This Chapter does not include a discussion of all remaining reproductive health (RH) issues. It deals with two particularly serious aspects of reproductive health: managing complications of spontaneous and unsafe abortion, and eliminating the practice of female genital mutilation and caring for women who have undergone this procedure.

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CHAPTER SEVEN

Other Reproductive Health Concerns

Contents:

1. This section draws heavily on WHO's Clinical Management of Abortion Complications: A Practical Guide, WHO's Complications of Abortion, Technical and Managerial Guidelines for Prevention and Treatment and the Post-abortion Care: A Reference Manual for Improving Quality of Care, Post-abortion Care Consortium 1995.

2. This section draws heavily upon "Female Genital Mutilation", WHO Information Kit and the WHO Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation.

Other Reproductive Health Concerns

Introduction

Complications of Spontaneous and Unsafe Abortion

Health professionals should be able to recognise and manage the complications of spontaneous and unsafe abortions, which are major public health concerns as recognised in both the International Conference on Population and Development (ICPD) in Cairo (1994) and The Fourth World Conference on Women in Beijing (1995).

The following statement from the ICPD underpins the guidance offered in this Chapter:

"In no cases should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancy must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling....where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions."

Cairo, ICPD, 1994, paragraph 8.25

Unsafe abortion contributes significantly to the morbidity and mortality of women of reproductive age throughout the world. WHO defines unsafe abortion as "a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both." Every day, an estimated 55,000 unsafe abortions take place, resulting in the deaths of 200 women daily. WHO reports that up to 13 per cent of pregnancy-related deaths, world-wide, are due to unsafe abortions. In some countries, deaths due to unsafe abortion may be responsible for up to 45 per cent of all maternal deaths. Furthermore, it has been estimated that for every death, hundreds more women suffer chronic pain or disability. The most frequent complications are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury. Long-term health problems include chronic pelvic inflammatory disease, tubal blockage and secondary infertility.

Spontaneous abortion or miscarriage can result in complications that require life-saving emergency care.

Female Genital Mutilation

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. Female genital mutilation is widespread among refugee women who come from the cultures in which it is practised. While it is not required by any religion, it is a practice rooted in traditions related to gender and power inequalities entrenched in a society's political, social, cultural and economic structures. Many women and men believe that genital mutilation is necessary for women's health, to maintain virginity and to make them acceptable to their community.

Care provided to women who have been subjected to female genital mutilation will be improved if staff fully understand and are able

to deal with its potential consequences. Health care workers should make it a priority to eliminate harmful traditional practices, such as female genital mutilation.

Post-Abortion Care for Managing Complications of Spontaneous and Unsafe Abortion

Post-abortion care (PAC) is the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. The elements of PAC are:

- emergency management of incomplete abortion and potentially life-threatening complications
- post-abortion family planning counselling and services
- making links between post-abortion emergency services and other RH care services.

Since incomplete and/or septic abortions may threaten a woman's life, health providers must be able to deal promptly with their consequences. As for obstetric emergencies, an appropriate referral system should be established and available 24 hours a day. (See Chapter Three.)

When planning for PAC, community needs and perceptions, including women's preferences for type and gender of PAC provider and location of services, must be solicited and considered.

Each refugee situation requires a protocol for managing post-abortion complications. Refer to Table 1 for broad guidelines on the type of facility, the composition of staff and the types of emergency post-abortion care that may be available. Factors to consider in developing the protocol are:

- staff training, qualifications and supervision to achieve minimum standards,
- supplies and equipment,
- conditions (cleanliness, space, privacy, etc.) at the health facilities,
- emergency transport system, and
- capacity of referral facility.

Where feasible, host-country health referral facilities should be used and supported.

Emergency Management of Post-Abortion Complications

Women of reproductive age experiencing at least two out of three of the following symptoms should be considered as potential patients with a threatened or incomplete abortion:

- vaginal bleeding
- cramping and/or lower abdominal pain
- a possible history of amenorrhoea (no menses for over one month)

The following steps should be taken to manage post-abortion complications:

Talk to the woman about her condition.
Any woman who presents with complications of unsafe abortion or miscarriage needs immediate high-quality care. Health care workers should be aware that women seeking such care are under severe emotional stress in addition to physical discomfort. Privacy, confidentiality and consent for treatment should be ensured.

Conduct initial clinical assessment.
The initial assessment may reveal or suggest the presence of an immediate life-threatening complication such as shock. Shock should be addressed without delay in order to prevent death or keep the woman's condition from worsening.

