Reproductive Health

in refugee situations

an Inter-agency Field Manual

Corrections to the Inter-agency Field Manual

21 August 2007

Foreword

Reproductive Health in Refugee Situations, an Inter-agency Field Manual is widely used as the standard-setting guideline on reproductive health in humanitarian situations. The manual was printed in its current version in 1999, after extensive field-testing.

Whilst much of the content of the manual is still valid today, significant advances in reproductive health clinical standards/guidelines have been made, and some of the information in the manual is out of date. An extensive revision of the manual has been undertaken. However, there are several critical, evidence-based updates that the Interagency Working Group felt were important to share in advance of the revision. The Corrigendum provides these updates in a simplified and focused document. The updates reflect the current state of the art and are subject to change—please check the website (www.rhrc.org/iawg/) regularly for possible changes in the future.

Although the Corrigendum is available in English and French, the upcoming revision will be translated into several more languages commonly used in humanitarian work.

How to use

The Corrigendum is published in two formats—a print copy of the key clinical practice recommendations, and a web version, which also includes references and other pertinent information. The print copy of the Corrigendum should be used alongside the Inter-Agency Field Manual. Please refer to the web version for more extensive chapter information, updates, references, and other resources

We hope the Corrigendum will serve as a useful adjunct to the Inter-agency Field Manual, and we welcome your comments and suggestions (iawg@rhrc.org).

The Inter-Agency Working Group (IAWG) for Reproductive Health in Crises

Chapter Two: Minimum Initial Service Package (MISP)

2

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

New Resource Materials:

The "Interagency Emergency Health Kit 2006 (IEHK)" (www.who.int/medicines/publications/mrhealthkit.pdf) contains a midwifery kit, emergency contraceptive pills, post-exposure prophylaxis treatment to prevent transmission of HIV after rape, and supplies for the adherence to universal precautions. However, to provide the full range of priority RH services in an emergency situation, it is recommended that the Interagency RH Kits are ordered or other supply sources are identified to ensure all necessary equipment and materials are available.

Information on the Interagency RH Kits (www.rhrc.org/pdf/rhrkit.pdf) or assistance with ordering can be provided by UNFPA field offices, agency partners, or the UNFPA Humanitarian Response Unit (HRU) in New York or Geneva:

UNFPA/HRU 220 East 42nd Street New York, NY 10017 USA tel: +1 212 297 5245 fax: +1 212 297 4915 email: hru@unfpa.org website: www.unfpa.org	UNFPA/HRU 11-13, chemin des Anémones 1219 Chatelaine, Geneva Switzerland tel: +41 22 917 83 14 fax: +41 22 917 80 16 email: doedens@unfpa.org	Kits can also be directly ordered from: UNFPA Procurement Services Section Midtermolen 3 2100 Copenhagen Denmark tel: +45 3546 7368/7000

Chapter Three: Safe Motherhood (Maternal and Newborn Care)

3

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

Prevention of Mother-to-Child Transmission (PMTCT)

(Refer to Page 18.)

Provision of antiretrovirals (ARVs) to an HIV-positive pregnant woman and newborn to reduce the likelihood of HIV transmission from mother to child:

a. PMTCT programmes should be implemented for pregnant women and newborns as soon as feasible.
b. PMTCT programmes should be as comprehensive as possible and at a minimum include comprehensive maternal-child healthcare; counseling and testing services; counseling and support about safe infant feeding practices (also see corrections in chapter 5); optimal obstetrical care practices; short-course ARV for HIV-infected pregnant women and newborns; family planning counseling and services linked to voluntary counseling and testing. Such programmes must follow international standards and norms.
c. Other components of PMTCT, such as long-term ART and care of the mother, should be considered in all PMTCT programmes.

