



Impossible Nowhere

Family Planning for Women and Girls in Crises

International Rescue Committee | NOVEMBER 2015





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FRONT: Daw Aye Than, a member of an IRC-organized support group, shows various contraception methods in Yae Kyaw village.
Peter Biro/The IRC

BACK: Girls on their way home from school at the Tunkia Secondary School in Sierra Leone. Audrey Wade/The IRC

OPPOSITE PAGE: A mother and child seeking refuge a few meters from the Sudanese border. Peter Biro/The IRC



Executive summary

Family planning is one of the most life-saving and empowering interventions in health. Yet misguided assumptions are restricting it from the women and girls who need it most.

225 million women and girls around the world have an unmet need for family planning. They include those who want to delay pregnancy and those that don't want more children. Millions of these women and girls are also experiencing humanitarian crises, at a global scale unseen since World War II.

Despite an overwhelming need, family planning remains one of the biggest gaps in humanitarian response. A miniscule portion of women's health funding has gone to conflict-affected countries, despite the fact that they have worse reproductive health indicators than stable countries with similar incomes. Areas affected by crisis remain responsible for 60 percent of all preventable maternal deaths.

Many of the barriers to family planning in these contexts are well-known: expenses, biases of well-intentioned providers, lack of supplies and shortages of trained health care workers. But we must recognize that unsupportive, misinformed people and systems are also standing in the way — both near and far.

For years, key actors of the aid community have used myths to steer funding and political support away from family planning for those who need it most.

These assumptions include that:

- Family planning is neither desired nor possible in certain cultural, religious or humanitarian contexts.
- Short-acting contraception satisfies the demand of women and girls.
- Women in emergencies do not want family planning.
- Family planning is too difficult to provide in humanitarian settings.

These notions are both false and harmful. The International Rescue Committee (IRC) knows that donors, governments and aid agencies are neglecting what women want, what is possible, and our responsibility to save lives. We must shift the conversation from myths to realities.

First, the global community cannot claim to prioritize the lives of women and children in crises while neglecting family planning. Family planning is the most proven and cost-effective way to reduce maternal death and disabilities, and need for abortion. Unsafe abortions are responsible for 13 percent of maternal mortality, which is

likely even higher in refugee settings. With a historic number of women and girls affected by crisis, we must reassess our priorities now.

Second, there is no place that we know of — regardless of cultural, religious or humanitarian context — where family planning isn't possible or desired. The reality is that women of all faiths use family planning, and many with the support of their religious leaders. For example, the IRC is working with Catholic communities in the Democratic Republic of Congo that are supporting family planning, as well as religious leaders in Pakistan who embrace contraception based on, not despite, their Islamic beliefs.

Above all, whether women are fleeing from crisis or supporting the recovery of their communities, they have shown that they want family planning.

It is time to start listening.

The IRC recommends:

- › **Family planning must be recognized as a right of all women and girls, regardless of where they live, or their displaced status.** Regardless of context, donors and agencies should seize opportunities to provide family planning throughout a woman's life cycle and for vulnerable populations. This includes testing new and promising service delivery models and scaling up high-impact interventions.
- › **Family planning, including long-acting and permanent methods, must be a priority in responding to acute emergencies.** Humanitarian interventions must incorporate comprehensive family planning at the beginning of every health response. This can be significantly improved by codifying family planning as a primary component of the international standards for reproductive health in humanitarian response. Donors must address the lack of funding for comprehensive family planning in crisis settings.
- › **All health care interventions should include family planning.** Whether donors and aid organizations are supporting crisis or recovery, primary care interventions should incorporate family planning. Family planning should be available to all women and girls, regardless of where they fall along the relief-to-development continuum. ■

Failure to provide

Family planning continues to be one of the most overlooked areas of humanitarian response by aid agencies and donors.

The need for family planning in crisis-affected areas is indisputable. As noted, areas affected by crisis are responsible for a majority of all preventable maternal deaths. Unfortunately, chronic neglect of family planning for these women and girls is equally evident.

Family planning is not a primary component of the international standards for reproductive health in emergency response, most notably the Minimum Initial Service Package for Reproductive Health in emergencies. As a result, other reproductive health services are prioritized before family planning is made available, if ever.

