY

The Women's Refugee Commission (WRC) completed a landscaping assessment from 2018–2020 to evaluate and build the evidence base on barriers, opportunities, and effective strategies to provide contraceptive services to women and girls affected by crises. The assessment included a literature review, a global contraceptive programming survey, case studies in three humanitarian settings, and two sets of key informant interviews (KIIs). The second set of KIIs was conducted after the COVID-19 pandemic began and aimed specifically to understand the effects of COVID-19 on contraceptive services. All other assessment components were completed before the start of the pandemic.

The findings revealed several primary gaps that hinder access to contraceptive programming in humanitarian settings. Based on the findings, key overarching recommendations for governments, donors, and implementing agencies across the humanitarian-development continuum include:

- **Continue building awareness that contraception is part of the package of essential health services in humanitarian settings:** Conduct ongoing advocacy and mobilization with governments, donors, and other partners to prioritize sexual and reproductive health (SRH), including contraception, within humanitarian preparedness, response, and recovery, and to improve understanding that contraception is a lifesaving health service and the standard of care that must be made available in all crises.
- **Improve provision of the full range of contraceptive methods, particularly long-acting reversible contraception (LARCs) and emergency contraception (EC):** Implement task-sharing policies, remove policy restrictions on EC and LARCs, and make EC available in a wide range of outlets; increase providers' knowledge of EC and LARCs, including LARC insertion and removal, and provide training on rights-based contraceptive counseling that emphasizes client choice and informed decision-making; and build awareness of EC and LARCs among populations affected by crises.
- **Increase access to contraceptive services for adolescents and members of other marginalized populations:** Engage adolescents, persons living with disabilities, and members of other marginalized populations, including local organizations led by these groups, in contraceptive programming from preparedness to response to recovery; employ alternative service delivery modalities to reach adolescents and members of other marginalized populations; and address stigma through community sensitization and values clarification activities.
- **Improve contraceptive commodity availability:** Engage staff with pharmaceutical supply chain management skills during emergency preparedness, response, and recovery; integrate emergency preparedness into investments in strengthening SRH supply chains during stable times, including training on management of contraceptive commodities in emergencies; and invest in strengthening SRH supply chains after an acute emergency to transition to a more stable supply chain.
- **Strengthen data collection and use for contraceptive service delivery:** Train health facility staff on contraceptive data collection, analysis, and use, and budget adequately for data collection activities; standardize and streamline contraceptive indicators and data collection tools used in humanitarian settings; and build the evidence base on effective strategies to deliver contraceptive services across the emergency programming cycle.
- **Invest in preparedness for contraceptive service delivery:** Integrate contraception in emergency preparedness and disaster risk management policies and budgets; strengthen capacity of governments and partners across the humanitarian-development continuum to

engage in preparedness and response; and advocate for preparedness to become a routine component of governments' and development agencies' SRH programming and coordination during stable times.

- **Localize contraceptive service delivery in crisis-affected settings:** Support and strengthen local partners, from governments to community-based organizations, to lead contraceptive service delivery from preparedness to response to recovery; provide flexible, long-term direct funding to local SRH organizations and government agencies; and address barriers in the international aid architecture that impede participation of local SRH stakeholders.
- **Extend and institutionalize mechanisms that have been instituted during COVID-19 to improve contraceptive availability and access,** including multi-month provision of short-acting methods, telemedicine and digital protocols, task-shifting and sharing, community-based provision of methods, integration of contraception in primary health activities, and [self-care methods](#) including self-injection of subcutaneous injectables.

A complete list of recommendations can be found at the end of each section.



A staff member of the NGO AMODEFA and a health provider display reproductive health IEC materials in the family planning and consultation tent in a rural health center in Dondo, Sofala Province, Mozambique.
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INTRODUCTION

Contraception is lifesaving and a priority health service in emergencies. The 2018 [Minimum Initial Services Package](#) (MISP) for sexual and reproductive health (SRH),¹ the global standard for SRH response in acute emergencies, includes prevention of unintended pregnancies as one of six objectives. Contraception should be made available along with other essential SRH services at the outset of every emergency response, including epidemics and pandemics, and should be [scaled up](#)² further after the acute stage of an emergency.³

Despite some progress made toward making contraceptives available in humanitarian settings, contraceptive service provision continues to be a gap in humanitarian health funding and programming, even as humanitarian needs are climbing at an unprecedented pace.⁴ This inattention undercuts the efficacy of humanitarian assistance and does a significant disservice to crisis-affected individuals. The global COVID-19 pandemic has only amplified the need for humanitarian assistance, with the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) reporting that 235 million people will need humanitarian assistance in 2021, a nearly 40 percent increase from 2020.⁵ Moreover, several Sustainable Development Goals depend on robust, equitable access to voluntary contraceptive services—particularly as COVID-19 erodes hard-won development gains on a global scale.⁶ Investing in contraceptive services prevents maternal mortality and morbidity, fosters resilience, promotes participation in livelihoods and education initiatives, and empowers women and girls.

It is therefore critical that stakeholders—including donors, governments, and implementing agencies across the humanitarian-development continuum—have access to robust evidence on the state of contraceptive service provision in humanitarian settings. Accordingly, with support from the Bill & Melinda Gates Foundation and Danida, the Women's Refugee Commission (WRC) launched a landscaping assessment to evaluate and build the evidence base on barriers, opportunities, and effective strategies to provide the full range of contraceptives to women and girls affected by crises.

This brief summarizes findings from the landscaping assessment and provides recommendations developed collaboratively during two consultations (one in English and one in French) with stakeholders from the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and Family Planning 2030 (FP2030) (formerly FP2020) to improve access to contraception in humanitarian settings and across the humanitarian-development nexus.

