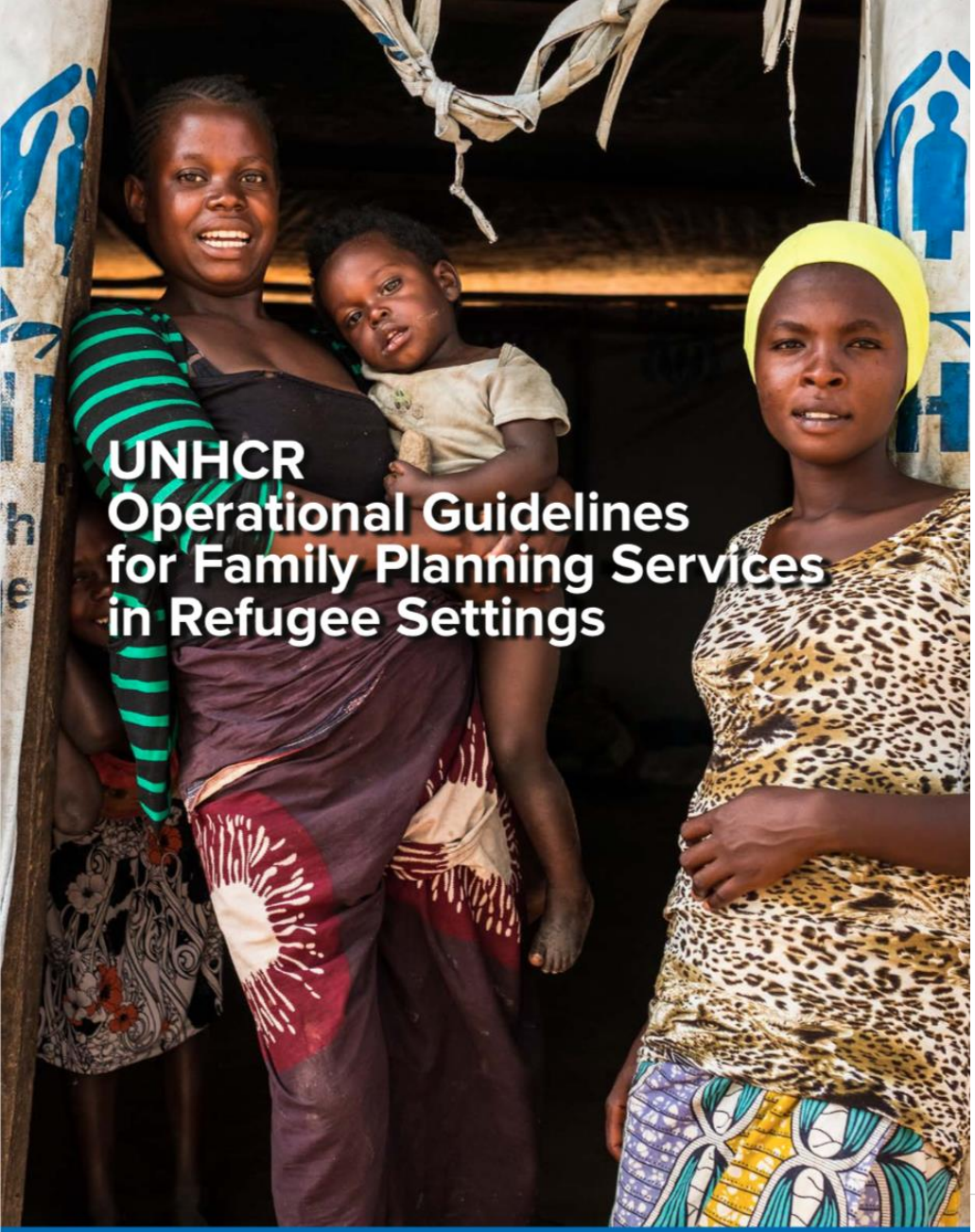

Contraception and Family Planning in Refugee Settings

Part 1

UNHCR

December 5, 2019

Stephanie Gee, Project Coordinator, Saving Maternal Newborn Lives project
gee@unhcr.org

Catrin Schulte-Hillen, Snr. RH and HIV advisor, Geneva
schulteh@unhcr.org

Liz Noznesky, Snr. program advisor for Sexual and Reproductive Health in Crisis Settings CARE
enoznesky@care.org

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BILL & MELINDA GATES foundation

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Agenda – Part 1

1. Background and Rationale
2. Global overview and trends (fertility/contraceptive use)
3. Family planning/contraception in humanitarian/refugee settings
4. Contraceptive services in Emergencies: MISP and Implementation Case Study in Cox's Bazar, Bangladesh by CARE
5. Essential components of FP/contraceptive clinical visit
6. Focus: LARCs and Emergency contraception

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Agenda - Part 2

1. Engaging men and boys: École de Maris (School for Husbands) program UNFPA Niger (Issa Sadou, UNFPA Niger)
2. Community-based FP activities (including use of DMPA-SC at community level)
3. Adolescent SRH
4. Postpartum/post-abortion contraception
5. Other integrated service delivery approaches
6. Tools for Improving Quality of Care
   - Monitoring tools
   - Protocols and clinical guidelines
   - Capacity Building for Staff
   - Essential Supplies and Equipment

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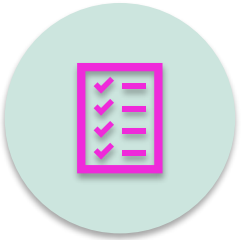
OBJECTIVES of WEBINAR

TO UNDERSTAND THE IMPORTANCE OF CONTRACEPTIVE SERVICES

TO BECOME FAMILIAR WITH CONTEXT SPECIFIC TO HUMANITARIAN/

REFUGEE SETTINGS

TO KNOW THE ESSENTIAL SERVICES COMPONENTS OF THAT SHOULD BE FOUND IN YOUR PROJECTS



TO MOTIVATE YOU TO ASSESS YOUR OWN PROJECT SITES AND MAKE A PLAN TO FILL GAPS

TO SHARE YOUR EXPERIENCES AND IDEAS WITH ONE ANOTHER

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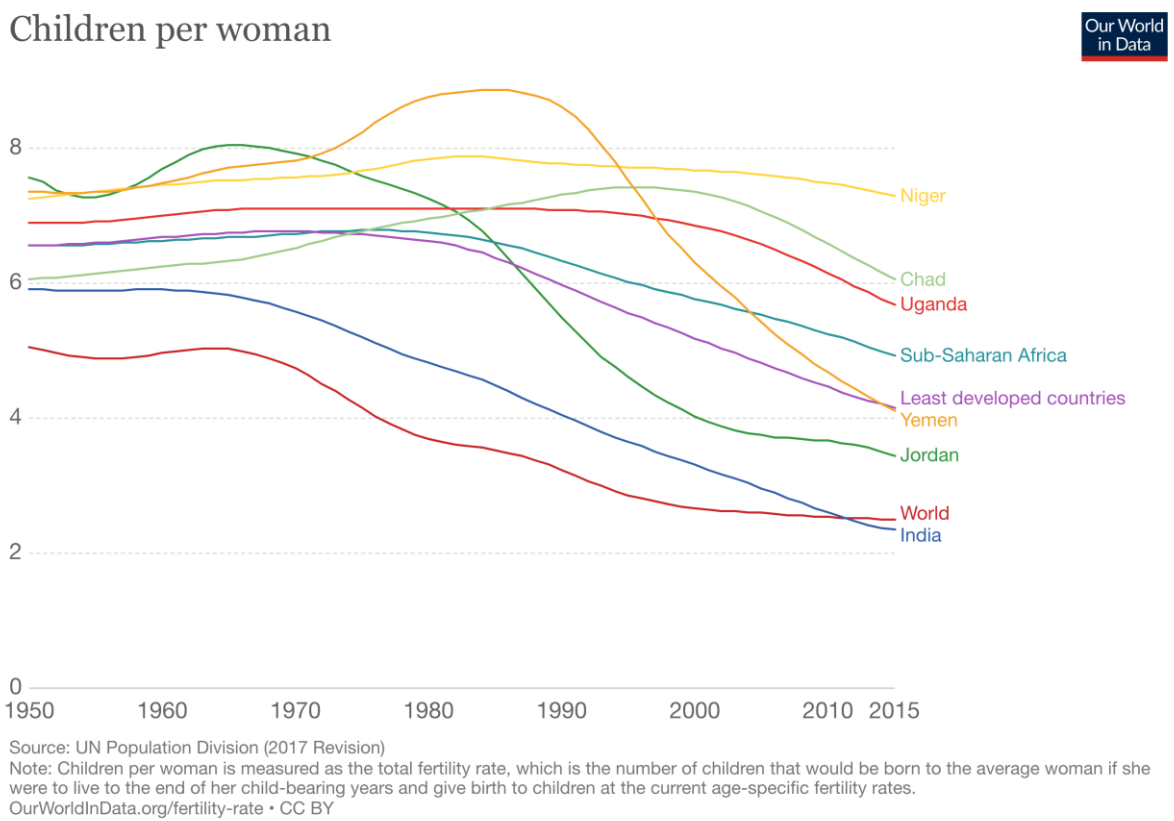
Background and Rationale

- 214 million women of reproductive age in developing countries have an unmet need for contraception - they want to avoid pregnancy are not using a modern contraceptive method
- Access to contraception is a **human right** and is an **essential health service** in refugee operations.
- Scaling up access to contraception can reduce maternal, newborn and child deaths, eliminate millions of abortions, and reduce the risks from adolescent pregnancies.
- Social benefits: sustainable environment, poverty reduction, better nutrition, improving girls' education and empowerment.
- UNHCR Public Health Officers and NGO partner medical coordinators have a responsibility to ensure quality reproductive health services for refugees
- Many gaps exist in our operations, and more support is needed (for both managers and clinicians) to provide quality services

