



# Ebola Virus Disease (EVD) & Sexual and Reproductive Health (SRH)

## Operational Guidance



### OVERARCHING GOAL



Contribute to the reduction of mortality and morbidity related to sexual and reproductive health (SRH) while minimizing Ebola virus disease (EVD) transmission throughout the outbreak and keeping the health care workers and people and their communities safe.

### OBJECTIVE OF THIS GUIDANCE



Provide programmatic guidance to ensure continuity of care of SRH services, during an EVD epidemic outbreak and guidance for best practice regarding care of pregnant, postnatal and breast-feeding women and girls infected with EVD.<sup>1</sup>



### TARGET

Health care providers and programme managers in humanitarian and fragile settings at risk or experiencing an EVD outbreak.

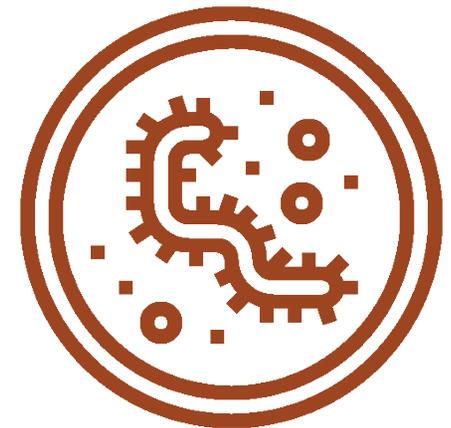
# 1

# INTRODUCTION

Ebola virus disease (EVD) causes acute, often fatal, illness and has a crude mortality rate of approximately 50%. During the 2010s, there have been several outbreaks of EVD, including the epidemic in West Africa, mainly in Guinea, Liberia and Sierra Leone in 2014-2016, with an estimated 28,000 cases and 11,310 deaths (1); and recurring outbreaks in the Democratic Republic of Congo (DRC), with the largest one being in 2018-2020 with 3,470 cases. As of 2021, Guinea is experiencing a new outbreak, as is DRC.

Experience in past epidemics has shown that lack of access to essential health services and shut down of **services unrelated to the epidemic response resulted in more deaths than those caused by the epidemic itself.** (2) It is therefore essential that health services, especially the minimum initial service package (MISP) for SRH, continue throughout an epidemic, that the population is informed and encouraged to continue utilizing services, and that services are safe and secure for health care staff, patients and their communities.

New treatments for EVD have recently been developed and approved but are still not widely available. Symptomatic treatment is mainly provided including intravenous fluid administration, oxygen, blood transfusions, treatment of potential co-infections etc. The successes of early treatment in both EVD and pregnancy complications are well documented. (2,3)



As of 2016, effective vaccines are available against EVD and have been implemented using a ring strategy in several outbreaks. Pregnant and breast-feeding women should be offered vaccination, strictly following national protocols. (3)

This guidance aims to support implementers to provide MISP for SRH and, if possible, comprehensive SRH services throughout an EVD outbreak and during community recovery phases. It focuses on the continuation of services and adaptation of strategies for all people in settings with EVD outbreaks, regardless of infection status.

<sup>1</sup>Women and girls are used when talking about pregnant and menstruating people throughout this document, however services need to be available for trans and nonbinary people in need of them.

# 2

## WHAT DO WE KNOW ABOUT EVD & SRH?

### Effects on public health/SRH in outbreak contexts

There is a **risk that access to and demand for essential SRH services and supplies in EVD settings decreases.**

