Field Hand Book on
Sexual and Reproductive Health Services during Emergencies

IPPF International Planned Parenthood Federation

fpa SRI LANKA enriching relationships

Field Hand Book on
Sexual and Reproductive Health Services during Emergencies

The Family Planning Association of Sri Lanka, pioneer in introducing Family Planning to Sri Lanka was founded in the year 1953. With a history of over 65 years, the Association has grown and expanded its scope to encompass all aspects of Sexual and Reproductive Health and Rights today.

In 1954, FPA Sri Lanka (FPASL) become a member of the International Planned Parenthood Federation (IPPF), a global body working in over 161 countries. Subscribing to the principles of IPPF, FPASL today addresses SRH related issues through a rights based and gender sensitive approach.

The Family Planning Association of Sri Lanka is implementing the SPRINT Project since 2011.Throghout this journey, we have undertaken various initiatives and are experienced in implementing the MISP in the country. The goal of the SPRINT initiative is to improve health outcomes of the affected population during a crisis by reducing preventable sexual and reproductive health morbidity and mortality.

Compiled by: Dr. Harischandra Yakandawala
Tharanga Sachinthani
Natasha de Rosayro

Published by: FPA Sri Lanka
No. 37/27, Bullers Lane, Colombo 07
Tel: +94 11 2 555 455
Fax: +94 11 2 580 915
Email: fpa@fpasrilanka.org
Web: www.fpasrilanka.org

First Publication: December, 2019

Message from the Executive Director

It is with a sense of accomplishment I pen this note for the useful Handbook on **Sexual and Reproductive Health Services during Emergencies.** It also marks the culmination of the many years of engagement of FPA Sri Lanka in ensuring and delivering Sexual and Reproductive Health and Rights (SRHR) to affected communities during emergencies and displacement. Over the last decade we have seen many natural and manmade disasters causing displacement and emergencies within our country and beyond. The first reaction often associated with panic, results in the most needed help and support getting submerged in the perceived priorities of respondents.

Often Sexual and Reproductive Health of affected communities get a low priority and **International Planned Parenthood Federation (IPPF)** has been working consistently to ensure that there will be a coordinated, prepared response in these settings to deliver its mission in all circumstances. These activities initiated by the **Humanitarian Hub of IPPF** located in Thailand lends technical and funding support to Member Associations of IPPF. We at FPA Sri Lanka have received technical assistance from the Hub over the years and consequently have been able to build capacity of the country to deliver a well-coordinated response to ensure Sexual and Reproductive Health of affected people during emergencies.

Our response has evolved to include many components of the SRHR spectrum from pregnancy to gender based violence. In recent times we demonstrated inclusiveness by rolling out trainings on responding to the needs of LGBTIQ and disabled communities within emergency settings. The team at FPA Sri Lanka worked tirelessly to complete the necessary capacity building for all stakeholders that include government officers. Designing and assembling special dignity kits for each community was another step in this direction.

This handbook covers the key elements of the SRHR response during emergencies in a comprehensive and succinct manner. My sincere hope is that it will be a practical tool that will guide many stakeholders who save lives by springing into action during disasters.

Thushara Agus
Executive Director
The Family Planning Association of Sri Lanka

Content

- Introduction to Sexual and Reproductive Health 5
- Minimum Initial Service Package (MISP) 6
- Objectives of MISP
- Objective 01: Ensure the health sector identifies an official to lead implementation of the MISP 7
- Objective 02: Prevent sexual violence and respond to the needs of survivors 10
- Objective 03: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs 15
- Objective 04: Prevent excess maternal and newborn morbidity and mortality 24
- Objective 05: Prevent unintended pregnancies 29
- Objective 06: Plan for comprehensive SRH services, integrated into primary health care as soon as possible 31

Target Group of the Handbook

- All the first level emergency respondents at field level
- Health Staff:
    1. Medical Officer Health (MOH)
    2. Public Health Nursing Sister (PHNS)
    3. Public Health Inspector (PHI)
    4. Public Health Midwife (PHM)
- Staff of Disaster Management Centre and National Disaster Relief Service Centre
- Probation Officers
- Women Development Officers
- Grama Niladhari
- Samurdhi NIladhari

