



## The spaces in between: Providing contraception across the arc of crisis

More than 80 years after Albert Einstein helped create the International Rescue Committee, the number and intensity of humanitarian crises across the globe warrant a dose of Einstein-inspired innovation.



More than 32 million women and girls of reproductive age are in need of humanitarian assistance, requiring more investment than ever before to match the scale and urgency of today's crises. Policies and global movements – like FP2020 – now recognize contraception as an essential and standard part of how we respond to women and girls in crisis. This means for people crossing borders to escape violence, struck by natural disasters or living in countries with daily threats of insecurity, contraceptive services of quality must be available and accessible.

Yet progress to scale contraception in crisis and fragile settings has not kept pace with the escalating threats facing women and girls. Whether in camps in Cox's Bazaar, Bangladesh, displaced along the Lake Chad basin, in boats crossing the Mediterranean or on the road to asylum at the American border: women and girls want and need contraceptive choice.

The International Rescue Committee (IRC) joined other actors and advocates at the 2017 Family Planning Summit to call for greater attention to and investment in humanitarian settings, countries and regions often overlooked by development actors. Today's crises start suddenly, last longer and affect more people. To reach global commitments made through the Summit as well as nearly half the Sustainable Development Goals (SDGs), development actors, donors and governments and the humanitarian community must work together to reach women and girls when it matters the most.

The IRC strives to deliver contraception in the “spaces in between” – where traditional approaches to health system strengthening are inadequate. This report is a synthesis of approaches that have worked and, if replicated and taken to scale, can meet the needs of the millions of women and girls across the humanitarian-development nexus.



Global health leaders agree: contraception in crises is feasible, saves lives and is in fierce demand.

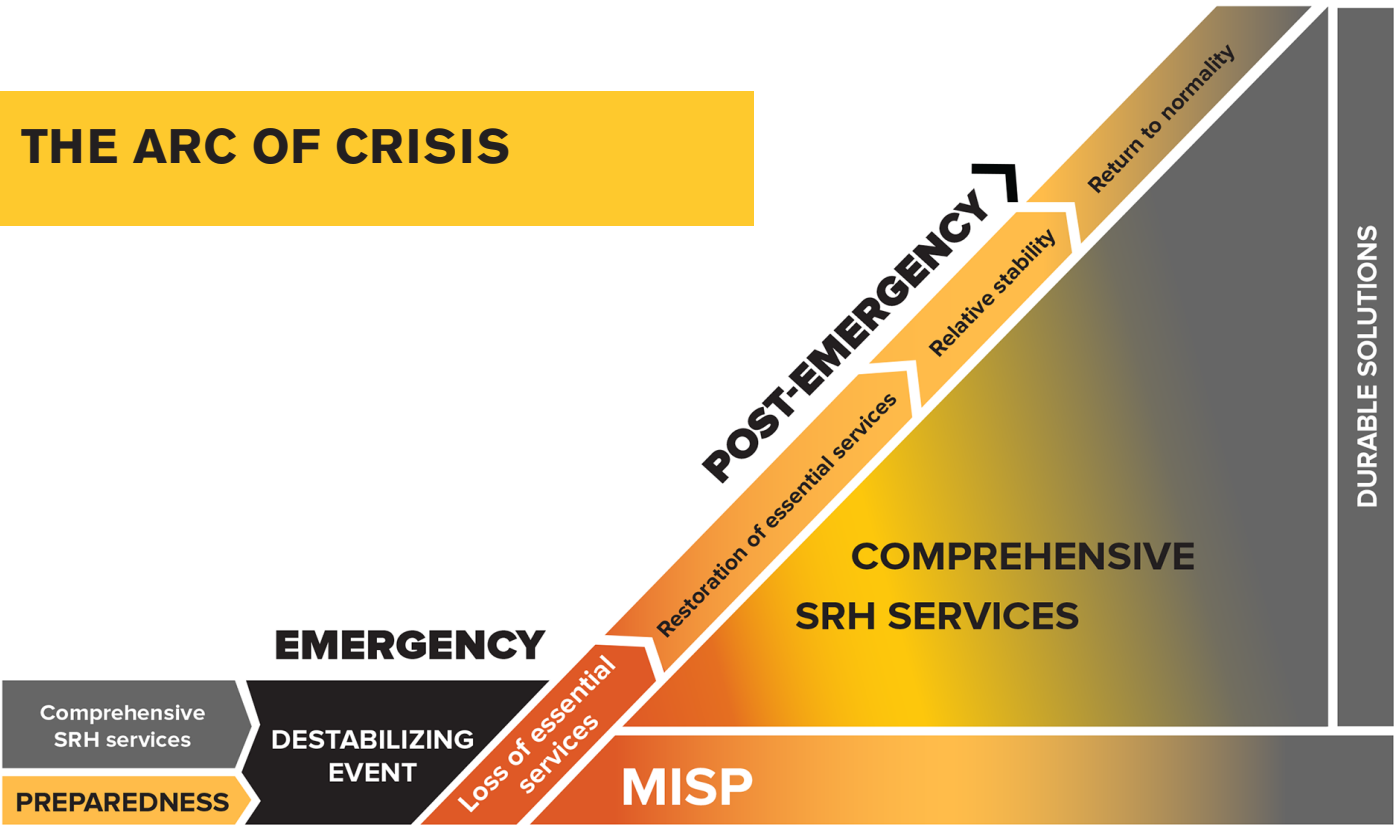
The newly revised 2018 Inter-agency Field Manual (IAFM) on Sexual and Reproductive Health in Humanitarian Settings features updates to increase provision of contraception at the onset of a crisis. The Minimum Initial Service Package (MISP) chapter of the IAFM is a set of priority interventions designed to save lives and avert preventable injuries, illness and suffering, particularly among women and girls, at the onset of a crisis.