- ▶ The added burden of disease and additional needed procedures connected to EVD puts a further **strain** on fragile health systems.
- ▶ In previous outbreaks, **utilisation of maternal health services** (including institutional delivery and antenatal care (ANC)) has decreased, attributed to both the lack of availability of maternal health services (e.g. because of shut down of services and lack of health personnel), as well as decreased demand for services (e.g. because of fear and/or mistrust to services). This is assumed to have led to an excess of **maternal mortality**, related to the effects of EVD rather than the virus itself. (4)
- ▶ **Key MISP for SRH services** are often **disregarded** and deemed non-essential in the context of emerging outbreaks, resulting in unavailability of lifesaving care for women and girls.
- ▶ **Fear** of contracting EVD at health facilities, of being triaged to isolation or sent to EVD treatment centres (ETC) can **affect the decision to seek care**. These fears can increase if women and girls contract EVD after giving birth at health facility level, are isolated after triage without receiving required care or are sent to ETC without adequate care and support (2).
- ▶ There can be **increased delays** in reaching health care services because of e.g. unwillingness to let pregnant women and girls use transportations i.e. taxi and motorcycles, increasing costs, and delays induced by EVD screening posts. (2)
- ▶ **Delay to obstetric care** can happen at health facilities because of **triage, testing and waiting** for results, and **lack of** access to adequate **supplies**. (2)
- ▶ People **bleeding for other reasons** than EVD (including survivors of sexual violence, menstruating women and girls, women and girls experiencing miscarriages, abortion etc.) may be reluctant to seek care, or inform about bleeding during e.g. triage. (2)

- ▶ Women and girls giving birth, that are **positive for EVD, pose a risk** for caregivers, both health care and lay care.
- ▶ **Fear among health care providers** have led to refusals of provision of facility based labour and delivery care and an increase in home deliveries. (5)
- ▶ A disproportionate number of **EVD infections and deaths** of previous outbreaks have been among **health care providers**. (6)
- ▶ Outbreaks can **disrupt supply chains** and increase logistics bottlenecks in distribution of lifesaving SRH supplies to health service delivery points.
- ▶ Outbreaks like EVD can **drain supplies** from lifesaving SRH services as limited supplies are re-allocated to provide clinical care for EVD positive patients.

### Clinical effects of EVD specific to maternal & newborn health

- ▶ **Mortality of pregnant women and girls:** There has been a presumed increased risk of mortality from EVD for pregnant women and girls, however a recent review did not show higher mortality among pregnant women. Previously this assumption has led to the risk of pregnant women receiving less care than others. (1)
- ▶ **Pregnancy outcomes:** The current evidence shows an extremely high, almost 100%, risk of spontaneous abortion, foetal or neonatal deaths among women and girls that acquire EVD during pregnancy.<sup>2</sup> (1)
- ▶ **EVD symptoms during pregnancy:** EVD among pregnant women can be difficult to distinguish from obstetric complications. Symptom based standard screening has a low specificity on pregnant women and girls, and presentation can sometimes be atypical (1, 7). Obstetric complications can also be presented as symptoms associated with EVD, making health care personnel suspect EVD in uninfected individuals. (2, 7) This can reinforce stigma and fear among care providers.
- ▶ **Newborns:** Newborns may not show the typical signs of EVD and remain asymptomatic despite being infectious. (7)
- ▶ **Transmission during pregnancy, labour and delivery:** transmission of EVD happens through contact with bodily fluids and products of conception, making post-abortion care, labour and delivery particular risky events. RT-PCR<sup>3</sup> remains positive for Ebola in products of conception for prolonged lengths of time, including in women who have survived and long after they tested negative post recovery. Positive PCR is assumed to reflect ongoing infectivity (in the absence of viral cultures). EVD in the mother and/or infant have led to several secondary infections. (1, 7)

<sup>2</sup> With access to new treatments this however might change.

<sup>3</sup> Reverse transcriptase-polymerase chain reaction (RT-PCR) is a diagnostic tool used when testing for Ebola.

