SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING INFECTIOUS DISEASE OUTBREAKS:

Operational Guidance for Humanitarian and Fragile Settings

USAID FROM THE AMERICAN PEOPLE
READY GLOBAL READINESS FOR MAJOR DISEASE OUTBREAK RESPONSE
INTERNATIONAL RESCUE COMMITTEE
the David & Lucile Packard FOUNDATION
IAWG Inter-Agency Working Group on Reproductive Health in Crises

Cover Photo: International Rescue Committee

DEDICATION

This guidance is dedicated to the memories of Jennifer Schlecht and her daughter, Abaynesh. This work would not have been possible without Jennifer Schlecht's commitment to and technical leadership on emergency preparedness for sexual and reproductive health in humanitarian and fragile settings.

ACKNOWLEDGEMENTS

This guidance was made possible by the generous support of the American people through the United States Agency for International Development (USAID). This report was also funded by the David and Lucile Packard Foundation with leadership from the International Rescue Committee (IRC) and Save the Children's READY Initiative. The contents are the responsibility of READY and IRC and do not necessarily reflect the views of USAID or the United States Government. Led by Save the Children, the READY initiative is implemented in partnership with the Johns Hopkins Center for Humanitarian Health, the Johns Hopkins Center for Communication Programs, UK-Med, and the Humanitarian Leadership Academy. READY is augmenting global capacity for non-governmental organizations to respond to large-scale infectious disease outbreaks.

March 2022

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Johns Hopkins Center for Communication Programs

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humanitarian leadership academy

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International Rescue Committee

the David & Lucile Packard Foundation

IAWG Inter-Agency Working Group on Reproductive Health in Crises

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Source: Jonathan Hyams / Save the Children
Jeanne is a midwife at the Mahama Refugee Camp in Rwanda.

ACRONYMS

27/4	24-hour per day, 7 days per week
ANC	Antenatal care
ARV	Antiretroviral
BMS	Breast milk substitute
CCP	Johns Hopkins Center for Communication Programs
CEmoNC	Comprehensive emergency obstetric and newborn care
COVID-19	Coronavirus disease 2019
DRC	Democratic Republic of Congo
EmONC	Emergency obstetric and newborn care
EC	Emergency contraception
EOC	Emergency operations centers
ETC	Ebola treatment center
EVD	Ebola virus disease
FP	Family planning
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HRP	Humanitarian response plan
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IEC	Information, education, and communications
IPC	Infection prevention and control
IPV	Intimate partner violence
IRC	International Rescue Committee
ITC	Isolation and treatment centers
KMC	Kangaroo mother care

LARC	Long-acting reversible contraceptive
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual
MISP	Minimum initial service package
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
PAC	Post-abortion care
PEP	Post exposure prophylaxis
PFA	Psychological first aid
PMTCT	Prevention of mother-to-child transmission
PNC	Post-natal care
PPE	Personal protective equipment
PPH	Post-partum hemorrhage
PrEP	Pre-exposure prophylaxis
RCCE	Risk communication and community engagement
RCOG	Royal College of Obstetricians and Gynaecologists
SOP	Standard operating procedures
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

INTRODUCTION

What is the Purpose of This Guide?

The **objective** of this guide is to provide practical advice for health staff undertaking infectious disease preparedness and response activities to ensure that the sexual and reproductive health (SRH) needs of the population are met when an outbreak occurs. It is an operational guide to support health actors to maintain critical SRH services during infectious disease outbreaks and ensure necessary SRH considerations are integrated within the outbreak response; it is not a clinical guide. The locational focus of this document is on humanitarian and fragile settings; however, recommendations may apply to infectious disease outbreaks in all low-resource situations.

The **target audience** for this guide is program managers and health care providers from implementing partner agencies and governments located in humanitarian and fragile settings that are at risk of, or experiencing, infectious disease outbreaks.

How is This Guide Organized?

This guide assumes that in any given setting, the Minimum initial service package (MISP) for SRH in crises, or more comprehensive SRH services, are in being implemented. The guidance is divided into the following eight units:

- Section 1: The Effects of Infectious Disease Outbreaks on SRH
- Section 2: Cross-Cutting Considerations
- Section 3: Maintaining the Safety and Continuity of Essential SRH Services During Infectious Disease Outbreaks.
- Section 4: Integrating SRH Needs Within Infectious Disease Outbreak Response
- Glossary
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SECTION 1: THE EFFECTS OF INFECTIOUS DISEASE OUTBREAKS ON SEXUAL AND REPRODUCTIVE HEALTH

Emergencies occur when an event, or series of events, results in a critical threat to the health, safety, security, or wellbeing of a community.

These can result from armed conflict, natural disasters, infectious disease outbreaks, or famine; often involving population displacement. The coping capacity of the affected community is overwhelmed, infrastructure disrupted, and additional assistance is required to prevent excess morbidity and mortality.[1]

SRH services are lifesaving, essential, and time-critical.[2] In order to limit SRH-related mortality and morbidity and ensure dignity and human rights, the delivery of SRH services is an essential component of any effective humanitarian response.[3] Yet too often, access to SRH services in humanitarian settings is limited even though approximately one in four people needing humanitarian assistance are women and girls of reproductive age.[4]

During acute and destabilizing infectious disease outbreaks, health systems are disrupted and can collapse as resources are diverted to the outbreak response, while SRH needs persist or increase. This hazardous dynamic leads to both direct mortality from infectious disease outbreaks and indirect mortality from preventable and treatable conditions.

Increased Morbidity and Mortality

Infectious diseases are often more impactful to women and adolescents who are pregnant, exacerbating morbidity and mortality numbers. The examples abound. Pregnant women are more likely to experience severe disease and hospitalization from coronavirus disease 2019 (COVID-19), particularly in the third trimester. In addition to an increased risk of pre-term delivery and still-birth;[5] Zika can cause serious birth defects,[6] while Ebola virus disease (EVD) infection in pregnancy often results in miscarriage, stillbirth, and neonatal death.[7] Hepatitis E infection (genotype 1) can lead to maternal mortality in 15% to 25% of cases.[8] Moreover, adolescent girls already have an increased risk of complications during pregnancy and childbirth without the added hazards of infectious diseases.[9]

Increased Risk of Gender-Based Violence

The lockdowns imposed during the COVID-19 pandemic limited the mobility of women and girls and increased their proximity to their abusers, heightening risk of gender-based violence.[10] United Nations Population Fund (UNFPA) estimated that every three months of lockdown contributed to an additional 15 million cases of gender-based violence (GBV) worldwide.[11] Interviews with 852 women living in crisis settings across 15 countries revealed that 73% of women interviewed reported an increase in intimate partner violence (IPV), 51% cited sexual violence, and 32% observed a growth in the levels of early and forced marriage as a result of the lockdowns.[12] Married adolescents experienced social isolation in all settings and were at higher risk of IPV and forced sexual intercourse.[13]

Reduced Access to Essential Services

The reduction in access and utilization of essential services during an infectious disease outbreak has a secondary impact on the number of women, adolescent girls, and newborns who suffer complications or die during pregnancy, childbirth, and the postnatal period.[14] When health facilities are overwhelmed, staff are often redeployed to emergency clinical areas treating infected patients.[15] As a consequence, other essential services, e.g., SRH, are left understaffed and often forced to close.[16] For example, during the EVD outbreak in West Africa (2014–2016), Sierra Leone, Guinea, and Liberia documented reductions in the provision of contraceptive services, antenatal care visits,

and facility deliveries, with the cuts in service outlasting the outbreak itself.[17,18,19,20,21,22] In Sierra Leone, one study estimated that there were 3,600 additional deaths, including maternal, neonatal, and stillbirths, related to the decrease in health service utilization during the outbreak.[23] Whilst in the 2018 EVD outbreak in the Democratic Republic of Congo (DRC), triage and isolation protocols caused potentially life-threatening delays for women requiring emergency obstetric care.[24] During the COVID-19 pandemic, a systematic review of the pandemic's effects on access to SRH services found consistent reductions in access to contraception and abortion care across all contexts.[25] An assessment of the pandemic's effects on SRH services in six countries documented reduced access to contraception in Bangladesh, Colombia, and the DRC; increased early and forced marriage and adolescent pregnancy in the DRC, Northeast Nigeria, and Syria; as well as increased rates of unsafe abortion in some contexts. Furthermore, the COVID-19 pandemic coincided with reduction in facility-based delivery in Nigeria, Syria, and Bangladesh; while maternal mortality increased in Colombia and the DRC during this time.[26]

Reduction in Care Quality

During the early months of the COVID-19 pandemic in 2020, health providers noticed a reduction in quality of SRH services due to a lack of prioritization of SRH in response planning and financing. Midwives and SRH service providers, a primarily female workforce, were not prioritized for infection prevention and control (IPC) training or personal protective equipment (PPE). This led to high-risk service provision that put providers and clients alike at increased risk.[27] Changes in health protocols during the pandemic may have also led to lower quality care that affected health outcomes. For example, widespread disruptions in access to kangaroo mother care (KMC) for small and sick newborns likely increased mortality. One study found that more than half of health workers in 62 countries reported discontinuing or discouraging KMC for those confirmed or suspected to have COVID-19, while half reported separating the mother-baby dyad in the case of COVID-19 infection.[28]

Women's Role as Carers

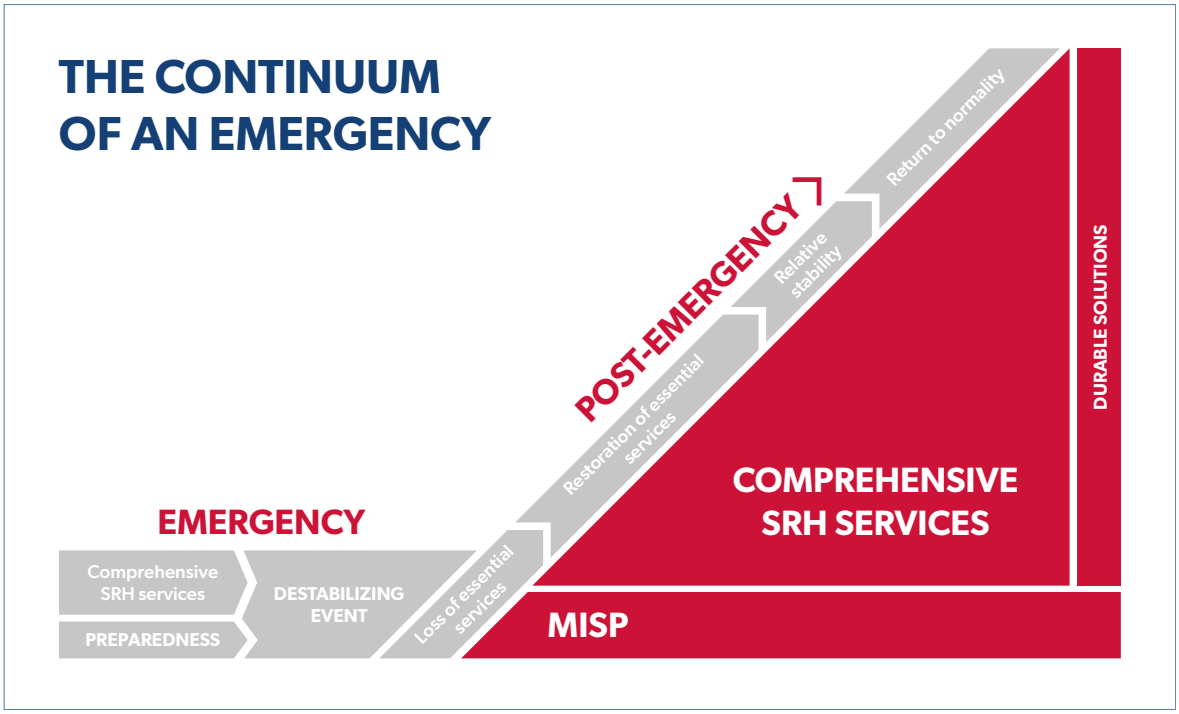
In most societies, women and girls are more likely than men and boys to be caregivers for the sick in healthcare settings and at home. This has a two-fold negative consequence of (a) greater exposure to the infectious disease, which is particularly relevant when diseases are transmitted by close contact, and (b) a barrier of access to healthcare, since women and girls prioritize the care and treatment of other household members over their own wellbeing.[29]

Source: Sarah Waiswa / Save the Children
All four children of Emily, from Bungoma, Kenya, were born at Kabula Health Center supported by Save the Children.

Continued SRH Service Provision

These well-documented effects of infectious disease outbreaks and responses on SRH outcomes highlight the importance of specific actions before and during an outbreak response to ensure the continuation of SRH services. Health actors have a responsibility to ensure the continuity of essential, lifesaving services during infectious disease outbreaks. When action is taken early to adapt clinical service delivery, mitigate service disruptions, and ensure that SRHR specific considerations are in place within outbreak response, then essential SRH services can be maintained. Therefore, it is essential that investments in SRH service delivery are made as part of preparedness efforts and that the MISP is prioritized at the onset of, and throughout, an outbreak. Comprehensive SRH services should be provided as soon as possible, and ideally within 3–6 months of the outbreak's onset (Figure 1).