Agencies and donors have failed to support this life-saving and transformative intervention for those who need it most. The Inter-Agency Working Group for Reproductive Health in Crises evaluated official development assistance (2002-2011) and appeals (2002-2013) in the humanitarian context. It found that of the five primary reproductive health areas (family planning, maternal newborn health, HIV/sexually transmitted infections, general reproductive health and gender-based violence):

- In absolute dollar amounts, family planning was one of the least funded reproductive health interventions.
- In appeals, family planning comprised the smallest proportion of proposals. Only 14 percent of funding appeals for reproductive health included family planning. Long-acting or permanent methods were rarely mentioned.
- Only 17% of health facilities in three crisis settings were capable of providing all methods of family planning. Long-acting methods were least likely to be available.

The report also found that funding for reproductive health activities was 57 percent lower for conflict countries than non-conflict countries, a concerning trend given the immense needs in conflict-affected settings.

Fortunately, the neglect of family planning is being addressed by unprecedented global efforts. But even the movements expanding access to family planning in developing countries are not prioritizing conflict and disaster-affected settings.

FP2020 is an admirable and much-needed effort that aims to enable 120 million women and girls from the world's poorest countries to use contraceptives by 2020. But FP2020 commitments and core indicators used to measure progress do not yet include displaced populations. As a result Syria, nor the countries hosting Syrian refugees, are included on its list of priority countries.

Areas affected by conflict can contribute millions of new family planning users to meet the initiative's target. For example, the Democratic Republic of Congo is one of the most populous FP2020 priority countries in Africa. But to meet this goal, national efforts to expand family planning must specifically plan for, and address, the displaced populations in conflict-affected areas like North and South Kivu and Katanga.

Possibility is proven. The IRC, CARE, Save the Children and International Medical Corps are working with the Ministry of Health, and have brought family planning to more than 128,000 women affected by crisis, despite ongoing insecurity.

FP2020 steering committees in the DRC have begun to recognize that contraception cannot be limited to stable, urban areas. Family planning must reach the millions of women and girls living in a state of fear, displacement or uncertainty. ■

Global evaluation findings



14% of appeals for reproductive health included family planning



17% of health facilities in crisis settings could provide all methods of family planning

Tackling the myths

Harmful assumptions about the feasibility and desire for family planning in crisis-affected settings are common. The reality is far more complex — and full of opportunity.

Myth No. 1: Certain religious and cultural contexts will not accept family planning.

Assumptions about religious beliefs, particularly Islam and Catholicism, can prevent humanitarian actors from considering the provision of family planning. In interviews, practitioners at multiple organizations told us that officials, UN agency staff and even their own employees commonly express doubt about providing contraception in “conservative” or “religious” settings.

“We all need to agree to stop calling religion a barrier to family planning,” said a practitioner at a humanitarian aid organization. “Even directors say it, fearful of starting a program on what they think will be controversial. My organization has seen big changes in this attitude, but we had to invest time to sensitize staff. People would slowly realize, for example, that religions and local customs often have references that support contraception and the right of women to use it. But people were unaware or hadn’t had a chance to have meaningful dialogue about it.”

Certain religious doctrines may formally discourage the use of modern contraception, but the reality is that women of all faiths use family planning, and many with the support of their religious leaders. From Christian communities in eastern Congo to devout Muslim refugees from Sudan, the IRC’s experience is that no religious group should be excluded from the option to use high-quality modern contraception.

In **Pakistan’s** Federally Administered Tribal Areas and Khyber Pakhtunkhwa Province, the IRC has worked with 162 imams and female religious leaders who are activists for family planning within their communities. Many Islamic clerics helped develop educational materials citing Quranic verses that describe the benefits of birth spacing. Through other activities, like hosting events for World Population Day, religious leaders have been critical partners in bringing family planning to 40,000 clients in four years.

In the **Democratic Republic of Congo**, where 94 percent of women are Christian, Catholic and Protestant, religious groups in South Kivu are providing education on family planning with Ministry of Health partners. As a nurse at Kabare Hospital in South Kivu, Sister Francoise said she had seen too many women die from having too many children, too young or too close together. She is a nun who is an outspoken advocate helping to make the most effective contraceptive methods — implants, IUDs and tubal ligation — available in an area where the Catholic church is particularly influential.

