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Abbreviations

CBPF  country-based pooled fund
CERF  central emergency response fund
DAC  Development Assistance Committee
DFID  Department for International Development (United Kingdom; now the Foreign, Commonwealth & Development Office)
FCDO  Foreign, Commonwealth & Development Office
FTS  Financial Tracking Service
HP+  Health Policy Plus
HRP  Humanitarian response plan
IASC  Inter-Agency Standing Committee (United Nations)
IAWG  Inter-Agency Working Group for Reproductive Health in Crises
IUD  intrauterine device
MISP  Minimum Initial Service Package for Reproductive Health
MSF  Médecins Sans Frontières
NGO  nongovernmental organization
OCHA  Office for the Coordination of Humanitarian Affairs (United Nations)
OFDA  Office of Foreign Disaster Assistance (United States)
PPAT  Planned Parenthood Association of Thailand
SMRU  Shoklo Malaria Research Unit
UN  United Nations
UNFPA  United Nations Population Fund
UNHCR  United Nations High Commissioner for Refugees
US$  U.S. dollar
USAID  U.S. Agency for International Development
WHO  World Health Organization
Executive Summary

Globally, an estimated 1 out of 70 people are affected by a humanitarian crisis with approximately 132 million people across the world in need of assistance (UNOCHA, 2018c). Due to natural or man-made emergencies disrupting the functioning of communities and causing widespread human, material, economic, or environment loss, affected people cannot cope using their own resources and need national or international assistance (Singh et al., 2018). While such investments have increased significantly, there are substantial funding gaps for humanitarian aid (UNOCHA, 2018a). These funding limitations have restricted humanitarian response efforts, leaving large numbers of displaced individuals without adequate healthcare services. Approximately a quarter of those facing internal and cross-border displacement are women and girls of reproductive age representing a large population in need of critical basic reproductive healthcare services, including family planning (UNFPA, 2018). Yet, despite clear evidence of demand for family planning within humanitarian crises, response efforts suffer from several challenges linked to humanitarian funding dynamics.

In light of these challenges, the U.S. Agency for International Development-funded Health Policy Plus (HP+) project conducted a review of the humanitarian crisis response planning processes, cases, and associated literature to understand how family planning needs are managed and financed across humanitarian crisis contexts. This report presents the critical challenges, key lessons learned, and possible opportunities that HP+ has identified to help improve financing for family planning as part of humanitarian response efforts.

Key Findings

**Coordination and collaboration across actors as part of the overall health response often remains a significant challenge.** Effective coordination is critical to ensure a comprehensive family planning response. Failure to adequately include family planning in the pre-crisis preparedness planning limits humanitarian responders’ ability to deliver services during an emergency. Often development actors are not involved in the planning process, creating issues in provision of sustainable comprehensive family planning services during the post-crisis phase.

**Governing laws, policies, and regulations affect the availability of commodities and ability to access healthcare, including family planning.** Humanitarian contexts are often unpredictable and unstable—this can have an impact on family planning commodities and supplies. Factors affecting the ability of the supply chain to ensure continuity of care for clients include delays due to a country’s import regulations and costs, higher requirements for last-mile delivery, and lack of capacity of local suppliers.

**Predicting and supplying commodities through a tailored response that meets the needs and preferences of the displaced population across different crisis phases is challenging.** One of the major difficulties for family planning humanitarian response actors is associated with their ability to navigate the transition from the use of reproductive health kits, designed for immediate short-term response, to sustainable supply chains when the crisis stabilizes or becomes protracted. This lack of transition preparedness is compounded by funding fluctuations and gaps leading to inappropriate financing decisions over methods offered that are associated, at least in part, with changes in the humanitarian actors managing the reproductive health response over time.
**Subsidized health services in long-term refugee contexts contribute to increases in family planning knowledge and use.** However, out-of-pocket payments are a critical issue that restrict access to reproductive health in humanitarian crisis contexts. Setting up financial protection programs that include family planning would address immediate issues linked to the financial cost of accessing services while mitigating the longer-term financial burden that women and adolescent girls might experience in unplanned birth. Currently, there is little evidence on existing financial protection measures and how these might reduce out-of-pocket payments across different contexts of crisis response, but generating that evidence could help guide future efforts to reduce financial barriers to women and adolescent girls during humanitarian crises.

**Funding streams specific to the family planning humanitarian crisis response are difficult to track due to their limited visibility in financial data reporting systems.** With funding information aggregated to reflect the overall health response, family planning humanitarian program actors are unable to clearly estimate current funding gaps, predict unanticipated financing challenges, or promote financial accountability. The absence of a central repository for reproductive health data collected during a humanitarian emergency limits the ability to share information and data for informed decision making and improved coordination across partners and to draw comparisons across crisis settings.

**Recommendations**

Better and earlier planned integration of family planning services in host country health systems provides opportunities to create more synergies between central and local host governments, philanthropic agencies and institutions, implementers, and partners. A united and concerted effort by these actors toward the family planning humanitarian response will help to: (1) agree on and implement standards for family planning service quality and affordability, (2) develop mitigation plans for foreseen financing gaps to achieve the desired scale and quality of services, and (3) explore gender-sensitive interventions and programs focused on economic and financial inclusion of displaced populations as potential transition opportunities for more sustainable family planning.

The family planning-humanitarian crisis response framework introduced in this report, and the discussion of cases and issues, can be applied to predict and address problems that affect access, quality, and financial protection for family planning services in future crises. Use of such frameworks, together with ongoing changes to humanitarian crisis response financing (as laid out in the Grand Bargain and other approaches), may lead to improvements in a number of areas, including planning and coordination, pre-positioning and conditioning of the supply chain for family planning commodities, shared data to inform decision making, and more sustainable service delivery.

Looking to the future, the protracted nature of some crises does not clearly fit the mission of purely humanitarian crisis response actors. As a result, addressing the long-term reproductive health and family planning needs of refugees and other displaced people in these situations requires sustainable solutions. Humanitarian crisis response plans can evolve to cater to long-term settled situations for displaced people. However, planning for family planning services over these longer-term arrangements is a developing area of work that requires further attention.
Introduction

Approximately 132 million people across the world—an estimated 1 in 70—is affected by a humanitarian crisis and in need of assistance (UNOCHA, 2018c). A humanitarian crisis is an event that affects large groups of individuals and causes significant risks to their safety, health, and liberty. The crisis may be due to human interactions (e.g., armed conflict, persecution), natural disasters (e.g., earthquakes, droughts, typhoons), or complex disasters (a combination of man-made and natural disasters). Humanitarian crises can involuntarily displace people both within and across state borders. Globally, there is a high level of displacement due to crises, including movement of individuals across borders for economic reasons or to avoid political persecution. At the end of 2017, 68.5 million individuals were displaced due to war, violence, and persecution—an increase of almost 10 million from 2014 (UNOCHA, 2018a). These crises now not only affect more people, but they also last longer. The average humanitarian crisis now lasts more than nine years, compared to 5.2 years in 2014 (UNOCHA, 2018c), and the average time individuals spend in displacement has now reached 20 years (Askew et al., 2016). These larger and longer crises require increased levels of humanitarian assistance. While investments increased significantly from US$10.6 billion in 2014 to US$13.9 billion in 2017, funding for United Nations (UN)-led humanitarian response plans has a shortfall of approximately US$5.6 billion—a gap of about 40 percent (UNOCHA, 2018a). This funding shortfall has affected response efforts, leaving large numbers of displaced individuals in need of healthcare services.

Access to affordable essential health services is a challenge for individuals and families affected by humanitarian crises. Because humanitarian crises have political, economic, social, and health implications, their effects can last beyond the immediate response. Conflict and natural disasters may damage hospitals and other health infrastructure and severely disrupt public health efforts (WHO, 2013). Individuals who continue living in areas undergoing humanitarian crises face barriers when trying to use healthcare services, including family planning. Due to these barriers, displaced women and girls face heightened reproductive health concerns (see Box 1), including higher risks of unintended pregnancy and associated complications

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**Box 1. Impact of Reduced Access to Family Planning and Other Reproductive Health Services in Humanitarian Crises**

1. Higher maternal and neonatal mortality due to more unplanned pregnancies, and increased risks in labor and delivery due to lack of skilled birth assistance, alongside greater cumulative risks to maternal health

2. Unsatisfied demand for family planning due to modern or preferred contraception being either unavailable or not affordable, leading to a rise in unsafe abortions

3. Lack of emergency contraception in situations with increased risk of sexual assault

4. Lack of barrier methods for family planning and for protection in situations with enhanced risk of sexually transmitted infections alongside higher risk of sexual assault and reduced sexual health prevention interventions

5. Lack of comprehensive reproductive health services for adolescents, especially when adolescents are removed from previous areas where access was possible

Source: IAWG, 2018
While there is growing awareness around these issues, they are often inadequately addressed.

Family planning services are usually severely disrupted and compromised in humanitarian crisis contexts. According to McGinn et al. (2011), 30–40 percent of women surveyed in conflict-affected African countries reported that they wanted to delay birth for two years, and an additional 12–35 percent wanted to limit family size. However, only one-third of facilities had the necessary staff, equipment, and supplies to provide those services. Key reasons for service limitations included inadequate or damaged health infrastructure, gaps in human resources for health, weakened supply chains and stockouts, weakened capacity for policymaking and program implementation, and poor mobilization and awareness. The potential magnitude of negative impacts, as outlined in Box 1, has focused attention on these barriers to family planning and reproductive health service delivery.

To identify solutions to these barriers, the Health Policy Plus (HP+) project—funded by the U.S. Agency for International Development (USAID)—conducted a review of the planning processes for humanitarian crisis response, cases, and associated literature to understand the typical arrangements for financing family planning services as a part of the overall reproductive health response for displaced individuals. The objective of this report is to connect health financing opportunities to service delivery situations for family planning as a part of the humanitarian crisis response. This work is carried out in the context of sustainably financing access to family planning services while ensuring principles of voluntarism, quality, and informed choice are upheld. The findings support improving and expanding the financing of family planning for humanitarian crises, especially given the scale of the populations affected. It also links humanitarian crises to the broader context of financing family planning scale-up under the emerging “post FP2020” vision. Additionally, given that these crises are lasting longer than in the past, there is a pressing need to link humanitarian responses (often shorter-term) with development aid (usually longer-term) to build and improve financial linkages between these efforts. In that light, this report aims to build a deeper understanding within the development aid community around the challenges and best practices for financing, implementing, and sustaining high-quality family planning services in the context of humanitarian crisis response.

The report is divided into four sections: (1) the humanitarian crisis response architecture today, (2) family planning within the humanitarian crisis response architecture, (3) challenges in financing high-quality family planning services in humanitarian crisis response, and (4) opportunities to improve financing of family planning services for displaced populations. Together, these sections describe family planning features in the current humanitarian aid architecture, highlight some of the major challenges affecting family planning in these contexts, and offer initial recommendations and an agenda for financing solutions to increase availability of family planning services during crisis. The report is designed to catalyze further dialogue on family planning and primary healthcare between the humanitarian crisis response actors and the global health and development aid communities—so that they can explore opportunities to better connect financing of short- and long-term family planning efforts within humanitarian response.
1. The Humanitarian Crisis Response Architecture Today

This section explores the current humanitarian crisis response architecture, highlighting the critical actors that coordinate, mobilize, and allocate resources for family planning in this context. The section also outlines the typical UN-led mechanisms for delivering humanitarian responses across different types of crises.

The present-day architecture of humanitarian crisis response is geared to respond to a diverse set of complex emergencies. The basic taxonomy for different types of humanitarian crises, affected populations, duration, and service delivery settings is presented in Table 1. The diversity in populations, settings, and contexts, plus varying access to rights (for citizens compared to non-citizens), requires a flexible and adaptive system for financing and delivering humanitarian aid. The actors involved, response mechanism used, and in many cases the challenges that arise—especially for financing and implementing family planning services—will depend on these factors. Understanding the current humanitarian aid architecture, and how family planning fits within it, is critical for developing a comprehensive family planning response for displaced individuals.