Figure 1 *SRH in the Emergency Continuum*[30]



Components of the MISP for SRH

The MISP for SRH in emergencies is a standardized set of priority lifesaving services and activities that prevent excess morbidity, mortality, and disability in crisis-affected populations. The MISP defines which SRH services are most important in averting morbidity and mortality, while also protecting the right to life with dignity, particularly among women and girls, in humanitarian settings. For the MISP to be successful, all service delivery activities need to be implemented simultaneously by coordinating with all relevant partners. All health actors should complete the MISP distance learning module in order to have a foundational understanding of key services that must be made available during all crises, including infectious disease outbreaks. Health actors ought to also familiarize themselves with the adolescent-inclusive MISP in the *2020 Adolescent sexual and reproductive health toolkit for humanitarian settings*, which outlines considerations for adolescents when implementing the MISP. Six MISP objectives form the minimum implementation requirements in a response and should be carried out in humanitarian contexts (Table 1).

Table 1 MISP Objectives

MISP Objective	Minimum Response
1) Ensure the health sector/ cluster identifies an organization to lead implementation of the MISP	Nominates an SRH coordinator to provide technical and operational support to all agencies providing health services.
	Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP.
	Reports back to the health cluster, GBV sub-cluster/sector, and/or human immunodeficiency virus (HIV) national coordination meetings on any issues related to MISP implementation.
	In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services.
	Shares information about the availability of SRH services and commodities.
	Ensures the community is aware of the availability and location of reproductive health services.
2) Prevent sexual violence and respond to the needs of survivors	Work with other clusters especially the gender-based violence sub-cluster to put preventative measures in place at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence.
	Make clinical care and referral to other supportive services available for survivors of sexual violence.
	Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.
3) Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections (STIs)	Establish the safe and rational use of blood transfusion.
	Ensure application of standard precautions.
	Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.
	Support the provision of antiretrovirals to continue treatment for people who were enrolled in an anti-retroviral program prior to the emergency, including women who were enrolled in prevention of mother to child transmission IPC programs.
	Provide post exposure prophylaxis 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.

MISP Objective	Minimum Response
4) Prevent excess maternal and new-born mortality and morbidity	Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including: • At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmoNC). • At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and new-born care. • At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
	Establish a 24-hour per day, 7 days per week (24/7) referral system to facilitate transport and communication from the community to the health center and hospital.
	Ensure the availability of life-saving post-abortion care in health centers and hospitals.
	Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable.
5) Prevent unintended pregnancies	Ensure availability of a range of long-acting reversible contraceptives (LARCs) and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary health care facilities to meet demand.
	Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counselling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination.
	Ensure the community is aware of the availability of contraceptives for women, adolescents, and men.
6) Plan for comprehensive SRH services, integrated into primary health care, as soon as possible	Work with the health sector/cluster partners to address the six health system building blocks including: service delivery, health workforce, health information system, medical commodities, financing and governance, and leadership.
Other priority	Refer to MISP Chapter 3 for other priority activities that should be made available during infectious disease outbreaks.

Components of an Infectious Disease Response

Routinely, the prevention and control of infectious disease outbreaks involves the operational categorization of the response into pillars.[31] The use of these pillars in a response guides the grouping of different activities and responders around thematic areas that ensures clarity of actions, appropriate structures of teams, and reduction in siloed action and redundancies. The emphasis and importance of specific pillars may change from outbreak to outbreak based on the disease profile and corresponding mitigation and containment strategies. The final makeup of the response pillars will be context dependent; e.g., the existence of an available licensed and effective vaccine, or whether the transmission mode of the given pathogen requires special attention to safe and dignified burials.[32] Some pillars will always be essential elements; such as coordination, case management, logistics, contact tracing, and risk communication and community engagement (RCCE). While other response pillars, such as response research or safe burial, may be less of a priority. A set of core pillars that can be expected in any outbreak response are outlined in Table 2. This guidance has included mental health and psychosocial support (MHPSS) as a core response pillar, acknowledging that previous infectious disease outbreaks have been associated with poor mental health outcomes for women and girls.

Source: Sacha Myers / Save the Children
In North Kivu, Ituri and Petit North Kivu in the DRC, Save the Children and its Emergency Health Unit supported health facilities during the Ebola outbreak.

Table 2 Core Pillars of an Outbreak Response

Core pillar	Activities
Coordination	• Review national policy and legislative frameworks • Visas, importation of goods, and vaccination • Establish or maintain emergency operations centers • Map list of donors and partners • Create templates for Situation reports (SitReps) and press releases • Set up operational budget • Develop resource mobilization plan
Surveillance, epidemiological investigation and contact tracing	• Reinforce integrated disease surveillance and response systems • Integrate pathogen of interest within the surveillance system • Train on case definitions, detection, and reporting • Set up of community-based surveillance systems • Establish rapid response teams • Start contact tracing • Create strong links with RCCE, case management, and analytics pillars
Laboratory and diagnostics	• Assess national systems for sample collection, transport, testing and tracking • Equip facilities with supplies • Launch appropriate and effective stock management systems • Establish and strengthen testing networks to decentralize testing and diagnostic capacity • Train staff • Begin a data management system that allows prompt dissemination of results • Start internal and external quality control systems
Case management	• Establish treatment centers and units in different districts, designed in line with World Health Organization (WHO) standardized guidance in locations determined by risk and population ratios • Disseminate standardized and evidence-based treatment guidelines, Standard Operating Procedures (SOPs) and tools • Train staff, including specific training for experimental therapies • Create a case management team • Prepare appropriate ambulance transport system with trained staff • Start safe screening, triage, and isolation capacities within the facility or center • Ensure pharmacy and supply management system in place • Establish patient referral system and transit structures • Conduct regular quality and safety audits

Core pillar	Activities
IPC	• Activate IPC taskforce • Disseminate standardized and evidence-based IPC guidelines, SOPs, and tools • Train staff • Ensure appropriate supply and utilization of PPE • Conduct WASH assessments in communities and health facilities • Identify priority response locations and areas
Epidemiological and outbreak analysis	• Equip the data management and analysis system and team • Ensure clear flow of data to and from each activity • Guarantee real time analysis and timely dissemination of updated information • Safeguard strong links with RCCE, case management, vaccination, and surveillance pillars
Logistics	• Support key logistics in other pillars • Consolidate supply need forecasts • Map and evaluate medical facilities • Manage the ambulance transport system • Evaluate transport system • Transport cargo, people, patients, and samples • Evaluate storage and warehouse capacity • Assess communication network capacity
RCCE	• Establish/activate RCCE coordination mechanism • Perform qualitative analysis • Conduct knowledge, attitude, and practice surveys, anthropological studies, and rumor tracking • Ensure engagement with local networks, e.g., health facilities, schools, and churches • Safeguard information dissemination • Guarantee key messages are developed and adapted as the outbreak evolves, based on the results of the qualitative study results
MHPSS	• Establish multi-sectoral mental health and psychosocial support coordination platforms • Monitor and evaluation to measure activities • Integrate MHPSS in public health assessments, preparations, response, and recovery plans • Train frontline workers in each facility and activity • Map existing services • Design strategy that aligns with needs, culture, and context of the region

SECTION 2: CROSS CUTTING CONSIDERATIONS

It is recommended that the following cross-cutting issues are addressed in any infectious disease outbreak to ensure the continuity of essential SRH services, guaranteeing that all health facilities meet the SRH needs of the population.

Coordination

In all crisis settings, coordination between agencies and partners is essential. The humanitarian cluster system is designed to enhance coordination during emergencies, ensuring access to essential services and effective use of resources. This system also minimizes overlaps and should remain the core coordination mechanism during an outbreak. Additionally, if established, it is important for health actors, including SRH staff, to coordinate with emergency operation centers, which may be used to coordinate the preparedness and response efforts. Specific actions regarding coordination in outbreaks are highlighted in Annex 1.

The first objective of the MISP requires that there is a lead agency to coordinate actors responding to SRH needs during a crisis. This is critical to ensure accountability and allocate resources effectively for MISP implementation. As with other types of emergencies, the SRH group should be activated at the onset of an outbreak, if not already, and an SRH coordinating agency should be identified. If an SRH group is not established, SRH actors should actively ensure that SRH needs are prioritized within the health cluster and with other coordination bodies. The SRH working group should proactively collaborate with, and integrate within, the relevant outbreak response pillars, promoting adaptations and experience-sharing among SRH actors to ensure the continuity of SRH care throughout the outbreak.

SRH experts should be included in policy- and decision-making, planning, and response to infectious disease outbreaks. There should be an SRH/MISP coordinator who regularly attends other health cluster and disease task force meetings to ensure information is transmitted across relevant groups. There must be strong and continuous coordination and collaboration between SRH implementers and those responding to the outbreak from the outset. SRH representatives should be present in outbreak response coordination mechanisms and review and input into programmatic and clinical guidance for the specific pathogen to confirm that SRH needs are integrated and risks are mitigated. Regular updates need to be provided and cascaded down across coordination groups on care and outcomes for SRH clients, including women and girls that are pregnant.

Coordination silos lead to inefficiencies and oversights

During the 2018 EVD outbreak in the DRC, the EVD response coordination was set up as a separate, parallel system with insufficient coordination and collaboration with the existing health cluster system for the first year of the outbreak. SRH coordination and priority setting continued with a conflict-response focus under UNFPA and its integration within the EVD response did not have clear leadership. The result was that SRH needs were not prioritized within the EVD response and SRH programs did not adapt to the changing dynamics of the EVD outbreak and response, impacting SRH related morbidity and mortality throughout the outbreak.[33]

Respectful Client-Centered Care

The provision of respectful and rights-based care is central to SRH service delivery. Disrespectful and abusive care violates human rights, and contributes to poor health outcomes and experiences for SRH service users.[34] During an infectious disease outbreak, enhanced efforts to curb nosocomial transmission in health facilities may be perceived as more important than ensuring standards of respectful and rights-based care. This can result in the implementation of inappropriate and non-evidence based SRH protocols and practices, which can be harmful to SRH clients. This is particularly true for uncommon or novel pathogens, for which knowledge is constantly evolving, with protocols needing to be revised accordingly.

For example, during the COVID-19 pandemic, health care workers reported disruptions in the core tenants of respectful maternity care, including birth companions and emotional support, which compromised standards of care.[35] Furthermore, adolescents and people with disabilities often experience poor treatment during SRH services even in stable times, highlighting that special attention needs to be taken to secure their access to respectful care during outbreaks.

- Policies and protocols must effectively balance the risks of disrespectful care with perceived benefits of reduced disease transmission and be regularly updated to align with the latest evidence.
- Respectful and client-centered care should always be prioritized, with exceptions made only if necessary and in consultation with SRH experts.

Given the importance of breastfeeding and unrestricted skin-to-skin for all babies, and KMC for small and sick newborns, all efforts should be made to avoid the separation of mothers and newborns during an infectious disease outbreak. Separation is likely to cause severe stress, harm mental health, impact development, weaken breast milk protection against infectious disease, carry a high risk of breastfeeding failure, and place a high burden on healthcare systems.

It is important to consider that during an outbreak of a pathogen associated with high mortality, there will likely be cases of maternal death and severe maternal illness, which prevent effective breastfeeding. Considerations should be made to ensure that temporary alternative methods of feeding are available in such cases, e.g., mother's expressed breastmilk, donor human milk, wet nursing (breastfeeding by another woman), or use of breast milk substitute (BMS) as a last resort.[36]

- Avoid separation of mother and newborns where possible.

Respectful Maternity Care Charter: The Universal Rights of Women and Newborns[37]

1. Everyone has the right to freedom from harm and ill-treatment.
2. Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.
3. Everyone has the right to privacy and confidentiality.
4. Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.
5. Everyone has the right to equality, freedom from discrimination and equitable care.
6. Everyone has the right to healthcare and to the highest attainable level of health.
7. Everyone has the right to liberty, autonomy, self-determination and freedom from arbitrary detention.
8. Every child has the right to be with their parents or guardians.
9. Every child has the right to an identity and nationality from birth.
10. Everyone has the right to adequate nutrition and clean water.

Staff Health and Wellbeing

Program implementers should have ongoing discussions with health care workers about their comfort and their ability to continue providing SRH care safely. For example, if PPE is required, consider refreshments for staff and temperature control of the clinical space. Appropriate SOPs should be in place in case of occupational exposure to the disease.

- Ensure that staff have access to necessary treatment, post-exposure prophylaxis (if available), accurate information, and protected time off.

The SRH needs of staff and their dependents should be considered, particularly if healthcare is becoming harder to access.

- Women and their families may choose to delay or avoid pregnancy during an infectious disease outbreak; therefore, staff should have access to voluntary contraception.

- Consider reassigning vulnerable individuals working at the facility if their condition would put them at risk of poor outcomes if infected, or if there is concern about poor outcomes during novel outbreaks with limited data, e.g., all pregnant women during an EVD outbreak.

- Workplace support for breastfeeding health workers, e.g., expression breaks and breastmilk storage facilities should be available if required.

Many health care staff will be directly impacted by the infectious disease outbreak in their community at a professional and personal level.

- Staff wellbeing can be protected through the provision of safe human resource practices and updated organizational duty of care policies, e.g., flexible work schedules, time off according to personal circumstances, available counselling support, and safe and appropriate staffing levels.