- 1 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM), Chapter 3: Minimum Initial Services Package*, <https://iawgfieldmanual.com/manual/misp>.
- 2 IAWG, IAFM, Chapter 7: Contraception, <https://iawgfieldmanual.com/manual/contraception>.
- 3 IAWG, IAFM, <https://iawgfieldmanual.com>.
- 4 S.K. Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review," *Conflict and Health*, 2015;9: 11. doi:10.1186/1752-1505-9-S1-11.
- 5 OCHA, *Global Humanitarian Overview 2021* (2020), https://reliefweb.int/sites/reliefweb.int/files/resources/GHO2021_EN.pdf; OCHA, *Global Humanitarian Overview 2020*, (2019), <https://reliefweb.int/report/world/global-humanitarian-overview-2020-enarfrzh>.
- 6 *The Sustainable Development Goals Report 2020*, <https://unstats.un.org/sdgs/report/2020>.

METHODS

The assessment included a literature review, a global contraceptive programming survey, case studies in three humanitarian settings, and two sets of key informant interviews (KIIs). All assessment components were completed before the start of the COVID-19 pandemic, except the second set of KIIs, which were conducted after the pandemic began and aimed specifically to understand the effects of COVID-19 on contraceptive services.⁷

Literature review: The literature review assessed the evidence on contraceptive service delivery in humanitarian settings published between 2010 and 2019. Researchers searched PubMed for peer-reviewed literature, and used Google, ReliefWeb, and organizational websites to identify grey literature. WRC identified 75 peer-reviewed articles and 22 grey publications for inclusion.

Global contraceptive programming survey: The survey captured a snapshot of the state of contraceptive service delivery among organizations providing contraception in humanitarian settings. Seven international NGOs, 12 national or regional NGOs, and one UN agency participated, representing 84 programs providing contraceptive services across 42 countries and territories. Data collection concluded in spring 2019.

Case studies: WRC conducted case studies in 2019 in Cox's Bazar, Bangladesh⁸; Borno State, Nigeria⁹; and Cyclone Idai-affected areas of Mozambique¹⁰ to document contraceptive service delivery to affected populations. In each setting, WRC completed KIIs with government, UN, and partner organizations; facility assessments, including the administration of knowledge and attitudes questionnaires to providers; and focus group discussions (FGDs) with affected communities.

First set of key informant interviews (before the start of COVID-19): The first set of KIIs examined what works to support contraceptive programming in transition periods across the preparedness to relief to recovery continuum, including challenges and strategies to improve collaboration across the humanitarian-development nexus. WRC conducted 14 interviews in 2019 with 17 key informants working across humanitarian and development settings, including one UN agency, six international nongovernmental organizations (INGOs), and one national nongovernmental organization (NGO), representing nine headquarters-based staff and eight field-based staff.

Second set of key informant interviews (after the start of COVID-19): The second set of KIIs aimed to document the effects of COVID-19 on contraceptive service delivery; innovations and adaptations to ensure that contraceptive services remained available and accessible; and facilitators and barriers to contraceptive service delivery during COVID-19 across the humanitarian-development nexus. WRC conducted 29 interviews in fall 2020 with representatives of one UN agency, three representatives of government health authorities from three countries, 11 INGOs (including a mix of headquarters- and field-based staff), and five national NGOs in humanitarian and development settings across regions. Twenty-three interviews were conducted in English and six interviews were conducted in French.

7 For more details on methodology and findings from each component of the research, refer to the five reports consolidated at www.womensrefugeecommission.org/research-resources/contraceptive-services-humanitarian-settings-and-the-humanitarian-development-nexus.

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

9 WRC, *Gap between Supply and Demand for Contraceptive Services in Northeast Nigeria* (2020), www.womensrefugeecommission.org/research-resources/contraceptive-services-gap-nigeria.

10 WRC, *Opportunities and Challenges for Contraceptive Service Delivery in Cyclone Idai-Affected Areas of Mozambique* (2020), www.womensrefugeecommission.org/research-resources/opportunities-challenges-for-contraceptive-service-delivery-in-cyclone-idai-affected-areas-mozambique.



KEY THEMES ACROSS THE ASSESSMENT

The assessment findings reinforce the importance of conducting ongoing advocacy and mobilization with governments, donors, and implementing agencies across the humanitarian-development continuum to **prioritize contraception as part of SRH in humanitarian settings, from preparedness to response to recovery**. Among the 20 organizations that completed the global contraceptive programming survey, one-fourth of their health programs did not include contraceptive services. As the survey targeted organizations that regularly integrate contraception into their programs, this proportion would likely be higher for many humanitarian organizations that did not participate in the survey.

It is therefore critical to continue to **build consensus that contraception is lifesaving and part of the package of essential health services that must be made available to all women and girls affected by crises**. The COVID-19 crisis has underlined the need to continue raising awareness that contraceptive services, along with other essential SRH services, are part of the standard of care in all emergencies. Many key informants reported that contraception and other SRH services were particularly impacted during the pandemic because key decision-makers did not perceive them to be essential or lifesaving. Contraception must be integrated, along with other SRH services, into humanitarian response plans and funding, emergency preparedness policies and budgets, and health programming provided during acute response, protracted response, and recovery.

The findings across the assessment revealed several **specific gaps that hinder access to and availability of high-quality contraceptive programming**—inclusive of services and information—in humanitarian settings, including:

- provision of the full range of contraceptive methods, particularly long-acting reversible contraception (LARCs) and emergency contraception (EC);
- access to contraceptive services for adolescents and members of other marginalized populations;
- contraceptive commodity availability;
- data collection and use for contraceptive service delivery programs;
- preparedness for contraceptive service delivery prior to an emergency, including through collaboration across humanitarian and development partners;
- localization of humanitarian response, including government and local NGO engagement, for contraceptive service delivery.

The findings and recommendations presented below are organized by these key gap areas, and also include a section discussing disruptions and adaptations to contraceptive service delivery amid the COVID-19 pandemic.

Contraceptive method mix and quality of care

Across all research methods, key findings reflected persistent gaps in provision of the full range of contraceptive methods in humanitarian settings. It is important to note that while much of the available data and research about contraceptive programming in humanitarian settings address a specific set of methods, other methods are also critical to a full method mix.

The contraceptive programming survey showed that oral contraceptive pills (OCPs) and injectables were available in more than 90 percent of contraceptive programs, while EC and LARCs, including implants and intrauterine devices (IUDs), were somewhat less available.¹¹ The case studies also reflected lower availability of LARCs and EC as compared to OCPs and injectables. The survey showed that permanent methods were offered even less frequently, in less than half of contraceptive programs. Permanent methods were not discussed widely across the literature review or in the other assessment methods.

