Health Emergency and Disaster Risk Management

SEXUAL AND REPRODUCTIVE HEALTH

Key Points

- Reproductive health is a human right.
- Sexual and reproductive health (SRH) is a significant public health issue, including in emergencies.[1]
- A range of adverse outcomes can be prevented by timely provision of healthcare services before and after emergencies.
- Safe pregnancies and childbirth depend on sufficient numbers of trained healthcare workers and adequate facilities for providing essential and emergency care.
- Comprehensive, high quality reproductive health care requires input from all sectors: protection, nutrition, education, and community services, as well as health.[1]
- Promoting SRH through primary health care at all times, including in emergencies, consists of family planning and comprehensive abortion care, prenatal care, skilled childbirth care; and post-natal care for the mother and baby.
- In emergencies, communities are the first responders and can rapidly identify pregnant women and support them in getting the care they need.
- The Minimum Initial Service Package (MISP) for Reproductive Health is a coordinated minimum set of priority activities for decreasing morbidity and disability in crisis-affected populations.[1] MISP is a SPHERE standard.[2]

Examples of gender-based violence in humanitarian settings

Taken from IASC Guidelines on gender-based violence[3]

"Human relations were laid bare and the strengths and weaknesses in relationships came more sharply into focus. Thus, socially isolated women became more isolated, domestic violence increased and the core of relationships with family, friends and spouses were exposed." (Based on a field report in the aftermath of an Australian flood)

Increases in violence against women were also noted in reports from the Philippines after the Mount Pinatubo eruption, in Central and North America after Hurricane Mitch, and in several countries after the 2004 tsunami.

Why is this important?

There are an estimated 26 million women and girls of reproductive age living in emergency situations, all of whom need sexual and reproductive services.[4]

Lack of adequate reproductive health services (including contraception and comprehensive abortion care) and gender based violence including sexual violence can lead to a range of adverse outcomes[1]:

- Trauma
- Sexually transmitted infections
- Possible spread of HIV
- Unwanted pregnancies and unsafe abortions
- Maternal and neonatal deaths

An estimated 358,000 maternal deaths occur annually. 99% of these occur in the developing world; 87% in Sub-Saharan Africa and South Asia.[4]

In any emergency situation, one in five women of childbearing age is likely to be pregnant.[5]

Countries in conflict or experiencing other forms of instability often experience the highest rates of maternal and neonatal mortality.

What are the health risks?

Adolescence[1]

- Adolescents face increased vulnerability to exploitation, violence and transactional sex.
- Increase in risk taking behaviour due to:
  - Breakdown of youth-adult partnerships.
  - Distortion of future perspectives.
- Lack of services that are tailored to the needs of, and easy to access for adolescents by age group (e.g. 13 year olds compared with 17 year olds) and gender.

Family Planning[1]

Disruption to provision of basic contraceptive methods and lack of availability of emergency contraception may lead to:

- Increased risk of unplanned pregnancy.
- Increased risk of unsafe abortion, with further risk in situations where there is rape and sexual violence.

World Health Organization

Public Health England

Maternal and Newborn Health

- Poor access to skilled care for childbirth, including care for obstetric and neonatal complications; most maternal and neonatal deaths occur around the time of labour, childbirth and the immediate postnatal period.[6]
- Maternal and neonatal mortality is higher in developing countries than in developed countries, largely due to poor access to skilled health care workers for childbirth and the difficulties faced in referring for obstetric and neonatal complications.
- Disasters put women and their newborns at increased risk of morbidity and mortality because of the sudden loss of support and reduction of access, compounded in many cases by trauma, malnutrition or disease, and exposure to violence.[5]

Trauma – Gender-based violence (GBV) [1,7]

- The stress and disruption of emergencies often leads to a rise in sexual violence and domestic abuse.
- GBV affects women and girls most commonly, but may also affect men and boys as well.
  - GBV includes: sexual violence; domestic violence; forced and early marriage; harmful traditional practices such as female genital mutilation, honour crimes; and trafficking.
  - GBV has physical and psychological consequences.
  - GBV also impacts upon the individual's social health in terms of stigma, isolation and rejection.

Sexual transmitted infections (STIs) and HIV[1,7]

- STIs may spread more rapidly where there is disruption to the community and/or health infrastructure, such as in emergency situations.
- Populations (particularly if affected by complex emergencies) are at greater risk of HIV due to:
  - Reduced access to HIV prevention and treatment services.
  - Disrupted social networks leading to greater exposure to sexual violence and transactional sex.
  - Population movements to areas of higher HIV prevalence.

Risk management considerations

Governments and communities can protect and promote SRH through:

- Designing, building and maintaining water and sanitation systems which include simple modifications to withstand the risks of disasters.[2,4,8]
- Action across all sectors to ensure that SRH is included in disaster risk management legislative frameworks, policies and strategies with necessary resources and community participation.
- Undertaking risk and capacity assessments of populations and the health system in relation to SRH.
- Building resilient health systems and primary care capacities which can continue operating in a disaster.
- Identify health workers with midwifery skills and facilities and estimate the capacity for the provision of basic and comprehensive emergency obstetric care.
- Undertake population-based health education around the needs of women and babies before, during and after birth with a particular emphasis on danger signs and when and where to seek care.
- Integrated SRH messages into health sector and non-health sector-driven public awareness campaigns and educational materials about disaster risk management.
- Strengthening existing SRH services to absorb impacts, adapt, respond to and recover from emergencies, through: coordination; response planning; training and capacity development – sufficient to implement the MISP immediately at the onset of an emergency.

The MISP focuses on preventing and managing the consequences of sexual violence; reducing HIV transmission; preventing excess maternal and newborn morbidity and mortality; and planning for comprehensive RH services, integrated into primary health care as the situation permits.

References

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