<table>
<thead>
<tr>
<th>Type of Humanitarian Crisis</th>
<th>Natural Disaster: Events which are geophysical (e.g., earthquakes, tsunamis, and volcanic eruptions), hydrological (e.g., floods, avalanches), longer-term climatological (e.g., droughts), meteorological (e.g., storms, cyclones), or biological (e.g., epidemics, plagues) in nature.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Man-Made Emergency: Events such as armed conflict, transportation-related disaster (plane or train crashes), major fires, and industrial accidents.</td>
</tr>
<tr>
<td></td>
<td>Complex Humanitarian Disaster: A combination of natural and man-made elements. Examples include food insecurity, armed conflicts, and displaced populations.</td>
</tr>
<tr>
<td>Affected Population(s)</td>
<td>Internally Displaced Persons: Person or group of persons who have been forced from their homes due to conflict, natural disasters, or man-made disasters, but have not crossed an internationally recognized border.</td>
</tr>
<tr>
<td></td>
<td>Refugee: A person who is compelled to leave their country of origin and/or nationality to seek another residence/refuge outside of the country due to fear of being persecuted (due to race, religion, nationality, or membership in a social or political group), due to a humanitarian crisis, or due to an event that seriously disturbs public order.</td>
</tr>
<tr>
<td></td>
<td>Stateless People: A group comprising persons who are not considered as a national by any state under the operation of its law.</td>
</tr>
</tbody>
</table>

Table 1. Types of Humanitarian Crises, Affected Populations in Need, Length of Time, and Service Delivery Settings
Sudden Onset: Emergencies that happen quickly, with little or no warning (e.g., an earthquake) or with some warning (e.g., a typhoon or hurricane). This may also include events that are broadly anticipated but escalate unexpectedly, such as conflict or cyclical flooding.

Slow Onset: An emergency that does not emerge from a single, distinct event but one that emerges gradually over time, often based on a confluence of different events.

Protracted: Situations in which a large number of people (e.g., 25,000 or more) experience exile for five years or more. The crisis emerges when such a population is vulnerable to death, disease, or disruption of livelihood over such a prolonged period.

Camp-based: The camp is intended as a temporary accommodation, whether in-country or cross-border, for people who have been involuntarily removed from their homes because of the humanitarian crisis. These camps are constructed while a crisis is unfolding or in anticipation of one.

Urban and Peri-Urban Settled: Situations in which refugees and/or internally displaced persons find shelter in host communities or in assigned housing in urban or peri-urban environments, rather than in camps.

Roles and Responsibilities of Actors within Humanitarian Crisis Response Coordination

The provision of humanitarian response requires a diverse network of institutions working together to meet the needs of displaced populations. Under UN General Assembly Resolution 46/182 of December 19, 1991, the national or local government(s) of the crisis-affected region or the receiving region is responsible for the initiation, organization, coordination, and implementation of humanitarian assistance for displaced populations within their borders, including the reproductive health response (UNOCHA, n.d.c). However, many humanitarian crises occur in low-resource countries and cross-border flows of refugees are often accommodated by neighboring countries that are low- or middle-income and with weaker health systems and limited national resources to respond to the crisis. As a result, external assistance is often mobilized. Based on established practice, bilateral and multilateral development partners, UN technical agencies, and national and international nongovernmental organizations (NGOs) play a critical role in establishing and maintaining humanitarian assistance, including family planning financing and service delivery. Table 2 summarizes the typical roles played by some of these institutions.
Table 2. Actors and Roles in the International Response to Humanitarian Crises, Including for Family Planning

<table>
<thead>
<tr>
<th>Actor</th>
<th>Typical Role in Coordination, Financing, and Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Nations Office for the Coordination of Humanitarian Affairs (OCHA)</td>
<td>Responsible for coordinating response and providing emergency relief through the Inter-Agency Standing Committee (includes other UN entities). Also responsible for bringing together humanitarian actors to ensure a coherent response to emergencies.</td>
</tr>
<tr>
<td>Inter-Agency Standing Committee (IASC)</td>
<td>Supports UN interagency decision making in response to complex and natural disasters. Includes a focus on ensuring women’s and adolescent girls’ access to basic reproductive health services (including the minimum initial service package for reproductive health).</td>
</tr>
<tr>
<td>United Nations High Commission for Refugees (UNHCR)</td>
<td>As part of its global work to protect refugees, prioritizes high-quality reproductive health services, including reproductive health awareness and education for adults and adolescents, provision of family planning, and security from gender-based violence.</td>
</tr>
<tr>
<td>Local or host government</td>
<td>Holds the primary responsibility to aid the displaced population within the country’s borders during a crisis—providing social and financial support for the displaced population—and responsible for setting up regulations and legislation to govern the operation of aid agencies within the territory. The Ministry of Health has joint responsibility with the health sector/cluster to ensure implementation of priority reproductive health activities, including family planning.</td>
</tr>
<tr>
<td>World Health Organization (WHO)</td>
<td>Typically leads coordination on the health response in humanitarian crisis settings, supported by other UN partners. Includes access to reproductive health services and provision of security against gender-based violence as priorities of humanitarian response.</td>
</tr>
<tr>
<td>United Nations Population Fund (UNFPA)</td>
<td>During a crisis, takes the lead role for reproductive health, including family planning. Provides lifesaving sexual and reproductive health services and addresses gender-based violence. Produces reproductive health kits for rapid distribution.</td>
</tr>
<tr>
<td>Bilateral funders</td>
<td>Provide the bulk of international humanitarian aid. Donor countries allocate funding to areas/projects/populations with the most need. Some top funders include: the Government of the United States of America (Bureau of Population, Refugees, and Migration and Office of Foreign Disaster Assistance), Government of Germany (Federal Foreign Office), European Commission, and Government of the United Kingdom (previously, the Department for International Development).</td>
</tr>
</tbody>
</table>
The Office for Coordination of Humanitarian Affairs (OCHA) is the overarching UN body responsible for organizing humanitarian aid worldwide. At the country level, OCHA plays the role of building common strategies and implementation plans and coordinating group appeals. At a global level, this work is used to develop the Global Humanitarian Overview, an annual evidence-based overview of the current state and future trends in humanitarian action. OCHA ensures responsive and predictable humanitarian financing is made available through its dual leadership of the central emergency response fund (CERF) and country-based pooled funds (CBPFs) (further described in Box 2) (UNOCHA, 2018b). In addition, OCHA’s financial tracking tools and services help manage humanitarian donations. One tool, the Financial Tracking Service (FTS), provides information to support OCHA’s advocacy, policymaking, and humanitarian financing work, and helps improve operational decision making by facilitating field coordination.

In addition to OCHA, two other UN institutions are critical for the overall coordination of the humanitarian response—the Inter-Agency Standing Committee (IASC) and the United Nations High Commissioner for Refugees (UNHCR). The IASC serves as the primary mechanism for inter-agency coordination of humanitarian assistance in response to complex and major emergencies, under the leadership of the emergency relief coordinator. The IASC works to improve the effectiveness of humanitarian action by coordinating the activities of IASC members and other humanitarian actors, assigning responsibilities, and sharing resources and knowledge. The committee also develops system-wide humanitarian policies and resolves disputes or disagreements between humanitarian agencies over system-wide humanitarian issues. UNHCR is the leading organization charged with protecting refugees and other forcibly displaced people and with helping to resolve problems of statelessness. As a member of the IASC, UNHCR typically leads the response coordination for refugees and stateless persons while IASC typically leads the response for internally displaced people.

While these two institutions take the lead on coordination, each works with a wide variety of donors and partners to adequately fulfill their role. Figure 1 outlines how the UN-led channels for resource mobilization and response coordination operate across two broad categories of humanitarian emergencies. Not all humanitarian crises have a response linked to these actors, as funding for relief efforts through bilateral and non-UN-led mechanisms is also common and significant. (Some of the aspects of these financing situations will be discussed in the next section.) In addition to UN-led responses, host countries receiving displaced persons also organize and fund aspects of the response. However, this report focuses largely on UN-led response channels.

**Box 2. Humanitarian Crisis Pooled Funds**

OCHA-managed pooled funds allow governments and private donors to pool their contributions into common, unearmarked funds to deliver life-saving assistance. There are two types of pooled funds: the central emergency response fund (CERF), which can cover emergencies anywhere in the world, and country-based pooled funds (CBPFs), which cover crises in specific countries. OCHA-managed pooled-fund allocations represent a relatively small portion of global humanitarian funding, but they are critical to the delivery of life-saving assistance. CERF and CBPF allocations are designed to complement other humanitarian funding sources, such as bilateral funding. They can be used independently but also work in synergy with other tools at the country level.
Analyzing and Improving the Financing of Family Planning Service Delivery in Humanitarian Crises

Figure 1. UN-Led Emergency Response Overview

Preparedness
- Emergency Preparedness Approach

What type of crisis?
- Natural Disaster
- Man-Made Disaster
- Complex Disaster

Who is affected?
- Internally displaced people
- Refugees and asylum-seekers

Who coordinates?
- Inter-Agency Standing Committee (IASC)
- United Nations High Commissioner for Refugees (UNHCR)

Type of response?
- Cluster Approach via humanitarian program cycle
- Refugee Coordination Model, stand-alone refugee crises or “mixed situation”

Path to resource mobilization?
- Fund activities within humanitarian response plans
- Fund activities outside any type of plan or appeal
- Fund activities within refugee response plans/regional refugee response plan (if outflows)

Where does funding come from?
- Bilateral donors/governments
- Foundations
- Private sector

Pooled funds:
- Country-based pooled funds
- Central emergency response fund

Agency emergency funds (e.g., UNHCR, UNFPA)

Note: In situations with mixed populations (internally displaced people, refugees, and other groups) IASC and UNHCR work together to provide a comprehensive response for all displaced individuals. While IASC leads the response for internally displaced people and UNHCR leads the response for refugees, the organizations collaborate to develop a common vision and response plan for the humanitarian response. The 2014 OCHA-UNHCR Joint Note on Coordination in Mixed Situations delineates the respective responsibilities within this joint model. Resources are mobilized in what are known as strategic response plans.

UN-Led Response Mechanisms

There are two main models for coordinating large-scale multisectoral response in emergency settings (as shown in Figure 1): the Cluster Approach (developed by IASC in 2005) and the Refugee Coordination Model (developed in 2013 by UNHCR). These models help to illustrate the roles and responsibilities of humanitarian actors and provide a comprehensive platform to ensure an effective response.

IASC Cluster Approach. Under the humanitarian program cycle, the Cluster Approach draws on thematic clusters, similar to the sectors referenced under the Refugee Coordination Model.

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Analyzing and Improving the Financing of Family Planning Service Delivery in Humanitarian Crises

(next section), to specialize the humanitarian response. It is used in large non-refugee humanitarian disasters when the crisis exceeds a government’s capacity for response and in which the needs, scale, and complexity require a multisectoral response by a diverse set of humanitarian actors. The cluster response is activated and led by the designated humanitarian coordinator within IASC when clear humanitarian needs exist within a sector, when there are numerous actors within sectors, and/or when national authorities need coordination support. Each cluster is accountable to the humanitarian coordinator through its Cluster Lead Agency, which is also accountable to national authorities and to people affected by the crisis. The World Health Organization (WHO) is the Cluster Lead Agency for health—the cluster where reproductive health and family planning are based. OCHA supports the humanitarian coordinator and typically convenes inter-cluster coordination meetings that also include national cluster coordinators (UNHCR, 2019).

Refugee Coordination Model. This model is a platform for inclusive coordination and leadership to ensure effective and accountable delivery of protection and assistance for refugees and people of concern. Led by a representative from UNHCR, the Refugee Coordination Model can be used in all refugee emergency situations and throughout a refugee response (regardless of how long the emergency has lasted) and can be used in a camp, or urban setting, or in mixed situations. The model draws on thematic sectors—education; water, sanitation, and hygiene; health/nutrition; shelter/non-food items; food/food security; and livelihoods/self-reliance—to streamline and specialize assistance for the response. Sectors are intended to connect to government-led humanitarian and development mechanisms, where possible, and come together at operational coordination meetings. The host government generally coordinates the sectors, but UNHCR and its partners will coordinate or co-coordinate them when necessary. Coordination is decentralized and based in the geographic areas where refugees or other persons of concern are residing (UNHCR, n.d.).

Resource Mobilization under UN-Led Response Mechanisms

As part of coordinating the overall crisis response, the lead organization is also responsible for mobilizing resources for the response. Working with other implementing partners, the lead institutions develop an inter-agency response strategy with financial requirements of all partners to ensure response coherence. The response plans are built on humanitarian needs overviews that provide evidence on the magnitude of the crisis and identify the most pressing needs. The response plans are primarily management tools for response delivery, but they are also used to communicate the scope of the emergency response to donors and the public in order to mobilize resources (UNOCHA, n.d.c).