The literature review and case studies suggest that a lack of trained providers is a critical barrier to the provision of LARCs, and a lack of provider awareness about EC, along with misconceptions, are barriers to provision of information about EC. Across the case studies, health facility assessments and knowledge and attitudes questionnaires indicated some providers had not been trained on or had inaccurate information about these methods.

Knowledge of LARCs and EC among affected populations is also low. The literature review showed that knowledge of EC among affected communities was extremely low across settings, even where knowledge of other methods was relatively high. In all three case studies, crisis-affected people were unfamiliar with or had extremely low knowledge of EC, and were less familiar with LARCs than with short-acting methods.

Moreover, dedicated EC products continue to be only intermittently available in humanitarian settings. Where EC is available, it is often limited to post-rape care. The literature review suggests that commodity availability is impacted when products are not registered in-country, as is sometimes the case with EC pills. The case studies also showed that stockouts of supplies and equipment contributed to lower availability of LARCs.

KIIs conducted after the start of COVID-19 suggest that the availability of LARCs was particularly impacted, especially in the earlier phases of the pandemic. Respondents posited that this was due to providers needing to use personal protective equipment (PPE), which was often in short supply, for insertion and removals, and because LARC provision cannot be supported via telemedicine.

To improve contraceptive method mix and quality of care in crisis-affected settings:

- **Expand provision of the full contraceptive method mix**, including EC, LARCs, permanent methods, and other methods. Evidence indicates that the more methods available, the more women and girls will use a method.¹² As new methods become available, the method mix in

11 Many of the contraceptive programs surveyed included multiple service delivery points. If methods were provided in at least one service delivery point within a contraceptive program, they were counted as available in the program.

12 J. Rosset al., "Contraceptive method choice in developing countries," *Int Fam Plan Perspect*, 2002;28:32–40; J. Ross and J. Stover, "Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009," *Glob Health Sci Pract*, 2013;1:203–12; S.E. Casey et al., "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*, 2013;8:284–97; 1. S.E. Casey and M. Tshipamba, "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.



humanitarian settings should adjust to reflect the full method mix through efforts to integrate new methods during preparedness and in post-acute emergency settings. For example, it is important to continue to authorize and support self-injection of DMPA-SC.

- **Increase knowledge of EC among people affected by crises through partnerships with local organizations working in affected communities and mass media campaigns** to broadly disseminate information about EC. Campaigns and messaging should be tailored to reach members of marginalized populations.
- **Make EC widely available in a range of service delivery points and modalities in humanitarian settings**, including pharmacies, markets, health facilities, community-based distribution, and safe spaces. Ensure that staff in these outlets have access to accurate information about EC. Where dedicated EC pills are not available, the Yuzpe method (use of OCPs to make EC) should be made available. EC can be made available to populations in transit by piloting the inclusion of EC in supplies provided to women on the go.
- **Register EC products nationally and remove policy restrictions on EC and LARCs**, such as parental and spousal consent requirements, prescription requirements, and residence requirements. Integrating methods fully into contraceptive policies and programming during stable times will improve preparedness for full method mix during emergencies.
- **Authorize community-based distribution of short-acting methods, including EC, and authorize mid-level providers to insert and remove LARCs.**¹³ Ensure all authorized providers, including community-based distributors, are trained, stocked, and supported to provide these methods.
- **Conduct values clarification with health providers to address misconceptions and negative attitudes toward EC and LARCs.** Ensure that providers are aware that EC can be used not only for post-rape care, but at any time unprotected sex occurs.
- **Conduct clinical, on-the-job, and refresher trainings with practicums on LARC insertion and removal, paired with ongoing supportive supervision mechanisms.** During acute response, use tailored trainings such as the [SRH Clinical Outreach Refresher Trainings for Humanitarian Settings](#) (S-CORTS).¹⁴ Allow mid-level providers to conduct trainings where high-level staff are not available. During training, disseminate relevant job aids, including guidance and checklists.
- **Train health providers on rights-based contraceptive counseling** emphasizing client choice and autonomy, fully informed decision-making, confidentiality, and respect for individual needs and dignity. Ensure that training addresses counseling on all available methods, including EC and LARCs, and highlights that condoms are the only method that prevents both pregnancy and transmission of HIV/STIs.

13 WHO, *Task sharing to improve access to Family Planning/Contraception* (2017) <https://apps.who.int/iris/bitstream/handle/10665/259633/WHO-RHR-17.20-eng.pdf?sequence=1>.

14 IAWG Training Partnership Initiative, *SRH Clinical Outreach Refresher Trainings for Humanitarian Settings (S-CORTS)* (2020), <https://iawg.net/resources/srh-clinical-outreach-refresher-trainings-for-humanitarian-settings>.

Adolescents and other marginalized populations

Data across the assessment clearly shows that adolescents want, need access to, and will use SRH information and services, including contraception, but continue to face heightened barriers to SRH in humanitarian settings. The assessment also indicates a paucity of targeted programming and research on the unique contraceptive programming needs for diverse groups, including persons with disabilities and members of other marginalized populations.

Adolescents: The case studies highlighted that stigma and negative attitudes from both community members and health providers, and opposition from parents and/or spouses, present significant barriers to accessing contraceptive services for adolescents, particularly unmarried girls.

In the contraceptive programming survey, across all regions, 41 percent of programs reported that contraceptive services were available and accessible for unmarried adolescent girls most of the time or always, but 41 percent also reported that they were never or only sometimes available. Regional variations emerged, with only 13 percent of respondents in the Middle East and North Africa reporting contraceptive services to be available and accessible to unmarried adolescent girls most of the time or always, as compared to 68 percent of respondents in Sub-Saharan Africa.

Persons with disabilities: In the case studies, crisis-affected people in FGDs reported that persons with disabilities faced greater barriers to accessing contraceptive services, including distance to service delivery points, lack of transportation, and inaccessible facilities. However, the literature review showed very limited evidence on contraceptive programming, barriers, and access for persons with disabilities. Moreover, in the contraceptive programming survey, high percentages of respondents across regions reported that they did not know about the accessibility and availability of contraceptive services for persons with disabilities—reflecting the need for increased data collection, research, and programming designed to meet the needs of persons with disabilities.