- ***Managing shock:*** All health personnel should know the universal measures to treat shock: do not give fluids by mouth; keep airway open; turn head and body to

one side and keep warm. Health centres should be equipped with IV fluids (saline, plasma substitutes or safe blood), systemic antibiotics and oxygen.

Complete clinical assessment.
This consists of taking a thorough RH history, performing careful physical and pelvic examinations and, when necessary, obtaining appropriate laboratory tests. A complete assessment will identify other possible complications (such as intra-abdominal injury, vaginal bleeding [light to severe], infection/sepsis and pain) leading to an appropriate treatment plan.

Manage complications.
Complications should be treated immediately by qualified personnel. Prompt referral and transfer may be needed if the woman requires treatment beyond the capability of the facility where she is seen. Her condition will need to be stabilised before she is transferred to a higher-level referral service. The following treatments may be necessary:

- **Rest:** in case of light to moderate bleeding.
- **Replacement of fluids:** in case of shock or severe vaginal bleeding**,** saline solution, plasma substitutes or safe blood.
- **Laparotomy/surgery:** in case of suspicion of an intra-abdominal injury. Intra-abdominal injury is commonly due to uterine perforation, possibly as a result of an attempted abortion.
- **Uterine evacuation:** for removal of retained products of conception. First and early second-trimester incomplete abortions can be treated by vacuum aspiration or dilatation and curettage (D&C). Vacuum aspiration, manual or electric, has been found to result in fewer complications than D&C and causes less trauma to the patient. Health workers should refer incomplete abortions in the middle- or late-second trimester to a facility with surgical and full emergency backup for treatment.
- **Antibiotics:** for infection or septic shock. These are common complications of incomplete abortion. Treatment with broad-spectrum antibiotics by IV or IM is indicated.
- **Management of pain:** Appropriate pain management ensures that the woman experiences a minimum of anxiety and discomfort. Women's needs for pain management will vary, depending on their physical and emotional state.
- **Prevention of tetanus:** A tetanus vaccination should be given, as a woman may have been exposed to tetanus and her vaccination history is likely to be uncertain.

Laparotomy, surgery and uterine evacuation should be undertaken by qualified and supervised staff in appropriate and safe conditions, preferably in a host-country health facility.

Table 1
Minimum Standard for the Provision of
Emergency Management of Post-abortion Complications
By Level of Health Care Facility and Staff

Level	Minimum Staff	Emergency Care
Health Post/ Clinic	Community Health Workers, Traditional Birth Attendants (TBAs)	■ Recognition of the signs and symptoms of the complications of spontaneous and unsafe abortion and referral to facilities where stabilisation and/or treatment is available
Health Centre[1]	Health Workers Nurses Midwives General Practitioners	All above activities plus: ■ Diagnosis based on medical history and physical and pelvic examination ■ Resuscitation/preparation for treatment or transfer ■ Initiation of emergency treatments (antibiotic therapy, IV fluid replacement and oxytocics) ■ Pain control, simple analgesia and sedation, and local anaesthesia ■ Haematocrit/Haemoglobin testing If trained staff, practising minimum safe standards, and appropriate equipment are available, above activities plus: ■ Uterine evacuation during first trimester for uncomplicated case of incomplete abortion
Referral-Level District Hospital (usually a host-country facility)	Nurses Midwives General Practitioners Ob/Gyn Specialists Surgeons	Above activities plus: ■ Emergency uterine evacuation through second trimester ■ Treatment of most post-abortion complications ■ Local and general anaesthesia ■ Diagnosis and referral for severe complications (septicaemia, peritonitis, renal failure) ■ Laparotomy ■ Blood crossmatch, HIV testing and safe blood transfusions
Tertiary-level Regional or National Hospital	Nurses Midwives General Practitioners Ob/Gyn Specialists Surgeons	Above activities plus: ■ Uterine evacuation as indicated for all incomplete abortions ■ Treatment of severe complications (including bowel injury, severe sepsis, renal failure) ■ Treatment of bleeding/clotting disorders

1. A health centre in a refugee situation usually provides in-patient and outpatient services, has a basic laboratory and pharmacy, and is supervised by one or more medical doctors.

Taken from: "Complications of Abortion, Technical and Managerial Guidelines for Prevention and Treatment", WHO, 1995.