Trends in Global Fertility rates



- Fertility rates have declined remarkably in most countries since 1950s
- Global average: 1950: 5 children/woman 2015: 2.5 children per woman
- Some countries (mainly in Sub-saharan Africa) have seen little/no declines

Total fertility rate: https://www.prb.org/international/indicator/fertility/snapshot/

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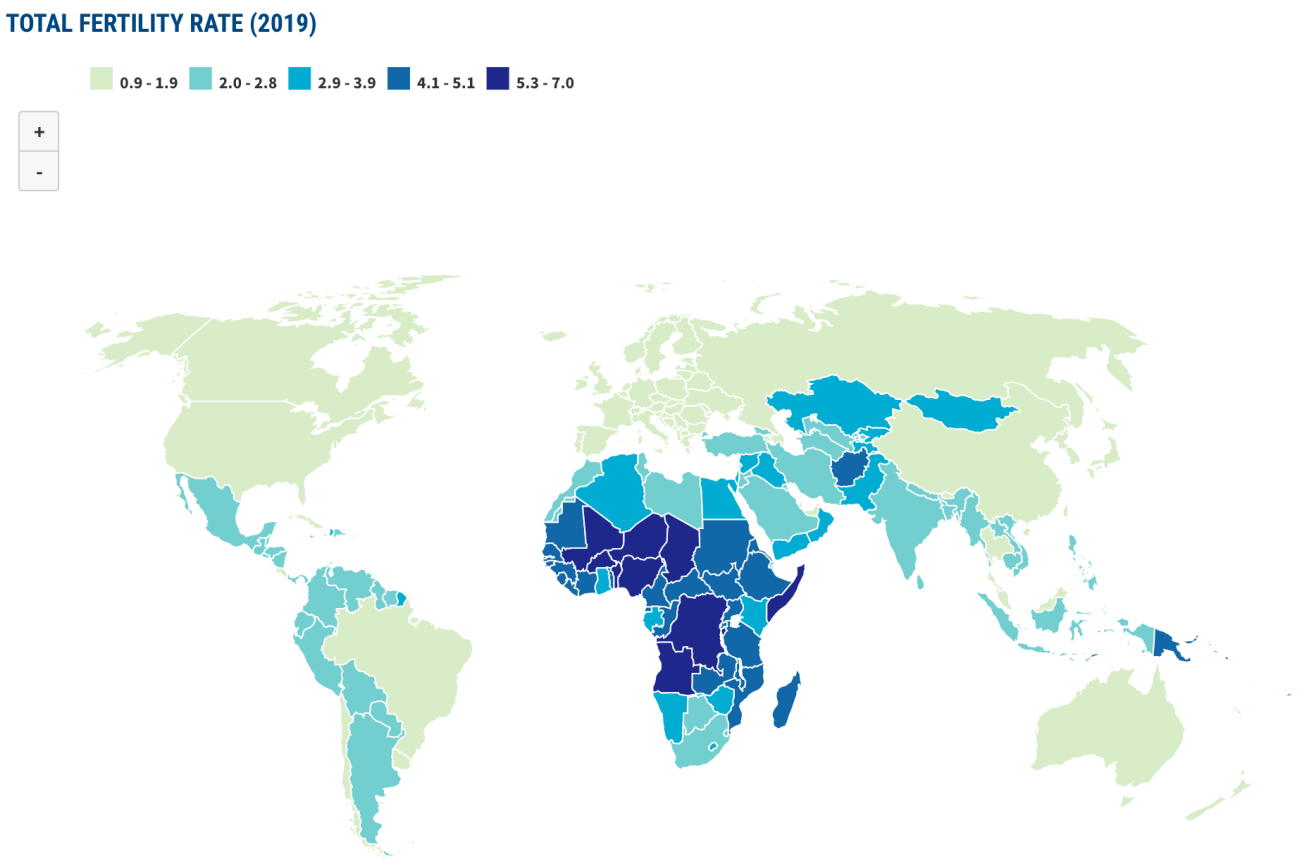
Reasons for reductions in global fertility rates



- Empowerment of women (increased education and participation in the labour force)
- Declining child mortality
- Costs of raising children
- Access to contraception

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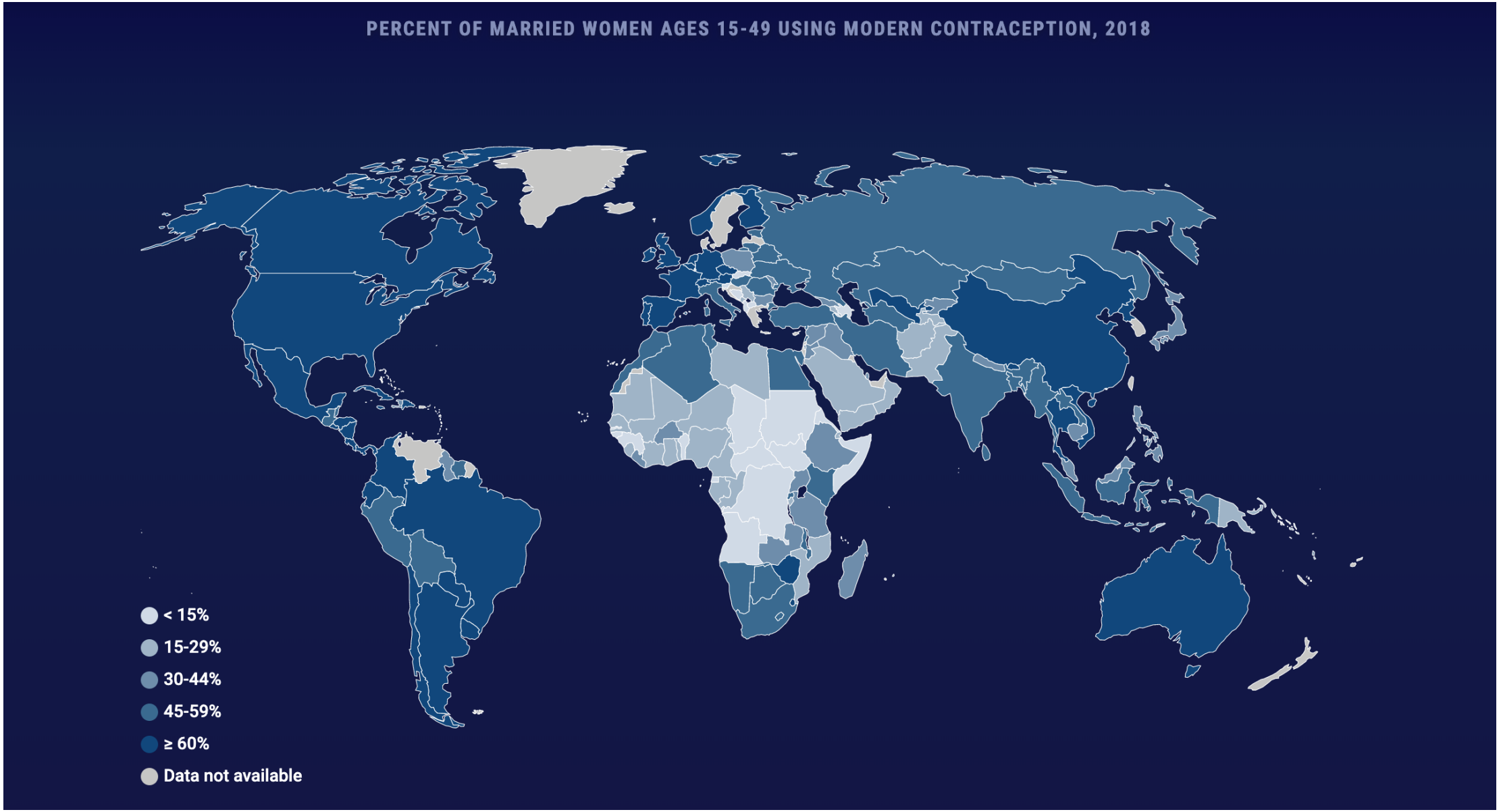

Reference: PRB. 2019. Family Planning Data. Available from https://www.prb.org/fpdata/#section_2