Other marginalized populations: Large percentages of respondents in the contraceptive programming survey also reported that they did not know if contraceptive services were accessible and available for LGBTQI and gender nonconforming persons and people engaged in transactional sex—again reflecting the need for increased data collection and programming for diverse populations.

To improve access to contraceptive services for adolescents and members of other marginalized populations in crisis-affected settings:

- **Engage adolescents¹⁵ and other marginalized populations in all stages of contraceptive program planning, implementation, monitoring and evaluation, and decision-making processes,** from preparedness to response to recovery. Specifically, integrate adolescents and other marginalized populations into broader SRH needs assessments; use participatory methods like storytelling to collect and share data; co-analyze data and co-facilitate presentation; and employ tested social accountability tools.
- **Partner with local organizations led by youth, persons with disabilities, LGBTQI persons, and other marginalized populations** to improve access for marginalized groups while strengthening local partners.
- **Identify and employ alternative service delivery modalities and locations to reach adolescents**

15 IAWG, *Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings: 2020 Edition* (2020), https://iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition?utm_source=resource-launch&utm_medium=email&utm_campaign=asrh-toolki.



and other marginalized populations. For example, identify service delivery points outside of traditional facilities that are frequented by these populations; ensure that home-based services are available for people who cannot travel easily; address cost barriers for adolescents and other marginalized populations through vouchers and/or free services; and integrate contraceptive services with other health, including SRH, and non-health services.

- **Adapt and use digital and self-care approaches** to reach populations that face barriers to accessing contraceptive services. Build on telemedicine protocols implemented during COVID-19 and expand access to self-care methods, including self-injection of DMPA-SC.¹⁶
- **Conduct values clarification with health providers to strengthen adolescent-friendly services,** including educating providers on internationally agreed human rights standards and the unique needs of diverse groups of adolescents.
- **Conduct community sensitization to address stigma, build awareness of adolescents' rights and needs, engage men and boys, and develop community champions** for adolescents' access to contraception. Parents, educators, community and religious leaders, and adolescents should all be included in these efforts to address social norms related to adolescent contraceptive use.
- **Institute comprehensive sexuality education to consistently reach diverse groups of adolescents,** including age-appropriate messages and information for very young adolescents (ages 10-14 years).
- **Integrate a gender-transformative and inclusive approach in all contraceptive programming** from preparedness to response to recovery, including participatory accountability methods. These principles should be applied from program design to implementation and monitoring.
- **Build the evidence base for effective strategies to reach adolescents and other marginalized populations** in humanitarian contexts and adapt programming as new evidence emerges.



View of Kutupalong camp, Cox's Bazar, Bangladesh. © Cassandra Puls/WRC

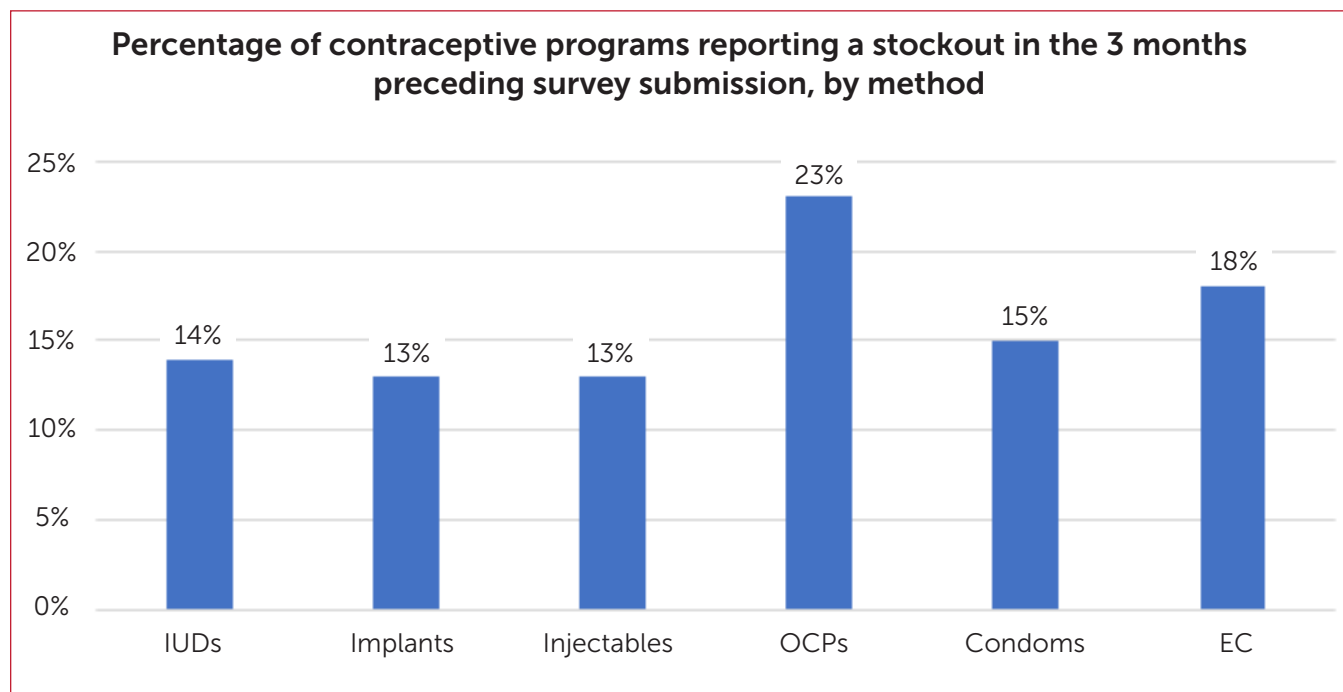
¹⁶ World Health Organization, *WHO Consolidated Guideline on Self-Care Interventions for Health. Sexual and Reproductive Health and Rights* (2019), <https://www.who.int/reproductivehealth/publications/self-care-interventions/en>.