Adapted from: Antiretroviral Medication Policy for Refugees. UNHCR, Geneva. 2007.
(www.unhcr.org/publ/PUBL/45b479642.pdf)

Delivery Care

(See also Chapter 5)

- Clinicians should note that episiotomy is no longer routine in obstetrical care and should only be performed when clinically indicated.
- Active Management of the Third Stage of Labor. Please see *Safe Motherhood: Care In Normal Birth: a practical guide*. (www.who.int/reproductive-health/publications/MSM_96_24/care_in_normal_birth_practical_guide.pdf)

Essential Newborn Care

- The three main causes of neonatal mortality are: birth asphyxia, infections, and complications of prematurity/ low birth weight (LBW). These conditions are preventable or can be managed if women and newborns had access to basic health care.
  Lawn, Joy E., Cousens, Simon, and Zupan, Jelka. "4 million neonatal deaths: When? Where? Why?" *The Lancet*. March 3, 2005. (Lynhurst Press Ltd: London) pp. 891.
  (www.who.int/child-adolescent-health/New_Publications/NEONATAL/The_Lancet/Neonatal_paper_1.pdf)

Main components of essential newborn care:

1) Management of main causes of mortality
   a. **Birth Asphyxia:** 5-10% of all newborns need resuscitation at birth. Newborn resuscitation comprises: keep baby dry and warm; stimulate; position and clear airway (suction); ventilate (bag-and-mask resuscitation); monitor.
   b. **Infections:** mainly sepsis, pneumonia, tetanus, diarrhea. Clean delivery; tetanus toxoid immunization during pregnancy, proper cord care; keeping the baby warm; immediate and exclusive breastfeeding can prevent majority of newborn infections. For specific disease management please read *Care of the Newborn Reference Manual.*
   c. **LBW/Pre-term birth:** complications associated with LBW/Pre-term birth are hypoglycemia, hypothermia, feeding difficulty, jaundice, risk of infection. Care of the LBW/pre-term include kangaroo mother care (KMC), keep baby warm, immediate and exclusive breastfeeding, feeding assistance, prevention of infection, and early identification and appropriate treatment of infections and complications
2) Health workers need to be trained on essential newborn care.
3) Public Health Surveillance systems in emergency settings should include neonatal morbidity and mortality data.

Please read:
Care of the Newborn reference manual
(www.savethechildren.org/publications/technical-resources/saving-newborn-lives/00-20-20Care-20of-20the-20Newborn-20Reference-20Manual-20-3-6MB.pdf)
Integrated Management of Pregnancy and Childbirth (IMPAC): Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. 2005. pp. S-141-149.
(www.who.int/reproductive-health/impac/mcpc.pdf)

Chapter Four: Sexual and Gender-based Violence

4

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

Emergency contraceptive pills (ECPs)
Guidelines have been revised to advise that ECPs can prevent unwanted pregnancies if used within 120 hours of the rape. (See box on page 5.)

Post-exposure Prophylaxis to Prevent Transmission of HIV (PEP)
Survivors of rape should be offered PEP as soon as possible, up to 72 hours after the rape. PEP should be prescribed according to the health care provider's assessment of risk, which should be based on the history of the attack (i.e. penetration, the number of attackers, injuries sustained, etc.) and HIV prevalence in the region.

Presumptive Treatment for Sexually Transmitted Diseases (STDs)
Survivors of rape who present within two (2) weeks of the rape should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis. If other STDs are prevalent in the area (such as trichomoniasis or chancroid), presumptive treatment for these infections should be given as well.

Emergency Contraceptive Pills

- There are two emergency contraceptive pill (ECP) regimens that can be used:
  1. **the levonorgestrel-only regimen:** 1.50 mg of levonorgestrel in a single dose (this is the recommended regimen, it is more effective and has fewer side effects); or
  2. **the combined estrogen-progestin regimen** (Yuzpe): two doses of 100 microgram ethinyl estradiol plus 0.5 mg of levonorgestrel, taken 12 hours apart.
- Treatment with either regimen should be started as soon as possible after the rape because efficacy declines with time. Both regimens are effective when used up to 72 hours, and continue to be moderately effective if started between 72 hours and 120 hours (5 days) after the rape. Longer delays have not been investigated.
- There are products that are specially packaged for emergency contraception, but they are not available in all countries. If pre-packaged ECPs are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills. Counsel the survivor about how to take the pills, what side effects may occur, and the effect the pills may have on her next period. ECPs do not prevent pregnancy from sexual acts that take place after their use. Provide her with condoms for use in the immediate future.
- Make it clear to the survivor that there is a small risk that the pills will not work. Menstruation should occur around the time when she would normally expect it. It may be up to a week early or a few days late. If she has not had a period within a week after it was expected, she should return to have a pregnancy test and/or to discuss the options in case of pregnancy. Explain to her that spotting or slight bleeding is common with the levonorgestrel regimen and that it is nothing to worry about. This should not be confused with a normal menstruation.
- **Side effects:** Up to 50% of users report nausea with ECP. Taking the pills with food decreases nausea. The levonorgestrel-only regimen has been shown to cause significantly less nausea and vomiting than the combined estrogen-progestin regimen (Yuzpe). If vomiting occurs within 2 hours of taking a dose, repeat the dose. In cases of severe vomiting, ECPs can be administered vaginally.
- **Precautions:** ECPs will not be effective in the case of an established pregnancy. ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