Congregations and communities are also regularly receiving educational sessions on family planning through the teachings of 44 pastors trained by the IRC. More than 30,000 women have chosen family planning in IRC-supported health facilities in South Kivu from 2011 to 2015, and half of all new clients accepted long-acting or permanent methods. ■



KEY DEFINITIONS

COUPLE-YEARS OF PROTECTION (CYP):

Couple-Years of Protection (CYP) is a measure that estimates the protection from pregnancy during a one-year period.

LONG-ACTING METHOD: Long-acting methods include the intrauterine device (IUD) and the birth control implant.

Myth No. 2: Short-acting contraception satisfies the needs of women and girls.

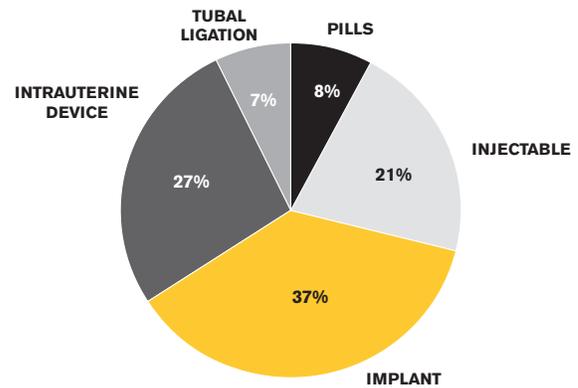
Humanitarian standards have come a long way, recognizing the need for contraception in the wake of any acute crisis. But they have not come far enough. In 2010, the Inter-Agency Field Manual for Reproductive Health added that contraceptives must be available to meet demand. However, the Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP), which describes minimum standards, stops short of endorsing the immediate availability of long-acting contraception. The manual also suggests that family planning is appropriate to provide in situations as they stabilize.

This influences emergency response kits for women's health pre-packaged by the United Nations Population Fund (UNFPA), which are intended to speed up implementation of the minimum standards. Since the standards do not require comprehensive family planning, only condoms and emergency contraception pills are often available at the onset of emergency response. Currently, the two pre-packaged kits intended for routine family planning services primarily respond to needs for short-acting methods. IUDs are provided in very limited quantities, based on forecasts that just 5 percent of new clients will choose the method. **No kit contains implants.**

These kits are critical during crises. When humanitarian organizations do not have licenses to import medical equipment and supplies into a country, they often rely on UNFPA's in-country kits or its ability to rapidly import supplies. Organizations that need a full range of methods are left to pursue a challenging parallel process to procure supplies.

COUPLE-YEARS OF PROTECTION METHOD MIX

(January 2013 - June 2015, 13 country programs)



Current guidance also makes it less likely that donors will fund long-acting contraceptives in rapid response interventions, despite undeniable demand. In 2015, more than half (53%) of clients in IRC's flagship program in Chad, Pakistan, DRC and Myanmar opted for long-acting or permanent methods. **IUDs and implants led demand, which can prevent unintended pregnancies for up to 12 or 5 years, respectively.**

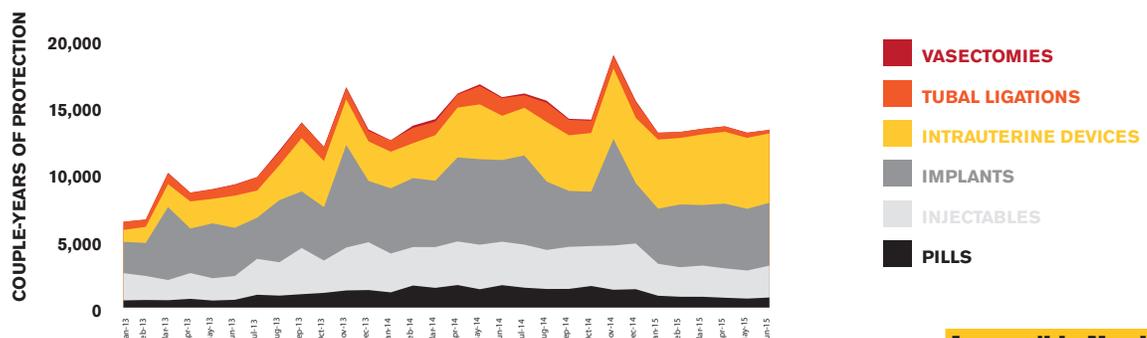
Research demonstrates, and our experience confirms, that greater contraceptive choice does more than increase options; it increases use. Overall, contraceptive use and coverage has increased across IRC programs in 13 countries. The majority of contraceptive protection was attributed to implants (37%) and IUDs (27%).

