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# Do Family Planning High Impact Practices Work in Humanitarian Settings? A Preliminary Review of the Evidence

June 2024



**The Women's Refugee Commission** (WRC) improves the lives and protects the rights of women, children, youth, and other people who are often overlooked, undervalued, and underserved in humanitarian responses to displacement and crises. We work in partnership with displaced communities to research their needs, identify solutions, and advocate for gender-transformative and sustained improvement in humanitarian, development, and displacement policy and practice. Since our founding in 1989, we have been a leading expert on the needs of refugee women, children, and youth and the policies that can protect and empower them.

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## Acknowledgments

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Cover photo: Aime is a midwife and trainer at the maternity hospital in Kintambo, Democratic Republic of Congo (DRC). Working through Ipas DRC, she speaks to an audience on how to use modern contraceptive methods to prevent pregnancy. The organization works with local partners to educate all relevant stakeholders on sexual and reproductive health. Courtesy of Getty Images/ Images of Empowerment. Some rights reserved.

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**All countries must be prepared to respond to humanitarian emergencies, and there is a critical need for evidence-based approaches to deliver family planning (FP) services to meet the sexual and reproductive health needs of crisis-affected populations. The Family Planning High Impact Practices (HIPs) provide vetted, evidence-based best practices for effective FP programming, but have largely been developed with evidence from development contexts.**

**In 2023, the Women's Refugee Commission undertook a scoping review of the literature to explore whether service delivery and social and behavior change HIPs have been successfully implemented in humanitarian settings. This brief demonstrates that programming aligned with numerous HIPs has increased contraceptive use in diverse humanitarian contexts, highlighting the feasibility and impact of implementing evidence-based FP practices in these settings.**



# Introduction

In 2024, nearly 300 million people will be in need of humanitarian assistance, including approximately 75 million women and girls of reproductive age—many of whom have unmet need for basic health care, including sexual and reproductive health (SRH) services.<sup>1 2</sup> Family planning (FP) is lifesaving and part of the minimum standard of SRH care in humanitarian settings. The [Minimum Initial Service Package](#) (MISP) for Sexual and Reproductive Health—the global standard for SRH response in acute emergencies—includes the prevention of unintended pregnancies as one of six objectives; these objectives are also integrated into the [Sphere](#) standards for humanitarian response.<sup>3</sup> FP services must be available along with other SRH services at the outset of every crisis and expanded as the acute stage subsides, in alignment with the MISP for SRH and the [Inter-Agency Field Manual](#) (IAFM) on Reproductive Health in Humanitarian Settings.<sup>4</sup> There is documented demand for FP in diverse humanitarian settings, but FP services are not consistently available and accessible.<sup>5 6</sup> **It is essential that governments, national and international implementing partners, and donors are equipped with evidence on effective approaches to delivering FP services to meet the SRH needs of crisis-affected populations.**

The Family Planning High Impact Practices (HIPs) are a set of evidence-based FP practices endorsed by more than 60 organizations to help build consensus around what works in FP. HIPs are thoroughly vetted to have a demonstrated impact on contraceptive use, with consideration to other relevant outcome measures and evidence of replicability, scalability, sustainability, and cost-effectiveness.<sup>7</sup> HIPs are organized into four categories—enabling environment; service delivery; social and behavior change; and enhancements. Service delivery and social behavior change HIPs are further categorized as “proven” or “promising,” based on the strength of the available evidence.\* While HIPs are determined based on potential application in a wide range of settings, they have largely been developed with evidence from non-humanitarian low- and middle-income country contexts.<sup>8</sup>

In 2020, a [strategic planning guide for FP in humanitarian settings](#) was published as a complementary guidance document to the HIPs.<sup>9</sup> The strategic planning guide targets national and sub-national decision-makers with a series of key actions that should be taken across emergency preparedness, response, and recovery to improve the accessibility and availability of FP in the event of crises. Actions in the strategic planning guide primarily target a country's health system, including its emergency preparedness and disaster risk management frameworks, to strengthen national capacity to coordinate SRH humanitarian response, and deliver FP services as part of the MISP for SRH.

**This brief builds on the strategic planning guide by undertaking a more focused exploration of the implementation of the service delivery and social and behavior change HIPs in humanitarian settings.** For each of these HIPs, we assess whether there is sufficient or insufficient evidence that programming aligned with the HIP has been implemented in humanitarian settings and that it impacted contraceptive use. We also present evidence on successful or promising approaches to strengthen the availability and accessibility of FP services in humanitarian settings that do not necessarily align with the current HIPs. **This brief demonstrates that programming aligned with numerous HIPs has increased contraceptive use in diverse humanitarian contexts, highlighting the feasibility of implementing evidence-based FP practices in these settings.**

\* Proven HIPs have sufficient evidence to support widespread implementation with careful monitoring of FP service coverage, quality, and cost. Promising HIPs have good evidence that the intervention can lead to impact, but more research is needed to fully document implementation experience and impact. See: High Impact Practices in Family Planning (HIPs). Family planning high impact practices list. Washington, DC: The High Impact Practices Partnership; August 2022. <https://www.fphighimpactpractices.org/briefs/family-planning-high-impact-practices-list/>.