Supplies

Contraceptive service delivery depends on the availability of supplies—but data from across the landscaping assessment suggests that challenges with supply chain management and supply availability persist across humanitarian settings.

The global contraceptive programming survey indicated that stockouts pose challenges across programs and methods. Stockouts of specific methods were reported in 13–23 percent of programs (although many submissions indicated that they did not know about the occurrence of stockouts, so it is possible that the occurrence of stockouts was even higher than is reflected in the data).



The literature review and case studies confirmed challenges with the availability of contraceptive supplies across humanitarian settings. In all three case studies, WRC documented stockouts of contraceptive commodities during health facility assessments. In the literature review, stockouts of various contraceptive methods, and of [Inter-Agency Emergency Reproductive Health](#) (IARH) kits,¹⁷ were documented or reported in multiple settings.

Across the three case study settings, IARH kits—which are designed specifically for the acute phase of an emergency—were in use. They were a primary source of contraceptive commodities in Cox’s Bazar and Borno State at the time of data collection. The contraceptive programming survey also measured the percentages of programs procuring methods through various sources in acute and post-acute settings. In both acute and post-acute emergency settings, approximately half of programs reported procuring contraceptive commodities from the UN Population Fund (UNFPA)/UN agencies. A greater proportion of respondents in post-acute settings reported procurement of methods from the government than in acute settings, where government procurement was least reported.

¹⁷ The IARH Kits are a set of pre-packaged kits managed by UNFPA, on behalf of IAWG, that contain all the medicines, devices, and commodities needed to implement the MISIP. They are complementary to the Interagency Emergency Health Kits (IEHK). <https://www.unfpaprocedurement.org/humanitarian-supplies>.



The contraceptive programming survey also documented common sources of delays for supplies and found that across regions, delays due to transportation in-country and financing were frequently reported. In the case studies, respondents in Borno State and Mozambique reported challenges related to supply chain management and stockouts that negatively impacted the availability of services. Challenges in these settings also included last-mile delivery, storage conditions, wastage, and quantification. The literature review reflected that poor data collection on supply chains and stocks impedes the ability of programs to forecast appropriately and procure supplies on a regular and sustainable basis.

During COVID-19, IIR respondents reported that movement restrictions had significant impacts on SRH supply chains at every level, from manufacturing, to imports and exports, to last-mile delivery. They also reported that limited international and domestic transportation options drove up transportation and shipping costs. Additionally, several respondents reported a decreased availability in IARH kits.

To improve contraceptive supply availability in crisis-affected settings:

- **Engage staff skilled in pharmaceutical supply chain management, including contraceptive commodities**, in all crisis-affected settings. This expertise should be integrated across the humanitarian program cycle, from preparedness, to acute and protracted response, to recovery.
- **Bolster training before and during crises on how to order, manage, use, and monitor IARH kits and bulk contraceptive commodities.** Implement practical, hands-on training sessions with refresher trainings and supportive supervision and mentoring mechanisms. Make online training available when in-person training is not possible.
- **Improve supply chain resilience by integrating emergency preparedness planning and budgeting into SRH supply chain strengthening investments during stable times.** The IAWG and Reproductive Health Supplies Coalition (RHSC) [recommend](#)¹⁸ robust collaborative action across national and sub-national governments and partners along the humanitarian-development continuum, including the following [activities](#)¹⁹:
 - » Map out likely needs, challenges, and contingencies along the supply chain.
 - » Create enabling policy environments to facilitate rapid entry of SRH products in crises.
 - » Integrate emergency SRH supplies into logistics management information systems (LMIS).
 - » Decentralize stock regionally or pre-position key supplies nationally, when strategic.
- **Invest in SRH supply chain strengthening after acute emergency response to transition to a more informed and stable supply chain** that meets demand for contraceptive methods while minimizing stockouts and wastage. The IAWG and RHSC [recommend](#)²⁰ decreasing reliance on the IARH Kits (which are designed for use specifically during acute crises) through [activities](#)²¹ such as strengthening data collection to inform SRH supply planning and quantification for bulk commodity procurement.

18 Reproductive Health Supplies Coalition and IAWG, *Ensuring universal access to sexual and reproductive health supplies* (no date), <https://cdn.iawg.rvgn.io/documents/Ensuring-universal-access-to-SRH-supplies.pdf?mtime=20201013164935&focal=none>.

19 IAWG et al., *Strengthening Supply Chains for Sexual and Reproductive Health Across the Humanitarian-Development Continuum to Fulfill the 2030 Agenda* (2019), https://cdn.iawg.rvgn.io/documents/Strengthening-supply-chains-for-SRH-across-humanitarian-development-continuum_information-brief_March-2019.pdf?mtime=20200206235434&focal=none.

20 Reproductive Health Supplies Coalition and IAWG, *Ensuring universal access to sexual and reproductive health supplies*.

21 IAWG et al., *Strengthening Supply Chains*.



- **Improve supply chain data collection, visibility, and use before and during crises** by disseminating supply chain data collection tools adapted for humanitarian settings, tracking IARH Kits and other contraceptive supplies to the last mile, and interfacing supplies data with health management information systems (HMIS) to improve communication between programs and logistics.
- **Partner with private sector service delivery outlets, including local drug stores and medicine vendors**, to broaden the range of outlets where consumers can obtain high-quality contraceptive supplies.



Contraceptive supplies in a health center, Mozambique. © Katherine Gambir/WRC



Data collection and use, including building the evidence base

Findings across the landscaping assessment demonstrated gaps in data collection and use—which is essential to ensure successful contraceptive service delivery.

While coordination mechanisms were in place across all three case studies to present and review data regularly among partners participating in the SRH response, the data was often incomplete, late, or of low quality. Additionally, the health facility assessments indicated limited displays of data across sites, and varying capacity among providers to describe trends in contraceptive service delivery data and actions taken as a result of data reviews.

The case studies also indicate inconsistent and shifting definitions of indicators that led to challenges interpreting and using data. Respondents in Cox's Bazar noted that inconsistent definitions of indicators among implementing partners complicated efforts to review and compare data. In Mozambique, several respondents reported that a change in the national definition of "new user of family planning" prior to the cyclone led to challenges with data accuracy, including during the cyclone response.

