Family planning saves lives and promotes resilience in humanitarian contexts

INTERNATIONAL RESCUE COMMITTEE

WOMEN'S REFUGEE COMMISSION
Research. Rethink. Resolve.

care®

Save the Children

IAWG
INTER-AGENCY WORKING GROUP ON REPRODUCTIVE HEALTH IN CRISES

Summary

Globally, it is estimated that 128.6 million people are currently in need of humanitarian assistance.[1] Of these individuals, approximately one-fourth are women and girls of reproductive age.[2] Although family planning is one of the most life-saving, empowering, and cost-effective interventions for women and girls, it remains an overwhelming gap in emergency responses due to a lack of prioritisation and funding. Consequently, many women and girls are forced to contend with an unmet need for family planning and unplanned pregnancies in addition to the traumas of conflict, disaster, and displacement.

The Family Planning Summit (FP Summit), convened in London on 11 July 2017, presents a critical opportunity to accelerate efforts to deliver family planning to women and girls globally—including those affected by humanitarian crises. In preparation, on 4 May 2017, the Inter-agency Working Group for Reproductive Health in Crises (IAWG) convened an expert consultation on family planning in humanitarian contexts, on behalf of the humanitarian workstream of the 2017 FP Summit, including DFID, the Bill & Melinda Gates Foundation and UNFPA. At the expert consultation, IAWG members presented their experiences providing family planning in diverse humanitarian contexts, demonstrating that there is consistent demand for family planning services and that it is feasible to provide them, even in the most challenging contexts.

Building on this momentum, the International Rescue Committee, in partnership with Care, Save the Children and the Women's Refugee Commission, organised a donor consultation on 7 June 2017 to seek input from donors and stakeholders to shape messages and recommendations for the London FP summit. This paper is a synthesis of the findings developed through both consultations and identifies collaborative solutions and actions to be taken at the FP Summit and beyond.

COVER: Gloria Ibrahim, 29, fled her home in 2014 after Boko Haram killed her husband. To be able to look after her three children, she volunteers at a tailor shop in Yola, Nigeria, hoping to learn enough to open up her own business. *Peter Biro/IRC*

In order to meet FP2020 and global development goals, it is essential to provide family planning to populations affected by humanitarian crises.

At its inception, FP2020 was founded on the principle that "all women, no matter where they live, should have access to life-saving contraceptives."[3] Women and girls who live in settings impacted by humanitarian crises have the same right, as women and girls elsewhere, to make informed decisions about their sexual and reproductive health, and must have the same opportunities to do so.

Moreover, to achieve FP2020's ambitious goal of providing contraception to 120 million additional women and girls by 2020, it is critical to reach these populations. As of FP2020's midpoint in July 2016, 30.2 million additional women and girls are using modern contraception as compared to 2012—a shortfall of 19.2 million users from the number projected at this stage, indicating that while the initiative has made great progress, it is not on track to meet its goal.[4] Progress has been stronger in countries with broad support and high levels of resources, such as those included in the Ouagadougou Partnership.[5]

On the other hand, many conflict-affected countries are making the slowest progress overall with the lowest rates of contraceptive use, while also making up some of the highest maternal and infant mortality rates. Of the 225 million women with unmet need for family planning, many are actively displaced because of conflict or natural disaster. Among FP2020's 69 focus countries, 26 (or 37.6%) have UN OCHA humanitarian response plans or are included in regional refugee response plans.[6] Of the 30 focus countries with a low modern contraceptive prevalence rate (mCPR) and that are either experiencing slow mCPR growth on the S-curve or entering the period where rapid growth can occur—that is to say, countries of particular importance for FP2020's efforts to reach additional users—15, or a full 50%, have UN OCHA humanitarian response plans or are included in regional refugee response plans.[7]