This brief is an initial exploration of the applicability of HIPs in humanitarian settings and is not intended to serve as definitive guidance on HIP implementation in these settings. It is critical to note that, in this brief, having insufficient evidence does not mean that the HIP would not be feasible in humanitarian settings, or that the HIP would not positively impact FP outcomes. Rather, it means that the scoping review did not identify evidence of programming from humanitarian settings that aligned with the HIP, or that the impacts on contraceptive use were not measured or documented.

Evidence presented in this brief draws from a scoping review of peer-reviewed and gray literature for data generated by FP service delivery interventions in humanitarian settings. Researchers included both quantitative and qualitative data, and both routine program data and data generated by program evaluations. For the purposes of the scoping review, “humanitarian settings” were defined as settings affected by conflict or natural disasters, including both acute and protracted crisis settings, as well as communities affected by displacement. The findings draw from two separate literature searches: the first search was completed in 2019 and identified publications from 2010–19, and the second search was completed in July 2023 and identified publications from 2019–2023. Peer-reviewed literature was identified via the PubMed search engine, and gray literature was identified using Google and ReliefWeb searches. **See more details in “Annex 1”** (page 14).

## Family Planning High Impact Practices (HIPs)

### *Service Delivery HIPs*

#### Proven HIPs

**Community Health Workers: Integrate trained, equipped, and supported community health workers into the health system.**

There is demonstrated impact from a range of settings that community health worker (CHW) programs can increase use of contraception, particularly where there is high unmet need, low access, and/or geographic or social barriers to using services.<sup>10</sup> **There is evidence that CHWs increase contraceptive use in humanitarian settings.**

Systematic reviews of SRH services in humanitarian settings conclude that engaging CHWs is associated with increased use of contraception.<sup>11 12</sup> In Afghanistan, when CHWs distributed free contraceptives in rural areas, contraceptive use increased from 16 percent to 26 percent and unmet need for contraception decreased by 16 percent.<sup>13</sup> Another study in Afghanistan found that community-informed messaging on FP coupled with CHW distribution of contraceptive methods resulted in an increase in contraceptive prevalence from 24 to 27 percent.<sup>14</sup> In Sudan, a home-based FP counselling program for internally displaced people (IDPs) led to an increase in the use of modern family planning methods.<sup>15</sup> In eastern Myanmar, a three-tiered network of community-based providers for delivery of maternal health interventions, including contraceptive services, saw use of modern methods increase from 25 percent to 45 percent, and unmet need for contraception reduced from 62 percent to 41 percent.<sup>16</sup> In Borno State, Nigeria, following a program aimed at building capacity of CHWs, the percentage of women and adolescent girls aged 15 to 49 years visited by a CHW who reported using contraception increased from 5% to 17% in one site and from 7% to 18% in another.<sup>17</sup>



**Immediate Postpartum Family Planning: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility.**

The provision of FP services as part of care provided during childbirth increases postpartum contraceptive use and may reduce unintended pregnancies and support birth spacing.<sup>18</sup> **There is evidence that immediate postpartum family planning increases contraceptive use in humanitarian settings.**

In the Democratic Republic of Congo (DRC), Pakistan, and Somalia, an intervention aimed to implement higher intensity integrated postpartum contraceptive services with a focus on long-acting reversible contraception (LARC).<sup>19</sup> As a result, the proportion of women and girls who adopted an intrauterine device (IUD) or implant within the first 48 hours following delivery significantly increased. The mean percentage of postpartum IUD or implant uptake among all deliveries in the three intervention countries was 10 percent, compared to less than 1 percent in the three countries providing standard care. Additionally, a 2012 quality improvement intervention aimed at integrating FP into postpartum care in Afghanistan resulted in an increase in the proportion of postpartum women who agreed to use family planning and left the hospital with their preferred method from 12 percent to 95 percent after 10 months of the intervention.<sup>20</sup>

**Mobile Outreach Services: Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods.**

Evidence demonstrates that mobile outreach services can address inequitable access to FP services and increase contraceptive use, particularly where there is limited availability of and barriers to accessing FP services, and high unmet need and low contraceptive prevalence.<sup>21</sup> **There is evidence that mobile outreach services increase contraceptive use in humanitarian settings.**

In northern Uganda, mobile outreach teams supported an increase in contraceptive use from 7.1 percent at baseline to 22.6 percent at endline, including an increase in use of long-acting and permanent methods from 1.2 percent to 9.8 percent. The proportion of women with unmet need for family planning decreased from 52.1 percent to 35.7 percent.<sup>22</sup> In Myanmar, mobile clinics provided family planning advice, contraceptives, antenatal and postnatal check-ups, safe birth support, and HIV infection risk reduction and treatment, resulting in service uptake from 2016 to 2018.<sup>23</sup>

