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HUMANITARIANISM AND COVID-19: STRUCTURAL DILEMMAS, FAULT LINES, AND NEW PERSPECTIVES

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Covid-19's Effects on Contraceptive Services Across the Humanitarian–Development Nexus*†

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Abstract Sexual and reproductive health (SRH) services, including contraception, save lives in humanitarian emergencies. To document practitioners' perceptions of the effects of the Covid-19 pandemic on contraceptive programming in humanitarian settings and across the humanitarian–development nexus, the Women's Refugee Commission conducted 29 key informant interviews with respondents from non-governmental organisations, the United Nations, and government ministries. Disruptions to contraceptive services included closures or repurposing of health facilities, limited availability of health providers, supply chain interruptions, restricted service delivery modalities, and lower demand for services. Adaptations to sustain services included telemedicine, task-shifting and sharing, community-based service delivery, and other innovations. Underlying factors affecting the types and extent of disruptions and adaptations included emergency preparedness for SRH, decision makers' prioritisation of SRH services, funding, and coordination. Findings reinforce the need to build awareness that SRH services, including contraception, are lifesaving and essential in humanitarian settings, and to improve preparedness, including bridging gaps between humanitarian and development actors.

Keywords sexual and reproductive health, contraception, family planning, humanitarian settings, Covid-19, humanitarian–development nexus, emergency preparedness.

1 Introduction

Access to basic, primary health care is a critical component of humanitarian response. Sexual and reproductive health (SRH) services – including maternal and newborn care, family planning, prevention and treatment of sexually transmitted infections, and gender-based violence prevention and response – are lifesaving and critical to meeting basic health needs. The 2018 Minimum

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Initial Services Package (MISP) for SRH, the global standard for SRH response in acute emergencies, outlines the priority activities to be implemented at the outset of all crises to save lives and mitigate impacts – including the prevention of unintended pregnancies (IAWG 2018). Contraception must be made available with other essential SRH services at the outset of every emergency response, including epidemics and pandemics, and should be expanded after the acute stage of an emergency (*ibid.*).

Investing in contraceptive services reduces maternal mortality and morbidity (Ahmed *et al*. 2012) and is essential to respect, protect, and fulfil the human rights of women and girls, as established by multiple human rights treaty bodies (UNFPA and CRR 2011). Moreover, investing in contraception fosters resilience, promotes participation in livelihoods and education initiatives, and empowers women and girls – amplifying humanitarian investments across the board (Singh, Darroch and Ashford 2014).

Numerous studies document robust demand for contraception across diverse humanitarian settings, and evidence shows that more women and girls will find a contraceptive method that works for them when services are of good quality and a range of methods are available (Jacobi and Rich 2021; Hancock *et al*. 2016). For example, studies in conflict-affected areas of Sudan, Uganda, and the Democratic Republic of the Congo (DRC) found that 43–71 per cent of women wanted to delay pregnancy or did not want additional children (McGinn *et al*. 2011), and a survey of Syrian refugee women in Lebanon found that nearly three quarters of them wished to prevent future pregnancies (Kabakian-Khasholian *et al*. 2017). Yet gaps in the availability, accessibility, and quality of contraceptive services persist across diverse humanitarian settings, including stockouts of supplies and equipment, poor quality of care, and barriers for women and girls such as stigma, partner opposition, low knowledge of contraception, and prohibitive costs (McGinn *et al*. 2011; Casey *et al*. 2015; Chynoweth 2015; Tanabe *et al*. 2017; Jacobi and Rich 2021; Ackerson and Zielinski 2017; Ivanova, Rai and Kemigisha 2018).