Funding for humanitarian crisis response comes from a number of sources: bilateral and multilateral aid, private institutions, pooled funding mechanisms (e.g., OCHA’s CERF and CBPFs), and agency-specific funds (e.g., WHO’s contingency fund for emergencies or the United Nations Population Fund’s emergency fund). However, funding from governments worldwide and the European Union continue to make up the majority of humanitarian aid (about 76 percent in 2017). The U.S. Government (through the State Department’s Bureau of Population, Refugees, and Migration and USAID’s Office of Foreign Disaster Assistance), the UK Government (previously through the Department for International Development, now called the Foreign, Commonwealth & Development Office), and the German Government (through the Federal Foreign Office) have been the three largest bilateral donors, contributing almost 33.3
percent of funding toward humanitarian response plans in 2017 (UNOCHA, n.d.a). While each donor might have its own technical areas of response or sectors of humanitarian action, most humanitarian actors and donors commit and disburse funding based on the sectors outlined previously for the Refugee Coordination Model: education; water, sanitation, and hygiene; health/nutrition; shelter/non-food items; food/food security; and livelihoods/self-reliance.

Funding for humanitarian response is realized in two chief ways: the funding provided by the lead agency and contained in its response plan and additional funding provided by other sources outside the response plan. In some cases, resources mobilized outside the response plan are equal to or greater than what is provided through the plan. Examples of funding provided outside the lead agency response plan are organizational or agency-specific fundraising through UN institutions and civil society organizations. These often are crucial for adequate resource mobilization. Additionally, institutions such as the World Health Organization and UNFPA have agency-specific emergency funds that can contribute to the resources for humanitarian response. UNFPA, for example, has multiple agency-specific funds—such as the Humanitarian Action Thematic Fund, the Emergency Fund, and the Emergency Response Reserve—that can be used to support response efforts. Without these additional organizational and agency-specific funds, the gaps in humanitarian crises resources would be much higher and put greater burden on humanitarian actors to provide relief under even more constrained budgets.

**Humanitarian Crises Response Outside UN-Led Response Plans**

As noted previously, the national or local government(s) of the crisis-affected region or the receiving region is responsible for the initiation, organization, coordination, and implementation of humanitarian assistance for displaced populations within their borders. While the host/recipient countries often work closely with the UN institutions, the host/recipient countries also coordinate their own response, spending their own resources toward meeting the demands of displaced individuals. These governments also collaborate with bilateral donors such as the governments of the United States and United Kingdom, as well as the European Union and its member countries, that engage in humanitarian response efforts outside of the UN-led systems.

**U.S. Government.** A humanitarian response from the U.S. Government’s Office of Foreign Disaster Assistance, for example, begins with a request from the government of the affected country to the U.S. ambassador. The Office of Foreign Disaster Assistance (OFDA) is structured to provide rapid non-food humanitarian response and draw on resources from other U.S. government agencies on the ground. The office has immediate use of up to US$50,000 (through the Disaster Assistance Authority) that can be provided to a local disaster response organization, or used to buy relief supplies, or hire personnel locally. Current disaster response protocols followed by the U.S. Government suggest that the U.S. ambassador begin working with the affected government to determine what, if any, additional aid may be needed, so that direct grants to UN agencies, other multilateral organizations, international governmental and non-governmental organizations, and private or religious voluntary organizations can also be provided (Margesson, 2015).

**UK Government.** The UK Government, working through the Department for International Development (DFID)—as of September 2020 renamed the Foreign, Commonwealth & Development Office (FCDO)—has more than doubled funding for humanitarian assistance from
484 million pounds in 2009 to 1,266 million pounds provided bilaterally in 2015. The UK Government has also been investing in research and innovation and promoting more effective humanitarian approaches, such as the use of cash transfers, job creation, and education for long-term refugees. Funding has supported the improvement of safe and timely access to lifesaving services for women and girls in humanitarian crisis contexts, including to address family planning and violence against women and girls in emergencies. DFID has promoted rapid response and pushed humanitarian logisticians to be on the ground to help facilitate activities. Additionally, DFID has invested in risk management tools to inform response design, such as the Index for Risk Management, which supports decision making around prevention, mitigation, preparedness, and response. It also supports insurance mechanisms, such as Africa Risk Capacity (DFID, 2017).

Over the past decade, there has been a strong movement toward institutionalizing reproductive health and family planning into humanitarian response efforts, including in the resource mobilization efforts mentioned above. The next section highlights family planning financing and programming within the humanitarian response architecture, focusing on the coordination bodies and response models involved.

2. Family Planning within the Humanitarian Crisis Response Architecture

Interest in including family planning within the health services offered as part of humanitarian crisis response has grown and awareness of the consequences of neglecting these services has expanded. As a result, reproductive health and family planning have been increasingly mainstreamed into international standards and guidelines for humanitarian contexts. Prominent resources such as the Humanitarian Charter and the Minimum Standards in Disaster Response, the Minimum Initial Service Package (MISP) for Reproductive Health, and the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings include family planning within an essential healthcare package offered to those affected by crises. The MISP provides a roadmap for implementing a minimum requirement of priority reproductive health services at the onset of humanitarian crises, through which family planning services and supplies can be delivered (Barot, 2017).

The Inter-Agency Field Manual provides further guidance on how actors can plan and execute the MISP on the ground. With the recent revision of the field manual (IAWG, 2018), prevention of unintended pregnancies is considered a life-saving activity at the onset of a crisis. While the MISP priorities can be implemented without a needs assessment at the onset of an emergency, a more comprehensive reproductive health services assessment grounded in wider health system strengthening objectives should be offered when the crisis stabilizes and program capacity improves. It is crucial, therefore, to understand the limits of the minimum requirements and their implication for family planning and to determine what threshold of stability would be needed before one could plan to expand the depth and breadth of family planning access. While

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1 At the time of publication, the UK government had proposed cutting foreign aid by more than 50 percent (Wintour, 2021).
the Inter-Agency Field Manual provides guidance on when and how to expand toward a comprehensive response, these programming considerations are discretionary and left to implementers. This level of independence is an opportunity for implementers to respond to emerging needs through operational and programmatic flexibility, however, it is also a risk if not adequately considered.

**Reproductive Health Coordination under the Refugee Coordination Model and Cluster Approach**

Under the MISP and Inter-Agency Field Manual, the health sector/cluster is responsible for identifying an organization to lead the reproductive health response, and for developing a reproductive health sub-cluster at the beginning of response planning. The nominated organization can be a national or international NGO, the Ministry of Health, or a UN agency; it should be the organization that has the most capacity to fulfill this role. Often, the United Nations Population Fund (UNFPA) is designated for this role. Once nominated, the reproductive health lead organization dedicates a full-time sexual and reproductive health coordinator for a minimum period of three to six months. The coordinator’s role is to ensure that reproductive health is included within cluster/sector priorities and to provide operational and technical support to the health partners implementing the MISP and planning for service delivery (IAWG, 2019a). The lead organization works closely with governments, international and local NGOs, UN agencies, and other partners to ensure that sexual and reproductive health and rights are integrated into the emergency response. Case 1 illustrates an example of effective reproductive health coordination within the Rohingya refugee response in Cox’s Bazar, Bangladesh. While this example illustrates that strong coordination of reproductive health is possible in these contexts, effective coordination often remains a significant challenge in humanitarian emergencies. These challenges are discussed in section 3.
Case 1. Family Planning Services for Rohingya Refugees in Cox's Bazar, Bangladesh

In the refugee camp settlements of Cox’s Bazar, humanitarian crisis response actors, working with the Bangladeshi Ministry of Health and Family Welfare, have been responsible for delivering contraception, along with other health services. Consistent funding and strong coordination have been crucial for sustained family planning service provision:

- UNFPA-Bangladesh had consistent funding before and during the emergency, which contributed to the pre-positioning of contraceptive supplies, the availability of supplies from the onset of the emergency, and the presence of a dedicated reproductive health coordination team.
- UNFPA has had the same sexual and reproductive health coordinator in place since before the emergency, allowing for continuity in leadership and effective maintenance of NGO/government relationship-building efforts.
- The Sexual and Reproductive Health Sub-Working Group, made up of UNFPA and NGOs implementing related services, prioritized contraception from the beginning of the emergency by using weekly meetings, information management, mapping, and updates about commodity availability to support services.
- Memoranda of understanding among NGOs operating in the refugee camps allowed multiple NGOs to operate in the same facilities, enabling partners to work in their areas of expertise and to quickly increase coverage of contraception services.

Despite strong coordination efforts, response actors in the camps reported encountering policy and other barriers by the second year of the response that impeded timely provision of the full range of contraceptives in the camps. Critical gaps included:

- While short-acting contraceptive methods were widely available, barriers limited access to long-acting reversible contraception.
- Adolescent girls faced high barriers to accessing contraceptive methods due to perceived bias from service providers and community stigma.
- Contraception was provided primarily through midwives, who were inexperienced and lacked practical skills in family planning service delivery.

Source: Casey et al., 2019; Schnabel and Huang, 2019; Gordon et al., 2018; Ainul et al., 2018
**Reproductive Health Kits**

In addition to coordinating reproductive health efforts, UNFPA is responsible for assembling and delivering reproductive health kits on behalf of the Inter-Agency Working Group for Reproductive Health in Crises (IAWG) to support the MISP. There are 12 types of kits that provide different types of services; only three kits contain family planning commodities, supplies, and equipment, including short- and long-acting methods of contraception (IAWG, 2018). The kits, which focus on the first three-month period of response, are available for aid agencies to buy (see Box 3). Stocks of reproductive health kits are prepositioned around the world to support rapid distribution. Most organizations procure these kits from UNFPA using humanitarian funds and submit proposals for family planning or reproductive health activities during the resource mobilization phase of the response. However, implementing agencies can also identify other sources to ensure that all necessary equipment and materials are available to provide the full range of reproductive health services. As a result of reproductive health kits, refugees and internally displaced people now have significantly better access to reproductive health supplies and commodities during crises. However, challenges remain in ensuring timely access to adequate numbers of kits and to ensuring that family planning supplies are integrated into the preparedness and post-acute emergency programming (IAWG, 2019b). These challenges are discussed in section 3.

**Box 3. Reproductive Health Kits**

- **Block 1:** community and primary healthcare level (10,000 persons for 3 months)
  - Kit 1: Condoms
  - Kit 2: Clean delivery
  - Kit 3: Post-rape treatment
  - Kit 4: Oral and injectable contraception
  - Kit 5: Treatment of sexually transmitted infections
- **Block 2:** primary healthcare and referral hospital level (30,000 persons for 3 months)
  - Kit 6: Clinical delivery assistance
  - Kit 7: Intraterine device
  - Kit 8: Management of miscarriage and complications of abortion
  - Kit 9: Suture of tears and vaginal examination
  - Kit 10: Vacuum extraction delivery
- **Block 3:** referral hospital level (150,000 persons for 3 months)
  - Kit 11: Referral level kit for reproductive health
  - Kit 12: Blood transfusion

Source: IAWG, 2018

**Financing for Family Planning Needs in Humanitarian Crises**

While mobilizing resources to address family planning needs in crisis settings is itself a large challenge, related challenges include ensuring the funds are allocated and spent appropriately. Inadequate resources limit the quality of family planning services (see Box 4 for principles of high-quality family planning programming), increasing women’s risk of an unintended pregnancy while in an unstable environment. Even if adequate resources can be spent, weakened health systems compromise achieving value for money and scale in the area affected by a crisis and in the area receiving an influx of people.

Funding requested and received for reproductive health and allied services within humanitarian crisis response has grown by 15 percent per year from 2009 to 2013. In spite of this increase, it is still less frequently requested than other health priorities (Tanabe et al., 2015). A 2015 IAWG
assessment found that reproductive health services in crisis settings are significantly underfunded, undermining implementation of the MISP (IAWG, 2015). Tanabe et al. (2015) found that over 2002–2013, maternal and neonatal health activities were mentioned in 59 percent of humanitarian crisis response appeals, while family planning was mentioned in only 12 percent. The funding for family planning, whether integrated into reproductive health or stand-alone, was lowest among all reproductive health components. And while less funding was requested, even less was released: family planning received 47 percent of funding requested (US$76 million) compared to 56 percent (US$685 million) for maternal and neonatal health.