In a response to serve Burundian refugees in Tanzania, 83 percent of CYPs have been delivered through implants. Women in this crisis, and others, have asked for long-acting methods by name. Many women asked for long-acting methods, anticipating prolonged displacement. Globally, displaced people experience displacement for an average of 17 years.

As FP2020 expands access to family planning, women and girls will, and should, expect long-acting contraception as a basic element of health care. The humanitarian field must evolve to meet this necessary and urgent need. **■**

COUPLE-YEARS OF PROTECTION DELIVERED, BY METHOD

(January 2013 - June 2015, 13 country programs)



Myth No. 3: Family planning is too difficult to provide in humanitarian settings.

Skeptics often doubt that a full range of contraceptive methods, including long-acting methods, can be provided in settings with disrupted health systems, a lack of skilled providers and competing global priorities. Yet, it repeatedly proves to be possible — and desired — in crises across the world.

Reaching women in acute emergencies

War has forced 12 million Syrians to seek refuge in neighboring countries or within their own. As the refugee situation escalates, the humanitarian community, including the IRC, struggles to meet the needs of women at the center of its conflict.

In **northern Syria**, the IRC restored access to family planning by repairing health centers, delivering contraceptives and supplies, and recruiting and training health staff. Within four months, more than 600 women started family planning. Across the border in Jordan, the IRC worked to provide reproductive health to thousands of urban refugees in Mafraq and Ramtha. Between January 2013 and June 2015, the IRC distributed 2,165 CYPs to refugees at two fixed and two mobile clinics.

Another crisis erupted in Burundi in the spring of 2015, forcing more than 217,000 people to flee into neighboring countries, including Tanzania. Within a few months, the **Nyarugusu Refugee Camp** in northwestern **Tanzania** became the third largest refugee camp in the world. Women seeking reproductive health services overwhelmed the camp's reproductive health clinic. The IRC helped open a second, and then a third clinic and a maternity ward to satisfy the demand. Within days, masses of women and girls arrived for family planning, and one waiting room was expanded twice. From July to October 2015, the clinic provided 472 CYPs. Needs continue to persist.

34-year-old Felicite was one of the women who arrived at the clinic. "Living in fear is so hard," she said. "It's also hard for the



ABOVE: Felicite, 34, received an implant to avoid pregnancies while seeking refuge in Tanzania, after fleeing from Burundi. Photo by Anna Kim

children, who aren't in school. They are sleeping outside, and they don't have purpose." Felicite asked for an implant that will prevent pregnancies for five years. "My dreams for my girls and boys are the same for them all," she said. "I just want them to be safe in their lives."

Reaching women in protracted conflict

Twenty years of conflict has displaced three million people in the **Democratic Republic of Congo**. The severity of the conflict led to the creation of many of today's humanitarian response standards. At the same time, the conflict spurred the provincial and local health authorities to build the resilience of

Providing Contraceptive Choice in Acute Crisis

Since 2012, the IRC has integrated family planning services in 12 acute emergency responses.



women and families while addressing high rates of maternal mortality. Since 2002, the IRC has supported the rebuilding of the health system and, since 2009, has worked to make family planning a part of the standard health package in five health zones in North and South Kivu.

As of October 2015, nurses and doctors skilled in providing long-acting contraception are offering free services in 41 IRC-supported government health facilities. More than 45,000 clients started modern contraception and 58 percent accepted a long-acting or permanent method in four years.

A woman named Anasthasie received her first implant in an IRC clinic, free of charge.

“Before I received this, I was unable to control pregnancy, resulting in too many children and frequent sicknesses,” she said. “Since using this implant, my own health has significantly improved.”

Reaching women in the time of Ebola

When Ebola struck **Sierra Leone** in 2014, experts predicted that fear of the virus would stop women from coming to health centers for family planning. Despite a slight decrease, this was not the case. Before Ebola, IRC-supported facilities in Kenema delivered an average of 2,103 CYPs per month. At the height of the outbreak, family planning use dropped to an average of 1,937 CYPs between June and August 2014.

