Final Report

Emergency Contraception in Crisis Settings Consultation

April 2nd, 2014

Arlington, VA
Executive Summary

On April 2, 2014, the Population Council, Women’s Refugee Commission, International Consortium for Emergency Contraception, and John Snow Inc. (JSI) hosted a Consultation on Emergency Contraception (EC) in Crisis Settings at the JSI offices in Arlington, Virginia. The purpose of this Consultation was to move toward the goal of increased access to EC in the full range of crisis settings (from onset to long-term crisis). More specifically, the Consultation’s goals included to develop strategies to overcome EC access/availability barriers, to raise the profile of EC in these settings, to promote youth sexual and reproductive health (SRH), and to understand links between international development and crisis management. At the conclusion of the Consultation, the 22 participants from 14 partners and donor organizations formulated six-month action plans to address the overall goals. During the consultation, the participants agreed on the pivotal importance of the Humanitarian and Development Sectors working together collectively in order to provide sustainable programming and access to EC in crisis settings.

Introduction

The Consultation on EC in Crisis Settings focused on four main goals to move toward increased access to EC in the full range of crisis settings (from onset to long-term crises):

- **Develop strategies to overcome access/availability barriers**: Identify the key barriers to EC access in crisis settings and generate strategies to overcome these barriers.
- **Raise the profile**: Promote the appropriate use of EC in crisis settings, taking advantage of a favorable political climate.
- **Promote youth SRH**: Promote youth access to EC and to adolescent/youth-friendly reproductive health services.
- **Development and Crisis Links**: Foster strategic links between the Development and Humanitarian sectors/agencies to promote EC access globally.

Participants

Twenty-two participants representing 14 implementing partners and donor organizations attended the Consultation. See Annex 1 for a full participant list.

Summaries of Presentations

1. **Introduction to the Humanitarian Context and Examining EC Availability in Crisis-Affected Settings: Sandra Krause (Women’s Refugee Commission)**

   Overall 172 million people were affected by conflict in 2012 while another 32.4 million were forced to flee natural disasters. There is increased risk for sexual violence including exploitation and abuse in these settings. A Disaster Cycle Management model can help us to better
understand the roles and responsibilities during a Crisis Setting. A typical cycle includes Disaster Prevention, Mitigation, Preparedness, Response and Recovery. Actors across each part of the cycle must work together in order to have consistent and fluid disaster management. Results from an FP study conducted in six crisis-affected countries showed overall low awareness levels regarding modern FP methods, with respondents least aware of EC. EC in these settings is primarily given in post-rape cases. There is very little effective documentation on best practices regarding EC access/delivery/awareness and youth. This presentation discussed the need to look into possible provider bias on a larger scale in future studies.

II.  

The Diversity of Needs of Adolescent Girls and Young Women in Crisis Settings: Martha Brady (Population Council)

This presentation focused on the heterogeneity of adolescents and the diversity of risks for adolescent girls in particular. Understanding the underlying drivers of these risks is critical to designing and implementing effective and appropriate programs. Adolescent girls often suffer from a lack of knowledge, pressure for sexual activity, stigmatization, and provider insensitivity or bias. Moreover, exposure to forced sex and reduced availability of SRH services can compound the risk of unintended pregnancy and/or sexually transmitted infections (STIs) among adolescent girls in crisis settings. It is critical that we raise awareness on the availability of EC in this population. Currently we do not have a significant amount of evidence on the overall situation of youth in crisis settings. Moving forward it will be important to prioritize better data collection on youth overall, and adolescent girls in particular. Data related to physical and sexual violence, economic and social vulnerabilities should be gathered in order in order to provide appropriate services to adolescents.

III.  

Overview of EC: Global Access, Guidelines, and Challenges: Sarah Rich (ICEC)

EC product registration has increased significantly in the past several years, but there are still countries where EC is not available, including a number of crisis-affected countries. Moreover, studies show that the majority of women in developing countries still have very low awareness of EC, and health care providers often have misconceptions and unfavorable attitudes toward EC. To increase access to EC, it is important to increase knowledge and dispel misperceptions among policymakers, service providers and communities. Key messages include that women of any age can use EC, EC is not abortion, EC is safe and can be used more than once, and women have a right to access EC. EC should also be incorporated into key national and organizational policy documents, health systems and training. Training on the Yuzpe method should be encouraged where dedicated EC products are not available. Focus should also be placed on increasing EC awareness and demand among women and communities, including in humanitarian settings. There is a need to ensure that EC is available from the onset of a crisis as well as in long-term settings.
IV.  **Results from the Survey of Organizations Working in Crisis Settings: Kathryn Davis (JSI)**

Please see Survey Findings section below for more information.

