

# EVIDENCE BRIEF

## Improving family planning service delivery in humanitarian crises

→ Meeting family planning needs in humanitarian emergencies is challenging, but feasible, and could present opportunities for reaching marginalized, remote, or otherwise underserved populations.

Since the 2012 London Summit on Family Planning, 30 million additional women and girls have chosen to use modern contraception. This means that in 2016, we reached a landmark as some 300 million women and girls in the world's poorest countries were using modern methods of contraception (1). But 2016 also saw another landmark reached: the highest number of forcibly displaced people in recorded history (2).

Described as a sudden occurrence caused by epidemics, technological or environmental catastrophe, strife, or natural/man-made causes and demanding immediate action (3), humanitarian crises have caused a dramatic rise in the number of displaced populations, both within and across national borders. In 2016, 65.3 million individuals were considered to be internally displaced people and international migrants (2), with the average time spent in displacement being currently up to 20 years (2). Humanitarian crises expose weaknesses in health systems, with particularly serious consequences for women, children and adolescents (4).

From 2003 to 2015, the proportion of women among refugees held steady at between 47% and 49%, while the proportion of refugees who were children below 18 years of age increased from 41% in 2009 to 51% in 2015 (4). Globally, the estimated 26 million women and girl refugees are affected disproportionately by emergencies and face multiple sexual and reproductive health (SRH) risks, requiring access to key services, including contraception (5). With the disruption of protection services, sexual violence often increases during emergencies to affect about 1 in 5 women (6), exacerbating threats to the health and survival of women and girls. The situation is further aggravated by the lack of access to emergency contraception (7) as highlighted in a recent review by the Inter-Agency Working Group on Reproductive Health in Crises (8). Furthermore, 12 of the 13 countries with the lowest prevalence of modern contraceptive use in 2016 are 'fragile states' (9). The reality of sexual



### POLICY AND PROGRAM CONSIDERATIONS

- Provide a **full range of family planning methods via mobile clinics** and strengthen health centres' provision of short- and long-acting methods.
- **Train mobile health workers** to provide short-acting methods.
- **Train community health workers** to conduct family planning education and provide short-acting methods.

violence in humanitarian settings heightens the need to expand access to emergency contraception, long-acting reversible contraception (LARCs), and safe abortion services.

## POSSIBILITIES

Meeting family planning needs in humanitarian emergencies is challenging but feasible, and could present opportunities for reaching marginalized, remote, or otherwise underserved populations. Young people in such settings are usually new users of contraception and could initiate contraceptive use that continues into adulthood (10). Where humanitarian assistance is delivered in encamped spaces, this structure could facilitate the provision of family planning services and information (11). In camp settings specifically, the process of resettling displaced persons requires communication of health information to underserved populations (11,12), and there are openings for integrating family planning information and services into such processes.

## CHALLENGES AND LESSONS LEARNED

Nonetheless, there is a lack of evidence and high-quality routine data related to family planning in crises (13). Little is known about the context of family planning in humanitarian settings (14): its availability and use; attitudes and barriers to the use of various contraceptive methods; and the extent and context of emergency contraception use following sexual violence (15).

In the absence of a clear accountability and monitoring framework for SRH (including family planning) in humanitarian crises, available data are derived from specific studies. The sparse evidence demonstrates a need for the increased uptake of emergency contraception to mitigate rape-related pregnancy (7). Further, when family planning services are available and accessible, women's use of family planning has increased (13).

Still, gaps remain in regard to how to implement family planning interventions in humanitarian situations. Evidence exists from stable settings on effective family planning interventions (13), even if evidence on how to deliver such interventions in these settings is often inconclusive (16). Higher-quality evidence on family planning in emergencies through a common accountability framework is needed to improve access to voluntary family planning services in humanitarian settings. Providing greater access could make a substantial contribution to the achievement of the FP2020 goals.

## CONSIDERATIONS FOR IMPROVING FAMILY PLANNING SERVICE DELIVERY IN HUMANITARIAN CRISES

In the context of humanitarian crises, several promising, evidence-based interventions for family planning service delivery can help improve the uptake of these services (17). These interventions are summarized as follows:

- **Provide comprehensive SRH services in line with global norms**, such as the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations (18).
- **Provide a full range of family planning methods via mobile clinics and strengthen health centres' provision of short- and long-acting methods** (19).
- **Train mobile health workers to provide short-acting methods** (20).
- **Second refugee providers to health facilities to provide family planning in humanitarian settings**, and train female community health workers (CHWs) to promote FP use (21).
- **Train CHWs to conduct FP education** and provide short-acting methods (22).
- **Collaborate with the Ministry of Health** on competency-based training, supply chain management, systematic supervision, and community mobilization to raise awareness and alter family planning norms (23).
- **Engage adolescents** through (24):
  - Family planning counselling and referrals, coupled with recreational activities and group discussions.
  - Delivery of youth-friendly SRH care and education via clinics, mobile health brigades, and community education.
  - Provision of SRH information and services through a comprehensive prevention approach, combining 'Talk,' 'Services,' and 'Livelihoods.'

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This is one of seven Family Planning Evidence Briefs prepared for the Family Planning Summit held in London on July 11, 2017. The briefs highlight evidence and provide research and programme considerations for improving access to family planning and reducing unintended pregnancy. Programme considerations are based on the expert views of the authors, who undertook desk reviews drawing on existing evidence.

### Family Planning Evidence Briefs

- Accelerating uptake of voluntary, rights-based family planning in developing countries (*overview*)
- Ensuring adequate financing of family planning commodities and services
- Reducing early and unintended pregnancies among adolescents
- Improving family planning service delivery in humanitarian crises
- Ensuring contraceptive security through effective supply chains
- Expanding contraceptive choice
- Partnering with the private sector to strengthen provision of contraception

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