During the COVID-19 pandemic, some KII respondents reported that movement restrictions impacted data collection, although not all respondents had this experience. Respondents also said that data collection became increasingly electronic, including via WhatsApp.

Finally, the literature review revealed a lack of robust data evaluating what works to deliver effective contraceptive services in humanitarian settings. 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. There is also evidence for community-based service delivery via mobile health units and community health workers, the provision of contraception in post-abortion care, and subsidies and voucher programs. However, more data is needed to improve understanding of what works to effectively deliver contraceptive services across diverse humanitarian settings.

To improve contraceptive data collection and use in crisis-affected settings:

- **Budget appropriately for contraceptive data collection activities in health facilities to improve data quality and reporting consistency.** Health facility staffing plans must take into account the level of effort needed to collect timely and accurate data.
- **Train health facility staff on contraceptive data collection, analysis, and use.** Training should address why timely and accurate data is important; how to interpret, visualize, and display data; and how to use data to inform decision-making. As much as possible, training on contraceptive data collection during crises should be integrated into emergency preparedness.
- **Standardize and streamline contraceptive indicators and data collection tools used in humanitarian settings** so that data can be captured consistently and compared across programs, locations, and implementers. Ensure that family planning registers track all methods, including EC. Data disaggregation across sex, age, and disability with standard groupings should be routinized. Transitioning to digital data collection systems prior to emergencies may help prevent disruptions that occur during emergencies, such as destroyed health facility registers.
- **Strengthen mechanisms to facilitate regular use of data in decision-making,** including consistent data review meetings with all relevant partners, at national to sub-national to facility levels.



- **Build the evidence base on effective strategies to deliver contraceptive services across the emergency programming cycle** by publishing routine program data as well as conducting rigorous, mixed-methods research. Disseminate findings, including what does not work.



The head of family planning at the Mogcolis clinic in Borno State, Nigeria (left) reviews the family planning registry with WRC's project consultant. © Katherine Gambir/WRC



Emergency preparedness

Key findings across the landscaping assessment, particularly in the case studies and KIs, consistently highlighted the importance of preparedness for efficient and effective SRH humanitarian response—largely by demonstrating that it is a persistent gap.

In the KIs focused on contraceptive programming in transition periods across the preparedness to relief to recovery continuum, conducted prior to COVID-19, respondents emphasized that 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 recovery. Respondents discussed implementing preparedness activities, including supply chain strengthening, strengthening providers' clinical skills, and developing staff capacity to advocate for inclusion of SRH, including contraception, in emergency preparedness and response. These activities also contribute to building local ownership, ensuring programs are sustainable and resilient. Both humanitarian and development respondents felt that the preparedness phase of the continuum offers a critical window for partners across the humanitarian-development nexus to coordinate and work together.

Findings from the Cox's Bazar case study reinforced that effective preparedness strategies supported contraceptive service delivery and coordination during the crisis. UNFPA reported having supplies from early in the emergency, in part because IARH kits were pre-positioned in Bangladesh as part of preparedness for cyclone season. UNFPA's early support to organizations that were already present and registered in Bangladesh, as well as a strong NGO sector in Bangladesh, also helped to ensure availability of contraceptive services early in the response.

In Mozambique, respondents reported that the presence of government family planning focal points at the district level prior to Cyclone Idai supported the inclusion of contraceptive service delivery in the response. However, multiple respondents noted that a general lack of emergency preparedness prior to the cyclone posed challenges during the response. Respondents reported that awareness of the MISP for SRH was generally low among government staff and providers at the outset of the response. Respondents also reported lack of familiarity with IARH kits and their management. More broadly, they said that lack of capacity for supply chain management prior to the cyclone exacerbated challenges with contraceptive supply availability during the response.

KIs conducted after the start of the COVID-19 pandemic reinforced the importance of preparedness. Several respondents reported that preparedness activities conducted prior to the pandemic, particularly training staff and providers on the MISP for SRH and strengthening the supply chain, supported the response. However, humanitarian and development respondents largely reported that neither governments nor organizations had health or SRH preparedness plans in place prior to the pandemic, a gap that impeded actors' ability to respond quickly. Several respondents perceived that settings with experience responding to Ebola were more prepared for COVID-19 response. Notably, several development respondents expressed the perception that development stakeholders still consider preparedness to be under the humanitarian remit, not part of the development remit.

To improve preparedness for contraceptive service delivery during emergencies:

- **Integrate SRH, including contraception, in emergency preparedness plans and disaster risk management for health policies.**²² These plans should incorporate the MISP for SRH and anticipate the specific barriers that arise in accessing contraceptive services during

22 Family Planning 2020 (now FP2030), *Ready to Save Lives: Sexual and Reproductive Health Care in Emergencies* (2020), <http://familyplanning2020.org/srh-toolkit>.

emergencies, including providing a full range of methods to meet demand; reaching adolescents and members of other marginalized populations; ensuring reliable supply of commodities; and collecting and using accurate and timely data.

- **Advocate for emergency preparedness to become a routine component of governments' and development agencies' SRH programming and coordination during stable times.** Preparedness activities and funds should be integrated widely, including in standing national and sub-national technical working group activities. To make the case for governments and development agencies to include preparedness in their routine SRH work, disseminate evidence to governments, donors, and development stakeholders on the benefits and cost-effectiveness of preparedness, the disruptions that crises pose to ongoing SRH programming, the vulnerability of specific locations to crises, proven preparedness interventions, and the fact that contraception is a standard, essential, lifesaving service during emergencies.
- **Budget and provide funding for emergency preparedness for SRH, including contraceptive access,** within governments and implementing organizations across the humanitarian-development continuum. Designing and implementing preparedness strategies requires dedicated funding. Donors should fund, governments should budget for, and implementing partners should seek dedicated funding for SRH preparedness activities.
- **Identify, build relationships with, and strengthen local SRHR organizations serving marginalized groups before emergencies strike** to develop networks and establish trust that can be leveraged during emergencies, and to facilitate funding flows to these organizations.
- **Strengthen capacity of governments and partners across the humanitarian-development continuum to conduct preparedness planning and participate in the response** in the event of an emergency, including participation in humanitarian coordination systems and [training](#) on implementation of the MISP for SRH and IARH kit management.²³ Advocate for governments to publicly signal commitment to provision of contraceptive services when crises emerge.



