THE STATE OF ACCESS TO CONTRACEPTIVE OPTIONS IN FRAGILE SETTINGS: A FOCUS ON SUB-SAHARAN AFRICA.

LITERATURE REVIEW.

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THE STATE OF ACCESS TO CONTRACEPTIVE OPTIONS IN FRAGILE SETTINGS: A FOCUS ON SUB-SAHARAN AFRICA.

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

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Declaration:

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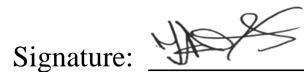
Signature: 

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ABREVIATIONS

AIDS .... Acquired immune deficiency syndrome

CHW .... Community health workers

DMPA-SC .... Depot-medroxyprogesterone acetate subcutaneous

DMPA-IM .... Depot-medroxyprogesterone acetate intramuscular

DRR .... Disaster risk reduction

GBV... Gender based violence

HIV.. Human immune deficiency syndrome

HIP... High impact practices

IAWG .... International agency working group

ICDP .... International conference on

population and development

ICRC... International committee of the red cross

IDP.. Internally displaced persons

IOM... International organization for migration

IPC.. Inter- personal communication

LARC .... Long-acting reversible contraceptives

LGBTI .... Lesbians, gays, bisexuals,

transgender, and intersex

LMIC .... Low- and Middle-income countries

MISP .... Minimal Initial Service Package

PTSD .... post-traumatic stress disorders

SEA .... Sexual exploitation and abuse

SRH .... Sexual and reproductive health

SRHR .... Sexual and reproductive health and

rights

SRC .... Swiss Red Cross

SSA .... Sub - Saharan Africa

STI .... Sexually transmitted infection

UNHCR .... United nations high commission for Refugees

UNFPA .... United Nations Population Fund

WHO .... World health organization

WRC .... Women refugee council

WASH .... Water, sanitation and hygiene

YCBDA .... Youth Community-Based Distribution Agents

THE STATE OF ACCESS TO CONTRACEPTIVE OPTIONS IN FRAGILE SETTINGS: A FOCUS ON SUB-SAHARAN AFRICA.

ABSTRACT

Introduction: Globally, an estimated 225 million women including adolescent girls of reproductive age 15 – 49 years have unmet need for modern contraceptives. This need is increased in fragile setting; a common phenomenon in SSA (sub-Saharan Africa). A review of MISP implementation for the last decade highlighted some barriers to access like; poor community involvement, reduced access to long-acting contraceptives, lack of awareness and accessibility to contraceptive services and little documentation on the progress in service delivery in humanitarian settings. This systematized literature review attempt to identify and discuss the barriers and enablers to accessing contraceptive options by women and girls of reproductive age 15 – 49 years in fragile settings in SSA and document progress made in service delivery.

Methodology: Databases such as Medline and PubMed and search engines like Google scholar was used for the literature search with Snow-balling technics. Networking platforms like Academia including Journal sites like the Lancet, PLOs, BMJ, Guttmacher publications and some grey literature where utilized.

Results and Discussion: This review demonstrated levels of success in contraceptive services program implementation across different contexts of fragile settings in SSA. Though degrees of preparedness were shown to translate to better program implementation but has not always translated to improvement in the utilization of contraceptive services. Various barriers and enablers were identified and discussed. Analysis showed various contraceptive services delivery strategies existing in different contexts aimed at solving some observed barriers with varying levels of success. Promising strategies where also identified and discussed with recommendations on the way forward.

Key words: contraception, access, “fragile OR humanitarian settings”, “sub-Saharan Africa”, barriers, enablers and humanitarian response

Chapter 1: INTRODUCTION

States of fragility are a common phenomenon in sub – Saharan Africa with a steady and alarming increase in both the frequency, magnitude, and duration in the past decade. Though there are various definition of fragile settings, fragile settings are defined here as hard to reach areas either due to conflicts, disasters, or other protean causes of difficulty in access, in other words, settings of humanitarian emergencies resulting in internal displacement or refugee status[1].

The health systems of most fragile states are already weak prior to crisis or disaster[2]. Generally, in crisis and natural disasters, there are various health impacts like mental effects such as post-traumatic stress disorders(PTSD)[3], physical effects on Children such as separation from parents and child trafficking and high children and infant mortality[4] as well as effects on SRH such as gender based violence(GBV)[5][6],HIV/AIDS due to rape and sexual exploitation and abuse (SEA)[7][8], human trafficking and prostitution in post-conflict settings[9][10]. There is also a sudden change in the societal and family structures with a sudden stop in educational and social services. In the absence of the protective social systems, adolescents usually become sexually active especially the girls who are susceptible to SAE[11].

Though crisis affects all people including the men and boys, women and girls disproportionately suffer from preventable illnesses and death. They experience more gender-based violence, and face more difficulties accessing basic health services, such as obstetric care and contraceptive services. For instance, during the West African Ebola epidemic, there was a sharp rise in maternal mortality between 2013 and 2015. This was also true for the HIV epidemic with high rates soaring among young women in sub-Saharan Africa(SSA)[12]. There is also an increased need for contraceptives amongst these displaced women and girls. Studies of three crisis-affected countries in Africa showed that 30 to 40% of women desired to delay childbearing for two years. Also between 12% and 35% did not want more children[13][14][15].

Contraception is defined as preventing conception intentionally using different devices, sexual practices, chemicals, drugs, or surgical procedures. In other words, any device or act aimed at preventing a woman from becoming pregnant can be considered as a contraceptive[16]. Conversely, family planning helps people to achieve desired family size and helps space the pregnancies. This is done by using contraceptive methods and the treating infertility[17].

Evidences show that contraception empowers women thereby reducing poverty and generally improves health. A high-quality contraception program therefore will increase the decline of fertility. This improves health and boost the economy. Indeed, contraception is one of the most efficient health and development investments options governments have[18].This underscores the important need for access to contraception in humanitarian settings.

The researcher is a program implementation manager in humanitarian settings in SSA thus the focus in SSA. This is also informed by the high number of fragile states in the SSA region and the increasing number and protraction of humanitarian crisis globally[19]. The analysis of the state of contraceptive services delivery programs in fragile settings in SSA is an attempt at unpacking the various contraceptive services program implementation strategies in humanitarian settings in SSA.

In this study, the various barriers and enablers to access to contraceptives are analyzed in the context of the needs of these women and girls. This is done considering the different phases and contexts of crisis. Various contraceptive implementation strategies that has evolved so far to overcome these obstacles are analyzed and promising strategies examined to make recommendations for best practices.

Chapter 2: BACKGROUND

There is a steady upward trend in the number of those affected by crisis leading to forced displacements and migrations. The number of crises being led by international responses has increased almost twofold, from 16 to 30, between 2005 and 2017. This increase is both in frequency and durations leading to more prolonged displacements and complexity[20].Within the past two decades, there was a 75% rise of forced displacements from 37.3 million(1996) to 65.3 million(2015). Man-made disasters like conflicts and natural disasters now go hand in hand according to the global humanitarian overview 2020[21]. Though most of these displacements are due to persecutions, conflicts, and generalized violence with human rights violations, by 2015, the number of new displacements attributable to natural disasters in 113 Countries was 19.2 million[22].

Fragile settings are a common phenomenon in sub – Saharan Africa with a steady and alarming increase both in the frequency, magnitude, and duration of humanitarian crises and emergencies in the past decade. According to a UNFPA report in 2018, the armed conflict in South Sudan has created over 3.10 million refugees, consisting of 79,050 pregnant women, 1.01 million youths, and 775,000 women of reproductive age. Also, in the DRC with a population of 77.3 million, worsening humanitarian crisis, created 12.80 million refugees, with 3.20 million women of reproductive age, 4.02 million young people, and about 422,400 pregnant women[13][14].

Similar data are reported in Ethiopia which saw recent increases in internally displaced people with a total of 13.00 million people in need. These include 3.25 million Women of reproductive age, 331,500 pregnant women and 4.49 million young people[15]. Uganda also, a Country with a total population of 39 million, has 1 million displaced people from South Sudan, of which 84% are women and children. There is also an additional 300,000 forcefully displaced people from the Democratic Republic of the Congo(DRC) and Burundi[23].

An important part of the universal right to health is the right to the reproductive and sexual health of which access to modern contraceptive options is a part[22]. Unfortunately, the most overlooked and disproportionately affected group within conflicts and other forms of natural disasters that leads to forced displacements are the adolescent girls and women whose sexual and reproductive health(SRH) needs are not given the desired attention[24][22].

However, there has also been an upwards trend, a greater awareness and mainstreaming of SRH in humanitarian responses since the International conference on population and development(ICDP) held in 1994 at Cairo. At the ICPD the attention of the stakeholders was drawn to the negative consequences of crisis such as: unwanted pregnancies, high maternal and neonatal mortality, Unsafe abortions and increased incidence of Sexually Transmitted Infections(STIs) and HIV/AIDS[25].

The unmet contraceptive needs of women of reproductive age are increased in fragile/humanitarian settings. In these settings, often women and girls are most affected and suffer greater consequences than the men and boys[26]. They, however, face a lot of challenges accessing these needed contraceptive services. The challenges of lack of access to contraception is in varied forms such as lack of information, finance and non-availability of service and products[27]. There is also the challenge of lack of funding for contraceptive services compared to other reproductive health packages. Even the available funds are not being utilized efficiently or effectively[28][29].

Chapter 3: Problem Statement and Justification

Globally, an estimated 225 million women of reproductive age 15 – 49 years including adolescent girls have a high unmet need for modern contraceptives[30][27]. In Africa, four in every ten women of reproductive age want to prevent pregnancy totaling about 125 million women, 47%(about 58 million women) are either not using any form of contraception at all or are depending on traditional methods[31].

Furthermore, women with unmet contraceptive needs accounted for about 84% of all cases of unintended pregnancies in developing countries by 2017 and the majority of these countries are in SSA[32].

The unmet contraceptive needs of women of reproductive age are increased in fragile/humanitarian settings where they are more affected and suffer greater consequences than the men and boys[26]. Women and girls, in particular, are more susceptible due to the very frequent phenomenon of sexual and gender-based violence especially rape and transactional sex for food [34][35][33]. Reasons consistently cited for these unmet needs hindering the utilization, as well as quality of services include ability to pay and distance to services[36][37][38].

The consequence of these displacements due to crisis is a rise in the number of vulnerable women and girls and thus an increased need for contraceptives. Women in crisis settings desire to postpone or reduce pregnancy. A study of three countries affected by conflicts in Africa showed that between 30 and 40% of women wanted to postpone bearing children for at least two years also between 12% and 35% did not want any more children[39].

Women's increased unmet contraceptive needs are further complicated in these fragile settings in SSA by the adverse SRH consequences. These include unwanted pregnancies, increased rates of unsafe abortions, maternal mortality and morbidity, STIs, and increased incidence of HIV[20] [21]. Globally, about 60% of all maternal deaths occur in crisis situations, like refugee camps, or in fragile conditions[40]. The latest United Nations Population Fund(UNFPA) humanitarian report highlighted that all 10 countries with the highest maternal mortality ratios globally are affected by or emerging from war[41][40]. Also, more than 500 women and girls in crisis settings die daily during pregnancy and childbirth as a distal consequence of unmet contraceptive needs[40].

The international conference on population and development (ICPD) at Cairo in 1994, led to the formation of the International agency working group (IAWG) on reproductive health. Subsequently, the Minimal Initial Service Package (MISP) for Reproductive health in crises of which contraceptive services is a part was developed[42]. Implementing the MISP, various humanitarian organizations and workers have made some progress in addressing contraceptive challenges in humanitarian settings[43]. Unfortunately, when crisis occurs, a huge number of women and girls of reproductive age still do not have access to the contraceptive services[43][44].