# 3

## CONTINUE & ADAPT SRH CARE

### General recommendations

- ▶ **Sexual transmission post EVD recovery:** Ebola virus has been detected in semen for at least a period of months after an EVD recovery (the exact duration of viral secretion is not well known) and sexual transmission from male to female, although very rare, has been reported. (8) Less is known about vaginal fluid.
- ▶ **Uninterrupted access to the MISP** for SRH services must be ensured.
- ▶ Standard **Infection Prevention and Control (IPC)** precautions should be incorporated for all procedures, regardless of suspicion or confirmation of EVD during the outbreak. **Personal protective equipment (PPE)** should be used according to level of exposure risk. Deliveries, post-abortion care (PAC) and other procedures where there is a risk of contact with any type of bodily fluid (e.g. during clinical management of rape etc) should be handled with standard PPE following standard IPC precautions. (9, 10)
- ▶ Ensure **health care workers' knowledge, attitude and practice** regarding strict adherence to IPC protocols, including donning and doffing the PPE.
- ▶ A **rigorous systematic triage system** should be put in place, screening for symptoms and EVD case definition, also taking in consideration that obstetric symptoms can incorrectly be perceived as EVD. This should be balanced with the history of potential contact with EVD (2). Testing and isolation needs to be available for people triaged as suspected EVD. (10)
- ▶ **Standard Operating Procedures (SOPs) for isolation** of women and girls until status is confirmed should be established, following WHO IPC guidelines, as well as **referrals to EVD treatment centres (ETC)** for infected women and girls. (10)
- ▶ **Vaccination** should be offered to and prioritized for midwives, OB/GYN, general practitioners, nurses and other frontline health care workers, including community midwives and health workers, to ensure safety for providers (potential vaccination resistance should be addressed). Ebola ring vaccine treatment strategy<sup>4</sup> should include pregnant, breast-feeding and women and girls in reproductive age. Consider offering vaccinations to all patients admitted to the hospital.

<sup>4</sup> A strategy that vaccinates the contacts of confirmed patients, and people who are in close contact with those contacts.

- ▶ Increased investment in waste management at SRH facilities to manage used PPE disposal, and improved **waste management** practices for products of conception, pregnancy related bodily fluids and used menstrual hygiene products (e.g. safe placenta disposal) are needed.
- ▶ In the area of **SRH services**, provision of care during labour and delivery and potential contact with blood and bodily fluids presents the primary risk for EVD infection. **Outpatient** services can and should continue (including clinical management of rape, family planning and contraception, and abortion related services) without need for significant adjustment except those necessary to address additional EVD related service needs (and enforcement of standard IPC measures).
  - ▶ **Telemedicine, remote counselling and self-management** can be considered for relevant outpatient services, especially taking in consideration the COVID-19 situation in addition to the EVD outbreak, and can include e.g. family planning and contraception services, ANC and postnatal care (PNC) components. (ANC and PNC are not part of the MISP for SRH but should be provided to the extent possible). (11)
- ▶ **SRH supplies** and required space **for EVD-positive persons** must be made available at **ETC**, including appropriate **equipment and space** for vaginal delivery, C-section and post abortion care, so that women and girls and their babies receive adequate Emergency Obstetric and Neonatal Care (EmONC). This adds a supply chain and logistics burden in terms of the number of facilities supported.
- ▶ Pregnancy tests should be offered systematically to all women and adolescent girls that arrive with suspected EVD. In case of a positive test: women and girls should be counselled on available options. They should be prepared to know what to expect in case of a miscarriage, when and where to seek care, supplied with misoprostol (if clinically indicated, feasible and acceptable) and offered a range of long-acting reversible and short-acting methods of contraception for post-abortion period or in case of negative pregnancy test. They should also be psychologically supported through Psychological First Aid (PFA); and referred to specialised Mental Health and Psychosocial Support (MHPSS) care should be ensured whenever needed or requested.

### Information & education

- ▶ **Community health messaging** should be updated and reinforced to include messages on SRH and EVD. (6)
- ▶ Outreach activities should be adapted to the situation and **consider IPC measures** (including for both EVD and COVID-19) and empower and ensure information to communities. Engage associations of EVD survivors, community leaders and others, including women and youth, in outreach activities with special attention to reaching adolescents, key populations and other vulnerable populations.