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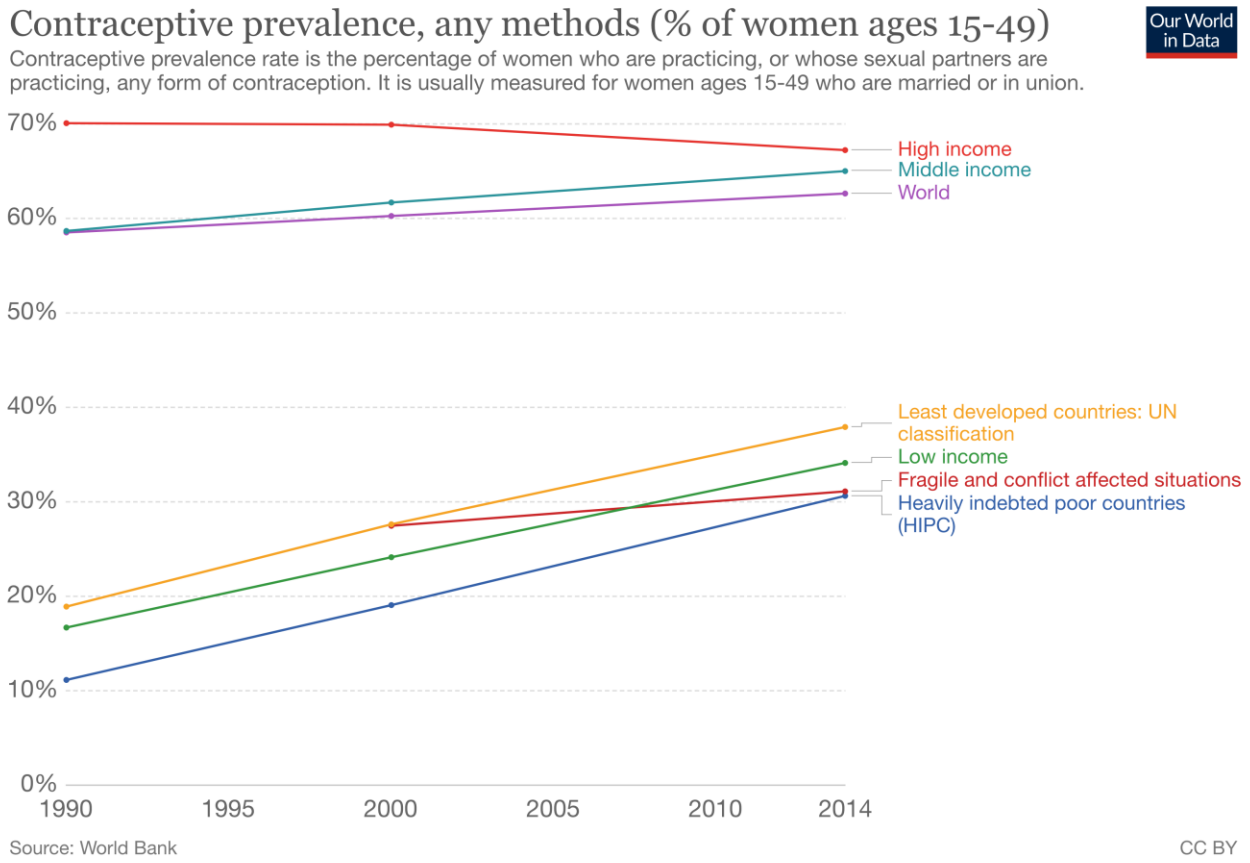
Socioeconomic gap in contraceptive use

- Poorest/least developed countries continue to have lowest contraceptive prevalence rates
- Fragile and conflict affected situations are similar to low income rates (CPR <30%)
- Within countries, rural has 1.4x higher unmet need than urban; no education 1.3x; lowest income 1.6x higher unmet need[1]



[1] UNFPA. 2016. Universal Access to Reproductive Health: Progress and Challenges. Available from https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf

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Women in humanitarian settings

- Access to contraception is very important in humanitarian settings - NEED may be increased but ACCESS to services decreased
- Additional risks to women from displacement:
  - disrupted family and social structures
  - disruptions in education and livelihoods
  - risks of sexual and gender-based violence
  - sexual exploitation and transactional sex
  - early or forced marriage

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Status of FP provision in refugee operations

Reviews of contraceptive services in refugee settings have found[1]:

- Failure to fully implement the MISP
- Inadequate provision of long-acting and permanent contraceptive options.
- Insufficient provision of emergency contraception and low awareness about the method
- Weak service provision for vulnerable groups (adolescents, sex workers)
- Poor service quality (disrespect, long waits, lack of privacy, poor hygiene)
- Poor supply chain management leading to stock-outs
- Provider-level barriers include lack of knowledge and training; biases; and hesitancy of health staff to discuss or offer contraceptives due to “perceived sociocultural resistance”.

[1]Casey et al, 2015 (in Burkina Faso, DRC, South Sudan);
UNHCR and WRC, 2011 (in Djibouti, Kenya, Uganda, Jordan, Malaysia)

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Baseline Assessment 2018: Chad, Cameroon, Niger

Health facility Readiness	Chad (n=15 HFs)	Cameroon (n=11 HFs)	Niger (n= 7 HFs)
Availability of key contraceptive supplies	58%	66%	70%
Clinical guidelines on contraceptives available	34%	45%	14%
Health workers providing FP services **who have NEVER received trainings or updates in:**	Chad (n=10)	Cameroon (n=13)	Niger (n=38)
Family planning/ contraceptive methods (general)	70%	69 %	45%
Postpartum family planning	70%	69 %	55%
Insertion of Intrauterine Device (IUD)	70 %	77 %	68%
Contraceptive Implant insertion	70 %	54 %	50%
Emergency Contraception	60 %	62 %	55%
Adolescent Sexual and Reproductive Health	83 %	77 %	71%

Key message: Need to improve “enabling environment” Staff need training, support with guidelines/protocols and supply chain strengthening

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Family Planning in Humanitarian Settings: snapshots from the field

Elizabeth Noznesky, Senior Program Advisor for SRHR, CARE

December 5, 2019

Why is FP essential in humanitarian settings?

- **Contraceptive needs** do not go away
- Needs often **increase** because:
  - Desire to delay pregnancy until return to stability
  - Increased risk of forced sex and risk-taking behaviors that could lead to pregnancy
- Access to services **decreases**
- Women and girls are at **greater risk of unwanted pregnancies**

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What is the standard for FP in humanitarian settings?

The Inter-Agency Field Manual for Reproductive Health in Crisis Settings (IAFM)

- **Acute settings: the Minimum Initial Package for Reproductive Health in Crisis Settings**
- Protracted settings: transition to comprehensive SRH services

MISP Obj 5: Prevent unintended pregnancies

- Ensure the availability of a **range of contraceptive methods**, including LARC methods, at primary health care facilities to meet demand
- Provide **information** and **contraceptive counseling** as soon as possible to ensure quality of care that emphasizes informed choice, confidentiality and privacy.
- Make sure that the **community is aware** of where and how to seek access to contraception

What is the standard for FP in humanitarian settings?

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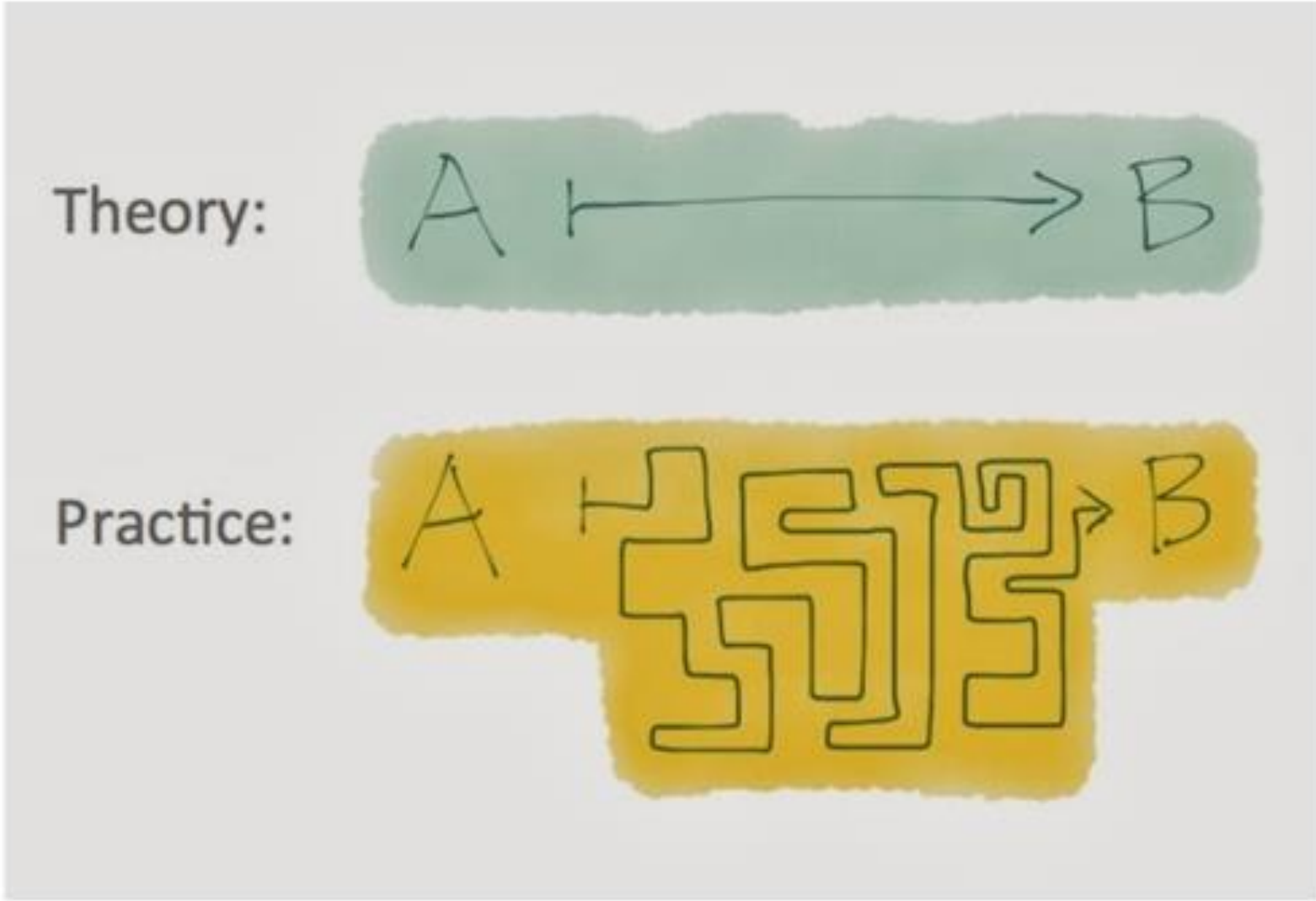
- Acute settings: the Minimum Initial Package for Reproductive Health in Crisis Settings
- **Protracted settings: transition to comprehensive SRH services**

What does this look like in real life?