Health care workers are often placed under extreme stress during infectious disease outbreaks, which will have short- and long-term impacts on their mental health. For example, health care workers may experience moral injury during an outbreak as a result of and witnessing suffering and needing to make difficult, life and death decisions. This sense of moral injury may be particularly acute for those treating SRH patients, because the overlapping risks faced by these patients, including gender-based violence and pregnancy complications, can be especially difficult to manage and witness. As such, health care workers themselves should be considered a vulnerable group during an outbreak, and should be prioritized for specialized and non-specialized MHPSS interventions and support.

Health workers, including midwives and other SRH health workers, should be prioritized for available vaccination. Reducing the risk of mortality and morbidity in health staff protects the availability of critical essential services during the infectious disease outbreak. Vaccinating SRH workers also reduces the risk of onward transmission to people at high risk of serious disease outcomes.

Mental Health & Psychosocial Support

Expect an increase in stress levels and the development or exacerbation of mental health problems in all patients and caregivers. Deteriorated mental health carries increased risk of pregnancy and delivery complications, preterm delivery, growth restriction, poor mother-infant attachment, and altered SRH risks in women.[38,39]

- Ask all patients about their wellbeing in order to provide psychosocial support, or be able to refer them to more specialized mental health services.[40]

- Ensure that frontline clinical staff receive training on psychological first aid (PFA), trauma-informed care, referral to non-specialized MHPSS service provision, and if available, referral to specialized mental health professionals.

- Establish access to psychosocial support and trauma-informed care for all patients, including GBV survivors, women who are breastfeeding during severe illness, or have temporarily stopped breastfeeding, as well as for mothers and other caregivers who are temporarily separated from their children.

MHPSS technical specialists should be consulted by SRH and outbreak responders alike to ensure access to MHPSS services. Confirm that MHPSS is designed and implemented as an integrated, inter-sectoral, and cross-sectoral approach; based on the context, needs assessments, and overall MHPSS services mapping.

Referral pathways and updated MHPSS service mapping should be undertaken or refreshed, ensuring MHPSS service availability during potential community-wide lockdowns and quarantines, with an emphasis on remote support options where possible and safe to do so, e.g., mental health hotlines and home-based support. Advocacy will be needed to resource the gaps in MHPSS service provisions.

Monitoring and Evaluation

Comprehensive and high-quality data on SRH is essential for decision-making. Health actors need to work to strengthen safe data collection systems for key SRH indicators before an infectious disease outbreak occurs, assuring preparedness to track the effects of emergencies on SRH services. Implementers must agree on key indicators that will be used to monitor SRH services at the onset of an outbreak and these standard indicators should be integrated within the Health Management Information Systems monitoring the outbreak response.

- Data should be regularly analyzed and used by the SRH working group, health cluster, and outbreak coordination bodies for program decision-making and addressing gaps in SRH services.

Source: International Rescue Committee

Regular monitoring of MISP activities can be conducted using the MISP monitoring checklist to ensure full availability of minimum services. Once the situation stabilizes, and program activities move from response to the recovery phase, an SRH assessment can be conducted to plan for comprehensive services.

When designing data collection systems specific to the infectious disease outbreak, arrange the use of official outbreak line lists. These are normally available through the Ministry of Health (MoH). Such line lists will normally include demographic characteristics, biometrics (e.g., pregnancy and breastfeeding status), symptoms, and disease status (e.g., suspect, probable, confirmed) according to official case definitions, treatment, and outcome.

- As per routine health programming recommendations, ensure you take steps to confirm that these data are not identifiable to individuals. Dis-aggregate data where necessary, by age and gender, and implement other data protection measures available, e.g., password protected data files.

Poor SRH data leads to poor monitoring

An assessment of the impact of COVID-19 on SRH services in six countries found incomplete and inconsistent data on SRH services in DRC, Colombia, Bangladesh, and Nigeria, making it difficult to determine the effects of the pandemic on access to SRH services. The inconsistencies included differences in indicators collected by region, across different partners, as well as inconsistencies in indicators over time, making data pre- and post-pandemic incomparable. In Syria, almost no SRH data were available.[41] These gaps made it difficult to draw conclusions about how the pandemic was affecting access to SRH services, inhibiting decision-making amidst crisis.

Isolation and Referral

During infectious disease outbreaks, primary health care facilities will need to establish clear screening, isolation, treatment, and referral mechanisms for suspected and confirmed cases identified in triage. Designated treatment centers with obstetric capacity need to be identified. While the location of ongoing care may differ depending on the specific pathogen and protocols, all facilities need to be prepared to offer lifesaving treatment (e.g. in case of imminent delivery, need for post abortion care [PAC]) while awaiting referral and transfer regardless of the pathogen. This is a critical component of planning as it can mean the difference between life and death.

If services at certain health facilities have been limited to accommodate more patients for treatment, information should be provided for clients to access routine services, e.g., contraception and STI testing, in addition to referral options.

Referral and emergency transport procedures may need to be adapted to ensure access to emergency SRH services. If patients with SRH requirements, including pregnant girls and women, are to be transferred during care (e.g., from a SRH facility to infectious disease treatment center, or from an infectious disease treatment center to an emergency obstetric referral center), the following protocols should be clearly established:

- Agreement on transfer system, route, and vehicle.
- Identification of staff with obstetric experience to support with transfer.
- Confidential management of patient details between referring and receiving facility, including relevant SRH information.
- Adherence to necessary IPC requirements during transfer.
- Availability of appropriate transfer equipment (e.g., clean delivery kit for women in labor).
- Agreement on how and where the transferred patient will be repatriated to the referring facility.

Even if transfer is the preferred clinical option, facilities must have emergency equipment and medication prepositioned in an isolation room that is equipped and ready to manage obstetric emergencies in case transfer is not feasible, e.g., delivery equipment for imminent birth, newborn resuscitation equipment, Post-partum hemorrhage (PPH) kit, and manual vacuum aspiration kit.

Novel Treatments and Vaccination

Inclusion into clinical trials for experimental treatments, prevention methods, and vaccinations will depend on the severity of disease and known safety profile of the interventions. Guidance from medical, ethical, and international bodies should be sought. It is vital that correct and consistent information is provided to avoid confusion or the exclusion of individuals from lifesaving interventions.

- Pregnancy, breastfeeding, and being of reproductive age are not contraindications to novel therapeutics or vaccinations by default. Indeed, including women and adolescents who are or could be pregnant in trials for experimental treatments and vaccines, while effectively weighing risks and benefits and certifying informed consent, is important for establishing their future access to lifesaving prevention and treatment.

From three delays to five[42]

During the 2018 EVD outbreak in the DRC, the response structure resulted in a five-delay model for emergency obstetric and newborn care. This differed from a three-delay model present in most low-income settings, leading to life threatening delays for clients whose obstetric complications matched the case definition for EVD. Ensuring rapid access to life-saving emergency obstetric care while protecting health care workers during infectious disease outbreaks is critical.

- Delay 1: Decision making to attend health facility: "They will wait at home until they have to move here."
- Delay 2: Getting to the facility: "It can take a long time to arrive."
- Delay 3: Receiving Care at the Facility: "If there is bleeding, they will send the woman away."
- Delay 4: Getting to the Ebola Treatment Center (ETC): "Sometimes the ambulance can take time."
- Delay 5: Receiving care at the ETC: "The ETC is a health facility like many others."[43]

Logistics

During the preparedness phase and early stages of an outbreak, greater quantities of SRH supplies, equipment, and PPE should be pre-positioned. This will mitigate potential disruptions due to movement restrictions and potential national or global shortages. SRH supply needs (including reproductive health kits) can be determined using the Inter-agency working group on reproductive health in crises (IAWG) MISP calculator and the *Interagency reproductive health kits manual (6th edition)*; distribution plans can then be developed to include remote locations. Once in the response phase, stock distribution should occur as needed, with clear reporting on supplies to avoid stockouts. Quantification and distribution plans should take into account plans for providing greater quantities of medications to clients to avoid unnecessary health facility visits, e.g., oral contraceptive pills, self-injectable contraception, and antiretrovirals, as well as plans for advanced distribution of certain medications, including emergency contraception, misoprostol to prevent PPH, and chlorohexidine for clean cord care. Ongoing efforts should be supported to gather, aggregate, and share data on supply and demand in the face of supply constraints to guarantee equitable allocation and distribution.[44]

In infectious disease outbreaks where there are high numbers of maternal orphans, or when breastfeeding is not recommended for infected mothers or infants, and feeding alternatives other than BMS are not feasible or recommended, make sure that breastmilk substitutes are procured in a timely manner. This should be done in strict compliance with the WHO international code[45,46] and the *Operational guidance on infant feeding in emergencies*.[47] Implementation capacity should be assessed in preparation and systems established for the management of non-breastfed infants, ensuring BMS can be rapidly supplied. For instance, by establishing long-term agreements with pre-approved suppliers. Refer to *Infant feeding during infectious disease outbreaks guidance* for further information.

SECTION 3: MAINTAINING THE SAFETY AND CONTINUITY OF ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH SERVICES DURING INFECTIOUS DISEASE OUTBREAKS

Source: Nadège Mazars / Save the Children
Martina with her son receiving services at the Sexual and Reproductive Health Unit of Save the Children in Maicao, Colombia.

Ensuring the continuity of essential SRH services during an infectious disease outbreak requires more than maintaining existing services. SRH services and interventions must be proactively adapted to respond to the changing health system, reallocation of resources, and client preferences and experiences.

The MISP should serve as a guiding framework for the minimum package of essential SRH services that must be available during an outbreak. Comprehensive SRH services should be ensured as soon as possible, ideally within three to six months following the onset of the outbreak. In addition to the considerations below, refer to the "Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks," in Annex 1, for a more detailed list of actions that should be taken to ensure the continuity of essential SRH services.

Clinical Service Provision

Making Facility-Based SRH Clinical Services Safe

Infectious disease outbreaks pose risks to clients and providers alike through the possibility of nosocomial transmission. Obstetric care may pose an increased risk of nosocomial transmission for certain modes of transmission, e.g., blood-borne or respiratory, given the nature of some care provided in maternity services e.g. prolonged 1-1 care provided when a woman is in labor, higher chances of contact with blood in the provision of PAC and management of PPH. Regardless of the disease mode of transmission, SRH services should continue and SRH service providers should be prioritized for capacity strengthening on IPC and have access to necessary and adequate PPE. There should be recognition that with novel pathogens, tests may not be available, providers may not know if patients are infected, and there may still be a lot to learn about the infection. Adherence to IPC measures is essential to prevent transmission to staff and other patients, while enabling SRH services to safely continue in the context of an outbreak. SRH implementers should follow local IPC guidance to reduce risks of nosocomial spread and risks to healthcare workers. Universal precautions remain consistent, as transmission-based precautions will be dependent on the infectious disease in question.

- Standard precautions should be strengthened, in addition to relevant transmission-based precautions. Appropriate administrative, environmental, and engineering controls need to be enforced to minimize the risk of infection. Program implementers should conduct training on SRH and IPC to fill gaps in skills, whilst working with providers to reorganize services and patient flow to allow for the safe provision of SRH services.

Training support for all healthcare staff during outbreak preparedness and response efforts is essential to guarantee the safety of staff, and therefore the continuity of SRH services. This should happen at all healthcare facilities. When possible, training support is best provided in the preparedness and readiness phases before the onset of an outbreak. SRH providers may require surge staff to maintain the continuity of SRH services during the outbreak.

- Support should include competency-based training in all SRH topics, MISP training, and IPC training (inclusive of PPE), in addition to regular supportive supervision.

- Programs should confirm that funds and an emergency roster are available to increase staffing levels to accommodate health care workers who are sick or self-isolating. They should also adapt supervision and support mechanisms to remote platforms, e.g., Whatsapp, when needed to minimize the risk of disease transmission.

Expanding Community-Based and Self-Care

When facility-based SRH services are disrupted, overstretched, or in circumstances when clients fear facility-based healthcare, programs should be adapted to make SRH services available through community-based and self-care models in line with global evidence. Shifting to these models may relieve pressure on overstretched facilities while also providing fearful clients with other options to receive care. Community-based and self-care models will be most successful during outbreaks when they are launched during stable times, so these models should be implemented as part of preparedness efforts. These program models should be developed with a thoughtful approach to local partnerships (e.g. private sector, pharmacies) so that services are accessible outside the formal health system. Community health care providers and those linking clients to self-care, including traditional birth attendants (TBA), must be provided with necessary IPC training and PPE as part of early response efforts when an outbreak occurs. Refer to WHO's self-care guidelines for more guidance.

Community-based distribution of family planning (FP) in South Sudan during the COVID-19 pandemic

The International Rescue Committee (IRC) introduced community-based distribution of FP in Rubkhona and Aweil East counties in Unity and Northern Bahr el Ghazel states in South Sudan in June 2020 in order to extend services to harder-to-reach populations and overcome barriers to facility-based services during the COVID-19 pandemic. In addition to necessary training, support and supplies for FP service provision, the IRC ensured the safety of community health volunteers by prioritizing training on and provision of PPE and access to routine COVID-19 testing and, once available, COVID-19 vaccination. The percent of couple-years of protection achieved through community-based distribution of FP increased from 6% in June 2020 to 23% in January 2022. Of the 122,138 clients reached with FP services during this period, 59% (53,883) were new FP users who were reached through community-based distribution. This strategy was especially successful at reaching youth under 20 years - 65% of IRC's youth clients accessed FP services through community-based distribution.