**Postabortion Family Planning: Proactively offer voluntary contraceptive counseling and services at the same time and location where women receive facility-based postabortion care.**

Providing FP services as part of postabortion care (PAC), which includes treatment for complications from spontaneous or induced abortion, supports contraceptive uptake.<sup>24</sup> **There is evidence that postabortion family planning increases contraceptive use in humanitarian settings.**

In DRC, Somalia, and Yemen, following a program focused on strengthening PAC services, including integrated contraceptive counseling, there was a demonstrated increase in the proportion of PAC clients choosing contraception.<sup>25</sup> In DRC, 42 percent of all PAC clients chose a contraceptive method in 2012; by 2017, the proportion had increased to 70 percent. In the first two years of the intervention in Somalia, 98 percent of PAC clients were counselled for postabortion contraception, of which 88 percent accepted a contraceptive method before leaving the facility, with 30 percent opting for long-acting reversible contraception.<sup>26</sup> Over the entire program period, from 2012 to 2017, Somalia saw the percentage of PAC clients opting for post-abortion contraception increase from 64 percent to 82 percent. In Yemen, the percentage of PAC clients choosing postabortion contraception rose from 17 percent in 2013 to 38 percent in 2017.



**Social Marketing: Use marketing principles and techniques to shape the provision of contraceptive services and products to improve access, choice, and use, for target populations.**

Social marketing programs aim to increase knowledge of, demand for, and use of FP through promotion of products and services, while expanding the range of available contraceptive methods and/or clients' options for obtaining products and services.<sup>27</sup> **There is currently insufficient evidence of social marketing increasing contraceptive use in humanitarian settings.**

While studies from humanitarian settings addressed creating demand and meeting target populations' needs, few were grounded in private sector and market principles such as social marketing.<sup>28 29</sup> Components of social marketing may be embedded in programs and interventions from the identified literature, but more research is needed to understand the impact of social marketing on contraceptive use in humanitarian settings.

**Promising HIPs**

**Pharmacies and Drug Shops: Train and support pharmacies and drug shops to provide family planning information and a broad range of quality contraceptive methods.**

Evidence shows that pharmacy and drug shop staff can be trained and supported to provide FP information and a range of methods, and support contraceptive use, particularly in areas with limited access to services, shortages of health workers, and high levels of unmet need.<sup>30</sup> **There is currently insufficient evidence of pharmacies and drug shops increasing contraceptive use in humanitarian settings.**

Some publications illustrated the potential for engagement from pharmacies and drug shops in humanitarian settings, but did not document increased contraceptive use. Several descriptive studies from humanitarian settings discussed that women preferred to receive contraception from private pharmacies and other nonpublic facilities.<sup>31</sup> A 2019 qualitative study among pharmacists in Jordan found that pharmacists were enthusiastic to add emergency contraception to their method mix.<sup>32</sup> A 2021 study from northern Uganda examined the role that private, for-profit providers—including pharmacies, drug shops, and private clinics—play in enabling access to health services, including FP, for those unable to pay. While the study found that for-profit providers employed fee exemptions, fee reductions, loan books, and partial payments, the study also found that for-profit providers face a continuous dilemma of balancing profit and altruism objectives.<sup>33</sup> More research is needed on how pharmacies and drug shops can provide FP information and a broad range of quality contraceptive methods in humanitarian settings.

**Family Planning and Immunization Integration: Offer family planning information and services proactively to women in the extended postpartum period during routine child immunization contacts.**

Integrating FP services with infant-child immunization services throughout the extended postpartum period (the 12 months following birth) can facilitate access to and uptake of contraception.<sup>34</sup> **There is currently insufficient evidence of family planning and immunization integration increasing contraceptive use in humanitarian settings.**

While studies and guidelines from humanitarian settings discussed integrating FP into antenatal care, newborn care, postnatal care, and childhood nutrition visits,<sup>35 36 37</sup> no articles discussed integrating FP into routine child immunization visits. More research is needed to assess whether FP and immunization integration can lead to an increase in contraceptive use in humanitarian settings.





**Social Franchising: Organize private providers into branded, quality-assured networks to increase access to provider-dependent contraceptive methods and related services.**

Social franchising engages networks of private-sector providers to deliver health services under a common franchise brand. Social franchising can improve the availability and quality of private sector FP services, especially for methods that depend on the availability of a provider.<sup>38</sup> **There is currently insufficient evidence of social franchising increasing contraceptive use in humanitarian settings.**

While some studies from humanitarian settings used private providers for contraceptive service delivery, none used social franchising. A 2021 study of private, for-profit providers from northern Uganda found concerns around quality and standardization of pricing. For example, some managers reported exaggerating the price of treatment while withholding information from clients.<sup>39</sup> Additional research is needed to understand the feasibility of social franchising in humanitarian settings.