In Kenema district, where one-third of the country’s cases originated, the IRC partnered with the U.S. Centers for Disease Control and the Kenema District Health Management Team to understand what kept women away from health centers, and what might encourage them to return. Results helped improve infection control at all health centers and hospitals throughout the country, and informed communities that health workers were properly trained and equipped to stop the spread.

An average of 1,950 CYPs were delivered per month for the nine months following these efforts to restore confidence in health services. This number continues to increase. 

IRC: FAMILY PLANNING IN EMERGENCIES

Initiating a reproductive health emergency response frequently requires overcoming gaps in political will and trained staff, as well as complex procurement processes.

Deployable champions: The IRC deploys a medical expert within days to initiate emergency reproductive health services that include family planning.

Pre-positioned supplies: The IRC maintains a stock of pre-positioned supplies, including contraceptives, that can be shipped anywhere in the world within two weeks.

Health staff: The IRC identifies and trains staff that can provide a package of reproductive health services, including family planning counseling and delivery.

Community outreach volunteers: The IRC works with community outreach volunteers to increase the community’s awareness of core reproductive health messages, including the benefits of family planning.

Partners: The IRC works with partners to effectively coordinate a response, solicit buy-in and obtain permissions. Partners include Ministry of Health staff; local government officials; UN agencies; international NGOs and local community-based organizations.

IRC IMPACT

Between January 2013 - June 2015*

388,267
CYPs delivered by IRC-supported facilities

84,683
unintended pregnancies prevented

10,187
unsafe abortions were prevented

* To estimate the impact of our family planning services, we used Impact 2, a peer-reviewed model developed by Marie Stopes International.

2014

May

Southern Chad
CAR crisis

Kiryandango Camp, Uganda
Sudan crisis

Bor and Bentiu,
South Sudan

2015

February

Triangle of Death, Katanga Province,
Democratic Republic of Congo

July

Diffa, Niger
Nigeria crisis

August

Nyarugusu
Camp, Tanzania
Burundi crisis

September

Aden, Yemen

Answering the call

Family planning remains out of reach for millions of women and girls affected by crisis. But these gaps can be closed if we commit to the right actions now.

No matter the context, our experience has indicated that family planning is possible and desired. To address the pressing contraceptive needs of women and girls in crises, the international community must immediately focus on reaching vulnerable populations and serving women throughout their life-cycle. These efforts include testing promising service delivery models and scaling up high-impact interventions.

Reaching adolescents

Adolescent girls are at greatest risk for complications and death from childbirth. Reaching girls with family planning delays first pregnancy, decreases maternal mortality risk, and improves health, social and economic outcomes. However, girls often lack access to contraception due to provider misconceptions. Family planning programs in crises must address negative provider attitudes and provide access to adolescent-friendly services. The IRC is working to improve our ability to reach this underserved population. In three years, IRC-supported services in Democratic Republic of Congo, Myanmar and Pakistan helped bring contraception to 6,800 girls.

Providing post-abortion family planning

Family planning is an essential component of post-abortion care that helps end the cycle of unintended pregnancy and abortion. All post-abortion care clients served by the IRC receive client-centered counseling and family planning services. This led to nearly 4,000 post-abortion care clients accepting family planning in Chad, DRC, Myanmar and Pakistan, representing over half of clients treated for complications of abortion between June 2011 and July 2015.

Reducing unmet need among post-partum women

Research has shown that many women in their first year post-partum want to delay pregnancy for at least two years or altogether. To enable access to post-partum IUD services in Liberia, family planning was integrated into immunization services at seven health facilities in Lofa County. Health staff were trained on integration, counseling and strong referrals. As a result, 73 percent of all women referred for family planning by vaccinators adopted a family planning method on the same day of the referral between October 2013 and September 2014.

In Liberia, the IRC, in partnership with the Ministry of Health and Social Welfare, the Planned Parenthood Association of Liberia, and Columbia University are testing and implementing

interventions, including this one, that can help increase awareness, quality, and use of family planning.

Supporting community-based distribution

Family planning services can be effectively delivered by taking them out clinics and directly into the community, working with the health workers closest to the women in need. In Liberia, women in remote Lofa County and urban neighborhoods of Montserrado have access to injectable contraception through trained community health workers supported by the IRC and our partners. Findings from our pilot demonstrate that the provision of injectables by community health workers is safe, effective, and satisfactory for clients. Over the course of the initial seven-month pilot, nearly 7,000 depo-provera injections were administered by trained community health workers.