Post-Abortion Family Planning

Lack of access to adequate family planning services is a major contributor to the problem of unsafe abortion. Conversely, unwanted pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective family planning services. In most health systems, women treated for the complications of unsafe abortions rarely receive any counselling services to prevent subsequent unwanted pregnancies. Clearly, when a woman receives care for post-abortion complications she should also receive comprehensive family planning counselling and services, if she so desires. At a minimum, all women receiving PAC should understand:

- that the prompt return of ovulation can result in pregnancy even before menses returns; and
- that there are safe contraceptive methods that can prevent pregnancy, and where those methods can be obtained.

In addition, all staff providing PAC should know how to counsel and provide family planning services.

(Refer to Chapter Six for further details on family planning services.)

Links to Other Reproductive Health Services

Linking emergency PAC services with other RH services is essential and logical, yet in much of the world these services remain distinctly separate. As a result, many women have no access to RH care and suffer poor overall health.

It is important to identify the RH services that each woman may need and offer her as wide a range of services as possible, such as:

- Treatment for reproductive tract infections
- Cervical and breast cancer screening and treatment (if applicable)
- Advice on proper nutrition
- Advice on family planning methods
- Advice about antenatal care
- Links to under-five clinics for existing children (if applicable)
- Referral for services following sexual violence
- Referral for counselling services following diagnosis as HIV-positive.

Monitoring and Surveillance

PAC services should be continuously reviewed. Managers of these services should assess the level of use of these services, review all clients' records, the availability and proper use of equipment and supplies, regularly assess specific indicators of the quality of care, identify changes or problems that occur, provide feedback to staff, and intervene to correct any problems identified.

Checklist for Post-abortion Care

- ✔ Protocol for management of complications of unsafe and spontaneous abortions is developed and used
- ✔ Staff are trained to manage complications of unsafe and spontaneous abortions
- ✔ Health facilities are equipped with appropriate materials
- ✔ Protocol for post-abortion family planning and links with other RH services are developed and used
- ✔ Reporting and monitoring system to ensure quality of care are in place

Monitoring may include: direct observation of staff at work; use of checklists (for example, to evaluate critical skills); examination of clinic records; and discussions with patients, staff and the community.

Indicators to monitor effectiveness of PAC services

- **Incidence of unsafe and spontaneous abortions:** The incidence will indicate the magnitude of the problem and point to possible underlying causes. For instance, the incidence of unsafe abortion might indicate inadequate family planning coverage for women who want to avoid or delay pregnancy.
- **Quality of PAC services:** The ability of staff to undertake all aspects of PAC should be reviewed periodically through direct observation of staff and/or review of medical records.

WHO Classification

- ✔ **Type I:** Excision of the prepuce with or without excision of part or all of the clitoris.
- ✔ **Type II:** Excision of the clitoris together with partial or total excision of the labia minora.
- ✔ **Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- ✔ **Type IV:** Unclassified
  - pricking, piercing or incision of the clitoris and/or labia
  - stretching of the clitoris and/or labia
  - introcision
  - scraping (angurya cuts) or cutting (gishiri cuts) of the vagina or surrounding tissue
  - introduction of corrosive substances or herbs into the vagina
  - any other procedure that falls under the definition of female genital mutilation

Female Genital Mutilation

Scope and Definition

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. It is estimated that female genital mutilation has been performed on approximately 130 million women and girls. About two million girls risk being subjected to female genital mutilation each year. Most of the girls and women who have undergone female genital mutilation live in 28 African countries, although some live in Asia, and in other regions.

Approximately 15 per cent of women and girls subjected to female genital mutilation undergo infibulation. Most others undergo a clitoridectomy or excision. There is a high incidence of infibulation in Djibouti, Somalia and northern Sudan, and a high rate of complications.

Infibulation is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria.

Physical Consequences

Female genital mutilation causes grave damage to girls and women and frequently results in serious health consequences which may include an increased individual risk of bloodborne infections such as HIV. Some of the effects are immediate; others become apparent only years later. Girls and women undergoing the more severe forms of mutilation are particularly likely to suffer serious and long-lasting complications. Documentation and studies are available on the nature of the physical short-term and long-term complications described below, but there has been little study of the sexual or psychological effects of the procedure or of the frequency with which complications occur. The mortality rate of girls and women undergoing genital mutilation is unknown as few records are kept and deaths due to the practice are rarely reported.

Usually the operation is performed on girls between four and ten years of age or younger, or, in some areas, adolescent girls. Village women, TBAs or male barbers generally perform the operation, usually without anaesthetics or antiseptics. The effects on health depend on the extent of the cutting, the skill of the operator, the cleanliness of the tools and environment, and the physical condition of the girl.