Risk Communication and Community Engagement

When new infectious disease outbreaks emerge, communities need practical, timely, and accurate information to prevent infections, reduce harm, and control the outbreak. This includes information relevant to SRH services. However, providing information alone is not enough. Effective public health and humanitarian responses engage and partner with communities in two-way communication approaches. These are tailored to affected communities' needs and perceptions, leveraging their capacities and working in their local contexts and languages. This style of engagement increases acceptance of a response and enhances a community's ability to limit the spread of diseases and the impacts of an outbreak.

While routine community engagement activities may be limited or suspended during certain highly infectious disease outbreaks (e.g. airborne transmission), health actors still have a responsibility to engage the community about the availability of SRH services. Specifically, it is important to:

- Work with communities to communicate and gain input on changes to services and those available through the community or self-care. Highlighting the measures taken to ensure the safety of clients seeking care and how the outbreak might influence their vulnerability to SRH-related morbidity and mortality.
- Continue to engage pregnant women and adolescent girls about pregnancy danger signs and provide updated information about where to receive pregnancy, labor, delivery, postnatal services, as well as pathogen-specific risk information.
- Ensure that underserved populations are not left out of community engagement and adapted communications channels, including adolescent, lesbian, gay, bisexual, transgender, queer, intersex, and asexual residents. This will require consultation and assessments with these groups to ensure engagement activities and messaging are effectively tailored and transmitted through targeted and accessible channels, including diverse languages and for persons with low/no literacy.
- Use a mix of communication approaches that align with the affected communities' preferred and trusted sources of communication, and how they are already adapting to the emergency to communicate with each other. Some examples of communication channels include: socially distant in-person events with safety protocols; social media (e.g., Facebook platforms and WhatsApp groups); interactive and participatory radio that allow community members to call in or send questions via short message services; print media; and megaphone or loudspeakers for low connectivity areas.

Source: Hugh Kinsella Cunningham / Save the Children
Two pregnant women receive services outside a Save the Children-supported health center in Eastern Congo during an Ebola outbreak.

SECTION 4: INTEGRATING SEXUAL AND REPRODUCTIVE HEALTH NEEDS WITHIN INFECTIOUS DISEASE OUTBREAK RESPONSE

Health actors managing infectious disease outbreak preparedness and response have a responsibility to consider and integrate SRH needs as part of the response.

SRH patients with suspected or confirmed infection have a right to SRH care, though decision-making about where each service should be provided is specific to the type of outbreak. This includes considering the intersection of infectious disease, screening, triage, and SRH related health needs; ensuring all cases continue to have access to essential SRH services, in line with the MISP. Program managers should carefully consider how to ensure SRH needs are met, either through provision at specialized infectious disease care centers, or through close collaboration with existing local health services. In addition to these considerations, refer to "Preparedness and Response Checklists for General Health/Infectious Disease Responders considering SRH needs" in Annex 1.

Clinical Service Provision

Screening, Triage, and Testing

It is common for health facilities to implement a screening and triage system during infectious disease outbreaks, with screening usually occurring next to the facility entrance. It is important to ensure the privacy of people entering the facility is maintained when establishing these spaces, particularly during triage when more detailed information will be discussed. The triage process will normally involve asking questions and conducting basic clinical investigations, which may include reason for attendance and symptoms. For people attending with SRH concerns, these can be sensitive questions and may also raise issues of protection.

- Triage should be designed in a way that it allows for confidential consultation and privacy from other staff and patients, and staff should be well trained in how to respond sensitively and appropriately. This is a particular concern for adolescent clients, who may be hesitant to come to the facility for fear of other adult clients seeing them there.

Screening, triage, and testing are time consuming. Many SRH needs require time critical interventions, e.g., obstetric emergencies or clinical response to sexual violence.

- Clear protocols should be in place to ensure the timely provision of emergency treatment and reduce delays, whilst ensuring the safety of health workers. These should consider likely delays in testing that will result in patients with unknown status throughout the provision of care. Examples of preparedness could include having pre-packed emergency kits that can be used within the isolation area, or establishing patient flow pathways for those with acute obstetric emergencies, including PPE protocols for staff receiving and treating them.

- Screening protocols should have an escalation process included for emergency cases and an isolation room should be in place where patients can be stabilized.

If referral to a different treatment center (e.g. facility providing CEmONC services or infectious disease treatment center) is needed, there should be a plan in place for the patient to be accompanied by a skilled health care provider en route to ensure necessary treatment.

The symptoms of an infectious disease may be difficult to differentiate from other common conditions that do not have an infectious process. This can make triaging SRH patients challenging. For example, the women presenting with vaginal bleeding secondary to an incomplete abortion met the case definition for EVD in the 2018 DRC outbreak. To avoid unnecessary isolation or delay in care for patients attending with SRH concerns, it is important to consider the full clinical picture and ensure staff understand and follow the case definition.

- Clinical definitions of suspected cases should be regularly reviewed and revised to reduce the likelihood of misdiagnosis and inappropriate management. Definitions should account for the normal physiological changes that occur during pregnancy and labor.

- A healthcare worker with obstetric experience should be available to support the triage process where available, as they may be able to help diagnose obstetric complications and inform critical decision making around next steps.

Case Management at Treatment Centers

For infections where pregnant women and adolescent girls may experience severe disease and require in-patient treatment and isolation (e.g., Hepatitis E, COVID-19, EVD), EMONC services and routine labor and delivery care must be available 24/7 at the treatment center itself. Provisions should also be made to ensure that clients admitted to the treatment center who are receiving long-term medication for chronic conditions are able to continue their regular medications. Special arrangements must be made with consideration to:

- Appropriately trained staff. Ideally, all treatment centers should have available staff who are competent in the provision of routine labor and delivery care, emergency obstetric and newborn care. If not possible, a functioning referral pathway must be available and staff must be competent to provide initial clinical stabilization prior to referral.

- Supplies and equipment for SRH services offered at the health facility, including cold chain for oxytocin storage.

- Accessible area for patients and staff meeting IPC requirements and allowing for privacy, confidentiality, and dignity.

- Psychosocial consideration for acute episode and aftercare, including linking with other providers for follow-up after discharge.

- Protection from sexual exploitation and violence.

There should be referral mechanisms in place for all other services listed in MISP Chapter 3 that are not available at the health facility or treatment center.

Source: Mackenson Saint-Felix / Save the Children
Jeffna receives a check-up with midwife Nelzy at a clinic supported by the Emergency Health Unit in Haiti.

Risk Communication and Community Engagement

It is critical that the RCCE sub-groups involved in the outbreak response coordinate closely with the SRH group, health cluster, GBV sub-cluster, and other coordinating bodies to ensure messaging is coordinated and well-integrated. It is important to work with communities and partners, including those within the SRH sector, to understand the health beliefs and concerns of the community and work with them on the development and implementation of messages, materials, and activities. If a community's questions and concerns are ineffectively addressed, people may try to fill gaps in knowledge with information that makes the most sense to them, including rumors and misinformation. Community myths and misconceptions about the disease, how it is transmitted, and treated may occur in the community and relate to SRH concerns.

In alignment with national and global level guidance, e.g., MoH, RCCE working group, and WHO, engage communities on infectious disease danger signs and signs of early infection, including information about risks particular to pregnant adolescent girls and women. These include an increased risk of contracting the infectious disease, increased risk of severe illness in pregnancy and the postnatal period, as well as options for preventing pregnancy. Outreach should include information on modes of infectious disease transmission, e.g., through sexual intercourse, vertical transmission, and contact with an infected person.

- Ensure that messages, materials, and engagement activities are updated as the outbreak context shifts.

Conduct a participatory community engagement process to engage community-level leaders (formal or informal), trusted community groups and the local population with two-way dialogues about the infectious disease response plans, and where and how to access services, supplies, and testing. Such messaging should be tailored to segmented audiences, in accessible languages, and through preferred and trusted channels, considering specific SRH needs; e.g., where should pregnant adolescent girls and women access care, and what are the recommended breastfeeding practices.

- Understand local community fears around health facility attendance because of perceived risk of infectious disease transmission, or potentially forced isolation at a facility if identified as positive. Make sure that clients understand how facility-based services are being made safe and how they can access needed services outside of the facility.

Continuously monitor community-level perceptions and feedback related to the outbreak and SRH needs, to understand changing needs, concerns, perceptions, and behaviors. In partnership with communities, adapt messages, materials, and activities accordingly.

Consider engaging with traditional birth attendants and other key SRH influential groups to understand concerns about the outbreak, barriers, and hesitancy in accessing services and ways that these issues can be addressed.

GLOSSARY

Case management: A strategy to coordinate the services and care required by a group of patients.[48]

Community engagement: A process of developing relationships that enable stakeholders to work together to address health related issues and promote wellbeing to achieve positive health impact and outcomes.[49]

Epidemiological analysis: The study of how often diseases occur in different groups and why. Epidemiological information is used to plan and evaluate strategies to prevent illness and guide the management of patients in whom the disease has already developed.[50]

Infection prevention and control: A practical, evidence-based approach which prevents patients and health workers from being harmed by avoidable infection.[51]

Kangaroo Mother Care: Early, continuous, and prolonged skin–to–skin contact between the mother and preterm babies; exclusive breastfeeding or breast milk feeding; early discharge after hospital–initiated KMC with continuation at home; and adequate support and follow–up for mothers at home.[52]

Laboratory and diagnostics: In the context of infectious diseases, rapid diagnostic tests most commonly refer to lateral flow, immunochromatographic tests used to detect certain infections.[53,54]

Logistics: The leveraging of relationships for proper forecasting of commodity demand and quantities needed. Procuring, warehousing, transporting, and distributing goods with the aim to better align supply and demand.[55]

Nosocomial infection: Nosocomial infections or healthcare associated infections occur in patients under medical care. As these infections occur during hospital stay, they cause prolonged stay, disability, and economic burden. Transmission of these infections should be restricted for prevention. Nosocomial infections can be controlled by practicing infection control programs, keep check on antimicrobial use and its resistance, adopting antibiotic control policy. Efficient surveillance system can play its part at national and international level. Efforts are required by all stakeholders to prevent and control nosocomial infections.[56]

Preparedness: Refers to the ability of governments, professional response organizations, communities, and individuals to anticipate and respond effectively to the impact of likely, imminent, or current hazards, events', or conditions. It means putting in place mechanisms that will allow national authorities and relief organizations to be aware of risks and deploy staff and resources quickly once a crisis strikes.[57]

Response: The acute emergency phase begins immediately after disaster strikes. During this phase, humanitarian organizations begin to respond, focusing on providing critical services such as food, water, sanitation, primary healthcare, and shelter. The priority during this phase is to keep the population alive. As the crude mortality rate returns to its baseline rate, a disaster enters what is called the post emergency phase. During this phase, aid agencies turn their focus to providing more routine services and developing local capacity to support the needs of the organization.[58]

Recovery: When the focus shifts from emergency response to recovery and development. International relief organizations often leave during this phase. Development agencies take a more prominent role, and the responsibility for providing assistance is turned over to local authorities.[59]

Risk communication: Includes the range of communication capacities required through the preparedness, response, and recovery phases of a serious public health event to encourage informed decision making, positive behavior change and the maintenance of trust.[60]

Sexual and reproductive health: A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of SRH relies on the realization of sexual and reproductive rights, which are based on the human rights of individuals to:

- Have their bodily integrity, privacy, and personal autonomy respected
- Freely define their own sexuality, including sexual orientation and gender identity and expression
- Decide whether and when to be sexually active
- Choose their sexual partners
- Have safe and pleasurable sexual experiences
- Decide whether, when, and whom to marry
- Decide whether, when, and by what means to have a child or children, and how many children to have
- Have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.[61]

Surveillance: Public health surveillance is the continuous, systematic collection, analysis, and interpretation of health-related data. Disease surveillance data:

- Serves as an early warning system for impending outbreaks that could become public health emergencies.
- Enables monitoring and evaluation of the impact of an intervention, helps track progress towards specified goals.
- Monitors and clarifies the epidemiology of health problems, guiding priority-setting and planning and evaluation public health policy and strategies.[62]

Testing: In the context of infectious diseases, rapid diagnostic tests most commonly refer to lateral flow, immunochromatographic tests used to detect certain infections.[63]

ANNEX 1: PREPAREDNESS AND RESPONSE CHECKLISTS

Purpose

The objective of this guidance is to provide practical advice for health staff undertaking infectious disease preparedness and response activities to ensure that the sexual and reproductive health and rights (SRHR) needs of the population are met if and when an outbreak occurs. It serves as a companion document to the narrative guidance "Sexual and Reproductive Health and Infectious Disease Outbreaks: Operational Guidance for Humanitarian and Fragile Settings." The target audience for this guidance is program managers and healthcare providers from implementing partner agencies and governments in humanitarian and fragile settings at risk of, or experiencing, infectious disease outbreaks. Users of this document should carefully consider context, stage, and progression of the infectious disease outbreak. It is important to recognize that outbreaks may move from less severe to more severe epidemic phases, or from more to less severe. Therefore, staff must be ready to constantly monitor, adjust, move forward, and quickly reverse processes depending on the disease transmission patterns and how they change as a result of the shifts in government-implemented measures. It is important to remember that sexual and reproductive health (SRH) services at the facility level should remain accessible to the greatest extent possible.