(Adapted from: Consortium for Emergency Contraception, Emergency contraceptive pills, medical and service delivery guidelines. Second edition. Washington, D.C. 2004.)

Chapter Five: Sexually Transmitted Diseases, Including HIV/AIDS

5

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

Checklist for STD/HIV/AIDS Programmes (See also Chapter 6)

From MISP

- o Guarantee availability of free condoms.
- o Enforce universal precautions.
- HIV/STD/AIDS situational analysis is undertaken.
- Trained people from refugee community are identified.
- Information, education and communication programmes are in place.
- Universal precautions in health settings are practiced.
- Free good-quality condoms are regularly available and accessible.
- System of condom distribution is in place.
- Safe blood transfusion services are in place, guidelines disseminated, HIV test kits available, staff trained.
- Management protocols for STDs are defined and disseminated.
- Drugs for STD treatment are on hand.
- Staff are trained/retrained on syndromic case management.
- System for partner notification and treatment is instituted.
- Voluntary counseling and testing (VCT) services are in place (as appropriate).
- Home-based care for people with AIDS is in place.
- Counseling and support services for people with HIV/AIDS are in place.
- PMTCT programmes are in place. (See Chapter 3.)
- Cotrimoxizole to prevent opportunistic infections is prescribed to HIV-positive adults and children.
- Medicines and services to treat opportunistic infections are available.
- Continuation of antiretroviral therapy (ART) is available for people who were already on ART before the crisis.
- Where appropriate, access to ART is available for all HIV-positive people who meet eligibility criteria.
- HIV programming is youth-friendly.

Mother-to-Child Transmission and HIV and Infant Feeding

This is a rapidly evolving field. Current recommendations include:
New evidence on HIV transmission has shown that exclusive breastfeeding for up to six months is associated with a three- to four-fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding.

- The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take into consideration the health services available and the counseling and support she is likely to receive.
- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable, and safe for them and their infants before that time.
- When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, HIV-infected women should be counseled about the avoidance of all breastfeeding.
- Heat treating breast milk is no longer recommended.

Please check for new updates:
WHO HIV and Infant Feeding Technical Consultation Held on Behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and Their Infants. Geneva, October 25-27, 2006. Consensus Statement.
(www.who.int/child-adolescent-health/New_Publications/NUTRITION/consensus_statement.pdf)

See box on following pages for drugs for treatment of STDs.

Drugs for Treatment of STDs

Treat for	Drugs-Depending on Sensitivity Studies	Adult dose (for uncomplicated or early infections)
Gonorrhoea	Ciprofloxacin[1] Ceftriaxone Cefixime Spectinomycin	500 mg - oral - single dose 125 mg - IM - single dose 400 mg - oral - single dose 2 g - IM - single dose
Chlamydia	Doxycycline[1] Azithromycin Amoxycillin Erythromycin Ofloxacin[1] Tetracycline[1]	100 mg - oral - twice daily for 7 days 1 g - oral - single dose 500 mg - oral - 3 times a day for 7 days 500 mg - oral - 4 times a day for 7 days 300 mg - oral - twice a day for 7 days 500 mg - oral - 4 times a day for 7 days
Syphilis	Benzathine benzylpenicillin Procaine benzylpenicillin Doxycycline[1] Tetracycline[1, 2] Erythromycin	2.4 million IU - IM - single dose 1.2 million IU - IM - daily for 10 days 100 mg - oral - twice daily for 14 days 500 mg - oral - 4 times daily for 14 days 500 mg - oral - 4 times daily for 14 days
Chancroid	Ciprofloxacin[1] Erythromycin base Azithromycin Ceftriaxone	500 mg - oral - twice daily for 3 days 500 mg - oral - 4 times daily for 7 days 1 g - oral - single dose 250 mg - IM - single dose
Donovanosis	Azithromycin Doxycycline[1] Erythromycin Tetracycline[1] Trimethoprim/ sulfamethoxazole	1 g first day, followed by 500 mg once a day - oral[3] 100 mg - oral - twice daily[3] 500 mg - oral - 4 times daily[3] 500 mg - oral - 4 times daily[3] 160 mg/800 mg (2 tablets) - oral - twice daily for a minimum of 14 days
Candidosis	Miconazole or clotrimazole Clotrimazole Fluconazole Nystatin	200 mg - intravaginally - daily for 3 days 500 mg - intravaginally - single dose 150 mg - oral - single dose 100 000 IU - intravaginally - daily for 14 days
Bacterial vaginosis	Metronidazole[4] Metronidazole[4] Clindamycin Metronidazole[4] Clindamycin	400 mg or 500 mg - oral - twice daily for 7 days 2 g - oral - single dose 2% vaginal cream - 5 g intravaginally - at bedtime for 7 days 0.75% gel - 5 g intravaginally - twice daily for 5 days 300 mg - oral - twice daily for 7 days
Check for updates		