- ▶ Information and education can be done by using media outlets (including the internet and social media) and dissemination of simple, and preferably pictorial health education materials.
- ▶ Outreach should include clear and consistent public health messaging focusing on SRH and EVD. **Key messages** to give to the community should include:
  - ▶ Promotion of the use of health services in particular MISP for SRH services. Community members are encouraged to continue to seek and receive care during labour, delivery and other obstetric emergencies, and for all emergencies resulting from other diseases, trauma, or (sexual) violence.
  - ▶ Information on available SRH services and how to access them (this will need to be updated on a regular basis, reflecting the existing referral pathways and potential shutdowns).
  - ▶ Pregnancy danger signs and having a safe birth plan.
  - ▶ Family planning and a range of long-acting reversible and short-acting contraception options including male and female (where already used) condoms and emergency contraception.
  - ▶ General information on EVD (including information on the vaccine) and IPC measures (including safe disposals of menstrual health and hygiene material).
  - ▶ Particular risks with pregnancy and EVD, the risks of products of conception and pregnancy related body fluids and how to handle them.
  - ▶ The difference between “explicable bleeding” (e.g. menstruation, metrorrhagia, or from violence) and “inexplicable bleeding” (suspected EVD).
  - ▶ Sexual transmission of EVD and promotion of safe sex practices.
  - ▶ Address stigma and misconceptions around SRH (pregnancy, abortion, miscarriages, menstruation) and EVD.



## Coordination (MISP for SRH objective 1)

- ▶ Ensure that SRH needs are considered in the full EVD response, and that continuation and adaptation of **MISP for SRH services are prioritised** throughout the outbreak.
- ▶ If there is a separate EVD response coordination structure, the **SRH coordinator/SRH actors** need to be included, to ensure that SRH needs and rights are considered and addressed throughout the EVD response (including SRH needs assessment and prioritising SRH access and continuation of services). (2)
- ▶ Advocate for the inclusion of midwives, OB/GYN, general practitioners, nurses and other frontline SRH care workers, including community midwives and community health workers, in **national vaccination plans**.
- ▶ Ensure that **health staff** are trained on proper PPE usage and IPC measures, case management and EVD surveillance.
- ▶ Development, validation and distribution of adapted IPC and SRH **clinical protocols** to ensure standard of care should be supported through coordination structures, including Health Cluster and SRH working groups.
- ▶ Ensure that **relevant supplies**, including PPE and other IPC supplies (including hand wash stations, waste disposal, etc.), to handle all pregnant and labouring women and girls during the outbreak, are available at SRH facilities and ETC. Supply needs and plans should be addressed during coordination meetings.
- ▶ Ensure that **referral systems** are strengthened to ensure continued access to services (in particular EmONC and CMR) throughout quarantine and in view of other obstacles.

## Care for survivors of sexual violence (MISP for SRH objective 2)

- ▶ **Clinical care and referral to other supportive services** for survivors of sexual violence should remain available 24/7, prioritizing access to emergency contraception (EC), STI and HIV tests and Post-Exposure Prophylaxis (PEP) within the 72 hour window. Since these services are often provided through out-patient departments, they present less risk for providers and patients. There is a risk that an EVD outbreak causes an increase in GBV within a community. (2)
- ▶ There is also a risk that survivors will avoid coming to health services, for fear of being put in isolation, especially if they are bleeding, (2). Ensure that there is a **clear understanding in the triage system** of the difference between “explicable bleeding” (e.g. menstruation, metrorrhagia, or from violence) and “inexplicable bleeding” (suspected EVD).
- ▶ Survivors can seek **post-rape care any time after the event**. Survivors who present with a pregnancy at any gestational age due to sexual violence should receive information about all options open to them, including safe abortion care or a referral for that care, to the full extent of the law.

## Prevention of HIV & STI related mortality and morbidity (MISP for SRH objective 3)

- ▶ Standard universal **precautions** and HIV **prevention** measures, and continuation of antiretroviral treatment should be ensured in conjunction with HIV actors, as per the MISP for SRH and local protocols. Provide postexposure prophylaxis to rape survivors as appropriate and for occupational exposure.
- ▶ Ensure HIV patients **continue** their ARVs without having to do multiple visits at the facilities. When supplies allow, provide patients with **multi-month supply of ARVs** to reduce “refill” visits to health facilities.
- ▶ Reinforcement of **universal IPC measures** in response to EVD, addresses key HIV transmission risks.
- ▶ Ensure that people that have recovered from EVD do not transmit the infection to their sexual partners. Male and female (where already used) **condoms** should be **available** throughout and post outbreak, based on a clear condom distribution strategy (including availability in the community and taking considerations to make them accessible for adolescents). Condoms should also be available at the ETC and provided to recovered patients at discharge, together with information about possible sexual transmission. Male EVD survivors are recommended condom use (or abstinence) for at least 1 year or until two semen PCR tests are negative. (12)