Objectives of the Handbook

1. To understand Sexual and Reproductive Health needs of the affected population and host community
2. To understand mode of providing SRH services and multi-sectorial responsibility
3. To coordinate the mechanism of SRH service provision
4. To take measures on prevention of SGBV and make referrals

Introduction to Sexual and Reproductive Health

Sexual and Reproductive Health (SRH) is an essential component of the humanitarian response. Sexual and Reproductive Health is a state of complete physical, mental and social well-being (not merely the absence of disease and infirmity) in all matters relating to the reproductive system and its functions and processes. SRH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

Implicit in this last condition are people's rights to be informed and the need to have access to safe, effective, affordable, and acceptable contraceptive methods of their choice. People should also have the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide individuals and couples with the best chance of having a healthy infant.

All people, including those living in humanitarian settings, have the right to Sexual and Reproductive Health. To exercise this right, affected populations must have an enabling environment and access to comprehensive SRH information and services so they can make free and informed choices. Quality SRH services must be based on the needs of the affected populations, particularly the needs of women and girls. SRH services must respect the religious and ethical values and cultural backgrounds of the communities, while conforming to universally recognized international human rights standards.

The timely provision of SRH services can prevent death, disease, and disability related to unintended pregnancy, obstetric complications, sexual and other forms of gender-based violence, HIV infection, and a range of reproductive disorders. Providing comprehensive, high-quality SRH services in humanitarian settings requires a multi-sectoral, integrated approach. Protection, health, nutrition, education as well as water, sanitation, and hygiene and community service personnel all have a part to play in planning and delivering SRH services. The best

way to ensure that SRH services meet the needs of the affected population is to involve the community in every phase of the development of those services. Only then will people benefit from services specifically tailored to their needs and demands and only then will they have a stake in the future of those services.

Minimum Initial Service Package (MISP)

Providing comprehensive Sexual and Reproductive Health (SRH) care to all affected populations is a responsibility of the health sector. Yet, the nature of crisis-affected settings often results in the disruption of the population's access to many of their basic and survival needs. These include security, water, food, shelter, sanitation and health services. Minimum Initial Service Package (MISP) for SRH describes the humanitarian response to the SRH needs of populations at the onset of an emergency (within 48 hours wherever possible). The MISP defines which SRH services are most important in preventing morbidity and mortality, while protecting the right to life with dignity, particularly among women and girls, in humanitarian settings. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

Objectives of MISP

There are 6 main objectives for MISP implementation which covers all the SRH needs and services to be implemented during emergencies.

1. Ensure the health sector identifies an organization to lead implementation of the MISP.

2. Prevent sexual violence and **respond** to the needs of survivors.

3. Prevent the transmission of and **reduce** morbidity and mortality due to HIV and other STIs.

4. Prevent excess maternal and newborn morbidity and mortality.

5. Prevent unintended pregnancies**.**

6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible.

Objective 01: Ensure the health sector identifies an official to lead implementation of the MISP

Who Should Lead MISP?

From the beginning of the response in each humanitarian setting, the health sector must identify an officer to lead MISP implementation. In Sri Lanka, the Family Health Bureau of the Ministry of Health is the focal point in delivering SRH services in emergency situations as well. FHB operates its activities through the MOMCH at the district level and the MOH system at the divisional level.

This nominated official will be identified as having the greatest capacity to fulfil this role and will immediately be dedicated for full-time SRH coordination for a minimum period of 3-6 months according to the scale of the emergency. He/she will provide operational and technical support to the health partners and facilitate coordinated planning to ensure the prioritization of SRH and effective provision of MISP services.

.

