

UNIT 6: PREVENT UNINTENDED PREGNANCIES



Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. Global data suggests that an additional 29% of maternal deaths could be reduced through the provision of contraception for women who desire to prevent or delay pregnancy at that time.¹⁰⁵ However, as health systems are compromised during natural disasters and conflicts, access to contraception decreases. It is critical that the importance of the provision of contraception and its lifesaving effects are understood by Sexual and Reproductive Health (SRH) Coordinators, health program managers, and service providers to be part of essential health programming from the earliest phase of an emergency through recovery.

There are several useful resources that provide in-depth information on contraceptive methods and medical eligibility criteria, including the *Contraceptive Delivery Tool for Humanitarian Settings*¹⁰⁶ and *Family Planning: A Global Handbook for Providers*.¹⁰⁷

At the end of the unit, learners will be able to:

- ▶ explain why preventing unintended pregnancies is a lifesaving priority;
- ▶ list what contraception methods should be available in primary health care centers;
- ▶ explain what information should be available and how to ensure women, adolescents, and men are aware of the availability of contraceptives; and
- ▶ list ways to share information about the availability of contraceptives with the community.

105 Saifuddin Ahmed, Qingfeng Li, Li Liu, and Amy O Tsui, "Maternal Deaths Averted by Contraceptive Use: An Analysis of 172 Countries," *The Lancet* 380, no. 9837 (July 14, 2012), p. 111–125, [https://doi.org/10.1016/S0140-6736\(12\)60478-4](https://doi.org/10.1016/S0140-6736(12)60478-4).

106 *Contraceptive Delivery Tool for Humanitarian Settings* (WHO, 2018), <https://apps.who.int/iris/handle/10665/276553>.

107 *Medical Eligibility Criteria for Contraceptive Use* (WHO, 2015), https://apps.who.int/iris/bitstream/handle/10665/181468/9789241549158_eng.pdf?sequence=1; and *Family Planning: A Global Handbook for Providers* (WHO, Johns Hopkins Bloomberg School of Public Health, and USAID 2018), <http://www.fphandbook.org>.

MISP for SRH objectives and activities

PREVENT UNINTENDED PREGNANCIES.

To prevent unintended pregnancies from the onset of an emergency, it is important to ensure contraceptives are available. The SRH Coordinator, program managers, and services providers must work to:

- ▶ ensure availability of a range of long-acting, reversible, and short-acting contraceptive methods (including male and female [where already used] condoms and emergency contraception [EC]) at primary health care facilities to meet demand;
- ▶ provide information, including existing information, education, and communications materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination;
- ▶ ensure the community is aware of the availability of contraceptives for women, adolescents, and men.

Why is preventing unintended pregnancies a priority?

Women, men, and adolescents' SRH needs do not disappear when they are forced to flee their homes and communities; this includes the need for contraception. Displacement and insecurity may even increase people's desire and need for contraception, at the same time as they experience increased barriers to access. Those fleeing an emergency may not be able to bring their contraceptives with them or obtain contraceptives at their site of refuge. Conflict and natural disasters also expose women and girls to increased risks of sexual violence and subsequent unwanted pregnancy. Further, people continue to have sex lives during an emergency. Women may wish to postpone or cease bearing children in emergencies for many reasons, including to avoid exposing newborns to the risks of displacement. The disruption of family and social support structures can further pose challenges, particularly for adolescents who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices. It is therefore vital that contraception is properly integrated into humanitarian response and that services and supplies are made available to meet the demand in the affected population from the onset of an emergency.





The Reality of Implementing the MISP for SRH in Nigeria

Boko Haram violence forced people to flee from their homes into internally displaced persons camps and host communities.¹⁰⁸ To respond to the health needs of women and girls, the International Rescue Committee's Emergency Response Team deployed an SRH Coordinator to launch the Minimum Initial Service Package (MISP) for SRH in the newly liberated government areas. The international nongovernmental organization (NGO) recruited midwives and skilled staff to augment and support existing Ministry of Health providers. Inter-Agency Emergency Reproductive Health (IARH) Kits were ordered and delivered, including SRH equipment, medications, contraceptives, and supplies for six months. The SRH Coordinator also conducted on-the-job training to provide clinical care for survivors of sexual violence, contraception, and post-abortion care. The International Rescue Committee supported a total of five clinics. Within four weeks, it set up the only RH clinic in the Bakassi internally displaced persons camp, which included family planning services—registering 134 new contraception acceptors within the first month.

Lessons learned: Emergency responders must anticipate and prepare for a low number of available skilled health staff, long lead times for procurement and recruitment, and a low priority placed on SRH.