## Continuity of maternal and newborn health care (MISP for SRH objective 4)

Access to skilled birth attendance and emergency obstetric and newborn care (EmONC) for all births is among the most essential services, is part of the MISP for SRH, and needs to be ensured for all women and girls in need and their newborns.

### All pregnant women and girls:

- ▶ At Basic EmONC (BEmONC) and Comprehensive EmONC (CEmONC) levels:
  - ▶ Continued **access to BEmONC and CEmONC** services needs to be ensured for all women and girls in need of services regardless of infection status.
  - ▶ Each labour and delivery (as well as other EmONC services, including post-abortion care) should be handled in full respect of **IPC measures** and frontline workers need to have the training to do so during an outbreak. Strict precautions should be followed throughout the outbreak, especially considering limited sensitivity of tests and case definitions. (7)
  - ▶ Pregnant women and girls should be triaged by health care staff with obstetric experience to ensure that **complications of pregnancies are identified and urgently addressed and that normal signs of labour are not confused** with EVD to the extent possible. (1, 3)

- ▶ **SOPs for testing and isolation** need to be set up with consideration for women and girls in need of EmONC services.
- ▶ **Testing** should be available for all pregnant and labouring women and girls presenting any type of symptoms. Testing should be fast and preferably on site to avoid delays. (2) The testing should be done in combination with triage, as tests alone are not perfect, and neither is triage. Standard IPC precautions should always be followed regardless of test outcome. (7)
- ▶ At community level:
  - ▶ As a preparedness and mitigation measure, pregnant women and girls in affected areas can be provided with **clean delivery kits** (IARH kit 2a) in the event that health facilities are inaccessible or unavailable (clean delivery is not the same as a safe delivery). Distribution should be combined with clear information and a strong recommendation to give birth with a skilled birth attendant/ at a health facility to the furthest extent possible (the clean delivery kits can be brought to the health facility/skilled birth attendant). Clean delivery kits can be expanded (according to context and capacity) with: misoprostol (for prevention of postpartum haemorrhage), chlorhexidine gel (for cord care), 2 pairs of extra single use gloves, and pictorial descriptions of how to use the materials. (6)
  - ▶ Pregnant women and girls should be continuously **informed** about pregnancy danger signs, how to reach health care and updated information about pregnancy, labour and delivery and EVD.
  - ▶ Community midwives should be prioritized for **vaccination**, equipped with **PPE** and other **IPC** material and trained on IPC to be able to support women, who do not want to or cannot reach a health facility, during delivery at home/in the community. Health facility level birth with skilled birth attendance remains the recommended modus operandi.
  - ▶ **Lifesaving community midwife strategies** including the usage of misoprostol for the prevention of postpartum hemorrhage are encouraged, however community-based delivery is not recommended, with the exception of settings where community-based midwives are linked to facilities, authorized, and fully equipped to attend home births.