Understanding the budgeting process for family planning within crisis response is necessary to improve the financing situation and reduce financing gaps. Overall, information surrounding the budgeting process is limited, with insufficient data to break down the response budget by specific services. Most of the funding data available is aggregated and received as part of one-year funding cycles for multisectoral refugee and humanitarian response plans. The lack of disaggregation makes it difficult for decisionmakers to plan, procure, and deliver family planning effectively. Funding data for humanitarian assistance is captured on two main reporting platforms: the Organization for Economic Co-operation and Development’s Development Assistance Committee (DAC) and the Office for Coordination of Humanitarian Affairs’ Financial Tracking System (FTS). While DAC members are obligated to report their humanitarian assistance as part of their Official Development Assistance (ODA), both platforms are open to all humanitarian donors and implementing agencies to report contributions of internationally provided humanitarian assistance. However, the two platforms do not have the same criteria for what is included as humanitarian assistance, resulting in differences in the volumes reported (Berretta, unpublished).

Financing challenges impact the family planning response in the acute and post-crisis phases of humanitarian crises. The next section examines operational challenges that result from and contribute to these financing issues.
**Box 4. Principles of High-Quality Family Planning Service Delivery**

- **Voluntarism**: Guarantee clients’ decisions are grounded in voluntary action and non-coercion.

- **Informed choice**: Provide accurate, complete, correct, and comprehensible information so individuals and couples can make informed reproductive health and contraception decisions.

- **Contraceptive method choice**: Make the broadest feasible range of contraceptive methods available and accessible that are appropriate to the level of service.

- **Client-centered**: Create a safe, non-judgmental environment that respects and recognizes client reproductive intentions (delaying, spacing, or limiting pregnancy), lifestyles, and preferences throughout their lives.

- **Continuity of care**: Build and sustain systems to support clients through an uninterrupted supply of contraceptives and related commodities, integrated services along the reproductive life course where feasible, referral systems, and follow-up care.

- **Equity**: Strive to identify and understand social, ethnic, financial, geographic, age-related, linguistic, and other barriers that may inhibit health-seeking behavior and voluntary contraceptive use and make programmatic adjustments to overcome these disparities.

- **Gender equality**: Endeavor to be inclusive of women and men by removing barriers to their active engagement and decision making, recognizing the role of family planning in supporting more equitable power dynamics and healthy relationships.

- **Financial protection**: Safeguard prospective family planning users against some or all of the cost of obtaining needed quality services through direct payments that would constitute a financial hardship.

*Source: HIPs, 2021

* Adapted from the WHO’s definition of financial protection.
3. Challenges in Financing High-Quality Family Planning Services in Humanitarian Crisis Response

Delivering family planning as part of a humanitarian crisis response faces many challenges. Insufficient resources means that there is limited access to services, not all methods are available, quality may be variable, and financial protection inadequate. This section explores how these challenges are linked to response decision making and to broader sustainable financing principles, especially in light of the emergency contexts included in Table 1 and the coordination mechanisms discussed previously.

Issues complicating the financing of family planning service arise at different stages of humanitarian crisis response and have different implications for service delivery. However, even if sufficient and well-planned financing were available, the complexity of providing high-quality services (see Box 4) in crisis contexts would likely persist.

A literature review identified five critical challenges related to financing for family planning services in crisis situations:

1. **Insufficient planning and coordination** that affects preparedness and response, integration with local health systems, and capacity for long-term transition and sustainable financing.

2. **Legal and regulatory contexts** that impact access and availability, especially in the implementation and longer-term transition phases, which can cause failure to meet any financing criteria.

3. **Supply chain management issues** that impact capacity to allocate resources—and impede users’ rights and respect for method choice—in both preparedness and implementation stages of response.

4. **Quality and affordability of service delivery**, which impacts utilization of services—particularly when supply-side capacity is inadequate and services are not free or subsidized—and undermines financial protection for women seeking services. This occurs when financing criteria have not been met, in both implementation and long-term transition phases of response.

5. **Limited data availability, transparency, and information sharing**, which can impact access and availability of family planning across all stages of crisis response and limit localization of the family planning response.

These five challenges do not necessarily appear in a predetermined order. The issue of data availability, transparency, and information sharing can be seen as crosscutting issues that impact the other four. Each of these challenges is explored next, followed by a schematic that outlines various outcomes based on financial decision making for family planning in humanitarian settings.
Planning and Coordination

Coordination and collaboration across actors, such as those shown in Table 2, as part of the overall health sector/cluster response is critical to ensure a comprehensive family planning response and yet effective coordination often remains a significant challenge (Tanabe and Krause, 2008). Failure to adequately include family planning in the preparedness planning before crises occur limits humanitarian responders’ ability to deliver services when an emergency happens. Additionally, if development actors are not involved in the planning, they are less likely to sustainably provide comprehensive family planning services during the post-crisis phase.

At the field implementation level, there is no guarantee that a reproductive health lead will come forward and coordinate the reproductive health sub-cluster. Even though the MISP provides explicit guidance for reproductive health coordination, the sector/cluster architecture designed by IASC or UNHCR does not include reproductive health as an area of responsibility (see section 1). As a result, developing a reproductive health sub-cluster often depends on the extent and level of stakeholder engagement in reproductive health. While support for reproductive health has grown significantly, it is frequently still not prioritized within humanitarian concerns, often resulting in family planning services having a secondary status behind other essential services (UNFPA Evaluation Office, 2018; Jurman and Doedens, 2017). Failure to fully implement the MISP at the onset of emergencies continues to be a substantial problem (Barot, 2017).

Even when a reproductive health sub-cluster has been developed, it does not automatically guarantee strong coordination and programming in that area. The complex nature of humanitarian crises makes effective coordination and programming significantly more difficult than in long-term development programs. Further, displaced populations often settle into urban areas, making coordinating and delivering a crisis health response even more complicated.

Influxes of displaced individuals can overburden the receiving healthcare system, leading to inadequate or interrupted access to family planning services for everyone served by the system. In some settings, a stipulation requires that displaced individuals must meet the requirements of the receiving country or locality to access family planning services. Obtaining legal identification or registering with the proper authorities may be difficult for cross-border refugees and limit their ability to obtain any sort of health service. Additionally, individuals who settle in urban areas often blend into host communities for various reasons, including security, making them less visible and harder to reach for targeted interventions or to create awareness of access to healthcare. Case 2 illustrates how coordination barriers affected family planning access for Syrian refugees in Jordan.
Case 2. Family Planning for Syrian Refugees in Jordan: Zaatari Refugee Camp versus Irbid City

As of November 2019, an estimated 654,266 registered Syrian refugees were living in Jordan. Of these, 531,232 refugees were living in urban, peri-urban, and rural out-of-camp settings and 123,034 refugees were residing in refugee camps. Of all registered refugees, 134,707 resided in Irbid Governorate located in northern Jordan.

A recent evaluation of MISP implementation for Syrian refugees in Jordan found that there were important differences in family planning service provision for refugees living in Zaatari Camp compared to those residing in urban areas. While there was available funding for reproductive health overall, there was insufficient funding for the urban health response. The lead health agencies addressed the MISP by securing funding and supplies and establishing reproductive health focal points, services, and coordination mechanisms. However, coordination for urban areas lagged compared to refugee camps. Coordination meetings tended to focus on the more visible daily refugee influx and refugees settling in Zaatari Camp, with refugees in other areas of Jordan being less visible. As a result, Irbid City was less likely to be included in coordination activities and health facilities reported challenges in human resource capacity.

Through focus group discussions with female youth (18–24 years of age) and women (25–49 years of age), the issue of cost emerged as a barrier within the urban context. Although the focus group participants expressed a strong need for family planning, almost all refugees in Irbid City were unaware of the locations for free services. In comparison, at least half of the participants in Zaatari Camp were aware of locations where free family planning services were available. Registered refugees did not have to pay for clinical services in Irbid City health facilities, as they are covered by the Ministry of Health. However, in most government clinics, unregistered refugees paid similar fees to uninsured Jordanians (unless they were referred by the Jordan Health Aid Society, in which case UNHCR covered the cost). As the majority of unregistered refugees were residing in these urban areas, having to pay fees created a significant barrier for access and use of family planning services.

Sources: Operational Data Portal, n.d.; Krause et al., 2015; Chynoweth, 2015; IAWG, 2018

Key Takeaways: Planning and Coordination

1. Failure to adequately include family planning in pre-crisis preparedness planning limits humanitarian responders’ ability to deliver services in the acute emergency and restricts response efforts to provide comprehensive, sustainable family planning services in the post-crisis phase.

2. Reproductive health is not a specific area of responsibility within the sector/cluster architecture designed by IASC or UNHCR, which means that a reproductive health sub-cluster might not be formed and that reproductive health is not always a priority.

3. Coordinating and delivering a humanitarian crisis health response has become increasingly complicated with the increase in displaced populations settling into urban areas.
**Legal and Regulatory Context**

Legal and regulatory differences on which healthcare workers can provide family planning methods across different locations can create a barrier to service delivery and funding. This challenge can be especially true in refugee contexts. Depending on where displaced persons find themselves, their ability to access any healthcare as a right can be affected (e.g., rights of citizens compared to non-citizens, de jure residents versus de facto residents). In addition, laws and regulations around family planning services (e.g., the legality of and providers’ ability to provide quality family planning services to adolescents) can affect access to services (WHO, n.d.). In the case of family planning, refugees may also face local restrictions on access to information and certain services. In Bangladesh for example, national policy required displaced individuals in camps to present an identification card with a fixed address in order to receive long-acting reversible contraception. This policy’s application to Rohingya refugees made it impossible for refugees to obtain such contraception legally in 2017. This restriction remained in place until May 2018, when UNFPA was able to establish a cooperative agreement with the government of Bangladesh to allow refugees to obtain long-acting reversible contraception in the camps without an identification card (Casey et al., 2019).

As an example of a regulatory challenge, if a particular contraceptive is not registered in the country of operation before an emergency, there may be issues for arrival and customs clearance even when humanitarian import exemptions are in place (IAWG, 2019a). To facilitate rapid entry of these commodities during an emergency, as part of pre-crisis coordination planning, host governments need to ensure that a full range of family planning commodities are included in national essential medicines lists (HIPs, 2020). Without these measures in place, women’s contraceptive method choice may be limited, leaving them unable to access the method of their choice. This situation can lead to increased rates in unintended pregnancy, which contributes to an increase in the use of maternal and child healthcare services and associated costs.

To ensure humanitarian response meets the population’s needs, relevant actors need to understand the laws and policies of host countries, as well as of the refugees’ countries of origin, and how they might affect access to family planning services prior to migration. Yet too often, the international community responds late to disasters and such legal and regulatory issues are not included in planning and coordination discussions. Addressing these legal and regulatory challenges as part of pre-crisis preparedness planning can help reduce these barriers to accessing contraceptives during emergencies.

While the country legal and regulatory context determines what family planning commodities and services are available—and how they are delivered—as part of the humanitarian response, the fact that decisionmakers choose not to follow national directives—or create local directives in conflict with national directives—poses yet another challenge. In Gauteng, South Africa, refugees and asylum seekers from socioeconomic and politically unstable neighboring states face barriers in accessing health services due to provincial directives that require up-front payments for essential health services, including family planning (Matlin et al., 2018). These provincial recommendations exclude the financial protection measures set out by national health directives, thereby limiting equity of healthcare services and weakening efforts to provide affordable health services.
Supply Chain Management

Tools exist to support kit procurement (e.g., the IAWG calculator mobile app), but estimating the number of each kind of kit needed is still difficult. When family planning commodities and supplies are limited, providers in humanitarian settings will be limited in the services they can offer. While the creation of the reproductive health kits has improved the availability of contraceptives, persistent logistical challenges affect procurement and use of the kits and the unpredictability and instability of emergency contexts makes it difficult to predict commodity needs. Tools such as the MISP and reproductive health kit calculators help to provide estimates of what will be needed, but they are not always accurate and kit procurement does not always meet the population’s needs. Delays and stockouts continue to be persistent problems with reproductive health kits. Sometimes this is due to supplies being delayed due to in-country import regulations and costs, challenges of last-mile delivery across unstable environments, and large procurement orders but insufficient capacity of local suppliers (Jurman and Doedens, 2017).

A UNFPA evaluation of reproductive health kits found that crisis response actors face significant challenges transitioning away from these kits to sustainable supply chains once the crisis either stabilizes or becomes protracted (Jurman and Doedens, 2017). This poses a problem for several reasons. When actors continue procuring kits for longer periods of time, it can negatively impact global supply levels and contribute to stockouts. Reproductive health kits are designed to provide a minimum level of essential care required at the outset of a crisis but they are neither context specific nor comprehensive for longer-term use. Long-term use of the kits limits humanitarian actors’ ability to tailor family planning response to meet the population’s needs and to ensure continuity of care for family planning clients. Overuse of kits can also result in waste of unused supplies and commodities, which means that financial resources are used inefficiently (Jurman and Doedens, 2017).