The Covid-19 pandemic has amplified the need for humanitarian assistance, yet emerging evidence suggests that the pandemic and related response measures have severely impacted the availability and accessibility of SRH services around the world. A World Health Organization (WHO) survey in mid-2020 found that contraceptive services were one of the most frequently disrupted health services, with 68 per cent of respondents from 105 countries reporting disruptions (WHO 2020b). A second WHO survey, in early 2021, found that 40 per cent of 135 reporting countries were experiencing disruptions in contraceptive services (WHO 2021b). Studies from Nigeria, Bangladesh, and Ethiopia all found reductions in the use of contraceptive services (Adelekan *et al*. 2021; Roy *et al*. 2021; Ahmed *et al*. 2021; Belay *et al*. 2020). Estimates suggest that a 10 per cent decline in the

use of short-acting and long-acting reversible contraceptive (LARC) methods across 132 low- and middle-income countries due to Covid-19-related disruptions could result in 48.5 million additional women with unmet need for modern contraceptives and 15.4 million additional unintended pregnancies over a 12-month period (Riley *et al*. 2020).

However, there is still limited evidence available that is specific to the impact of Covid-19-related disruptions to contraceptive services in humanitarian settings and the health and rights of crisis-affected women and girls. This is a critical gap: in 2022, an estimated 274 million people will be in need of humanitarian assistance – the highest number in decades and an increase of 39 million people from 2021 (OCHA 2021). The Women's Refugee Commission undertook a series of key informant interviews (KIIs) with global stakeholders working across humanitarian and development settings to document their perceptions of the effects of the pandemic on contraceptive programming in humanitarian settings and across the humanitarian–development nexus. For the purposes of this assessment, the humanitarian–development nexus was defined as the continuum and intersection of settings and stakeholders spanning stable development settings, fragility, humanitarian response, and recovery.

This qualitative assessment was part of a broader, mixed-methods landscaping assessment funded by a private foundation to evaluate and build the evidence base on barriers, opportunities, and effective strategies to ensure access to contraceptive services among women and girls affected by crises. The assessment also included a literature review, a global contraceptive programming survey, KIIs, and three case studies, all conducted prior to the Covid-19 pandemic (see other assessment findings in Rich and Jacobi 2021). This article presents findings from the KIIs focused on the impact of the Covid-19 pandemic.

Section 2 lays out methods and limitations. Section 3 discusses findings from the research, including disruptions to contraceptive services and programmes; service delivery and programming adaptations; and underlying factors affecting contraceptive access and availability during the pandemic. Section 4 provides concluding remarks.

2 Methods and limitations

Between August and October 2020, the Women's Refugee Commission conducted 29 KIIs to collect qualitative data from stakeholders supporting contraceptive service delivery on (1) their experiences of the effects of the Covid-19 pandemic on contraceptive service delivery; (2) innovations and adaptations to ensure contraceptive services remained available and accessible; and (3) facilitators and barriers to contraceptive service delivery during the pandemic across the humanitarian–development nexus.

Respondents were identified using purposive and snowballing sampling and included representatives of one UN agency, 11 international non-governmental organisations (INGOs), five national non-governmental organisations (NGOs) across various regions, and three government health authorities from three countries (all of which were in sub-Saharan Africa). Among the UN agency and INGO respondents, 12 were based at headquarters, and eight were working at the regional or country level. For the purposes of anonymisation, data from UN agency respondents are reported as INGO respondents. Six interviews were conducted and transcribed in French, then translated into English for coding and analysis. All other interviews were conducted and transcribed in English. All interviews were conducted virtually.

Data were analysed using thematic analysis: the primary data collector first developed a small number of deductive codes, then read and annotated the transcripts to identify trends and emergent themes, which were used to develop the codebook. All transcripts were coded in NVivo 12 Plus by either the primary data collector or a second coder who was trained on the codebook prior to coding. Both coders analysed a selected transcript to assess and establish intercoder agreement and the primary data collector reviewed coding for all transcripts to identify any excerpts needing further discussion to ensure intercoder agreement.

Researchers obtained verbal informed consent prior to all interviews, and all data and materials were stored on secure, password-protected devices. No identifying information about respondents or their organisations is included in this article or any product of the assessment. Research was conducted in accordance with the Women's Refugee Commission's *Ethical Guidelines for Working with Displaced Populations*, which establishes ethical standards for data collection (Women's Refugee Commission 2016). Researchers did not submit the research for approval from an Institutional Review Board because personal information was not collected, the interviews aimed to understand organisational perceptions and experiences, and there was minimal risk to participants.