The SRH Coordinator ensures:

- All health agencies working in each of the crisis areas address SRH and implement or refer to SRH services

- Regular SRH coordination meetings are held with all relevant stakeholders, including representatives working in the field of SRH from the government, relevant UN agencies, local and international NGOs, the private sector, donors, the protection working group or cluster and gender-based violence is discussed

- Area of Responsibility (AoR) with members of the local affected populations to ensure the MISP is effectively implemented

- Operational and technical support is provided to health partners to implement the MISP in all locations affected by the emergency. This includes:
  - Providing guidance and technical support for ordering of SRH supplies and identifying skilled health workers to implement MISP services
  - Identifying effective and confidential referral mechanisms between health service delivery points and between health services and other service sectors

- Systems are established for regular data collection and analysis of data among partners implementing SRH services; at a minimum this data should be disaggregated by age and sex

- Clinical refresher trainings are conducted as needed and is feasible

- Once the situation allows, a mapping and analysis exercise of existing SRH services is undertaken in collaboration with health, protection, gender-based violence (GBV), and HIV stakeholders. This exercise should include gaps and opportunities followed by a complete situation analysis and a planning exercise to support accessible, effective, efficient, equitable, and sustainable services

- Information from SRH working group meetings is shared and discussed in the general health sector/cluster, protection, GBV, and HIV coordination meetings

- The community is made aware of the availability and location of the SRH services. This should include:

➢ Utilizing appropriate communication channels such as leaflets, radio, and text messages

➢ Using community-led outreach mechanisms, where possible, through adolescents, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual **(LGBTQIA)** groups, **people with disabilities** (PWD), women's groups, sex workers, traditional birth attendants, and other community outreach workers to inform the affected population of the availability of SRH services and the importance of survivors of sexual violence seeking care as soon as possible after an incident

Objective 02: Prevent sexual violence and respond to the needs of survivors

Sexual violence is often a frequent occurrence in all types of humanitarian settings and especially in conflict situations. Survivors of sexual violence can be of any sex, gender, or age. Survivors can be women, men, adolescents, people with disabilities, young children, LGBTQIA people, ethnic and religious minorities, and sex workers, among others. Women and girls are most affected. Perpetrators of sexual violence are often male intimate partners (including spouses) or others known to survivors (family, friends, or community members). All actors in humanitarian settings must be aware of the risks of sexual violence and those agencies/ organizations connected to the prevention of sexual exploitation and abuse must coordinate multi-sectoral activities to prevent such and protect the affected population, particularly women, girls, and other at-risk populations.

To prevent sexual violence and respond to the needs of survivors from the onset of an emergency, in the health sector:

- Work with other clusters especially the protection of GBV sub cluster, to put in place, preventive measures at community, local and district levels including health to protect affected populations, particularly women and girls from sexual violence.
- Make clinical care and referrals to other supportive services available for survivors of sexual violence
- Ensure confidential and safe spaces within health facilities to provide services to survivors of sexual violence

Health and protection coordination meetings should consistently address sexual violence to ensure coordination in the response between the SRH Coordinator and other sectoral actors. Confidential operating and coordination procedures should be agreed upon and implemented to assess and respond to at-risk situations or settings disclosed by survivors during clinical management (keeping personal identifiers confidential) for risk mitigation. In collaboration with the overall health sector/cluster mechanism, the SRH Coordinator and program staff must ensure that the humanitarian health sector/cluster and health actors:

1. Ensure safe access to basic health services, including sexual and reproductive health

- Design and locate health facilities to enhance physical security and safety and be accessible to persons with disabilities, in consultation with the population, in particular, women, adolescents, PWDs, and other marginalized populations
- Consult with service providers and clients about security and safety concerns regarding access to and within health facilities
- Ensure health facilities are in secure locations and have adequate path lighting at night
- Consider the need for security personnel at facility entrances
- Locate male and female latrines (1 for 20 people, male and female segregated) and washing areas separately in the health facility and ensure doors lock from the inside
- Hire and train female service providers, community health workers, program staff and interpreters
- Ensure all ethnic subgroup languages are represented among service providers. Alternatively, interpreters to be made available and also sign language interpreters if needed
- Inform service providers and all other facility staff of the importance of maintaining confidentiality, including protecting survivor information and data
- Ensure health workers and all other facility staff have signed and abide by the code of conduct against sexual exploitation and abuse (SEA)

- Ensure that codes of conduct and reporting mechanisms on SEA (which ensure whistle blower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct

2. Respond to the needs of survivors of sexual violence

- Reassure the survivor she or he is not at fault or to blame. Inquire about the survivor's needs and concerns, offer information about other support services, and always support the survivor's decisions.
- For the health sector to prevent and manage possible health consequences, survivors of sexual violence must have access to clinical care, including supportive psychosocial counseling, as soon as possible after the incident. Ensure health services can provide such care at the onset of a humanitarian response.