## Pregnant women and girls with suspected /confirmed EVD:

- ▶ At BEmONC and CEmONC:
  - ▶ BEmONC and CEmONC facilities should be provided with necessary **staff training, supplies, equipment and appropriate space** to care for suspected and confirmed cases that might arrive.
  - ▶ Whenever possible, women and girls in labour who meet **EVD case definition** should be **referred** to and deliver at in ETC. (7)
  - ▶ Women and girls in labour and placed into isolation with EVD suspicion, need to be cared for with **IPC measures**, **EVD testing** needs to be ensured without delay and **labour monitoring** continued as for any woman or girl in labour. **Lifesaving care must not be delayed** for suspected or confirmed EVD patients with obstetric complications. (3, 10)
  - ▶ ETC should have supplies and **capacity to ensure skilled birth attendance and EmONC**. Specialist support can be provided by a mobile team. (2, 3).
- ▶ **Clinical care:**
  - ▶ Women and girls that are pregnant that show EVD symptoms should get **equal access to clinical treatment of EVD**, including access to optimized supportive care and investigational therapies in the context of rigorous research or in accordance with the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI) protocol. (3)
  - ▶ Labour should only be induced, and other invasive and/or obstetric procedures should only be done, on **maternal indication**. (3)
  - ▶ Surgically removing foetal tissue from the uterus after a maternal death (post-mortem c-section) is **strongly discouraged** (to ensure this recommendation counselling to the family might be needed). (3)
- ▶ Ensure placentae are **buried in a safe manner**, following WHO guidelines on IPC in EVD. Placenta and anatomical samples should be buried in a separate pit. (10)
- ▶ **At community level:**
  - ▶ Pregnant women and girls at risk of giving birth at home should have previously received clean delivery kits with additional supplies, as relevant and compatible with the local legal framework (see above).
  - ▶ If a woman or girl with EVD symptoms is giving birth at home this should be alerted according to the EVD surveillance system.
  - ▶ Women and girls in labour should, when feasible, only be attended by persons who have been trained on IPC and have enough PPE to adequately protect themselves. Attendance should be kept to a minimum (one person) and in a limited/isolated area of the patient's home, allowing for postpartum decontamination.
  - ▶ Products of conception and pregnancy related fluids should be disposed of with strict IPC measures, buried in a leak-proof waste bag in the ground. Decontamination teams should be contacted. (3, 5)

## Pregnant women and girls that have recovered from EVD:

- ▶ In EVD positive pregnant women and girls, pregnancy related fluids and products of conception have been shown to be PCR positive long after recovery of the patient. The point of delivery/miscarriage may present a **significant risk** to caretakers, family and community.
- ▶ **Antenatal care (ANC)**, although not a priority within the MISP for SRH, should be provided to the largest extent possible, including psychosocial support. If there is no risk of exposure to pregnancy-related fluids during the visit, only standard precautions are required. (3)
- ▶ **Delivery kits and education** on proper handling of products of conception and bodily fluids using IPC measures should be provided to women, girls and community focal points, as a preparedness measure, in the event of an unavoidable home birth. (3)
- ▶ Pregnant women and girls should be informed about the **risks** for the pregnancy and provided with **options** to induce the labour/ abort the foetus at the ETC (see Post Abortion Care and Safe Abortion Care below). (3)

## Postnatal Care (PNC) for women and girls with suspected /confirmed EVD:

- ▶ Although not a component of the MISP for SRH, women and girls with confirmed or suspected EVD:
  - ▶ **Breastfeeding** should be stopped if either the mother or the infant have confirmed or suspected EVD and the pair should be separated. If the infant is under 6 months, they should be provided with breast milk substitution (with information and safety recommendations, taking into consideration the presence of clean water needed).<sup>5</sup>
  - ▶ If a **breastfeeding** woman and her infant are both diagnosed with EVD, breastfeeding should be discontinued, the pair should be separated. However, if the infant is under six months of age and no safe and appropriate breastmilk substitutes are available, or the infant cannot be adequately cared for, then the option to not separate and continue breastfeeding may be considered. (3)
  - ▶ The infant should only be provided the mothers breast milk again (if they want to continue) after two consecutive negative RT-PCR breastmilk tests for Ebola Virus, separated by 24 hours. (3)
  - ▶ Consider the potential to procure **breast milk substitutes** as a component of the coordinated response, ensuring adequate information on safety and access to clean water.