Researchers did not attempt to reach saturation, and findings are not representative of all practitioners' and organisations' experiences providing or supporting contraceptive service delivery in settings across the humanitarian–development nexus following the onset of the pandemic. Many respondents worked at the global or regional level and were reporting on numerous countries comprising both humanitarian and development settings, or supporting humanitarian and development programming; other respondents were representing one country with both humanitarian and development settings. Thus, the authors are not able to describe each respondent as representing humanitarian or development organisations and/or settings. Similarly, the authors are not able to systematically identify

respondents' country contexts, either to preserve confidentiality or because many respondents were reporting on multiple countries. Data presented in this article are key informants' perceptions and self-described experiences, and may not be representative of all humanitarian or development contexts. The study did not examine additional programming or quantitative data.

3 Findings

3.1 Disruptions to contraceptive services and programmes

Respondents were essentially unanimous in reporting that the Covid-19 pandemic had disrupted contraceptive programming and service delivery. Disruptions included closure or repurposing of health facilities, limited availability of providers, supply chain disruptions, restricted service delivery modalities, and limited access to services due to movement restrictions and other factors.

3.1.1 Health facility and provider availability and capacity

Many respondents reported that health facilities delivering contraceptive services were closed, at least temporarily, as a result of lockdowns and movement restrictions. Respondents working in both humanitarian and development settings described disruptions due to providers being redirected to and/or facilities being converted for Covid-19 response. One respondent lamented,

> *Some of the staff have been moved to emergency response for Covid-19. So, this already creates a big gap, and definitely some clients visit the facility, and they might not get the services they need. And once a client* [has visited the facility] *for family planning, that means they really need it – they probably needed it yesterday*.

Some respondents also noted that movement restrictions prevented providers from reaching health facilities. Multiple respondents also reported health workers falling ill, and in some cases dying, from the Covid-19 virus.

3.1.2 Contraceptive and PPE supply availability

Many respondents across organisations and settings described challenges with the availability of contraceptive and SRH supplies, and personal protective equipment (PPE). Respondents described supply chain disruptions at the international, national, and subnational levels caused by movement restrictions, including international production and availability of supplies, increased shipping and transportation costs, the ability to import supplies, and staff ability to reach warehouses. Two respondents working in humanitarian settings noted that Inter-agency Reproductive Health (IARH) kits were not available when respondents tried to order them.

Respondents also emphasised that PPE was extremely expensive given global demand. Multiple respondents reported that lack of PPE disrupted services at the outset of the pandemic, even

when all other elements required for contraceptive services were in place. Several respondents noted that providers went on strike due to lack of PPE; one respondent reported that providers decided to 'strike, saying that they are not protected and no one cared about them.' Another respondent explained that they had to shift funding intended to purchase contraceptive supplies to purchase PPE.

3.1.3 Range of services and service delivery modalities offered

Several respondents working across a range of settings described greater challenges to the provision of LARCs compared to short-acting methods, particularly early in the pandemic. This was reportedly due to the required provider presence for insertion and removal, limited availability of PPE, and reduced client flows through static facilities. Additionally, a few respondents reported that their organisations were following government guidelines on service delivery during the Covid-19 pandemic, emphasising the provision of short-acting methods over LARCs. However, some respondents across organisations and settings said that they were able to continue providing a diverse method mix, suggesting the pandemic's impact was strongly influenced by context, including the parameters of government guidelines on health service provision during the pandemic.

Many respondents across contexts stated that community sensitisation activities were severely disrupted, particularly by movement restrictions and lockdowns, but explained that demand generation activities gradually resumed as restrictions eased.

3.1.4 Clients' ability to reach and obtain services

Respondents representing diverse settings reported that people were unable to leave their homes due to movement restrictions or were stopped by authorities when attempting to reach facilities. Most respondents also explained that communities were afraid to seek services due to the risk of catching Covid-19 or were deterred by messaging about the importance of staying at home. Several respondents also reported decreases in client flow due to mistrust of health authorities and systems, including in settings with a history of Ebola, and myths and misinformation about Covid-19.