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Rohingya orphan Bushra (10, middle) in Kutupalong
CARE/2018

Myanmar Refugee Crisis in Cox's Bazar

Emergency response

- 4 camps in Cox's Bazar
- 97,943 people
- 4 health posts
- 8 mobile outreach teams
- 40 outreach spots
- 200 sub-spots
- 12 Women's and Girl's Safe Spaces

Kutupalong, the world's largest refugee camp in Bangladesh, CARE/2018

care

Results

Health posts

- 947 FP services /month
- 46% of FP clients w/ injectable

Mobile outreach teams

- 346 FP services / month
- 39% of FP clients w/ injectable

Total

- 17,130 contraceptive services (not including condoms)

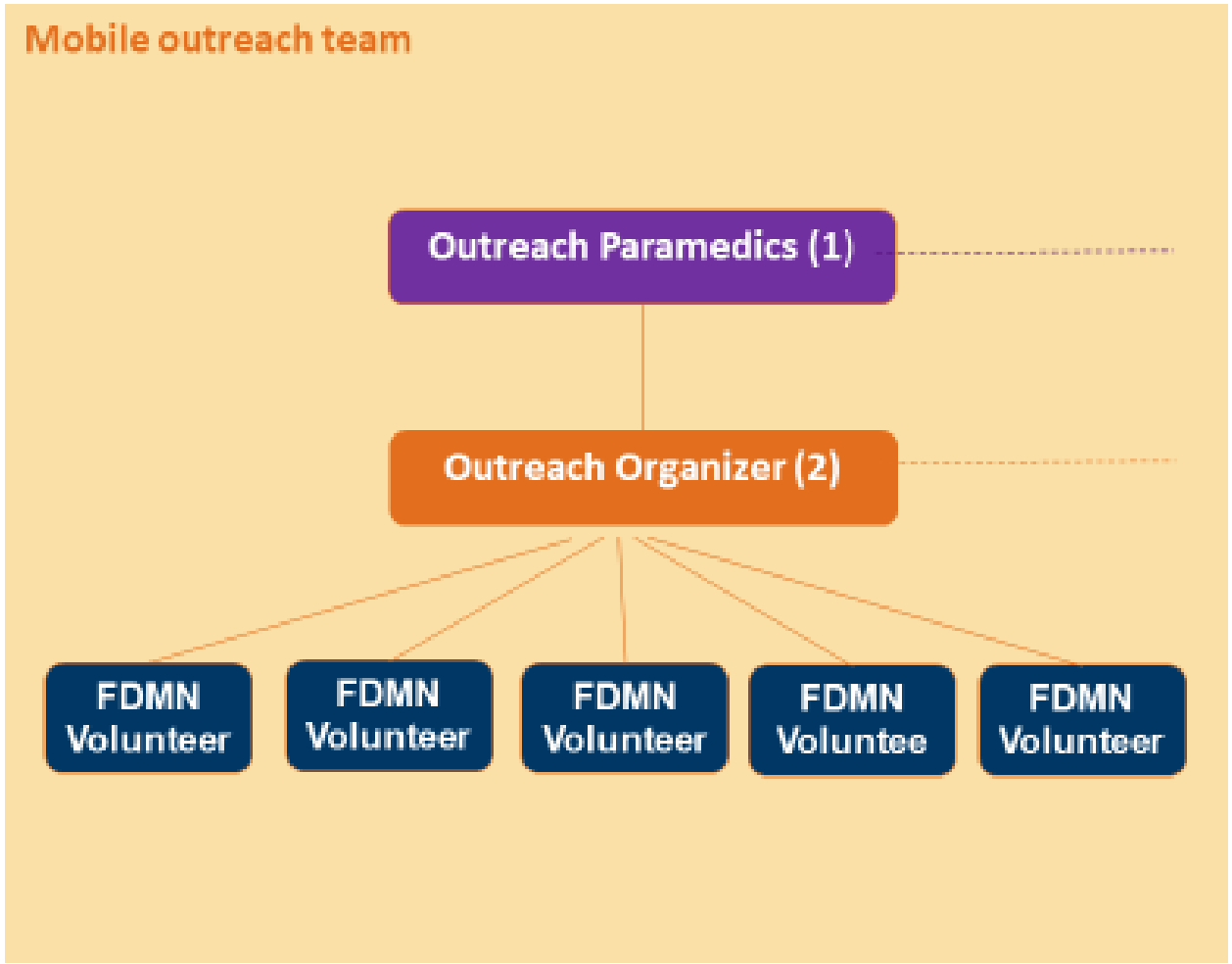
Nurse Lipi Bala (25) gives the contraceptive pill to Rohingya Noor Fatima in Kutupalong, the world's largest refugee camp in Bangladesh, CARE/2018

Key elements of success

Indicator	Intervention	Cross-cutting
Availability	Policy advocacy for LARC services	Partnership w/ Family Development Services and Research (FDSR)
Accessibility	Mobile outreach to women and girls	
Acceptability	Rohingya volunteers	
Quality	Shifting provider attitudes	

Policy advocacy to expand availability of LARC

Mobile outreach to women and girls



- SRH service provision at community level
- Facilitate referral
- Support the organizers in quality information delivery and reporting

- Supervise and support FDMN volunteers
- IFA and commodity distribution
- Courtyard meeting, birth planning
- Support outreach SRH service delivery

- HH visit and PW identification
- SRH service promotion
- IFA distribution
- Support outreach service delivery and Courtyard meeting

Rohingya volunteers

"Trust is key. Initially, providers struggled with speaking to women about FP. But as they came for ANC and GBV, the provider developed relationships and trust with their clients, and were able to discuss FP methods and even family issues like how husbands might not be supportive…"

CARE staff

Shifting provider attitudes

Challenges

- LARC services are still not widely available
- Difficult to ensure total privacy during service delivery

What's next?

To meet the long-term contraceptive needs of the population, we will:

- **Expanding the pool of master trainers on LARCs**
- **Improving the quality of family planning counseling**
- **Build the capacity on the ground to meet the needs of adolescents**
- **Institute a contextually appropriate client tracking and follow-up**
- **Increase accountability for the quality of service provision**
- **Strengthen local health system**
- **Focus on consistency and quality**

Providing comprehensive RH services: Policy Questions

- What are the reproductive ‘norms’ in host community and refugee population (such ideal family size, contraceptive prevalence rates, unmet need, beliefs/rumours around contraceptive methods, role of religion, community leaders’ perceptions)
- What is the **legal scope of practice** for health workers – i.e. what type of provider can provide what contraceptive (eg any restrictions on CHWs giving injections, midwives inserting IUDs, etc.)
- What **contraceptives are available** inside and outside the public sector (private clinics, pharmacies, shops, etc.)? Which providers are refugees accessing most?
- How reliable is **supply chain**? Are there frequent stock-outs? Back-up supply?
- Are there any **legal/policy restrictions** on providing contraception to adolescents or unmarried persons? If so, is the law/policy upheld?

Essential components of clinical visit

1. Ethical considerations
2. Privacy (audio/visual) and confidentiality
3. Information and counseling
4. Safe provision of method
5. Follow-up

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Ethical considerations: Voluntary contraceptive services

- Why "*voluntary*"? Historical human rights abuses in many countries (forced sterilization, bribes or payment for sterilizations - often targeting the poorest/marginalized groups)

- **Free choice**: free of coercion (avoid giving incentives for use) and free of barriers
- **Full choice**: providing a wide range of options
- **Informed choice**: ensuring the patient understands the risks and benefits of various methods

Threats to voluntary family planning may include:

- Counselling approaches that don't respect client choice
- Provider biases, for or against certain methods
- Failure to provide access to a wide range of options
- Use of quotas, rewards or incentives

Privacy and Confidentiality / Access

- Ensure visual and audio privacy. Keep register with names out of sight of others.
- Offer contraceptives in outpatient consultations as well as maternity/FP clinic
- Offering contraceptives only in maternity will exclude many adolescents, unmarried, men and boys
- Consider “Provider-Initiated” approach – ask any person of reproductive age if they would like information on contraception or birth spacing
- Integrated approaches (next week)

“Even if the service would be offered from the camp clinic, they would not go considering the risk that the community might get informed, noticing them going to the family planning clinic.” Adolescent boy, Cox’s Bazar (Tanabe et al., 2017)

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To increase access, every consultation room (not just maternity/FP room) may have….

- All methods displayed in a tray
- Condoms
- WHO Medical Eligibility Criteria Wheel and clinical guidelines
- Brochures, posters and other IEC materials
- Trained clinician
- Register books and client card

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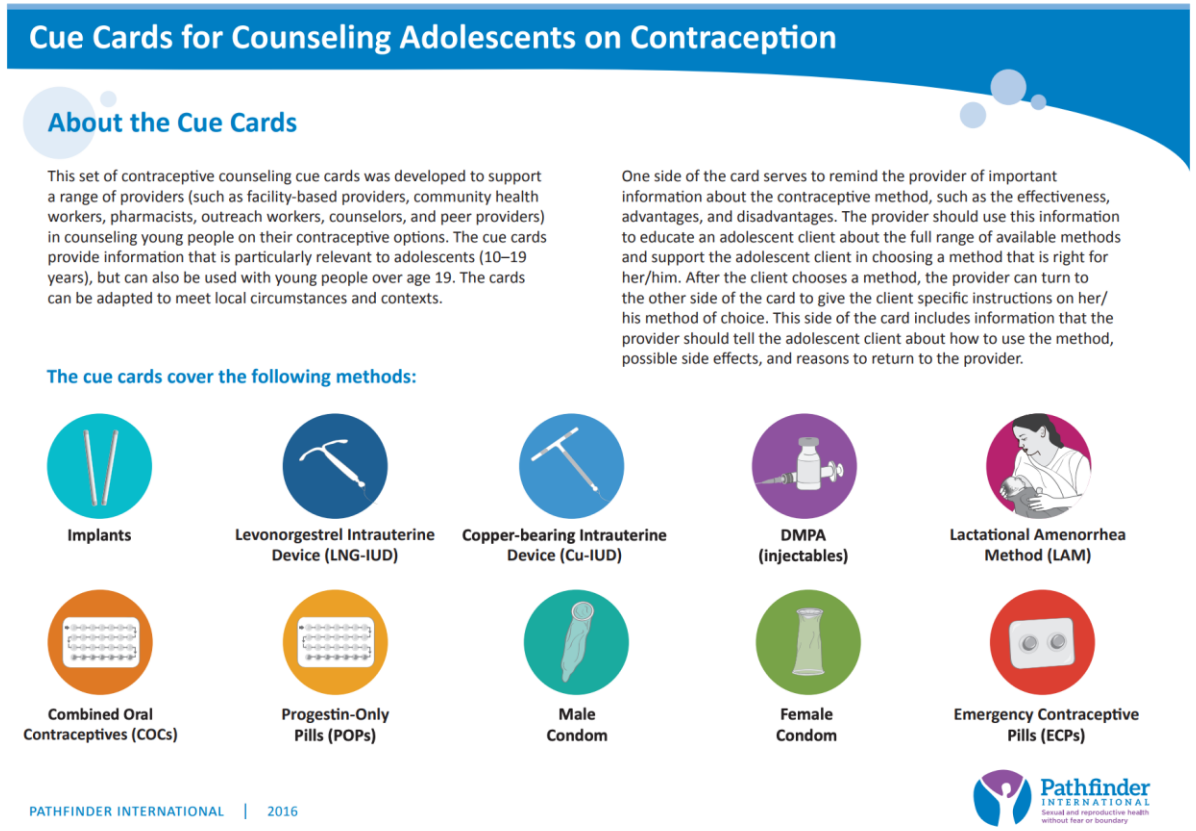
“Informed Choice” – Quality Counselling