A review of the progress for the last decade of 2004 – 2013 on the implementation of MISP highlighted some barriers to access by adolescent girls to reproductive health services. This include, poor community involvement in reproductive health care delivery, and challenges in increasing access to long-acting contraceptive services in humanitarian settings[45]. A joint multi-country assessment was

also conducted by the United Nations High Commission on Refugees (UNHCR) and women's refugees' commission (WRC). The findings show that there is evidence of increasing awareness of and desire to use modern contraceptives amongst women of reproductive age. This desire to use modern contraceptive services is even higher in fragile settings[46].

Barriers identified include lack of awareness and accessibility to contraceptive services especially more amongst the adolescent age groups15 – 19 years[46]. There is also little documentation to date of the progress in service delivery in humanitarian settings and lack of programs that has effectively integrated Sexual and Reproductive Health(SRH) services including contraceptive services in humanitarian settings.[47] [46].

This study is intended to fill the gap of documenting the state of contraception in humanitarian settings especially in SSA[48]. The barriers and enablers to accessing contraceptive services in fragile settings in Sub-Saharan Africa will also be identified. Programs that has so far effectively integrated contraceptive services with other SRH services will also be analysed[49].

Though the researcher is aware that states of fragility and crisis are not limited to SSA, recent study reports have highlighted a greater percentage of states of fragility in SSA. In fact, most of the ten most under-reported humanitarian emergencies are all in sub - Saharan Africa (see figure below), thus, the need for more insight into the context.

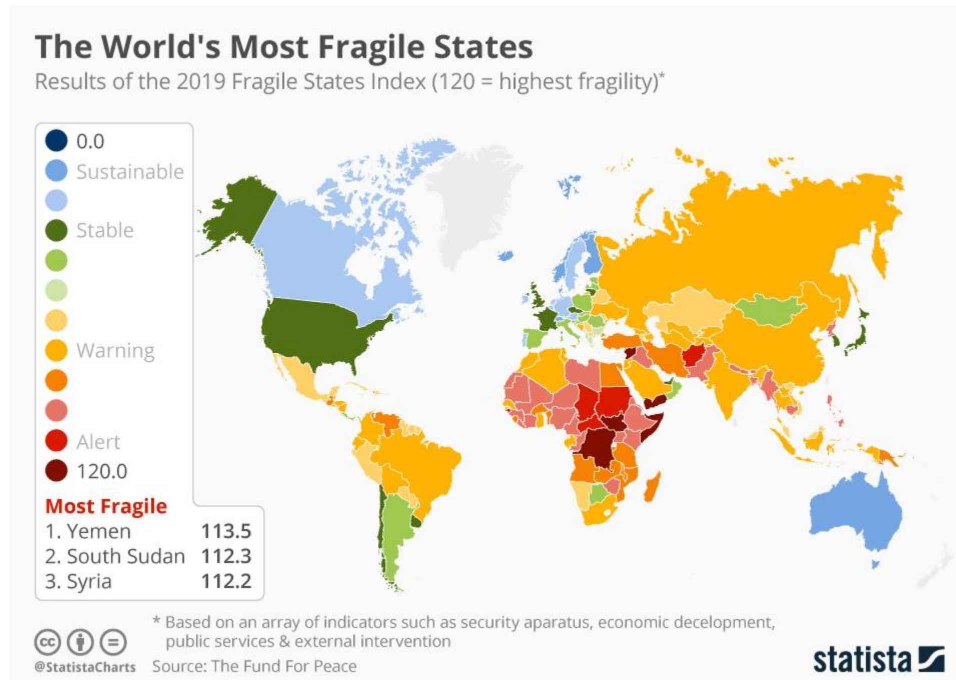

Figure 1: Result of 2019 fragile states index (source: Statistica - free access)

Section 3.1: Objectives

SECTION 3.1A: MAIN OBJECTIVE: To identify and discuss the barriers and enablers to accessing contraceptive options by women of reproductive age 15 – 49 years in fragile settings in sub - Saharan Africa in order to advise on appropriate program implementation strategies to stakeholders working in humanitarian settings.

SECTION 3.1B: SUB OBJECTIVES:

1. To describe the contexts of women's and girls' needs for contraceptives in fragile settings in Sub – Saharan Africa.
2. To analyse the factors influencing access to contraceptive services for women and girls age 15 – 49 years in fragile settings in Sub – Saharan Africa.
3. To review the pros and cons of existing contraceptive service delivery strategies in fragile settings in Sub – Saharan Africa and analyse promising strategies that expand women's and girls' access to these services in fragile settings in Sub – Saharan Africa
4. To recommend best practices in expanding women and girls’ access to contraceptive services in fragile settings in Sub – Saharan Africa to stakeholders working in humanitarian settings.

Chapter 4: Methodology

The methodology of this study will be a systematized literature review utilizing identified relevant literature that will be screened for eligibility according to set inclusion and exclusion criteria using the Prisma flow- diagram as a guide.

Findings from the included literature will be synthesized, themes labelled, and associations analysed using NVivo 12 and interpreted manually. It is important to state at this point that this is not a systematic literature review. This guide is only being utilized to help in doing an effective and exhaustive literature review. It is an attempt at contributing to the dearth in the documentation of implementation information of contraceptive service deliveries in humanitarian settings especially in SSA.

Section 4.1: SEARCH STRATEGY

Literature search was done using keywords "contraception AND access AND fragile OR humanitarian settings AND sub-Saharan Africa", "Safe access AND humanitarian response", "Strategy AND planning AND humanitarian response" details of search keywords and Boolean operators utilized can be found in the table attached in the annex.

Section 4.2: CONCEPTUAL FRAMEWORK

For this review, the conceptual framework the author will use is an adaptation from the HIP family planning in humanitarian settings framework. The Adaptations include contextualization of the setting to the different stages of humanitarian crisis, elements put into consideration are the strategic planning framework for family planning in humanitarian settings as outlined in the family planning high impact practices(HIP) journal[50] with modifications to accommodate the access to contraceptive services in the different contexts of crisis. In other words, response and their outcomes in Contraceptive services provision will depend on the stage of the crisis and the safety of the service providers.

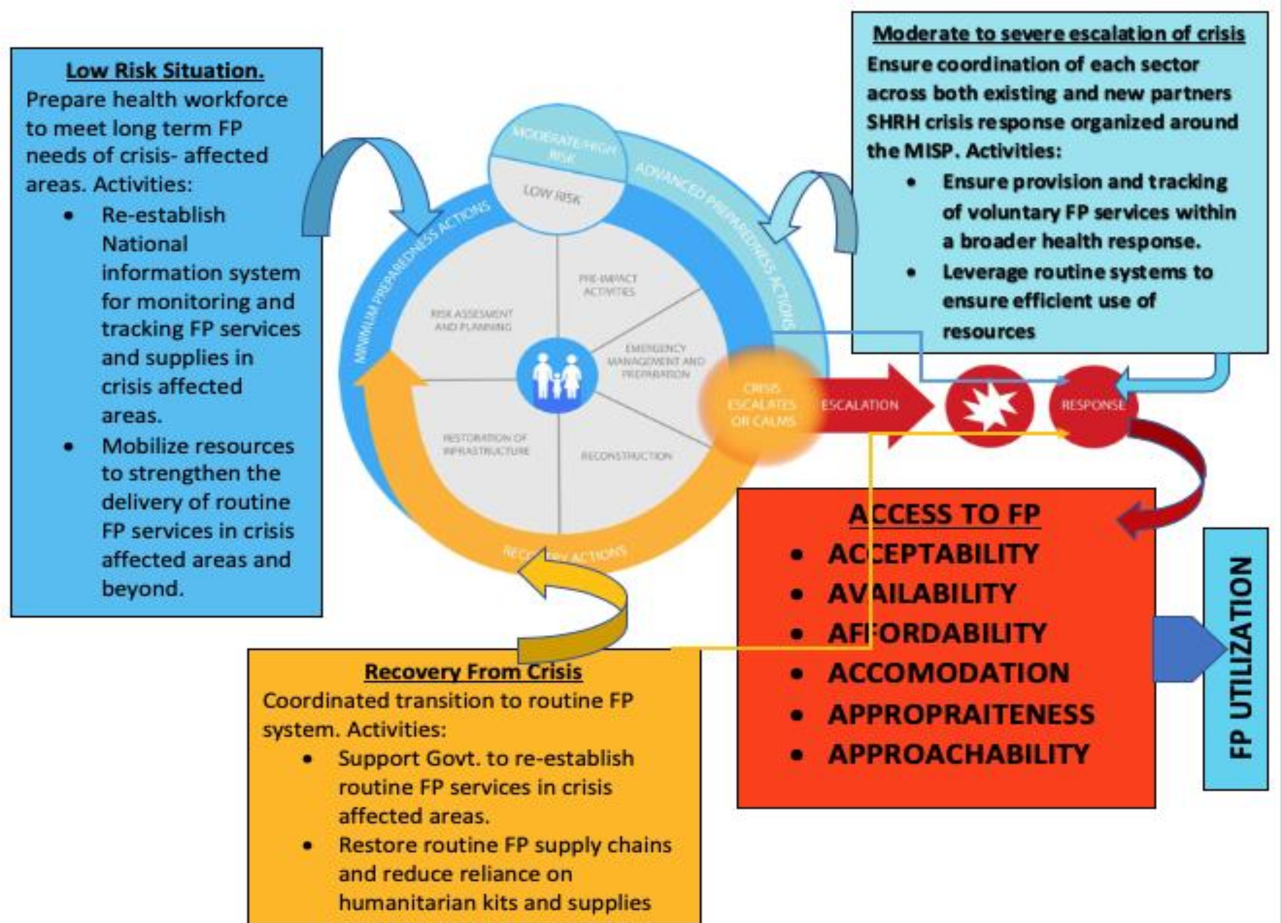

Fig. 3:The modified HIP family planning in humanitarian settings framework: An Adaptation (Researcher)

Other conceptual frameworks contemplated include: Causal framework for the reasons for unmet need for family planning by Kayuzo Machiyama et al.[51] this was not chosen because, it is only client centred and does not exhaustively address the various components of barriers and enablers from both the supply and demand sides. Conceptual framework for assessing access to health services by David H. Peters et al.[52] This is an alternative that could be applicable in this context , however the adapted Hip framework was chosen because it explores all possibilities more exhaustively in this context. Swiss Red Cross's (SRC) health program approach conceptual framework of addressing fragility through community based health programs[53] This framework addresses a community based approach only which will limit other program options that may be applicable in fragile settings and The Person-Cantered Care Framework for Reproductive Health Equity by Sudhinaraset et al[54] which explores access from a patient cantered right based approach and is an alternative that could be discussed and recommended but may be difficult to implement in the context of fragile settings.

Section 4.3: Search criteria.

Databases such as Medline and PubMed and search engines like Google scholar will be used for the literature search. Snow-balling technics will be used to access the cited literature references of the

relevant literature. Also, networking platforms like Academia will be utilized. Journal sites to be utilized include Lancet, PLOs, BMJ, Guttmacher publications amongst others. Some grey literature from DHS, UN agencies, and other international stakeholder organizations like WHO, UNFPA, IOM, UNHCR, PLAN, CARE, RELIEFWEB, HIP, ICRC and similar sources will also be included in the literature search based on the established search criteria. Details of search terms including exclusion and inclusion criteria and the tables can be seen below.

Section 4.3a: Inclusion Criteria.

1. Only Peer-reviewed papers published within the past 10 years (from 2010 – 2020) were included in the search with few exceptions where historical landmarks were mentioned. This is because the author wants to use only current information due to the dynamic nature of the context of this study and the fact that there have been recent reviews and modifications in the internationally adopted operating procedures in these settings.
2. Only English language publications were selected because the author is more fluent in the English language.
3. Only papers referring to the context of humanitarian settings are included in the search.

Section 4.3b: Exclusion criteria.

