



PROGRAMMATIC GUIDANCE FOR SEXUAL AND REPRODUCTIVE HEALTH IN HUMANITARIAN AND FRAGILE SETTINGS DURING COVID-19 PANDEMIC

GOAL



Maintenance of essential preventive, promotive, and curative sexual and reproductive health services in fragile and humanitarian settings during the COVID-19 epidemic threat and outbreak period

OBJECTIVE



Provide programmatic guidance for decision making on sexual and reproductive health, including maternal and newborn health services, in fragile and humanitarian settings in face of threat or reality of COVID-19

FOCUS



Fragile and humanitarian settings

SCOPE



Essential routine as well as emergency sexual and reproductive health services

This guidance was current as of late March 2020, but is subject to change as we gain more knowledge and experience in addressing COVID-19 and ensuring continuity of essential health services during this pandemic. Please check for updates and continue to share relevant experience.

1

GENERAL GUIDANCE

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 the epidemic itself.¹

As the world tackles the COVID-19 pandemic, it is important to ensure that essential health services and operations continue to address the sexual and reproductive health needs and rights of people living in humanitarian and fragile settings.

- First and foremost, **all emergency clinical services for sexual and reproductive health must remain available.** This includes intrapartum care for all births, emergency obstetric and newborn care, post-abortion care, clinical care for rape survivors, and HIV prevention measures. Risks of adverse outcomes from medical complications outweigh the potential risks of COVID-19 transmission at health facilities.
- **Comprehensive sexual and reproductive health services should be maintained as long as the system is not overstretched with COVID-19 case management.** This includes all antenatal care, postnatal care, essential newborn care, breastfeeding support, family planning and contraception services, cervical cancer screening, safe abortion care (to the full extent of the law), clinical management of HIV and sexually transmitted infections. These services should stay available to all who need them, including adolescents, for as long as possible.

Reductions or modification in routine services should only be considered to (1) ensure support to the epidemic response and COVID-19 case management and/or (2) to avert undue exposure to risk of contracting the virus in a health facility during an epidemic outbreak and/or when community transmission has been confirmed.

¹ Health-Care Access during the Ebola Virus Epidemic in Liberia. 2017 Sep 7. ASTMA available [here](#).

2

CONTINUATION OF SEXUAL & REPRODUCTIVE HEALTH (SRH) SERVICES

This guidance assumes basic or comprehensive sexual and reproductive health services are in place, and is designed to assist stakeholders faced with difficult decisions on when and how to scale-back or modify services as part of COVID-19 mitigation and response measures. ²

2.1 | Essential emergency services (minimum requirements):

- ▶ Access to **skilled birth attendance and emergency obstetric and newborn care** for all births is among the most essential services and needs to be ensured for all women and girls in need and for their newborns. Care for the mother-newborn dyad should extend to 24-hours following birth.
 - Women with high risk conditions or warning signs of complications during pregnancy (e.g. bleeding, preterm labor) need to have access to skilled care 24/7. Ensure access to treatment and medication for all pregnant women with chronic conditions in need of continuous treatment, particularly access to antiretrovirals as well as medications for hypertension and diabetes.
 - Assess women presenting for intrapartum care, and adjust personal protective equipment as well as infection prevention and control measures accordingly. Ensure facilities have supplies and protocols to ensure appropriate isolation of pregnant women and mothers/newborns who have confirmed COVID-19 and/or develop systems.
 - Cesarean surgeries should only be performed when medically indicated. COVID-19 positive status is NOT an indication for cesarean section.

² *The Interagency Field Manual for Reproductive Health in Humanitarian Settings* provides guidance for provision of the *Minimum Initial Service Package for Sexual and Reproductive Health* in the initial phases of an emergency response, and support for comprehensive sexual and reproductive health services in established and protracted humanitarian responses.

- Continue to promote early and exclusive breastfeeding and skin-to-skin contact. In cases of suspected or confirmed COVID-19 infections, do not separate mother and newborn unless the one or both are critically ill.