Cue Cards for Counseling Adolescents on Contraception

About the Cue Cards

This set of contraceptive counseling cue cards was developed to support a range of providers (such as facility-based providers, community health workers, pharmacists, outreach workers, counselors, and peer providers) in counseling young people on their contraceptive options. The cue cards provide information that is particularly relevant to adolescents (10–19 years), but can also be used with young people over age 19. The cards can be adapted to meet local circumstances and contexts.

One side of the card serves to remind the provider of important information about the contraceptive method, such as the effectiveness, advantages, and disadvantages. The provider should use this information to educate an adolescent client about the full range of available methods and support the adolescent client in choosing a method that is right for her/him. After the client chooses a method, the provider can turn to the other side of the card to give the client specific instructions on her/his method of choice. This side of the card includes information that the provider should tell the adolescent client about how to use the method, possible side effects, and reasons to return to the provider.

The cue cards cover the following methods:

Implants

Levonorgestrel Intrauterine Device (LNG-IUD)

Copper-bearing Intrauterine Device (Cu-IUD)

DMPA (injectables)

Lactational Amenorrhea Method (LAM)

Combined Oral Contraceptives (COCs)

Progestin-Only Pills (POPs)

Male Condom

Female Condom

Emergency Contraceptive Pills (ECPs)

PATHFINDER INTERNATIONAL | 2016

Pathfinder INTERNATIONAL

- ✓ Importance of healthy timing and spacing of pregnancies
- ✓ Using visual aids: describe various method options, including effectiveness, correct use, advantages, and disadvantages
- ✓ Describe the mechanism(s) of action, common side effects, and management of side-effects
- ✓ Use **Medical Eligibility Criteria** to identify any contraindications
- ✓ Allow time for questions and clarifications
- ✓ Clarifying misperceptions (rumours are common)

Counselling cards available from:
https://www.pathfinder.org/publications/cue-cards-for-counseling-adolescents-on-contraception

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Quality Indicator: Method Information Index

- RH **household survey (2018-2019) in Chad and Cameroon refugee camps** asked contraceptive users what counseling they received when receiving their contraceptive method.
- "Method Information Index" measures quality of counseling taking into account 3 key counselling points

Indicator	Chad	Cameroon
Percentage of current users of selected contraceptive methods who were informed about **potential side effects** of the method used.	35%	44%
Percentage of current users of selected contraceptive methods who were informed of **what to do if they experienced side effects** or problems with the method used.	17%	26%
Percentage of current users of selected contraceptive methods who were **informed of other methods of contraception that could be used.**	11%	11%
Method Information Index: Percentage of current users of selected contraceptive methods who were informed of all three points above	0%	8%

Key message: Quality of counselling needs improvement

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Contraceptive Methods - “Full choice”

Method type	Example
Barrier method	Condoms (male/female) Diaphragm, cervical cap
Long-acting Reversible (LARCs)	Implant Intrauterine device (IUD) (copper or levonorgestrel)
Short-acting methods	Injectable Oral contraceptive pill (progestogen only and combined estrogen/progestogen) Patch Vaginal Ring
Emergency contraceptives	Emergency contraceptive pills Copper IUD
Permanent methods	Vasectomy (male) Tubal ligation (female)
Other methods	Lactational Amenorrhea Method (LAM) Fertility awareness methods

Offer a ***full range of methods*** – that means at least one option per method type

More choices = more likely to accept a method and to more likely to continue long-term

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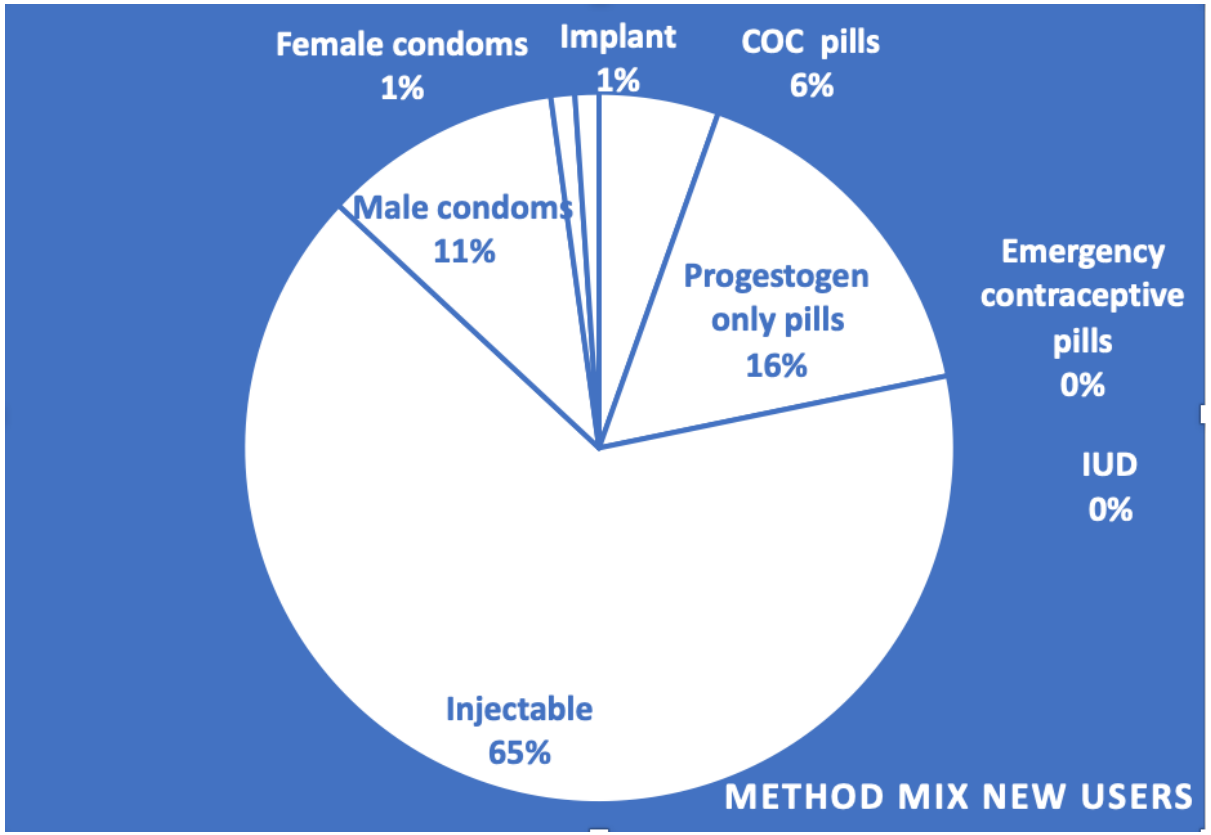
Method Mix – What is the problem?



- "Method skew" is where majority of users are using 1 method only
- May indicate:
  - Problem with supply chain
  - Poor counselling skills (not providing clear counselling on all available methods)
  - Midwife preferences (bias)
  - Lack of skills/knowledge in some methods (for example IUD/implants)
  - Rumors/misperceptions in community on certain methods

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Providing contraceptives safely

- Health workers require training (many will require post-service training) and updates
- **Written clinical guidelines** and **medical eligibility criteria** must be available in all service delivery sites
- Pregnancy determination (new users)
- Physical exam (only needed in specific situations such as pelvic exam prior to IUD insertion)
- Hygiene standards for procedures (implants/IUD)

Order copies free of charge
WHO. 2018. Family Planning: A Global Handbook for Providers. Available from https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/