Preparedness

Preparedness is the ability of governments, response organizations, communities, and individuals to anticipate and respond effectively to the impact of likely, imminent, or current hazards, events, or conditions. It means putting in place mechanisms that will allow national authorities and relief organizations to be aware of risks and deploy staff and resources quickly once a crisis strikes (OCHA, 2021). Preparedness recommendations are included in this document, to help program managers and healthcare providers plan for potential infectious disease outbreaks.

Response

Response, or the "acute emergency phase," begins immediately after disaster strikes—in this case, an outbreak of an infectious disease. Humanitarian organizations begin to respond, focusing on providing critical services, such as food, water, sanitation, primary health care, and shelter. The priority during this phase is to keep the population alive. Response recommendations included in this document aim to help program managers and healthcare providers respond to an infectious disease outbreak.

Recovery

During the recovery phase of an emergency response, the focus shifts from response to recovery and development. International relief organizations often leave during this phase. Development agencies take a more prominent role, and the responsibility for providing assistance is turned over to local authorities (Anderson & Gerber, 2018). Recovery recommendations have not been addressed in this checklist, as many recommendations are quite general and not specific. However, it is recommended that planning for the return of comprehensive SRH services, integrated into primary health care, should begin as soon as possible.

1. Ensuring access to the MISP

Table 1, "Preparedness and Response Checklist for SRH Responders in ID Outbreaks," uses the Minimal Initial Service Package (MISP) objectives to recommend operational actions for SRH managers, categorized by preparedness and response.

2. Integrating SRH needs in infectious disease outbreak response

Table 2, "Preparedness and Response Checklist for General Health/ID Responders Considering SRH Needs," uses the pillars of an outbreak response to recommend priority sexual and reproductive health operational interventions, for general health and infectious disease specialists, categorized by preparedness and response. Preparedness recommendations describe general actions to be taken before an outbreak occurs and are not pathogen-specific.

Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks						
MISP Objective	**Recommended Preparedness Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started	**Recommended Response Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started
1. Coordination	Participate in SRH Sub-working Group/Technical Working Group and in health cluster and outbreak preparedness-related task teams.			Shift ongoing coordination efforts to virtual platforms, when needed and where feasible, and ensure continued participation. Ensure SRH staff participation in relevant outbreak and health coordination mechanisms (i.e., logistics cluster, health cluster, outbreak coordination body) to ensure SRH is prioritized in response planning.		
	Advocate for and mainstream SRH into national/district/local outbreak action/contingency plans in line with the Minimal Initial Service Package (MISP) standards.			Activate SRH and outbreak contingency and adaptation plans within the framework of outbreak preparedness and response.		
	Review experiences from previous outbreaks (e.g. Coronavirus disease 2019 [COVID-19], Ebola, Cholera, etc.), as applicable, with all stakeholders; document lessons learned, and incorporate into contingency plans.					
	Conduct MISP refresher training for health actors (including providers and stakeholders), considering infectious disease outbreak context.			Provide additional MISP training as required and advocate for the MISP as the minimum package of SRH services to be offered during the outbreak.		
	Calculate SRH supply needs; procure and pre-position SRH supplies or kits using MISP calculator and develop distribution plans including for hardest-to-reach locations.			Support distribution of SRH supplies or kits, and ensure clear reporting on supplies to avoid shortages.		
	Advocate for task shifting of all SRH services and the development of community-based and self-care guidelines, in line with WHO self-care guidelines.					

Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks						
MISP Objective	**Recommended Preparedness Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started	**Recommended Response Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started
	Calculate personal protective equipment (PPE) needs for different outbreak transmission scenarios (remember to include community health workers); procure and pre-position PPE.			Work with Ministry of Health (MoH), UNFPA, World Health Organization (WHO), and SRH Sub-Working Group to ensure SRH health providers have relevant PPE to support continuity of services (in line with rational use of PPE and the humanitarian response plan).		
	Make/strengthen connections and engage meaningfully with community groups, local partners, and government stakeholders on the importance of SRHR and the ways in which outbreaks might alter or increase SRHR needs.			Work with community health workers (CHWs), community leaders, youth groups, and community groups to regularly update communities on where/when/how to access different SRH services and changes to services as they happen; utilize modified approaches for information sharing (megaphones, SMS, WhatsApp, hotlines, in addition to small group meetings that follow guidelines on physical distancing, hand hygiene, and other hygiene practices, where feasible).		
				Maintain and circulate 3Ws (Who does What and Where) every two weeks, given the likely changes to locations of service availability.		
	Map potential isolation and treatment centers (ITC) that may be used for patient referral.			Establish and maintain strong links with ITC, where established.		
	Ensure that Humanitarian Response Plans (HRPs), outbreak preparedness and response plans, and relevant funding proposals include SRH needs in line with the MISP.			Update funding proposals for outbreaks to include SRH needs, and update SRH proposals to include outbreak adaptations.		

Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks						
MISP Objective	**Recommended Preparedness Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐Completed ☐In progress ☐Not started	**Recommended Response Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐Completed ☐In progress ☐Not started
	Maintain stock of essential PPE (including allocation for SRH services). This should be appropriate for standard precautions and regionally based seasonal outbreaks, e.g., cholera, malaria.			Shift focus from standard-precaution PPE to infection-specific PPE, e.g., based on mode of transmission, and ensure stock is procured and maintained (including for SRH services and staff).		
	Identify trusted sources of information in the community (e.g., CHWs, traditional birth attendant [TBA]) and preferred modes of communication (e.g., radio, WhatsApp) to plan for effective communication, outreach, and community engagement (Inter-agency Working Group on Reproductive Health in Crises, 2020).			Continue community engagement with continuous feedback loops; track and address rumors, myths, and misinformation/disinformation about the infectious disease, especially related to sexual and reproductive health.		
2. Prevent sexual violence and respond to needs of survivors	Participate in gender-based violence (GBV) sub-cluster coordination.			Continue coordination efforts with GBV sub-cluster.		
	Ensure that the following elements are included in contingency plans for SRHR and outbreaks: (1) safety planning with current clients; (2) plan for confidential storage of documentation; (3) developing a clear plan for clinical management of rape and case management, including mobile and remote service delivery options and referral systems during outbreaks; (4) modalities for remote supervision; (5) guidelines on supporting survivors through digital and remote support; (6) training/skills-building for staff on any new technology that may be used for remote support.			Activate and update the plans developed during preparedness, as necessary. Ensure sufficient PPE and other essential supplies for case managers, medical providers, and others who will have direct contact with survivors.		

Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks						
MISP Objective	**Recommended Preparedness Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started	**Recommended Response Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started
	Raise awareness about and support refresher trainings to enhance practical skills to support first line response (LIVES) and clinical management of rape for survivors.			Continue to provide clinical care for rape survivors, including emergency contraception, postexposure prophylaxis (PEP) for human immunodeficiency virus (HIV), and safe abortion care where legal. Ensure that standard operating procedures (SOP) and referral pathways for clinical care for survivors of sexual assault and case management are established, widely disseminated, and updated regularly.		
	Prepare information, education, and communication (IEC) materials for prevention and response to GBV, anticipating the increase in GBV cases associated with infectious disease outbreaks. IAWG's IEC Template G, "What to do after forced sex," may be helpful to adapt (IAWG, 2021).			Ensure ongoing awareness-raising on GBV services, including communicating openly with women and girls about the outbreak and any changes or potential changes in methods of service delivery. Distribute IEC materials related to GBV prevention and services at health facility triage area, all other triage sites, and throughout the community, including to underserved populations. Utilize online (SMS, WhatsApp) and radio messaging to reach clients, where possible.		
	Map trained staff and volunteers who could be mobilized to meet demand for clinical care for survivors of sexual assault, including community-based care or other task-shifting approaches.			Implement alternative methods to reach GBV survivors, who may avoid health facilities due to the perceived risk of infectious disease transmission. If survivors cannot access existing services, consider task-shifting to community-level health providers for community delivery of services and/or use of phone hotlines, if appropriate to the context. Ensure that linkages between CHWs and healthcare providers are strengthened.		

Preparedness and Response Checklist for Sexual and Reproductive Health Responders in Infectious Disease Outbreaks						
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	Work with women's and youth groups to develop outbreak-specific approaches for outreach and support in case in-person support becomes unavailable (helplines, digital platforms, virtual counseling with particular emphasis on safety planning if a situation were to escalate).			Implement and monitor adapted approaches for outreach and support (helplines, digital platforms, virtual counseling with particular focus on safety planning if a situation were to escalate) in collaboration with women's groups.		
3. HIV/sexually transmitted infection (STI)	Ensure the following elements are included in contingency plans for SRHR and outbreaks: (1) remote communication and follow-up channels for HIV/STI clients; (2) advance distribution of greater quantities of antiretrovirals (ARVs) to current HIV clients for self-management; (3) distribution plans for condoms outside of health facilities, including for sex workers, youth, people with disabilities, and lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+); (4) consider providing pre-exposure prophylaxis (PrEP) for high-risk groups who may struggle to access timely protective or postexposure treatment.			Continue to provide syndromic management of STIs, but limit patient flow by (1) using a telephone triage, (2) expanding access to STI self-sampling, and (3) treating for STIs presumptively according to patient description and risk criteria, where possible. Where examination is deemed necessary, consider urgency of the condition and follow infection, prevention, and control (IPC) precautions.		
				Continue supporting those previously on ARVs to access services and follow-up care, and complete necessary referrals and distribute greater quantities of medications to existing clients to reduce the need for visits. If the facility is inaccessible, consider organizing community-based distribution of PEP and prevention of mother-to-child transmission (PMTCT) via telephone helplines and/or CHW networks.		
	Establish connections with local groups of people living with HIV and engage them in contingency planning for SRHR and outbreaks.			Ensure the availability of context-adapted IEC materials for HIV and STIs. Continue to provide and update information throughout outbreak.		

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	Work with government and UN to ensure sufficient pre-positioned stock of ARVs and condoms (male and female).			Distribute condoms at multiple access points, and monitor uptake and resupply needs (through community-based distribution, if necessary).		
	Advocate for national protocols and guidelines for HIV self-testing and STI self-sampling, and support program rollout if possible.			Ensure that community SRH teams and health facility staff provide information on availability of STI treatment, condoms, ARVs, etc., at health facilities and referral options.		
				Work with community organizations, including youth-led, LGBTQIA+, and harm-reduction organizations for users of injectable drugs (including organizations focusing on sex workers), to provide information for people with HIV about where they can access antiretrovirals and treatments for STIs.		
				Continue provision of post-exposure prophylaxis (PEP) for survivors of sexual violence and occupational exposure. Prepare private consultation room for clients with suspected cases requiring urgent PEP or voluntary counseling and testing. Expand access to HIV self-testing, if possible.		

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				Depending on the nature of the infectious disease outbreak, review treatment protocols relating to ARV distribution for people on treatment for HIV and PMTCT; adapt protocols for safest method of treatment adherence (e.g., considering the risk of persistent vomiting in cholera outbreaks).		
4. Maternal and neonatal health	Ensure the following are included in contingency plans for SRHR and outbreaks: 1) emergency obstetric and newborn care (EmONC) protocols, triage, and referrals for different outbreak scenarios, including at treatment centers, 2) protocols to reduce patient contacts if necessary with maintaining availability of essential services, 3) expansion of community-based maternal and newborn care services, 4) Plan to increase staffing to account for the possibility of staff illness or quarantine.			Prioritize continuation of safe delivery, EmONC, and PAC services for patients. Establish and regularly update EmONC referral pathways. Consider transport support for clients.		
	Conduct competency-based refresher training on safe delivery, emergency obstetric, newborn care and post-abortion care (PAC).			Consider shifting routine antenatal care and post-natal care visits for low-risk patients to remote consultations, and establish telephone screening for PAC, where possible.		
				Ensure misoprostol (or misoprostol and mifepristone when indicated) as a frontline option is available for uterine evacuation as clinically indicated; where manual vacuum aspiration is required, follow standard guidance for PPE and IPC.		

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				Conservative (expectant) or medical management should be first-line options for incomplete abortions. Where the patient is deemed stable and it is safe for her to go home, treatment can continue outside the facility. Advice and phone numbers should be given in case of complications.		
				Consider halting routine, facility based follow up for sexual and reproductive health/obstetric complications and set up a phone line for remote follow up support, when needed and clinically appropriate		
	Forecast for and preposition supplies for safe delivery, emergency obstetric and newborn care and uterine evacuation, including clean delivery kits and misoprostol for advance distribution to prevent post-partum hemorrhage and chlorohexidine for clean cord care (depending on national guidelines). Ensure allocated back stock for PPE for different transmission types as needed for delivery/obstetric emergencies.			Develop clear service delivery and referral protocols for where pregnant women with mild, moderate, and severe infections should deliver and how they can be supported to remain safely with their newborn. This will be dependent on the transmissibility and mortality of the pathogen and the severity of the infection. In most outbreaks, treatment centers should be equipped to provide safe delivery and emergency obstetric care to severely ill pregnant women receiving treatment.		
				Segregate sexual and reproductive health units (e.g., maternity) for noninfectious patients from patients either confirmed or suspected of meeting the case definition.		