- For more specific guidance on management of pregnant and postpartum women with severe acute respiratory infection (SARI) in relation to COVID-19, consult the following documents:

- [WHO Interim Guidance on Clinical Management of Severe Acute Respiratory Infection when Novel Coronavirus \(nCoV\) is Suspected](#)
- [RCOG Information for Healthcare Professionals on Coronavirus \(COVID-19\) Infection in Pregnancy](#)

- ▶ **Post-abortion complications are considered obstetric emergencies and access to care needs to be maintained 24/7.**
- ▶ **Clinical care for rape survivors is an emergency health service and access to care needs to be maintained 24/7.** If restrictions need to be made, focus on provision of first-line support using the WHO LIVES steps for all survivors³, and for those who reach facilities within the first 72-120 hours, including post-exposure prophylaxis for HIV and emergency contraception, as well as wound care, tetanus vaccination when relevant. Reconvene with patient at a later stage for complete vaccination, STI treatment, further medical examination and certificate.
- ▶ **Standard precautions and HIV prevention measures**, including safe and rational use of blood transfusion and provision of antiretrovirals to continue treatment for people who were enrolled in an anti-retroviral therapy program prior to the emergency, including women who were enrolled in programs to prevent vertical transmission. Provide post-exposure prophylaxis to survivors of sexual violence as appropriate and for occupational exposure.

³ *WHO. Caring for women subjected to violence: a WHO curriculum for training health-care providers. 2019.*

2.2 | Other Sexual & Reproductive Health Services

Where feasible, consider remote approaches (telephone, digital applications, SMS text messaging, voice calls, interactive voice response) for relevant consultations, follow-up or screening.

- ▶ **Access to contraceptives needs to be maintained.**
 - Continue to offer a range of long-acting reversible and short-acting contraceptive methods at service delivery points including post pregnancy contraception.
 - If restrictions need to be made, focus on providing continuity of contraceptive coverage, optimize access through community health systems, and remote counseling, provide supply for several months, and shift to self-management when possible.
- ▶ **Antenatal care.**
 - Consider reducing routine antenatal (ANC) clinic visits to the minimum required and advise women with low-risk pregnancies to postpone clinic visits during early pregnancy for a few weeks. Women with ANC complication need to have access to care 24/7.
 - Prioritize routine visits for women in the third trimester and high-risk pregnancies.
 - Consider redistribution of facility-level staff to provide ANC in the community following standard infection prevention and control precautions, and remote counseling and screening where feasible.
Note: Community-based intrapartum care is not recommended, with the exception of settings where community-based midwives are linked to facilities, authorized and fully equipped to attend home births.
- ▶ **Postnatal care (PNC)** is critical for reducing preventable mortality and should be maintained.
 - Ensure access to PNC within 24 hours post-partum for women who left the maternity early after delivery or delivered at home.
 - If restrictions need to be made, focus on first week post-natal visits for women and newborns, including breastfeeding support
 - Where a community health care system exists, community health workers following standard precautions can support basic antenatal and postnatal care at patients' homes. Remote counseling and screening for danger signs should also be considered where feasible.

⁴ WHO *Consolidated Guidelines on Self-Care interventions for Health*. SRH. 2019.

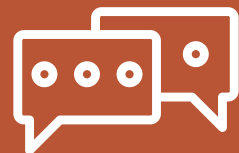
⁵ WHO *Telehealth (website)*.

- ▶ Access to **safe abortion and post abortion care** needs to be maintained to the full extent of the law, as provision of safe abortion services is time-bound (legal restrictions on gestational age).
 - Ensure support for self-management of medical abortion up until 12 weeks. To improve access to care, remote approaches can be considered for counseling on self-management.
 - Continue to offer a range of options for post-pregnancy contraception.
- ▶ Health workers should be prepared to **care for those subjected to intimate partner violence**, as violence is likely to increase during epidemic outbreaks due to stress, increased confinement and exposure to perpetrators and reduced access to basic needs. Anyone who discloses intimate partner violence or comes to the attention of health workers for medical treatment related to violence, should be at minimum be offered first-line support using WHO LIVES job aid.