The MISP for SRH activity:

Ensure availability of a range of long-acting, reversible, and short-acting contraceptive methods at primary health facilities

A range of long-acting, reversible (implants and intrauterine devices [IUDs]), and short-acting (oral contraceptive pills, hormonal injectables, male condoms, female condoms where applicable, e.g., already used by the population prior to the crisis, and EC pills) contraceptive methods should be made immediately available to meet the demand of the affected population where providers are trained and skilled to provide and, in the case of long-term reversible contraception, remove the method.

Providers with existing competency should begin providing all available methods at the onset of the crisis. All forms of contraception should be provided on a confidential basis, without requiring the consent of a partner, parent, or caregiver. Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection (to prevent pregnancy and sexually transmitted infections [STIs], including human immunodeficiency virus [HIV]). More information on delivering contraceptive services in humanitarian settings and the World Health Organization (WHO) medical eligibility criteria can be found at who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/ and srhr.org/mecwheel/.

¹⁰⁸ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, case study MISP chapter, 2018.

As part of the planning for comprehensive SRH programming after the acute phase of the emergency, it is important to work on expanding the method mix available to the target population. Work with the Ministry of Health, the United Nations Population Fund (UNFPA) and other partners nationally to register methods, expand method mix, and train providers. A range of contraceptive methods beyond what is offered in the IARH kits can be procured through UNFPA Procurement Services Branch.



Noted Practice: Preventing Unintended Pregnancies in Cox's Bazar, Bangladesh

- ▶ Negotiations with the government took place at the beginning of the emergency for the government to provide short-acting methods temporarily for refugees—this was later replenished with humanitarian procurement by UNFPA.¹⁰⁹
- ▶ Existing information, education, and communications materials were used among partners and from the country of origin rather than designing new materials (language similarity, although not the same, between refugees and host communities helped to an extent).

What are some factors to consider in determining appropriate method mix in an acute humanitarian setting?

When determining what contraceptive methods to offer in the initial acute humanitarian response, some factors to consider include what methods were available to, and used by, the target population prior to the emergency and what methods are registered in the country of operation. Methods that were available to the target population before the emergency and for which demand exists should be provided. However, in an acute emergency setting, the ethical roll out of a new method, that was previously not available to the displaced population or not provided in the specific context, to a distressed population may be difficult to guarantee. Local providers may be unfamiliar with the new method, which may compromise high-quality counseling and service provision during an acute emergency. If a product was not registered in the country of operation before an emergency, there may be issues for arrival and customs clearance even when humanitarian import exemptions are in place. If a product is not registered but is necessary to implement lifesaving MISP for SRH services, work with the SRH Coordinator to anticipate and address potential import challenges. Further, when providing long-acting methods of contraception that require removal, it is important to consider if the affected population has a high likelihood of onward migration, in which case they may not have ongoing access to removal services. Consider prioritizing new method uptake (registration and rollout) in preparedness planning, to enable smooth import and use in the event of an acute emergency, and in post-acute emergency settings as part of expanding on the MISP to achieve comprehensive SRH programming.

¹⁰⁹ Communications, Chief, Health, United Nations Population Fund, September 2018.

Why is it important to provide long-acting contraceptive methods?

Women have the right to access a safe, effective, and acceptable method of contraception of their choice. It is important that long-acting contraceptive methods, such as the IUD and implants, are available because they are highly effective, repeat visits to a health facility are not necessary (this is especially important in unstable environments), and they do not require user action (e.g., taking a pill) when there are competing priorities for their time. In addition, the evidence shows that when more methods are available, more women find a method they like and use it.

How can a provider ensure quality of care?

Quality contraceptive service delivery emphasizes clients' confidentiality, privacy, voluntary and informed choice and consent. Counseling should also include information about method eligibility, effectiveness, possible side effects management and follow-up, guidance on method removal and return to fertility after method discontinuation. Women of all ages, including adolescent girls, should receive full information and services. With the important exception of emergency contraceptive pills and condoms, it is important to ensure the client is not pregnant before providing contraceptives.

If a client is pregnant, inform her of her options: giving birth and raising the child, putting the child up for adoption, or providing or referring for safe abortion care to the full extent of the law.



The MISIP for SRH activity:

Provide information that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and nondiscrimination

Ensuring Contraceptive Use Is Voluntary

All persons have the human right to reproductive self-determination and, thus, to make decisions regarding their reproductive health without being subjected to violence, coercion, or discrimination. Consequently, a human rights–based approach to providing contraception requires that all contraceptive services be offered on a voluntary and informed basis.