3. Establish Clinical services for survivors of sexual violence

- When setting up clinical services for survivors of sexual violence, SRH Coordinators and program staff must:

➢ Establish a private, non-stigmatizing consultation area with a lockable filing cabinet
➢ Put in place, clear protocols and a list of patient rights in the languages used by service of providers and patients
➢ Have sufficient supplies and equipment available
➢ Hire male and female service providers fluent in local languages and sign language interpreters if necessary and also train male and female chaperones and interpreters
➢ Involve women, adolescent girls and boys, and other at-risk populations, such as people with disabilities and LGBTQIA groups, in decisions on accessibility and acceptability of services
➢ With the health cluster lead, ensure that services and a referral mechanism including transport to a hospital in case of life-

threatening complications are available 24 hours a day, 7 days a week.

- Once services are established, SRH Coordinators and program staff should inform the community about:
  - The importance of seeking immediate medical care following sexual violence:
  - No later than 72 hours for prevention of HIV
  - No later than 120 hours for prevention of pregnancy

- The hours and locations of services. This information should be provided in multiple formats and languages to ensure accessibility, (eg: Braille, sign language, pictorial formats) and through community-led outreach mechanisms (women, youth, and LGBTQIA and PWD groups) and other appropriate channels. (e.g: through schools, midwives, community health workers, community leaders, radio messages or informational leaflets in women's latrines). Messaging should also include information about what health services are offered to survivors who are unable to seek immediate care.

- The SRH Coordinator, with the SRH working group and health sector/cluster, should ensure service providers are skilled and able to provide non-discriminatory and unbiased services. Where needed, organize information sessions or brief refresher trainings on clinical care for survivors of sexual violence that includes the following components:
  - Supportive communication
  - History and examination
  - The medico-legal system and forensic evidence collection, where feasible and when needed.
  - Compassionate and confidential treatment and counseling, including:
    - Emergency contraception

- Pregnancy testing, information on pregnancy options, and safe abortion care
- Referral for safe abortion care, to the full extent of the law
- Presumptive treatment of STIs, Post-exposure prophylaxis (PEP) to prevent HIV transmission
- Prevention of Hepatitis B and human papillomavirus (HPV)
- Care of wounds and prevention of tetanus
- Referral for further services, such as other health, psychological, and social services and medico-legal services

Objective 03: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

To reduce the transmission of HIV and other STIs from the onset of the humanitarian response, the SRH Coordinator, health program managers, and service providers must work with the health sector/cluster partners to:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms
- Support the provision of antiretroviral (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

1. Establish safe and rational use of blood transfusion

- The rational and safe use of blood for transfusions is essential to prevent the transmission of HIV and other transfusion-transmissible infections (TTIs) such as Hepatitis B, Hepatitis C, and Syphilis. If HIV-contaminated blood is transfused, transmission of HIV to the recipient is almost 100%. Blood transfusions must not be undertaken if the facilities, supplies, and appropriately qualified staff do not exist.