<sup>5</sup> Breastfeeding should be promoted, protected and supported. However for infants that should not be breastfeed because of maternal and/or infant EVD, breast milk substitutes are necessary and must be accompanied by training on hygiene, preparation and use to minimize their associated risks. See Joint statement from the Nutrition Cluster on breastfeeding and breast-milk substitutes and Infant and Young Children Feeding in Refugee Situations: A Multi-Sectoral Framework for Action

- ▶ Babies to mothers with EVD should be cared for with contact **precautions** and closely **monitored** for 21 days. (1, 3)
- ▶ **Postpartum contraception** (including a range of long-acting reversible and short-acting contraceptive methods including male and female condoms (where already used) and emergency contraception) and family planning options should be proactively offered and provided as best practice for childbirth distancing, in all times and particularly since there is some evidence of increased adverse pregnancy outcomes in early subsequent pregnancies. (13)

## Maternal and newborn deaths

- ▶ Any death, including **maternal death**, occurring in communities affected by an Ebola outbreak should be subject to **EVD testing**, as the cause of the maternal death could be EVD. This should be integrated into maternal death audits, where they exist. If EVD is confirmed, reporting, contact tracing and decontamination needs to be ensured according to the local mechanisms in place.
- ▶ In the event of maternal or newborn death/stillbirth, ensure practices are in place for **proper burial** in compliance with WHO guidelines on EVD.

## Post abortion care and safe abortion care

Post abortion care (PAC) for all women and girls in need is part of the MISP for SRH and should be available throughout an outbreak. Safe abortion care (SAC) is highlighted as a specific consideration in the MISP for SRH and is an integral part of comprehensive SRH care. SAC should be made available, to the full extent of the law, with particular consideration for the impact EVD has on pregnancy risks and outcomes related to the loss of pregnancy, labour and delivery throughout an EVD epidemic for all pregnant women and girls, regardless of infection status.

### All women and girls:

- ▶ Considering the risks with pregnancy and EVD, there needs to be access to **safe abortion care** to the furthest extent possible in each setting with EVD.<sup>6</sup>
- ▶ All **miscarriages** should be appropriately **triaged** and handled with strict **IPC** measures, including in the disposal of the products of conception. (1, 3) PAC patients should receive the acute care needed while waiting for testing/referral.
  - ▶ In some settings routine EVD RT-PCR testing of products of conception and/or foetal death may be in place. This should be checked prior to disposal.
- ▶ **Contraceptive** methods including a range of long-acting reversible and short-acting contraceptive methods should be proactively **offered** to all SAC/PAC patients (See preventing unintended pregnancies below).

- ▶ Ensure proper **disposal** of tissue or bodily material resulting from PAC/SAC in line with WHO guidelines on IPC in EVD. (10)
- ▶ Consider alternative **approaches** to care including:
  - ▶ **Self-care** through **medical abortion** (medication abortion) at home with clear instructions on how to take the medication, what to expect, danger signs and referral pathways.<sup>7</sup> Women should be provided information on and receive IPC material to handle products of conception, i.e. the extended delivery kit (see above). (3) In addition information around the normal effects and potential side effects from the medication (e.g. bleeding, nausea, vomiting, diarrhoea, chills, fever, etc) need to be given since these can be confused with EVD symptoms.
  - ▶ SAC (and PAC) provided at health facilities needs to be done with **IPC measures** for women and girls that have suspected/confirmed **EVD** or have recovered from EVD. Medical abortion should be the method of first choice unless the clinical characteristics indicate an aspiration (using WHO safe abortion guidelines.) (14, 15)
  - ▶ **Telemedicine** should be used if available particularly for **non-emergency care**.

### Women and girls that have recovered from EVD:

- ▶ According to current available evidence, almost no foetus/newborns survive after a maternal EVD infection. Women and girls who survive EVD need to receive **accurate information, be granted access to SAC and PAC and be supported** in their wish of the continuation or termination of the pregnancy. (3)
  - ▶ Medical abortion is considered the safest abortion care method. (3)
- ▶ Women and girls who became pregnant **prior to the EVD infection** who have an abortion are encouraged to do so at **ETC** to prevent spread of EVD through contaminated pregnancy related fluids and products of conception. (3).
- ▶ If a woman/girl does not wish to or cannot initiate an abortion at the ETC, she needs to be **informed about the risks** of going home and given an **extended delivery kit** (see above) and clear instructions on how to handle the products of conception in accordance with IPC measures. The woman/girl should also be offered a full-range of free contraceptive methods of their choice (see preventing unintended pregnancies below).
- ▶ Whenever possible, a **follow up call** or visit by a trained healthcare worker should be arranged for these women and girls, at a clear interval (suggested on a weekly basis initially, but depending on case specifics and gestational age). If an EVD contact tracing and follow up mechanism for pregnant women is in place, these actions should be integrated in the follow up.