Respondents were particularly concerned about reaching isolated and marginalised communities, including adolescents. Multiple respondents across settings described increased transportation costs for clients, while facility closures exacerbated existing barriers posed by distance to health facilities. One national NGO respondent explained that many refugees in their country had lost their jobs due to the pandemic and could not afford services. Several respondents noted that clients were not able to seek services, or were turned away, because they did not have their own masks.

3.2 Service delivery and programming adaptations

Organisations implemented innovations and adaptations to sustain or resume contraceptive service delivery, including using telemedicine or other technology; task-shifting and sharing, including community-based service delivery; and implementing new service delivery, training, and supply chain mechanisms.

3.2.1 Technology and telemedicine

Nearly all respondents described using technology to maintain operations and, depending on the organisation, some elements of service delivery. Respondents described developing protocols and training and supplying providers to connect with clients via telephone and WhatsApp to schedule appointments, provide counselling, direct clients to obtain contraceptive methods, and conduct follow-up. Some respondents described establishing helplines or call centres to field inquiries on SRH services. One respondent working in a humanitarian setting said,

> *In two-and-a-half weeks, we seamlessly shifted from having crowds in our clinics to actually saying, 'Call the centre and you go through your symptoms, tell us what your location is, and we'll tell you what's the easiest way to get* [your method].'

Another respondent, working on humanitarian programming at the headquarters level of an INGO, remarked, 'There's such an opportunity there. We'll just make certain people's lives a lot easier, and decrease travel for women and providers, and everyone involved… We've discussed [this] for a long time… This is just the kickstart.' However, some respondents' organisations in both development and humanitarian settings could not implement telemedicine because they did not have the necessary electricity, internet connectivity, time, or resources.

3.2.2 Task-shifting and sharing, including community-based distribution of services and information

Some respondents reported task-shifting and/or sharing, including authorising community health workers to provide contraceptive methods and shifting provision of certain methods to pharmacies or dispensaries. One INGO respondent said that the pandemic has 'primed' stakeholders for task-sharing and shifting, as they recognised that 'We can't be doing this at our district hospitals because all [the] beds are taken by Covid-19. Therefore, it's okay for it to be happening at the [primary health-care] level.' He continued, 'It's also showed that change is possible… we need to really recognise that, as we say, necessity is the mother of invention.'

Several respondents across organisations and settings cited community-based distribution as an effective tool to reach communities and deliver contraceptive services and commodities. One respondent from a national NGO in a humanitarian setting said,

> *If people are not coming to the clinics, we have to reach them in their home. Believe me – when we were… reaching them in their homes, they were saying that* [they were] *out of contraceptives. We were thinking we had to get them these services*.

An INGO respondent, based at the headquarters level and working on a project in several development settings, felt shifting to community-based service delivery even had added benefits of reaching new populations, including 'married adolescents that may normally not be able to go outside that have perhaps been getting access to information'.

Conversely, some respondents reported that community-based distribution was suspended or reduced due to concerns that community health workers could spread the Covid-19 virus. Others explained that community-based distribution resumed or continued with PPE provision and social distancing. These variations reflect the extent to which disruptions and adaptations were highly context dependent.

In addition, respondents across organisations and settings described adopting new mechanisms to share information about contraceptive services, including radio, television, social media, community leaders, and socially distanced community-based mechanisms. For example, one INGO respondent working at the country level in humanitarian settings described using 'town criers' who 'had an individual megaphone… [and they] remind [communities] that all the services are open, and that anyone who needs family planning services can go there.'

3.2.3 Alternate service delivery modalities

Many respondents across settings reported increasing the amount of short-acting contraceptives dispensed to clients at one time to reduce facility visits. Respondents representing a range of settings noted that Covid-19 guidelines issued by global health authorities and many governments promoted multi-month distribution of these methods.

Respondents across settings expressed their perceptions that the pandemic had increased interest in self-injection of subcutaneous injectable contraceptives. Two respondents cited the DRC as an example of a crisis-affected country that accelerated approval of self-injection in response to Covid-19. Multiple respondents representing both humanitarian and development settings where self-administration was already authorised noted that greater emphasis was placed on self-administration as part of the Covid-19 response.

