ABSTRACT

Background: Floods and subsequent landslides in May 2017 caused considerable loss of lives and massive physical and infrastructural damages in several districts of Sri Lanka. Neluwa MOH area of Galle district and Kotapola MOH area of Matara district were among the worst affected. Displaced people of these two MOH areas were accommodated in temporary shelters. Considerable numbers of reproductive age women were displaced thus creating the necessity for provision of sexual and reproductive health services in temporary shelters. Therefore this study was designed with the aim of finding to which extent these services were provided to displaced women at the shelters and their satisfaction on receiving those services.

Objective: To assess the provision and satisfaction regarding sexual and reproductive health services to disaster affected women of reproductive age at temporary shelters in Neluwa and Kotapola MOH areas during floods and landslides of 2017.

Methodology: A community based cross sectional descriptive study was designed. All reproductive age women at temporary shelters in Neluwa MOH and Kotapola MOH areas were included. Out of 109 reproductive age women 101 participated in the study. An interviewer administered questionnaire was prepared to assess all the key aspects of sexual and reproductive health provision highlighted in Minimal Initial Service Package (MISP). Service satisfaction was also assessed. Service gaps were identified by using a check list in MISP, Registers and minutes on temporary shelter activities at MOH offices and Disaster Preparedness and Response Division at Ministry of Health. Frequencies and percentages were used to analyze the service provision and satisfaction. Ethical clearance was obtained from the ethical review committee of National Hospital of Sri Lanka.

Results: Adherence to key components of MISP during service provision was surveyed in the study. Respondents have identified a manager of the shelter (92, 91. 1%). Grama Sewa Niladari was identified as the manager (n=70, 76.1%) whereas Public Health Midwife was identified as reproductive health officer (49, 48.5%). All pregnant women received the services of a medical officer during their stay while majority of infants were examined either by a medical officer or a PHM (11, 84.6%). Sufficient number of separate latrines

and water for sanitation were available at the shelters (n=49, 48.5%). Majority of women received sanitary towels (89, 88.1%).

High satisfaction was recorded regarding the helpfulness of services (54, 53.5%) and service delivery by health staff (57, 56.4%). Majority of women were highly satisfied with the respect received for their rights as a woman (60, 59.4%). Low satisfaction was recorded regarding the delay in initiating SRH services from the onset of the disaster (55, 54.5%).

Absence of instructions and guidance regarding where to seek help in case of sexual violence is a key service gap identified (94, 93.1%). An emergency vehicle to refer pregnant mothers to the closest hospital was not present at the shelters (4, 80%). There was no doctor to attend for sexually transmitted diseases (64, 63.4%). Standard precautions such as wearing gloves and masks were not practiced (64, 63.5%). Despite being prohibited lactating mothers were supplied with infant formula milk (12, 92.3%). No private space was available at the shelter for breast feeding as well (9, 69.2%). Majority of contraceptive users confirmed that existing family planning methods were interrupted during their stay at the shelter (37, 57.8%). Health education materials regarding sexual and reproductive health were also unavailable at shelters (93, 92.1%).

Conclusion: Some components of MISP have been followed while delivering sexual and reproductive health services to women. There was coordination on reproductive health issues and measures have been taken to prevent maternal and infant morbidity and mortality despite some lapses. Provision of menstrual protection material to displaced women has also been achieved. Nevertheless, there were significant lapses in prevention and management of consequences of sexual violence. Services to reduce transmission of sexually transmitted diseases were also not adequate. There were deficiencies in adherence to standard precautions in handling patients at shelter site. Contraceptive methods were not provided at site thus interruption of family planning services were recorded. Although service satisfaction was high, steps must be taken to provide SRH services from the onset of disaster to further increase service satisfaction. Therefore, it is essential to address these service gaps in future and consider reproductive and sexual health service delivery as a priority in disaster relief.