## *Social and Behavior Change HIPs*

### Proven HIPs

**Knowledge, Beliefs, Attitudes, and Self-Efficacy: Implement interventions to strengthen an individual's ability to achieve their reproductive intentions by addressing their knowledge, beliefs, attitudes, and self-efficacy.**

In addition to having accurate knowledge about FP, an individual's beliefs, attitudes, and self-efficacy influence their ability to achieve their FP goals.<sup>40</sup> **There is evidence that interventions targeting individuals' knowledge, beliefs, attitudes, and self-efficacy increase contraceptive use in humanitarian settings.**

In Liberia, a group randomized control trial measured the impact of an intervention with youth that aimed to promote positive condom attitudes and increase skills and self-efficacy to refuse sex, negotiate condom use, and use condoms effectively.<sup>41</sup> The intervention significantly improved protective peer norms and positive condom attitudes and increased frequency of condom use at the nine-month follow-up. A 2021 randomized controlled trial from northern Uganda found that adolescents who received peer counseling were more likely to accept a contraceptive method compared to those who received routine counseling.<sup>42</sup>

**Mass Media: Use mass media channels to support healthy reproductive behaviors.**

Mass media programming can support healthy reproductive behaviors by addressing lack of knowledge, misperceptions, and concerns about fertility, unintended pregnancy, and contraception, including side effects, and promote self-efficacy and positive social norms around FP.<sup>43</sup> **There is currently insufficient evidence of mass media channels increasing contraceptive use in humanitarian settings.**

Some studies in humanitarian settings found correlations between radio/television ownership and contraceptive use, but no studies document the impact of specific mass media campaigns on contraceptive uptake. A 2020 cross-sectional survey from Afghanistan found positive associations between mass media exposure (television/radio ownership) with reported modern contraceptive use.<sup>44</sup> A 2022 study from Iraq found factors significantly associated with modern contraceptive use among married women aged 15-49 to similarly include exposure to television.<sup>45</sup> The UNFPA Arab Region has documented many outreach initiatives that included television, radio, and social media to reach communities with SRH information during the COVID-19 pandemic, but did not document the impact of these campaigns on contraceptive uptake.<sup>46</sup> Additional research should measure how mass media channels can support healthy reproductive behaviors in humanitarian settings.



**Promoting Healthy Couples' Communication: Implement interventions demonstrated to encourage couples to discuss family planning/reproductive health and make equitable, joint decisions to reach fertility intentions.**

Interventions that supporting healthy couples' communication can increase the uptake of contraception and help couples achieve their fertility goals while also promoting gender equality.<sup>47</sup>

**There is currently insufficient evidence of promoting healthy couples' communication increasing contraceptive use humanitarian settings.**

While there was no evidence identified from humanitarian settings focused specifically on couples' communication, there were several studies showing linkages between women's participation in household decision-making and contraceptive use. A 2020 cross-sectional survey from Afghanistan found positive associations between wives' participation in household decisions with reported modern contraceptive use.<sup>48</sup> Studies that additionally found enhanced decision-making ability or self-efficacy in humanitarian contexts were often linked with girls' education or women's participation in economic activity.<sup>49 50</sup> Additional research is needed to document the impact of promoting health couples' communication on contraceptive use in humanitarian settings.

**Social Norms: Implement interventions that address social norms to support an individual's or couple's decision-making power to meet their reproductive intentions.**

Social norms establish which behaviors in a community or group are appropriate and acceptable, and are reinforced by important people in an individual's life, such as friends, family members, romantic partners, and community and religious leaders. Contraceptive use is influenced not only by individual knowledge, beliefs, and attitudes but also by social norms.<sup>51</sup> **There is currently insufficient evidence of social norms interventions increasing contraceptive use in humanitarian settings.**

Social norms interventions in humanitarian settings are often linked to programs intended to address individual knowledge, beliefs, and attitudes. However, we did not identify any studies from humanitarian settings that measured the impact of social norms interventions on contraceptive use. In Syria, an intervention for adolescent girls targeted community consciousness and engagement around gender, power, and social norms to support enabling structures and environments, with the ultimate goal of improving pregnant adolescents and first-time mothers SRH knowledge and behaviors.<sup>52</sup> A mixed-methods evaluation found that the intervention decreased expectations of early marriage and increased acceptance of contraception. Community support for girls' use of contraception increased by 27 percent and community support for girls' equal access to health services increased by 35 percent. Evidence is needed on how social norms interventions can impact contraceptive use in humanitarian settings.