1. With few exceptions, publications older than 2010 will be excluded for the reasons stated above.
2. Publications in other languages apart from the English language will be excluded because the author is fluent in the English language.

Table 1: Inclusion and Exclusion criteria for a systematized literature review

CATEGORY	INCLUDED	EXCLUDED
Population of interest	Women and girls of reproductive age 15 – 49 years living in humanitarian settings in sub-Saharan Africa	Populations living outside humanitarian settings in or outside Sub- Saharan Africa
Article type	Peer-reviewed articles and grey literature	
Intervention	Family planning/contraceptive interventions	Any other article describing a different intervention
Crisis type	Any acute or protracted armed conflict or natural disaster	Studies conducted before a crisis has occurred
Publication date	Any publication between 2010 and 2020	Publications before 2010
Language	English language	Other languages

Section 4.4: Data Analysis

Identified/retrieved papers were stored in Zotero, a total of 460 papers were identified. After the removal of duplicates, 98 papers were selected based on the inclusion criteria. The 98 papers comprise of 79 from databases and 19 from other sources. These were further screened first based on title and then based on the abstracts. The papers were further screened according to study type and quality using critical appraisal check lists (see table below) according to the study types to grade them into three categories- high, medium and low-quality papers. The quality appraisal was done for the peer reviewed literature using the critical appraisal skills program (CASP) checklist while the grey literature was appraised using the authority, accuracy, coverage, objectivity, date and significance (AACODS) checklist.

The selected papers where then catalogued on an excel spreadsheet according to author, year article type, study design and quality, study settings, target population, intervention and key findings. See annex for a table of the literatures and their grades. They were then exported into NVivo 12 for Mac and labelled using a thematic approach according to the set objectives of the study and analysed.

A summary of the thematic arears coded on NVivo 12 can be seen on the figure and table below:

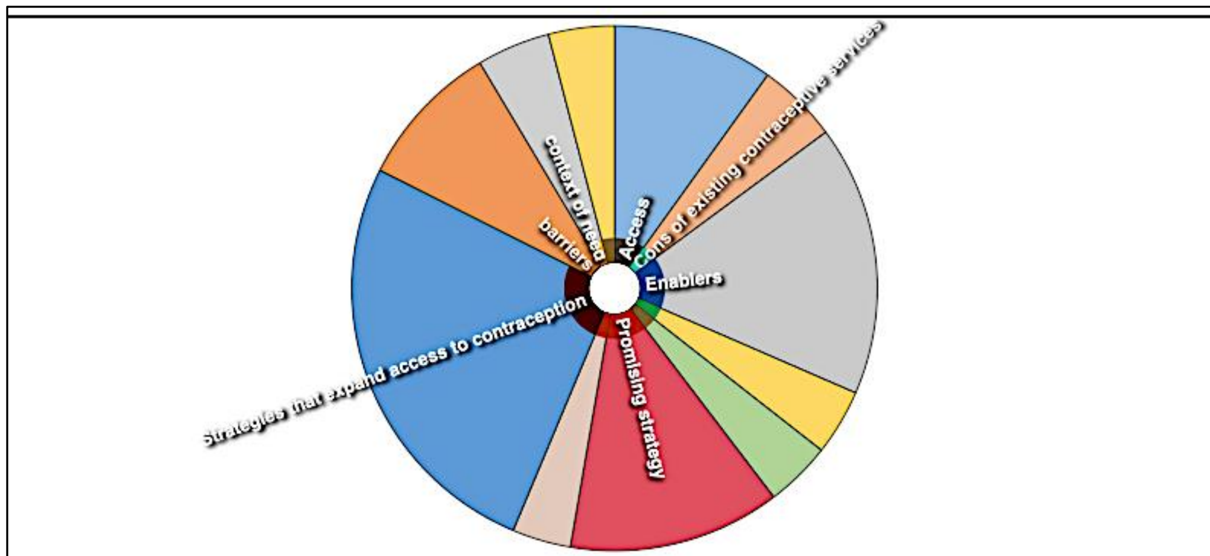

Fig. 4: A Pie chart of the distribution of various thematic literature codes from retrieved literature on Nvivo12

Table 2: The distribution of various thematic literature codes from retrieved literature on Nvivo 12

Treemap Sunburst Summary

Codes	Number of coding refere...	Aggregate number of co...	Number of items co...	Aggregate number of items...
Codes\\Access	22	22	12	12
Codes\\barriers	20	20	14	14
Codes\\Cons of existing contracep...	11	11	6	6
Codes\\context of need	10	10	7	7
Codes\\Enablers	37	37	9	9
Codes\\Lack of documentation	9	9	7	7
Codes\\Preparedness	9	9	3	3
Codes\\Promising strategy	29	29	17	17
Codes\\pros of existing contracept...	9	9	6	6
Codes\\Safer Access	8	8	2	2
Codes\\Strategies that expand acc...	58	58	21	21

TABLE 3: QUALITY APPRAISAL CHECK LIST

Study Type	Quality Appraisal check list
Qualitative study	Critical Appraisal Skills Program (CASP) checklist
Grey Literatures	Authority, accuracy, coverage, objectivity, date, significance (AACODS) checklist[55]
Systematic Reviews	Critical Appraisal Skills Program (CASP) checklist[56]

Chapter 5: RESULTS

The results of these reviews shall be presented according to the outline of the study objectives thus; the contexts of women's and girls' needs for contraceptives in fragile settings in SSA, the factors influencing access to contraceptive services for women and girls age 15 – 49 years in fragile settings in SSA and the existing contraceptive service delivery strategies in fragile settings in Sub – Saharan Africa and analysis of promising strategies that expand women's and girls' access to these services in fragile settings in SSA.

The discussion of each objective will be approached according to themes from the conceptual framework reflecting the different contexts of the different phases of crisis as they modify the nature of the responses in humanitarian settings. Note that some of the themes in the framework like Access to FP is specific to study objective two. A summary of these findings will be discussed and recommendations for future best practices made.

Section 5.1: Context of needs for contraceptive services in fragile settings in SSA

In the context of emergency preparedness, many countries in SSA either lack an emergency preparedness or disaster management plan as a part of country agenda or the plans in place are ineffective[57]. However, some countries in SSA like South Africa is an example of nations that is gradually responding to the need for preparednesss. Since South Africa is regularly exposed to a lot of natural hazards and near several economically weaker countries, there are the increased risks of cross border forced displacements and migration. This realisation led to the creation of the Disaster Management Act of 2002[58][59]. Most developing countries in SSA thus have weak infrastructures with priorities competing with public health priorities[60].

The health care systems in SSA are barely able to meet the need of the general population. They suffer from acute shortages of skilled health workers and lack supply of drugs and medical supplies[29] before crisis. This is further complicated by restrictive policies limiting effective SRH provision[29][61][62]. Crises therefore presents a major challenge for RH care systems including contraceptive service[29]. These systems are thus overwhelmed when the added burden of injuries and infectious diseases that tends to increase during crisis are added. Besides, studies still show that contraceptive services are the least funded program 25 years after the ICPD[63][2]. However, irrespective of the stage of a crisis women and girls find themselves, whether fleeing from crisis or during the recovery phase, there are evidences that they want contraception[64].

The actions needed during the phase of preparedness therefore will involve working with communities towards disaster risk reduction (DRR). There is a need to build partnership, capacity and to strengthen the existing supply chain system. In the context of capacity building, the role and availability of trained midwives in the contraceptive services delivery in crisis settings cannot be over-emphasized[65].

Studies has shown that strategies drawn from more stable development settings —such as competency-based training, supportive supervision, simple quality improvement tools, and community mobilization that works in local communities while taking into account the context of restrictive norms can be modified to work in even these fragile settings[37]. Implementation of this strategy through the

government health system will build national capacity and will contribute to the data base. This will help create a more supportive environment in terms of favorable governmental policy formulation. The result of this approach is a significant expansion of contraceptive access not only in the short term but also supports longer term improvements in rebuilding the weak health systems[37].

Prior to crisis and at the low risk phase, already the health systems in SSA are weak with shortages of skilled health providers, stock-out of supplies, and unfavorable policies which hinder effective SRH service delivery[29]. There is, a need to strengthen the supply chains to meet the growing demand for contraception. This needs a careful study of the health care systems and a redesign or adjusting of the supply chain. Distribution systems need to be strategically located and adequate staffs need to be trained. The available information on finance and inventory of materials is also not reliable for an appropriate response[63][66]. In this context of resource mobilization at the low risk phase, a key issue is the accommodation and approachability of the staffs that are being mobilized.

Several programs have evolved to develop adolescent girls' through a safe spaces model thereby improving their SRH. Included in this model is the provision of a physical space that promotes regular meeting of girls; the use of older or peer mentors to support adolescents ; the provision of life skills such as accurate SRH information, literacy programs, and training on negotiation skills. Sometimes vocational training may be included with varieties of recreational activities[67][68]. Safe spaces interventions have been implemented in many Countries in SSA such as Burkina Faso, Kenya, Nigeria, Rwanda, Tanzania, and Uganda and can be leveraged for efficient resource use in crises settings[69][70].

During moderate to severe escalation phase of crisis, like in non- crisis settings, adolescents have similar needs and desire for SRH information and services. However, studies have documented specific needs of adolescents in humanitarian settings. For instance, the cross-sectional qualitative assessments undertaken by the women refugee council(WRC) and partners showed that there was an increased risk of sexual exploitation and abuse (SEA) in contexts such as after the post-election violence that occurred in Kenya and after the 2010 earthquake that occurred in Haiti[71]. Also, a 12-month contraceptive continuation study among women in humanitarian settings showed a very high percentage of women will like to initiate and continue the use of contraceptive of their choice even in unstable and low contraceptive prevalence setting like North Kivu[64].

Findings from three crisis-affected settings in SSA showed that of 63 health facilities assessed, only five provided adequate emergency obstetric and newborn care[66]. Just three(3) of these provided any component of the clinical management of rape. Services were not available for safe abortion across settings[66]. This is despite the fact that an between 25 and 50% of maternal deaths in refugee camps in SSA are due to unsafe abortion[29][66].

Conversely, it is important to note that despite the need of women and girls for contraception in humanitarian settings, available services, may not translate into acceptability and uptake. Critical to ensuring the uptake or utilization of available services is the extent to which the socio-cultural settings and barriers is understood. As in the case of South Sudan, populations may see limiting pregnancy and childbirth as undesirable due to high child mortality. They may also become suspicious in the context of ethnic violence[72][73]. A perceived advantage of extra security for the community or ethnic group is a larger family size. Another perceived advantage is the fact that the children assist with family duties in a structure that is heavily dependent on subsistence[72]. Also, the parents see the children as a social

service investment as they age since they expect these children to provide for their needs during old age[74]. Religious and moral objections to contraception are also very potent barriers to contraception that need to be understood[75][76]. Nevertheless when offered in an appropriate manner for their needs, contraceptive services are desired by women living in crisis situations[77].

An important context impacting contraceptive needs in these communities is that the women lack access to informed information, they tend to rely on societal learning from interactions[78][79]. Even though written materials in the form of posters and pamphlets may be available, the low literacy levels in the populations in these settings especially amongst the women in the refugee camps in Sub- Saharan Africa, limits their understanding of these information. The health seeking behavior whether to seek or avoid the available contraceptive services is thus based on the general socially accepted beliefs instead of evidence-based information. Information strategies on contraceptive services therefore needs to be done in an appropriate way to be effective[80]. The objective of response actions in the context of women and girl's needs for contraception are the provision and tracking of the full range of voluntary contraceptive services and ensuring efficient use of resources by leveraging on routine systems[81].

After crisis, at the recovery phase, countries face great difficulty. There is a weakening or complete breakdown of the eeconomic, political, and social structures. The absence of both physical and human resources for rebuilding make reconstruction difficult. Of primary concern to most governments and the humanitarian community is the health of the population. A stable and legitimate governance and political structure therefore has positive effects on the health system of any country coming out of crisis. Conversely, improvements in the health structures and system also has a peace building potential and may significantly improve the political stability and governance of a State[82].