Even when actors are able to transition to sustainable supply chains, commodity management and security remains a challenge—and it often is directly linked to funding. Fluctuations in funding levels impact what methods are available in crisis and in post-crisis settings. When funding is limited, preference may be given to the procurement of cheaper family planning

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**Key Takeaways: Legal and Regulatory Context**

1. Depending on the jurisdiction displaced persons find themselves in, individuals’ access to healthcare and family planning can be affected. Refugees in particular can be faced with local restrictions on certain services and on access to information. Local directives should not undermine financial protection for refugees.

2. To ensure a humanitarian response meets the population’s needs, relevant actors need to understand the laws and policies that might impact access to family planning services for all countries—host countries and refugees’ countries of origin prior to migration.

3. To facilitate rapid entry of these commodities during an emergency, as part of pre-crisis coordination planning, host governments need to ensure that a full range of family planning commodities are included in national essential medicines lists and that humanitarian import exemptions are in place.
commodities, so that the response can serve more people. Yet, choosing less expensive methods to save money may limit informed choice across a diverse range of family planning methods. Additionally, if the method chosen is not one preferred by the population, demand for and uptake of family planning services may decrease. Case 3 illustrates how funding fluctuations affected the provision of family planning in the Maela Refugee Camp in Thailand. Given these financial challenges, investment in gender-sensitive interventions focused on economic and financial inclusion of displaced populations may provide an opportunity for women to access money to obtain non-subsidized family planning services. This would allow women to access a wider range of safe and effective family planning methods even if it comes at a financial cost. Financial inclusion will be discussed further in section 4.

### Case 3. Family Planning Fluctuations in Maela Refugee Camp, Thailand

Maela Refugee Camp was created in the early 1990s through the consolidation of small village-sized camps set up in the early 1980s for refugees and internally displaced people fleeing conflict in Myanmar (then called Burma). The people settled in small camps along the international border between Thailand and Myanmar. From its start, Maela camp had rapid population growth, growing from 6,000 individuals in 1994 to 31,000 in 1998, then to almost 50,000 in 2006 before declining to about 38,000 by December 2015. The camp is ethnically diverse but is primarily composed of the Karen minority group and other minority ethnic groups from Myanmar. From the late 1980s (before the smaller camps were consolidated into one) until 2015, the camp had a diverse set of actors coordinating the provision of family planning:

- Prior to 1991, Médecins Sans Frontières (MSF) provided a limited range of contraceptives (combined oral contraceptive pills and Depo-Provera injections) to women through medical outpatient clinics with only brief counseling offered in the outpatient department. MSF continued to provide services until it withdrew in 2005.

- In 1996, the Shoklo Malaria Research Unit (SMRU) joined MSF in the provision of family planning services, expanding method choice to include natural methods, condoms, emergency contraception, implants, intrauterine devices (IUDs), vasectomy, and tubal ligation, which was primarily provided in the Thai Public Hospital, approximately 20 kilometers away. The program also increased family planning education and counseling to women and men.

- From April 2000 to 2015, the Planned Parenthood Association of Thailand (PPAT) took over as the main family planning partner (with continued collaboration with SMRU) and provided comprehensive reproductive health services. PPAT expanded family planning services to include family planning counseling to all postpartum women and provided reproductive health education outreach for men, women, and adolescents in the camp.

Supply of contraceptives was initially fully supported by the Thai Department of Public Health. However, as a result of the 1997 Asian financial crisis, the department was unable to continue to provide pills and condoms. SMRU sought funding from Family Planning Australia, which provided an emergency budget for contraceptive supplies for 36 months. PPAT received partial funding from the Thai royal family. Fluctuations in global and local economics and political sentiment adversely affected the International Planned Parenthood Association and, as a result, PPAT operations. In 2011 and 2015, PPAT and SMRU, respectively, received large donations.
The fluctuations in funding have directly affected family planning commodities and uptake. For example, with the end of Family Planning Australia funding, the camp saw lower rates of implant uptake from 2000 to 2001. From 2005 through 2007, SMRU employed a camp surgeon, who established a female tubal ligation service on site, overcoming the need for referral to the Thai Public Hospital system. Onsite tubal ligation marked a sharp increase in uptake of female sterilization beginning in 2005. And in 2015, with a smaller family planning budget, a decision was made to primarily provide IUDs in order to reach more women (the cost of an implant is four times greater than for an IUD).

Sources: Srikanok et al., 2017; Weerasuriya et al., 2012; Women’s Commission for Refugee Women and Children, 2006

Funding fluctuations are often associated with changes in which organizations are managing the reproductive health response as it persists over time (Srikanok et al., 2017). Further, the variations in mandates by specific actors often determine which methods they provide as part of their reproductive health response. While the MISP is the standard guideline for family planning provision in emergency contexts, each international and local NGO has its own policies and guidelines for family planning provision. For example, Médecins Sans Frontières has a refugee reproductive health policy with specific protocols for family planning that supersede the Inter-Agency Field Manual whenever it is deemed incomplete. Comparatively, some faith-based organizations promote the healthy timing and spacing of pregnancies and encourage the use of voluntary family planning, but oppose any form of contraception considered abortifacient, and do not provide, recommend, or refer women for these methods (World Vision, n.d.; Girard and Waldman, 2000). As actors transition in or out of the crisis response, these variations become increasingly important, as women who are in greatest need of family planning may be categorically excluded from services because of the provider organization’s policies. Given these challenges, it is important for funders to prioritize the provision of the full range of family planning methods and services when awarding contracts for humanitarian settings.

Key Takeaways: Supply Chain Management

1. The unpredictability and instability of emergency contexts makes it difficult to predict and meet commodity needs. Supplies may be delayed due to in-country import regulations and costs, as well as the challenges of last-mile delivery across unstable environments, while stockouts may result from large procurement orders and lack of capacity of local suppliers.

2. Crisis response actors face significant challenges transitioning from reproductive health kits to sustainable supply chains once the crisis stabilizes or becomes protracted. As a result, actors continue procuring kits for longer periods of time, limiting humanitarian actors’ ability to tailor the family planning response to meet the needs and preferences of the population and reducing their ability to ensure continuity of care for family planning clients.

3. Funding fluctuations and financing decisions over method provision are interlinked and often associated with changes in the humanitarian actors managing the reproductive health response over time. In addition, international and local NGOs have their own policies and guidelines for family planning provision.
Quality and Affordability of Service Delivery

The call for humanitarian crisis response actors and governments to provide free or subsidized healthcare services, including family planning, for displaced and marginalized populations is not a new concept. Yet, displaced populations around the world continue to face out-of-pocket payments, which severely limit their access to essential health services. A recent survey for UNHCR on health access and utilization found that 78 percent of non-camp based Syrian refugees interviewed had spent 63 percent of their combined monthly income on healthcare the month preceding the interview (Dajani Consulting, 2018). Out-of-pocket payments are also a critical issue restricting access to reproductive health. In a 2017 qualitative study, Congolese refugees living in Kampala reported the cost of emergency contraceptive pills as prohibitive. While emergency contraceptives were available at pharmacies, the typical price of 10,000 Ugandan Shillings (US$2.66) was too expensive for refugee women, frequently preventing them from purchasing the contraception they needed. In addition, these refugees faced challenges securing formal sector employment and income-generating opportunities. Due to these financial realities, emergency contraceptive pills were often out of reach for this population (Nara et al., 2020).

Evidence has shown that subsidized health services in long-term refugee contexts increases family planning knowledge and utilization. A 2012 study focusing on the effect of subsidized family planning services for Afghan refugee women in Karachi, Pakistan found that women receiving subsidies were 44 percent more likely to know about family planning than Afghan refugee women who were not receiving subsidized services. Further, the women receiving subsidized care reported almost double the use of contraceptives compared to those not receiving subsidies (Raheel et al., 2012). However, continued funding gaps limit the ability of humanitarian response agencies to provide subsidized services for long periods. Humanitarian actors working in protracted crises must set up financial protection measures to ensure displaced women have access to affordable health services, including family planning, with limited out-of-pocket expenditure.

However, little evidence exists that describes financial protection measures across different humanitarian crisis response contexts. For displaced women and families, resources are generally limited for every aspect of life. Preventing unplanned pregnancies among the most vulnerable and socioeconomically disadvantaged—and therefore avoiding future costs of raising a child in sometimes precarious conditions—is a good example of how family planning intersects with long-term financial protection. With the increase in both the number of protracted crises and the length of time individuals remain displaced, financial protection of these populations for family planning must address immediate costs of accessing services while mitigating the long-term financial risk/burden that unplanned births might cause.
Limited data availability, transparency, and information sharing for family planning in humanitarian crises has been documented as a critical gap that impedes the delivery of high-quality family planning services to people affected by crises. These data challenges are especially significant for tracking reproductive health financial allocations and expenditures within the Development Assistance Committee (DAC) and Financial Tracking System (FTS) platforms.

Family planning and, broadly, reproductive health activities, are given very little visibility within multisectoral response plans and are often integrated into the overarching health response. This focus on multisector activities leads to aggregated financial data that often does not show distinct funding patterns within sectors/clusters. As a result, family planning activities often get recorded under the umbrella of “protection” or “health.” Consequently, tracking funding streams within the cross-cutting area of reproductive health becomes almost impossible, leaving family planning-specific funding patterns nearly untraceable.

Figure 2 illustrates how family planning is featured in Yemen’s 2018 financial data from the FTS, demonstrating the lack of funding flows adequately tagged for family planning and reproductive health. The upper left green quadrant shows the recorded funding need within the humanitarian response plan (HRP), the total funding assistance recorded, and funding that was provided within the plan versus funds that were mobilized outside of the plan (e.g., agency fundraising and bilateral investments). When reviewing the funding flows for key terms such as “reproductive,” “family planning,” “pregnancy,” and “MISP,” most were almost completely absent within the FTS data (lower purple boxes for paid contributions toward the HRP and upper purple box for contributions outside of the HRP). However, eleven funding flows were going to UNFPA. UNFPA’s humanitarian emergency dashboard for Yemen shows that the organization received US$29,139,651 (almost US$24.5 million less than requested) and reached nearly 67,860 individuals with family planning services and 219,330 individuals who directly benefited from emergency reproductive health kits (lower right green box, (UNFPA, 2020)).
The lack of a system to tag or earmark financing flows for family planning within financing data on humanitarian crisis responses inhibits the ability to understand and track funding flows for family planning specifically. The disconnect between funding and implementation data makes it difficult to understand how funding is supporting family planning activities. Without this information, family planning stakeholders and humanitarian crisis response actors are unable to clearly estimate current funding gaps, predict unanticipated financing challenges, or promote financial accountability.

Implementation data is also an important challenge in humanitarian contexts. While there has been an increase in recent research focusing on reproductive health in crisis settings, the majority of studies and data collected evaluate ongoing interventions beyond the acute emergency phase. The complicated environments and the necessity of providing life-saving measures at the onset of an emergency make capturing data extremely difficult, which has led to information and data gaps during this stage of crisis response. However, it is critical to have information to understand the changing needs for family planning to inform appropriate provision of the family planning response (Pyone et al., 2015). To date, there is no central repository for reproductive health data collected during a humanitarian emergency, which limits humanitarian actors' ability to share information and data. The development of such a repository would allow any user to submit or explore reproductive health and family planning campaigns.
data to inform decision making, improve coordination across actors, and enable comparisons between and across settings. Additionally, creating a mechanism to promote higher-quality data that reaches more humanitarian actors will improve the response to beneficiaries and promote accountability to donors.

Key Takeaways: Data Availability, Transparency, and Sharing

1. Family planning and, broadly, reproductive health activities, are given little visibility within multisectoral response plans and are often integrated into the overarching health response. This focus on multisector activities leads to aggregated financial data that makes tracking funding streams within the cross-cutting areas of reproductive health almost impossible.

2. Without clear and accurate funding information, family planning stakeholders and humanitarian crisis response actors are unable to clearly estimate current funding gaps, predict unanticipated financing challenges, or promote financial accountability.

3. To date, there is no central repository for reproductive health data collected during a humanitarian emergency, which limits humanitarian actors’ ability to share information and data. The development of such a repository would improve data-informed decision making, improve coordination across actors, and enable comparisons across humanitarian settings.