The 2018 MISP priorities are to:

- Ensure health sector/cluster identifies an agency to lead MISP implementation
- Prevent sexual violence and respond to the needs of survivors
- Prevent the transmission and reduce morbidity and mortality due to HIV and other STIs
- Prevent excess maternal and newborn morbidity and mortality
- **Prevent unintended pregnancy**
- Plan for comprehensive SRH services
- Other SRH priority: Provide safe abortion care to full extent of law

Other established guidelines, like the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Responses, have also included contraception as an essential pillar of emergency response.

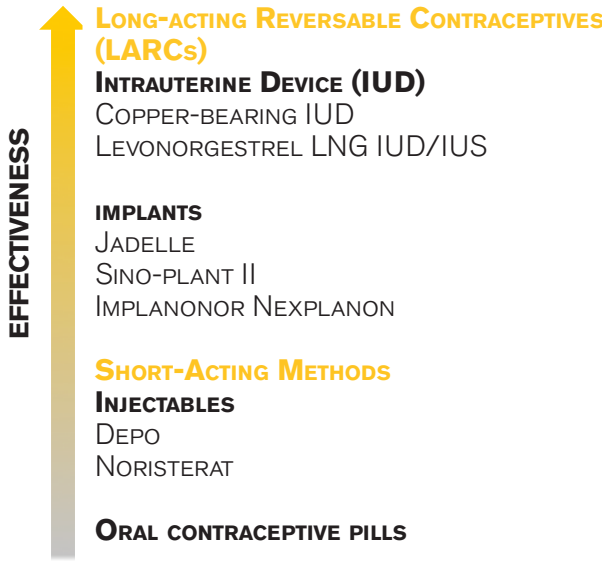
THE ARC OF CRISIS



Adapted from the 2018 IAFM

As the number of people in humanitarian settings grows, there is a critical need for practical examples of how to effectively deliver contraception at every stage of crisis, from emergency preparedness, to acute emergency response and through recovery. Many places go from stability to crisis — and back again — with little warning. Others languish in low-grade state of conflict. These settings require attention to health systems combined with some emergency response capacity. The following case studies demonstrate the IRC's success in providing uninterrupted access to contraception for women and girls living in these places in between.

