CHAPTER 7
CONTRACEPTION

7.1 INTRODUCTION

Over 220 million women, most of whom are in the poorest countries in the world and most of whom wish to use contraception, still do not have access to modern contraceptive methods. Access to contraception decreases during natural or human-created crises, as health systems are compromised. New barriers to access come at a time when many people's desire and need for birth spacing and pregnancy prevention increase. Evidence shows that many recently displaced couples express having no desire to become pregnant for two or more years. Additionally, the loss of social structure and protective mechanisms during emergencies increase the risk of forced sex, risk-taking behaviors, and exposure to high-risk situations, highlighting the critical role of the availability of contraception, including emergency contraception and adolescent-responsive sexual and reproductive health (SRH) services. Each year,

these factors put thousands of women and girls at risk of unintended pregnancy, unsafe abortion, and related mortality and morbidity.

BOX 7.1: A NOTE ABOUT TERMINOLOGY

The terms birth spacing, family planning, and contraception are often used interchangeably. Providers should note the following distinctions. Birth spacing refers to the practice of maintaining an interval between births; the World Health Organization recommends a minimum interval of 24 months. Contraception prevents pregnancy by interfering with ovulation, fertilization, and/or implantation. Family planning refers to the comprehensive range of practices that allow individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.

Within this chapter, the term contraception is used with the understanding that contraception can also be used outside of family planning and can, in a number of ways, improve the health of women, girls, and their communities. Additionally, although not explicitly stated in every case, all references to contraception throughout this manual are on a strictly voluntary basis.

Improving access to contraception for women in crises has a significant impact on multiple fronts. It safely and cost-effectively prevents unintended pregnancies and reduces maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. Roughly 90% of unsafe abortion-related morbidity could be prevented by the use of effective contraception. Additionally, global data suggest that the provision of contraception could reduce maternal deaths by an additional 29%. An analysis of 22 US Agency for International Development priority countries found that increasing the availability of contraception from 2012 to 2020 could help avert approximately 7 million under-5 deaths and prevent 450,000 maternal deaths. The provision of comprehensive family planning information and services also leads to substantial improvements in women's earnings and children's schooling.

Access to contraception will also increase the engagement of women and girls in education, protection, life skills, and livelihoods programming by allowing them control over their fertility. The inability to control fertility and access these critical programs during crises will impact their life trajectories long after the emergency has passed.

It is critical that the provision of contraception is understood by SRH Coordinators, health program managers, and service providers to be part of essential health programming from the earliest phase of an emergency through recovery.

7.2 OBJECTIVES

The objectives of this chapter are to provide guidance to SRH Coordinators, health program managers, and service providers that will:

- Outline critical aspects of delivering contraceptive services during humanitarian emergencies, in terms of contraceptive availability, quality, and demand
- Support the transition of contraceptive service delivery from an acute emergency through stabilization and recovery

7.3 CONTRACEPTION PROGRAMMING

7.3.1 Principles

INFORMED CONSENT

- Women, couples, and families have a right to determine the timing and size of their families, regardless of their displaced status or living in a fragile context
- Every contraceptive client has the right to information, confidentiality, and privacy and to be able to voluntarily choose a contraceptive method
- The affected population, both men and women, must be involved in all aspects of contraceptive programming
- High-quality contraceptive services meet individuals' and couples' needs at every stage of their reproductive lives through providing opportunities for making

informed decisions, a full range of methods, safe procedures, and continuity of services

- When available and of good quality, contraceptive services will be used, regardless of arguments against feasibility or acceptance
- Respect for client confidentiality and for the client's opinion and choices is paramount

HUMAN RIGHTS FRAMEWORK

- Coercing people to use a contraceptive method is unacceptable and in violation of international human rights law
- Under international law, universal access to family planning is a human right as all individuals and couples have the right to decide on the number, spacing, and timing of their children
- Everyone has a right to privacy and the right to equality and non-discrimination
- Everyone has a right to impart and receive information on contraception and birth spacing

PUBLIC HEALTH IMPERATIVE

- A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy

SUPPORT ACCESS FOR THE ENTIRE POPULATION

- Design contraceptive services so that they are accessible and convenient
- SRH Coordinators and health program managers should advocate for provision of comprehensive family planning services whenever possible
- The use of contraceptive methods contributes to women's empowerment, schooling, and economic stability

7.3.2 Minimum Initial Service Package implementation

At the onset of an emergency, it is important to ensure contraceptives are available as this constitutes a life-saving intervention. Consequently, preventing unintended pregnancy is an objective of the Minimum Initial Service Package (MISP). Priority activities for SRH Coordinators, health program managers, and service providers should focus on:

1) Ensuring availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
2) Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
3) Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

A range of contraceptive methods, including condoms, emergency contraceptive pills, and intrauterine devices (IUDs) are available through the Inter-Agency Reproductive Health Kits (RH Kits). In many contexts contraceptive methods are also available through local sources.

7.3.3 Needs assessment

At the onset of a humanitarian crisis, the MISP should be implemented without undertaking a needs assessment. Priorities within the MISP are considered basic and essential to reduce SRH-related mortality and morbidity. However, Emergency Reproductive Health Coordinators can improve their initial response by obtaining situational information that will better inform the ordering of RH Kits and supplies:

- Population of the crisis-affected community
- Contraceptive Prevalence Rate (CPR) for host and displaced communities
- Method mix for host and displaced/affected communities
- The capacity of providers to provide specific methods of contraception

RH Kits provide a wide range of contraceptive methods that should be made available at the onset of new emergencies, based on available provider capacity. As the situation stabilizes, health service providers should coordinate a rapid initial assessment to inform further program development. Periodically, assessment findings and program recommendations must be reassessed to adapt to the changing needs of a population and their resulting family planning intentions.

ASSESS LOCAL CAPACITY

Trained health cadres (doctors, midwives, clinical officers, community health workers, etc.) exist within nearly every crisis-affected community. Efforts should be taken to identify them, verify their skills, and mobilize them for service delivery. Engaging local providers will support rapid scale-up of both clinical and community-based contraceptive services and establish more sustainable service delivery models that will more effectively transition to recovery. While taking stock of local capacity, humanitarian stakeholders can explore:

- What trained health cadres exist within this community?
- What methods have they been trained to provide?
- What capacity currently exists to deliver information about contraceptive methods, such as current and former community health workers, male and female family planning champions, or existing women's or religious groups in the crisis-affected population, job aides, point-of-service materials, posters promoting family planning, or local language training curricula for services, logistics, or health information systems?

Much of this information also can be gleaned from existing sources and materials reproduced. Few refugee programs have funding to develop quality behavior change communications (BCC) materials from scratch. And yet they are important to provision of quality services.

GATHER DATA

As programs move beyond emergency provision of MISP services (after the first 3 to 6 months), it is critical to tease out the special features that should characterize comprehensive contraceptive service delivery, including:

- Existence, location, and funding for programs that remain in place to deliver contraceptive services
- Community and cultural beliefs around fertility, family planning, and contraception
- Existence of religious prohibitions against and/or support for family planning, contraception, and birth spacing
- The role of men in contraceptive decision-making
- Cultural values and norms that affect access to services for women and youth
- Existence of stigmatized minorities in the refugee population and the barriers that may impact their access to contraception
- Laws and policies (prior to migration) that might impact access to a range of contraceptive services for all countries represented by host, IDP, and refugee populations
- Existence of national and sub-national family planning platforms, a National Population Policy, signatory to rights conventions, or Family Planning 2020 (FP2020) commitment
- Agencies or advocacy bodies that focus on laws, practices, or customs likely to restrain or restrict access to SRH services by refugees

This information can be gathered through:

- Donor and government reports
- Interviews or focus group discussions within host and displaced communities
- Formal knowledge, attitudes, and practices (KAP) studies
- Site visits
- Desk review and internet searches

7.3.4 Service availability

METHODS AVAILABLE

There are many different types of contraceptive methods and products that can be offered by providers

in humanitarian settings. Depending on the emergency context, many of these methods may have been made available during the earliest phase of the emergency (if provider capacity existed and there was sufficient demand). However, as the situation stabilizes and program capacity improves, it becomes increasingly important to ensure that an appropriate method mix is available for the entire population and that family planning intentions are understood and met. Programs need to address the context of their operations, as the expectations of the affected population will be shaped by their previous exposure and use of a broader contraceptive method mix.

Not all methods and products are appropriate for all individuals and women's contraceptive needs may change throughout the reproductive life cycle and the emergency continuum. The World Health Organization's Medical Eligibility Criteria (MEC) for Contraceptive Use provides evidence-based guidance regarding who can use contraceptive methods safely, based on their medical conditions (see Fig. 7.1). At the facility, providers should also use the MEC wheel as a practical tool during counseling and method decision-making together with the woman. A woman who has actively chosen a method based on quality information is more likely to use it consistently and correctly.

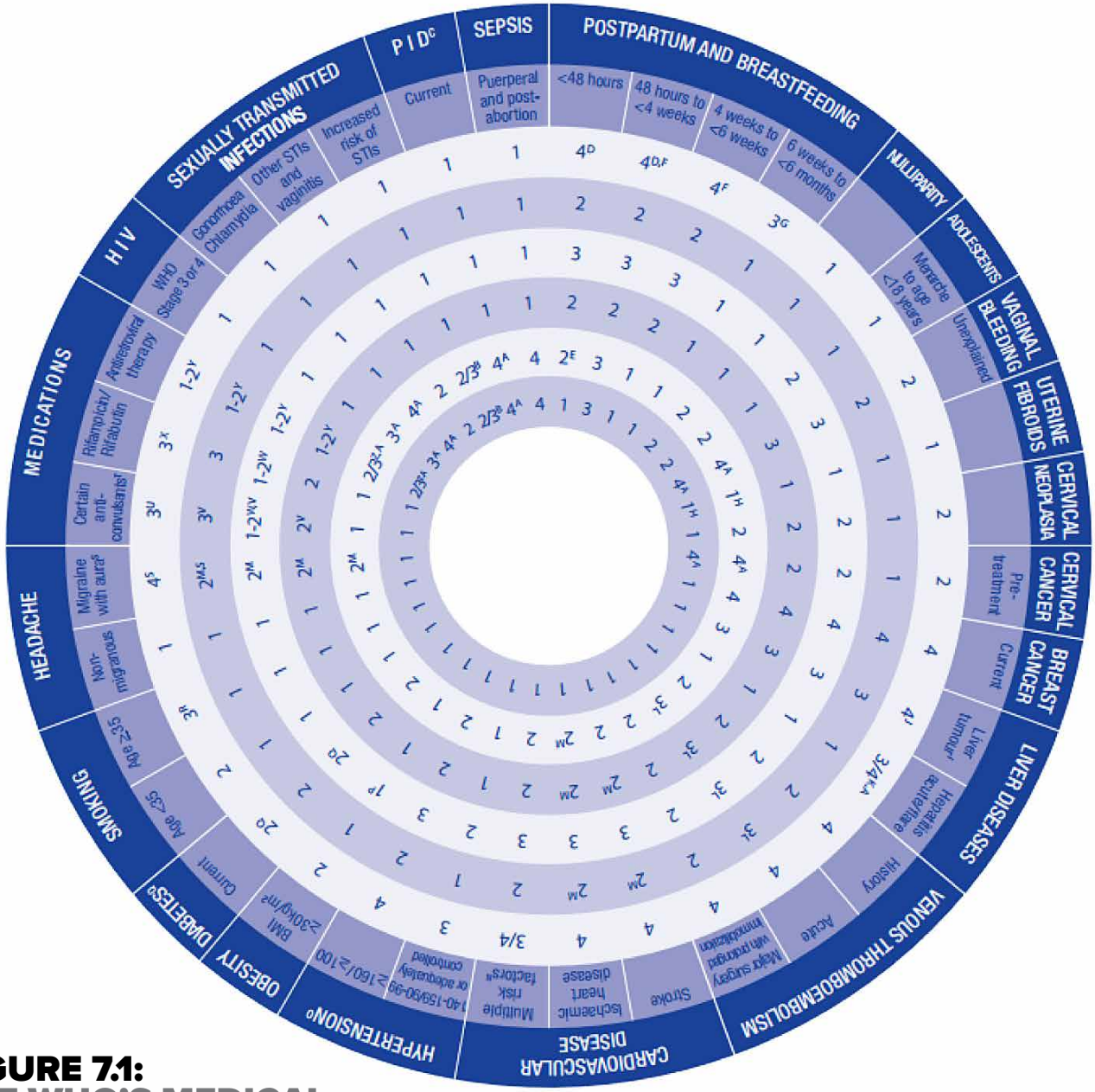

FIGURE 7.1:
THE WHO'S MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE

Service providers must be able to help individuals make an informed and voluntary choice of contraceptive method. At a minimum, service providers should cover the issues listed in Box 7.2. They should also tailor the information to the reproductive health goals and profile of the individual and consider the needs of specific groups, including adolescents, women living with HIV/AIDS, breastfeeding women in the postpartum period, and women in the post-abortion period. Additionally, service providers should know where to refer women and couples if the method of choice is not available at the service point. Visual aids and posters with information related to each method should also be available at the service point. The 2018 version of *Family Planning: A Global Handbook for Providers* has all the essential information required and it should be the book of reference for every SRH service provider (see section 7.6).

BOX 7.2: ESSENTIAL INFORMATION WHEN PROVIDING CONTRACEPTIVE INFORMATION

- **Relative effectiveness of the method**
- **Correct use of the method**
- **How the method works**
- **Common side effects**
- **Health risks and benefits of the method**
- **Signs and symptoms that would necessitate a return to the clinic**
- **Return to fertility after method discontinuation**
- **STI protection**

Contraceptive research, innovation, and technologies are constantly developing and evolving. A range of new and not so new contraceptive methods is available. The following list includes the most common contraceptive and family planning methods that can be sourced and used globally in humanitarian settings.

- Condoms (male and female)
- Emergency contraception (EC)
- Lactational amenorrhea method (LAM)
- Oral contraceptive pills (OCPs)
- Injectables
- Implants
- IUDs
- Permanent methods (tubal ligation, vasectomy)

BOX 7.3: WHAT IS EMERGENCY CONTRACEPTION?

Emergency contraceptives are medications or devices that are used after sex to reduce the risk of pregnancy. A number of different modalities of emergency contraception are available globally. These include the post-coital insertion of the copper-bearing intrauterine device, non-hormonal pills that interact with progesterone receptors, progestin-only pills, and combined hormonal pills. Progestin-only emergency contraceptive pills, commonly referred to as ECPs, are the most widely used and best-known post-coital method of contraception (see Chapter 3 for more detail).

Although information should be provided about all of these methods, information about additional methods should be provided based on the context of the crisis or the geographical location.

LOGISTICS AND SUPPLY CHAIN

RH Kits provide basic contraceptive supplies for the delivery of the MISP during the first 3-6 months of an emergency. Dependence on RH Kits, as a situation stabilizes, should be avoided. Humanitarian actors should procure locally whenever possible and quality goods are available and work to establish or link with functioning logistics systems to ensure an ongoing supply of contraceptives and order supplies based on existing forecasting formulas.

PROGRAMMATIC EXAMPLE 7.1: COMPREHENSIVE CONTRACEPTIVE SERVICE DELIVERY IN A CRISIS SETTING

ORGANIZATION: CARE

LOCATION: Northern Syria

INTRODUCTION: The Syrian civil war has triggered the largest, most complex humanitarian response since the United Nations Office for the Coordination of Humanitarian Affairs declared it an emergency in September 2012. One of the biggest challenges for humanitarian agencies has been accessing affected populations in areas controlled by armed opposition groups. Much of the response for this crisis has focused on trauma care and primary health care, with little attention to sexual and reproductive health (SRH). In northern Syria, CARE has provided a wide range of sexual and reproductive health services like family planning and contraceptive services, referrals to emergency obstetric care, and management of sexual violence. Contraceptive services included short-acting methods as well as long-acting reversible contraception, specifically IUDs. This has been possible because of a collaboration to provide integrated SRH services between CARE, Syria Relief and Development, and UNFPA. Contraceptive services were integrated into primary health care services provided in static health facilities (supported by another donor) as well as mobile SRH clinics to take services to the communities.

PROJECT DESCRIPTION: At the primary health care level, both at static and mobile SRH clinics, midwives and nurses provided contraceptive services, including counseling, pregnancy testing, and a range of contraceptive methods (IUDs, injectables, oral contraceptive pills, progestin-only emergency contraception, and condoms). Additionally, they provided clean delivery kits (for those who could not or would not deliver in a facility), antenatal care, safe delivery services, postnatal care, syndromic management of STIs, health education, and referrals for safe delivery and emergency obstetric care.

RESULTS: These interventions have proven to be successful, as this partnership has created 10 primary health clinics, 10 mobile clinics serving 60 communities and accounting for 61% of all family planning service delivery, and 1 "Women and Girls' Safe Space." Overall, the partnership has reached an estimated 388,660 people, including 97,165 women of reproductive age. Between April 2016 and July 2017, the partnership provided 60,876 family planning services including 9,726 IUD insertions, 7,156 injections with Depo-Provera, 22,611 cycles of oral contraceptives and 10,711 condoms.

LESSONS LEARNED: Pre-crisis, oral contraceptive pills dominated the method mix and now the preferred method is IUDs due to increased access to contraceptive services and supplies.

BOX 7.4: CONTRACEPTIVE FORECASTING FORMULAS

Contraceptive forecasting is the process of estimating the quantities of products that will be dispensed or used during a period of time and can be accomplished using a variety of methods. If reliable information on historical use is available, those data can be used to project future use as they will likely be the best predictors of short-term future use. If reliable historical data are not available, forecast demand using demographic data (number of estimated users by method for a year based on population data X the number of contraceptives a user of that method would use in a year, commonly known as a couple years of protection (CYP) factor) or service statistics (number of clients expected by method over a period of time X the number of contraceptives a user receives at a visit according to standard treatment guidelines.) After forecasting use, engage in supply planning to determine the quantities of contraceptives required to fill the supply pipeline (including safety stock), schedule shipments, and estimate costs.

For further information on forecasting and supply planning, consult the following resources:

- The Quantification of Health Commodities (2017) produced by JSI
- The Quantification of Health Commodities: RMNCH Supplement produced by JSI Research & Training, Inc. with funding from the United Nations Children's Fund (UNICEF) and Management Sciences for Health under the USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program

SPECIAL CONSIDERATIONS FOR CONTRACEPTIVE LOGISTICS INCLUDE:

- EC is hard to estimate early on. Use demand to forecast future needs. However, EC is not well known, so demand will likely increase as the population realizes it exists and understands when and how to use it
- Unlike other procured drugs (such as antimalarials and antibiotics) demand for contraceptive methods will likely grow over time. Supply projections and planning need to take this into consideration or there will be stock-outs. Plan to have a 3-month stock on hand and reorder accordingly
- There is no such thing as "condoms for HIV/AIDS and condoms for contraception." People should be counseled about condom use for dual protection, and supplied liberally with condoms, through both clinics and community distribution channels
- If good user data to calculate contraceptive needs (after the MISP) is unavailable, country Demographic and Health Survey (DHS) or Health Management Information System (HMIS) data from before the crisis can help. Consult an expert as needed!

7.3.5 Implementing contraception and family planning programming

PROVIDERS

Family planning and contraceptive method providers at the health facility level should be qualified nurses, midwives, or doctors. Certain settings may have other nationally recognized qualified providers by different names (e.g., health assistants, clinical officers); qualified nurses, midwives, or doctors should supervise these cadres of providers. Identify and hire local staff from members of the host community as well as from the affected community who have skills and experience to provide quality contraceptive services. In rapid onset and complex emergencies, hiring providers with these skills is of high importance as the scope for conducting immediate trainings on any of the clinical skills is limited.

Community outreach with possible community distribution becomes an important option for service delivery to increase accessibility. When community distribution of contraceptive commodities is part of the health response, ensure supervision and training of lay health workers. It is important for the community-based distributors to recognize medical issues that require referral to a health facility and follow-up. Create awareness among community members that the lay health worker is supervised by a nurse or a doctor who is available for clinical care or counseling, if necessary.

FACILITY

Facility-based contraceptive services should include a broad method mix with long-acting and short-acting methods, including barrier methods and emergency contraception. Facilities can be categorized using the primary health care model, where health posts are the most peripheral health facility functioning at the community level, followed by a mid-level health center, with both of these structures supported by a district-level hospital, functioning as the referral point for community-level health facilities. There may be other structures in between these main structures in different settings.

In the event of a disaster, many of these structures will have limited or no functionality and programs will have to make do with what little might be left behind in the aftermath. Provision of contraception is a relatively simple public health intervention with great potential for saving lives for women as well as for newborns and infants. However, it is important to ensure that basic amenities as well as good practices are put in place; this can be achieved with planning and modest resources. Some of the important aspects to consider are:

- Ensuring application of best practices in contraceptive services
- Establishing a good referral system for higher-level clinical care and client follow-up
- Designing contraceptive services in a manner that ensures clients' rights to privacy, confidentiality, and informed consent
- Implementing appropriate infection prevention and waste management procedures

QUALITY

High-quality contraceptive services meet individuals' and couples' needs at every stage of their reproductive lives through clinical competence of providers, counseling skills, including the information given to clients, method choice, interpersonal skills, support for continuation of method use, and integration with other health services. Service providers should provide clients with accurate and complete information, allowing women, men, and adolescents to voluntarily select a method that suits their needs.

Method choice and continuation

Due to personal preference and changing needs over the life course, a broad range of methods is an essential component of good contraceptive services. Method mix, including long-acting reversible contraception (LARC) and emergency contraception, is important to address informed and voluntary choice and changing client needs. These aspects of family planning programs have been associated with increased contraceptive prevalence. In the case of short-acting methods, it is important to facilitate the client's return visit so she can continue her method of choice. This should be addressed through providing longer term commodity allocation as well as introducing a reliable appointment or follow-up system encouraging clients to return for services for continued protection against unintended pregnancy. Maintaining a client follow up card at the health facility for each client can help health providers keep track of follow up services.

Provider competence

In order to provide a broad range of methods, providers must have the technical competence to provide related services, including skills in contraceptive insertion and removal. Providers need to be able to apply the following skills in their counseling and service provision:

- Describe methods, including effectiveness, correct use, advantages, and disadvantages
- Describe the mechanism(s) of action, common side effects, potential complications, and management of complications
- Use Medical Eligibility Criteria and identify associated drug interactions
- Provide instructions for accurate use of method and/or its proper administration
- Implement infection prevention principles and practices

Further, in order to provide good quality services, providers need to be aware of, and be prepared to adhere to, the following guidelines:

- Means for maintaining consistent and sufficient supply of contraceptive commodities and related supplies
- Mechanisms for documenting and keeping records of service provision, as well as for commodities and supplies required for service delivery
- Methods to initiate and maintain appropriate referrals to higher level facilities based on sound clinical decision-making practices

Counseling skills

For any contraceptive service delivery intervention, counseling is an essential component that forms the cornerstone for volunteerism and informed choice. High-quality counseling ensures clients are informed about their chosen method and fosters longer continuation. Being in a humanitarian setting is not a reason to cut corners on this quality aspect of service provision; on the contrary, investing in this integral part of quality contraceptive services helps to lay the foundation for high-quality services that are critical to establishing trust with clients and facilitating longer term service delivery interventions.

The following basic principles of contraceptive counseling should be demonstrated:

- Non-judgmental attitudes toward contraceptive users and nonusers, respecting their choices, dignity, privacy, and confidentiality
- Full explanation of advantages and disadvantages of different methods and information on management of side effects
- Evidence-based and tactful responses to rumors and misconceptions regarding contraceptive methods
- Sensitivity to the needs of specific groups (e.g., adolescents, persons with disabilities, people living

with HIV, persons engaged in sex work)

- Maintaining confidentiality for services and recognizing that partner permission or notification is not required
- Communication techniques, such as open interactive dialogue with clients: encouraging clients to express their questions and concerns, active listening, clarifying, asking clients to restate their understanding, acknowledging client feelings, and summarizing the discussion
- Documenting method choice and storing information in a confidential location

Providers should also be mindful of the possibility that a client is experiencing intimate partner violence or reproductive coercion in her/his/their relationship. If a provider suspects that a client is experiencing reproductive coercion, she/he/they should provide a safe and supportive environment and ensure the client's right to confidentiality is respected. It is also important for providers to know the referral system for gender-based violence (GBV) and provide information about services to the client.

BOX 7.5: 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 and family planning requires that all services be offered on a voluntary 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 family planning includes:

- **People have the opportunity to choose voluntarily whether to use family planning or a specific contraceptive method**
- **Individuals have access to information on a wide variety of contraceptive choices, including the benefits and 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**

Service integration

Contraception services must be comprehensive as well as convenient. For example, a client should be able to complete all the services necessary for a visit and receive her/his/their contraception method of choice on the same day and at the same location as where the initial counseling took place.

SOCIAL BEHAVIOR CHANGE

Social behavior change communication (SBCC) is the use of communication to change behaviors, including service utilization, by positively influencing knowledge, attitudes, and social norms. SBCC is systematic, evidence-based, and participatory and strengthens capacity. Because behaviors are deeply rooted in the social constructs of individuals and societies, the process of changing negative health behaviors involves developing a deep understanding of these constructs. During implementation of the MISP, humanitarian actors will focus on ensuring that clients know what services are available to them and where they can be found, that they feel safe and welcomed when they seek services, that services are open to all who need them, and that they are delivered with sensitivity to their specific

PROGRAMMATIC EXAMPLE 7.2: COMPREHENSIVE CONTRACEPTIVE SERVICE DELIVERY IN A CRISIS SETTING

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Nigeria

INTRODUCTION: Boko Haram violence has forced some 1.82 million people from their home in Northeast Nigeria. As the uprooted continued to flee, internally displaced person (IDP) camps and host communities swelled in Borno State. Health facilities in formal and informal IDP camps run by the Federal Ministry of Health had never recovered from the Boko Haram insurgency and were ill-equipped and understaffed. Health services, including sexual reproductive health (SRH), were almost non-existent in Maiduguri, placing women and girls at increased risk of life-threatening health problems.

PROJECT DESCRIPTION: In August 2016, the IRC initiated MISP services and within 4 weeks had established the only reproductive health clinic in the Bakassi camp, which served 21,293 IDPs. The IRC also supported 4 government primary health care facilities within the Maiduguri Metropolitan Council-Jere area, with a particular focus on contraceptive services, post-abortion care, care for sexual assault survivors, and delivery care. Additionally, the IRC had established comprehensive reproductive health services in Konduga (population 9,371) and Monguno (population 40,147) through SRH clinics. During this period, the IRC provided support to a total of 291,767 people in Borno State.

RESULTS: The IRC successfully scaled up contraception uptake through a combination of staffing support, commodity provision, community outreach by engaging volunteers and traditional birth attendants and training of government health providers. Following a contraception training for health care providers, new acceptors increased by 50% in just one week. Between January and March 2017 across all supported sites, the IRC served a total of 3,474 family planning clients. Of these clients, 69% (2,398) were new acceptors of contraception and 14.4% (346) opted for a long-acting reversible contraceptive method.

LESSONS LEARNED: These results demonstrate a capacity to rapidly scale contraceptive services in a fragile context with low contraceptive prevalence. Emergency responders must anticipate a low number of skilled health staff available, long lead times for procurement and recruitment, and low priority for SRH. To fill these gaps, responders must budget for more skilled staff including procurement staff and prepare data and evidence to share with local authorities and in the health cluster to prioritize SRH.

needs. As the transition to comprehensive SRH services occurs, more intensive SBCC should be a feature.

COMMUNITY OUTREACH AND INVOLVEMENT

Communities should be involved in the development and implementation of family planning programs, including specific sub-populations that may be more difficult to reach (adolescents, sex workers, persons with disabilities, lesbian, gay, bisexual, queer, questioning, intersex, and asexual (LGBTQIA) people, among others).

Male involvement

Male partners are often the decision-makers about whether their female partner can use contraception and, if permission is granted, which method she uses. Involve men as key stakeholders and partners to increase acceptance

BOX 7.6: DEFINING CULTURAL HUMILITY

In 1998, Melanie Tervalon and Jann Murray-Garcia developed the term "cultural humility" to describe an on-going process by which social work and medical professionals can learn about different cultures while engaging in meaningful reflection on their own cultural traditions, beliefs, and biases. In family planning, the most sensitive and complex areas of culture come into play. How we feel about pregnancy, contraception, abortion, female genital cutting, STIs, and the value of girl infants can divide even those within one culture. High-quality contraceptive service delivery recognizes the importance of practicing cultural humility while providing care, and places responsibility for establishing a respectful and non-judgmental space on the health service provider and agency.

of the program within the community and recognition of other SRH issues, such as the prevention and treatment of sexually transmitted infections (STIs), including HIV. Considering men's perspectives and motivations is integral to program activities.

Contraceptive use by men enables them to share the responsibility of pregnancy prevention with their female partners. Some services may need to be specifically tailored to meet the needs of male users. Activities to encourage men's involvement include couples counseling, condom promotion, health facility times for men, peer-group sessions, and dissemination of SRH information at male social groups.

PROGRAMMATIC EXAMPLE 7.3: INVOLVING MEN IN CONTRACEPTION PROGRAMMING IN CONFLICT SETTINGS

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Chad

INTRODUCTION: In the Oure Cassoni camp of Amdjarass, the IRC-supported health center serves a total population of 46,000, including a host population of 20,000. Despite service availability and community mobilization activities in the camp, low acceptance of contraceptive methods posed a real challenge, particularly due to the influence of religious leaders on women's decision-making and health-seeking behaviors.

PROJECT DESCRIPTION: The IRC identified 40 influential religious leaders to attend awareness-raising and training sessions. The sessions presented the importance of contraception and, quite critically, addressed its advantages within the broader context of maternal and child health in Chad. The President's endorsement of reproductive health and contraception and references of supportive religious passages were reiterated throughout the trainings. A committee of religious leaders in support of contraception was formed to begin community sensitization efforts in mosques and to participate in data analysis meetings.

RESULTS: In Amdjarass, 316 clients accepted contraception during the project's reporting period, exceeding the target and surpassing the achievement during the previous semester, when 180 clients accepted contraception. This performance is largely explained by religious leaders' involvement in contraception-sensitizations, especially at mosques, and the permanence of one trained IRC staff at the Ouré Cassoni health post to ensure service provision and capacity building of existing refugee staff. Before mobilization efforts took place, the IRC saw an average of 20 new acceptors per month, with an average of 8 acceptors of long-acting reversible contraception (LARC). After trainings of religious leaders and subsequent community sensitization efforts, the IRC saw an average of 33 new acceptors, with an average of 17 acceptors of methods of LARC.

LESSONS LEARNED: Religious leaders are often considered as a barrier to contraception in humanitarian contexts. Yet even in a context considered traditional and religious, contraception is accepted once people are well informed and quality services are in place. The perception of religious community beliefs as barriers is never an excuse to not offer contraceptive services during emergencies. However, more sensitization is needed to expand access for vulnerable groups as contraceptive use among adolescents girls and unwed women is still taboo.

Consulting with populations facing unique needs or specific risks

Contraceptive services should be made available to all segments of the population and thus key stakeholders should be involved in the consultation and development of programs. It is recommended that efforts be made to identify local groups who currently provide services to specific groups, such as the LGBTQIA community, and persons engaged in sex work, in order to establish referral pathways through existing networks. Providers can simultaneously receive training in service delivery and sensitivity to groups that they may encounter through their work.

INFORMATION, EDUCATION, AND COMMUNICATION MATERIALS

Information, education, and communication (IEC) materials should be used in the acute phase to create basic awareness about availability of contraceptive services. These IEC materials can include posters, fliers in local languages with locally-appropriate images, and radio messages. In moving to the comprehensive service

delivery phase, IEC materials should shift to messages that motivate women, adolescents, men, couples, and other members of the community to use contraceptive services.

RESPONDING TO MISINFORMATION AND METHOD DISCONTINUATION

A comprehensive and client-centered contraception service delivery program facilitates method continuation and responds quickly and supportively to method switching. However, many women discontinue their contraceptive method for reasons other than desiring pregnancy, and very often these women do not switch to a new method. This leaves many of clients with an unmet need for contraception and at-risk of unintended pregnancy.

Providers offering contraception can minimize discontinuation by accurately describing side effects and ways to manage them if they arise. Providers should also be prepared and equipped to remove implants and IUDs if clients seek their removal.

As part of comprehensive SRH services, efforts can be made to ensure continuation including:

- Strengthen provider skills on counseling including side effects management
- Active follow-up for clients who miss an appointment to renew a contraceptive method
- Incorporation of community health workers (CHWs) into community-based contraceptive service delivery
- Active engagement of community members to dispel rumors
- Ensuring reliable stocking of contraceptives to prevent stock outs

7.3.6 Working with specific populations

ADOLESCENTS

Complications of pregnancy and childbirth are the second leading cause of death among girls 15-19 and 50% of sexual assaults are to girls 15 and younger. In humanitarian emergencies, risks for adolescents are exacerbated and therefore their reproductive health needs must be a priority. Adolescents in humanitarian emergencies face increased risks of sexual violence, abuse and exploitation, unplanned pregnancy, and unsafe abortion. Health providers must ensure that adolescents - married, unmarried, with disabilities, in-school and out of school - are able to access SRH services in general and contraceptive services in particular. Circumstances that bring adolescents to care may not always be known and it is critical for providers to deliver non-judgmental, high-quality services and when the opportunity occurs to leverage this point of access to identify and deliver other needed services and resources as appropriate. For more information on adolescent sexual and reproductive health, see Chapter 6.

BOX 7.7: DEFINING "PERSONS ENGAGED IN SEX WORK"

Persons engaged in sex work is a term that encompasses female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work may vary in the degree to which it is "formal" or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. Additionally, in many contexts, including humanitarian settings, many individuals engaging in this practice do not self-identify as sex workers.

PERSONS ENGAGED IN SEX WORK

All persons engaged in sex work have a fundamental human right to the highest attainable standard of health. It is important that actions are taken programmatically, and at the point of service delivery, to ensure that these rights are realized. Service providers have an obligation to provide care to persons engaged in sex work, regardless of the legal status of sex work in the specific setting. Service providers should also keep in mind that persons engaged in sex work are capable of making informed decisions.

Service providers should offer persons engaged in sex work the same quality of care as all other clients. During their counseling, providers should:

- Discuss available methods of contraception, including dual method protection
- Provide counseling on safe sex and sexually

transmitted infection (STI)/HIV protection that addresses the specific needs of persons engaged in sex work, including instructions on the proper use of male and female condoms and lubricants

- Promote and provide condoms and lubricants in sufficient quantities
- Screen for HIV and other STIs and provide appropriate counseling, treatment, and follow-up
- Discuss the client's pregnancy intention
- Determine medical eligibility for the desired contraceptive method
- Provide or prescribe the client's preferred contraceptive method
- Make EC available

In addition, clients should be linked to safe abortion care and safe pregnancy care, as needed. Providers should be mindful that persons engaged in sex work confront many of the same SRH needs—including planned and unplanned pregnancies—as their peers who are not engaged in sex work, and should ensure to address these needs.

PERSONS WITH DISABILITIES

The Convention on the Rights of Persons with Disabilities (CRPD) declares that persons with disabilities should have the same range, quality, and standard of free or affordable health care and programs as provided to other persons, including in the area of SRH. However, the diverse reproductive health needs of persons with disabilities are rarely understood or addressed through SRH programming in emergency contexts. The SRH needs of persons with disabilities, their family planning intentions, and their access to contraceptive services should be understood and mainstreamed within comprehensive SRH programming.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, QUESTIONING, INTERSEX, AND ASEXUAL PEOPLE

Under international human rights law, States must secure equal rights—including rights to life, health, and security of person—for all individuals, regardless of their gender identity, sexual orientation, or other status. However, discriminatory laws, attitudes, and practices often produce health disparities and compromise the ability of LGBTQIA individuals to access quality reproductive health services. Providers are critical to ensuring that LGBTQIA individuals' equal rights to health are protected and fulfilled, and should be mindful of the particular barriers that LGBTQIA persons may face when seeking care. Providers should adopt a respectful and non-judgmental attitude when providing services and should strive to address any concerns that may be specific to this population.

BOX 7.8: PROVIDING EMERGENCY CONTRACEPTION TO RAPE SURVIVORS

Emergency contraception can reduce the risk of pregnancy after an instance of unprotected sex, including in cases of sexual violence. Global guidance from the WHO is clear that EC should be offered to women and girls to prevent the traumatic consequences of pregnancy resulting from rape, as part of comprehensive, woman-centered care. Failure to ensure that sexual violence survivors receive EC may harm their physical and psychological health (especially in areas where safe abortion is illegal or unavailable); such failure is a violation of their human rights.

For the millions of women and girls who have been affected by conflict, natural disasters and emergencies, both the need to access EC and barriers to it are increased. Forced displacement, exposure to violence, and separation from families and communities expose crisis-affected populations to increased risk of sexual violence and the accompanying risk of unintended pregnancies. At the same time, their access to regular contraception, which protect against such risk, is diminished.

And yet routine access to EC is lacking due to barriers at the levels of policy, laws, health systems, and awareness. Many of the countries with no registered EC product are currently, or have recently been, affected by conflict and may also host large displaced populations. Fragile settings may also be more likely to lack skilled staff and sufficient supplies.

BOX 7.9: POST-ABORTION CONTRACEPTION SERVICE DELIVERY

Providing timely and effective post-abortion counseling can help prevent future unintended pregnancies. Post-abortion contraceptive counseling is also associated with a reduction in maternal and child mortality and prevention of mother-to-child HIV transmission. Unfortunately, the proportion of women who receive a contraceptive method after abortion care remains low. Therefore, contraceptive counseling and provision of a method should be priorities in all abortion services. In addition, some women may have experienced an unintended pregnancy while already using a method; it is important to address the reasons for method failure, and counsel women accordingly. The World Health Organization recommends all women should receive contraceptive information and be offered counseling for and methods of post-abortion contraception, including emergency contraception, before leaving the health-care facility.

Providers must ensure that all women, including young women, receiving abortion-related care know:

- Ovulation and thus pregnancy can occur almost immediately after a uterine evacuation
- In general, all methods of contraception can be used immediately following a uterine evacuation
- Where she can obtain contraceptive services and methods including emergency contraception

Providing contraceptive services at the same time and in the same location as the abortion care can help ensure that a woman receives a contraceptive method before leaving the facility. If a woman is eligible and has been counseled and consented to the method, all methods of contraception—including IUDs and female sterilization—may be started at the same time as a vacuum aspiration. Most methods of contraception can be given at the same time as the first pill of a medication abortion. After medication abortion, an IUD may be inserted when it is reasonably certain that a woman is no longer pregnant and provided the client consents to the procedure.

7.3.7 Coordinating and making linkages

SRH Coordinators need to aim for the integration of contraceptive services and family planning programs in primary health care and other SRH programs, including:

- Provision of emergency contraception as part of the response to survivors of sexual violence and to meet demand
- Integration of contraceptive counseling and service delivery in STI and HIV programs, by ensuring that service providers
  - o Discuss pregnancy prevention and contraception with clients as needed
  - o Encourage dual protection (against pregnancy and STIs)
- Inclusion of contraceptive programming in adolescent healthcare services
- Incorporation of contraceptive counseling and management in the antenatal, delivery, and postpartum periods in maternal and newborn health programs
- Inclusion of contraceptive counseling and services, and screening for contraceptive coercion, in gender-based violence programs

7.3.8 Advocacy

SRH Coordinators and health program managers should advocate for provision of comprehensive family planning information and services whenever possible. Efforts should be made to ensure service providers are aware of and implementing existing policies.

Engagement with local civil society organizations is essential to identifying and meeting the needs of affected populations. Local actors often best know the landscape and needs of the community and should be a resource in working with the government, donors, and other agencies to ensure that comprehensive, rights-based family planning programs are implemented. While national guidance and law take precedent, bringing these standards in line with international norms, standards, and protocols, is important to ensure that people have access to comprehensive, quality contraceptive information, services and supplies. Meeting with the local Ministry of Health officials, private donors, and other agencies to present data on unmet need, potential cost savings, and the health benefits of providing contraceptive services may result in stronger policies that save lives.

7.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

Under international law, universal access to family planning is a human right: all individuals and couples have the right to decide on the number, spacing and timing of children. At the 1994 International Conference on Population and Development (ICPD), governments agreed to make reproductive health care available to all, including a full range of contraceptive services. The right to the highest attainable standard of health includes the right to be informed and to have access to safe, effective, affordable, and acceptable methods of contraception. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee has explicitly called on states to ensure access to contraception, including emergency contraception, in conflict-affected settings.

Coercing people to use a contraceptive method is not family planning and is a violation of international human rights law. For example, forced sterilization without consent violates the right to informed consent, the right to health, the right to security and liberty of the person, and the right of individuals to decide freely on the number and spacing of their children.

7.5 MONITORING AND EVALUATION

7.5.1 Clinic/service register

Maintain a clinical register to record information and offer effective follow-up. In mobile populations, clients may wish to keep a copy of their records. The following information should be recorded in the client register (one client per row):

- Date
- Client name, or, if required for confidentiality, a unique identifier
- Client age and other demographic information
- Type of client
    - o New: Service providers must define the meaning of "new" client. Is this client new to the facility (starting contraceptive use for the first time at this facility)? New to the specific method (starting this method for the first time)? New to using contraception (starting contraception for the first time in her life)? If using Ministry of Health forms, please note the correct definition.
    - o Return: A client who is not new (according to the specific definition). This can include a client returning for a follow-up visit, for re-supply, or to change methods
    - o Switcher: A client who switches immediately from using one method to using another. Both methods should be recorded
- Method selected (and brand name): Be sure to include all methods. It is best if there is a column to each method (e.g., OCPs, injectable, implant, IUD, etc.)
- Method removal (for IUDs and implants): Note reason for removal in a "comments" column
- Referred by: If the program integrates with other services and uses CHWs, this column can specify the source of the referral

The individual client form may also allow for tracking contraceptive use by a single client over time. This individual client record should contain additional information, including date, reason(s) for method discontinuation or switching, side effects, side effect management/treatment, etc.

7.5.2 Support client continuation

An integral part of any contraceptive program is to track continuation of use. To do this, SRH Coordinators, health program managers, and service providers need a system to identify clients who have not returned for re-supply appointments and remind them that they missed their appointment. The recommended system uses a box with dividers to file client cards as described below. If the standard practice is for the client to keep her/his/their card, then use a card with the following information to file in the appropriate month: name, age, date of visit, method taken, and date of return visit.

INFORMATION MANAGEMENT

Obtain a box sufficient to hold the filed cards. Divide the box into slots or shelves, one for each month of the year plus one for long-acting methods and one for "loss to follow-up less than 6 months." After the appointment, place the client card in the appropriate slot for the month when the client is scheduled to return for her/his/their re-supply. At the end of the month, it is easy to see which clients missed their appointments and contact them with a reminder. It is important to maintain client confidentiality when reminding them of missed appointments.

Record-keeping forms should be simple and appropriate for the collected data and staff literacy levels. Use national or local formats that are known by the local staff and the affected population. Train all staff on maintaining appropriate records, including definitions and how to complete forms, and using the information collected in their program.

7.5.3 Indicators

Figure 7.2 provides information about the key indicators for provision of contraceptive services.

FIGURE 7.2: KEY INDICATORS

INDICATOR	DEFINITION	DATA SOURCE	COMMENTS
FACILITY INDICATORS			
Number of clients who start a modern contraceptive method at this facility, by method	Number of clients who begin using a contraceptive method, by method a. IUD b. Implants c. Tubal ligation d. Vasectomy e. Daily oral contraceptive pill f. Injectables g. Condoms (male or female) h. Emergency contraception 1. EC pills 2. IUD as EC	Facility registers	Please include any client who starts a modern method, including those switching from another method You must define how long a client stops a method before re-starting; e.g., if a client has stopped using a method for 6 months (i.e., missed her last appointment for 6 months), she should be counted as re-starting
Integration	• Percentage of contraceptive clients also counseled about sexually transmitted infections • Percentage of contraceptive clients also referred to source of ongoing contraceptive method		
Method mix	Numerator: Number of contraceptive clients who start each method Denominator: Number of clients who start a modern contraceptive method at this facility	Facility registers	
PROGRAMMATIC INDICATORS			
Number of contraceptive service delivery points that had no stock-outs of methods in previous month	Number of contraceptive service delivery points that had no stock-outs (for more than 1 day) of methods in previous month	Stock registers	It is important to check stocks of all methods that are provided by the facility (e.g., OCPs, injectables, IUDs, implants, EC)
Number of providers with technical competence to provide contraception	Number of providers with technical competence, as measured using a checklist, to provide contraceptive methods, by method	Program or supervision records	Supervisors should observe providers' competence using a checklist with each method periodically (for example, twice a year)

7.6 FURTHER READING AND ADDITIONAL RESOURCES

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