- Rational blood transfusion includes:

➢ Transfusing blood only in life-threatening circumstances and when there is no other alternative. Using medicines to prevent or reduce active bleeding (e.g., oxytocin and misoprostol)

➢ Using blood substitutes to replace lost volume, such as crystalloid based substitutes (Ringer's lactate, normal saline) wherever possible

- Safe blood transfusion includes:

➢ Collecting blood only from voluntary, unpaid blood donors at low risk of acquiring TTIs and developing stringent blood donor selection criteria

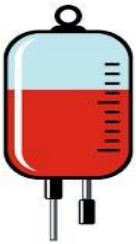
➢ Screening all blood for transfusion for at least HIV 1 and 2, Hepatitis B, Hepatitis C, and Syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine HIV status. Although blood donation services should not be seen as a way for people to access HIV testing, if someone donating blood has a reactive test result, this should be communicated to them. They should then be supported to link with clinical services for further testing to confirm their HIV status and, if confirmed, be linked to appropriate services

➢ Linking blood transfusion services with HIV counseling and testing services as soon as these are established as part of the comprehensive response and refer donors for HIV counseling and testing prior to screening their blood

➢ Conducting ABO grouping and Rhesus D typing and, if time permits, cross-matching

- Only transfusing blood to women of reproductive age with appropriate Rhesus type blood
- Ensuring safe transfusion practice at the bedside and safe disposal of blood bags, needles, and syringes

- In order to make rational and safe blood transfusion available, the SRH Coordinator and health program managers must work with the health cluster/sector partners to ensure that:
- Referral-level hospitals have sufficient supplies for safe and rational blood transfusion
- Staff have appropriate knowledge of safe blood transfusion practices and have access to supplies to reduce the need for blood transfusion
- Safe donors are recruited. Safe donors can be selected through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety. Recruit voluntary donors and do not request staff to donate blood.
- Standard operating procedures for blood transfusion are in place. SOPs are essential components of a quality system in any organization and are used to ensure consistency in performing an activity. The use of SOPs is mandatory for all staff members performing blood transfusions. Keep copies of SOPs in a central location where each procedure is performed, so they are available for easy reference
- Responsibility for the decision to transfuse is assigned and medical staff are held accountable
- Staff are informed of protocols and follow procedures at all times to ensure safe bedside blood transfusion practices
- Waste products, such as blood bags, needles and syringes, are safely disposed
- Have reliable light sources at sites where blood is screened and where transfusion is performed. To minimize the risk of errors, avoid blood transfusion at night as much as possible, unless sufficient lighting is available.



2. Ensure application of standard precautions

- Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health workers at medical centers established during emergencies. Under the "standard precautions" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person. Standard precautions prevent the spread of infections such as HIV, Hepatitis B, Hepatitis C, and other pathogens within health care settings. In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload.

- Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected. Regular supervision can help to reduce the risk of occupational exposure in the workplace. Emphasize the importance of standard precautions during the first health coordination meeting.

- Standard precautions are:

➢ Frequent hand washing: Wash hands with soap and water before and after all patient contact. Make facilities and supplies for hand washing easily available for all service providers

➢ Wearing gloves: Wear non-sterile single use gloves for all procedures where contact with blood or other potentially infected body fluids is anticipated

➢ Wearing protective clothing, such as waterproof gowns or aprons, where blood or other body fluids might splash. Require staff to wear masks and eye shields where there is a possibility of exposure to large amounts of blood

➢ Cover any cuts and abrasions with a waterproof dressing

➢ Safe handling of sharp objects:
  - Minimize the need to handle needles and syringes
  - Use a sterile disposable syringe and needle for each injection
  - Set up the work area where injections are given to reduce the risk of injury
  - Use single-dose vials rather than multi-dose vials. If multi-dose vials are used, avoid leaving a needle in the stopper. Once opened, store multi-dose vials in a refrigerator
  - Do not recap needles
  - Position and inform patients correctly for injections
  - Dispose needles and sharps in puncture and liquid proof safety boxes.

➢ Disposal of waste materials: Collect all medical waste in a separate area safely, preferably within the health facility grounds. Bury items that still pose a threat, such as sharp objects, in a covered pit at least 10 meters from a water source

➢ Instrument processing: Process used instruments in the following order:
  - Decontaminate instruments to kill viruses (HIV and Hepatitis B) and make items safer to handle

- Clean instruments to remove debris before sterilization or high-level disinfection (HLD)
- Sterilize (eliminates all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. HLD (through boiling or soaking in a chlorine solution) may not eliminate spores
- Use or properly store items immediately after sterilization

➢ Housekeeping: Clean up spills of blood or other body fluids promptly and carefully with a 0.5% chlorine solution

3. Establish and implement workplace policies for occupational exposure

- Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. Ensure PEP is available within the health sector as part of a comprehensive standard precautions package to reduce staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces and inform all staff how to access treatment for exposure.