Also, as crisis transition to the recovery phase, there is a change in the dynamics and context for contraception. This is because, with the restoration of stability, one of the peacebuilding processes are also a positive return to gender empowerment. Studies representing about 3 million women from 74 datasets of national surveys shows that as gender empowerment and education increases so does the demand for and access to contraception increases[83]. This is a confirmation of the formal recognition 25years ago at the fourth world ICPD conference on women in Beijing that the health and reproductive choices of women is inseparable from the social context of their lives[84]. However, ensuring that the increasing need for contraceptive needs of these women and girls are met at this phase of crisis will require an adaptation of the integrated approach to SRH in practice and by policy [85][83]. Studies has demonstrated that many Countries in SSA are committing to giving women power to plan their lives[86].

Section 5.2: Factors influencing access to contraceptive services in humanitarian settings.

Though contraception and family planning are beneficial to both MCH, the utilization of contraceptive services amongst refugee women in SSA has been found to be low. Evidence from literatures has shown that women face a lot of barriers to using modern contraceptive services such as lack of access in the different domain of availability, affordability, accommodation, appropriateness and approachability which will be discussed here. Beyond these barriers, the influence of social networks as important agencies of behavior change is explored.

Though studies have shown that different methods of information delivery may increase the awareness of contraceptive methods by displaced men and women, this information may be ineffective in overcoming the personal barriers to utilization of the services such as misperceptions and fear regarding side effects and the influence of their spouses. They also tend to trust information on contraception that come from people that they are familiar with like community leaders or members from the community that is perceived to be well informed. The risk in this is that these people themselves may not have evidence informed knowledge. This may further contributee to their misperceptions and fear[87].

Section 5.2.1: ACCOMMODATION AND APPROACHABILITY

During the phase of preparedness, a major barrier that creates a culture of silence is the ssocial norms and taboos related to gender, sexuality, and SRH issues. This is the case for adolescent girls who are still living with their parents in these settings. They seek information or want to discuss their worries about SRH issues; this is important when communicating with adult family or community members. The presence of a trained health care service provider who is accommodating and easily approachable will therefore remove this barrier thus improving their SRH[88].

In preparation for a resilient SRH system during crisis, deliberately working towards creating enabling environments that empower young people and women to realize their SRHR is fast emerging as the accepted status quo. Though the evidence has not been fully established. The experiences and findings so far are encouraging[89]. This issue of lack of knowledge and negative attitudes and behavior of health care workers as barriers to utilization has been highlighted in several studies[66][90][25] Thus underscoring the importance. Also, it is most essential that, humanitarian stakeholders find ways to identify policies and legal barriers that undermine the sexual and reproductive rights of the populations in these settings and advocate collectively for a positive change so they can realize their fundamental human rights[22]

At all phases of crisis, a service provision that is sensitive to the culture and shows respect for all women, without regard to their status socially or economically or any regard for the country that they come from by midwives and other women health providers makes them more approachable and accommodating. This is key to enhancing acceptability of contraceptive or other reproductive health services[87]. However, in this settings, studies show that women doubt the qualification of some health care providers since many complain of disrespectful treatments when they go to the clinics[87].

Though RH services including contraceptive services are being provided during the phase of moderate to severe escalation of crisis in SSA, there is an inconsistency of good quality RH. In a study of the progress and gaps across three humanitarian settings in SSA involving 63 health facilities, only 11 health facilities (5 in Burkina Faso and 6 in DRC) fulfilled the basic standards as contraceptive delivery points. The need to improve the attitudes (i.e. more approachable and accommodating) and upgrading their capacities both technical and administrative is very critical for them to deliver these services in a respective and efficient way. Further-more, beyond the system service delivery, it was noted that there is a need for the humanitarian workers to engage the communities affected by crisis through-out the continuum of care to improve utilization of services. Same study showed that many service providers lacked essential knowledge and skills[66].

These factors also apply in the recovery phase.

Section 5.2.2 ACCEPTABILITY

At the phase of moderate to severe escalation of crisis, contraceptive service delivery planning and implementation must consider the contextual nuances of various socio- cultural perceptions for the services to be acceptable both in the variety of available options and in the form in which these options are provided. The enabling environment and the confidentiality factors should also be acceptable[72]. It is therefore crucial to engage in continuous community education utilizing local initiatives from within the refugee camps as well as employing wider region-wide structural strategies to ensure sustainability. It is important that while making efforts to meet the reproductive rights of these women that care is taken to put these actions in the context of the religious and socio- cultural context of the community[72][91].

It has been observed that the women in these settings tend to trust the health workers that they are familiar with, thus the community health workers (CHWs) are more acceptable service providers for them, although they may risk the lack of confidentiality or anonymity within the community[53]. A Community-based distribution is also more cost effective and may improve continuity when compared to facility-based distribution of contraceptives. In fact, many supports for CHWs is gaining popularity in many Countries as can be seen in many favorable policy revisions in support of their incorporation and utilization in service provision since they are much more acceptable and sustainable[92]. Their effectiveness however depends to what extent they are trained and supervised and also an effective referral system needs to be put in place in case the women wish to switch to different contraceptive method[92][53].

It is important to note that acceptability of both the organization and the individual partners' service providers is key both in enhancing the utilization of the services as well as ensuring the safety of the workers in this settings especially .

In the context of acceptability, DMPA-SC(Depot-medroxyprogesterone acetate subcutaneous) which is a variant of the long acting injectable hormonal contraceptive is an emerging option that has the potential to significantly expand women's contraceptive options. It has the advantage of increased personal autonomy through self-care. Studies are showing evidence that DMPA-SC is safe and can be effectively task-shifted to community healthcare workers across different contexts and health systems. These studies also show that self-injection by women is safe, effective and acceptable[94][95][96].

Section 5.2.3: AVAILABILITY

At the phase of preparedness, the key role that Finance play in ensuring access to quality SRHR for victims of crisis and fragility cannot be over-emphasized. However, according to the commodity gap analysis for the year 2019 done by the reproductive health supplies coalition, ccurrently the total amount spent on contraceptive supplies in Low- and Middle-income countries (LMICs) alone is $3.33 billion; but this money is not appropriately expended as more than 80% comes from individuals donors who use it to buy supplies from the private sectors (see figure below)

Figure 5: Current spending on contraceptive supplies(Source: Global health coalition annual report-2019-open source)[97]

In the year 2019 , the Ccommodity Gap Analysis projects a gap of $178 million in 2020, to reach $266 million by 2025. The five years cumulative gap (2021–2025) will be reaching $1.17 billion for contraceptives supplies alone. (Reproductive Health Supplies Coalition, 2019)[20]. Evidence shows that there is generally an underfunding for SRHR in fragile and humanitarian settings as compared to other health services, especially contraception, safe abortion and post rape[28][37].

During the phase of moderate to severe escalation of crisis, though reproductive health(RH) services are being provided in the humanitarian settings in SSA, the availability of good quality services have been found to be erratic and unevenly distributed across different sites and the supplies are difficult to track[98]. The management and security of commodities is therefore a priorityy to ensure consistent availability of supplies[39]. In conflict-affected countries, access to contraceptives is often limited to short-acting methods or not available at all[37]. However, studies have demonstrated that when a full range of contraceptive options are available women with unmet need will voluntarily use them[99][39].

While contraceptive services are desired by women living in humanitarian settings especially when offered in an acceptable manner in terms of options and forms appropriate to their needs, these services are rarely adequate to meet these needs and when available, are usually limited to oral contraceptive pills and condoms[37]. It is therefore very important that international humanitarian organizations and RH agencies including National Governments prioritise contraceptive services for these vulnerable populations, by providing the full range of short-acting, long-acting and permanent methods[100]. This is especially important because to ensure continuous use, oonce demand for contraceptive use is achieved, the supply should be readily available and accessible[101]. It is also important to note that the

availability of services alone does not translate to utilization of the services. It has to also be acceptable[72].

A very critical area that can improve the RH of adolescents in the IDP and refugee camps is the availability, accessibility and full understanding of RH information. This has been found to be lacking in many humanitarian settings in SSA leading to risky sexual behaviors without contraceptive use since they lack information. Examples of this can be found in the IDP camps in the Northern parts of Nigeria[102]. Due to this lack of information in these settings, studies has shown that even when RH services are available, they are under - utilized since these adolescents are not aware of these services[103]The RH information is lacking due to shortage of trained service providers.

Also, in the context of these information barriers, studies on the reported reasons for discontinuation of contraception by women suggests that more can be done to support women desiring to continue using contraception especially for longer periods. For instance, evidence show that many women discontinue injectables for method-related reasons (such as side effects or myths) [104] There are serious concerns about damage to health, impairment of their fertility in the future especially when they take the contraceptives for a long time without taking a break; this is also the case in crisis settings. Studies has shown that this was a common concern amongst the refugees in Kenyan sites and may explain the high rates of discontinuation observed[90]. These results reinforce the importance of offering a variety of contraceptive options to enable switching from unfavourable methods to other options. Also, adequate and evidence based counselling and education about side effects should be provided[105].This documentation therefore provides useful guidance for counselling and evidence based campaigns. Program's focus should not only improve individual counselling but efforts should be made to do sustained social marketing to effect positive behaviour change especially for those that are dissatisfied from previous experiences[90].

When varieties of contraceptive options are offered, there has been an observed rapid expansion of contraceptive use in crisis-affected settings. This is especially so when long-acting reversible contraceptives (LARCs) options are included. For instance, the Chadian and DRC(Democratic republic of Congo) Governments, supported by an NGO, was able to provide nearly 85,000 new clients with contraceptives by increasing the mix of contraceptive options. LARC users including an increasing number of IUD users, accounted for 73% of the new clients[106].

Section 5.2.4: AFFORDABILITY

This factor is most relevant at the recovery phase of crisis. An analysis of the response system to humanitarian crisis shows that it tends to be designed to respond to crisis that are of short duration. However in view the recent tendencies for crisis to be more protracted, this approach of the response system has lost relevance[107]. In the UNHCR report on the global trends in forced displacements 2015, involving about 6.4 million refugees showed that most refugee situations in over 26 countries last for a minimum of five(5) years[108]. There is therefore the need to invest in long-term sustainable systems and infrastructure in various areas including health and thus contraceptive care by implication. This however remains a politically sensitive fact for most host Countries. It is however important to highlight that evidence from recent crisis like the case Ebola epidemic in West Africa, the crisis in South Sudan and the crisis in Yemen spilling over to Europe has exposed these failures[107]. In view of these

challenges, a re- establishment of the National information system is a key response strategy at this phase of crisis in SSA. Development of core indicators for supplies and services tracking therefore is a key step at this point[101].

As a consequence of the present trends of the protracted nature of crisis , an emerging important factor that can influence the utilization of contraceptive services in humanitarian settings is the affordability of the options available since the there is a gradual transitioning of the services to governmental health system[87]. Most of the women lack economic power and are therefore dependent on spousal approval since they must navigate the socio- cultural norms that emphasizes the dominant position of the male in family decision. Though in the camps these services are usually free of charge, there is a changing dynamics of some of these refugees staying with relatives and friends outside the camp as a result of the protracted nature of these crisis[19].These women therefore may not use the services for lack of money especially those who may need to incur some form of out of pocket expenses due to distance to access the services[109]. Aaccess and availability of these services therefore are often either completely denied or limited to these women and adolescents because of distances, costs and stigma[110].

