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Editorial

MISP for sexual and reproductive health to prevent transmission of HIV/STIs during humanitarian crisis

Shehla Shaukat, Amina Afzal, Mahwish Zahoor, Maryam Rafat, Ijaz Hussain

Department of Dermatology, Mayo Hospital, Lahore.

The World Health Organization (WHO) defines health emergencies as sudden-onset events from naturally occurring or man-made hazards, or gradually deteriorating situations through which the risk to public health steadily increases over time. Recently conflicts, violence and disasters have dramatically increased the number of displaced people, both internal and across national borders.[1]

Sexual and reproductive health (SRH) services in humanitarian emergencies remain a critical priority when a great number of people become displaced. Ensuring access to the SRH services must be included in all types of emergency response efforts.[2]

Awareness of SRH needs in emergencies began in the mid-1990s and led to the formation of the Inter-Agency Working Group (IAWG) for reproductive health (RH). Subsequently, the Minimum Initial Service Package (MISP), a set of guidelines for RH service delivery in crisis settings, was created.[3-5]

MISP for RH is a coordinated set of priority activities designed to: prevent and manage the consequences of sexual violence; prevent excess maternal and newborn morbidity and mortality; reduce human immunodeficiency virus (HIV) transmission; and plan for comprehensive RH services.[6,7] The goal of the MISP is to reduce mortality, morbidity and disability, particularly among women and girls in populations affected by crises, including internally displaced persons (IDPs), refugees and those affected but not displaced.

Displaced populations in humanitarian crisis situations are especially vulnerable to sexually transmitted infections (STIs). STIs incidence increases under crisis conditions where access to means of prevention, treatment and care are limited. STIs spread quickly when there is poverty, lawlessness and instability. Efforts to prevent new infections are required in this environment.[8,9]

Risk for the spread of STIs and HIV in displacement settings is multifactorial including environmental changes like food insecurity, psychosocial instability and disrupted social structure. Emotional changes observed in crisis situation are depression, low self-esteem, post-traumatic stress and excessive drug and alcohol use. Other factors include disruption of support networks leading to domestic violence, gender-based violence (GBV), rape and child abuse. All these factors increase the incidence of high-risk sex which includes unprotected sex, multiple partners and sex work with limited or no access to condoms causing spread of STIs and HIV.

STIs and HIV transmission among displaced populations is complex. The main transmission

Address for correspondence
Dr. Shehla Shaukat
Department of Dermatology Unit I,
Mayo Hospital, Lahore.
Email: shehla786@hotmail.com

routes of HIV are through unprotected sex, infected blood and mother-to-child transmission (PMTCT).[10]

Preventing transmission of HIV and STIs

Reducing transmission of HIV and meeting the needs of individuals with an STI is Objective 3 of the MISP. The MISP outlines a number of activities to meet this objective:

- Safe and rational blood transfusion
- Adherence to standard precautions
- Making free condoms available and accessible to the entire sexually active population, including adolescents
- Antiretrovirals (ARVs) for continuing users
- Prevention of mother to child transmission (PMTCT)
- Syndromic approach to STIs

1. ***Safe and rational blood transfusion*** Improperly screened or unscreened blood and the incorrect use of blood and blood products increase the risk of HIV/STIs to recipients. Blood transfusions must undertake only if there is availability of proper facility, adequate supplies and qualified staff.[11]

2. ***Infection control*** Ensure all staff in health care settings understands standard precautions. Standard precautions are:

    - Frequent hand washing, wearing gloves and protective clothing, safe handling of sharp objects, disposal of waste materials, using single-dose vials rather than multi-dose vials and instrument processing (decontaminate instruments to kill viruses and make items safer to handle, clean instruments before sterilization or high-level disinfection (HLD) to remove debris, sterilize instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. Use or properly store items immediately after sterilization. Clean up spills of blood or other body fluids promptly and carefully. Despite putting standard precautions in place and adhering to them, occupational exposure to HIV may occur. For these ensure post-exposure prophylaxis (PEP) is available for reducing staff exposure to infectious hazards at work. Maintain confidentiality, counsel the person regarding HIV testing and conduct an HIV test if consent is obtained. Assess the risk of HIV transmission in case of occupational exposure. An HIV test is not required before prescribing PEP and no one should be forcibly tested.[11]

3. ***Make free condoms available*** Condoms are a key method of protection for the prevention of HIV and other STIs. Although not everyone is knowledgeable about them, condoms should be available in accessible, private areas from the earliest days of an emergency so that anyone who is familiar with them, both the affected populations and humanitarian staff, has access. Sufficient supplies should be available immediately.[11]

4. Continue provision of antiretroviral drugs without interruption for people who were enrolled in antiretroviral therapy (ART) programme before the onset of the crisis.

5. ***Provide prophylaxis to PMTCT of HIV*** Mother should be provided with life-long ART or ARV prophylaxis through pregnancy and breastfeeding. A single dose treatment at the onset of labor is the least that can be done. Prophylaxis for the baby is given where the supply of ARV drugs is insufficient to treat the mother.

Method	
History	Ask about STI/RTI symptoms at each Family Planning or Antenatal Care visit
Clinical screening	When doing speculum & bimanual: look for signs of STI/RTI
Lab screening	Voluntary counselling and testing (VCT) Serological screening for syphilis Cervical cancer screening
Presumptive treatment on basis of risk factors	Treatment of partners of STI cases Sex workers Survivors of sexual violence Treatment of women before transcervical procedure
Combination strategies	Presumptive treatment of sex workers at first clinic visit followed by regular visits for speculum/bimanual examination and Gram stain of cervical smear

6. ***Syndromic approach to STIs*** There is a strong connection between STIs and HIV. STIs increase the chance of acquiring HIV and vice versa. Diagnosing STIs is critical as inability to do so leads to complications like infertility, miscarriage, pre-term delivery, stillbirth, ectopic pregnancy, ano-genital cancer, premature death, neonatal and infant infections. STIs are diagnosed clinically and with laboratory tests. Kits are available to screen for STIs in case of blood transfusions or when there is clinical suspicion of STIs and HIV. In case of syndromic approach only clinical diagnosis is required. The coordination team in disaster struck areas should be trained about the algorithms for syndromic approach. Common syndromes include genital ulcers, urethral or vaginal discharge, inguinal buboes, anal and scrotal symptoms.

Comprehensive STI prevention and treatment services, including STI surveillance systems should be established. All the patients should be assessed for the presence of an STI or HIV through following steps.

Pakistan as a country has dealt with natural as well as man made disasters like Soviet-Afghan war, earthquakes, military actions in Swat and FATA with millions of IDPs.[12] The National Disaster Management Authority (NDMA) is the lead agency at the federal level to deal with the whole spectrum of disaster management activities in Pakistan. Capacity building to implement the MISP for SRH in humanitarian crisis in Pakistan was started in 2013. The MISP activities are implemented at the onset of an emergency in a coordinated manner by trained staff. Trainings were done at various levels targeting mainly service providers, emergency responders and more recently policy-makers. To date, a total of almost 600 people/government officials have been trained.[13]

There is an urgent need to inculcate the training for MISP for RH in public and private health sector to remain prepared in cases of emergencies. The training would provide national level trainers and resource persons who could advocate for RH in emergencies, apply core techniques and coordination skills for the implementation of MISP and develop an action plan to integrate RH and GBV into disaster management plans of respective agencies.

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