## **Promising HIPs**

**Community Group Engagement: Engage and mobilize communities in group dialogue and action to promote healthy sexual relationships.**

Rather than targeting individuals alone, community group engagement aims to strengthen individual knowledge, attitudes, and practices and influence social norms around FP by working with community groups.<sup>53</sup> **There is evidence that community group engagement increases contraceptive use in humanitarian settings.**

Community and stakeholder engagement proved critical for an SRH program in the Somali region of Ethiopia, where increased service uptake was attributed to successful community mobilization.<sup>54</sup> Similarly, community group engagement, including community dialogues with



health providers, contributed to increased contraceptive uptake among South Sudanese refugees in northern Uganda.<sup>55</sup> One program in Syria included reflective dialogues with girls' marital family and community members, which resulted in community support for girls' use of contraception increasing by 27 percent and community support for girls' equal access to services increasing by 35 percent.<sup>56</sup> In North and South Kivu, DRC, SRH programming included active engagement with community leaders through activities such as community mapping, values clarification and transformation, situational analyses, and education.<sup>57</sup> The program's 2019 qualitative study assessing perceptions of community leaders found that when thoughtfully engaged by health interventions, community leaders can be empowered to become advocates for SRH through sharing information and referring community members to FP services.

**Digital Health for Social and Behavior Change: Use digital technologies to support, maintain, and adopt healthy sexual and reproductive behaviors.**

Digital technologies can provide accurate SRH information on demand, in time- and cost-efficient formats, and influence individual's FP knowledge, attitudes, and practices.<sup>58</sup> **There currently is insufficient evidence of digital health for social and behavior change increasing contraceptive use in humanitarian settings.**

No studies were identified that measured the impact of digital technologies to support, maintain, and adopt healthy SRH behaviors in humanitarian settings. A 2022 study with forcibly displaced adolescents in Kampala, Uganda, evaluated texting-based sexual communication as a means of encouraging condom use.<sup>59</sup> The study found that texting-based condom negotiation improved condom practices, and the authors conclude that future digital sexual health interventions should consider the utility of texting-based applications in promoting knowledge and use of condoms. However, this study did not include any intervention, and thus additional research is required to evaluate the impact of digital technology on contraceptive use in humanitarian settings.

## Good and Promising Practices beyond the HIPs

The HIPs do not represent an exhaustive list of all effective or promising practices and program models to strengthen the enabling environment for FP services, improve FP service delivery, or increase demand for and use of FP. The scoping review also identified evidence for other good and/or promising practices to support effective FP programming and SRH emergency response in humanitarian settings.

### *Self-care initiatives for FP*

Contraceptive self-care is the self-administration of a range of contraceptive methods, including oral contraceptive pills, emergency contraceptive pills, and the injectable contraceptive subcutaneous DMPA (DMPA-SC). Self-care initiatives are particularly important in humanitarian settings, where clients may face heightened barriers to accessing providers and health facilities. A 2022 scoping review of self-care interventions in humanitarian settings found two studies on contraception in humanitarian settings.<sup>60</sup> One study examined the acceptability and feasibility of self-injection of DMPA-SC in the DRC. The study found that of 640 clients, 80 percent reported feeling ready and confident in their ability to self-inject DMPA-SC after having been trained by a provider, and 97 percent described self-injection as easy when surveyed three and six months later.<sup>61</sup> PATH worked to expand access to DMPA-SC in two refugee settings in Uganda from January to November 2019, engaging women and key stakeholders in the design and implementation following PATH's Self-Injection Best Practices.<sup>62</sup>

Multiple organizations are seeking to roll out DMPA-SC across humanitarian settings, including Marie Stopes International in Nigeria, Pathfinder in DRC, Jhpiego in Mali, and MSF in numerous locations.<sup>63</sup> As in development settings, the COVID-19 pandemic accelerated pre-existing efforts to promote self-care initiatives in humanitarian settings, including self-injectable contraception.<sup>64</sup>

### *Cash and voucher assistance and subsidies for FP services*

Cash and voucher assistance (CVA) can improve access to and use of health services, including SRH, in humanitarian settings. There is evidence that addressing user costs through subsidies and CVA can contribute to an increase in contraceptive use in humanitarian settings. Notably, vouchers are a HIP enhancement that can be used to facilitate access to FP services. One study evaluating the impact of health subsidies on the knowledge, attitudes, and practices towards contraception of Afghan refugee women in Pakistan found that among women who received subsidies for health services, 90 percent reported knowledge of contraception when surveyed, compared to 45 percent of women who had not received health subsidies; current contraceptive use among the group of women who received subsidies was 54.5 percent, compared to 24.9 percent.<sup>65</sup> A 2016 study assessed the impact of vouchers on access to and uptake of contraceptive services in Yemen and Pakistan, and found that in Yemen, the uptake of LARCs and permanent methods was 38 percent higher than what would have been expected without the voucher program when compared to the estimate of expected uptake of LARCs and PMs based on contraceptive prevalence rates.<sup>66</sup> In Pakistan, researchers estimated that vouchers enabled 10 times more clients than expected to choose LARCs and permanent methods in the districts where the program was implemented.