Section 5.2.5: APPROPRIATENESS

This can be defined as the balance between services and clients need, the timing and amount of care spent in assessing health problems to determine the correct treatment and the technical and interpersonal quality of the services provided[111].The task of providing good quality and available contraceptive services in an acceptable way that fits appropriately into the specific context of humanitarian settings in SSA though challenging is not impossible. Though fragile states will not be transformed suddenly, there is opportunity to slowly and incrementally influence and bring about changes both at the local and national level. The reality is that most crisis situations now tend to be protracted and will last many months and often years[112][113]. In view of these facts and scenario it is important that programs ensure that at least the basic minimum and appropriate quality of services are made available. In doing this, it is also equally important to try to tackle the root causes of poor health services like poverty, lack of information, supply chain issues, security, lack of education[114].

Against the backdrop of poor funding of SRH in crisis as highlighted above impacting availability of contraceptive services, at the phase of preparedness, it has been observed that even the amount that is available for the funding of SRH activities are not appropriately utilized since there is often a lack of recognition and empowerment for the leadership role of national and local authorities including communities both in the formulation of the strategy of service delivery or in the form of contraceptive service provision[113]. There is thus a lack of transparency in the commitment to enhance local ownership in the way the funding is streamed. For instance, only 3% of humanitarian aid was directed to local and national organizations in 2017 with even less focusing on girls and women. This is very far from the target 25% by the end of 2020 as agreed upon as demonstrated in the global humanitarian assistance report 2018[97], see table below.

TABLE 4: CURRENT SPENDING BY SECTOR ON CONTRACEPTIVE SUPPLIES

Current Spending by Sector
Segmented by GNI Group

			WITHIN PUBLIC			WITHIN PRIVATE	
	TOTAL	PUBLIC	DONOR	GOVERNMENT	PRIVATE	SUBSIDIZED	NON-SUBSIDIZED
LIC	191,000,000	126,000,000	94,000,000	32,400,000	64,300,000	10,100,000	54,200,000
L-MIC	905,000,000	321,000,000	58,400,000	263,000,000	584,000,000	36,600,000	547,000,000
U-MIC	2,240,000,000	177,000,000	6,850,000	170,000,000	2,060,000,000	43,700	2,060,000,000
Total	**3,330,000,000**	**624,000,000**	**159,000,000**	**465,000,000**	**2,710,000,000**	**46,700,000**	**2,660,000,000**

At the moderate to severe escalation of crisis phase, sstudies have shown that both demand- and supply-side interventions improves the knowledge, attitudes, discussion of contraception and sexuality, and the desire to use contraception though they were less conclusive on the effects contraceptives has on fertility. An examination of mass media interventions showed positive results on the use of contraceptives and reduced unmet need. This effect was less demonstrated by using interpersonal communication. This implies that mass media interventions have been shown to be more effective in increasing contraceptive uptake compared to interpersonal communication[101]. However, there are limitations on the usefulness of community education alone especially in the context of family and community needs, preferences and beliefs[72].There is therefore the need to encourage and support women on contraception to continue while targeting the unmet needs in these settings. Furthermore, the high rate of contraceptive discontinuation can be reduced by facilitating switching among methods[115].

Equally as important as the demand creation for contraception use is the need to ensure that contraceptive supply are available and accessible once the demand is created. Findings from studies has shown that supply-side interventions which addressed increased access to contraceptive options led to positive effects on contraceptive uptake when compared to just improved quality of contraceptive services. Also, programs targeting male involvement are becoming increasingly important in the international family planning programs. However, studies has shown a mixed result of increasing male involvement in regards to outcomes in behaviour change such as contraceptive use and unintended pregnancies[116][117]. These studies however have not incorporated a gender transformative conceptual approach in the interpretations of these findings thus the full potential of this approach has not been demonstrated.

An enabling activity in humanitarian settings is the provision of in-service training for all health facility personnel on reproductive health, including FP. For instance, findings at the health facility at the refugee camp in Ali Addeh at Djibouti, showed that though they had the capacity to provide injectables, contraceptive pills and condoms. They are only able to attend to a small part of the contraceptive demand of the women in this refugee camp due to few skilled staffs. This limits their access to wider choice of contraceptive methods thus limiting their rights to choose. Though data from focus group discussions and in-depth interviews showed that religious beliefs were important reasons for low contraceptive uptake among the refugees. There is evidence to show that important factors in the low uptake of contraceptives in this camp were the lack of variety in contraceptive options and the inability of the health care providers to recommend alternative options in case the women have side effects to

the options that they are using. This study demonstrates the need to train all health care workers in the facility in these settings as an enabling factor in increasing contraceptive uptakes in humanitarian settings[118].

Integrating contraceptive services with other services like into HIV/AIDS national sensitization programs AIDS and prevention of mother to-child transmission (PMTCT) services have also been found to be an effective way of making better use of the limited resources in humanitarian settings. This have been found to increase the reach to a wider population. Findings from Focus group discussions indicated that some adolescents became familiar with some contraceptive options, such as condoms, as a result of HIV/AIDS sensitization programs[119][120].

The cultural norms and religion also play a very important role when introducing contraceptive services in humanitarian settings. A good intention and comprehension of intended benefits of contraception use of contraception may be rendered ineffective by complexities on issues of morality and religiosity either negatively or positively. Therefore, though community education may be a proper means to improve knowledge thereby increasing the rates of informed use of contraception, education alone is limited in usefulness in the context of familial and community needs, preferences and beliefs. These context is heavily influenced by religion and socio-cultural beliefs which defines the meaning of morality[72]. An enabling practice in humanitarian settings therefore will be to choose an approach or range of services that will be acceptable taking into consideration the religious and cultural values of the community.

The role of community and governmental leadership in ensuring the provision of appropriate contraceptive services to women and girls in crisis is therefore very important. However, in SSA, there is a lack of appropriate leadership and co-ordination amongst the various humanitarian organizations – a role that should be played by the National and local government, each organization operate with their own mandate and priority. These focus mostly are not in line with the community perspectives and cultural practices, thereby disrupting the existing services provision strategy of the health system. Thus there are parallel programs which leads to inefficiency and lack of utilization of available services[121]. [122]. These factors lead to the provision of contraceptive services that are not appropriate for the needs of the women and girls in these settings.

Section 5.3: the existing contraceptive service delivery strategies and promising strategies in fragile settings in SSA

Studies in health care systems has shown that more expenses does not necessarily yield a more effective healthcare or better service delivery outcome[123]. For instance the commodity gap analysis for the year 2019 done by the reproductive health supplies coalition showed that money is not appropriately expended as more than 80% comes from individuals donors who use it to buy supplies from the private sectors[28]. This is against the backdrop of the very low funding of contraceptive services in humanitarian settings[37]. There is therefore a need to leverage good practices from routine systems to efficiently use scarce resources in crisis situations. The practice if integration of contraceptive services with other SRH services in crisis settings therefore has been found to be an efficient practice[124].

A basic purpose of existing interventions aimed at improving access to contraceptive services in fragile settings is making it as affordable, available and appropriate as much as possible. This include a community led education about available contraceptive methods[87]. Unfortunately, though RH services are being provided, these service are inconsistent both in the quality or the availability of appropriate options across the settings[66]. Various strategies are currently employed in humanitarian settings in SSA.

During the moderate to severe phase of crisis, various partners have attempted to reduce the various barriers by implementing various demand side interventions like the use of Vouchers for contraceptive services to reduce the barriers of cost and availability. In fact studies has shown increased use of contraception in areas where it was more readily available where the barrier of cost has been removed for vulnerable populations[125].

Another approach used in the moderate to severe escalation phase of crisis is conditional cash transfer programs which involve the transfer of cash on the condition that a desired behavior or outcome is fulfilled. This sort of program seek to address the issue of both short and long term poverty by investing in human capital and cash transfer and tends to target the root causes of lack of utilization such as poverty, ignorance and lack of decision making power[126]. This seems to be a more sustainable approach since it seeks to empower the women and adolescents. This is because closely linked to the greater vulnerability to poor SRH outcomes of adolescents, especially girls, for a variety of reasons is ppoverty and a lack of resources for key needs and expenses. For instance, evidence from Sub - Saharan Africa shows that a lot of young women age 15 to 24 years are exposed to various risks of STIs, HIV infections and unwanted pregnancies at these humanitarian settings because they engage in various forms of transactional sex for money, education and other things that they fancy[89].

Progestin only EC pills are being used for emergency contraception especially in crisis settings like Somalia, where there is a constant threat of sexual violence [127]. The women often lack the privilege of negotiating the use of contraceptives before sex, and they lack access to trained health service providers even though this may not be as effective as other hormonal options like the oral pills and longer acting reversible contraceptive methods[127]. It is therefore a good practice to include this EC options in the contraceptive services in crisis situations.

An integrated inter- personal communication(IPC) and mass education campaign is effective for improving women's reproductive health in emergency settings[128]. Closer examination of existing programs found that: stakeholder involvement thereby establishing a strong community trust and the support of the adult population ensured success of RH programs[129][130].

Other existing programs with promising strategies include: The involvement of adolescents at all stages of program implementation planning and delivery. It has promising outlook for all stages of crisis response. In a pilot program that was implemented by IRC in the DRC aimed at increasing the uptake of contraception among adolescent girls, the participatory approach was used. These girls where included from the priority setting stage to the implementation. This program was shown to be successful since due to the program there was an observed increase in the number of adolescents that adopted new contraceptive methods from the baseline of 67 in March 2017 to 156 in December – a 10-month period. By the second month of the project, adolescents made up over one third of all the contraceptive clients with 89% of them opting for the long – acting methods within a 10- month period[131].

Similar approach was used to involve adolescents in the planning of youth clubs in Malawi. Initiated by Save the Children with funding from the Gates foundation, the five years program tagged the "Nchanda ni Nchanda" (Youth to Youth) program was implemented in Mangochi ; the objective was to improve the reproductive and sexual health of youths age 10 – 24 years. Innovative approaches used was establishment of youth clubs where peer-to-peer education program was done. 39 Youth Resource Centers were established as spaces where adolescents meet and socialize. Clinicians were trained in the provision of youth friendly health services and Youth Community-Based Distribution Agents (YCBDAs) were also trained. These YCBDAs counsel and provide contraceptive services to fellow adolescents. Success of the program included the training of Forty-five YCBDAs in contraception counseling and provision. Also, ten primary supervisors and one secondary supervisor were trained. YCBDAs were able to help negotiate youth-friendly days at their community health center. This helped youths to feel welcomed and help to increase the uptake of contraceptives by these adolescents. Within a two years period, 36,050 condoms and 3,047 packs of pills distribution was attributable to the YCBDAs.[132]. To promote access to and utilization of contraceptive services by adolescents, programs that combine community acceptance and demand generation activities with adolescent-friendly clinic-based approaches are are most effective[70].

At the preparedness and early phases of crisis, studies from Uganda, Thailand and Colombia showed that there was an initial resistance from community members to the provision of reproductive health services. This was mostly based on concern that such services would encourage the youths to engage in sexual activities. However, these studies showed that this resistance was overcome by building trust from the community members through community engagement activities[11]

A promising cost-effective channel to injectable contraceptive access during both the recovery phase and preparedness phases of crisis is the use of community-based distribution and self-injection. The aim of the study was to find out if there is a cost benefit to the clients for a community-based delivery of contraceptives and to find out if the cost benefits differ between DMPA-IM and DMPA-SC. No significant difference has been observed using this strategy in delivering DMPA-SC(Depot medroxyprogesterone acetate subcutaneous) and DMPA-IM(Depot medroxyprogesterone acetate intramuscular). This implies that this strategy has the potential of reducing direct cost of contraceptive service delivery to these women when ccompared to facility-based health worker administration[133].