<sup>6</sup> The Maputo protocol provides legal space for induced abortion on several indications including to preserve the physical and mental health of the woman. [https://www.un.org/en/africa/osaa/pdf/au/protocol\\_rights\\_women\\_africa\\_2003.pdf](https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf) As of July 2020, out of the 55 member countries in the African Union, 49 have signed the protocol and 42 have ratified and deposited the protocol.

<sup>7</sup> Different MA regimens are available for induced abortion with mifepristone and misoprostol or misoprostol alone, and for PAC with misoprostol if clinically eligible. All these medications are available through the Inter-Agency RH Kits.

- ▶ The management of a pregnancy and birth in an EVD survivor, where **conception** took place **after EVD recovery is not considered an EVD risk** and can be managed as a normal pregnancy according to standard IPC recommendations, and birth can happen in location of the woman's choice (does not need to be in an ETC).
- ▶ Provide **information** and **condoms** and encourage behaviour to ensure safe sex practices post-EVD.

## Prevent unintended pregnancy (MISP for SRH objective 5)

Access to contraception is a part of the MISP for SRH and should be ensured throughout an EVD outbreak.

- ▶ During an outbreak ensuring **access** to contraception and family planning options is essential since many women, girls and couples might want to postpone or completely avoid pregnancy because of the direct and indirect risks associated with pregnancy during the EVD outbreak.

Ensure that women and girls have information and access to their **contraceptive method of choice**, including EC and long-acting reversible contraception (LARC). Removal of LARC needs to be available for those that choose LARC.

- ▶ As a component of preparedness, consider working to **increase uptake of LARCs** and self-injectable contraception (e.g. DMPA-SC) and to increase awareness and knowledge of EC.
- ▶ Ensure that women and girls who choose **short term methods** (OCP or injectables) are given more cycles of the method than is accustomed (6-12 months, taking in consideration existing supplies), in order to **avoid refill visits** to health facilities.
- ▶ Promote **barrier** methods of contraception **condoms**, for quadruple protection against sexual transmission of EVD, HIV, other STIs, and prevention of unintended pregnancy.
- ▶ Ensure that **information** is made available about contraception and family planning and EVD. Community health workers and community midwives can potentially support this and facilitate access to some contraceptives.
- ▶ **Changing in bleeding patterns** as a **side effect** of contraceptive methods should be considered and differentiated from EVD symptoms through proper patient history take (without any EVD contact) and handled according to the contraceptive method side effects management protocol.

## Other issues

- ▶ During an outbreak, when public services are shut down, including schools, specific attention needs to be given to **adolescents**, especially **girls**, that might find themselves at **greater risk** of SRH adversities, including sexual abuse, exploitation, and violence; unplanned/unintended pregnancies, unsafe abortion, HIV and STIs transmission, in a setting with less access to SRH information and services. (16)
- ▶ **Menstruation is not a sign of EVD**, and it is important to differentiate between “explicable bleeding” (e.g. menstruation) and potentially “inexplicable bleeding.” (17)
- ▶ Attention should be paid to ensure provision of **menstrual** hygiene management (MHM) **supplies** and **female-friendly WASH facilities**, allowing safe and dignified **disposal** of menstruation materials, at ETC for patients and staff. Provision of MHM supplies can also be considered in the community and at SRH facilities, especially for adolescent girls.
- ▶ **Menstrual waste** from women and girls with suspected or confirmed EVD should be treated as infectious medical waste and disposed of in accordance with EVD SOPs, as bodily fluids of EVD patients are infectious. (17) However, at this time, there is no evidence of viral persistence in menstrual blood. Caution should be taken in articulating the potential infectiousness and handling of menstrual blood and material after EVD infections, to not further stigmatise EVD survivors.
- ▶ Women and girls **recovering from EVD** may face **irregular menstruation** patterns (13), which should be explained to women and girls following recovery.



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