### *Multi-pronged approaches to improve quality of care for FP services*

Much of the evidence on the impact of FP programming in humanitarian settings comes from monitoring and evaluation data from robust, multi-pronged FP service programs that were focused on providing a broad range of methods and improving quality of care. These programs were implemented by service delivery organizations, including CARE, the International Rescue Committee (IRC), and Save the Children, in collaboration with the RAISE Initiative at Columbia University, and in partnership with government ministries of health, in a range of humanitarian settings.<sup>67</sup> These programs included the following program components: staff training to strengthen clinical and counseling skills; supervision in health facilities; supply chain strengthening; community mobilization; and programmatic data collection and use. Results showed strong contraceptive uptake across these programs. For example, after 2.5 years of programming in Chad, DRC, Djibouti, Mali, and Pakistan, CARE reported a total of 52,616 new users of modern methods of contraception in these five countries.<sup>68</sup> In North and South Kivu, DRC, where CARE, IRC, and Save the Children implemented programming, modern contraceptive prevalence among women in union doubled from 3.1 percent to 5.9 percent from 2008 to 2010,<sup>69</sup> and was as high as 26.7 percent in certain health zones by 2017.<sup>70</sup> Findings from these programs also demonstrate the critical importance of investing in and conducting quality monitoring and evaluation, particularly in humanitarian settings, where there may be a need to pivot or adapt more quickly to insecurity or population movements.

### *Strong coordination to implement the MISP for SRH, including FP services*

The first objective of the MISP for SRH is coordination, underscoring the importance of strong coordination for effective SRH response. Documentation from SRH humanitarian responses in diverse settings reflects that strong coordination can improve the availability of SRH services, including FP. For example, a qualitative study from Lebanon found that the presence of a lead agency, the Ministry



of Public Health, to oversee and coordinate the SRH response for Syrian refugees in Lebanon was an essential facilitating factor for SRH service provision.<sup>71</sup> A 2019 WRC assessment of contraceptive service delivery as part of the Rohingya refugee response in Cox's Bazar, Bangladesh, found that the presence of an active SRH Working Group and a skilled coordinator prior to the 2017 influx of refugees allowed for continuity in leadership and effective maintenance of NGO and government relationships in the SRH response.<sup>72</sup> Another study documenting health sector coordination in Cox's Bazar corroborated that strong leadership, intersectoral collaboration, and technical expertise in the health response contributed to the availability of SRH services, including FP.<sup>73</sup>

## *Emergency preparedness for sexual and reproductive health, including FP*

Emergency preparedness is crucial to ensuring that health systems are prepared to respond to humanitarian crises, and that essential health services, including FP, are available during crises. Increasingly, stakeholders across the humanitarian-development nexus, including governments, donors, and implementing partners, are taking steps to strengthen emergency preparedness for SRH. In Pakistan, one organization documented efforts to implement district-level action plans to strengthen preparedness to implement the MISP for SRH. Action plans varied to reflect the specific needs of different districts, but included activities such as integrating the MISP for SRH into disaster risk management for health plans; training providers, program managers, and policy makers on the MISP for SRH; developing referral pathways for survivors of gender-based violence; establishing transport systems for obstetric emergencies; and conducting community mobilization about the importance of accessing SRH services, including contraception.<sup>74</sup> An assessment of MISP for SRH implementation in two districts in Nepal, post-2015 earthquake, found that SRH preparedness measures—including the incorporation of the MISP for SRH in disaster preparedness plans, pre-positioning supplies, and training providers on the MISP for SRH—facilitated a stronger SRH humanitarian response.<sup>75</sup>

## Bringing the Learning Together

Meeting FP needs in humanitarian settings saves lives, protects human rights, fosters agency and self-determination, and advances resilience. There is documented demand for FP services across a wide range of humanitarian settings, and a growing body of evidence of what works to meet demand and increase contraceptive use in these settings. Yet many documented best practices for delivering effective FP services, including the HIPs, draw from evidence primarily from nonhumanitarian low- and middle-income country contexts. **As more and more people globally are affected by various types of crises, there is an increasing need for clear, evidence-based approaches to best meet SRH needs in humanitarian settings.**

This brief was developed with the goal of exploring evidence of successful programming aligned with service delivery and social and behavior change HIPs in humanitarian settings. **Our scoping review of peer-reviewed articles and gray publications identified evidence of successful implementation of numerous HIPs in humanitarian settings.** Table 1 (page 11) summarizes the evidence cited for each HIP. Under the domain of service delivery, there is evidence that the following HIPs have increased contraceptive use in humanitarian settings: CHWs; immediate postpartum FP; mobile outreach services; and postabortion FP. We did not identify evidence documenting the successful implementation of social marketing; pharmacies and drug shops; FP and immunization integration; and social franchising. Under the domain of social and



behavior change, we found evidence that the following HIPs have increased contraceptive use in humanitarian settings: knowledge, beliefs, attitudes, and self-efficacy; and community group engagement. We did not identify evidence documenting the successful implementation of mass media; social norms; promoting healthy couples' communication; and digital health.