4. Guarantee the availability of free male condoms

- Condoms are key protection methods to prevent transmission of HIV, other STIs, and unplanned pregnancy from the earliest days of a humanitarian response.
- Order sufficient supplies of good quality male condoms immediately. Condom supply in a humanitarian emergency should focus on the type of condoms used in the local context. It is useful to discuss condom distribution with leaders and members of affected communities, so they understand the need and importance of condom use, to ensure that distribution takes place in a culturally appropriate manner, and to increase community acceptance of condoms.

- Provide condoms on request and ensure that condoms are available in all heath facilities and in accessible private areas in the community. These include latrines, non-food distribution

points, youth and community centers. Condoms should be made available to be distributed by health staff, NGO workers and relevant government personnel as well.

- Consult with local staff about how condoms can be made available in a culturally sensitive way, particularly for adolescents and key populations, such as sex workers and their clients, men who have sex with men, persons using drugs and transgender persons. Where possible, community led distribution of condoms within peer groups is useful. Key populations and adolescents will often know locations where their peers congregate and volunteers can be enlisted to distribute condoms to their peers.

- Ensure culturally appropriate messages are available to disseminate information on correct use and disposal of used condoms and educate key populations about correct use, as well as how to dispose used condoms. Ensure condoms are also available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, and others involved in the operation. Condom uptake should be monitored by conducting regular checks (and stock-up where needed) of distribution points.

5. Support the provision of ARVs to continue treatment

- Antiretroviral drugs reduce the transmission of HIV and excess mortality and morbidity from opportunistic infections and AIDS-defining illnesses. Continuation of ART for those already on treatment prior to the crises. Antiretroviral should be continued for people who were enrolled in an ART program prior to the emergency including women who were enrolled in PMTCT of HIV and Syphilis programs.
- Continuation of ARVs for those already on treatment prior to the emergency is a priority because sudden disruption of ARVs can cause deterioration of individual health (by allowing

opportunistic infection and immune-deficiency progression), potential transmission (due to viral rebound), and development of ARV resistance.

- The SRH Coordinator, in partnership with an HIV Coordinator if one exists, needs to support the health cluster/sector to rapidly provide ARVs to continue treatment.

6. Support the provision of Co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV

- Co-trimoxazole prophylaxis is a life-saving, simple, well tolerated, and cost-effective intervention for people living with HIV. It should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy care. Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery.

- Co-trimoxazole prophylaxis is an antibiotic used to prevent pneumocystis pneumonia and toxoplasmosis in adults and children with HIV, as well as other infectious and parasitic diseases, demonstrating significant benefits in regions affected by malaria. Co-trimoxazole prophylaxis is recommended for adults (including pregnant women) with severe or advanced HIV clinical disease and/or with a CD4 count of ≤350 cells/mm3. In settings where malaria and/or severe bacterial

infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or clinical disease severity. Co-trimoxazole prophylaxis is recommended for infants, children and adolescents with HIV, irrespective of clinical and immune conditions.

7. Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

- The transmission of HIV and STIs are closely linked. Certain STIs facilitate the transmission of HIV, such as STI producing ulcers in the genital area, and those associated with discharge, such as chlamydia or gonorrhea. On the other hand, the weakened immune system of people living with HIV, in particular those who do not have access to ARVs, can make people more susceptible to STI infections. The presence of HIV also increases the severity of symptoms for some STIs (such as genital herpes)

- The syndromic management of STIs is an approach which is currently implemented in many countries and therefore might exist before the crisis. It is a method built from algorithms (decision trees) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols. This approach is particularly relevant at the onset of a crisis, where people are less likely to come for a follow-up visit and where access to laboratories might be difficult, impossible, or expensive. Antibiotics recommended by WHO for syndromic treatment of STIs are available in the Inter-Agency Reproductive Health Kits. Syndromic management is cost-effective, satisfactory for the patients, predictable and has a strong public health base and impact.