The head of family planning in the procedure room at the clinic in Mogcolis, Borno State, Nigeria.
© Katherine Gambir/WRC

²³ WRC and IAWG, *Minimum Initial Service Package for Sexual and Reproductive Health In Crisis Situations: A Distance Learning Module* (2019), <https://iawg.net/resources/minimum-initial-service-package-distance-learning-module>.



Localization

Key findings demonstrate the value and importance of investing in local actors to lead humanitarian SRH responses.

In the first round of KIIs, which focused on contraceptive programming in transition periods across the preparedness to relief to recovery continuum, respondents reported that partnering with local stakeholders and investing in local capacity supported sustainable, resilient programs that were better able to absorb shocks and respond to crises. Respondents emphasized the importance of localization for immediate SRH service provision at the outset of an emergency, as local communities and organizations are first responders. Moreover, local partners will remain on the ground after international organizations have departed.

In Mozambique, AMODEFA, the International Planned Parenthood Federation (IPPF) member association in-country, played an important role in the SRH response to Cyclone Idai, including delivering contraceptive services. The organization's experience reflected both the advantages and challenges local and national organizational organizations face. AMODEFA leveraged its long history of providing SRH services in Mozambique and its existing services, networks of community health workers, and relationships with communities to launch activities immediately following the cyclone. It coordinated MISIP implementation and conducted outreach and sensitization on available SRH services to affected communities, playing a critical role in linking communities with humanitarian actors.

However, AMODEFA reported that securing funding to support and sustain their participation in the response was a challenge, and a key barrier to participation of other national NGOs in the response. Similarly, KII 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, and ensuring they are equipped to manage larger-scale programs.

KII respondents reported that during the COVID-19 pandemic, movement restrictions illuminated the essential role that local actors play in responding to crises. INGO respondents reported success in providing technical support remotely, reinforcing the feasibility of shifting resources closer to the field. However, respondents noted that even with many stakeholders discussing localization during COVID-19, they had not observed corresponding funding shifts. They emphasized that operationalizing localization will depend on donor prioritization and investment.

To improve emergency preparedness, response, and recovery through localization of contraceptive service delivery:

- **Provide flexible, long-term direct funding to local SRHR organizations, government agencies, and working groups to conduct activities from preparedness to response to recovery,** and across program implementation, monitoring and evaluation, advocacy, and research. Donors must make concrete commitments to fund local organizations directly and to invest in and develop capacity of national and local actors, including governments, along the full emergency response cycle. This includes ensuring that local actors have the operational infrastructure needed to access and manage larger grants and programs, and adjusting eligibility criteria and reporting requirements that present barriers to local actors.
- **Support and strengthen local partners, from governments to community-based organizations led by women, youth, and members of other marginalized populations, to lead**

contraceptive service delivery from preparedness to response to recovery. Local partners must be engaged and equipped with the knowledge and resources to navigate the international aid architecture, including obtaining funding, engaging with the cluster system, and conducting preparedness, response, and recovery activities.

- **Assess and address barriers in the international aid architecture that impede the participation and leadership of national and local SRH stakeholders,** while instituting measures to integrate local organizations into humanitarian coordination systems from global to national to local levels. For example, ensure that basic provisions such as translations are available to enable engagement of local partners and consider measures such as instituting civil society “quotas” at meetings. Streamlining emergency coordination and funding mechanisms is critical to making them more accessible to local actors and tailored to local and national contexts.
- **Ensure that programming implemented by international actors engages local stakeholders,** including government authorities, civil society organizations, and community-based organizations, to strengthen health systems and ensure sustainability over the course of the humanitarian response cycle and different phases of an emergency and beyond. Donors should ensure that grants and grant periods provide the resources and time required to establish and develop local partnerships.



A Save the Children health worker at a health post in Kutupalong camp, Cox’s Bazar, Bangladesh.
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COVID-19

The COVID-19 pandemic [impacted](#) the availability and accessibility of contraceptive services across humanitarian and development settings.²⁴ Respondents were essentially unanimous in reporting that contraceptive service delivery was disrupted by restrictions instituted at the outset of the pandemic, including lockdowns, facility closures, and movement restrictions.

These restrictions impacted contraceptive services in several ways. Respondents reported that facilities in some settings were forced to close and that restrictions impeded both providers' and clients' ability to reach facilities, disrupted supply chains for contraceptive commodities, and forced the cessation of some community-based service delivery and sensitization activities. Respondents also reported that restrictions disrupted data collection and reporting, provider supervision, and training. Moreover, the restrictions hindered communities from being able to reach service delivery points. Many respondents perceived that barriers were particularly onerous for adolescents, rural or isolated communities, and for members of marginalized populations, including persons with disabilities and refugees.

The types of disruptions and adaptations to contraceptive service delivery amid COVID-19 were largely consistent across humanitarian and development settings and different organizations; however, the extent of the disruptions and the specific adaptations appeared to be influenced by the context in which each program operated, particularly the parameters of the restrictions and service delivery guidelines implemented in response to COVID-19.

Many respondents reported that SRH services, including contraception, were particularly impacted in part because government authorities did not perceive them to be essential or lifesaving. Respondents said that they advocated to governments to resume contraceptive service delivery with some success, but that some governments shifted funding away from contraception. Respondents reported that effective advocacy strategies included drawing on the [WHO guidelines on continuity of essential services](#)²⁵ and citing the potential long-term impacts of a lack of SRH services on maternal morbidity and mortality, including lessons learned in the aftermath of Ebola.