3

INFORMATION & COMMUNICATION

- ▶ **Ensure clear, consistent public health messaging.**
 - Reaffirm that medical complications outweigh the potential risk of transmission at health facilities. Community members should continue to seek and receive care during childbirth, and for all emergencies resulting from other diseases, trauma, or violence.
 - Ensure understanding that any potential modifications of routine services are for patient benefit ⁽¹⁾ to ensure support to the epidemic response and ⁽²⁾ to avert undue exposure to risk of contracting the virus in a health facility during an epidemic outbreak.
- ▶ Ensure that **women, girls and SRH service providers are provided evidence-based information** on keeping themselves and their families healthy and to allay fears, counteract rumors and correct misperceptions. Where possible, disseminate simple health education materials with key messages such as handwashing. Also consider pictorial versions for illiterate women and health workers.



4

INFECTION PREVENTION & CONTROL

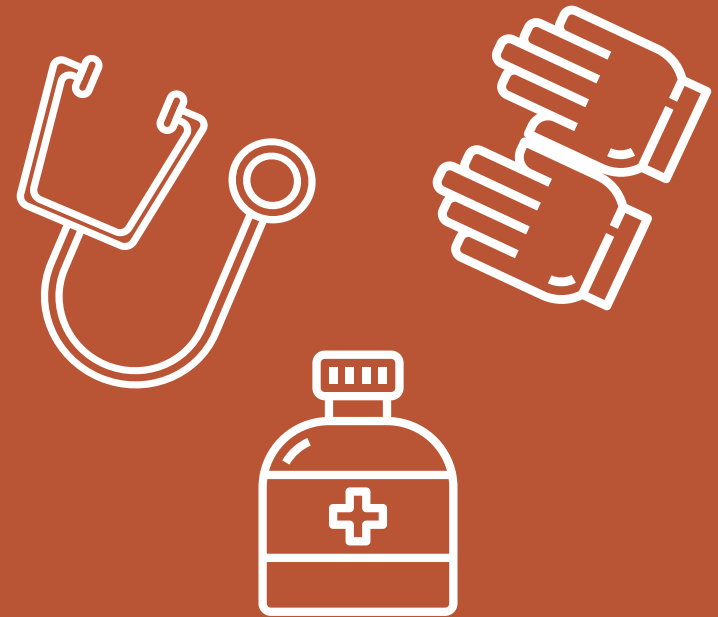
Infection prevention and control precautions apply for staff, patients and accompanying family members at health facilities. Establish a patient flow that includes triage before entrance into the health facility and an isolation area that patients with COVID-19 symptoms can be escorted to. See guidance [here](#).

Where applicable, ensure facility and health worker readiness for inpatient obstetric care. Every effort should be made to minimize overcrowding of maternity wards to reduce the risk of healthcare-associated infections.

- ▶ **Develop/adapt protocols for the management of COVID-19 in pregnancy** including labor and birth in line with national protocols. In the absence of obstetric complications or risk factors consideration could be given to advising women to stay at home for early labor if limitation of contacts is feasible (complete self-isolation is not advised for laboring women).
- ▶ Intrapartum care of women with suspected or confirmed COVID-19 needs to ensure (1) isolation of the patient from other patients and (2) PPE (mask, goggles, gloves, gown/apron) for relevant health staff; the number of staff in contact with the woman should be reduced to a minimum ensuring capacity to deal with both maternal and potential neonatal complications.
- ▶ The benefits of breastfeeding, early and uninterrupted skin-to-skin contact, prolonged kangaroo mother care, and enabling mothers and infants to remain together in the same room throughout the day and night outweighs the potential risks of SARS-Cov-2 transmission. The following precautions should be taken for mothers with suspected or confirmed COVID-19 infection:
 - wear a mask when holding a child
 - wash hands before and after contact with her child
 - clean/disinfect surfaces she has been in contact withIf a mother is too ill to breastfeed, she should be encouraged to express milk that can be given to the child by cup or spoon.
- ▶ The design and provision of temporary facilities should consider the needs of mother and newborns including adequate space for breastfeeding, kangaroo mother care, and management of sick newborns.

Appropriate infection prevention and control precautions must also be taken for any community-level service provision.

Please see [here](#) updated guidance and additional resources.



Inter-Agency Working Group on
Reproductive Health in Crises

<https://iawg.net>