Intersecting Pathways: Family Planning Response Financing and Implementation

The challenges described in this section occur due to planning, coordination, and implementation issues that span the entire family planning decision-making chain in humanitarian settings. To propose improvements, decisionmakers need to better understand the gaps and challenges. To help build this understanding, HP+ developed a schematic (Figure 3) that illustrates how a sequence of outcomes, from both a financing and service delivery perspective, affect access to and use of family planning services by women and adolescent girls. The purpose of the schematic is to provide an example of how decisions regarding financing for family planning in humanitarian contexts interact to either promote or restrict family planning for displaced populations.

The schematic analyzes decision-making outcomes along four potential scenarios:

1. No resources explicitly and/or exclusively mobilized for family planning response (red)
2. Some resources mobilized for family planning response, but resources are either not sufficient to meet population needs or not tailored to meet population needs and preferences (yellow)
3. Resources are sufficient to meet population needs in the short-term (green)
4. Sustainability of resources (orange)

The schematic first asks if a needs assessment was conducted to capture accurate information on population needs for family planning. A needs assessment should consider age distribution and fertility and contraceptive use patterns. The schematic then illustrates three chains of outcomes based on whether or not needs were correctly identified. For example, the yellow
scenario for mobilized yet insufficient resources illustrates how inaccurate data can result in family planning programing that is not to scale or lacks financial capacity to train healthcare providers for service delivery due to budget constraints. Finally, the schematic shows pathways that can lead to sustainable or unsustainable support toward providing resources for family planning in the post-crisis phase. For example, poor resource management or a lack of multi-year flexible funding options can lead to unsustainable services in the long term. While multi-year flexible funding options are currently quite limited, increasing collaborative humanitarian multi-year planning and funding is a key thematic area under the IASC and other’s “Grand Bargain” to fill the humanitarian financing gap. This is further explored in section 4.

The schematic is not intended to provide a holistic view of family planning financing pathways nor illustrate their complexity. Instead, it is meant to promote better understanding of how some of the challenges discussed in this section connect throughout the financing and implementation of the humanitarian response.

Understanding the complex challenges affecting family planning in crisis contexts can bring humanitarian and development aid actors one step closer to finding credible solutions that ensure high-quality, affordable family planning access for displaced populations. The next section will delve into some potential opportunities and financing solutions to scale up family planning programming across humanitarian contexts.
Figure 3. Illustrative Pathways for Family Planning in Humanitarian Contexts
4. Opportunities to Improve Financing of Family Planning Services for Displaced Populations

This section introduces a framework designed to identify and consolidate opportunities for sustainably improving the family planning humanitarian response across all crisis stages. These opportunities are further explored as recommendations for ongoing work and initiatives that connect the humanitarian crisis response, development aid, and broad family planning community spaces.

**Family Planning-Humanitarian Crisis Response Framework**

Despite the challenges outlined in the previous section, the humanitarian community has made significant progress in financing, implementing, and sustaining family planning services in a range of crisis settings. From this review of evidence, HP+ developed a framework (Table 3) that organizes recommended best practices to improve the financing of family planning services at different stages of the humanitarian crisis response. The framework is organized by the universal health coverage dimensions of access and availability, depth of services, and financial protection, and by family planning financing criteria within the humanitarian crisis planning stages, which are defined in Box 5. Best practices focus on the five areas discussed in the previous section: (1) planning and coordination, (2) legal and regulatory context, (3) supply chain management, (4) quality and affordability of service delivery, and (5) data and information sharing. The framework includes examples of context-specific practical situations discussed in this report that are related to some of the best practices.

**Box 5. Framework Dimensions**

Universal health coverage when viewed specifically from a family planning perspective (rows in the framework), are:

- **Access and availability** of family planning services
- The **depth** of family planning services provided, including the **quality of services** and **range of methods and ancillary services** that are included in the package of services covered by the health financing system
- The level of **financial affordability** offered in delivery of these services (e.g., out-of-pocket payments required for the average family planning user)

Family planning financing criteria within humanitarian crisis planning stages (columns in the framework) are:

- **Adequacy of financing**: capacity to fund the entire targeted population with diversified funding streams
- **Appropriateness of financing**: capacity to allocate resources supporting rights-based planning, services that respect voluntarism and informed choice, and that are delivered by trained health workers
- **Sustainability of financing**: the needs of the entire population can be sustained over time and integrated in the existing health system
### Table 3. Framework for Addressing Challenges Affecting Key Dimensions of Family Planning Services to Displaced Populations across Different Phases of Humanitarian Crisis Response*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Preparedness (Early Action)</th>
<th>Implementation</th>
<th>Longer-Term Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Financing Adequacy</td>
<td>Financing Adequacy</td>
<td>Sustainability of Financing</td>
</tr>
<tr>
<td>Access and Availability</td>
<td>Planning and Coordination: - Include UNFPA and other family planning stakeholders in early discussions with the host government. - Ensure presence of active family planning donors. - Include family planning in scenario-based contingency plans. Supply Chain: - Ensure family planning kits are prepositioned and locations optimally determined.</td>
<td>Planning and Coordination: - Include family planning in response plan budgets. - Allocate sufficient family planning funds to cover needs. - Ensure active in-country implementers meet the conditions required to unlock certain types of funding.</td>
<td>Planning and Coordination: - Facilitate discussions to secure funding commitments to transition the MISP to a comprehensive family planning program. - Build host government capacity to lead coordination in a preparedness and resiliency-building process.</td>
</tr>
<tr>
<td></td>
<td>Data and Information Sharing: - Build capacity of response preparedness structures to use analytics to guide family planning resource mobilization decisions, such as predicting size and family planning needs of displaced population.</td>
<td>Planning and Coordination: - Improve the presence of key family planning bilateral/multilateral donors to strengthen implementers’ service provision capacity. Supply Chain: - Target available family planning funds to reflect needs.</td>
<td>Data and Information Sharing: - Use data on family planning funds to project and easily track budgets.</td>
</tr>
<tr>
<td></td>
<td>Legal/Regulatory Context: - Mitigate laws which forbid the use of public funds to pay family planning service providers.</td>
<td>Service Delivery: - Improve human resources funding to mitigate gaps. - Explore the use of innovative platforms for provider payment. - Mitigate negative provider attitudes and behaviors that restrict the use of family planning services.</td>
<td>Legal/Regulatory Context: - Mitigate the challenge of competing or new priorities for family planning programs and operations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explore funding options designed to support activities for the humanitarian/development nexus.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promote integration of the family planning humanitarian response into the local health system.</td>
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<tr>
<td></td>
<td></td>
<td>Advocate for the availability of family planning funding that comes with a flexible timetable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data and Information Sharing: - Use data on family planning funds to project and easily track budgets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Legal/Regulatory Context: - Mitigate laws/regulations/policies preventing providers/implementers from raising awareness about family planning to enhance implementation of family planning services.</td>
<td></td>
</tr>
</tbody>
</table>

*For example, ensuring funding for faith-based implementers, which may face challenges when full implementation of the MISP is required to unlock certain types of funding.

*Examples of unanticipated financing challenges include higher costs for basic service delivery and commodities and additional costs for supply chain extension and last-mile commodity security, which can result when family planning needs are quantified for a smaller population, leading to funding exhaustion.

*For example, appropriate use of emergency health workers, community health workers, community volunteers, and local health professionals/experts.

*For example, advocacy is needed when donors have not agreed to provide funding for the duration of the crisis, when family planning funding is only available during the emergency relief phase, and when quantification of needs are for short-term financing only.
<table>
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<tr>
<th>Dimension</th>
<th>Preparedness (Early Action)</th>
<th>Implementation</th>
<th>Long-Term Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Financing Adequacy</td>
<td>Appropriateness of Financing</td>
<td>Financing Adequacy</td>
</tr>
<tr>
<td>Depth of Services: Method Choice and Service Quality</td>
<td>Supply Chain</td>
<td>Supply Chain</td>
<td>Planning and Coordination:</td>
</tr>
<tr>
<td></td>
<td>- Guarantee comprehensive MISP-based services by prepositioning adequate quantities of family planning kits with the optimal method mix.</td>
<td>- Align method mix with needs when selecting family planning kits for purchase and prepositioning.</td>
<td>- Discuss and agree on standards of care with implementors.</td>
</tr>
<tr>
<td></td>
<td>- Explore local supply chain possibilities to facilitate transition at the end of the acute emergency phase.</td>
<td>Planning and Coordination:</td>
<td>Service Delivery:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Consider client choice or preference as the only decision-drivers when financing family planning methods.</td>
<td>- Mitigate procurement challenges restricting family planning method choice.</td>
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<tr>
<td></td>
<td></td>
<td>Data and Information Sharing:</td>
<td>Service Delivery:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Strengthen response coordination and implementation structures to pinpoint displaced populations to mitigate family planning method mix gaps.</td>
<td>- Improve delivery channels to enhance quality and method choice.</td>
</tr>
</tbody>
</table>

For example, avoid prioritizing the cheapest methods due to resource constraints.

For example, delays in obtaining or distribution of family planning commodities (such as interagency reproductive health kits), identifying suppliers, sourcing quality family planning supplies, stockouts/shortages of family planning commodities, and supplies that are not identified or tracked can restrict method choice.

For example, ensure financing for well-trained health workers to deliver high-quality services.
## Analyzing and Improving the Financing of Family Planning Service Delivery in Humanitarian Crises

### Dimension

<table>
<thead>
<tr>
<th>Dimension</th>
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<th>Long-Term Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Financing Adequacy</td>
<td>Appropriateness of Financing</td>
<td>Financing Adequacy</td>
</tr>
<tr>
<td>Financial Protection</td>
<td>Planning and Coordination: - Ensure that pre-emergency planning initiatives between the host country and donors include family planning resources, prioritizing vulnerable users.</td>
<td>Planning and Coordination: - Define institutional and financing arrangements for financial protection during pre-emergency planning.</td>
<td>Service Delivery: - Avoid user fees related to provision of family planning services. - Mitigate high insurance copays for family planning services.</td>
</tr>
</tbody>
</table>

### Framework Definitions:

**Financing Adequacy:** Capacity to fund the entire targeted population with diversified funding streams.

**Appropriateness of Financing:** Capacity to allocate resources supporting family planning services that are rights-based, respectful of method choice, and are delivered by trained health workers.

**Sustainability of Financing:** The need of the entire population can be sustained and integrated in the existing health system.

**Service Delivery:** Includes human resources for health; technical capacity; information, education, and communication; and infrastructure and equipment.

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* For example, involve development implementers and relevant host government structures offering social protection for health, economic, and financial inclusion services.

* For example, implement mechanisms such as health insurance and waivers/exemptions.

* For example, when services are transitioned to higher-level out-of-camp health facilities, which may increase travel cost and time.
The framework was developed to explore action-oriented recommendations to mitigate challenges that can affect family planning service delivery to displaced populations, especially when financing criteria are not met (red and yellow boxes in Figure 3, previously). In the examples that follow, we present different issues from the cases described in sections 2 and 3 to highlight the connections between recommendations from the framework and specific situations that affect family planning services at various stages of the humanitarian crisis response.

1. **Lack of data and information-sharing to guide allocation of funds increases the risk of additional program costs.** Family planning service delivery during humanitarian crisis response carries unanticipated costs such as taxes or import fees for commodities; costs of linking with national supply chains, commodities security, and last-mile delivery; or costs that result from inaccurate estimates of method mix or quantification. These costs may increase the financing levels needed to ensure the availability of quality, affordable family planning services. However, some of these unanticipated costs and resulting service delivery issues can be avoided, or at least mitigated, if humanitarian actors have critical information about the family planning context that can lead to better understanding of family planning knowledge and practices among displaced populations prior to migration and the legal and regulatory contexts pre- and post-migration. Box 6 provides an example of how this kind of information was used for refugees in Tanzania. Including this type of predictive analytics within the overarching emergency risk analysis and preparedness actions could help humanitarian actors better plan for unanticipated costs. Improved generation, sharing, and timely use of data can lead to more tailor-made and effective financing of context-specific program interventions that catalyze high-quality service scale-up.

**Box 6. Family Planning for Refugees in Tanzania—Predictive Analytics**

A 2019 DFID-funded (now FCDO) study attempted to understand the barriers to family planning uptake for Congolese and Burundian refugees in Tanzania by examining the existing barriers to family planning within their home context, prior to their migration. The following were found to be critical historical barriers that limited uptake despite availability of modern contraceptives:

- A lack of available and trained providers for contraceptive services
- A mismatch between methods preferred by women and those easily available
- Providers denying family planning services to clients

This information was used to improve and scale up family planning services for these populations in refugee camps in Tanzania.

Source: Millington, 2019

2. **Prioritizing immediate cost-efficiency as a way of selecting methods instead of prioritizing client choice affects long-term efficiency of services.** Financing decisions involving service delivery quite often prioritize the least expensive family planning methods due to resource constraints, curtailing the range of methods and services provided. Evidence from the literature showed that overreliance on cost-efficiency to guide program decisions might not respect informed client choice and voluntarism principles. Lower rate of
implant uptake in Mae La refugee camp in Thailand, as described previously in Case 3, was related to a decision to primarily provide intrauterine devices at a fraction of the cost of implants because of the small family planning budget (Srikanok et al., 2017). Building response programs around cost-efficiency is important to achieve the lowest price under budget constraints. However, consideration of delivering high-quality interventions should also take into account client preference as a critical decision-driver when financing family planning methods, in order to avoid method discontinuation or lack of use, which will drive significant inefficiency over time.

3. **Donors focusing on the acute emergency phase.** Sustainability of family planning services is affected when donors agree to finance the acute phase of the response but do not commit funding for the long-term humanitarian response for the duration of the crisis. Planning and coordination that restricts family planning funding only to the emergency relief phase and quantifies needs for only short-term financing suggests a need to advocate for family planning funding with flexible time restrictions.

4. **Link between service delivery planning and financial affordability.** Evidence in the literature describing the issue of financial affordability problems for family planning in humanitarian crisis is extremely limited. However, financial affordability is a key dimension of family planning services in the humanitarian response and, therefore, it is important to explore opportunities for sustainably financing access to family planning. Limiting out-of-pocket payments from vulnerable family planning users, such as women and adolescent girls, directly impacts their ability to access and use rights-based family planning services that respect method choice. Decisions on how service delivery is financed plays a major role in determining the level of, or lack of, affordability, particularly in the implementation and longer-term transition phases.

5. **Transition from crisis response to recovery leads to additional costs for family planning users.** To remove financial barriers associated with access to family planning during transition, it is critical to consider financial protection mechanisms for users. These may include health insurance, waivers, and exemptions from user fees to mitigate funding gaps when services are no longer available free of charge or at a subsidized cost. It must be a strategic priority when designing the service delivery strategy of a humanitarian crisis family planning program to reduce out-of-pocket costs for affected populations. These costs may be high user fees, large differentials in rates for the displaced population versus host country citizens, and informal fees that providers charge due to the vulnerable status of displaced individuals. Other unanticipated costs can also severely affect access to family planning services if changes in the service delivery organization in the post-relief transition phase are not considered. For example, service delivery may be moved to out-of-camp locations or higher-level health facilities, which require additional travel costs and time.

The framework can be applied to look at improving financing of family planning at any stage of a humanitarian crisis response. It can also be used retrospectively to assess what has been done in past humanitarian crises and to identify lessons learned that may improve coherence, programming, and policymaking for family planning in future humanitarian crisis response globally. A prospective use of the framework at the pre-emergency or preparedness phases of a crisis would allow for comprehensive family planning response that includes program design,
Analyzing and Improving the Financing of Family Planning Service Delivery in Humanitarian Crises

management, financing, and implementation. Using the framework during ongoing relief efforts also offers opportunities for real-time corrective actions.

**Recommendations for Improving Financing of Family Planning Services in Humanitarian Crisis Response**

The identified areas of improvement highlighted in the framework are pointing to overarching themes across crisis types and phases. These themes were further explored and formulated into recommendations to address the challenges outlined in section 3 of this report, focusing on key dimensions of the framework: access and availability; depth and quality of family planning services; and financial inclusion and protection of displaced populations.

**Recommendation 1: Institute better and earlier planned integration of family planning services for displaced individuals into the host country health system.**

Integration of services for displaced populations in the host country health system is critical for the humanitarian crisis health-related response. This is relevant not only in the long term but at all stages of response, from preparedness to deployment of immediate onset emergency relief to post-crisis and rehabilitation efforts. In the family planning context, planning for integration is critical because social and cultural norms in the host country shape the service delivery context and potentially affect the reproductive health services that can be delivered to displaced populations. Box 7 describes the elements that should be coordinated to achieve full and functional integration across the stages of the humanitarian response effort.

**Box 7. Planning Priorities for Host Countries to Integrate Family Planning Services for Displaced Populations**

- **Coordination between host country and partners** defining the roles, responsibilities, type of contributions, and areas of support for family planning programming intended for the displaced population.

- **Defined modalities and payment streams** for the immediate release of domestic and international funds to support family planning services during crisis onset and funds for the long term.

- **Host country resource commitment** through contingency funds, budget allocations, contingent credit, budget reallocations, tax increases, and post-emergency credit to ensure availability of key components of family planning/reproductive health service delivery (e.g., health workforce, health infrastructure, and supply chains in the areas receiving displaced populations).

- **Analysis of health service delivery capacity at the site for displaced populations**, which will reduce displacement-related risks for users and ensure access to family planning services in a healthy and dignified environment.

- **Coordinated budgeting and sustainability planning with development partners and implementers** that incorporates family planning and considers all emergency and post-emergency financing instruments, including UN pooled and agency-specific funds, short-term or long-term catastrophe bonds, blended financing, local insurance schemes (if possible), and in-kind and financial donations.
Positioning host governments to spearhead post-emergency planning should start integration efforts—which can be stalled or stymied by weak or absent involvement of host governments. However, when host countries are struggling to allocate enough resources to support their own citizens’ needs, committing public funds to support refugees’ general and reproductive health needs becomes more difficult.

Anticipatory financial planning can mitigate this challenge and be a key enabler of enhanced funding for family planning services in humanitarian crisis. Reserves, contingency funds, humanitarian crisis budget contingencies, and contingent debt facilities are examples of host government anticipatory financing instruments that can be developed to support humanitarian crisis response, including for family planning (see Box 8). In the absence of anticipatory instruments, the humanitarian crisis response funding will continue to be restricted to: (1) global and local donations, unplanned budgetary reallocation, loans, tax increases, and post-emergency credits (at the host country level); (2) out-of-pocket payments by displaced populations to cover user fees for family planning services; and (3) development partner post-emergency financing mechanisms (usually capped), either in-kind or cash transfers, grants, and concessional loans (e.g., the World Bank Global Concessional Financing Facility).

### Box 8. Host Government Anticipatory/Pre-Emergency Financing Instruments

**Reserve funds** are disaster risk financing instruments that cover small and recurring losses caused by natural disasters. Normally, they are funded from annual budget allocations.

**Contingency funds** are resources host governments set aside or secure through a loan from multilateral finance institutions for the purpose of early disaster response and recovery financing.

**Budget contingencies** are general or disaster-specific contingency appropriations in host government annual budgets, which can be used to finance a variety of unexpected or crisis-related spending demands during the budget year without requiring cuts to other programs or severe budget reallocation.

**Contingent debt facilities** are a class of loans offered by international development banks or other private lenders to address shocks related to natural disasters and other crisis or health-related events. These loans grant countries a contingent financing line that provides immediate liquidity once a defined trigger (e.g., refugee-hosting country’s declaration of a state of emergency) has been breached. These can serve as early crisis response financing while other sources, such as bilateral and multilateral aid or reconstruction loans, are being mobilized.

Source: Poundrik, 2011; ADB, 2018; Allen et al., 2013; World Bank, 2018

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**Recommendation 2: Agree on and implement standards for family planning and reproductive health service quality and affordability that will be applied to displaced populations.**

Evidence from Jordan, Pakistan, South Africa, Thailand, and Uganda described in section 3 indicates that standards of family planning service delivery should be defined collaboratively among all humanitarian actors. Central and local host governments, implementers, and partners must agree on a pragmatic and implementable approach to rights-based, high-quality services offered in a setting that is appropriate to the displaced population. The criteria which may be
used could include that services are: (1) free of charge for all users or at least those with defined vulnerability; (2) free of barriers that implicitly differentiate access or method choice for users; (3) free of non-financial barriers to utilization, such as lack of providers with appropriate client-centered training or language skills for the recipient population; and (4) supported by incentives deterring providers from charging informal or other user fees.

Factors driving informal payments requested by providers or collection of user fees for health services, including family planning have been widely documented by the global health community. These factors are relevant, to some extent, to humanitarian crisis contexts where documented evidence is limited. These factors can be product-related, such as a high unit price for a method that is not included in a compensated list, a low or partial reimbursement rate that does not cover the full cost of services for the method, or a lack of affiliated providers. Informal payments can be driven by system-related factors associated with waiting time and referral system, low quality of care or lack of supplies, provider-induced demand that shifts clients to uncompensated method types, and cultural acceptance of informal payments at both the provider and client level. Desire to choose provider, lack of knowledge of entitlements, or perceived necessity to pay can also influence a client’s decision to support informal payment (WHO, 2014; Cockcroft et al., 2008; Paredes-Solís et al., 2011).

The Global Health Cluster of the IASC, chaired by the WHO, provided specific guidance to all humanitarian actors to remove user fees associated with providing primary healthcare services during humanitarian crises (IASC, 2010). Ongoing discussions and active coordination between stakeholders and host governments are critical to determine the type of service delivery channels and financing responsibilities required to support a broad-based family planning method mix and adequate payment of providers across crisis phases. By supporting changes in the existing policy environment focused on reforming providers’ incentive structure, host governments can reduce informal practices deterrent to family planning. Amending laws that forbid the use of public funds to pay family planning service providers or prevent implementers from raising awareness about the availability of family planning services and user entitlements, would enhance program implementation. Broader health system reforms at the host country level, such as the implementation of human resource policies for compensatory benefits targeting government health workers located in crisis-affected areas, would improve staff retention and motivation, mitigating potential turnover or absenteeism.

**Recommendation 3: Develop a mitigation plan for foreseen financing gaps to achieve desired scale and quality of family planning services for displaced populations.**

It is likely that family planning programming at scale for displaced populations, even when well-integrated into local systems and planned, will be under-resourced. Especially in protracted crises—and even in some crises after the immediate emergency response period—funding gaps are likely to develop and require further resource mobilization to sustain high-quality services to the entire displaced population. Actors that will need to participate in these continuing or

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2 Client-centered family planning refers to services that allow clients to “choose a method they want, continue using it, and return when they need help or change the method” (Walle and Woldie, 2017, p. 374). This definition is further complemented by the IAWG field manual, which describes client-centered family planning as a comprehensive contraception service delivery program that “facilitates method continuation and responds quickly and supportively to method switching” (IAWG, 2018, p. 139).
supplemental discussions on resource mobilization must now include host country NGOs and philanthropic institutions, national and local/regional government funders, and the pre-existing multilateral or bilateral funders and implementing agencies.

With protracted crises, income-generating activities might provide households in the displaced population a means to contribute minimal amounts to local user fees, especially for those who elect to receive services outside the camp setting. More market-based family planning programming informed by demand segmentation in these settings, conducted with a perspective of valuing the right to care, affordability, and an intention to protect, can then be part of long-term planning for protracted crisis settings. Social marketing programs for family planning in development aid have successfully used market segmentation to gain more insights on targeted population segments sharing similar needs, values, or characteristics and thereby to improve access to and use of a variety of family planning products. Applying similar approaches to the humanitarian crisis context would segment demand within displaced populations by assessing each group’s family planning intention and ability to pay. Therefore, resources supporting free and subsidized services can effectively target the poorest and most vulnerable displaced population segments using demand-side financing models, such as vouchers, to address financial barriers and allow for alternate service delivery points outside the camp, thus broadening the choice of providers.

In the long term, mitigating a foreseeable financing gap will require the coordinated efforts of humanitarian crisis response and development partners with host government structures. Mitigation strategies may include further enhancing opportunities for integrating services for displaced populations within local health financing mechanisms—for example, granting access to and utilization of services and funding streams under host country national social welfare systems, including health insurance schemes. In order to achieve access for displaced population households, these strategies would require: (1) appropriate changes to legal provisions allowing access to the schemes, including appropriate identification cards and information; (2) either subsidized membership for displaced populations or access to livelihood opportunities that allow households to pay for the scheme’s premiums and/or co-payments; and (3) supplementary or complementary contributions from development partners or philanthropic agencies to support the remaining cost of healthcare services, especially if they are accessed through additional NGOs or private for-profit providers.

**Recommendation 4: Consider economic and financial inclusion initiatives, with strong gender-sensitive programming, as potential opportunities to sustainably finance family planning.**

Significant reductions in out-of-pocket expenditures on family planning can be achieved; however, the low likelihood of complete elimination of direct payments in the long term stresses the importance for households to have some financial capacity to access family planning services. Examples follow on three existing gender-sensitive, income-generating interventions focused on economic and financial inclusion of displaced populations. These examples should be considered as potential transition opportunities to more sustainable family planning financing options.