During the recovery phase of crisis, a successful school- based sexuality education program was implemented in Liberia during the post conflict era of increased transactional sex tagged the " making proud choices intervention" targeted 6th grade students who were given sexuality education in modular forms by health educators. The target was the prevention of HIV by promoting condom use and skills for negotiating safe sex practices[134][135]. This strategy of targeting school age girls for sexuality education is therefore is an identified enabler for accessing contraceptive options by women and girls in humanitarian settings in SSA. A similar study from DRC also targeted in-school adolescents age 12-14 years. This time teachers were trained to be champions of adolescent SRH. The class selected peer educators who were trained in various SRH topics. Though many of the adolescents could not attend due to timing , it was shown to be an effective strategy[135]. The recruitment and training of teachers who then train peer educators on sexuality education is another identified enabling strategy that improves contraceptive uptake by girls and women in humanitarian settings in SSA.

A promising program approach in contraceptive services delivery in fragile settings especially during the recovery phase is the voucher system program approach. In collaboration with international donors, sseveral developing countries like India, Tanzania, Uganda, Kenya and Bangladesh[136] are exploring the prospect of implementing this program. Though more research is being done on the system with the aim of scaling this practice throughout the LMICs as an effective approach. Key focus of research presently is on the cost effectiveness and impact evaluation of the program. Studies are also being done into the possibility of leveraging technology to make the implementation simpler and cost effective. However, early results are encouraging[136][137]. The implementation of vouchers for contraceptive services have also been very successful in reducing barriers such as cost and availability thereby encouraging both private and public providers to improve skills and has led to increased uptake of both reversible long acting contraceptives and even permanent contraceptive methods in other parts of the world like Yemen and Pakistan[125]

Another promising strategy especially during moderate to severe escalation phase of crisis is conditional cash transfer programs which involve the transfer of cash on the condition that a desired behavior or outcome is fulfilled. This sort of program seek to address the issue of both short and long term poverty by investing in human capital and cash transfer and tends to target the root causes of lack of utilization such as poverty, ignorance and lack of decision making power[126]. This seems to be a more sustainable approach since it seeks to empower the women and adolescents. This is because closely linked to the greater vulnerability to poor SRH outcomes of adolescents, especially girls, for a variety of reasons is ppoverty and a lack of resources for key needs and expenses. For instance, evidence from SSA shows that a lot of young women age 15 to 24 years are exposed to various risks of STIs, HIV infections and unwanted pregnancies at these humanitarian settings because they engage in various forms of transactional sex for money, education and other things that they fancy[89]

Additional strategies that expand access to contraceptive in all phases of crisis is the use various mix of contraceptive options to improve utilization by the clients. Studies has shown that expanding access to various contraceptive options including long-acting reversible contraceptive(LARC) methods, is feasible in fragile settings. A focus on best practices in the area of provider training, effective and efficient supply chain support, supportive supervision, and community involvement with good use of data will help to facilitate program improvement and success in fragile settings[37]. In this context, an emerging promising contraceptive option is the self-injectable depot medroxyprogesterone acetate subcutaneous (DMPA-SC). This option has the potential to significantly expand women's contraceptive access and increase personal autonomy through self-care. Recent studies done in Senegal and Uganda show that DMPASC can safely and effectively be distributed by CHWs across different contexts and health systems[138]. Self injection by women is also safe, effective and acceptablee[138]. Also new results from Malawi, Uganda and the USA show a higher continuation rate among women who self-inject DMPA-SC than those who have to go to health workers for injection implying that the challenges of initiation and continuation of long lasting reversible injectable contraceptives in fragile settings is surmountable and that self- injection may not only increase the continuation rates but may do so without increasing the risk of pregnancy or side effects [139].

At the recovery phase, the objective of the activities in this phase is: (I)To assist Government health systems to restore routine contraceptive services and reducing dependency on emergency contraceptive kits and (II) restoring routine contraceptive supply chain.

For the Government to own the transitional process, the contraceptive services delivery interim programming partners should share information on: the services provided, the range of capacity that was improved, and the systems that were employed along with recommendations on best practices to ensure continuity [113][50]. A transition plan therefore needs to be established for the service delivery. The human resources should be transferable to the government after the interim period. Also, a clear referral pathway should be identifiable during the interim phase so that clients can know where to go for help[50].

An important strategy that can help Governments to re-establish contraceptive services in crisis area is the contracting out reproductive health services . This is the practice where the government contracts out service provision to the citizen in other to improve the effectiveness and efficiency of such services. Contracting has both political and practical advantages. For instance, in Afghanistan, most facilities were already being operated by NGOs who are already experienced in the challenges of service delivery in that setting. In fact, majority of health expertise can be found among the NGO community. Furthermore, NGOs are more adapted as opposed to the government in being able to recruit train and mobilize new staff and become fully operational rapidly unlike the government system due to bureaucracies.

Also, some of these NGOs have strong international financial and logistic support and thus can supplement the franchise/contract funds with their own resources. This coupled with the fact that the goal of these NGOs are closer to that of governmental public services orientation as opposed to private sector providers whose main goal is profit[140]. However, it is important to note that there is a major disadvantage since the activities of these NGOs may be difficult to monitor in humanitarian settings.

The strategy of task shifting/ sharing has been found to enhance many high impact practices including contraceptive service provision such as immediate postpartum contraception, postabortion contraception, Immunization and contraception. It allows health service providers to meet the needs of the clients through an integrated service delivery. This strategy makes it possible for health system to provide a comprehensive patient- centered care in an efficient way and maximizes the reach of these services. The task shifting can be done through a mix of the following :

- Social Franchising Community Health Workers, Mobile Outreach and Drug Shops/ Pharmacies
- Social Franchising Mobile Outreach Drug Shops/ Pharmacies.

FP Vouchers are used to Supportt client-centred access to products and services via service delivery points that they prefer depending on their convenience. This strengthens the capacity of the private health care professionals to provides variety of contraceptive options thereby expanding their reach to the clients. Ultimately, this strengthens the link between the private and the public health systems and increase the accessibility and availability of providers by overcoming the financial and information barriers to uptake of contraceptives[141].

Task shifting/sharing policies and practice utilizing CHWs and the use of mobile outreach service delivery should be encouraged. Social marketing strategies using the media for community engagement is desirable to encourage access. Provision for the tracking of voluntary contraceptive services should be made. It is also important to advocate for the inclusion of the full range of contraceptive methods in the crisis response at this recovery phase.

Studies also show positive contraceptive uptake outcomes when a multi-component program approach was used. Examples of components of such approaches include:

- The use of mass media and interpersonal communication(IPC)[142] [101][143].
- The use of mass media and social marketing as demonstrated by the work of population services international(PSI) in Soweto South Africa, Cameroon and Guinea[144][145][146] .
- The combination of strong media promotional presence with fractional social franchising[147][148]. and
- The use of community-based outreach and fractional social franchising[149].

These are all examples of the effectiveness of multi-component programs and promises to be an effective program approach for improve contraceptive uptake in humanitarian settings and help Government health systems to restore routine contraceptive services.

Efforts should be made to restore pre-crisis supply chain management mechanisms. These should include newly introduced contraceptive methods. Also, a calculation of the contraceptive needs and costing of the products should be done to help in the transitioning process[50]. Various methods have been used to restore routine contraceptive supply chain in countries at this recovery phase of crisis in SSA. For instance, in Senegal where the Informed push method (IPM) was used and found to be highly successful in making contraceptives fully available throughout all the regions and health facilities. This model was also able to facilitate flow of vital data on consumption and stockouts from facilities throughout all levels management highlighting the relevance of a professionalized supply chain management. A dependable ssupply of contraceptives is critical in initiating the demand for and continuation of contraception[150].

Chapter 6: DISCUSSION AND CONCLUSION

The objective of this literature review was to identify and discuss the barriers and enablers to accessing contraceptive options by women and girls of reproductive age 15 – 49 years in fragile settings in Sub - Saharan Africa in order to advise on appropriate program implementation strategies to stakeholders working in humanitarian settings.

In the contexts of women's and girls' needs for contraceptives in fragile settings in Sub – Saharan Africa, an analysis of the factors that impact access in the various domains of access at the different phases of crisis was done with the identification of various barriers and enablers to accessing contraceptive services. These are enumerated below:

Barriers identified include: Disrespect by healthcare providers, lack of accurate information about contraception or contraceptive options, negative societal norms and beliefs unacceptable contraceptive options. Others include; Lack of access to funds for contraceptive services, misconceptions and apprehensions concerning contraceptive methods, socio-cultural barriers, Lack of varieties of contraceptive options, security concerns for health workers and the contraceptive, products, lack of coordination and fragmentation of contraceptive services into various vertical programs, ineffective supply chain system, lack of adolescent or youth friendly contraceptive services and weakened healthcare systems.

Some enabling factors identified include : The use of mass media for information dissemination on contraception and contraceptives options, in-service training of healthcare service providers, recruiting and using of community health care workers from amongst the displaced communities, involvement of the community through community engagement including the religious and community leaders right from the planning stage to implementation of contraceptive services and availability of broad range of contraceptive options. Other enablers include; approachable and acceptable healthcare workers such as the CHWs, involvement of adolescents in program planning and implementation and task shifting strategies.

Analyzing the different factors influencing access to contraceptive services in humanitarian settings in the context of their relevance to the different phases of crisis, the issue of little knowledge, non-accommodating and unapproachable attitudes and behavior of health care workers as barriers to utilization has been highlighted in several studies[66][90][25] this underscores the importance especially in the context of crisis. It is important to understand that these women are already traumatized and also have problem with trusting strangers[3][151], any further display of negative attitudes therefore will alienate them to whatever services being offered.

Against this background, it becomes clear why women in these settings will tend to trust the familiar and empathetic care givers. The community health workers (CHWs) who are recruited from amongst fellow refugees that are health workers therefore, are more acceptable service providers for them, even if they may risk the lack of confidentiality or anonymity within the community[53]. An added advantage to the utilization of ccommunity-based distribution is that it is more cost effective and may improve continuity when compared to facility-based distribution of contraceptives. This explains why CHWs is gaining popularity in many Countries as demonstrated by the many favorable policy revisions in support

of utilizing them in service provision since they are much more acceptable and sustainable[92].This strategy is effective at all phases of crisis.

A common barrier to accessing contraceptives is the fact that in crisis settings, availability of contraceptives are often limited to short-acting methods or not available at all[37]. However, there are evidences to show that when a full range of contraceptive options are available women with unmet need will voluntarily use them[99][39]. An effective strategy to enable contraceptive utilization in this context therefore will be to provide different mix of contraceptive services including LARC. In this context, DMPA-SC(Depot-medroxyprogesterone acetate subcutaneous) which is a variant of the long acting injectable hormonal contraceptive is an emerging option that has the potential to significantly expand women's contraceptive options. It has the advantage of increased personal autonomy through self-care[94].

Many humanitarian settings in SSA lack access to a full understanding of RH information leading to risky sexual behaviors and not using contraceptives amongst adolescents in the IDP and refugee camps as was the case in the IDP camps in the Northern parts of Nigeria[102]. Consequently, even when RH services are available, they are under - utilized since these adolescents are not aware of these services[103].

A review of the pros and cons of existing contraceptive service delivery strategies and of promising strategies that expand women's and girls' access to these services in fragile settings in SSA showed various contraceptive services delivery strategies existing in different contexts aimed at mitigating against some observed barriers with varying levels of success. These strategies include; involvement of adolescents, the voucher program approach, the use of conditional cash transfers, school-based programs and task shifting strategies. Additional promising strategies include the use of LARC such as DMPA-SC and DMPA- IM and increasing the mix of contraceptive options available to clients.

This review has demonstrated different levels of success in the contraceptive services program implementation across the different contexts of humanitarian/ fragile settings in Sub-Saharan Africa. These differences reflect the complex nature of the different levels of fragility. This impacts on the resilience of the health systems and thus the ability to coordinate an acceptable and appropriate response that will adequately meet the needs of the women and girls in these settings.