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				Review comprehensive emergency obstetric and newborn care (CEmONC) capacity (specifically operating theatre), and ensure services are adapted to the outbreak pathogen, considering the chain of infection transmission. Considerations should include transfer and return from isolation to operating theatre, cleaning, and disinfection procedures, required PPE to operating theatre staff, ventilation, and waste management.		
	Advocate for national protocols and guidelines for community-based and-self-care for SRHR in line with WHO guidelines, including maternal and newborn health care and support program roll-out where possible.			Support rollout of community-based programs as needed.		
				Develop SOPs for visitor restrictions, considering respectful maternity care and possible constraints for facilities providing SRH care. If possible, make every effort to permit a companion of choice for women in labor and childbirth (WHO, 2022). Ensure that staff are oriented to planned changes appropriately.		
	Prepare for community distribution of RH commodities if routine health facilities become inaccessible.			Coordinate with treatment centers to establish maternity wards that are appropriately staffed and equipped to provide safe delivery and emergency obstetric care, including PAC, when needed.		

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	Ensure staff are trained in the provision of rational blood transfusion and ensure that the necessary supplies are available.			Ensure safe and rational use of blood transfusion, as required. Consider the infectious disease outbreak context, and if necessary, adapt blood transfusion SOPs accordingly (e.g., additional testing in Ebola contexts).		
				Where access to a health facility is not possible or is unreliable due to insecurity, geography, or outbreak-related movement restrictions, distribute clean delivery kits, inclusive of misoprostol and chlorhexidine, in line with national guidelines, to all visibly pregnant women, particularly as lockdowns may create additional barriers to accessing facility-based clean and safe delivery options. Ensure women and girls know signs of complications of pregnancy, childbirth, and newborn problems and how and where to seek help.		
				Strengthen triage and isolation capacity at facilities providing maternal and newborn health (MNH) services, including review of client flow and early detection of infection.		
				Develop and disseminate IEC materials to illustrate the differences between symptoms related to infectious disease and symptoms related to sexual and reproductive health (e.g., per vaginal bleeding in Ebola contexts, shortness of breath when pregnant in COVID-19 contexts).		

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				Inform pregnant women and girls about pregnancy danger signs, how to access health services and information about pregnancy, labor, birth, essential newborn care, and the infectious disease outbreak. Information that is appropriate for adolescent girls, particularly aged 10-14 years, should be available. If appropriate to the outbreak, continue to provide updated information, and advise pregnant women and girls to refrain from unnecessary travel and avoid crowds, public transport, and contact with sick people.		
5. Unintended pregnancies	Ensure the following are included in contingency plans for outbreaks: 1) Facility mapping that indicate which facilities will continue to offer full range of services 2) Expansion of community-based distribution and contraception self-care, including providing a 1-year supply of short-acting methods for current clients 3) Support for community-based and self-care family planning (FP) programs, including supplies and revised delivery modalities.			Ensure access to LARCs and short-acting contraceptive methods, including emergency contraception, at service delivery points. Where only short-acting methods are feasible, such as in mobile clinics or health posts, ensure referrals for LARCs are available. Efforts must be made to ensure access to LARCs, particularly because they require the least follow-up once administered, reducing the need for follow-up visits at facilities.		
				Use appropriate standard safety precautions and PPE when providing counseling and when administering long-acting contraceptive methods.		
				Ensure postabortion contraception is available and offered to all clients.		

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	Conduct competency-based refresher trainings on FP counseling and provision of long-acting reversible contraceptives (LARCs).			Consider expanding community-based distribution of contraception and self-care models.		
	Forecast for and pre-position supplies for contraception including emergency contraception, short-acting methods and LARCs.			If context-appropriate and in line with national guidance, delay routine removals of long-acting methods (but always remove when client requests).		
	Advocate for national protocols and guidelines for contraception self-care and community-based distribution (including oral contraceptive pills, condoms, DMPA-SC and emergency contraception) and support program roll-out if possible.			Distribute one-year supply of oral contraceptive pills and DMPA-SC (for self-injectors) to existing clients. Consider advance distribution of emergency contraception.		
6. Transition to comprehensive SRH services	Actively advocate and ensure that SRH services are part of transition and recovery plans through the SRH working group, outbreak preparedness coordination mechanisms and other related coordination mechanisms.			Continue comprehensive SRH services from the onset, if possible, and transition to comprehensive SRH services as soon as possible.		
				Review and adapt comprehensive SRH services to the situation. This could mean cycling programs back to the MISP when required, while ensuring its wide coverage and access for the populations most at risk.		
Cross-cutting - ensuring SRH services are safe	Develop IPC protocols and SOPs to ensure implementation and adherence to Standard Precautions and Transmission-based Precautions.			Implement IPC protocols and SOPs to ensure implementation and adherence to standard precautions and transmission-based precautions. Include clear protocols for handling of stillbirths and placentas.		

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	Develop plans for additional administrative and environmental and engineering controls to minimize the risk of infection.			Implement administrative, environmental, and engineering controls to minimize the risk of infection.		
	Provide training for SRH providers on universal precautions and IPC plus contact (gloves/handwashing), natural or augmented ventilation and masking for respiratory pathogens, sharps, patient and waiting patient spacing, safe blood supply/limiting blood transfusions, and specific training on IPC for different transmission types (contact, airborne/respiratory, blood, vertical, vector-borne, fecal-oral and waterborne, food borne, etc.).			Ensure all staff members are trained on IPC protocols, and provide refresher training as needed.		
	Procure needed equipment and supplies to support IPC implementation eg. soap, alchohol hand-gel, PPE, etc.			Monitor IPC implementation and adherence, and ensure PPE is available for all SRH staff, including those working in the community, e.g., TBAs and CHWS.		
	Collaborate with water, sanitation, and hygiene (WASH) colleagues to ensure WASH and IPC infrastructure upgrades to support implementation of IPC measures.			Procure needed equipment and supplies to support IPC implementation, e.g., soap, alcohol hand-gel, PPE., etc.		
	Conduct individual occupational health risk assessments, considering a range of factors that may put clinical staff (including SRH staff) at greater risk from the infectious disease, or have greater impact of the disease.			Collaborate with WASH colleagues to ensure WASH and IPC infrastructure upgrades to support implementation of IPC measures.		

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	Conduct a rapid assessment to establish community knowledge, attitude, practice and behavior on SRH care and prevailing public health risks/ events.			Redeploy health workers providing clinical care to other roles if it is deemed too high risk for them to provide direct patient care during an outbreak scenario.		
	Ensure all SRH service delivery points have: good ventilation, open windows or effective heating, ventilation, and air condition systems with privacy; ensure waiting areas have separation between those waiting and allow for outdoor waits where possible; sharps and human fluids and waste disposal; handwashing available and encouraged; ensure regular audits of blood safety.			If not redeployed due to clinical risk, ensure adequate workplace support for breastfeeding health workers (e.g., breastmilk storage facilities).		

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1. Coordination	Establish/maintain emergency operations centers (EOCs) that either have specific sections to manage patients with SRH considerations and pregnant women and girls or that plan to ensure infectious disease support for SRH services. Ensure SRH actors are involved with coordination and are able to inform decision-making, to ensure the needs of SRH clients are met.			Reestablish or activate the EOC or other coordination mechanism within the health cluster. Ensure consistent participation of SRH experts in outbreak-specific decision-making and protocol and policy development.		
	Establish working relationships with SRH coordination mechanisms (such as the SRH working group and GBV sub-cluster) and ensure the presence of an SRH focal point within infectious disease outbreak preparedness groups.			Strengthen coordination mechanisms between the SRH working group and the EOC or other outbreak-specific coordination structure, establish two-way communication channels between sectors.		
	Include SRH donors, agencies, and other actors in the mapping and engagement of key stakeholders for outbreak preparedness.			Provide continuing education and updates around care and outcomes for SRH clients, including pregnant women, to inform the provision of care across the health sector.		
2. Surveillance, epidemiological investigation, and contact tracing	All health staff, including SRH staff, should be informed about notifiable diseases and trained and supported to report appropriately.			Clinical definitions of suspected cases should be regularly reviewed and revised to reduce the likelihood of misdiagnosis and inappropriate management. Definitions should account for normal physiological changes that occur during pregnancy and labor.		

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	Ensure all health providers, including SRH service providers, receive training on infectious disease case definitions. When providing training, consider possible overlap with existing SRH conditions (e.g., chorioamnionitis), to reduce chance of misdiagnosis.			Consider including TBAs in surveillance and contact-tracing teams, as they may be in a position to quickly identify suspected infectious disease cases at the community level.		
	Ensure case reporting for known infectious diseases is disaggregated by pregnancy/postnatal/breastfeeding status.			Train the surveillance team and healthcare workers on the outbreak case definition and the ways in which it overlaps with SRH conditions, including pregnancy, pregnancy related complications such a vaginal bleeding, STIs, GBV, and contraception side-effects, as well as the appropriate referral pathway for these conditions.		
				When developing and using contact listing/tracing and surveillance forms, ensure that pregnancy/postnatal/ breastfeeding status is reflected, to allow the estimation of the burden of disease in the pregnant/postnatal/ breastfeeding population.		
				Ensure SOPs are in place and distributed for GBV disclosures and referrals. Train contact-tracers on response to GBV disclosures and appropriate referral pathways, if possible.		

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				Consider SRH needs when creating isolation/quarantine SOPs, which should consider needs of GBV survivors, the possibility of obstetric emergencies, ARV needs for HIV-positive patients, and access to contraception and condoms. Ensure preventative measures are considered to protect affected populations, particularly women and girls, from sexual violence in quarantine facilities, e.g., adequate lighting, lockable toilets.		
				If staffing allows, ensure that contact-tracers receive training to identify SRH needs and related danger signs and provide information on referral options. Otherwise, consider using existing SRH community staff alongside contact-tracers to share information.		
				Ensure that surveillance and case-management SOPs include timely review of maternal and newborn deaths related to the infectious disease. Lessons learned and recommendations should be shared with relevant stakeholders as needed.		
				When classifying deaths of women of reproductive age, clearly capture and distinguish between infectious disease-related mortality and deaths caused by SRH-related conditions, such as maternal death (during pregnancy or within 42 days of termination of pregnancy) (WHO, 2022).		

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3. Laboratory and diagnostics	Ensure that the data management system allows recording of the status of pregnant, postnatal, or breastfeeding mothers when conducting lab examinations for all pathogens.			Revise data-management systems specific to the infectious disease outbreak to ensure recording of the status of pregnant, postnatal, or breastfeeding women when conducting lab examinations.		
	Pre-position sufficient testing supplies, and consider needs for additional testing of blood supplies, based on identified pathogen and mode of transmission.			Ensure sufficient numbers of tests are available (including additional testing for blood bank stock, as required).		
				Ensure availability of other SRH-specific testing when it is specifically related to the disease outbreak of concern, e.g., availability of pregnancy tests during Zika outbreaks.		
4. Case management	Include SRH experts in policy, decision-making, planning, and preparedness for infectious disease outbreaks.			Coordinate with SRH actors to establish and implement agreed-upon and known referral pathways for essential SRH services, in line with the MISP, including for pregnant women and girls who are considered either noninfectious or potentially infectious (i.e., who are in quarantine or are admitted for testing and initiation of treatment or considered a suspect), from community to facility or treatment center. Post visual representations of referral pathways throughout health facilities.		

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	Ensure all health staff, regardless of subsector, and particularly those responsible for infectious disease and outbreak response, complete the MISP distance learning module.			Ensure that SOPs and guidelines developed for the disease outbreak include SRH-specific protocols, in line with the MISP. These should include an algorithm in place and person responsible for emergency treatment for SRH conditions, including if someone in labor and/or experiencing complications of pregnancy and/or GBV arrives, and take into account likely testing delays, which could result in patients delivering or requiring other immediate treatment with an unknown status.		
	Ensure that all health providers are trained on GBV risks and associated health consequences and can assist disclosing survivors by offering first-line support, appropriate medical treatment, and/or referral to a service that can provide appropriate medical treatment.			Ensure that care for pregnant, laboring, and postnatal (including breastfeeding) clients is included in infectious disease isolation and treatment centers. For example, ensure a dedicated area where a full, confidential, maternal, and fetal assessment can be conducted following screening, triage, and isolation, if required. Access to contraceptives, abortion care where legal, GBV services, and treatment for HIV and STIs should be available on site or by referral, regardless of age or marital status.		
	Incorporate screening for sexual exploitation and abuse, sexual harassment, and GBV into all recruitment for health facility staff.			Ensure that ambulance drivers receive training on respectful transfer protocols for potentially infectious patients with SRH considerations.		

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	Conduct and document referral mapping for SRH conditions for different outbreak scenarios.			Ensure mapping is regularly updated, appropriate to stage of outbreak and mode of transmission, depending on the identified pathogen.		
	Provide training/mentorship for all clinical providers, especially those in outbreak response and treatment, to ensure that routine signs of pregnancy, labor, and any obstetric or reproductive health complications are identified.					
5. IPC & WASH	Strengthen standard precautions in health facilities (including SRH facilities); ensure that basic IPC measures are in place. Additionally, ensure that the facility is prepared to adapt IPC measures to different pathogen transmission modalities. This includes management of hand hygiene, PPE, prevention of needlestick injuries, respiratory hygiene, environmental cleaning, linen management, waste disposal, and cleaning of patient care equipment.			Adapt standard precautions ensuring that they are appropriate to the mode of transmission. Provide additional equipment (e.g., appropriate PPE based on pathogen) and training to SRH service providers, as needed. In cases where the mode of transmission is unknown (i.e., unknown pathogen), ensure that standard precautions are adhered to.		