Organizations implemented numerous innovations and adaptations to ensure continuity of contraceptive services, including distributing short-acting methods in multi-month supplies; using telemedicine or other technology to provide counseling, direct clients to obtain methods, and conduct follow-up; task-shifting and sharing, including community-based service delivery; promoting self-administration of DMPA-SC and other self-care methods where feasible; and integrating contraceptive service delivery with the provision of other essential health services. Many respondents also reported using technology to adapt or maintain data collection and reporting, and to provide training, supervision, and psychosocial support to providers. However, some respondents reported not having the necessary resources, time, or electric and connectivity infrastructure to implement some technology-based adaptations or to reach all populations.

Respondents discussed a range of other factors influencing the availability of contraception amid COVID-19, including coordination and funding. Respondents reported that coordination was more effective in settings where stakeholders had existing relationships, and where robust coordination

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

25 WHO, *Coronavirus disease (COVID-19) technical guidance: Maintaining Essential Health Services and Systems*, www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/maintaining-essential-health-services-and-systems.

mechanisms were operating prior to the onset of the pandemic. Respondents from organizations working in both humanitarian and development settings cited the need to strengthen coordination across the nexus as an important lesson learned from their experience providing contraceptive services during the pandemic. Respondents reflected that as the number of countries at risk of or experiencing crisis mounts steadily, the distinctions between humanitarian and development settings are fading—rendering humanitarian and development silos outdated and inefficient.

To improve contraceptive access and availability during and after COVID-19:

- **Extend and institutionalize mechanisms that improve contraceptive availability and access**, including multi-month provision of short-acting methods, telemedicine and digital protocols, task-shifting and sharing, community-based provision of methods, integration of contraceptive service delivery in primary healthcare activities, and self-care methods including self-injection of DMPA-SC. These shifts will improve access during COVID-19, ensure preparedness for future crises, and boost access to contraceptive across stable and crisis times alike.
- **Address gaps in provision of or access to telemedicine and technology-based information and service delivery.** Invest in strengthening local organizations' and communities' access to technology and connectivity. Implement low- or no-tech service delivery modalities to avoid further marginalizing those with less access to technology.
- **Continue advocating that contraception is lifesaving and essential during the pandemic** using the [WHO guidelines on continuity of essential services](#)²⁶ and drawing on lessons learned from the Ebola crisis, which show the potential long-term impacts of a lack of SRH services on maternal morbidity and mortality.
- **Ensure that funding mechanisms and global recommendations empower implementing partners to adapt** contraceptive programming and service delivery to respond to emergent needs over the course and in the aftermath of the pandemic. Ensure that SRH service providers are supported to implement infection prevention measures, including provision of training and supplies.
- **Leverage heightened awareness of the risk of crisis to engage governments and development and humanitarian actors in emergency preparedness.** Introduce new actors into existing coordination mechanisms in both humanitarian and stable settings to integrate stakeholders across the humanitarian to development continuum at local, national, and global levels. For example, invite humanitarian partners to standing national and sub-national working groups and invite development stakeholders to cluster meetings. Ensure that contraceptive service delivery program design, implementation, and evaluation in humanitarian and development settings include health systems-strengthening activities to build resilience and capacity to absorb and manage shocks.
- **Integrate epidemic and pandemic preparedness into disaster risk reduction efforts**²⁷ to address barriers to contraceptive service delivery, such as movement restrictions, that emerged during COVID-19.

²⁶ Ibid.

²⁷ WHO, *Providing Family Planning Services During an Epidemic* (2021), www.fphandbook.org/sites/default/files/JHU%20HBk2021%20-%20NEW%20Chapter%2027%20proof%208%20%28002%29.pdf.



CONCLUSION

The assessment of contraceptive service delivery in humanitarian settings reinforces that people affected by crisis want and need access to contraception, but that contraceptive access in these settings remains uneven. The study identifies a clear set of barriers that must be addressed to improve contraceptive access for people affected by crises.

Governments, donors, and implementing agencies across the humanitarian-development continuum must **prioritize contraception within humanitarian programming from preparedness to response to recovery**, recognizing that contraception is lifesaving and part of the standard of care in emergencies. Specifically, they must mobilize to **improve access to the full method mix**, including LARCs and EC; **address barriers for adolescents and marginalized populations** to meet their clear demand for contraception; **improve data collection and use**; and **strengthen supply chains** to improve contraceptive commodity security. To address these gaps, stakeholders must collectively **strengthen preparedness** for SRH to mitigate the impact of crises and **invest in local partners** to foster effective, efficient SRH response and support sustainable recovery. Finally, it is critical to continue **building the evidence base** on effective contraceptive programming.

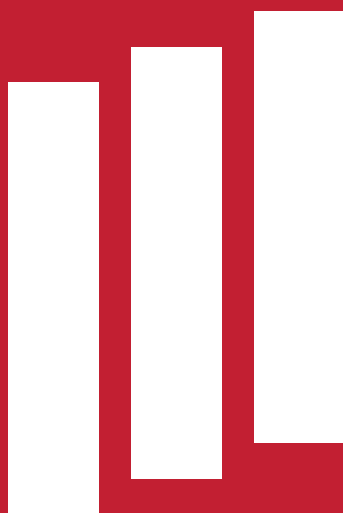
Addressing these key gaps will lead to significant improvements in contraceptive access in humanitarian settings and across the humanitarian-development nexus, improving the health and autonomy of women, girls, and others affected by crises.



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

Abbreviations

| | |
|---------|--|
| EC | Emergency contraception |
| FGDs | Focus group discussions |
| FP2030 | Family Planning 2030 (formerly FP2020) |
| IARH | Inter-Agency Reproductive Health (kits) |
| IAWG | Inter-Agency Working Group on Reproductive Health in Crises |
| IEHK | Interagency Emergency Health Kits |
| INGO | International nongovernmental organization |
| IPPF | International Planned Parenthood Federation |
| IUD | Intrauterine device |
| KII | Key informant interview |
| LARCs | Long-lasting reversible contraceptives |
| LMIS | Logistics management information systems |
| MISP | Minimum Initial Service Package (for SRH) |
| NGO | Nongovernmental organization |
| OCPs | Oral contraceptive pills |
| PPE | Personal protective equipment |
| RHSC | Reproductive Health Supplies Coalition |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| UN OCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| UNFPA | United Nations Population Fund |
| WRC | Women's Refugee Commission |



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