There is also need for a standardize data collection to document the outcomes of M&E of SRH services in humanitarian settings. This is important to critically analyze the scope of coverage of the different domains. An essential step in assessing the status of these responses over time as well as across countriess is the need to develop a list of core indicators[101]. This is lacking in the humanitarian settings in SSA. The contributing challenges to this phenomenon include insecurity, inadequate resources and skills both for the collection and analysis of these data. A combination of lack of validated methods results in the poor quality and quantity of information accessible to humanitarian workers in SSA[152]. A deliberate effort should be made therefore to document activities and develop standard operating procedures.

For instance, provision of the MISP at the moderate to severe escalation phase of crisis is still considered as the main stay response standard operating principles among donors and humanitarian workers in view of the scarce resources and reduced capacity in this setting. The focus is on few and essential activities and supplies that are practical and easy to use in the field environment. Most importantly they must be life saving for those in need and include a range of RH services which includes the contraceptive services[50]. This MISP was revised with some changes in 2018 creating some level of controversy amongst different stake holders in the humanitarian field. The contention is that it has diluted the key guidance and messages and leave the different stakeholders too much possible interpretations making response activities less uniform at implementation[153]. This highlights the need for greater documentations and coordination. This will provide examples of best practices for a more uniform response strategy in humanitarian settings.

An important barrier to the uptake of available contraceptives at all phases of crisis is the socio-cultural settings. The case of South Sudan, where due to the high child mortality and the dependence of the parents on large family since they see them as investments. Compounding this scenario is the ethnic nature of the conflicts which makes them suspicious of anyone who is not of a particular tribe[72][73]. They perceived a larger family size as an advantage of extra security for the community or ethnic group [74]. Any program strategy therefore that does not consider an economic empowerment package like skills transfer and use of indigenous community health care workers may not work. Attention also should be paid to an integrated maternal and child program to reduce the high child mortality for a sustainable solution. Here, the use of conditional cash transfers and task shifting strategies using indigenous CHWs would be an effective strategy.

Especially at the preparatory and early phase, the religious and moral objections to contraception to need to be understood[75][76]. This objections are usually due to distrust and a lack of informed knowledge as was shown in the cases of Uganda, Thailand and Colombia[11]. Community engagement combining mass media and interpersonal communication(IPC)[142] will be a promising strategy to build trust and provide informed knowledge.

The strategy of task shifting/ sharing has been found to enhance many high impact practices This strategy makes it possible for health system to provide a comprehensive patient- centered care in an efficient way and maximizes the reach of these services. This strategy is especially useful at the recovery phase and eases the transitioning process.

In other to provide a comprehensive package of health services in an integrated way, an objective assessment of the needs and vulnerabilities should be done [154][155]. Topics included in these packages range from, nutrition, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), as well as water, sanitation and hygiene (WASH). Also, for a sustainable service delivery, all programmes need to transition from the initial emergency response to health systems strengthening in the long term. It also important to recognize the critical need to ensure the safety of health workers and their facilities in conflict settings[93].

Section 6.1: Limitations of this study

Limitations of this study include the following:

- The literature search was limited to only literatures that were written in the English language. This was because the author is only comfortable with the English language.
- This study was only limited to fragile states within SSA. Though the findings from this study may be applicable to other settings, there is a need to consider the socio-cultural, political and religious differences in the various settings. Also, to what extent the laws and policies differ may affect the generalizations of some of the findings in this review.
- Reflecting on the fact that there has been lack of activity documentation on the various program implementation in this setting, various grey literatures were explored with varying degrees of quality though standard quality appraisal tools were used for the inclusion of these grey literatures.
- The researcher could not gain access to some peer review literatures because they were restricted. However, efforts were made to find suitable alternatives, thus quality of the facts were not compromised.

Section 6.2: Conclusion:

In conclusion, increasing access to contraceptive services is an urgent priority in fragile settings. To ensure that women in fragile settings have the freedom and the choice to control their fertility, interventions will benefit from focusing on working with CHWs as members of the displaced population and other task shifting/ sharing strategies. Also, strengthening of the health centers and clinics will ensure a sustainable contraceptive services program delivery in humanitarian settings and ease the transitioning of ownership. This will also reduce the incidence of vertical programs and promote efficiency.

Furthermore, the findings show that strategies drawn from more stable development settings such as integration of services using multi-component program approach, competency-based training, supportive supervision, simple quality improvement tools, and community mobilization can be modified to work in fragile settings. Such efforts require continued political and programmatic commitment to increase financial and human resources for contraceptive services, from both governments and humanitarian aid organisations. Also, there is a need for greater advocacy and more global commitment to the financing of contraceptive service provision in humanitarian settings[37][28].

Section 6.3: Recommendation

Humanitarian workers should recruit lower level cadres of health workers such as the CHWs (from amongst the displaced population to enhance acceptability) and traditional care providers should be trained to facilitate the scaling up of the MISP and work towards comprehensive SRHR. Their capacity especially in the area of clarifying their values in responsive services for all persons, especially for youths should be strengthened.

There should be a standardize data collection to document the outcomes of M&E of SRH services in humanitarian settings including the development of a standard operating procedure to create uniformity in response actions.

Humanitarian workers should prioritise access to accurate information about available SRH services including contraceptive services at the commencement of response activities.

Humanitarian workers also should increase the mix of contraceptive options available to clients including the use of LARC such as DMPA-SC and DMPA- IM.

For a sustainable response, the strategy in service delivery should emphasise integration of services which should reflect the context of a comprehensive needs' analysis.

Finally, there should be greater governmental advocacy and more global commitment to the financing of contraceptive service provision in humanitarian settings.

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ANNEX

RESEARCH TABLE

	Objective	Issues	Methods	Respondents
1.	To identify and discuss the barriers and enablers to accessing contraceptive options in fragile settings in Sub – Saharan Africa by women and girls of reproductive age 15 – 49 years to make appropriate best practice program implementation strategies advice to stakeholders working in humanitarian settings.	• Stigma • Spouse • Parents/ caretakers. • Peer pressure • Religion • Cultural beliefs and practices • Security • Education	Literature Search	Literature analysis
2.	To describe the contexts of women's and girls' needs for contraceptives in fragile settings in Sub – Saharan Africa.	• Sexual and gender-based violence • Transactional sex • Socio-economic factors • Education • Desire for Contraception • Unwanted pregnancy	Literature search	Literature analysis
3.	To analyse the factors influencing access to contraceptive services for women and girls age 15 – 49 years in fragile settings in Sub – Saharan Africa.	• Distance • Availability • Acceptability • Affordability • The attitude of the service provider	Literature search	Literature analysis

4.	To review the pros and cons of existing contraceptive service delivery strategies in fragile settings in Sub – Saharan Africa and analyse promising strategies that expand women's and girls' access to these services in fragile settings in Sub – Saharan Africa	• Community participation • Post Abortion care • Youth-friendly services • Free contraceptive services • Health literacy/promotion • Community participation • Spouse involvement • Emergency contraceptive pills	Literature search	Literature analysis

Spread sheet summary of retrieved literatures

Author(year) article type	Title	Study design and Quality	Study setting	Target population	Intervention	key findings
sood,suruchi et al.2004(Journal article)	'Come Gather Around Together' An Examination of Radio Listening Groups in Fulbari, Nepal	Qualitative study(Using survey data supplemented by anecdotal evidence and service statistics(**Moderate quality)**	Membership goups listening to radio programs in Fulbari language	Parbatipur and Fulbari VDCs in Chitwan district located in the Terai region of Nepal.	survey provides information on background sociodemographic characteristics, exposure to the media programs of interest, and knowledge of, attitudes toward and use of family planning	research on the effects of entertainment–education interventions also suggests that talking to others about campaign messages can lead to behavior change
Whelan et. Al.(2007) oeer reviewed article	'Halfway people': Refugee views of reproductive health services	Rapid appraisal methods included 46 focus group discussions and interviews with over 800 refugees, audits of 14 health facilities, referral hospital reviews, exit interviews with clients, and interviews with health workers(**High quality**)	11 sites in Uganda, Republic of Congo, and Yemen	Refugees in stable refugee sites	objective of this study was to identify factors that facilitate or hinder access to, use of, and satisfaction with reproductive health services in refugee settings, from the perspective of beneficiaries	The quality of services was variable, with high staff turnover in some areas affecting relationships with refugee clients. Referral hospitals in host countries were not all equipped to deal with obstetric and other emergencies of either local or refugee populations
Ackerso,Kelly et al.(201	"Family planning will mean that there will not be any babies" - Knowledge, beliefs, and acceptance of contraception among South Sudanese women	Ancillary analysis of qualitative data gathered from field notes taken during six Home Based Life-Saving Skills workshops conducted between 2013 and 2017. Participant responses recorded verbatim and analyzed through content analysis.(**High quality**)	South Sudan	68 Women in South Sudan in FGDs	Objective: Explore knowledge, beliefs and acceptance of modern family planning methods among South Sudanese women.	An overarching theme "double-edged sword" evolved from the narratives. Upheaval from villages in South Sudan to refugee camps in northern Uganda has changed reproductive health sub-themes evolved, cultural norms, changing times, and desire to learn. Cultural norms were to abstain from sex while breastfeeding 2 to 3 years, considered the norms with favorable and unfavorable consequences. Within that theme, three one acceptable family planning method. Women had very little knowledge of modern contraception, including condoms, but desired to learn and teach others.Participants recognized traditional ways of child spacing and avoiding pregnancy were no longer sufficient and contraceptive methods (outside of abstinence) were important to prevent mistimed pregnancy
Jennings Lauren et al.(2019)peer reviewed article	A forgotten group during humanitarian crises: a systematic review of sexual and reproductive health interventions for young people including adolescents in humanitarian settings	searched peer-reviewed and grey literature published between 1980 and 2018 using search terms for adolescents, young people, humanitarian crises in low- and middle- income countries and SRH in four databases and relevant websites**(High quality)**	Literature search	Humanitarian settings	stematic review assessed the evidence on SRH interventions for young people including adolescents in humanitarian settings, strategies to increase their utilisation and their effects on health outcomes.	Nine peer-reviewed and five grey literature articles, the majority published post-2012 and mostly high- or medium-quality, focusing on prevention of unintended pregnancies, HIV/STIs, maternal and newborn health, and prevention of sexual and gender-based violence. We found no studies on prevention of mother-to-child transmission (PMTCT), safe abortion, post-abortion care, urogenital fistulae or female genital mutilation (FGM). Thirteen studies reported positive effects on outcomes (majority were positive changes in knowledge and attitudes), seven studies reported no effects in some SRH outcomes measured, and one study reported a decrease in number of new and repeat FP clients. Strategies to increase intervention utilisation by young people include adolescent-friendly spaces, peer workers, school-based activities, and involving young people.