**It is critical to note that, in this brief, having insufficient evidence does not mean that it is not feasible to implement a HIP in humanitarian settings, or that the HIP would not positively impact FP outcomes.** Rather, it means that either: (1) we did not find evidence that programming aligned with the HIP has been implemented in humanitarian settings; or (2) while we found evidence of programming aligned with the HIP, the impacts on contraceptive uptake were not measured or documented. Similarly, our review is not meant to be an authoritative guide on whether certain HIPs should be implemented in humanitarian settings. Rather, this brief is an initial exploration of the evidence base for these HIPs in humanitarian settings.

In addition to the evidence on service delivery and social and behavior change HIPs, the literature has also shown promising FP practices in humanitarian settings that are not currently reflected in the HIPs, including self-care initiatives and CVA and subsidies for FP. Documentation from SRH response in diverse humanitarian settings further underscored the importance of emergency preparedness for SRH, including FP, to ensure that health systems are prepared to respond to SRH needs when crises strike, and the role that strong coordination plays in successful implementation of the MISP for SRH. Evidence from multipronged FP programming in diverse humanitarian contexts demonstrates the feasibility of providing good quality FP services, including the provision of a range of methods, and that there is high demand for FP services in these settings. Together, these good and promising practices highlight the importance of continued evidence generation from humanitarian settings to better meet the SRH needs of crisis-affected populations.

While we did not assess the available evidence for the full range of HIP enhancements (which include adolescent-responsive services; digital health to support FP providers; digital health for strengthening FP systems; and FP vouchers), evidence presented in this brief does overlap with these HIPs. For example, several studies presented evidence on adolescent-responsive FP programming, and some included evidence on various components of digital health interventions.<sup>76</sup> We also found evidence of the success of the use of vouchers for increasing contraceptive use in humanitarian settings. **As a next step, researchers should assess the extent to which there is evidence of successful implementation of HIP enhancements in humanitarian settings.**

This brief also does not assess evidence related to the enabling environment HIPs. Enabling environment HIPs aim to “address systemic barriers that affect an individual’s ability to access [FP] information and services” by strengthening policies, legislation, and financing (e.g., domestic public financing); institutions, collaborative governance, and management (e.g., supply chain management); and social and economic factors (e.g., educating girls).<sup>77</sup> Although humanitarian settings are marked by profound disruptions to systems and institutions, **efforts to strengthen enabling environments in stable and fragile settings can and should be leveraged to strengthen emergency preparedness and reinforce the resilience of health systems to absorb and adapt to shocks and stressors**—mitigating disruptions to SRH services and ensuring readiness to deliver an effective humanitarian SRH response.


**Table 1: Summary of evidence on HIP implementation in humanitarian settings**

Domain	High Impact Practice (HIP)	Select evidence demonstrating HIP in humanitarian setting	Finding
Service Delivery (Proven)	Community Health Workers	Afghanistan [13] [14] <sup>†</sup>	Sufficient evidence
		Myanmar [16]	
		Nigeria [17]	
		Sudan [15]	
	Immediate Postpartum FP	Afghanistan [20]	Sufficient evidence
		DRC [19]	
		Somalia [19]	
		Pakistan [19]	
	Mobile Outreach Services	Myanmar [23]	Sufficient evidence
		Uganda [22]	
Postabortion FP	DRC [25]	Sufficient evidence	
	Somalia [25] [26]		
	Yemen [25]		
Social Marketing	N/A	Insufficient evidence	
Service Delivery (Promising)	Pharmacies and Drug Shops	N/A	Insufficient evidence
	FP and Immunization Integration	N/A	Insufficient evidence
	Social Franchising	N/A	Insufficient evidence
Social and Behavior Change (Proven)	Knowledge, attitudes, and self-efficacy	Liberia [41]	Sufficient evidence
		Uganda [42]	Sufficient evidence
	Mass Media	N/A	Insufficient evidence
	Promoting Health Couples' Communication	N/A	Insufficient evidence
	Social Norms	N/A	Insufficient evidence
Social and Behavior Change (Promising)	Community Group Engagement	DRC [57]	Sufficient evidence
		Ethiopia [54]	
		South Sudan [55]	
		Syria [56]	
	Digital Health for Social and Behavior Change	N/A	Insufficient evidence

As humanitarian needs are increasing, and with more than half the world's countries are at medium, high, or very high risk of crisis, all countries must be prepared to respond to humanitarian

† Numbers in brackets refer to endnote numbers.



emergencies, and to meet the SRH needs of affected communities—including FP.<sup>78</sup> To do so, we need rigorous evidence of what works to deliver FP services, not only as part of an acute humanitarian response, but in fragile settings, in protracted and cyclical crises, and as part of emergency preparedness and resilience-building for SRH. The HIPs engage diverse stakeholders and experts from the FP community and provide vetted, evidence-based best practices for impactful FP programming. **This brief highlights that HIPs are not only relevant in stable, development contexts – but also in humanitarian settings.** With further research, the HIPs are positioned to provide guidance for policymakers, implementers, and donors seeking to deliver FP services across preparedness, response, and recovery.

## Recommendations for Future Research

This brief is an initial exploration of the evidence on implementation of service delivery and social and behavior change HIPs in humanitarian settings. In order to fully determine the applicability of each HIP in diverse humanitarian contexts, we recommend the following:

1. Undertake a review of existing evidence from humanitarian settings for the implementation of the HIP enhancements.
2. Assess how the enabling environment HIPs can be applied to strengthen emergency preparedness, facilitate effective SRH humanitarian response, and contribute to resilient health systems.
3. Undertake a Delphi study<sup>‡</sup> with practitioners to identify best practices in FP programming in humanitarian settings, inclusive of and beyond the existing HIPs.
4. Using a participatory process with technical experts, synthesize peer-reviewed literature, gray literature, programmatic knowledge, and identified best practices from humanitarian settings to comprehensively assess each HIP's impact on contraceptive use, as well as other relevant outcome measures, including unintended pregnancy, fertility, or one of the primary proximate determinants of fertility.

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<sup>‡</sup> Delphi is a research technique used to build consensus or answer questions on key topics through rounds of structured and iterative feedback with technical experts.





## Annex 1

Researchers searched in peer-reviewed journals and gray literature for quantitative and qualitative data on family planning (FP) programming and services in humanitarian settings. For the purposes of this scoping review, “humanitarian settings” were defined as settings affected by conflict or natural disasters, including protracted crisis settings, as well settings with communities affected by displacement.

Peer-reviewed literature was identified via the PubMed search engine, using the following search terms:

- Contraceptive (inclusive of contraceptives, contraceptive use, contraceptive services)
- Contraception
- Family planning
- Birth spacing
- Birth limiting
- LARCs (long-acting, reversible contraceptives)
- Removal
- DMPA-SC
- Sayana Press

In combination with the following:

- Humanitarian (inclusive of humanitarian settings, humanitarian emergencies, etc.)
- Displacement
- Crisis
- Conflict
- Disaster

Gray literature was identified using Google and ReliefWeb searches, and through past Inter-Agency Working Group (IAWG) on Reproductive Health in Crises' *IAWG Insider* updates. In the literature review conducted in 2019, data was also identified by searching relevant organizations' websites directly, while the 2023 search included publications—including guidelines and tools—identified via *IAWG Insider* updates.

To qualify for inclusion, publications needed to address some aspect of FP services in humanitarian settings, including (but not limited to) the provision and availability of contraceptive services; barriers to contraceptive service delivery; availability of removal services for LARCs; contraceptive prevalence or use among affected populations; specific information on contraceptive service delivery programs and/or interventions; and FP components of related programs such as newborn health. Publications that generally acknowledged the importance of FP or SRH services in humanitarian settings but lacked specific data on service delivery and/or contraceptive use (e.g., editorials, commentaries), were excluded. Articles published between 2010 and 2023 were included.

Researchers identified 81 descriptive and 190 program-related peer-reviewed articles, gray publications, guidelines, and tools. These resources were then reviewed to determine if they supported successful implementation of each service delivery and social and behavior change HIP. In order to qualify as supporting evidence for successful HIP implementation, literature had to report on the impact of the HIP on contraceptive use or other relevant outcome measures. Resources were also reviewed for interventions that had demonstrated impact on contraceptive use but were not aligned with a service delivery or social behavior change HIP.



## Acronyms and Abbreviations

CHW	Community health worker
CVA	Cash and voucher assistance
DRC	Democratic Republic of Congo
FP	Family planning
HIPs	High Impact Practices
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IDPs	Internally displaced people
IRC	International Rescue Committee
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MISP	Minimum Initial Service Package for Sexual and Reproductive Health
PAC	Postabortion care
WRC	Women's Refugee Commission



## Endnotes

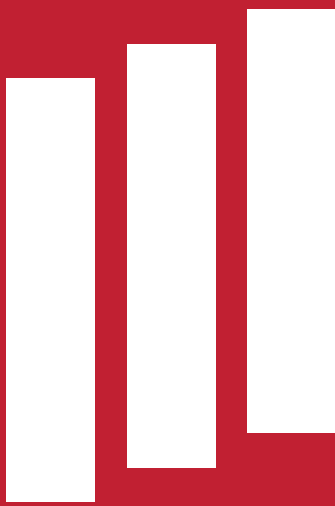
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