V.  **Programmatic Barriers (Including Provider Bias): What do we know and what can we do?: Janet Meyers (International Medical Corps)**

There are a variety of programmatic barriers including a major lack of knowledge/awareness within communities and among providers. Provider bias can often be attributed to a lack of training and clinical skills. Other programmatic barriers also include difficult geographic access, laws prohibiting access, procurement, and EC not being fully integrated into key guidance documents such as Sphere and/or registered in refugee host countries.

Possible solutions to these programmatic challenges include implementing pre-service and in-service training on EC and interventions to address provider attitudes; strengthening the linkage of emergency response to development programming to improve knowledge and acceptance of EC from policies to service delivery to the community level; increasing innovative and adolescent friendly services that are inclusive of EC; advocating to integrate EC into all health programming and drug orders; and ensuring indications for EC are clearly stated in key emergency response guidance documents.

VI.  **Supply Chain EC Sourcing: Melissa Sharer (JSI)**

EC is currently the least available and least used method of family planning. Current EC supply challenges include that it is difficult to forecast, is not mainstreamed into logistics reporting forms, requires reliable logistics data, and has unpredictable demand, with use heavily contingent on client and provider awareness. EC is currently most accessible in the commercial sector, which often serves more urban and wealthier clients, and it is not integrated into crisis settings. Another issue is that EC is only included on approximately half of countries’ National Essential Medicines Lists. Currently efforts are being made to better integrate EC into the main supply chain. To improve forecasting of EC, stakeholders can use several approaches, which include looking at sales data, demographic data, and consumption trends. In order to improve the supply chain of EC in crisis settings we need to prioritize EC inclusion on more countries’ EMLs, combine health/RH programs (i.e. GBV, SRH, HIV) to make EC available at multiple service points, train providers on EC, and make EC available without prescription.

VII.  **Donor Support for EC in Crisis Settings: Henia Dakkak (UNFPA)**

Through the work of the Inter-Agency Working Group and UNFPA, EC is included in Emergency RH kits that are designed to be available during the acute phase of an emergency. It is important to remember that even in countries where EC is registered and available there is still very low demand in the public sector and in humanitarian settings. Difficulty with supply chain management and logistical issues often delay access as well.
Funding for RH in humanitarian settings is lower than in development settings, which could be a possible barrier in programming. Difficulties arise from a lack of donor prioritization of trainings in crisis settings, some restrictions on pharmaceutical procurements, and the positioning of RH given competing humanitarian needs.

VIII. Field Experience EC from the Field: Angel Foster (Ibis Reproductive Health)

This presentation focused on a case study from the crisis-affected Thailand/Burma border. The project in Thailand and Burma focused on assessing the unmet reproductive health needs of cross-border populations, refugees and migrants. Major findings include that knowledge and use of EC is low, and supplies are especially limited to the cross-border population. Other findings include that there is much misinformation about EC among health workers and a deep concern about “repeat” use or “abuse”. Main recommendations from the report included to increase awareness of and access to EC, expand efforts to address adolescent reproductive health, and improve access to high quality FP information and services. Since the report was shared with donors and partners in February 2012, coordination has increased and there have been EC workshops and trainings in Tak Province, Thailand and Burma and a working group on EC policies along the border.

Survey Findings

To meet the need for accurate, current data on EC in crisis settings, the partners that co-hosted the Consultation on EC in Crisis Settings created an online survey and disseminated it over many email listserves (including IAWG, ICEC, etc.) in order to reach a large audience. The survey was shared in both English and French.

In total, there were 103 responses to the questionnaire from 37 different countries. 69% of the respondents surveyed work directly in Crisis Settings, with 15.5% respondents “sometimes” working in crisis settings and providing technical assistance remotely; the remaining 15.5% worked from HQ only. The respondents of the questionnaire stated that 85% of them use EC in their current programs.

In order to gain a better understanding of where programs used EC we asked respondents if their programs used EC in Refugee/IDP Camp Settings, MCH/Clinic Services, Post-Rape Services, GBV Services, or Other. Each respondent could choose as many settings as applicable to

![Figure 1: Results from Question 5: Where does your program use EC?](image)
their program. *(Please refer to Figure 1)*

A majority of respondents (86%) said their organization provided training to staff on EC, however in open responses many respondents discussed the need for staff to have refresher trainings on EC beyond the initial trainings.