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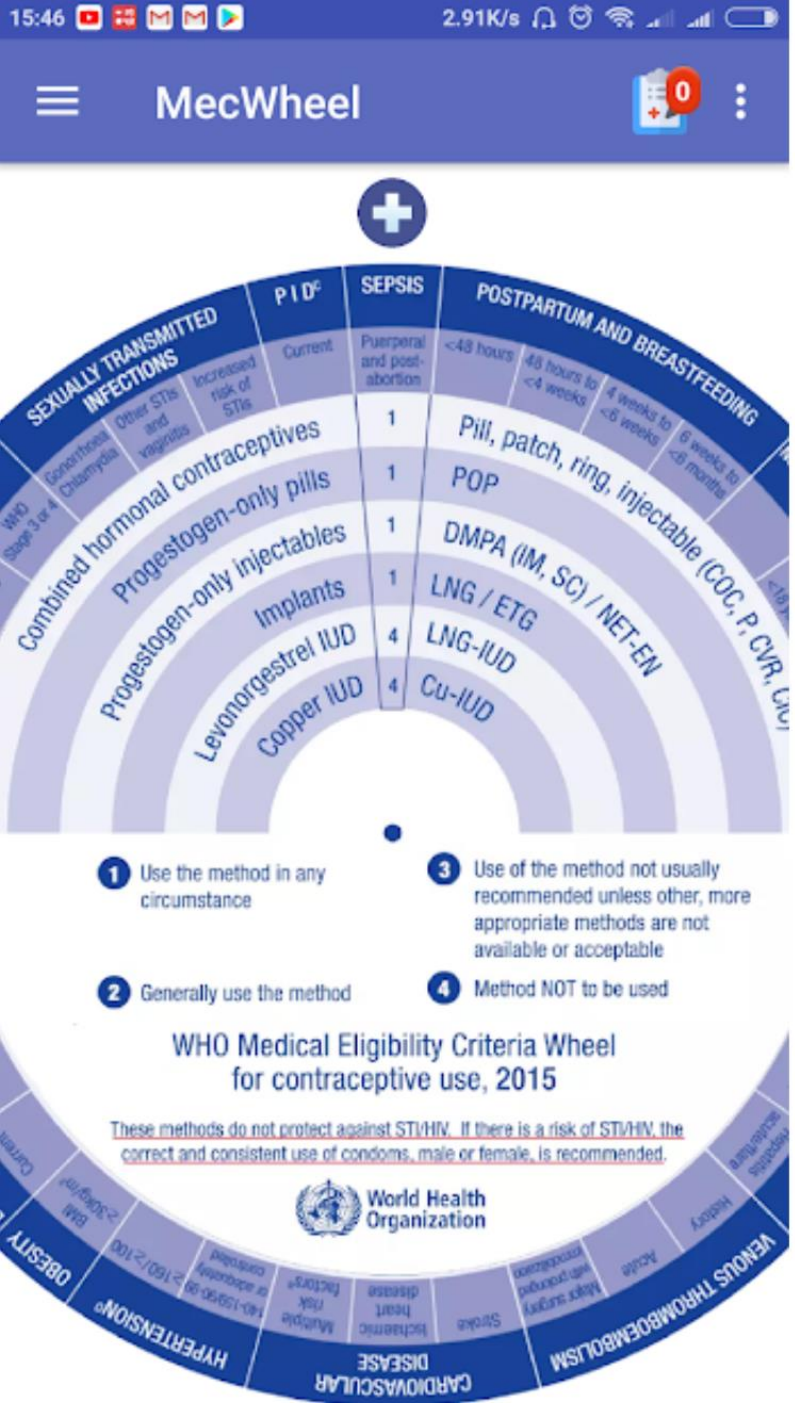
Medical Eligibility Criteria (MEC)



- Not every method is appropriate for every woman
- Certain contraceptives are contraindicated for health conditions such as breastfeeding; heart/vascular disease; cancer; migraines, etc.
- Health workers must have access to written medical eligibility criteria (MEC)
- MEC Wheel: Can be downloaded for printing or hard copies ordered; electronic version (App for free download)
- Multiple languages
- https://www.who.int/reproductivehealth/publications/family_planning/mec-wheel-5th/en/

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- Methods
- Medical or health conditions
- MEC Category
- Comments (A,B,C)

CATEGORY	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstance	YES (Use the method)
2	Generally use method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	NO (Do not use the method)
4	Method not to be used	

Comments

A	If condition develops while using method, can continue using it during treatment.
B	If very high likelihood of exposure to gonorrhoea or chlamydia =3.
C	If past pelvic inflammatory disease (PID) all methods =1, including IUDs.
D	If <3 wks, not breastfeeding & no other VTE risk factors =3.
E	If not breastfeeding =1.
F	If 3 to <6 wks, not breastfeeding & no other VTE risk factors =2, with other VTE risk factors =3.
G	If ≥6 wks & not breastfeeding =1.
H	If uterine cavity distorted preventing insertion =4.
I	Refers to hepatocellular adenoma (benign) or carcinoma/ hepatoma (malignant).
J	If adenoma CIC =3, if carcinoma/hepatoma CIC =3/4.
K	CIC =3.
L	If established on anticoagulation therapy =2.
M	If condition developed while on this method, consider switching to non-hormonal method.
N	Risk factors: older age, smoking, diabetes, hypertension, obesity & known dyslipidaemias.
O	If cannot measure blood pressure & no known history of hypertension, can use all methods. Either systolic or diastolic blood pressure may be elevated.
P	If age <18 yrs & obese DMPA/NET-EN =2.
Q	For insulin-dependent & non-insulin-dependent. If complicated or >20 yrs duration, COC/P/CVR, CIC =3/4; DMPA, NET-EN =3.
R	If <15 cigarettes/day CIC =2. If ≥15 cigarettes/day COC/P/CVR =4.
S	Aura is focal neurological symptoms, such as flickering lights. If no aura & age <35 COC/P/CVR, CIC =2, POP =1. If no aura & age ≥35 COC/P/CVR, CIC =3, POP =1.
T	Barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate & lamotrigine.
U	If barbituates, carbamazepine, oxcarbazepine, phenytoin, primidone or topiramate CIC =2.
V	If lamotrigine =1.
W	DMPA =1, NET-EN =2.
X	CICs =2.
Y	If antiretroviral therapy with EFV, NVP, ATV/r, LPV/r, DRV/r, RTV: COC/P/CVR, CIC, POP, NET-ET, Implants =2; DMPA =1. For all NRTIs, ETR, RPV, RAL each method =1. See jacket for full names of medications.
Z	If WHO Stage 3 or 4 (severe or advanced HIV clinical disease) IUD =3.

Conditions that are category 1 and 2 for all methods (method can be used)

Reproductive Conditions: Benign breast disease or undiagnosed mass • Benign ovarian tumours, including cysts • Dysmenorrhoea • Endometriosis • History of gestational diabetes • History of high blood pressure during pregnancy • History of pelvic surgery, including caesarean delivery • Irregular, heavy or prolonged menstrual bleeding (explained) • Past ectopic pregnancy • Past pelvic inflammatory disease • Post-abortion (no sepsis) • Postpartum ≥ 6 months

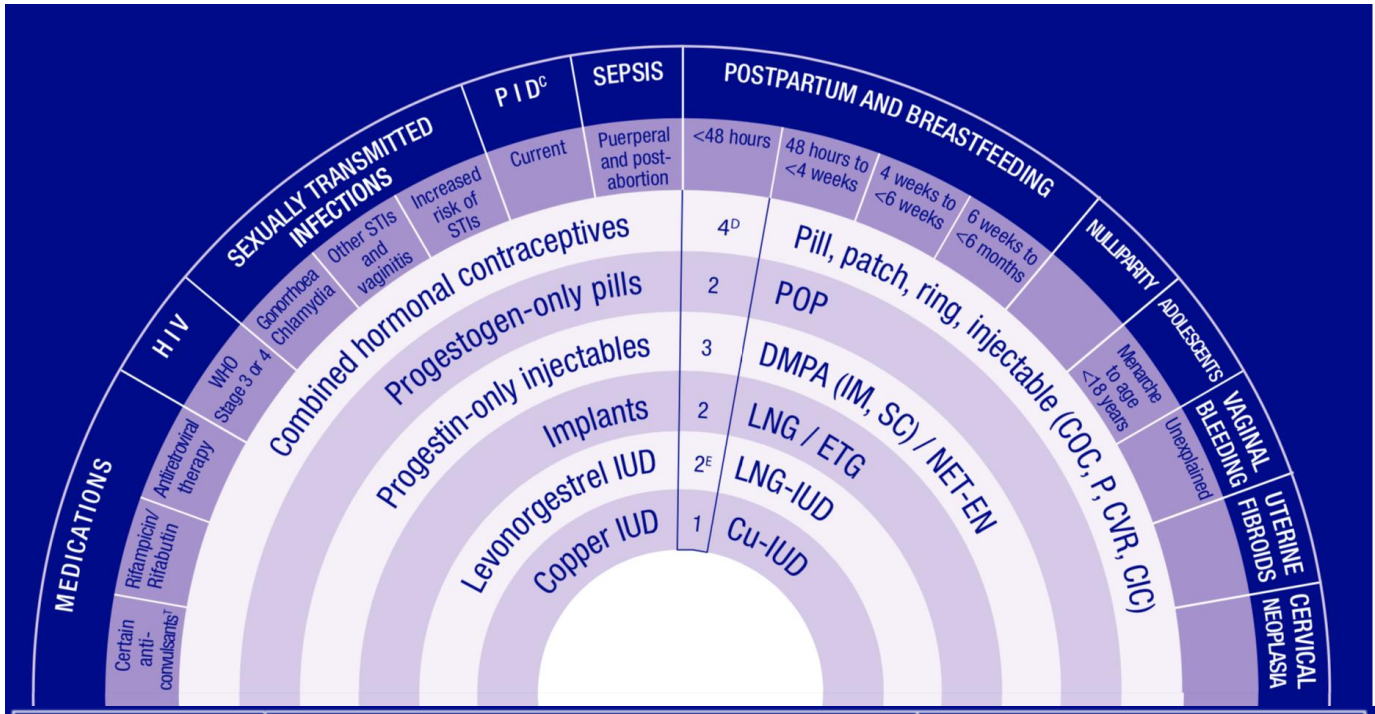
Medical Conditions: Depression • Epilepsy • HIV asymptomatic or mild clinical disease (WHO Stage 1 or 2) • Iron-deficiency anaemia, sickle-cell disease and thalassaemia • Malaria • Mild cirrhosis • Schistosomiasis (bilharzia) • Superficial venous disorders, including varicose veins • Thyroid disorders • Tuberculosis (non-pelvic) • Uncomplicated valvular heart disease • Viral hepatitis (carrier or chronic)

Other: Adolescents • Breast cancer family history • Venous thromboembolism (VTE) family history • High risk for HIV • Surgery without prolonged immobilization • Taking antibiotics (excluding rifampicin/rifabutin)

With few exceptions, all women can safely use emergency contraception, barrier and behavioural methods of contraception, including lactational amenorrhoea method; for the complete list of recommendations, please see the full document.