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	Discuss facility layout with healthcare staff, including SRH clinical staff, to prepare for structural adaptations based on mode of transmission, e.g., inclusion of separate labor and delivery isolation rooms, or adaptation of ANC waiting area to allow for social distancing.			Ensure timely adaptation of facilities based on mode of transmission and transmission phase. Changes to patient flow and facility structure should be communicated to all staff (including SRH staff) to ensure adherence to new measures.		
	Ensure that areas that may be difficult to ventilate in health facilities (e.g., often areas providing SRH care, such as labor and delivery rooms and operating theatres) are adapted to ensure adequate ventilation systems are in place, e.g., working windows that can be opened, negative pressure ventilation systems, if available. This is particularly important in case of use of aerosol-generating procedures (e.g., maternal intubation) that may be required during CEmONC care.					
	Ensure basic IPC measures are in place for the safe disposal of placentas. Consider development of SOPs for the management of placentas based on various modes of transmission (e.g., incineration, placenta pit). If appropriate to the context, engage the community to ensure local traditions and beliefs are considered and the risk of infection is minimized (include TBA engagement here, if appropriate).			Ensure that IPC measures for management of placentas are adapted according to the mode of transmission.		

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	Basic IPC measures should be in place for the management of blood and bodily fluid spillages in health facilities, e.g., in case of post-partum hemorrhage (PPH). Review SOPs based on various modes of transmission, and ensure staff (both clinical and cleaning staff) receive training for different infectious disease scenarios (e.g., Ebola virus disease [EVD]).			Ensure relevant SOP is followed according to mode of transmission, while ensuring that staff receive refresher training and that appropriate cleaning and PPE supplies are available.		
	If blood banks are available or in use, ensure regular audits and ensure protocols are available for additional infectious disease testing if needed (e.g., EVD), while ensuring SOPs for rationale use of blood in infectious disease outbreak settings are available (considering limited blood supply).			Ensure continued safety of the blood supply, including consistent testing for the outbreak pathogen.		
6. Epidemiological and outbreak analysis	Collaborate with SRH actors to ensure strong and consistent data collection of SRH-related indicators, e.g., maternal mortality and perinatal mortality, stillbirths, newborn deaths, premature delivery, etc.			Ensure that line lists and outbreak-specific data collection systems capture key SRH information, e.g., patient pregnancy and/or breastfeeding status, routine maternal hospital admission data, and timely reporting of maternal deaths.		

Preparedness and Response Checklist for General Health/ Infectious Disease Responders Considering SRH Needs	Preparedness and Response Checklist for General Health/Infectious Disease Responders Considering SRH Needs					
	Recommended Preparedness Actions	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started	**Recommended Response Actions**	**Actions/Changes Needed: Insert what programmatic changes are needed or actions that need to take place to ensure**	**Status** ☐ Completed ☐ In progress ☐ Not started
	Ensure data collection tools for infectious diseases are designed to capture information on pregnancy, postnatal, and breastfeeding status.			Key analytical outcomes for the outbreak should include reporting on maternal infectious-disease-related adverse outcomes (e.g., maternal admission to intensive care, emergency caesarean section, abortion complications, etc.); perinatal infectious-disease-related fetal and newborn outcomes (e.g., stillbirth, newborn death, premature delivery, newborn requiring medical intervention, etc.); HIV- or STI-related information, which will allow trends to be monitored (this may be particularly relevant if the infectious disease is transmitted via bodily fluids).		
7. Logistics	Calculate PPE, diagnostic and other SRH-related medical supply needs. Procure and pre-position to ensure availability of sufficient quantities of appropriate level PPE for SRH providers and services, including CHWs, supported by additional training on correct and appropriate usage.			Work with the MoH, UNFPA, and other SRH working groups to ensure that health providers, including CHWs and TBAs (if applicable) at both primary healthcare and treatment centers have appropriate PPE, etc., to support the continuity of services, including safe delivery and emergency obstetric care.		
				Share ongoing efforts to gather, aggregate, and share data on supply and demand, whether there are supply constraints, and ensuring supplies are allocated and distributed fairly.		

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	Provide budget support for epidemic preparedness an response, ensuring SRH needs are included.			Arrange for transport and communication systems to ensure that the referral pathway is maintained for SRH patients (inclusive of complicated/ uncomplicated, infectious, potentially infectious, and noninfectious), including during lockdowns, and that lifesaving care can be provided throughout the process.		
	Prepare to adapt referral pathways, vehicles, and SOPs based on stage of outbreak and mode of transmission, e.g., ensuring appropriate PPE will be available for drivers and appropriate IPC measures will be in place.					
	Assess implementation capacity: if required, establish systems for the management of non-breastfed infants, including ensuring that breast-milk substitute (BMS) can be rapidly supplied, e.g., by establishing long-term agreements with preapproved suppliers.			In situations where there are high numbers of maternal orphans and/ or in settings where breastfeeding is not recommended for infected mothers or infants and feeding alternatives other than BMS are not feasible or recommended, ensure BMS is procured in a timely manner, if required. This should be done in strict compliance with the WHO International Code and the Operational Guidance on Infant Feeding in Emergencies (IFE Core Group, 2017).		
8. Risk Communication & Community Engagement (RCCE)	Conduct an intersectional gender analysis to identify context-specific factors, including traditional beliefs and practices, risks, and harms, to women, girls, and other underserved groups that may affect their access to and use of services and resources. The research findings and recommendations should inform the design and implementation of all activities during an outbreak.			Develop a communication and community engagement plan; identify barriers and facilitators related to the outbreak and SRH care and how to address them; include measurable objectives, key audience segments, community engagement approaches, and indicators for measuring progress.		

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	Establish relationships and buy-in from local and community leaders (formal and informal), including women and adolescent girl leaders, and, if appropriate, TBAs; ensure meaningful engagement in outbreak efforts.			Develop outbreak-specific messages and materials with community-level input (aligned with national and global guidance); pretest these with key audiences, e.g.,, pregnant women, adolescent girls, and other often marginalized populations before using them. Ensure these are developed with consideration to different local languages and dialects and different literacy levels. Consider adapting MISP IEC templates to incorporate additional information relevant to the type of infectious disease outbreak (IAWG, 2021).		
	Involve women, adolescents, people with a disability, and other marginalized populations in local IPC measures, e.g., water, sanitation, and hygiene committees and decision-making about the location, design, and management of water points and toilet facilities.			Establish a community feedback system linked with RCCE and SRH working groups; establish a system to adapt messages and materials based on shifts in perceptions and changes in the epidemiology and outbreak context.		
	Collaborate and partner with existing formal and informal social networks, e.g., women's groups, youth groups, community groups, civil society organizations, and women's rights groups, to support their preparedness as first responders and develop tailored approaches for outreach and support (e.g., help lines, digital approaches, virtual counseling), with emphasis on safety planning if the situation is likely to deteriorate. Engage these groups in the design, implementation, and accountability mechanisms of programs and approaches to outbreaks.			Ensure availability of and distribute risk communication materials relevant to SRH and the infectious disease outbreak in health facilities and the community, ensuring that a two-way communication approach is established and a community feedback system is in place. These should include information about SRH-specific considerations relevant to the outbreak, as well as where and how to access essential SRH services.		

Preparedness and Response Checklist for General Health/ Infectious Disease Responders Considering SRH Needs	Preparedness and Response Checklist for General Health/Infectious Disease Responders Considering SRH Needs					
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	Invest in, train, and support community-level workforce (CHWs, TBAs, etc.) to support facility staff and increase trust between communities and the health care system. Training should include information on how to address questions with accurate information, how to provide a response when you do not have all of the information, and empathetic approaches to addressing concerns, rumors, and stigma in an infectious disease context.			Engage audiences with messaging, dialogues, and reflection on (if applicable to SRH) the increased risk of infectious disease or severe illness and modes of transmission, e.g., sexual intercourse, vertical transmission, contact with an infected person, etc. If relevant to the scenario, advise pregnant women and girls to refrain from unnecessary travel and to avoid crowds, public contact, and contact with potentially infectious people.		
				Ensure people with diverse backgrounds, including women and adolescent girls, people with disabilities, people from different socioeconomic strata, and other often underserved populations, are given opportunities to meaningfully engage and hold leadership positions in structures and processes established for the infectious disease outbreak scenario.		

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9. Mental health and psychosocial support (MHPSS)	Strengthen all frontline workers' basic psychosocial support skills. E.g., provide psychological first aid (PFA) training, as well as training in supportive communication, considering the specific impact of infectious disease outbreaks on SRH clients' mental health (e.g., increased risk of GBV, pregnancy loss, etc.).			Ensure psychosocial support and trauma-informed care for all clients and caregivers, including GBV survivors, women who are breastfeeding during severe illness or have temporarily stopped breastfeeding (e.g., for EVD), as well as for mothers and other caregivers who are temporarily separated from their children (if necessary).		
	Ensure mapping of available MHPSS services, referral options, and points of integration, considering anticipated mental health problems in SRH patients (e.g., GBV survivors) and staff providing care (e.g., high risk of burnout and moral injury for staff providing care to SRH patients).			Ensure referral pathways are functioning, and update mapping as needed.		

ANNEX 2: ADDITIONAL TOOLS AND RESOURCES

Key Guidance		
ID General Guidance		Infectious Disease Outbreak Response: Guidance on coordination within a humanitarian context
		IRC: Risk Communications and Community Engagement
		READY: Communicating with communities in epidemics and pandemics: RCCE readiness kit
		WHO: Ebola virus disease Guinea outbreak 2021 – multi-country strategic readiness & response plan, operational guidelines
		WHO: COVID-19 strategic preparedness and response plan (2021)
		WHO Africa: Technical guidelines for integrated disease surveillance & response in the African region: Third edition
ID SRH Guidance		Maternal and Newborn Health During Infectious Disease Outbreaks: Operational Guidance for Humanitarian and Fragile Settings
		Infant feeding during infectious disease outbreaks: A guide for national health authorities, health and nutrition policymakers, professional associations and other bodies and practitioners working in outbreak preparedness and response
ID Guidance - Specific	**COVID-19**	Global Health Cluster: Essential health services: A guidance note. How to prioritise and plan essential health services during COVID-19 response in humanitarian settings
		IASC: Identifying and mitigating gender-based violence risks within the COVID- 19 response
		IAWG: MISP considerations checklist for implementation during COVID-19
		IAWG: Programmatic guidance for SRH in humanitarian and fragile settings during COVID-19 pandemic
		IAWG: Advocating for SRH in COVID-19 response
		IAWG: Toolkit for mapping of the MISP for SRH and its adaptation for preparedness and response to COVID-19 and other pandemics and major outbreaks
		RCCE collective service: https://www.rcce-collective.net/

Key Guidance		
		IRC: Risk communication and community engagement website
		IRC: COVID-19 website
		Johns Hopkins CCP: COVID-19 communication network
		Royal College of Obstetricians and Gynaecologists: Coronavirus (COVID-19) infection and pregnancy
		Royal College of Obstetricians and Gynaecologists: Coronavirus infection and abortion care*
		READY: COVID-19 RCCE toolkit for humanitarian actors
		UNFPA: COVID-19 Technical brief for maternity services
		United Nations Development Programme (UNDP): UNDP Brief: Gender-based violence and COVID-19
		WHO: Maintaining essential health services – operational guidance for the COVID-19 context, interim guidance
		WHO: Living guidance for clinical management of COVID-19
		John Hopkins: COVID-19, maternal and child health, and nutrition
		Global Nutrition Cluster: Breastfeeding and COVID-19 for healthcare workers
		Global Nutrition Cluster: Frequently asked questions – COVID-19 vaccines and breastfeeding based on WHO Sage Interim recommendations
		Save the Children: Guidance for alternative care during COVID-19
		Save the Children; Technical Rapid Response Team: Programming in the context of COVID-19: considerations for adaptations
		The Alliance for Child Protection in humanitarian action: Technical note – adaptation of child protection case management to the COVID-19 pandemic – version 3
		UNFPA: COVID-19: Working with and for young people
		UNITED Nations International Children's Emergency Fund (UNICEF): Tip sheet in engaging https://www.corecommitments.unicef.org/kp/practical-tips-on-engaging-adolescents-and-youth-in-the-covid-19-response
	Ebola	WHO: Guidelines for the management of pregnant and breastfeeding women in the context of Ebola virus disease
		Johns Hopkins CCP: Ebola communication network
		IAWG: EVD & SRH operational guidance

Key Guidance		
		IRC: Not all that bleeds is Ebola – how has the DRC Ebola outbreak impacted SRH in North Kivu?
		IRC: Blood and body fluids transmission outbreak toolkit
		WHO; Save the Children; UNICEF: A guide to the provision of safe delivery and immediate newborn care in the context of an Ebola outbreak
		Global Nutrition Cluster Technical Alliance (2020): Supporting non-breastfed children as part of an Ebola response - Experiences from the Democratic Republic of the Congo.
		WHO: IPC Guidance summary: Ebola guidance package
	Cholera	UNICEF: Cholera toolkit
		Médecins Sans Frontières: Management of a cholera epidemic – cholera and pregnancy
		IRC: Waterborne transmission toolkit
		Global task force on cholera control: Cholera outbreak response field manual
		Global task force on cholera control: Interim technical note – treatment of cholera in pregnant women
SRH - General Guidance		IAWG: Interagency field manual on reproductive health in humanitarian settings
		IAWG: Adolescent SRH toolkit for humanitarian settings: 2020 edition
		IAWG: MISP distance learning module
		IAWG: Universal & adaptable IEC templates in the MISP
		WHO: Guideline on self-care for health and wellbeing
		IAWG: Newborn health in humanitarian settings field guide
IPC Guidance		Momentum: Operational guidance: Essential supply list for infection prevention and control in health care facilities
		WHO: Infection control standard precautions in healthcare
		WHO: Your 5 moments for hand hygiene
		WHO: Transmission-based precautions - open WHO