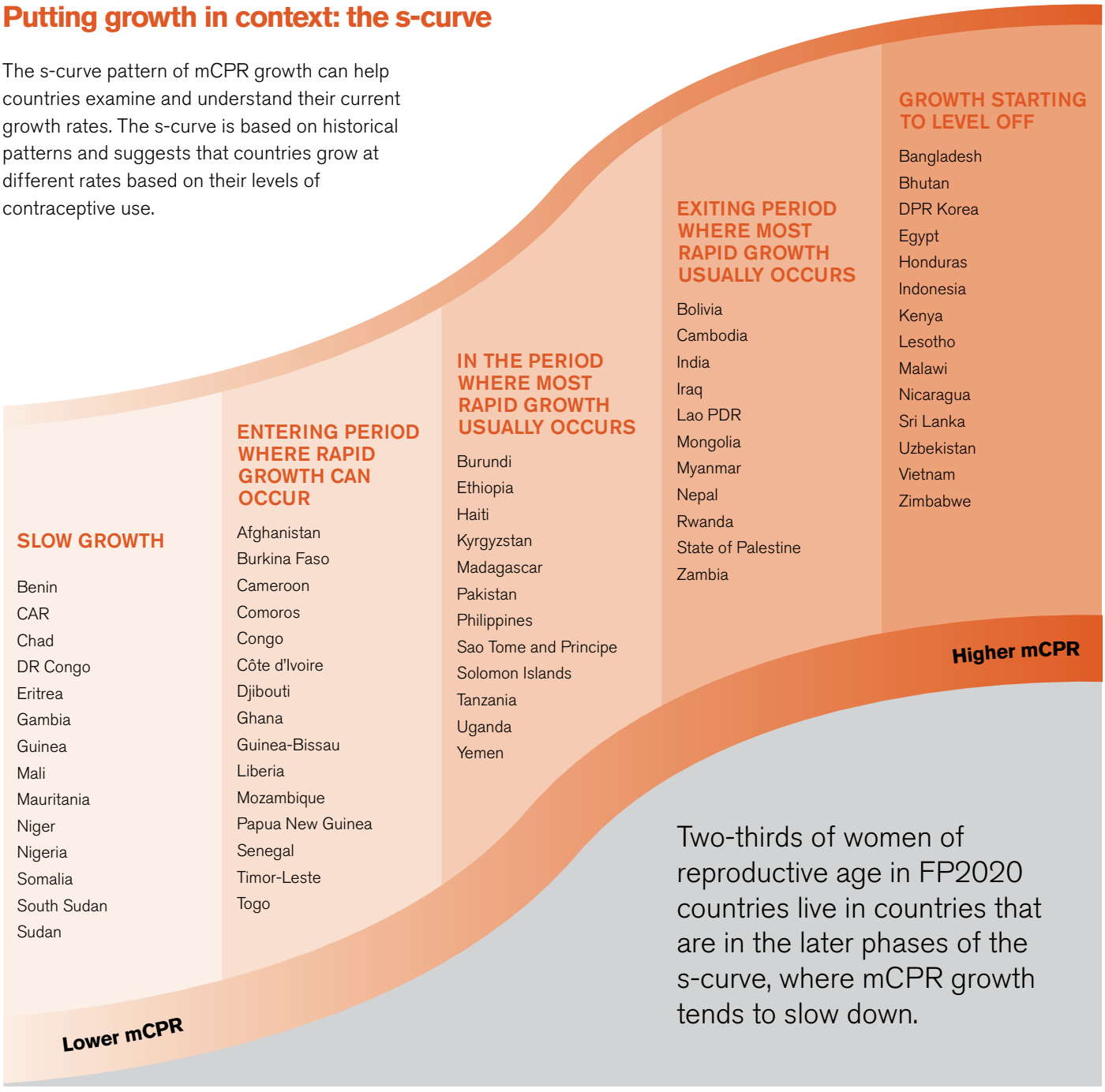
Family planning is a life-saving humanitarian intervention.

The Minimum Initial Service Package (MISP), the established standard for the provision of reproductive health care from the onset of an emergency, identifies the prevention of unintended pregnancy as one of six priority objectives. Family planning is additionally identified as a minimum standard for emergency response within the Sphere handbook—just like clean water, shelter and food. Family planning saves lives during humanitarian emergencies.

Globally, maternal death is the second leading cause of mortality for women of reproductive age.[8] It is estimated that if unmet need for contraception were fulfilled, an additional 104,000 maternal deaths could be prevented—a 29% reduction in global maternal mortality.[9] Unintended pregnancies would drop by 70%, from 74 million to 22 million per year, and unsafe abortions would decline by 74%, from 20 million to 5.1 million.[10] If all birth-to-pregnancy intervals were increased to three years, an additional 1.6 million under-five deaths could be averted on an annual basis.[11]

Putting growth in context: the s-curve

The s-curve pattern of mCPR growth can help countries examine and understand their current growth rates. The s-curve is based on historical patterns and suggests that countries grow at different rates based on their levels of contraceptive use.



- When mCPR is very low, countries tend to see slow annual growth in mCPR. The length of this period varies by country, but to position themselves to enter a period of rapid growth, countries should make sure that barriers to family planning services are not preventing growth.
- Countries will enter into a period of more rapid mCPR growth. The rate of growth and length of this period varies and depends on countries monitoring progress and investing wisely in the appropriate interventions that will maintain progress. Countries that are able to grow at very high rates will transition through this period quickly, increasing the potential benefits of a demographic dividend.
- Finally, when contraceptive prevalence reaches higher levels, growth begins to slow down and eventually plateaus. Programmes at this stage need to focus on long-term sustainability, continued improvements in service quality, expanding the range of methods available, and striving to reach underserved groups.

Adapted from FP2020 *http://progress.familyplanning2020.org/page/pace-of-progress/introduction1#s-curve*

It is possible to provide family planning services in even the most challenging of settings, and demand is fierce.

Strong evidence demonstrates that family planning services can and should be integrated into each stage of humanitarian interventions, from preparedness, to response and recovery. The following case studies demonstrate the feasibility of providing family planning services in crises at all phases of response and demonstrates demand, and thus opportunity for the growth of services across the most prevalent types of humanitarian crises: acute crisis caused by conflict; rapid onset emergencies due to natural disaster; large-scale displacement internally and across borders; and protracted or cyclical civil unrest.