"Combined" is a combination of ethinyl estradiol & a progestogen.

CIC: combined injectable contraceptive **COC**: combined oral contraceptive pill
Cu-IUD: copper intrauterine device **CVR**: combined contraceptive vaginal ring
DMPA (IM, SC): depot medroxyprogesterone acetate, intramuscular or subcutaneous
ETG: etonogestrel **LNG**: levonorgestrel **LNG-IUD**: levonorgestrel intrauterine device
NET-EN: norethisterone enanthate **P**: combined contraceptive patch
POP: progestogen-only pill



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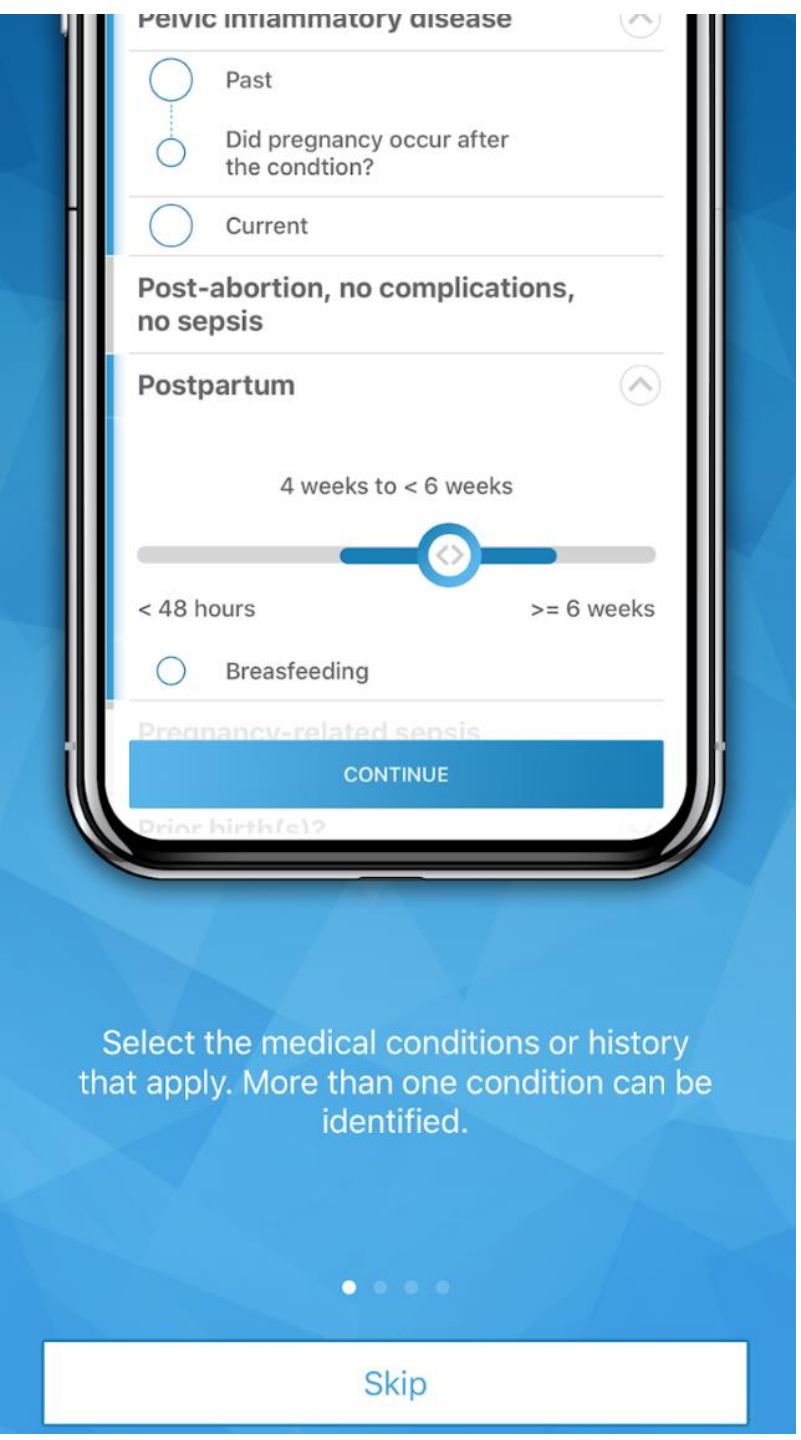

Contraception in Humanitarian Settings App

Contains information on:

- Medical eligibility criteria wheel
- Effectiveness of different methods
- Pregnancy determination checklist
- Initiating contraceptives
- Emergency contraceptives
- Intimate partner violence

Available as a free app for download

https://www.who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/

Pregnancy Determination Checklist

NO		YES
	1 Did your last monthly bleeding start within the past 7 days?*	
	2 Have you abstained from sexual intercourse since your last monthly bleeding, delivery, abortion, or miscarriage?	
	3 Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?	
	4 Have you had a baby in the last 4 weeks?	
	5 Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
	6 Have you had a miscarriage or abortion in the past 7 days?*	

* If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days.

If the client answered NO to *all of the questions*, pregnancy cannot be ruled out using the checklist.

Rule out pregnancy by other means.

If the client answered YES to *at least one of the questions*, you can be reasonably sure she is not pregnant.

- This tool can be used to check likelihood of pregnancy before initiating a contraceptive method
- Health workers providing contraceptive services should have access to this checklist (or similar)

Options for ruling out pregnancy (depends on method to be given):

1. Checklist
2. Urine pregnancy test (only valid after first day of missed period)
3. Delayed start until next menstruation (least favorable option)

WHO. 2018. p440-441 Family Planning: A Global Handbook for Providers.
Available from https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/

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Questions on Essential Components of the Clinical Visit and Tools?

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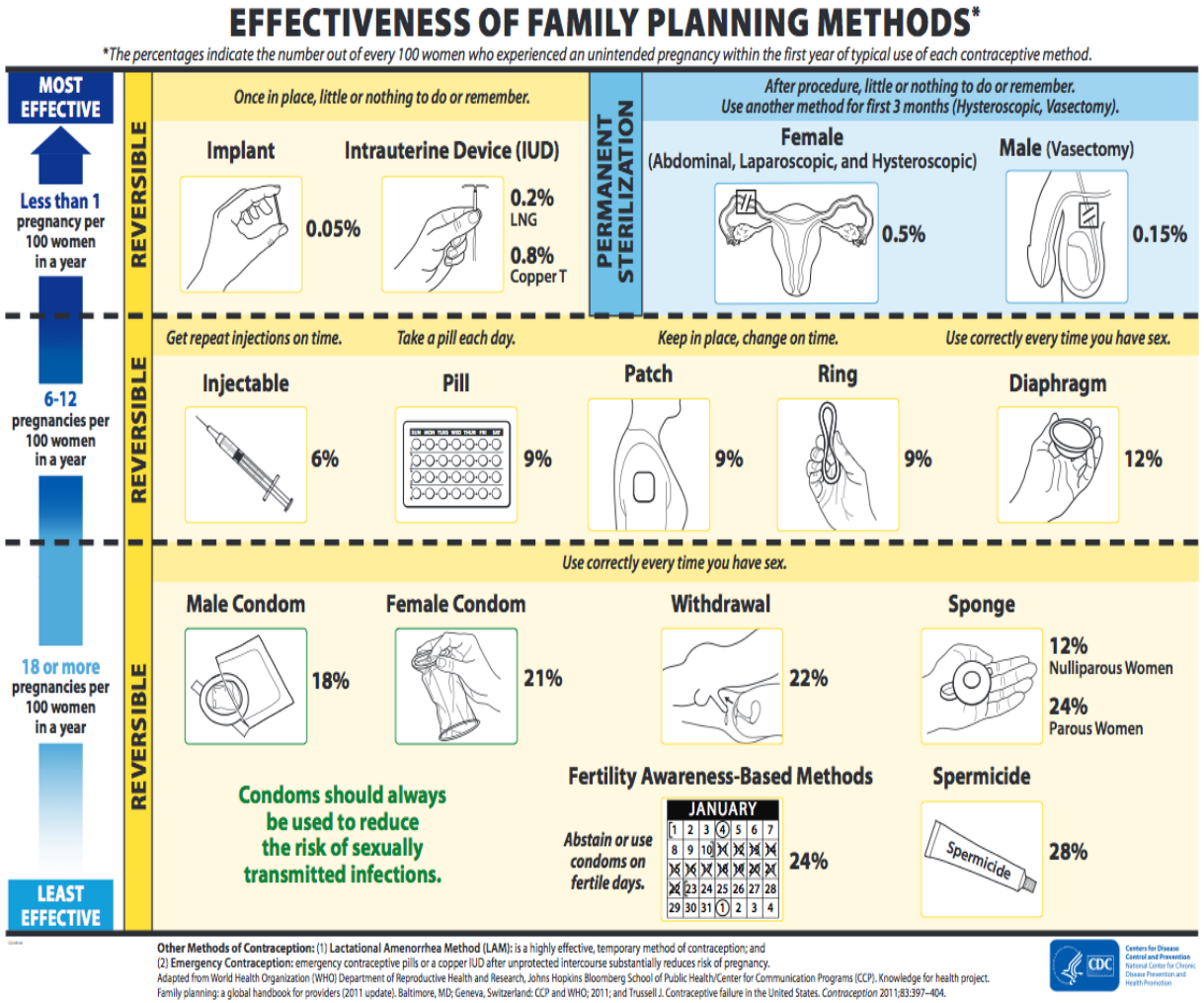
Updates on Contraceptive Methods

Please see “Updates on Contraceptive Methods” (WHO and HRP, 2018) for detailed review of each method:

https://www.gfmer.ch/SRH-Course-2018/family-planning/pdf/Updates-contraceptive-technology-Part1-Festin-2018.pdf
https://www.gfmer.ch/SRH-Course-2018/family-planning/pdf/Updates-contraceptive-technology-Part2-Festin-2018.pdf

Long-acting Reversible Contraceptives (LARCs)



Benefits of LARCS (IUDs/implants):

- Most effective methods
- Last 3-10 years (depending on method)
- Little to no chance of user error
- Nothing to remember
- Fewer contacts with health services required
- Easily reversible with quick return to fertility upon removal

Disadvantages:

- Require additional skills/equipment by providers
- Need access to health services for removal
- No protection from STIs/HIV

Needs:

- Confident staff (training++) plus clear counselling on method
- Additional equipment and supplies (insertion and removal equipment and autoclave etc. for hygiene)

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Emergency Contraception

WHO Statement on Emergency Contraception

All women and girls at risk of an unintended pregnancy have a right to access emergency contraception and these methods should be routinely included within all national family planning programmes.