Singh Nehar S et al.(2018) peer reviewed article	A long way to go: a systematic review to assess the utilisation of sexual and reproductive health services during humanitarian crises	searched for both quantitative and qualitative studies in peer-reviewed journals across the following four databases: EMBASE, Global Health, MEDLINE and PsychINFO from 1 January 1980 to 10 April 2017. Primary outcomes of interest included selfreported use and/or confirmed use of the Minimum Initial Service Package services and abortion services. Two authors independently extracted and analysed data from published papers on the effect of SRH interventions on a range of SRH care utilisation outcomes from the onset of emergencies, and used a narrative synthesis approach(High quality)	Literature search	Humanitarian settings	peer-led and interpersonal education and mass media campaigns, community-based programming and three-tiered network of community-based reproductive and maternal health providers.	Despite increased attention to SRH service provision in humanitarian crises settings, the evidence base is still very limited. More implementation research is required to identify interventions to increase utilisation of SRH services in diverse humanitarian crises settings and populations.
Ivanova, Olena et al.(2018)peer reviewed lit	A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa	A mixed methods systematic review, exploring qualitative and quantitative data, was conducted to assess our aim(**High quality**)	Literature search	Humanitarian settings	Two authors independently read all included articles and completed a data extraction form created to gather the following: authors, study setting, main study objectives, study population, study design and study findings. Due to the inclusion of studies using qualitative and quantitative design, conducting a meta-analysis of the data was not appropriate. A descriptive narrative synthesis was chosen as the most relevant and suitable method of data synthesis for this review. The results are supported with original quotations and examples	Results of this review demonstrate the gaps in the existed evidence on SRH of migrant, refugee and displaced girls and women living in Africa. The necessity of disaggregation by sex and age should be addressed in future research. Targeting young refugee, displaced and migrant adolescents of 10–14 years old is very important enabling the complexity of body and physiological changes and the paucity of information from this age and population group to be taken into account
Starrs, Ann M et al.(2018) Peer reviewed Lit	Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission	Systematice Literature review	Literature search	Humanitarian settings	Thematic Literature analysis	This Guttmacher–Lancet Commission presents a bold vision for advancing SRHR beyond the boundaries that politics, funding, and existing programme structures have imposed to date. It draws its inspiration from the international consensus reached more than 20 years ago at the ICPD and places the discussion of SRHR in the current context, using the latest evidence on needs and service gaps. Mobilisation of women's and human rights groups and engaging adolescents, men, and health activists will be essential for moving the SRHR agenda forward.
Keith, Bonnie et al. (2014)	Home-based administration of Sayana® Press: review and assessment of needs in low-resource settings	Systematic Literature review(High quality)	Literature search	Literature search		A new presentation of the subcutaneous (SC) injectable contraceptive depot medroxyprogesterone acetate (DMPA) increases the possibilities for home and self-administration of this popular contraceptive method. Sayana® Press is DMPA-SC in the prefilled Uniject™ injection system and consists of one dose that provides 3 months of contraceptive protection. Studies indicate that lay caregiver and self-injection of various medications, including other injectable presentations of DMPA-SC, are acceptable and effective. Introduction of Sayana® Press in developing countries could extend injectable contraceptive delivery safely and effectively beyond the clinic and, eventually, into the home, allowing lay caregiver or self-administration. Research needs for low-resource settings include assessing the acceptability and feasibility of self-injection with Sayana® Press. Feasibility studies necessary for implementing a sustainable home-based delivery program include assessment of training, health systems, policies, infrastructure needs and programmatic considerations to optimize women's ability to manage their self-injection schedule.
E, Macouillard et al. (2016)	How User Fees Influence Contraception in Low and Middle Income Countries: A Systematic Review.	Systematic Literature review(High quality)	Literature search	Literature search		Accessible and quality reproductive health services are critical for low- and middle-income countries (LMICs). After a decade of waning investment in family planning, interest and funding are growing once again. This article assesses whether introducing, removing, or changing user fees for contraception has an effect on contraceptive use. We conducted a search of 14 international databases. We included randomized controlled trials, interruptedtime series analyses, controlled before-and-after study designs, and cohort studies that reported contraception-related variables as an outcome and a change in the price of contraceptives as an intervention. Four studies were eligible but none was at low risk of bias overall. Most of these, as well as other studies not included in the present research, found that demand for contraception was not cost-sensitive. We could draw no robust summary of evidence, strongly suggesting that further research in this area is needed.
Mullany, Luke C. et al.(2010)	Impact of community-based maternal health workers on coverage of essential maternal health interventions among internally displaced communities in eastern Burma: the MOM project	Cross sectional study(high quality)	Surveys		Four ethnic health organizations from the Shan, Mon, Karen, and Karenni regions collaborated on a pilot project between 2005 and 2008 to examine the feasibility of an innovative three-tiered network of community-based providers for delivery of maternal health interventions in the complex emergency setting of eastern Burma. Two-stage cluster-sampling surveys among ever-married women of reproductive age (15-45 y) conducted before and after program implementation enabled evaluation of changes in coverage of essential antenatal care interventions, attendance at birth by those trained to manage complications, postnatal care, and family planning services.	BACKGROUND: Access to essential maternal and reproductive health care is poor throughout Burma, but is particularly lacking among internally displaced communities in the eastern border regions. In such settings, innovative strategies for accessing vulnerable populations and delivering basic public health interventions are urgently needed. CONCLUSIONS: Coverage of maternal health interventions and higher-level care at birth was substantially higher during the project period. The MOM Project's focus on task-shifting, capacity building, and empowerment at the community level might serve as a model approach for similarly constrained settings.

Casey, Sara E et al.(2015)	Evaluations of reproductive health programs in humanitarian settings: a systematic review	Systematic Literature review(High quality)	Literature search	Literature search	Literature search	Provision of reproductive health (RH) services is a minimum standard of health care in humanitarian settings; however access to these services is often limited. This systematic review, one component of a global evaluation of RH in humanitarian settings, sought to explore the evidence regarding RH services provided in humanitarian settings and to determine if programs are being evaluated. In addition, the review explored which RH services receive more attention based on program evaluations and descriptive data. Peer-reviewed papers published between 2004 and 2013 were identified via the Ovid MEDLINE database, followed by a PubMed search. Papers on quantitative evaluations of RH programs, including experimental and non-experimental designs that reported outcome data, implemented in conflict and natural disaster settings, were included. Of 5,669 papers identified in the initial search, 36 papers describing 30 programs met inclusion criteria. Twenty-five papers described programs in sub-Saharan Africa, six in Asia, two in Haiti and three reported data from multiple countries. Some RH technical areas were better represented than others: seven papers reported on maternal and newborn health (including two that also covered family planning), six on family planning, three on sexual violence, 20 on HIV and other sexually transmitted infections and two on general RH topics. In comparison to the program evaluation papers identified, three times as many papers were found that reported RH descriptive or prevalence data in humanitarian settings. While data demonstrating the magnitude of the problem are crucial and were previously lacking, the need for RH services and for
Austrian, Karen(2011)	Expanding safe spaces, financial education, and savings for adolescent girls in Kenya	Qualitative study(Moderate quality		Kenya	The study representatively sampled adolescents from four ethnically distinct villages in Kibera. Although both girls and boys face challenges growing up in this environment, the difficulties girls confront are particularly pronounced. The baseline data highlight a picture of social isolation for many of the girls. Only half of girls report having many friends in their neighborhood, and 55 percent of girls live with neither or only one parent. Only a quarter of girls have a safe place in their community to meet their friends. Of girls aged 10–19 who have ever had sex, 34 percent did not want to have sex the first time they did; 60 percent of girls aged 10–19 consider themselves at risk for being raped. The Binti Pamoja Center, with support from the Council, the Global Financial Education Program (GFEP), and Nike Foundation, set out to increase safe spaces and skills	Savings, when delivered in an appropriate program platform that builds assets for girls, has the potential to have both economic benefits and a broader effect on girls' overall well-being. The combination of safe spaces, financial education, and savings accounts addresses a range of vulnerabilities that girls face—social isolation, financial responsibilities, and relationships with men that involve high levels of economic dependence.
Machiyama, Kazuyo et al.(2018) Reportof population council-Grey literature(High quality)	Accelerating uptake of voluntary, rights-based family planning in developing countries	Family evidence brief update(2018)	Evidence Brief		This is one of seven Family Planning Evidence Briefs prepared for the Family Planning Summit held in London on July 11, 2017. The briefs highlight evidence and provide research and programme considerations for improving access to family planning and reducing unintended pregnancy. Programme considerations are based on the expert views of the authors, who undertook desk reviews drawing on existing evidence	**FAMILY PLANNING** To meet the FP2020 and Sustainable Development Goals, significant investments are required by countries and donors in the following priority areas: Sustainable financing, Reaching all adolescents , Expanding availability of services to the poorest and hard-to-reach populations, Improving the quality of services, Increasing the range of methods available, Strengthening procurement procedures and supply chains, Broadening social and behaviour change communication interventions, Sustaining R&D investments in contraceptive methods and their delivery .
Erismann Séverine et al. (2019) a qualitative study(High quality)	Addressing fragility through community-based health programmes: insights from two qualitative case study evaluations in South Sudan and Haiti	Qualitative study(**High quality**)	Qualitative study	South Sudan and Haiti	The study consisted of a document review, qualitative field research undertaken between June and August 2015 in South Sudan and Haiti, and two data triangulation/validation workshops. Semi-structured key informant interviews and focus group discussions included 49 purposively sampled participants who helped build a deeper understanding of what constitutes and drives fragility in the respective countries. Moreover, interviews and focus group discussions served to grasp positive and negative effects that the Swiss Red Cross's activities may have had on the overall state of fragility in the given contexts	Health programmes may not only reach their health objectives but might potentially also contribute towards mitigating overall fragility. However, considerable hurdles remain for aid agencies, especially where scope for action is limited for a single actor and where engagement with state structures is difficult. Thus, cooperation and exchange with other aid and development actors across the spectrum has to be strengthened to increase the coherence of aid policies and interventions of actors both within and across the different aid communities.
Morris, Jessica L. et al.(2015) Literature review (Moderate quality)	Adolescent sexual and reproductive health: The global challenges	Literature review **(Modearate quality)**	Litrature review	Literature search	Literature search	Innumerable health and social challenges face young people in all countries; it is time to improve our understanding of this age group and to focus our energies on alleviating these problems. Political efforts need to be directed to providing youth-appropriate services, and the health establishmentmust follow a comprehensive, evidence-based approach that raises the capacity of health workers and implements bold initiatives for, and with, adolescents. Importantly, obstetricians and gynecologists—through their national associations and through FIGO at the international level—have an important role to play in the advancement of ASRH services so that healthcare workers move from being part of the problem to part of the solution. FIGO is committed to promoting ASRH. Addressing the global challenges of adolescent health

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CASP Checklist: 10 questions to help you make sense of a Systematic Review

How to use this appraisal tool: Three broad issues need to be considered when appraising a systematic review study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Systematic Review) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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The Critical Appraisal Skills program(CASP) : Quality appraisal tool

Paper for appraisal and reference:

Section A: Are the results of the review valid?

1. Did the review address a clearly focused question?

Yes / Can't Tell / No

HINT: An issue can be 'focused' in terms of
- the population studied
- the intervention given
- the outcome considered

Comments:

2. Did the authors look for the right type of papers?

Yes / Can't Tell / No

HINT: 'The best sort of studies' would
- address the review's question
- have an appropriate study design (usually RCTs for papers evaluating interventions)

Comments:

Is it worth continuing?

3. Do you think all the important, relevant studies were included?

Yes / Can't Tell / No

HINT: Look for
- which bibliographic databases were used
- follow up from reference lists
- personal contact with experts
- unpublished as well as published studies
- non-English language studies

Comments:

4. Did the review's authors do enough to assess quality of the included studies?

Yes ☐
Can't Tell ☐
No ☐

HINT: The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies' results ("All that glisters is not gold" Merchant of Venice – Act II Scene 7)

Comments:

5. If the results of the review have been combined, was it reasonable to do so?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- results were similar from study to study
- results of all the included studies are clearly displayed
- results of different studies are similar
- reasons for any variations in results are discussed

Comments:

Section B: What are the results?

6. What are the overall results of the review?

HINT: Consider
- If you are clear about the review's 'bottom line' results
- what these are (numerically if appropriate)
- how were the results expressed (NNT, odds ratio etc.)

Comments:

7. How precise are the results?

HINT: Look at the confidence intervals, if given

Comments:

Section C: Will the results help locally?

8. Can the results be applied to the local population?

Yes
Can't Tell
No

HINT: Consider whether
- the patients covered by the review could be sufficiently different to your population to cause concern
- your local setting is likely to differ much from that of the review

Comments:

9. Were all important outcomes considered?

Yes
Can't Tell
No

HINT: Consider whether
- there is other information you would like to have seen

Comments:

10. Are the benefits worth the harms and costs?

Yes
Can't Tell
No

HINT: Consider
- even if this is not addressed by the review, what do you think?

Comments: