Special Population:
CONTRACEPTION IN DISASTER AND CRISIS SITUATIONS

In disaster situations, women are at higher risks for unwanted or unplanned pregnancies and sexually transmitted infections (STIs)
for several reasons.(131) Some of these reasons include the following:

- Routine behavior, that is, taking the daily pill or using condoms, may be disrupted and forgotten while attending to emergent needs.
- Access to contraceptives becomes difficult.
- Comfort-seeking behavior, such as intimacy and sex, may increase.

The risk of women and children for domestic violence and sexual assault is also increased, resulting in higher predisposition to STIs, possible spread of human immunodeficiency virus (HIV), unwanted pregnancies, unsafe abortions, and other adverse outcomes, such as trauma, as well as maternal and neonatal deaths.(130) Notably, women have more miscarriages, premature deliveries, fetuses with intrauterine growth restriction, and low birth weight infants after disasters. Adolescents, aside from vulnerability to exploitation, violence, and transactional sex, may also be prone to risk-taking behavior.

Four key aspects of reproductive healthcare in disaster and crisis situations should be addressed:

- Safe motherhood (antenatal care, delivery care, and postpartum care)
- Family planning
- Prevention and care of STIs and HIV/AIDS
- Protection from and response to sexual and gender-based violence

The following measures should be immediately undertaken:

- Determine contraceptive availability.
- Document the type, quantity, and expiration dates of the contraceptives.
- Distribute condoms to men and women.
- Provide emergency contraception, as needed.
- Promote use of injectable hormonal contraceptives.
- Plan protective measures against violence and exploitation for women and children

The following long-term measures must be employed:

- Institute OB-GYN healthcare services with trained staff in evacuation centers or camps.
- Provide education sessions on sexual health and reproductive health rights in these centers.
- Provide educational materials on the above topics.
- Establish a family planning program (as part of a comprehensive reproductive health program) that covers effective counseling, contraceptive choices, follow-up, education, and general information dissemination.

CONTRACEPTIVES AND SPECIAL CONSIDERATIONS IN DISASTER/ CRISIS AREAS*

Male/female condoms

- Condoms are suitable in disaster-hit areas because of their easy distribution by any provider, lack of medical contraindications, and prevention of STI transmission, including HIV.
- Failure rates, especially during the first year of use, may be higher than those for other methods because of improper or incorrect usage.
- Counseling must be given as early as possible in the post-emergency phase to ensure correct usage and to motivate both the man and woman to start and continue to use the method.

Emergency contraceptive pills (See ***Women-Victims of Violence)***

Injectables

- The advantage of this method is that women are not required to remember to take a daily pill, which may be difficult during a crisis.
- Pregnancy rates are approximately 3% in the first year of use.

- Irregular or prolonged bleeding often appears during the first three to six months of use (much less for the combined injectable). For the progestin-only injectable, bleeding becomes infrequent or disappears after the first few injections. This advantage may prove appealing for women because of the less-than-ideal sanitary set-up and inaccessibility to hygienic products and water in evacuation areas or camps.
- These methods can safely be provided by medical, paramedical, or any personnel trained in administering injections using the MEC checklist to determine client eligibility.
- Regular supply of the contraceptives and proper disposal of needles must be ensured.

Combined oral contraceptive (COC) pills

- Pregnancy rate during the first year of use is approximately eight percent and declines thereafter.
- The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.
- A regular supply and easy access to pills MUST be ensured in the camps or centers, as well as in the community.

Progestogen-only pills (POPs)

- Approximately 1 in 100 breastfeeding women becomes pregnant within the first year of use.
- This method is ideal for women in evacuation centers or camps who are breastfeeding and need additional protection because POPs do not affect the quality or quantity of breast milk.
- Additional advantage is that this method may prolong lactation amenorrhea.
- The pills can be dispensed by paramedical personnel or any trained provider using the MEC checklist to determine client eligibility.
- Similar to COCs, a steady regular supply of POPs must be established for easy access by clients.

Intrauterine devices (IUDs)

- The advantage of IUDs is that they are among the most effective methods of contraception with pregnancy rates of only 6 to 8 per 1000 women during the first year of use.
- The use of such devices in disaster areas depends on the availability of devices and skilled medical or paramedical providers for insertion.
- IUDs are suitable for clients coming from areas where the method is already known and where the IUD is likely to be available once the client has returned.
- Clients must also have access for post-insertion follow-up if the need for removal arises or if any complications occur (uncommon).

Implants

- Approximately 1 in 100 women becomes pregnant over the first year of implant placement.
- Prolonged protection is experienced for three, five, or seven years depending on the implant.
- This method requires a minor surgical procedure; thus, trained physicians are the sole providers.
- Clients must have access to follow-up and removal upon demand in the area of origin or in the new destination.

Lactation amenorrhea method

- For this method to be successful, the client must be fully or nearly fully breastfeeding, menses have not yet resumed, and the infant is less than six months old.
  Otherwise, an additional method, such as the POP, is needed.
- Pregnancy rates are approximately 2 per 100 women in the first six months.

Male and female sterilization

- These permanent methods of contraception are suitable for couples who no longer desire any children.
- Pregnancy rate for vasectomy is approximately 2 per 1000 over the first year after the male partners have had vasectomies, whereas that for tubal ligation is 5 pregnancies per 1000 over the first year.
- Access to these methods may not be as easy in the early phase of the crisis compared with other contraceptive options because of the need for a facility to perform the procedure. Such facility and the physicians who are trained to perform the procedure may not be available initially. Nevertheless, every
  effort must be exerted to make these services accessible to clients at the soonest possible time.

Fertility awareness-based methods

- Pregnancy rate is approximately 20 for 100 women over the first year of use.
- Clients should be well counseled and motivated to follow the instructions closely when determining the time of the month during which fertilization is possible. This step is especially critical because couples may be burdened by more pressing concerns, such as finding food and water sources, as well as dealing with the loss of relatives, homes, and livelihood.

*Adapted with modifications from Public Health Guide for Emergencies. Chapter on Reproductive Health Care.[3]See respective sections for detailed information on the following methods.