What is it?

- Methods of contraception that can be used to prevent pregnancy **after** unprotected sexual intercourse: **rape**, **contraceptive failure**, or when **no contraceptive method was used**
- Must be used **within 120 hours of the unprotected sex** but are more effective the sooner they are used (<72 hours ideally)

Mode of action:

1. Emergency contraceptive pills (ECPs) prevent pregnancy by preventing or delaying ovulation. They may also prevent fertilization by altering cervical mucous or the sperm's ability to bind to the egg. Do not induce an abortion.

2. Copper-bearing IUD prevents fertilization by causing a chemical change in sperm and egg before they meet.

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Types of ECPs include:

(1) Levonorgestrel-only: Single dose (preferred) or split dose
(2) Ulipristal acetate (UPA): Single dose
(3) Combined OCPs: less effective and more side effects than LNG or UPA

Advantages

- An advance supply of ECPs may be given
- May reduce need for abortion
- ECPs are safe and suitable for **all woman**, even those who cannot use regular hormonal methods **(no contraindications)**
- Reduces chance of pregnancy between 50-90% (depending on type and when used)
- Emergency contraception cannot interrupt an established pregnancy or harm a developing embryo. Does not cause abortion.

Disadvantages

- Don't provide ongoing protection against pregnancy
- Must be used within 120 hours after unprotected sex
- May change the woman's next menstrual period
- Not appropriate for regular use

Research on ECP in Humanitarian Settings

Research done in 2018 by Save the Children in DRC, Somalia, Yemen, Pakistan, Rwanda and Syria:

Health provider beliefs: Somalia

- 91% were familiar with EC as post-rape; only 45% knew it did not cause abortion; 91% of providers felt it could lead to promiscuity.
- Both providers and supervisors lacked knowledge on this method
- Need EC-specific training and EC-specific sensitization/messages

DRC:

- 18.8% of women had ever heard of EC, and 1% had ever used it
- Health facility assessments found only 48% of HF had adequate ECP stock and 76% had expired ECPs on the shelf

Save the Children. April 2019. Emergency Contraception in Reproductive Health Programs in Humanitarian Settings. Available from: http://iawg.net/wp-content/uploads/2019/06/Emergency-Contraception-FINAL.pdf

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Use of ECP in Chad, Cameroon, Niger

- 1 year of data (2018-2019)
- Used only for victims of rape in some clinics (not offered to any woman who needs it)
- Low rates of utilization indicates low recognition/treatment of rape; poor sensitization of community and/or health workers on method for non-rape related use
- Stock ruptures occurred but was not a leading barrier to use

Extremely low utilization rates:

- Chad: 19 users out of 35,897 women of reproductive age
- Cameroon: 2 users out of 27,734 women of reproductive age
- Niger: 8 users out of 13,047 women of reproductive age

Key lessons – Emergency Contraception

- ✓ Ensure staff have EC-specific training
- ✓ Provide **supportive supervision** in this method (observe consultation or role-play scenarios to check accuracy of messages and quality of counseling)
- ✓ Do not restrict use to victims of rape only
- ✓ Monitor use. Ensure EC is recorded as method in FP register.
- ✓ Supply chain strengthening to avoid stock-outs/expiry
- ✓ Train community health workers in EC
- ✓ Develop EC specific messages for community sensitization

Discussion – Use of Emergency Contraception in your Operations

- Is EC used in your operations? Only for victims of rape or for anyone who requires it?
- Is the community aware of this method?
- Do midwives support/promote this method?
- What are the main barriers to use?

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Thank you !

Questions?

Annexes

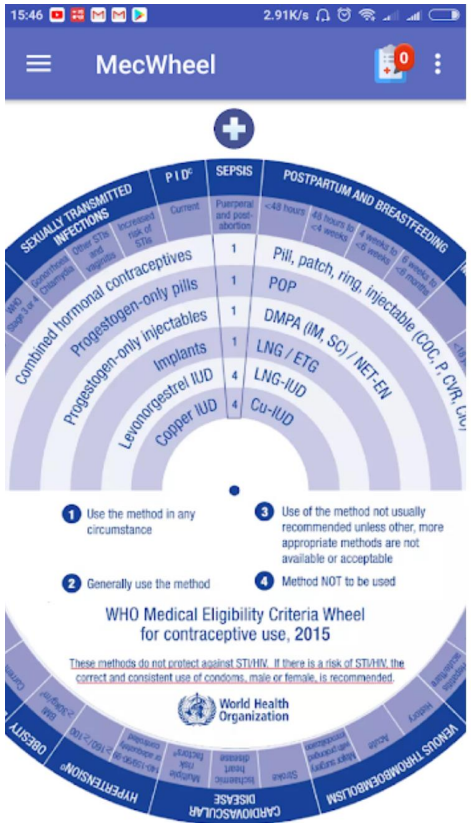
Additional resources

Key Resources

http://iawg.net/wp-content/uploads/2019/01/2018-inter-agency-field-manual.pdf

https://www.unhcr.org/protection/health/5d52bcbd4/adolescent-sexual-reproductive-health-refugee-situations-practical-guide.html

https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/



https://www.who.int/reproductivehealth/publications/family_planning/mec-wheel-5th/en/

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Minimum Initial Services Package (MISP) Resources

- MISP calculator (Excel spreadsheet): http://iawg.net/resource/misp-rh-kit-calculators/
- MISP Cheat sheet: http://iawg.net/resource/misp-reference/
- MISP online course (2011 version only): http://iawg.net/minimum-initial-service-package/

Emergency Preparedness Checklist for Family Planning/Contraception Services

- ✓ Health risk assessment completed for area
- ✓ Preparedness training sessions done (including MISP training)
- ✓ Health staff are trained in clinical management of rape and use of emergency contraception
- ✓ Procurement and pre-positioning of medical supplies including contraceptives
- ✓ Financial resources dedicated
- ✓ IEC materials developed
- ✓ Status of pre-existing health care infrastructure is known, including FP services offered
- ✓ Knowledge of national policies on reproductive health, including important restrictive conditions/laws (for example on emergency contraception, abortion, scope of practice for different cadres of health workers as it relates to family planning services)
- ✓ Map alternative providers of contraceptives, including private pharmacies and clinics, markets, youth centres, etc.
- ✓ Map adolescent sexual and reproductive health stakeholders and service providers (including health, social and recreational programs).
- ✓ Ensure links established between health and protection services for gender-based violence response
- ✓ Establish alternative routes for the provision of condoms and emergency contraceptives (outside of health facilities which may be non-functioning or overburdened in emergencies)

Emergency Contraceptive Pills

Pill Type and Hormone	Formulation	Pills to Take	
		At First	12 Hours Later
Dedicated ECP Products			
Progestin-only	1.5 mg LNG (levonorgestrel)	1	0
	0.75 mg LNG	2	0
Ulipristal acetate	30 mg ulipristal acetate	1	0
Oral Contraceptive Pills Used for Emergency Contraception			
Combined (estrogen-progestin) oral contraceptives	0.02 mg EE (ethinyl estradiol) + 0.1 mg LNG	5	5
	0.03 mg EE + 0.15 mg LNG	4	4
	0.03 mg EE + 0.125 mg LNG	4	4
	0.05 mg EE + 0.25 mg LNG	2	2
	0.03 mg EE + 0.3 mg norgestrel	4	4
	0.05 mg EE + 0.5 mg norgestrel	2	2
Progestin-only pills	0.03 mg LNG	50	0
	0.0375 mg LNG	40	0
	0.075 mg norgestrel	40	0

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update). Baltimore and Geneva: CCP and WHO; 2018.

Some Key Terms

- **Birth spacing** –maintaining a minimum interval between births for optimal health outcomes (birth-to next pregnancy at least 24 months)
- **Contraception**: prevention of pregnancy through interference with ovulation, fertilization, or implantation
- **Family planning**: Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. Sexuality education may be included under “FP”.
- “FP” terminology may not fit well with adolescents, sex workers, etc. – may be more appropriate to use the term “contraceptive services”
- **Contraceptive prevalence rates**: proportion of women of reproductive age (married or in a union) who are currently using a contraceptive method, out of all (married) women of reproductive age
- **Unmet need for family planning**: The percentage of fecund women of reproductive age who want to avoid pregnancy but are not using a contraceptive method. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour.
  Modern methods: may include pills, injectable, IUD, implant, condoms, etc.
- **Traditional methods**: abstinence, withdrawal, fertility awareness methods
- **Lactational amenorrhea method (LAM**) is sometimes classified as ‘modern’ or as ‘traditional’