The effects of the procedure last a lifetime and may threaten not only the woman's reproductive health and well being, but also the health of her children. Health workers in refugee situations are seldom knowledgeable about the physical, psychological and social consequences of female genital mutilation, nor are they always sensitive to the cultural beliefs that support the practice.

Therefore, it is vital that field staff determine whether female genital mutilation is practised within a refugee population and identify who is responsible for undertaking the procedure.

Prevention of Female Genital Mutilation in Refugee Situations

RH programmes should include strategies to discourage female genital mutilation, emphasising the link between the practice and poor reproductive, sexual and general health in women and girls. It is vital to understand the reasons for the practice before embarking on information campaigns. Efforts to eliminate female genital mutilation can greatly be enhanced by enlisting the support of responsible community members.

The "medicalisation" of female genital mutilation (i.e., supporting health care professionals to perform female genital mutilation in health facilities under more hygienic conditions) is not acceptable in the attempt to make this procedure "safer". Medicalisation does not eliminate the harm caused by female genital mutilation and it legitimises the procedure. Health workers employed in refugee situations must be informed that their involvement in "medicalising" female genital mutilation will not be tolerated under any circumstances. Severe disciplinary measures, including possible termination of workers' contracts, should be taken if they are found to be performing female genital mutilation.

Care of Women with Female Genital Mutilation in Refugee Situations

Women who have undergone female genital mutilation, particularly Type III, need special care, especially during pregnancy, delivery and the postpartum period. When an infibulated woman gives birth, staff should be aware of the following points:

- the formation of rigid scar tissue around the vaginal opening as a result of the mutilation is likely to lead to delay in the second stage of labour, which may endanger both the woman and the baby; and
- extensive episiotomies may be needed to allow for safe delivery.

Women who have undergone infibulation need special care when using some forms of contraceptive methods, such as the IUD, and in managing the complications of unsafe and sponta-

neous abortion. Sexually transmitted diseases (STDs) are also more difficult to diagnose and women may be at a greater individual risk for bloodborne infections, including HIV.

Strategies to Eliminate Harmful Traditional Practices, including Female Genital Mutilation

The issue of harmful traditional practices, including female genital mutilation, should be approached with great sensitivity. While there are no hard and fast rules when working to prevent and eliminate these practices, the following strategies and examples may provide some guidance to field workers:

Experience has shown that the initial step in addressing harmful traditional practices is providing education and information on such practices, focusing on their negative consequences. However, action-oriented activities must follow initial awareness building.

- Campaigns to eliminate these practices are more likely to succeed and be accepted by the target population when they initially emphasise the harmful health consequences rather than the legal or human rights aspects. Laws should be seen to be protective rather than punitive and designed to prevent harm to children. This aspect should be emphasised at the community level so that the law comes to be seen as providing protection and support to the individual.
- It is necessary to have a thorough understanding of the nature and extent of the particular practice, including its roots and social consequences. Health workers can acquire this knowledge through discussions with the refugees, themselves.
- Educate target populations (both men and women), such as religious leaders, traditional leaders (chiefs, tribal elders and political leaders), teachers, TBAs and other health workers, as well as the general refugee population (including women, men and children) about the harmful health consequences of these practices. It is particularly important to educate young girls about these issues.
- Promote, provide technical support to, and mobilise resources for national and local groups that will initiate community-based activities aimed at eliminating harmful traditional practices. National committees to eliminate harmful traditional practices exist in many countries and their expertise should be tapped.
- In Kenya, local NGOs running campaigns aimed at eliminating female genital mutilation discovered that refugees were more open to discussing the topic if it was included in workshops that covered other RH issues, such as STDs, HIV/AIDS and safe motherhood, rather than if it was presented on its own. However, the campaign in refugee situations in Ethiopia began as a stand-alone model and was very successful. Only later was it incorporated into a larger RH programme. Clearly then, each programme must be tailored to the community it serves.
- In some countries, alternative income-generating activities should be devised for those who earn money through harmful practices. Traditional practitioners must also be able to find other ways to secure the respect of their community.
- Videos provide an excellent means of demonstrating the harmful effects of some traditional practices. Videos depicting a female genital mutilation operation or a woman who has not undergone female genital mutilation giving birth have proved to be very effective.
- The use of drama and other cultural activities, such as plays or songs, can also be an effective method of disseminating information on the negative effects of harmful traditional practices. Radio, local papers, and mosques may also be used to help disseminate this information.
- In the Sudan, some health workers focus mostly on men in their campaign to save girls from female genital mutilation. Men are often the primary decision-makers in the family, though they are also generally unaware of the exact nature and severity of the procedure.