3.2.4 Adaptive training and provider support mechanisms

Respondents described adaptations to continue provider trainings, including social distancing, consolidated trainings,

smaller groups, and online trainings – although they noted negative implications for quality of training, cost, and the number of providers trained. Respondents across settings explained that providing PPE, training providers on infection prevention and control, openly communicating about risks, and providing psychosocial support was essential for addressing providers' concerns and resuming service delivery.

3.2.5 Coordinated supply chain actions

Respondents also discussed a range of solutions to address supply chain challenges, including redistributing supplies between districts and facilities according to demand and availability, and coordinating with partners to address stockouts. Several respondents working with INGOs in humanitarian and, in some cases, development settings described exploring or using local procurement options, given difficulties with sourcing and importing supplies from international suppliers.

3.3 Underlying factors affecting contraceptive access and availability during the Covid-19 pandemic

The types and extent of disruptions and adaptations differed across countries and settings. Respondents cited several factors affecting contraceptive service availability and accessibility during the pandemic, including emergency preparedness; the extent to which decision makers prioritised contraception; funding levels and flexibility; the crisis context preceding the pandemic; and coordination.

3.3.1 Emergency preparedness

Diverse respondents reported that contraceptive service delivery was negatively impacted by a lack of emergency preparedness, or that preparedness measures were ineffective. Respondents working in humanitarian and development settings largely explained that governments did not have emergency preparedness plans for health in place. Some reported that where government preparedness plans existed prior to the pandemic, they did not include or sufficiently prioritise SRH, or anticipate a global pandemic. However, several respondents in contexts impacted by Ebola outbreaks indicated that this experience primed stakeholders to respond to the Covid-19 pandemic. Respondents in humanitarian and development settings also noted that in some cases, strict lockdowns or movement restrictions instituted to prepare for the arrival of Covid-19 cases in-country severely disrupted essential health services and did not address the continuity of SRH services.

Diverse respondents across settings also reported organisational emergency preparedness to be a significant gap. Several development INGO respondents expressed the perception that many donors and implementing organisations operating in development settings largely do not consider preparedness to be part of their remit. However, several respondents – primarily

in humanitarian settings – did report that their organisation had preparedness plans in place and/or cited preparedness activities that supported Covid-19 response, such as training staff on the MISP for SRH and strengthening supply chains to ensure stock availability during emergencies.

3.3.2 Prioritisation of SRH services

Respondents' perceptions of the extent to which governments and other decision makers prioritised SRH services, including contraception, varied. Some respondents were adamant that governments failed to prioritise SRH and contraception during the pandemic. Others said that although authorities did not consider contraceptive and SRH services when instituting initial restrictions, many governments did include these services in the development of longer-term Covid-19 response guidelines and plans. However, a number of respondents clarified that even where governments recognised the importance of SRH, contraception specifically was not adequately prioritised.

Respondents shared that some governments were receptive to advocacy to prioritise contraceptive and SRH services. Advocacy emphasised the long-term risks of lack of contraceptive access, including increases in unintended pregnancies, unsafe abortion, and maternal mortality and morbidity. Several respondents also explained that high levels of attention to gender-based violence (GBV) during the pandemic provided an opportunity to advocate for increased prioritisation of SRH services. As one respondent stated, '[Y]ou cannot talk about GBV without talking about SRH… I think it's the opportunity to say, "Okay, this is a package, and you cannot do one without doing the other." ' Some respondents also noted that lessons learned from the impact of Ebola outbreaks on maternal and child mortality and morbidity were leveraged to ensure that SRH services remained available amid the Covid-19 pandemic. Two INGO respondents cited the WHO operational guidance for maintaining essential services (WHO 2020a), which include contraceptive services, as being an effective advocacy tool.

Respondents also acknowledged that the inclusion of SRH services in guidelines and plans did not guarantee available and accessible services. One respondent said that his organisation had worked with the national health ministry's emergency preparedness and response department in 2018 to include the MISP for SRH in preparedness and response plans, but reported that 'during Covid-19, it was not effective. It was of no use.' Respondents also described cases of governments in both humanitarian and development settings failing to allocate funding to or shifting funding away from contraception and SRH activities due to the pandemic.