Objective 04: Prevent excess maternal and newborn morbidity and mortality

During labor and the immediate postnatal period is when many maternal and newborn deaths occur. The first day of life is the highest risk period for newborns. This objective addresses the main causes of maternal and newborn mortality and morbidity, and the following life-saving interventions that must be available in any humanitarian crisis.

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services
- Establish a 24 hours a day, 7 days a week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure availability of post-abortion care at health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care when access to a health facility is not possible or is unreliable

1. Ensure availability and accessibility of clean and safe delivery, essential new born care, and emergency obstetric and new born care services

- In Sri Lanka, it is a policy that all the pregnant mothers should deliver their babies in a hospital and in every district there are district general hospitals, base hospitals and district hospitals with facilities for safe delivery. During emergencies, the Ministry of Health issues a circular to admit all pregnant mothers, 36 weeks and above POA to the nearest hospital with facilities for safe delivery or to transfer to the next level for specialized care

- At referral hospitals: All the above health facility activities as well as skilled medical staff and supplies for provision of **Comprehensive Emergency Obstetric and Neonatal Care** (EmONC) (CEmONC)

- At health centers: Public Health Midwives or skilled birth attendants and supplies for vaginal births, essential newborn care, and provision of basic EmONC (BEmONC)

- At the community level: Provision of clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
- Where feasible, health providers should promote PHMs or if PHMs are not accessible, skilled attendance of all births in a health facility to prevent excess maternal and newborn morbidity and mortality. Ensure sufficient skilled birth attendants, equipment, and supplies (especially lifesaving medicines) are available, and inform women of the location of health facilities.
- Basic EmONC: While skilled attendance at all births in a health facility is ideal because it can help reduce morbidity and mortality associated with pregnancy and childbirth, it may not be feasible at the start of a humanitarian response. However, at a minimum, ensure that each health center has capacity to

provide BEmONC and refer to a hospital for CEmONC, 24 hours a day, 7 days a week. Among the 15% of women with life-threatening obstetric complications, the most common problems are severe bleeding, pre-eclampsia and eclampsia, infection, and obstructed labor.

2. Establish a 24 hour a day, 7 days a week referral system to facilitate transport and communication from the community to the health center and hospital

- Coordinate with the health sector/cluster and host community leaders and authorities to ensure a referral system (including means of communication and transport) as soon as possible. Such a referral system must support the management of obstetric and newborn complications 24 hours a day, 7 days a week (24/7). Those who require emergency care should be referred from the community to a health center where BEmONC is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health center must be stabilized and transported to a hospital with CEmONC services.

- Determine distances from the affected community to functioning health centers and to the hospital, as well as transport options for referrals

- Post protocols in every health center, specifying when, where, and how to refer patients with obstetric and newborn emergencies to the next level of care

- Inform communities when and where to seek emergency care for complications of pregnancy and childbirth. Messages should be shared in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach mechanisms (with women's, LGBTQIA, and PWD groups) and

other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines). Meet with and inform community leaders, traditional birth attendants, and others to distribute illustrative brochures or undertake other creative information, education, and communication (IEC) approaches

- In this situation, it is helpful to establish a system of communication, such as the use of radios or cell phones, to get medical guidance and support from more qualified personnel.

3. Ensure availability of supplies and commodities for clean delivery and basic newborn care

- In all humanitarian settings, there are women and girls who are in the later stages of pregnancy and who will therefore deliver during the emergency. At the onset of a humanitarian response, births will often take place outside of a health Centre without the assistance of skilled birth attendants. Make a clean delivery package available to all visibly pregnant women to improve birth and essential newborn care practices when access to a health facility is not possible.

- For example, distribution can be done at registration sites or via community health workers where there is an established network. In settings where access to facilities is not possible and traditional birth attendants (TBAs) are assisting home deliveries, they can be given clean delivery kits and additional basic supplies.