ABOVE: A young girl poses at an IRC-run safe healing and learning space in Maiduguri, Nigeria. A safe healing and learning space is a secure, caring and predictable place where children and adolescents living in conflict and crisis settings can learn, develop and be protected. The war against Boko Haram has caused massive displacement and famine-like conditions in northeastern Nigeria. *Kellie Ryan/IRC*

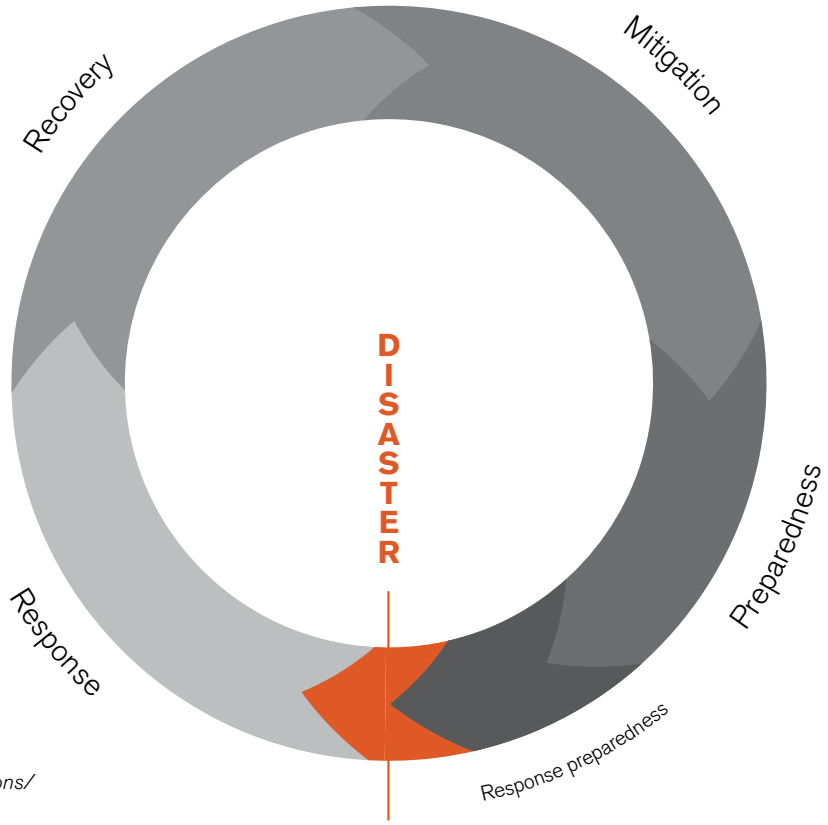
Early investment: family planning in acute crisis MISP response

BORNO STATE, NIGERIA

Following a recent escalation of violence in northeast Nigeria, the International Rescue Committee (IRC) launched an emergency health response in Borno state, which hosts the highest number of internally displaced people nationally. The conflict destroyed infrastructure and severely limited access to services, with only 35% of the primary health care clinics functioning and a lack of skilled staff and medical supplies.

The IRC initiated MISP services in August 2016 and established the only clinic providing comprehensive reproductive health services in the Bakassi IDP camp. The IRC also supports four government primary health care facilities within the Maiduguri Metropolitan Council-Jere area, with a particular focus on family planning services, post abortion care, clinical care for sexual assault survivors and delivery care. Additionally, the IRC has established comprehensive reproductive health services in Konduga and Monguno through reproductive health clinics, supporting a total population of 291,767 in all of Borno State. **Between January and March 2017, across all supported sites, the IRC served a total of 3,474 family planning clients. 69% (2,398) of these clients were new FP acceptors, 14.4% (346) of whom selected a long-acting reversible contraceptive method.**

The humanitarian spectrum: response and response preparedness



Adapted from OCHA

http://www.unocha.org/publications/asiadisasterresponse/index.html

Building back better

2015 NEPAL EARTHQUAKE

On 25 April 2015, a major earthquake struck central Nepal, devastating parts of the country. Almost one-third of the population and 43% of the country's health infrastructure were impacted. Within hours of the earthquake, CARE mounted a rapid emergency response to provide life-saving services to people in three of the worst affected districts of Nepal: Gorkha, Sindhupalchowk, and Dhading.

CARE partnered with UNFPA to implement the MISP in these intervention districts. CARE planned and coordinated its response through the Reproductive Health sub-cluster and the Association of International NGOs in Nepal (AIN).

CARE worked with government authorities, local NGOs and Female Community Health Workers to deliver community-based SRH services, including family planning, through mobile camps in 20 locations in two districts. In addition, CARE distributed essential medicines, supplies and equipment to health facilities to ensure the delivery of MISP services. CARE's emergency response ensured that women had full access to a wide range of modern contraceptive methods by supporting the delivery of short- and long-acting reversible contraceptive (LARC) methods to the affected population through mobile reproductive health camps and static primary health facilities. The response in these three crisis locations strengthened the health system beyond pre-crisis standards, leaving the communities better served and more resilient as a result of the response.

Scaling up family planning in protracted crisis through local leadership

NORTH KIVU, DRC

In 2016, CARE, in collaboration with local peer leaders, led a combination of outreach activities and satellite clinics to provide adolescents with needed services, including contraception. With the help of peer leaders, CARE worked to generate demand, provide services in a satellite clinic strategically located outside of the camp for patient privacy, and provide follow-up with referrals to nearby government health centres when needed.

The project engaged peer leaders in developing, implementing, and monitoring activities. Peer leaders reviewed baseline assessment data, implemented CARE's social accountability tool and designed and implemented the Community Scorecard – a tool that enables youth to define what adolescent and youth friendly services mean to them. Peer leaders are now able to monitor and track this data along with providers, providing them with a platform to negotiate access to family planning and contributing to their overall wellbeing. Uptake of LARCs is higher among adolescents than all other family planning user groups in health facilities, with 64% of adolescents choosing a LARC method. Given the protracted nature of this crisis, the early investments in well-designed programmes will improve the quality and long-term uptake of family planning in this context.

Strengthening health systems, for family planning service delivery, in chronic instability

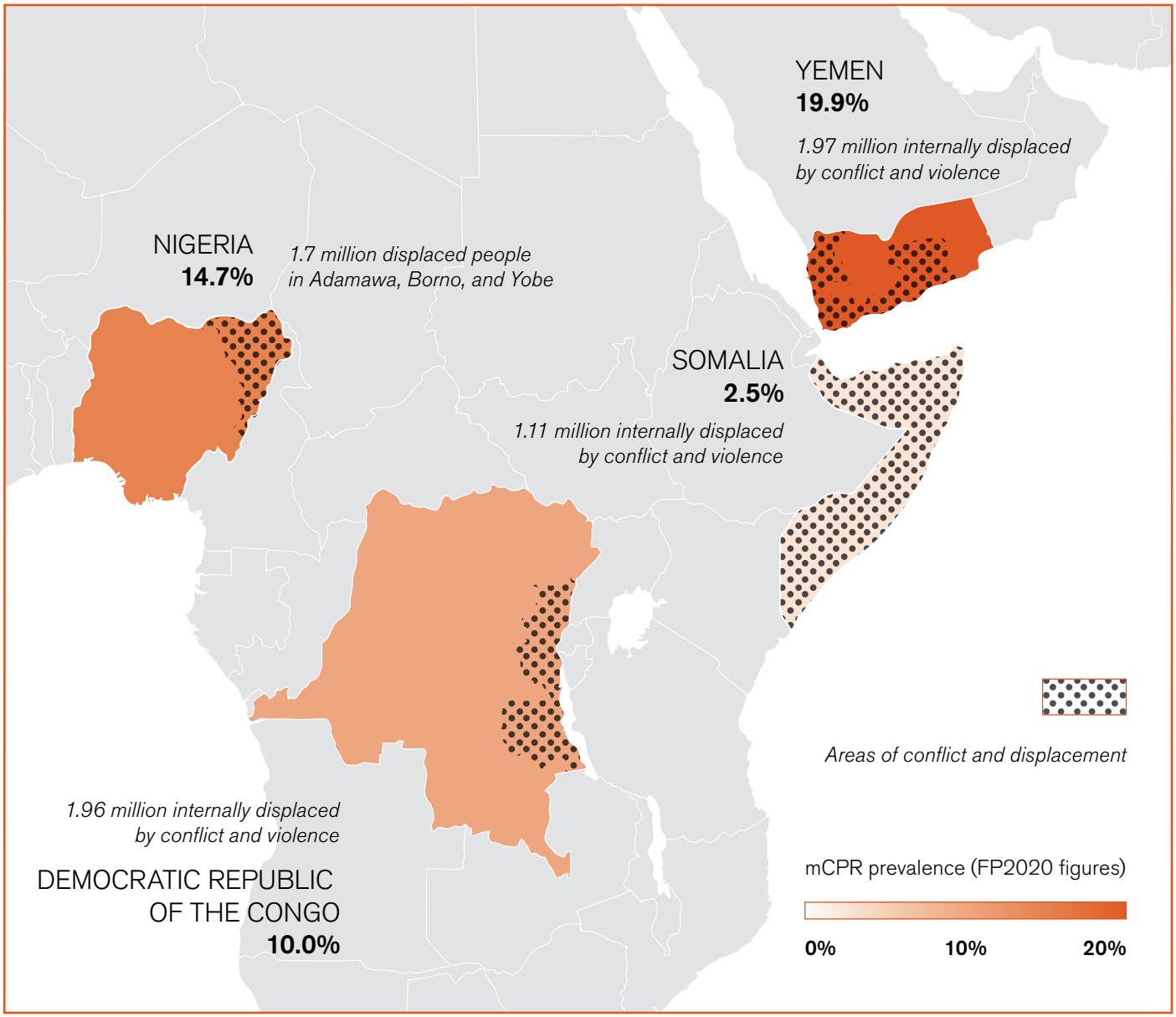
YEMEN

Continued armed conflict, population displacement, and a rise in infectious diseases has eroded the already fragile health care system in Yemen, where 10.3 million people are in acute need of humanitarian assistance.[12] Save the Children, in partnership with the Ministry of Health, is providing family planning services as part of its emergency health response strategy in the governorates Hodeida and Lahj. Save is currently supporting 16 health facilities, including four hospitals and 12 health centres.

Since 2013, these 16 health facilities, which serve 507,000 people, have provided family planning services to 37,347 new acceptors (first time to the facility and/ or method); 21% have accepted LARCs. The programme provides competency-based training and follow-up support for trainees. By April 2017, 60 health care workers had received competency-based clinical training, including family planning counselling and provision of short-acting and LARCs. In this context, the humanitarian response is meeting both immediate needs due to instability and long term health system and capacity needs of the country overall.

BELOW: A displaced girl in Atmeh camp, Syria *Peter Biro/IRC*

National mCPR in countries with significant new displacements by conflict and violence in 2016[13]



OPPOSITE: In the Kibondo District in Tanzania's northwestern border, more women are participating in the International Rescue Committee's programme to avert the spread of HIV from mothers to their young children.

In the photograph, the clinic staff member is checking the foetal heartbeat using a Pinard horn, a specialist type of stethoscope. It is a low-tech but highly effective piece of medical equipment and remains in common use for this purpose throughout the world.

Tanzania is a stable state in a troubled region, sharing borders with the DRC, Burundi and Rwanda, among others. Tanzania is host to a growing refugee population, totalling 281,000 at the end of 2016 – 82% from Burundi, 18% from the DRC. However, refugees are subject to a restrictive encampment policy, whereby most are required to stay in "designated areas" – a legal euphemism for the camps in the border regions, far from Dar es Salaam and any hope of economic independence.

Eliza Gregory/IRC

Providing family planning services in humanitarian settings supports efforts to build back better.

Humanitarian crises can provide a critical window of access to family planning, resources, and education for women and girls.[14] This early investment also pays dividends in the long run and contributes to better outcomes for recovery, reductions in health care expenditures, and resilience in the event of future shocks. Hussein, et al (2016) stressed that "strong family planning programmes that move countries toward the demographic transition can help people to adapt to, prevent, and recover more quickly from shocks and stressWWes in a manner that reduces chronic vulnerability and also facilitates inclusive growth." It is also widely accepted that family planning, leads to multiple health, economic and educational benefits for women, households and communities – contributing directly to resilience."[15]

Moreover, family planning is an investment multiplier. In Sub-Saharan Africa, every additional dollar spent on contraception reduces the cost of pregnancy-related care by $1.52.[16] Meeting the need for maternal and newborn care would cost $35.8 billion annually at current levels of contraceptive use. However, fully satisfying the need for modern contraception would lower this cost to $28 billion.

What can we do better?

Recommendations to deliver family planning to women and girls affected by crises

Countries agree to act

1 **Countries adopt FP2020 commitments and Costed Implementation Plans that advance FP and development goals by expanding FP to those who are hardest to reach, including the millions of women and girls affected by crises.** Many countries affected by crisis at the national or sub-national level continue to have low contraceptive prevalence rates, along with high maternal and infant mortality rates. Delivering family planning services to women and girls in these settings is critical to meeting national FP2020 commitments and the Sustainable Development Goals.

2 **Countries strengthen national and sub-national resilience by incorporating reproductive health – including the Minimum Initial Service Package (MISP) for Reproductive Health – into disaster preparedness and response plans.** Timely and effective provision of the MISP, inclusive of family planning, saves lives during an emergency. MISP implementation is facilitated by preparedness and response planning at the national and local level. Supporting SRH as part of resilience-building efforts is in line with the Sendai Framework for Disaster Risk Reduction, endorsed by the UN General Assembly in 2015.

3 **Countries seize opportunities to build back better from crises by investing in improved health infrastructure that reaches women and girls in crisis-prone areas with FP services.** There is significant value to "building back better" across recovery, rehabilitation and reconstruction. Ensuring that SRH, inclusive of FP, is part of infrastructure and health system investments across these phases will provide long-term benefits, especially for those affected by chronic crises.

BELOW: In Yemen in 2012, a mother and her young daughter in the doorway of the classroom where they have been living for the past year. The mother is now eight months pregnant with her second child. The Community Health Supervisor informed her that she can now visit the reproductive health ward for free, six days a week, and that there are now midwives on staff 24/7 to help with her delivery.

Rebecca Blum/IRC

Implementing agencies agree to act

1 **Implementing agencies deliver the MISP, inclusive of family planning, at the onset of new emergencies, and transition to comprehensive reproductive health services as the situation stabilises.** The MISP, including family planning, should be implemented within the first 48 hours and is the established standard of care for up to six months following an emergency. Organisations should then transition to comprehensive SRH services as soon as the situation allows. Failure to provide family planning at the earliest opportunity, and throughout all stages of a crisis, will result in unplanned pregnancies and lead to higher maternal and newborn mortality.

2 **Implementing agencies include family planning in their funding proposals for emergency preparedness, response, and recovery.** Despite documented demand for FP across diverse crisis settings and proven feasibility of service provision, funding appeals for humanitarian aid routinely omit FP. To meet the needs of women and girls affected by crises, FP must be included explicitly in preparedness, response and recovery proposals.

3 **FP stakeholders (including FP2020 and UN agencies) agree on key indicators and reporting mechanisms to measure need, progress, and investments in FP services for women and girls affected by crises.** Inconsistent data collection from crisis-affected settings significantly hinders accurate assessment of need and measurement of progress toward FP commitments at national and sub-national levels. Stakeholders must establish and monitor shared indicators, and develop a financial tracking tool measuring FP investments in crises to improve transparency and accountability.

ABOVE: A displaced girl in Atmeh camp, Syria *Peter Biro/IRC*

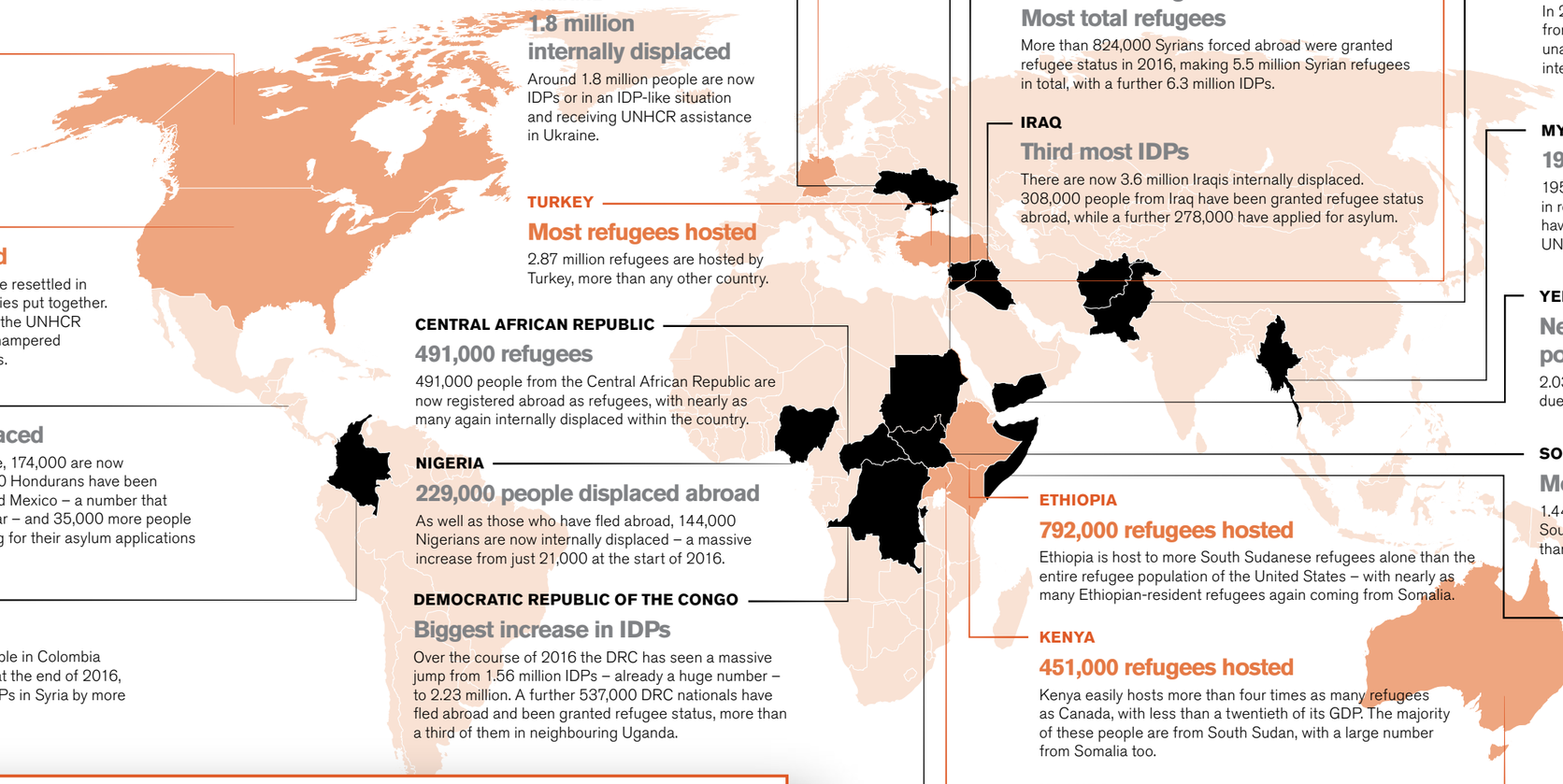
Donors agree to act

1 **Multilateral and bilateral donors commit to investing in family planning, as part of the life-saving package of interventions outlined in the MISP, in all humanitarian response efforts.** The prevention of unintended pregnancies is one of six objectives of the MISP, and requires the delivery of contraceptives to meet demand. MISP implementation, inclusive of family planning, prevents excess maternal morbidity and mortality in crises.

2 **Donors invest in emergency preparedness and resilient health systems that support provision of SRH, including family planning, across *all* settings.** Strong health systems are better equipped to meet health needs during crises and withstand crises. Including family planning in preparedness and resilience-building efforts is critical to ensuring that FP services and supplies are not interrupted during emergencies.

3 **Global funding mechanisms are adapted to facilitate efficient access to SRH funding during humanitarian response and recovery.** Key funding mechanisms, including the Global Financing Facility, World Bank IDA18, the Pandemic Emergency Fund (PEF), and the Global Fund for Disaster Risk Reduction, must include FP in their proposal review criteria and/or require high-risk countries to include FP in their investment cases.

Forced displacement in 2016[17]



CANADA
Nearly 47,000 refugees resettled

Exceeded only by the US, nearly 25% of all refugees resettled in 2016 were taken in by Canada.

UNITED STATES
Most refugees resettled

In 2016 nearly 97,000 refugees were resettled in the US, more than in all other countries put together. However, continuing participation in the UNHCR resettlement programme has been hampered by the current US executive's actions.

HONDURAS
174,000 internally displaced

In a country of just 8.7 million people, 174,000 are now internally displaced. A further 10,000 Hondurans have been granted refugee status in the US and Mexico – a number that has nearly doubled over the past year – and 35,000 more people have fled the country and are waiting for their asylum applications to be processed.

COLOMBIA
Most IDPs

7.41 milllion internally displaced people in Colombia were receiving UNHCR assistance at the end of 2016, a figure exceeding the number of IDPs in Syria by more than 1 million people.

GERMANY
Most asylum applications

Germany received 722,000 applications in 2016, almost four times as many as the US and more than a 60% increase on last year.

UKRAINE
1.8 million internally displaced

Around 1.8 million people are now IDPs or in an IDP-like situation and receiving UNHCR assistance in Ukraine.

TURKEY
Most refugees hosted

2.87 million refugees are hosted by Turkey, more than any other country.

CENTRAL AFRICAN REPUBLIC
491,000 refugees

491,000 people from the Central African Republic are now registered abroad as refugees, with nearly as many again internally displaced within the country.

NIGERIA
229,000 people displaced abroad

As well as those who have fled abroad, 144,000 Nigerians are now internally displaced – a massive increase from just 21,000 at the start of 2016.

DEMOCRATIC REPUBLIC OF THE CONGO
Biggest increase in IDPs

Over the course of 2016 the DRC has seen a massive jump from 1.56 million IDPs – already a huge number – to 2.23 million. A further 537,000 DRC nationals have fled abroad and been granted refugee status, more than a third of them in neighbouring Uganda.

SUDAN
2.23 million IDPs

Although the total number of IDPs in Sudan has fallen by more than 1 million over 2016, 2.23 million people remain internally displaced. 646,000 Sudanese refugees have fled to neighbouring countries.

SYRIA
Most new refugees
Most total refugees

More than 824,000 Syrians forced abroad were granted refugee status in 2016, making 5.5 million Syrian refugees in total, with a further 6.3 million IDPs.

IRAQ
Third most IDPs

There are now 3.6 million Iraqis internally displaced. 308,000 people from Iraq have been granted refugee status abroad, while a further 278,000 have applied for asylum.

ETHIOPIA
792,000 refugees hosted

Ethiopia is host to more South Sudanese refugees alone than the entire refugee population of the United States – with nearly as many Ethiopian-resident refugees again coming from Somalia.

KENYA
451,000 refugees hosted

Kenya easily hosts more than four times as many refugees as Canada, with less than a twentieth of its GDP. The majority of these people are from South Sudan, with a large number from Somalia too.

UGANDA
Third highest number of refugees hosted

Sharing borders with both South Sudan and the DRC, and with Burundi nearby, Uganda now has the third highest refugee population in the world in absolute terms – 941,000 people at the end of 2016.

BURUNDI
122,000 new refugees

122,000 new refugees were forced from their homes in Burundi in 2016, making a total of 408,000 Burundian refugees. A further 141,000 Burundians were internally displaced at the end of 2016.

LEBANON
Most refugees per capita

Lebanon has in excess of 169 refugees for every 1,000 inhabitants. These figures do not include the 450,000 Palestinian refugees in Lebanon.

PAKISTAN–AFGHANISTAN
Largest repatriation of refugees

In 2016, 381,300 refugees voluntarily returned to Afghanistan from Pakistan. However, 2.49 million Afghan refugees are still unable to return home and a further 1.78 million people are internally displaced within Afghanistan itself.

MYANMAR
195,000 refugees

195,000 Myanmarese are now refugees, with a further 295,000 in refugee-like situations. On top of this, a further 375,000 people have been internally displaced within the country and are receiving UNHCR assistance.

YEMEN
Nearly one tenth of the population displaced

2.03 million people are now internally displaced in Yemen due to the ongoing war.

SOUTH SUDAN
Most refugees hosted by GDP

1.44 million UNHCR-registered refugees worldwide are of South Sudanese nationality, yet South Sudan itself hosts more than 90 refugees for every USD 1 million of its GDP.

SOMALIA
1 million refugees

More than 1 million Somalis have now sought refuge abroad and are registered as refugees, while a further 1.56 million people are internally displaced within Somalia's borders.

AUSTRALIA
Nearly 28,000 refugees resettled

With only the US and Canada taking in more, Australia admitted nearly 28,000 refugees for resettlement in 2016, easily surpassing the combined total for all other countries participating in the resettlement programme.

TOP 15 COUNTRIES OF ORIGIN FOR PEOPLE OF CONCERN

Shaded black on the map, the top 15 countries of origin for people of concern to the UNHCR, including refugees, IDPs and others in similar situations, are:

1	Syria	*12.6 m*	6	Democratic Republic of the Congo	*3.5 m*	11	Ukraine	*2.1 m*
2	Colombia	*7.7 m*	7	Nigeria	*3.2 m*	12	Pakistan	*1.3 m*
3	Iraq	*5.6 m*	8	Yemen	*3.0 m*	13	Central African Republic	*1.0 m*
4	Afghanistan	*5.2 m*	9	Sudan	*3.0 m*	14	Myanmar	*0.9 m*
5	South Sudan	*4.0 m*	10	Somalia	*2.7 m*	15	Burundi	*0.7 m*

Together, the population of concern originating from these 15 countries is 56.6 million people, 84% of the global total.

Key terms and definitions

Humanitarian setting

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

Fragile state

States that lack the capacity and/or the will to deliver core state functions for the majority its people, including the poorest. The most important functions of the state for poverty reduction are territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people sustain themselves.

MISP: the Minimum Initial Service Package (MISP) for reproductive health in crises

This is a set of priority activities to be implemented at the onset of an emergency. The MISP defines which reproductive health services are most important in preventing morbidity and mortality, particularly among women and girls, in humanitarian settings.

Response standards by WHS

- Roll out the Minimum Initial Service Package (MISP) within 48 hours of an emergency, implementing comprehensive sexual and reproductive health services as soon as possible after an emergency.
- Invest in sexual and reproductive health services and supplies, as part of an essential health package in emergencies and implementation.

Build back better

The idea that post-conflict or post-disaster reconstruction should be designed to ensure that communities are rebuilt in a way that promotes community resilience, i.e. investing to provide communities with the supports (services, infrastructure, etc.) needed to build a strong foundation for the future.

Family planning, contraception, contraceptives

Family planning is the broad term often used to describe services that allow people to attain their desired number of children and determine the spacing of pregnancies. Family planning is achieved through use of contraceptive methods and the treatment of infertility. Contraception is the use of a contraceptive method to prevent pregnancies. Contraceptives include both short and long-acting methods, such as implants, injectables, and IUDs, and traditional methods.