3.3.3 Funding

Respondents across settings largely spoke positively about their donors' responses to the Covid-19 pandemic, including allowing flexibility to pivot and adapt programming. Respondents said that the pandemic significantly increased operating costs, but most did not report having to reallocate funding away from SRH to Covid-19 activities. Multiple respondents across organisations and settings also described seeking, and in some cases receiving, new funding to support PPE procurement and/or SRH service continuity.

However, a small number of respondents – representing both national NGOs and INGOs – reported that donors were not able to follow through on committed funding, either because funding was shifted to Covid-19 activities, or due to donors' financial challenges. Moreover, as previously mentioned, some respondents reported that governments had reallocated funding away from SRH, although others noted that their efforts to ensure that governments maintained funding for SRH were successful.

When asked about the longer-term impacts they anticipated in the funding environments, respondents described heightened uncertainty, with many noting that the economic impacts of the pandemic will also affect donors, which could in turn impact their long-term funding prospects.

3.3.4 Crisis context preceding the Covid-19 pandemic

Respondents expressed varying beliefs as to whether humanitarian or development settings and actors were better able to respond to the pandemic. Multiple respondents – working in both humanitarian and development settings – perceived development settings to be better resourced and thus able to absorb the shock of the pandemic, and that it was more challenging to maintain services in humanitarian settings due to weaker health systems, poor access to water and sanitation facilities, fewer resources, and limited technology. Several respondents from humanitarian settings expressed that insecurity compounded the effects of the pandemic, exacerbating challenges to reach affected populations and further deterring people from seeking services.

Conversely, a significant number of respondents – also working in both humanitarian and development settings – felt that humanitarian actors, and/or programmes in humanitarian settings, were more agile in responding to the pandemic and adapting service delivery. Some respondents felt that these settings were better prepared, with relevant policies and procedures in place for emergencies, including prior knowledge of the MISP for SRH and stronger coordination mechanisms.

3.3.5 Coordination

Respondents explained that stakeholder coordination affected the availability of contraception amid the pandemic, with coordination

being more effective in settings where stakeholders had existing relationships, and where robust coordination mechanisms were operating prior to the pandemic. One national NGO respondent from a humanitarian context said that the SRH coordination mechanism in her setting was effective because 'we've been working together and coordinating together for a long time. It's not just suddenly [that] it was created for Covid.'

Respondents from humanitarian and development settings specifically cited the need to strengthen coordination across the nexus as an important lesson learned. One development INGO respondent reflected, '[I]t seems so apparent that yes, of course, we should be reaching out to humanitarian actors… But I think those relationships don't necessarily exist across the nexus at the country level.' Respondents reflected that as the number of countries at risk of or experiencing crisis grows, distinctions between humanitarian and development settings are fading – rendering humanitarian and development silos outdated and inefficient. One respondent called for 'moving away from a discourse that talks about humanitarian versus development', and instead focusing on building resilient, adaptative health systems capable of absorbing and managing shocks, including epidemics and pandemics.

4 Conclusion

The Covid-19 pandemic affected the availability and accessibility of contraceptive services across humanitarian and development settings. Many respondents reported their perceptions that SRH services, including contraception, were particularly impacted because government authorities and other decision makers did not perceive them to be lifesaving or essential. The findings point to the critical need to continue building awareness among donors, governments, and partners across the humanitarian and development sectors that contraception is lifesaving, essential, and a human right in all emergencies, including the pandemic.

Stakeholders should also leverage the currently heightened awareness of the risk of crises to engage governments and development and humanitarian actors in emergency preparedness and resilience-building activities. SRH and contraception must be integrated into these plans and policies to address barriers to contraceptive service delivery, such as movement restrictions, that emerged during the pandemic (WHO 2021a).

Finally, stakeholders should institutionalise mechanisms implemented during the pandemic that improve contraceptive availability and access, including telemedicine and digital protocols, multi-month provision of short-acting methods, task-shifting and sharing, community-based provision of methods, and self-care methods. As well as improving access during the pandemic, these shifts will ensure preparedness for future crises, and boost access to contraceptives across stable and crisis times alike.

Notes

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