The methods



READY TO ACT: PREPAREDNESS EFFORTS AT THE IRC

The IRC aims to respond within the first 72 hours of a crisis. To achieve this, the IRC's internal preparedness and response systems include sexual and reproductive health. Staff is trained on the MISP and an internal and external emergency roster of reproductive health specialists is maintained. The IRC emergency teams employ context-adapted approaches to ensure the availability of contraception in acute settings, ranging from IRC-managed comprehensive women's centers in Nigeria and mobile health clinics in Chad to public and private referral systems in Europe.

Since 2011, the IRC has implemented 21 acute emergency responses that included contraception and abortion care as part of its basic health package.

**From 2016-2018, 10,737 women and girls accepted contraception and 25% adopted LARCs through 7 IRC acute emergency health responses:**

**Tanzania, DRC (Kasai), Serbia, Nigeria (Borno state), Ethiopia, Uganda (Adjumani & Yumbe and Lamwo) and, most recently, Colombia.**

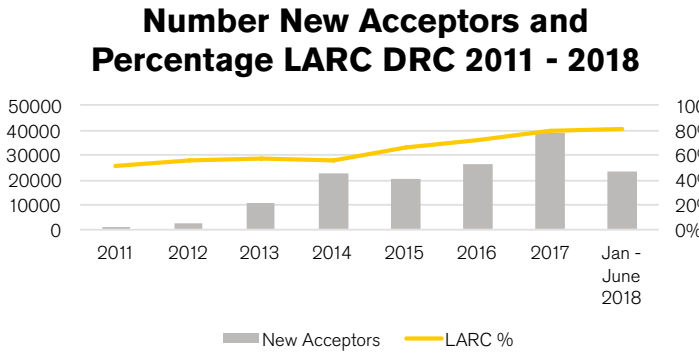


STRENGHTENING HEALTH SYSTEMS IN A PROTRACTED CRISIS

Since 2011, the IRC has worked to strengthen core elements of the local health system with an aim to increase contraception use among women and girls in crisis-affected areas of the Democratic Republic of Congo (DRC). Chronic flares of violence in the region worsened an already disrupted health sector – making contraception all but unavailable in most health zones.

The IRC has supported the Ministry of Public Health (MoPH) to deliver these services by strengthening key pillars of the health system to improve access to high-quality services at 61 health clinics and hospitals in North Kivu, South Kivu and Tanganyika.

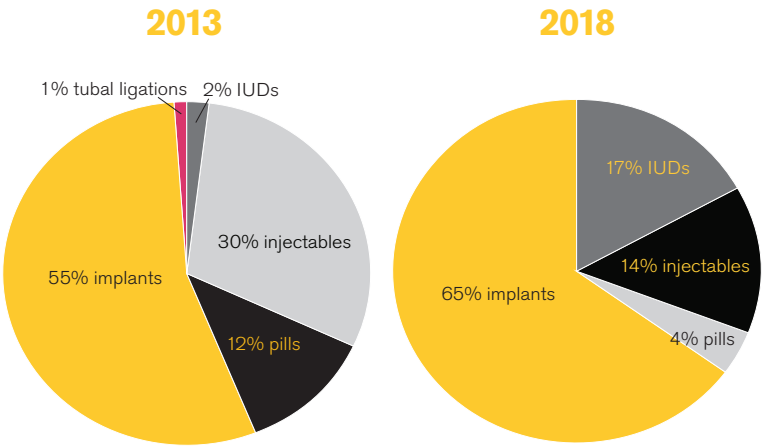
**The IRC’s approach focused on competency-based training, supportive supervision, procurement and supply chain management, data management and use, and community mobilization.** From June 2011-June 2018, 147,000 women and girls at IRC-supported facilities accepted contraceptive methods and 71% chose an implant or IUD.



When the project first began, contraception uptake was low and the method mix suggested not all methods were truly accessible as evidenced by a skew toward implants. A formative assessment revealed challenges with service delivery quality and widespread community-level misconceptions and were used to identify and implement supply – and demand – side program modifications.

**These interventions included systematic clinical coaching; peer supervision among providers; values clarification activities for providers; facility-level data analysis and use meetings; introduction of post-partum IUDs, LNG-IUS and Population Council’s Balanced Counseling Strategy; large contraception communication campaigns; sensitization by satisfied couples; and outreach to male partners.**

Following the introduction of these interventions, the percent of clients accepting LARCs increased from 56% to 80% and the percent of clients accepting IUDs increased from 2% to 17%. These efforts have also equipped government facilities to continue services even during times of increased insecurity.



**She knows best: engaging adolescent girls in programming**

The consequences of unintended pregnancies among adolescent girls in humanitarian settings are immense – physically, emotionally and socially. To address these needs, the IRC has piloted in Goma, DRC, to improve adolescent contraceptive uptake using a participatory approach that meaningfully engaged adolescents and health providers in developing action plans, conducting joint supervision visits and improving provider attitudes towards the provision of sexual and reproductive health (SRH) services for youth. In ten months, nearly 1,200 adolescent girls adopted a modern contraceptive method across three IRC-supported Ministry of Health facilities, 89% of which accepted a long-term method. By the last month of the intervention, almost half of all new acceptors were under the age of 20.

Drawing on lessons-learned from this pilot, the IRC is now implementing operational research in crisis-affected areas in northeastern Nigeria and South Sudan to assess different intervention packages aimed at improving contraceptive uptake among adolescents in acute crisis settings.



SUSTAINABLE INVESTMENT IN LOCAL CAPACITY IN EUROPE

With the signing of the EU-Turkey Deal in March 2016 that closed the Western Balkan route, more than 3000 refugees and migrants hoping to reach Germany became stranded in Serbia; many more people are living undocumented and in the shadows. Women and girls, uncertain of their next destination, are facing increased risks to their health, lacking access to sexual and reproductive health services both on their journey and during their stay in Serbia.

On the ground, the Association of Sexual and Reproductive Health and Rights Serbia (SRHS) had been working to provide and expand access to sexual and reproductive health services with support from the Ministry of Health since 2002. **Having existing capacity on the ground shaped the response in Europe: investing and supporting SRHS to**

**strengthen their technical and organizational capacities helps meet the current needs of refugees and can be sustained and continued well beyond the IRC’s presence.**

The results of these efforts within just a few months are promising and demonstrate the need to build a strong foundation to bring this work to scale. Since starting services in May through September of 2018, for 1500 refugees, SRHS was able to reach 88 new contraception acceptors and 22 women received emergency contraception. More than a third of new contraception acceptors (33 in total) accepted an IUD. Once word spread that other services were available as well, like comprehensive abortion care, women became even more interested in services. In the same timeframe, five women were able to access safe abortion care (SAC) services and 15 others received post-abortion care services, twelve of whom accepted a contraception method.

THE IRC’S IMPACT IN 2017 ACROSS COUNTRY PROGRAMS

\* between October 1 through September 30, 2017

**249,417**  
Couple Years of Protection (CYP) delivered

**32,745**  
Unsafe abortions prevented

**111,991**  
Unintended pregnancies averted





### CENTERING THE NEEDS OF SURVIVORS

Since 2009, the Boko Haram insurgency has crippled northeastern Nigeria and spilled over the border into neighboring Chad, Cameroon and Niger. In response to the rapidly changing emergency in Borno state in northeastern Nigeria, the IRC has developed a multi-pronged approach to delivering services. Women and girls can access contraception counseling and services in

- 1) four ministry of health facilities where the IRC is working to improve staff capacity,
- 2) a comprehensive SRH IDP camp clinic serving 36,000 IDPs, and
- 3) five Comprehensive Women's Centers (CWCs).

**CWCs are a unique model in humanitarian settings that center the holistic needs of women and girls at the center of programming. Sexual and reproductive health services, including contraception, are integrated with psychosocial services, case management of Gender-Based Violence (GBV) and other life skills acquisition in one convenient location.** Since 2017, more than 16,000 women and girls have accepted a new family planning method across these sites.

### A critical time and an opportunity

**Women and girls require access to high-quality contraception throughout their reproductive lives, but are often most in need just following an abortion and the birth of a child.** The IRC aims to reach women and girls during this time by providing access to contraception through client-centered counseling during antenatal care, post-delivery and as part of abortion counseling and integrating service delivery abortion services and maternity wards.

**In the IRC's programs in Chad, DRC, Pakistan and Myanmar, 54% of the 24,127 post-abortion care clients accepted contraception since 2011. From January 2016 to June 2018, 5734 women and girls accepted a post-partum IUD.**

### RESPONDING ON MULTIPLE FRONTS TO THE LARGEST REFUGEE CRISIS IN AFRICA

Since 2013, armed conflict in South Sudan has escalated to a full-blown humanitarian emergency. The total number of South Sudanese refugees has now passed 2 million – making it the largest refugee crisis in Africa, and the third largest in the world. **In Uganda, now host to over 1 million South Sudanese refugees, the IRC is working in the Bidibidi and Palabek camps along the border to delivery quality contraception services through trainings, on the job supervision and coaching for health providers and community mobilization.** A seven month response in 2017 enabled more than 1,570 women and girls to access a new contraceptive method, of which 35% opted for a long-acting method.

In nearby Ethiopia, South Sudanese are the largest refugee population in the country, totalling 421,867 at the close of 2017. **The IRC is an implementing partner in five refugee camps serving displaced South Sudanese in the Assosa region and provides community-based reproductive health and HIV/AIDS services along with UNHCR and the Administration for Refugee and Returnee Affairs (ARRA) of Ethiopia.** Over a ten month period between 2017 and 2018, the IRC worked to strengthen contraception service delivery in camp health centers reaching nearly 1,900 new contraception acceptors.

### COMPREHENSIVE CENTERS FOR ROHINGYAS

Nearly 700,000 Rohingya refugees have fled to neighboring Cox's Bazaar, Bangladesh – adding to the 300,000 Rohingyas already living in the area, having fled previous waves of violence in Myanmar. Women and girls have been exposed to extremely high levels of violence, sexual assault and rape, highlighting the urgent need for experienced emergency responders, particularly in GBV response and SRH.

The IRC's SRH emergency coordinator was deployed to Cox's Bazaar to ensure the availability of components of the MISP including contraception, screening and treatment for sexually transmitted infections (STIs), Clinical Care for Sexual Assault Survivors (CCSAS), safe delivery and emergency obstetric care. **CWCs can be an effective model to cater a multi-sector package of essential services, ensuring access for women and girls to life-saving protection and SRH services while supporting them to respond to and reduce the risk of GBV in a safe, dignified and confidential manner.** In two months following the start of services, 421 contraceptive methods were distributed and 427 clients received psychosocial counseling.

The IRC is now transitioning to comprehensive SRH services including basic emergency and neonatal care, post-abortion care and menstrual regulation (MR).





## FACILITATING ACCESS TO MULTIPLE SERVICES THROUGH INTEGRATION

The Karamoja region, Uganda's poorest subregion, is home to an estimated 1.2 million people. For decades, high levels of conflict and insecurity has plagued the region, which still suffers the lowest health and economic indicators in the country. **Since 2016, the IRC has been working to facilitate access to integrated contraception and immunization services, providing both services at once saving mother's time, travel and opportunity cost. The IRC also introduced Participatory Action Research (PAR) to support three project communities to better understand what influences the use of these integrated services and develop their own plans to strengthen services.** This contributed to improved integration at PAR health facilities where 45% of all new acceptors accepted contraception after an immunization referral (compared to an average of 23% across all district facilities). Improved integration services enabled more than 1,700 women to receive a new method across project districts between 2016 and 2017.



## LINKING RESETTLED REFUGEES TO LOCAL CONTRACEPTIVE SERVICES IN THE US

Even after seeking refuge in the US, barriers to accessing contraception can be difficult to navigate for newly resettled women and girls. **IRC Atlanta, in partnership with Advocates for Youth and the Oakhurst Medical Center, worked to improve the willingness and capacity of publicly funded health centers and clinical providers to offer contraceptive services for young women as well as raise awareness among vulnerable youth about contraception, and link these young clients to local contraceptive services.** These efforts have resulted in a 73% increase in women and girls seen at midyear 2018 as compared to midyear 2017, including a 45% increase in the total number of clients receiving moderate to highly effective contraception. Almost half (49%) of women aged 18-29 opted for the pill, patch and ring; 32% opted for Depo; 13% opted for implants and 5% for IUDs. The IRC is currently piloting potential strategies to improve contraception and comprehensive abortion care access to refugees resettled across the US.

# Recommendations

**There is an urgent need to increase access to contraception for women and girls in crises - and the humanitarian community cannot do it alone. Countries with very weak health systems need more intensive support to ensure access to services from the onset of crisis to recovery and beyond. Humanitarian and development donors and actors must coordinate better to ensure transition from MISP to comprehensive services. Meaningful coordination of development and humanitarian programs would improve quality, reach and responsiveness in protracted crises.**

### More specifically, donors should:

- Require inclusion of insecure regions and displaced populations in SRH funding applications – including in countries that might otherwise be stable.
- Prioritize funding for humanitarian actors to implement the 2018 MISP and IAFM, including contraception, at the onset of crisis and through recovery.
- Ensure continuous funding and fill gaps for emergency SRH preparedness and the transition from MISP to comprehensive sexual and reproductive health services.

### FP2020 countries should:

- Include the 2018 IAFM and MISP in preparedness and response plans and monitor their implementation during crises.
- Commit to providing the full range of contraceptive methods, including LARCs, to all women and girls, including those who live in hard-to-reach areas and who are affected by crisis.
- Facilitate and remove barriers to access for vulnerable groups among refugees, IDPs or migrants, including adolescents, LGBTQIA+ and sex workers.

### Development & humanitarian actors should:

- Collaborate with humanitarian actors to ensure uninterrupted access to contraception for women and girls in the “spaces in between” through preparedness and health system strengthening efforts.
- Partner with humanitarian actors to implement programs that reach all women and girls across the humanitarian - development nexus.

### Humanitarian actors should:

- Ensure the full range of methods, including LARCs, are available through every stage of crisis from preparedness through acute emergency response and recovery.
- Strengthen and invest in internal preparedness efforts, including prepositioned stocks, SRH commodities and experienced MISP implementers, for more effective and rapid response.



# Key terms & definitions

## Humanitarian setting

A country, region or society affected by conflict, natural disasters, slow- and rapid-onset events, or complex political emergencies.

## Family planning, contraception, contraceptives

Family planning is the broad term often used to describe services that allow people to attain their desired number of children and determine the spacing of pregnancies. Contraception is the use of a contraceptive method to prevent pregnancies. Contraceptives include both short and long-acting methods, such as implants, injectables, and IUDs, and traditional methods. Using family planning as a blanket term for contraception can obscure other important reasons why women and girls need access to birth control. Sexually active women and girls may not be necessarily concerned about planning a family, but still do not want to get pregnant. Other women use contraception for medical benefits unrelated to preventing pregnancy or birth spacing.

## Couple Years Protection (CYP)

The estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. Different contraceptive methods have different CYP values based on how long the method can be used for and its effectiveness in preventing pregnancy. Long-term and permanent methods, like implants, IUDs and voluntary sterilization, protect a couple from pregnancy for a longer period of time and thus have larger CYP values.