Providers must ensure that clients are provided with accurate information and are free to choose their preferred method without being subjected to undue influence or coercion.

The key tenets of voluntarism in providing contraception include the following:

- ▶ People have the opportunity to choose voluntarily whether to use a specific contraceptive method or not.
- ▶ Individuals have access to information on a wide variety of contraceptive choices, including the benefits, side effects and any health risks of particular methods.
- ▶ Clients are offered, either directly or through referral, a broad range of contraceptive methods and services.
- ▶ The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client.

What essential information should be provided to a client seeking contraception?

It is important that providers share the following information with clients who are seeking contraception:

- ▶ How the method works
- ▶ Effectiveness of the method
- ▶ Correct use of the method
- ▶ Benefits of the method
- ▶ Common side effects
- ▶ Other side effects and any health risks associated with the method
- ▶ How to overcome the side effects of the method

- ▶ Signs and symptoms that would necessitate a return to the clinic
- ▶ Return to fertility after method discontinuation
- ▶ STI prevention
- ▶ The right to get the method removed if desired (e.g., long-acting, reversible contraception)

The MISP for SRH activity:

Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

What can be done to ensure women, adolescents, and men are aware of the availability of contraceptives?

Ensure the community—including unmarried and adolescent community members—is aware of where and how to seek contraception. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms, and pictures). Community leaders and local volunteers, including peer promoters, can also be engaged to distribute information about the availability of contraceptive services. To aid service providers in providing family planning information, the Women’s Refugee Commission developed “universal” information, education, and communications materials on family planning topics. The templates can be found at iawg.net/resource/universal-and-adaptable-information-education-and-communication-templates-on-family-planning/.

What is emergency contraception?

Emergency contraceptives (EC) are medications or devices that can prevent pregnancy when used up to five days (120 hours) after intercourse.¹¹⁰ They should be used as quickly as possible for greater effectiveness. EC options include EC pills and insertion of the copper-bearing IUD (see Unit 3 for more information on EC). They can be used after unprotected intercourse, in cases of possible contraceptive failure and incorrect use of contraceptives, and following sexual violence. EC pills work by preventing ovulation and do not interfere with an existing pregnancy. A pregnancy test is not required in order to provide EC pills.

As part of the MISP for SRH, EC should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual. More information about EC and medical eligibility can be found at ec-ec.org/ecmethod/.

Overview of emergency contraceptive pill options

There are multiple regimens that can be used, including progestin-only, ulipristal acetate, and combined hormonal EC pills (the Yuzpe method, in which the client takes a higher dose

¹¹⁰ *Emergency Contraceptive Pills: Medical and Service Delivery Guidance* (International Consortium for Emergency Contraception and FIGO, 2018), https://www.cecinfo.org/wp-content/uploads/2018/12/ICEC-guides_FINAL.pdf.

of regular oral contraceptive pills).¹¹¹ Globally, progestin-only EC pills are the most widely available dedicated EC pill; however, dedicated progestin-only EC pills may not be available in all countries.

<p>Progestin-Only EC Pills</p>	<ul style="list-style-type: none"> ▶ One dose of Levonorgestrel (LNG) 1.5 mg taken within five days (120 hours) of unprotected intercourse ▶ Greatest efficacy when used closer to the time of sexual intercourse ▶ More effective and with fewer side effects than combined hormonal pills ▶ Most widely available type of dedicated emergency Contraceptive pill
<p>Ulipristal Acetate</p>	<ul style="list-style-type: none"> ▶ One dose of ulipristal acetate 30 mg taken within five days (120 hours) of unprotected intercourse ▶ More effective than progestin-only pills in the 73–120 hours after unprotected intercourse ▶ More effective and with fewer side effects than combined hormonal pills
<p>Combined Hormonal EC Pills</p>	<ul style="list-style-type: none"> ▶ Two doses of combined oral contraceptive pills, each containing estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel) ▶ The first dose taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) ▶ The second dose taken 12 hours later ▶ If vomiting occurs within two hours of dose, dose should be repeated ▶ Less effective and with more side effects than progestin-only EC pills and ulipristal acetate

¹¹¹ *Emergency Contraception, Fact Sheet*, (WHO 2018), <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>.