Using family planning as a blanket term for contraception can obscure other important reasons why women and girls need access to birth control. Sexually active women and girls may not be necessarily concerned about planning a family, but still do not want to get pregnant. Other women use contraception for medical benefits unrelated to preventing pregnancy or birth spacing.

Couple Years Protection

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

Costed Implementation Plan

A multi-year actionable roadmap designed to help governments achieve their family planning goals—goals that when achieved will save millions of lives and improve the health and wellbeing of women, families and communities. CIPs are a critical tool in transforming ambitious family planning commitments—such as those made through Family Planning 2020 and the Ouagadougou Partnership—into concrete programmes and policies.

Prepositioned stocks

A logistical technique where organisations hold critical material at predetermined strategic locations. This ultimately reduces the time taken to respond to emergencies, reduces costs.

Notes

1 United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "Global Humanitarian Overview 2017," (2016). Available at: *http://docs.unocha.org/sites/dms/Documents/GHO_2017.pdf*

2 United Nations Population Fund (UNFPA), "The State of World Population 2015: Shelter from the Storm," (2015). Available at: *http://www.unfpa.org/swop-2015*

3 Family Planning 2020, "About Us: What We Do," (2017). Available at: *http://www.familyplanning2020.org/microsite/about-us*

4 FP2020, "FP2020: Momentum at the Midpoint – 2015-2016 Progress Report," (2016). Available at: *http://progress.familyplanning2020.org/*

5 FP2020,"Ouagadougou Partnership surpasses goal of one million new contraceptive users". Available at: *http://www.familyplanning2020.org/articles/12132*

6 FP2020, "FP2020: Momentum at the Midpoint – 2015-2016 Progress Report," (2016). Available at: *http://progress.familyplanning2020.org/;* United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "Global Humanitarian Overview 2017," (2016). Available at: *http://docs.unocha.org/sites/dms/Documents/GHO_2017.pdf*

7 Ibid.

8 WHO, "Maternal Mortality," (2016). Available at: *http://www.who.int/mediacentre/factsheets/fs348/en/*

9 Ahmed et al., "Maternal deaths averted by contraceptive use: an analysis of 172 countries," Lancet (2012) 380: 111-125.

10 Singh S, Darroch JE and Ashford LS, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health—2014, New York: Guttmacher Institute, 2014.

11 USAID Division of Family Planning, "Healthy timing and spacing of pregnancies: a family planning investment strategy for accelerating the pace of improvements in child survival," (2012). Available at: *http://www.usaid.gov/sites/default/files/documents/1864/calltoaction.pdf*

12 UN OCHA, "Yemen Humanitarian Bulletin Issue 23:9," (May 2017). Available at: *http://www.unocha.org/yemen*

13 mCPR figures from FP2020, "FP2020: Momentum at the Midpoint – 2015-2016 Progress Report," (2016) *http://progress.familyplanning2020.org/*

Nigeria displacement figures from OCHA: *http://reliefweb.int/sites/reliefweb.int/files/resources/23052017_ocha_nga_humanitarian_dashboard_april_2017.pdf*

Somalia and Yemen displacement figures from IDMC: *http://www.internal-displacement.org/global-report/grid2017/*

Yemen conflict/displacement areas inferred from: *http://reliefweb.int/sites/reliefweb.int/files/resources/a3_yemen_cmwg_en_22022017_0.pdf*

DRC displacement figures from UNHCR: *http://reliefweb.int/sites/reliefweb.int/files/resources/20161231_DRC_Statistics_Map_3W_A3P_PI.pdf*

14 Casey et al., "Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies," Conflict and Health (2015) 9: S3.

15 Husain et al., "Fostering Economic Growth, Equity, and Resilience in Sub-Saharan Africa: The Role of Family Planning," Population Reference Bureau, (2016). Available at: *http://www.prb.org/Publications/Reports/2016/economic-growth-equity-ishrat.aspx*

16 Guttmacher Institute and UNFPA, "Investing in Sexual and Reproductive Health in Sub-Saharan Africa," (December 2014). Available at: *https://www.unfpa.org/sites/default/files/resource-pdf/383%20AIU3%20Regional_SSA_ENG%2011.19.14%20FINAL_0.pdf*

17 Except for the sources stated below, all figures drawn from or calculated on the basis of the annex tables of UNHCR, "Global Trends: Forced Displacement in 2016." (June 2017). Report available at: *http://www.unhcr.org/uk/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html*

Annex data available as Excel files from: *http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocAttachment.zip?COMID=595a52614*

2016 GDP figures for Kenya and Canada from the International Monetary Fund, World Economic Outlook Database: *http://data.imf.org*

2015 German refugee application numbers from UNHCR: *http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocAttachment.zip?COMID=576402377*

July 2016 Honduras official population estimate from: *http://www.ine.gob.hn/images/Productos%20ine/censo/Censo%202013/Proyecciones/Proyecciones%20Ine%202016.xlsx*

BACK COVER: Lillian Dawa, age 24, at the women's centre where she works in the Bidibidi refugee settlement in northern Uganda. As of March 3, 2017, the site houses over 270,000 South Sudanese refugees. *Adriane Ohanesian/IRC*

IAWG

INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

INTERNATIONAL RESCUE COMMITTEE

WOMEN'S REFUGEE COMMISSION
Research. Rethink. Resolve.

care®

Save the Children