1. Support employment-focused education, job placement services, and gender-inclusive entrepreneurship. Harnessing the skills and attributes of displaced people, in particular refugees, can help them achieve their potential for socio-economic growth and transition to self-
Case 4. Supporting Employment-Focused Education for Syrian Refugees

Luminus Education is a private company providing employment-focused education in Jordan. With funding from a dozen bilateral and multilateral development partners, Luminus Education was one of the first institutions to help Syrian refugees continue their education in Jordan. As of 2017, Luminus Education secured tuition for 3,208 refugee students by offering scholarships (50 percent of tuition) and mobilizing complementary funding through multi-year grants from the Jordan government and international partners. Beyond financial assistance, Luminus Education also provides job placement assistance with a network of more than 20 employment partners. The organization established Luminus ShamalStart in 2016 through which it is spearheading a large youth entrepreneurship initiative in the Irbid region, promoting startup businesses and creating jobs for female Syrian refugees and Jordanian women. Empowering refugees through education, employment, and entrepreneurial opportunities fosters financial inclusion and increases the likelihood that refugees can participate in financing their health needs, including family planning.

Source: IFC, 2018a

While host countries with a large informal sector might struggle to support formal employment, the private sector has a critical role to play in socioeconomic integration of refugees and internally displaced people within their host communities. Private capital can help expand existing woman-owned businesses and support local entrepreneurship to increase prospects for job opportunities among displaced women populations. Case 5 highlights the potential market and business opportunities for the private sector in the Kakuma camp in northeast Kenya following a consumer and market study from the International Finance Corporation (2018). Similar efforts supporting collection of empirical data on revenue, consumption patterns, consumer preferences, and financial transactions across crisis settings can address the lack of market information that is needed to create an adequate evidence base to attract private investors. Attracting private capital in these settings through gender-sensitive economic and financial inclusion programs can provide women with a greater opportunity to access money to obtain the health services they need, including non-subsidized family planning methods. Access to money also allows women to exercise informed choice and enables access to a wider possible range of safe and effective family planning methods, even if it comes at a financial cost (Reed et al., 2016).
Case 5. Opportunities for Private Sector Investment in Kakuma Refugee Camp

A 2018 study from the International Finance Corporation of the World Bank Group aimed to better understand Kakuma in northeastern Kenya as a potential market and identify business opportunities for the private sector. Kakuma camp in northeastern Kenya is one of the largest and longest-standing refugee camps in the world. It was originally created in 1992 for refugees fleeing conflict in Sudan. As of October 2016, Kakuma camp hosted more than 160,000 people from nine major nationalities. Kakuma’s informal sector economy has more than 2,000 businesses and 14 wholesalers located in the refugee camp. Businesses support a camp household consumption conservatively estimated at US$16.5 million per year at the time of the study. With 62 percent of the money spent by camp residents going toward consumer goods, the study findings suggest strong potential for further growth. Study respondents indicated that they were willing to pay for improved energy, housing, and sanitation services. Refugees are actively involved in economic activities as employers, consumers, and producers. Retail trade, mobile financial services, banking, energy, livestock, health, education, and water are the main sectors with potential for investment. Although 73 percent of camp households reported having an income, women business ownership and self-employment was only 7 percent. Households in Kakuma spent an estimated US$3.72 million per year on health (with camp residents contributing 9 percent of this amount). The study concluded by highlighting the need to focus on young people and women as a key objective to move toward achieving the global agenda of the Comprehensive Refugee Response Framework. Supporting young people and women business growth through vocational skills training, business development services, and microfinance opportunities will develop their entrepreneurship potential.

Source: IFC, 2018b

2. *Facilitate remittance flow to increase disposable income and spending.* The importance of remittances in helping address humanitarian needs has been widely documented and is an option for financing family planning needs of displaced populations. “Countries in humanitarian crises tend to be far more dependent on remittances, with the 20 largest humanitarian aid recipients receiving 40% of their total inflows from remittances…” (Bryant, 2019, p. 3). Reducing the cost of sending remittances to improve access is an explicit Sustainable Development Goal (goal 10). The United Kingdom’s Somalia Safer Corridor program illustrates how to increase remittance security and facilitate flow to refugees. This initiative brings together the UK government, banking sector, money service businesses, the World Bank, and the Somali community in the UK to address underlying deficiencies, risk management, and financial sector regulation issues in the UK-Somalia remittance corridor (UK–Somalia Safer Corridor Initiative, 2015).

3. *Use unconditional cash transfers to encourage entrepreneurship and increase cash use on healthcare.* Cash transfer programs can help displaced populations build their financial capacity to actively participate in financing their family planning needs. A study in Uganda aimed to understand what role large unconditional cash transfer programs could play in supporting refugees in protracted situations living in extreme poverty to rebuild their lives. During a six-month period, roughly US$660 per household in unconditional cash transfers were provided to 2,231 households in the Kyaka II settlement and to 2,140 households in the host community living in direct proximity. Results showed that among 14 areas of spending, nonagricultural
business was the top category of refugee spending. Savings (money not spent) was the third-highest area while education and healthcare were in seventh and tenth place, respectively. Increases in school attendance and improvement in financial inclusion were notable benefits of the cash transfers among both refugees and the host community (Williams and Cooke, 2018). Such initiatives that create more access to disposable income, combined with adequate demand-generation efforts for health and family planning services, could be adapted to target women.

Recommendation 5: Anticipate and mitigate the impact of local laws and regulations on the family planning service delivery context.

Strengthening overarching emergency risk analysis and preparedness actions through early efforts to engage receiving area authorities and humanitarian and development actors will help anticipate and mitigate the impact of local laws and regulations that can introduce legal and political barriers affecting the overall humanitarian crisis response, including family planning. Some of the issues affecting the host country environment that also affect family planning include financial sector laws on funding flows or blockage to the movement of aid-related commodities. Furthermore, when host governments—for legal and regulatory reasons—limit access to the in-country supply chain, health infrastructure, and health workforce, the cost of providing services to displaced populations can often require development of a parallel health system that becomes unsustainable. Engaging host governments in early coordination efforts focused on initiating and sustaining services can reduce the risk of higher costs for family planning services for displaced groups.

The Grand Bargain

Opportunities exist that can contribute to a more sustainable family planning humanitarian response. However, the degree to which they can be leveraged varies, depending on issues affecting family planning financing and service delivery at different stages of the response. Therefore, the abovementioned recommendations should be considered at the preparedness phase of humanitarian crisis response as humanitarian actors build strong host country–donor relationships. Additionally, the recommendations should complement other initiatives underway to address challenges in the financing and sustainability of responses to humanitarian crises, such as work conducted under the Grand Bargain, an initiative developed by the IASC and others.

Developed in response to a 2016 report on the humanitarian financing gap, the Grand Bargain proposes changes in the practices of response actors—including the use and coordination of cash programming, greater funding for local responders, and harmonized reporting requirements—which could result in an additional US$1 billion over five years. The Grand Bargain also prioritizes a cross-cutting commitment to enhance engagement between humanitarian and development actors, focusing on bridging the humanitarian (response)–development (aid) nexus. Linking innovative financing options to the work and achievements under the Grand Bargain, therefore, has great potential to help address the gap in transitioning from fulfilling short-term family planning needs to sustaining service delivery efforts as crises persist, improving access and sustainability in current and future response efforts. Box 9 explores potential connections between the recommendations provided in this report and the ongoing initiatives under the Grand Bargain. However, it is critical to incorporate family planning-
specific initiatives across all 10 of the Grand Bargain’s current thematic workstreams. As the Grand Bargain enters its fifth year, signatories should think critically about how to incorporate family planning-specific initiatives into the proposal for the future of the Grand Bargain after 2021.

Box 9. Linkages for Family Planning within the Grand Bargain Thematic Workstreams

**Greater transparency:** The Grand Bargain prioritizes building increased funding transparency through a shared open-data standard and common digital platform. It also recognizes the need for improvements to the FTS. Through this workstream, the Grand Bargain aims to demonstrate how funding moves from donors down the transaction chain until it reaches the final responders, and where feasible, affected persons. This level of tracking is particularly important for family planning given the current challenges that limit tracking of family planning financial allocations and expenditures. Inclusion of a system to tag or earmark financing flows for family planning across the financing data in specific humanitarian crisis responses within the data portal or improvements to FTS developed under the Grand Bargain would help to bridge the disconnect between funding and implementation data and improve decision-making by both donors and humanitarian responders.

**Increase the use and coordination of cash-based programming:** The Grand Bargain’s focus on increasing the routine use of cash alongside other tools, including in-kind assistance, health and nutrition service delivery, and vouchers, directly aligns with recommendation 4. Within the Grand Bargain’s broader efforts to increase cash-based programming, efforts should be placed on initiatives that create more access to disposable income for women combined with adequate demand-generation efforts for health and family planning services. Additionally, this workstream commits organizations to invest in new delivery models, which can be increased in scale while identifying best practices and mitigating risks in each context. Donors and response organizations should consider piloting the financial models discussed under recommendation 4 (e.g., employment-focused education, job placement services, gender-sensitive entrepreneurship, and facilitating remittances) to improve the family planning response within this workstream initiative and develop further evidence to support implementation at scale.

**Enhance engagement between humanitarian and development actors (cross-cutting commitment):** The Grand Bargain’s cross-cutting focus on increasing engagement between humanitarian and development actors directly aligns with recommendation 5. It is critical to ensure that family planning is prioritized as part of the Grand Bargain’s commitments to significantly increase preparedness for early action, while preventing and mitigating risks, to anticipate and secure resources for recovery. This will need to be the focus not only of humanitarian organizations and donors but also of national governments at all levels, development partners, civil society, and the private sector.

Source: IOM, 2016

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3 The Grand Bargain prioritizes 10 thematic workstreams including: (1) greater transparency, (2) more support and funding tools for local and national responders, (3) increasing the use and coordination of cash-based programming, (4) reducing duplication and management costs with periodic functional reviews, (5) improving joint and impartial needs assessments, (6) including people receiving aid in making decisions that affect their lives, (7) increasing collaborative humanitarian multi-year planning and funding, (8) reducing the earmarking of donor contributions, (9) harmonizing and simplifying reporting requirements, and (10) enhancing engagement between humanitarian and development actors (International Organization for Migration [IOM], 2016).
Conclusion

Over the past decade, understanding how family planning needs are managed and financed to reach users in immediate and protracted humanitarian crises has become a global priority. This report has summarized the current planning and implementation process, and related challenges, illustrating how financing decisions are made to deliver family planning services as part of humanitarian crisis response. Through this report, HP+ has identified critical information gaps, such as a lack of data to guide stakeholders across the humanitarian crisis response. Additional highlighted gaps include the need for better understanding of:

- The issues associated with family planning service delivery in humanitarian crisis responses, including provider competency, adequacy, and funding
- The method choice and preferences of users in any given humanitarian crisis
- The implications of the rules and financing arrangements of health systems in countries responding to a humanitarian crisis

Given the diversity of humanitarian crises, greater attention needs to be paid to the issues raised in this report and the possible solutions touched upon.

The family planning-humanitarian crisis response framework introduced in this report (Table 3), and the discussion of cases and issues, can be applied to predict and address problems that affect access, quality, and financial protection for family planning services in future crises. Use of such frameworks, together with ongoing changes to humanitarian crisis response financing (as laid out in the Grand Bargain and other approaches), may lead to improvements in a number of areas that include: planning and coordination, pre-positioning and conditioning of the supply chain for family planning commodities, shared data to inform decision making, and more sustainable service delivery. Taken together, these areas will ultimately affect key dimensions of family planning services to displaced populations.

Furthermore, the framework provides a basis for analyzing operational best practices to improve areas of family planning programming. Efforts focused on these areas will enable host government, humanitarian, and development stakeholders to understand how to act on a spectrum of program challenges using more effective and coordinated decision-making processes. Stakeholders can therefore consider new approaches for improved family planning service provision that match the scale of the crisis across the full continuum of the humanitarian response.

Looking to the future, the protracted nature of some crises does not clearly fit the mission of purely humanitarian crisis response actors. As a result, addressing the long-term reproductive health and family planning needs of refugees and other displaced people in these situations requires sustainable solutions. Humanitarian crisis response plans can evolve to cater to long-term settled situations for displaced people, as we know from various cases. However, planning for family planning services over these longer-term arrangements is a developing area of work that requires further attention.
References


Analyzing and Improving the Financing of Family Planning Service Delivery in Humanitarian Crises


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