UNIT 6: Key Points

- ▶ Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities.
- ▶ Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection (to prevent pregnancy and STIs/HIV).
- ▶ EC should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual.
- ▶ All forms of contraception should be provided on a confidential basis without requiring the consent of a partner, parent, or caregiver.
- ▶ Some considerations for selecting method mix in acute onset emergencies include what methods were available to, and used by, the target population prior to the emergency and what methods are registered in the country of operation.
- ▶ Providers should ensure quality of care that emphasizes clients' confidentiality, privacy, voluntary and informed choice and consent.
- ▶ Information about contraceptive methods should be given, including how the method works, effectiveness of the method, correct use of the method, benefits of the method, common side effects, other side effects and any health risks associated with the method, how to overcome the side effects of the method, signs and symptoms that would necessitate a return to the clinic, return to fertility after method discontinuation, and STI prevention.
- ▶ Ensure the community, including unmarried and adolescent community members, is aware of how and where to access contraception:
 - ▶ Information about contraception should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms, and pictures).
 - ▶ Community leaders and local volunteers, including peer promoters, can also be engaged to distribute information about the availability of contraceptive services.



Challenges and Solutions

Challenges	Solutions
What if there are no health providers trained in providing and removing long-acting methods (e.g., IUDs and implants)?	In partnership with national authorities, international NGOs should deploy staff trained in providing and removing long-acting methods of contraception, and women and girls who request these methods should be referred to a facility with the capacity to provide services until local staff are trained and skilled to provide these methods.
What if providers are reluctant to offer contraception to some clients (adolescents, unmarried women, etc.)?	In planning to expand services from the MISP for SRH to comprehensive SRH, undertake values clarification exercises and trainings on SRH rights. Continue these at various stages of service delivery in consideration of staff turnover. ¹¹²
What if providers lack knowledge of the full range of contraceptive methods?	International NGOs should deploy staff trained in all methods of contraception. When planning for comprehensive SRH services beyond the MISP for SRH, integrate trainings on contraceptive methods. If providers are not trained on long-acting, reversible contraception, a referral system can be established to guarantee that clients have access to the method of their choice.
What if emergency contraception is not available?	Health providers can use combined oral contraceptive pills as EC (the Yuzpe Method): This consists of two doses of combined oral contraceptive pills. Each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel [LNG] or 1.0–1.2 mg norgestrel). ¹¹³ The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) and the second dose should be taken 12 hours later.

¹¹² Undertaking values clarification exercises and trainings on SRH rights should also be done during the preparedness phase.

¹¹³ *Emergency Contraception, Fact Sheet*, (WHO 2018), <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>.

CHECKLIST: PREVENT UNINTENDED PREGNANCIES

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

6. Prevent Unintended Pregnancies			
6.1	Short-acting methods available in at least one facility	Yes	No
6.2	Condoms		
6.3	EC pills* ¹¹⁴		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine devices (IUDs)		
6.8	Number of health facilities that maintain a minimum of a three-month supply of each	Number	
	Condoms		
	EC pills		
	Combined oral contraceptive pills		
	Progestin-only contraceptive pills		
	Injectables		
	Implants		
	IUDs		

¹¹⁴ It is important to note the different emergency contraceptive pills that are available, including progestin-only EC pills, combined oral EC pills, and ulipristal acetate.

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide contraceptive services?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.¹¹⁵

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 1A	Male Condoms
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 4	Oral and Injectable Contraceptives

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Kit 1B Female Condoms	Kit 14
Community/health pos	Depot-Medroxyprogesterone Acetate–Subcutaneous (DMPA-SC)	Kit 4
Primary health care facility (BE _m ONC)	Kit 7A Intrauterine Device (IUD)	Kit 4
Primary health care facility (BE _m ONC)	Kit 7B Contraceptive Implant	Kit 4

¹¹⁵ The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org/>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>.

Unit 6 Quiz: Prevent Unintended Pregnancies

1. What are some considerations for determining a comprehensive method mix in acute onset emergency? Select all that apply:
 - a. Registration of the contraceptive method in country of operation
 - b. Use by the crisis-affected populations
 - c. Potential for further migration
 - d. Crude birth rate
 - e. Religion

2. Unmarried adolescents should **not** be given contraception.

True or False

3. Which statement about emergency contraception (EC) is **not** true?
 - a. EC will not harm an existing pregnancy
 - b. EC needs to be taken within 120 hours and the earlier it is taken the more effective it is
 - c. Adolescent girls cannot take EC
 - d. Where dedicated EC pills are not available, oral contraceptive pills in the correct dosage can be used
4. What three things should be emphasized to ensure quality of care when providing contraception? Select all that apply:
 - a. Confidentiality
 - b. Privacy
 - c. Informed choice
 - d. Approval from family members or partner
5. What information should be provided to all clients during contraceptive counseling? Select all that apply:
 - a. Effectiveness of the method
 - b. Common side effects of the contraceptive method
 - c. Antenatal counseling
 - d. How the method works
 - e. STI protection