46% of respondents stated that they source EC to their program sites via the public sector/government distribution, 43% source via UN agencies or other donors, 41% source via contraceptive kits, 34% via NGO or social marketing outlet, 31% via a private manufacturer/distributor, and 8% source through other means. Each respondent could choose as many sourcing methods as applicable to their program. Respondents were also asked about what specific supply chain was used to deliver EC products to their program. 80% of respondents said through an integrated supply chain with other commodities, while 12% were using a separate supply chain from other commodities, and 13% were using other supply methods for EC.

The survey found that the greatest barrier to EC in Crisis Settings was related to issues with logistics and supply chains. Issues related to providers also ranked high, including lack of understanding of EC, misconceptions, and stigma regarding EC use. Each respondent could choose up to five barriers. *(Please refer to Figure 2)*

Regarding counterfeit or low-quality EC products, 77% of respondents said they had not had problems with quality of EC products in their settings, while 23% of respondents indicated that they had problems with the quality of EC products.

Respondents also indicated the avenues of EC outreach that their organizations conducted, including community education (72%), counseling (67%), posters/informational pamphlets (41%), and Other (14%). Each respondent could choose as many outreach activities as were applicable to their program.

An open response question on what type of support is needed to improve the provision of EC in Crisis Settings highlighted three main areas that need improvement, including policy and advocacy, programming challenges, and access/availability. Under Policy and Advocacy respondents indicated the need to improve sensitization and increase awareness of EC among providers while also integrating EC
more deeply into reproductive health services as a part of basic health packages (among donors, direct providers and government ministries). Under Programming Challenges, respondents indicated the need to train adolescent peers, strengthen the knowledge of service providers to reduce misconceptions/stigma related to EC use, and provide formal and refresher training for all medical and health support staff (not just RH staff). Under Access/Availability, respondents indicated the need for sustainable supply chains that included EC, financial support to procure EC, improved access to free contraceptive methods, and improved access to EC among youth.

Overall, the survey provided more detailed information about current challenges in the field and guided the six-month action plans, which were the focus of the afternoon discussion. The group discussed the possibility of doing a follow-up survey identifying in more detail adolescent needs and/or other topics.

Moving Forward

The group divided into three groups to discuss the topics of 1) Programs 2) Access and Availability and 3) Policy. Out of those discussions, the groups developed interim goals for the next six months that our organizations could work towards in order to meet long-term goals.

Program Goals:

- Mobilize to include an EC leaflet in RH kits, with instructions on the Yuzpe method.
- Respond to issues that were raised by the survey, and email all respondents a link to the EC distance module. Consider asking respondents whether they would be interested in starting a listserv dedicated to EC in crisis settings.
- Create simple messages around EC for wide distribution (including Yuzpe).
- Link the EC Training Module to MISP Module.
- Create an EC course certificate for health care providers that complete EC training.

Access/Availability:

- Develop a one page brief and checklist on how to get a waiver when EC is not registered in country.
- Redouble efforts on registration in three target countries, by making a working group of partners in that country including ICEC, a Humanitarian Organization, and a Development Organization.
- Develop tools to help RH Coordinators in the field to access EC supplies through the UNFPA online ordering process, as well as through other outlets.
• Form a small Working Group with DKT/PSI and possibly other organizations to document lessons from social marketing organizations and generate suggestions to adapt them to crisis settings.

Policy

• Revise Minimum Initial Service Package information guidelines to better position FP and EC. (First step: Begin emphasizing EC concerns in IAWG’s MISP and FP working groups.)

• Develop provider Yuzpe one pager and disseminate widely.

• Interact with FP2020 and the UN Commission on Life-Saving Commodities for Women and Children to make EC, including the need for it in humanitarian settings, more visible.

• Endorse call to action at SV meeting in London and formulate EC talking points and FP statement.

• Address issue of “Repeat Use and Abuse”, by pushing out forthcoming ICEC fact sheet.

• Disseminate IAWG global evaluation findings and highlight EC.

• Consider giving presentations on EC to high-level officers at humanitarian organizations.

• Make a table of key EC indicators for the top 18 countries in crisis settings.

Conclusion

The Consultation brought together a diverse array of partners and donors to address the issue of access and availability of EC in crisis settings. The barriers specifically regarding supply chains for EC in crisis settings, provider knowledge and attitudes about EC, and access for adolescent girls/young women in crisis settings are considerable. Several six-month goals defined during the Consultation will guide the follow-up work and provide structure for future advocacy and action to improve access and availability to EC in a range of crisis settings. A better linkage between Humanitarian and Development Sectors is key to collectively determining how EC should fit within the context of SRH services in the full range of crisis settings.
### Annex 1

#### Participant List

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