- Health workers in Uganda support a "rite of passage" ceremony while trying to eliminate the harmful practices of female genital mutilation. Programmes encourage the ceremonial aspects of the "coming of age" for young women, but eliminate the "cutting" part of the process. In Sierra Leone, female genital mutilation is part of an initiation rite for women's secret societies. These societies can be very important for women's self-empowerment, not only because they provide a support network, but because they also provide contacts for income-generating activities. While it is important to encourage groups that empower women, it is equally important to encourage initiation ceremonies that do not require female genital mutilation.
- The importance of educating girls and women cannot be overstated. The incidence of harmful traditional practices, such as female genital mutilation and early childhood marriage, decreases as female literacy increases. Therefore, promoting and supporting female education, both the enrolment of girls in schools and adult literacy, should be a priority.
- Growing immigrant populations in industrialised countries have brought female genital mutilation with them to countries where it had not been practised. UNHCR discourages informing refugees, before resettlement, of the criminalisation of the practice in resettlement countries. Experience has shown that if told prior to departure, mass female genital mutilation operations may be conducted in the country of asylum before resettlement occurs. When refugees are resettled to countries that have laws against female genital mutilation, the authorities of the resettlement country should be encouraged to inform refugees of these laws upon their arrival.

Field staff are advised to plan carefully their strategy for eliminating harmful traditional practices in conjunction with the refugee community, implementing partners and any other relevant UN organisations. It is important to work with the refugee community to ensure measures taken are as effective as possible. Local NGOs, host communities, and the government, which may already have active campaigns in the country, could also be involved.

Monitoring and Supervision

Monitoring the change in female genital mutilation practices in a community is very difficult. Programmes should monitor complications experienced by women during birth and investigate any deaths that may be related to female genital mutilation. Health care providers, both in health facilities and in the community, should be supervised and monitored routinely to ensure that they are not practising female genital mutilation.

Further Readings

"Clinical Management of Abortion Complications: A Practical Guide", WHO, Geneva, 1994.

"Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment", WHO, Geneva, 1995.

"Female Genital Mutilation: Findings from the Demographic and Health Surveys Program", Macro International Inc., Washington, DC, 1997.

"Female Genital Mutilation Information Kit" (includes Joint UNICEF, UNFPA and WHO Statement on female genital mutilation), WHO, Geneva, 1994.

"How To Guide: From Awareness to Action – Eradicating Female Genital Mutilation in Refugee Camps in Eastern Ethiopia", UNHCR, Geneva, 1997.

"Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation: A Report of a WHO Technical Consultation", WHO, Geneva, 1998.

"Policy Paper on Eradication of Harmful Traditional Practices", UNHCR, Geneva 1997.

"Post-abortion Care: A Reference Manual for Improving Quality of Care", Post-abortion Care Consortium, JHPIEGO Corporation: Baltimore, MD, 1997.

"Post-abortion Family Planning: A Practical Guide for Programmes Managers", WHO, Geneva, 1997.

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CHAPTER EIGHT

Reproductive Health of Young People

Contents:

Growing up is stressful and challenging in the best of times. For those young people living as refugees, the stresses are much greater. Their transition to adulthood is often made more difficult by the absence of the usual role models and the break-down of the social and cultural system in which they live. They may have gone through personal trauma themselves, including armed conflict, violence, insecurity, sexual abuse, harm to or loss of family members, disruption of schooling or employment, of friendships, and of family and community support.

Defining Children and Young People

- ✔ **Children** **0-18 years**
  Convention on the Rights of the Child
- ✔ **Adolescents** **10-19 years**
  UNFPA, WHO, UNICEF
- ✔ **Youth** **15-24 years**
  UNFPA, WHO, UNICEF
- ✔ **Young People** **10-24 years**
  UNFPA, WHO, UNICEF

The definitions of children, adolescents and adults may change from culture to culture. Health workers must adapt the definitions they use to suit the specific refugee situation in which they are working. Whether an adolescent has assumed the roles and responsibilities of an adult is also a reflection of the culture and the refugee situation. When working with young people, the cultural, ethical and religious values of the refugee community must be respected.