[1] Contraindicated in pregnancy.
[2] For persons allergic to penicillin, but may be less effective. Close follow-up is necessary to ensure a cure.
[3] Treatment should be continued until all lesions have completely epithelialized.
[4] Metronidazole and Tinidzole are not recommended for use in the first trimester of pregnancy.

Further Reading on HIV/AIDS Management

Integrated Management of Adolescent and Adult Illness (IMAI) modules. WHO. Geneva. 2004 -2006.

1. Acute care
2. Chronic HIV care with antiretroviral therapy
3. General principles of good chronic care
4. Palliative care
5. Caregiver booklet

(www.who.int/3by5/publications/documents/imai/en/index.html)

Chapter Six: Family Planning

6

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

Barrier Methods

Repeated and high-dose use of the spermicide nonoxynol-9 was associated with increased risk of genital lesions, which may increase the risk of acquiring HIV infection.

Copper IUDs

An IUD should not be inserted in a woman with gonorrhoea or chlamydia, or if a woman is at very high risk for these infections.

Nulliparous women may use the IUD safely, as recent well-conducted studies suggest no increased risk of infertility.

Hormonal Implants

New products are being developed and guidelines are being revised as experience with hormonal implants accumulates.

Family Planning for People Living with HIV

Condom use should be encouraged for all people with HIV, to protect from STDs, infection from another strain of HIV, and also to prevent transmission to sexual partners. Condoms are also an effective method of contraception when used correctly and consistently (offering dual protection from both pregnancy and STD/HIV). However, if a woman desires further pregnancy protection, she may wish to use condoms with another contraceptive method.

Women with HIV can use most methods of contraception, with the following considerations:

- Women with HIV or clinically well on treatment for AIDS can use the IUD.
- Spermicides should not be used by women with HIV infection.
- A woman taking rifampicin for TB should not use birth control pills or implants as the contraceptive effectiveness may be lessened. Depot-medroxy progesterone acetate (DMPA) and the monthly injectable can be used by women taking rifampicin.
- Women on ART who are using hormonal methods are advised to also use condoms, in case the ART reduces the contraceptive effectiveness.

The current recommendations from WHO can be found in: *Medical Eligibility Criteria for Contraceptive Use. A WHO Family Planning Cornerstone*. Third edition. 2004. (www.who.int/reproductive-health/publications/mec/mec.pdf)

Chapter Seven: Other Reproductive Health Concerns

7

* Please check the website (www.rhrc.org/iawg/) regularly for possible changes.

Updated information

- **Uterine Evacuation:** Vacuum aspiration is recommended by WHO and has replaced dilatation and curettage (D&C) as standard of care.
- **Oxytocics:** for treatment of uterine atony. It is important to ensure the uterus is empty before giving uterotonic agents.
- **Antibiotics:** Prevent iatrogenic infection by following universal precautions, using aseptic technique, and ruling out or treating cervical infection before performing transcervical procedures.
- **Sexual intercourse** should be avoided for a few days after bleeding has stopped following a uterine evacuation due to an increased risk of infection.
- **Post-abortion Family Planning:** Contraception, including an IUD or hormonal methods, may be started immediately after first trimester uterine evacuation.

Notes