ENDNOTES

1 Inter-Agency Working Group on Reproduction Health in Crises. (2018). *Inter-agency field manual on reproductive health in humanitarian settings*. https://iawgfieldmanual.com/manual

2 Ibid.

3 Ibid.

4 United Nations Population Fund. (2015). *State of world population 2015: Shelter from the storm, a transformative agenda for women and girls in a crisis-prone world*. https://www.unfpa.org/swop-2015

5 Wei, S.Q., Bilodeau-Bertrand, M., Liu, S., & Auger, N. (2021). The impact of COVID-19 on pregnancy outcomes: A systematic review and meta-analysis. *CMAJ, 193*(16), E540–48. https://doi.org/10.1503/cmaj.202604

6 Martins, M.M., Cunha, A.J.L.A., Robaina, J.R., Raymundo, C.E., Barbosa, A.P., Medronho, R.A. (2021). Fetal, neonatal, and infant outcomes associated with maternal Zika virus infection during pregnancy: A systematic review and meta-analysis. *PLOS ONE, 16*(2), e0246643. https://doi.org/10.1371/journal.pone.0246643

7 Kayem, N.D., Benson, C., Aye, C.Y.L., Barker, S., Tome, M., Kennedy, S., Ariana, P., & Horby, P. (2021). Ebola virus disease in pregnancy: A systematic review and meta-analysis. *Transactions of The Royal Society of Tropical Medicine and Hygiene, trab180*, 1–14. https://doi.org/10.1093/trstmh/trab180

8 Chaudhry, S.A., Verma, N., & Koren, G. (2015). Hepatitis E infection during pregnancy. *Canadian Family Physician, 61*(607–608). https://pubmed.ncbi.nlm.nih.gov/26175368/

9 Inter-Agency Working Group on Reproduction Health in Crises. (2020). Adolescent sexual and reproductive health (ASRH) toolkit for humanitarian settings: 2020 Edition. https://iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

10 Murphy, M. & Bourassa, A. (2021). *Gap analysis of gender-based violence in humanitarian settings: A global consultation*. ELRHA. https://reliefweb.int/sites/reliefweb.int/files/resources/Elrha_GapAnalysis_GBV_Accessible_PDF_2021.pdf

11 United Nations Population Fund. (2020). *Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

12 Abwola, N., & Michelis, I. (2020). What happened? *How the humanitarian response to COVID-19 failed to protect women and girls. International Rescue Committee*. https://www.rescue.org/sites/default/files/document/5281/ircwpecovidreportv7.pdf

13 Inter-Agency Working Group on Reproduction Health in Crises. (2020).

14 Roberton, T., Carter, E.D., Chou, V.B., Stegmuller, A.R., Jackson, B.D., Tam, Y., Sawadogo-Lewis, T., & Walker, N. (2020). Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: A modelling study. *The Lancet Global Health, 8*(7), e901–908. https://doi.org/10.1016/S2214-109X(20)30229-1

15 Center for Disease Control and Prevention. (2022). *Strategies to mitigate healthcare personnel staffing shortages*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

16 Royal College of Midwives. (2020, September 30). *Leading royal colleges urge the NHS to learn lessons and avoid redeploying maternity staff ahead of second wave*. Rcm.org.uk. https://www.rcm.org.uk/media-releases/2020/september/leading-royal-colleges-urge-the-nhs-to-learn-lessons-and-avoid-redeploying-maternity-staff-ahead-of-second-wave/

17 Delamou, A., El Ayadi, A.M., Sidibe, S., et al. (2017). Effect of Ebola virus disease on maternal and child health services in Guinea: a retrospective observational cohort study. *The Lancet Global health*, 5(4), 448–e457. https://doi.org/10.1016/S2214-109X(17)30078-5

18 Luginaah, I.N., Kangmennaang, J., Fallah, M., Dahn, B., Kateh, F. and Nyenswah, T. (1982). Timing and utilization of antenatal care services in Liberia: understanding the pre-Ebola epidemic context. *Social science & medicine*, 160, 75–86. https://doi.org/10.1016/j.socscimed.2016.05.019

19 Lori, J.R., Rominski, S.D., et al. (2015). A case series study on the effect of Ebola on facility-based deliveries in rural Liberia. *BMC Pregnancy and Childbirth*, 15(1). https://doi.org/10.1186/s12884-015-0694-x

20 Ly, J., Sathananthan, V., et al. (2016). Facility-based delivery during the Ebola virus disease epidemic in rural Liberia: analysis from a cross-sectional, population-based household survey. *PLoS medicine*, 13(8). https://doi.org/10.1371/journal.pmed.1002096

21 Leno, N., Delamou, A., et al. (2018). Ebola virus disease outbreak in Guinea: what effects on prevention of mother-to-child transmission of HIV services? *Reproductive Health*, 15(1), 60. https://doi.org/10.1186/s12978-018-0502-y

22 Hyjazi, Y., Aribot, J., Waxman, R., Pleah, T., & Dao, B. (2015). The impact of the Ebola virus epidemic on reproductive and maternal health care services in Guinea. *International Journal of Gynecology & Obstetrics*, 131(5), E156–E1E7.

23 Brolin Ribacke, K.J., van Duinen, A.J., et al. (2016). The impact of the West Africa Ebola outbreak on obstetric health care in Sierra Leone. *PLoS One*, 11(2). https://doi.org/10.1371/journal.pone.0150080

24 McKay, G., Black, B., Mbambu Kahamba, S., Wheeler, E., Mearns, S., & Janvrin, A. (2019). *Not all that bleeds is Ebola: How has the DRC Ebola outbreak impacted sexual and reproductive health in North-Kivu?* The International Rescue Committee. https://www.rescue.org/sites/default/files/document/4416/srhebolareport1172020.pdf

25 Mukherjee, T.I., Khan, A.G., Dasgupta, A., & Samari, G. (2021). Reproductive justice in the time of COVID-19: A systematic review of the indirect impacts of COVID-19 on sexual and reproductive health. *Reproductive Health, 18*, 252. https://doi.org/10.1186/s12978-021-01286-6

26 Catterson, K. (2020). *The effects of COVID-19 on sexual and reproductive health: A case study of six countries*. Global COVID-19 Situation Analysis Project, USAID. https://reliefweb.int/sites/reliefweb.int/files/resources/9%20The%20effects%20of%20COVID-19%20on%20Sexual%20and%20Reproductive%20Health.pdf

27 Janvrin, A., & McKay, G. (2020). *Maternal, newborn, and reproductive health and COVID-19: Adaptations, successes, challenges, and next steps. An expert consultation*. READY Initiative. https://www.ready-initiative.org/wp-content/uploads/2020/12/MNRH-and-COVID-19-Consultation-Report-2020.pdf

28 Rao, S. P. N., et al. (2021). Small and sick newborn care during the COVID-19 pandemic: Global survey and thematic analysis of healthcare providers' voices and experiences. *BMJ Global Health 6*(3), e004347. https://doi.org/10.1136/bmjgh-2020-004347

29 World Health Organization. (2007). *Addressing sex and gender in epidemic-prone infectious diseases*. https://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf

30 Tran, N.T., Greer, A., Kini, B., Abdi, H., Rajeh, K., Cortier, H. & Boboeva, M. (2020). Integrating sexual and reproductive health into health system strengthening in humanitarian settings: A planning workshop toolkit to transition from minimum to comprehensive services in the Democratic Republic of Congo, Bangladesh, and Yemen. *Conflict and Health, 14*(1), 1–12. https://doi.org/10.1186/s13031-020-00326-5

31 Fisher, D.A., & Carson, G. (2020). Back to basics: The outbreak response pillars. *The Lancet, 396*(10251), 598. https://doi.org/10.1016/S0140-6736(20)31760-8

32 Ibid.

33 McKay, et al. (2019).

34 Miller, S., & Lalonde, A. (2015). The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother–baby friendly birthing facilities initiative. *International Journal of Gynecology & Obstetrics, 131*(October), S49–52. https://doi.org/10.1016/j.ijgo.2015.02.005

35 Asefa, A., Semaan, A., Delvaux, T., Huysmans, E., Galle, A., Sacks, E., Bohren, M.A., Morgan, A., Sadler, M., Vedam, S. & Benova, L. (2021). The impact of COVID-19 on the provision of respectful maternity care: Findings from a global survey of health workers. *Women and Birth*, September, 1–9. https://doi.org/10.1016/j.wombi.2021.09.003

36 IFE Core Group. (2021). *Infant feeding during infectious disease outbreaks*. https://www.ennonline.net/attachments/4237/Infant-feeding-during-infectious-disease-outbreaks-a-guide-for-policy-makers-(ENGLISH).pdf

37 White Ribbon Alliance. (n.d.). Respectful maternity care charter: The universal rights of women and newborns. https://www.whiteribbonalliance.org/respectful-maternity-care-charter/

38 Wadhwa, P.D., Entringer, S., Buss, C., & Lu, M.C. (2011). The contribution of maternal stress to preterm birth: Issues and considerations. *Clinics in Perinatology, 38*, 351–384. https://doi.org/10.1016/j.clp.2011.06.007

39 Vianna, P., Bauer, M.E., Dornfeld, D., & Chies, J.A. (2011). Distress conditions during pregnancy may lead to pre-eclampsia by increasing cortisol levels and altering lymphocyte sensitivity to glucocorticoids. *Medical Hypotheses, 77*, 188–191. https://doi.org/10.1016/j.mehy.2011.04.007

40 Warwick Medical School. (n.d.) About WEMWBS. https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/; Child Outcomes Research Consortium. (n.d.). *The World Health Organization-five well-being index (WHO-5)*. https://www.corc.uk.net/outcome-experience-measures/the-world-health-organisation-five-well-being-index-who-5/

41 Catterson. (2020).

42 International Rescue Committee. (2020, February 3). *Not all that bleeds is Ebola – How the DRC outbreak impacts reproductive health*. Rescue.org. https://www.rescue.org/report/not-all-bleeds-ebola-how-drc-outbreak-impacts-reproductive-health

43 McKay, et al. (2019).

44 Inter-Agency Working Group on Reproduction Health in Crises. (2020). *MISP considerations checklist for implementation during COVID-19*. https://iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19

45 World Health Organization. (1981). *International code of marketing of breast-milk substitutes*. https://apps.who.int/nutrition/netcode/resolutions/en/index.html

46 World Health Organization. (2020). The international code of marketing of breast-milk substitutes: Frequently asked questions on the roles and responsibilities of health workers. https://www.who.int/publications/i/item/9789240005990

47 IFE Core Group. (2017). *Operational guidance on infant feeding in emergencies (OG-IFE) version 3.0*. https://www.ennonline.net/operationalguidance-v3-2017

48 Hale, C., (1995). Clinical case management: case management and managed care. *Nursing Standard, 9*(19), 33-35. https://doi.org/10.7748/ns.9.19.33.s48

49 World Health Organization. (2020). *Community engagement: A health promotion guide for universal health coverage in the hands of the people*. https://www.who.int/publications/i/item/9789240010529

50 Coggon, D., Rose, G., & Barker, D.J.P. (2003). *Epidemiology for the uninitiated*. BMJ.

51 World Health Organization. (2021). *About infection prevention and control*. https://www.who.int/teams/integrated-health-services/infection-prevention-control/about

52 World Health Organization DoRHaR (2003). *Kangaroo mother care: a practical guide*. WHO Library. Geneva: https://www.who.int/publications/i/item/9241590351

53 Rabold, E., & Waggoner, J. (2020). *Rapid diagnostic tests for infectious diseases*. Center for Disease Control and Prevention. https://wwwnc.cdc.gov/travel/yellowbook/2020/posttravel-evaluation/rapid-diagnostic-tests-for-infectious-diseases

54 Center for Disease Control and Prevention. (2019). Rapid diagnostic tests for infectious diseases.

55 Inter-Agency Working Group on Reproduction Health in Crises. (2018).

56 Khan, H.A., Baig, F.K., & Mehboob, R. (2017). Nosocomial infections: Epidemiology, prevention, control and surveillance. *Asian Pacific Journal of Tropical Biomedicine, 7*(5), 478–82. https://doi.org/10.1016/j.apjtb.2017.01.019

57 United Nations Office for the Coordination of Humanitarian Affairs. (2021). *What is preparedness?* Humanitarianresponse.info https://www.humanitarianresponse.info/en/coordination/preparedness/what-preparedness

58 Townes, D., Gerber, M., & Anderson, M. (Eds.). (2018). Health in humanitarian emergencies: *Principles and practice for public health and healthcare practitioners*. Cambridge University Press.

59 Ibid.

60 World Health Organization. (2021). *Risk communications*. https://www.who.int/emergencies/risk-communications

61 Starrs, A.M., et al. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *Lancet, 391*(10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9

62 World Health Organization. (2021). *Surveillance in emergencies*. https://www.who.int/emergencies/surveillance

63 Rabold & Waggoner (2020).


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