Improving client choice

Contraceptive choice increases overall use of contraception and improves client satisfaction. This was demonstrated when the IRC and the Ministry of Health in North and South Kivu re-introduced IUDs to clients by offering the levonogestrel IUD, proven to minimize monthly bleeding, in addition to the copper-bearing IUD, in 2014. Since the levonogestrel IUD was introduced, the average number of clients who accepted IUDs has increased fivefold. Training and clinical mentorship restored confidence in the method for providers, while community outreach strategies, such as radio shows and theater groups, piqued client interest.

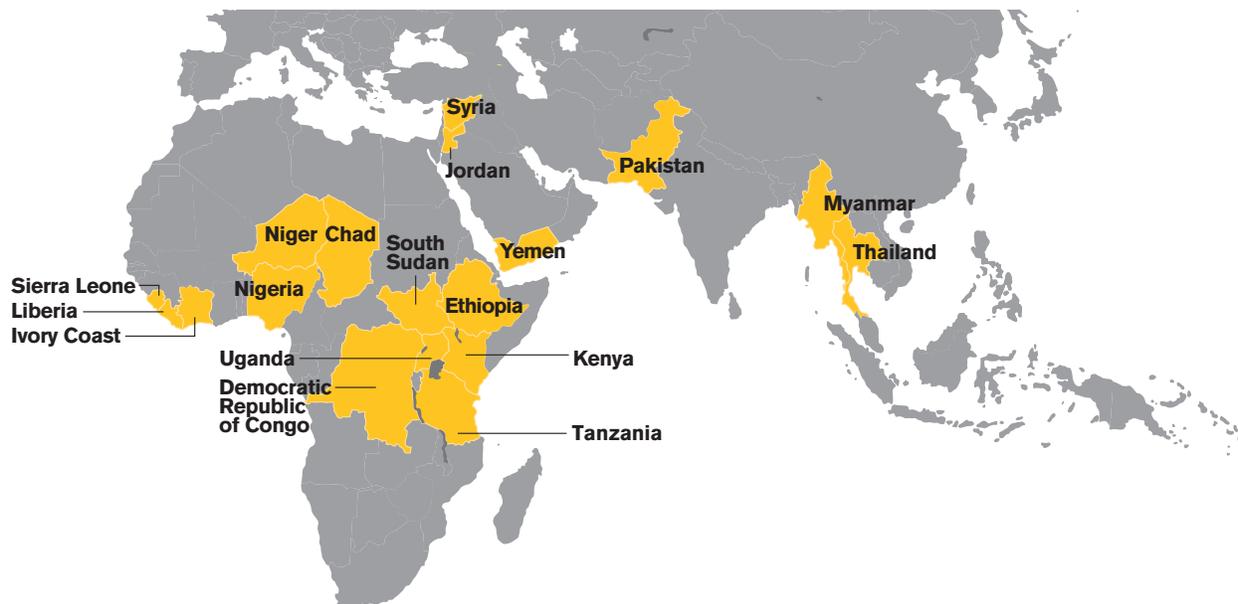
Conclusion

The IRC's experience demonstrates that it is not only possible to provide high-quality contraceptive services in emergencies, but that displaced women and girls want this life-saving service. It also shows that creative approaches and strong partnerships can ensure that family planning is provided from the acute phase through recovery, even in the most challenging and volatile humanitarian emergencies.

Governments, donors and aid agencies must work together to ensure that the contraceptive needs of women and girls in crises are explicitly addressed. The global community must dismiss myths and instead focus on the inspiring but urgent reality in front of us: family planning is desired everywhere and impossible nowhere. ■

The International Rescue Committee (IRC) responds to the world's worst humanitarian crises, helping to restore health, safety, education, economic wellbeing, and power to people devastated by conflict and disaster. Founded in 1933 at the call of Albert Einstein, the IRC is at work in over 40 countries and 26 U.S. cities helping people to survive, reclaim control of their future and strengthen their communities.

THE INTERNATIONAL RESCUE COMMITTEE AND FAMILY PLANNING



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