- The provision of supplies for the newborn will encourage essential newborn care practices. Where the community was trained in their use prior to the emergency, clean delivery kits can also include misoprostol tablets aimed at preventing PPH and a tube of chlorhexidine gel/solution 7.1% (delivering 4% Chlorhexidine (CHX)) to prevent cord infection among

newborns.) The provision of these high impact interventions are part of community-based interventions that also include educating pregnant women regarding their use. Recent evidence from both stable and crisis settings suggests that self-administration of misoprostol can be done safely and effectively. Misoprostol has the potential to reach women who give birth, by choice or by necessity, at home or in health facilities that lack electricity, refrigeration, and/or skilled health providers.

Objective 05: Prevent unintended pregnancies

At the onset of an emergency, it is important to ensure contraceptives are available to prevent unintended pregnancies. The SRH Coordinator, MOMCH/MOH/PHNS/PHMs, and other service providers must work to:

1. **Ensure availability of a range of long-acting reversible and short acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand**

- A range of oral contraceptive pills, hormonal injectable and implants, IUDs, male and female condoms, and emergency contraceptive pills should be made available immediately to meet the demand of the affected population where providers are trained and skilled to provide, and in the case of long-acting reversible contraceptive, remove the method
- Providers with existing competency should begin providing all methods at the onset of the crisis
- All forms of contraception should be provided on a confidential basis, without requiring the consent of a partner or parent
- Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection against STIs, HIV and pregnancy. Protection against pregnancy and STIs/HIV makes it a "dual protection" mechanism
- Emergency contraception should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual

2. Provide information, including existing IEC materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination

- Providers should ensure quality of care that emphasizes clients' confidentiality and privacy, clients' voluntary and informed choice and consent, method eligibility, effectiveness, possible side effects management, follow-up, and guidance on method removal as appropriate for women of all ages, including adolescent girls

3. Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

- Ensure the community is aware of where and how to seek access to contraception, including unmarried and adolescent community members. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms and pictures)
- Engage community leaders to disseminate information about availability of contraceptive services

Objective 06: Plan for comprehensive SRH services, integrated in to primary health care as soon as possible

The MISP is designed to form the starting point for SRH programming. It was developed based on well-documented evidence of SRH needs in humanitarian settings, and therefore, the four "clinical service delivery" components of the MISP (prevent and manage the consequences of sexual violence, prevent and respond to HIV, prevent excess maternal and newborn morbidity and mortality, and prevent unintended pregnancy) can be put in place without an in-depth SRH needs assessment among the affected population.

Even in settings where other service components of SRH are provided, such as antenatal care, it is important to ensure that the MISP objectives are also implemented, as they are high priority actions. When planning for the delivery of comprehensive SRH services, the clinical services put in place as part of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction. After the situation stabilizes and while preparing for comprehensive SRH services, plan to obtain input from the community on the initial response in order to identify gaps, successes, and avenues for improvement.

The implementation of the MISP not only entails coordination to make life-saving clinical services available, it is also essential to start addressing comprehensive SRH services as soon as possible. This requires vision, leadership, effective coordination skills, and a sound understanding of the local situation and opportunities related to health system reconstruction.

To fully achieve Objective 6 of the MISP and support local and international stakeholders in planning for the delivery of comprehensive SRH services, several critical aspects need to be considered. These include:

- Communication among decision-makers (including national governments) and implementing partners
- Adequate financing

- Effective coordination
- Supply chain management
- Human resources management
- Monitoring and evaluation
- System of information sharing, feedback, and accountability to the affected community
- Planning an exit strategy for humanitarian partners

Planning for the integration of comprehensive SRH activities into primary health care should be done at the onset of the humanitarian response. Failure to do so or unnecessarily delay in the provision of these services, may increase the risk of unintended pregnancies, the transmission of HIV/STIs, complications arising from GBV, and maternal and newborn morbidity and mortality. The Family Health Bureau of the Ministry of Health is the official body in providing SRH services to the population during normal situations as well as during emergencies. The FHB coordinates with the provincial health systems and also with the relevant UN organizations, bilateral organizations, local and international NGOs to provide comprehensive SRH services during any disaster situation.