## Safe abortion care (SAC)

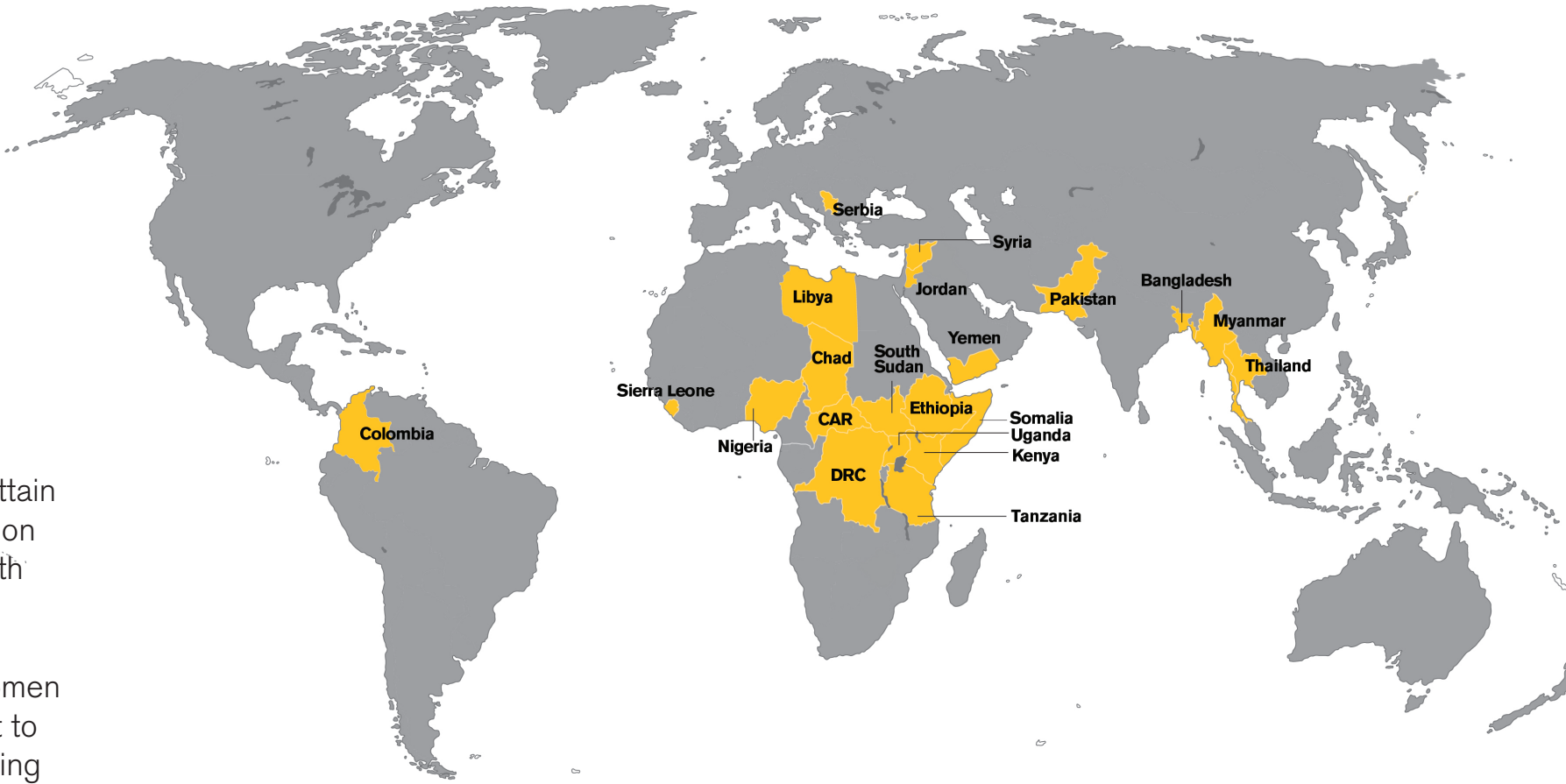
The procedure for terminating a pregnancy conducted by a skilled provider using recommended methods in an environment meeting minimum medical standards.

## Post-abortion care (PAC)

The treatment of complications from induced or spontaneous abortion and family planning.

## Comprehensive abortion care (CAC)

A package of services including safe abortion care, post-abortion care, contraception and referral for complications.



**The International Rescue Committee (IRC)** responds to the world's worst humanitarian crises and helps people to survive and rebuild their lives. Founded in 1933 at the request of Albert Einstein, the IRC offers lifesaving care and life-changing assistance to refugees forced to flee from war, persecution or natural disaster. At work today in over 40 countries and 22 U.S. cities, we restore safety, dignity and hope to millions who are uprooted and struggling to endure. The IRC leads the way from harm to home.

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From Harm to Home | [Rescue.org](https://www.rescue.org)