



Minimum Initial Service Package (MISP)
for Reproductive Health in Crisis Situations:



A Distance Learning Module



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The Women's Refugee Commission advocates for laws, policies and programs to improve the lives and protect the rights of refugee and internally displaced women, children and young people, including those seeking asylum—bringing about lasting, measurable change. Through research and fact-finding field missions, the Women's Refugee Commission identifies critical problems that affect displaced women, children and young people, including gaps in life-saving reproductive health care, lack of dignified livelihoods for refugees and, in the U.S., the treatment of asylum-seekers. We document best practices, and propose solutions and develop innovative tools to improve the way humanitarian assistance is delivered in crisis-affected or humanitarian settings. On Capitol Hill, at the United Nations (UN) and with humanitarian organizations, governments and donors, we push for improvements in refugee policy and practice until measurable long-term change is realized.

The Women's Refugee Commission was founded in 1989 under the auspices of the International Rescue Committee (IRC). The organization is legally part of the IRC but receives no funding or direction from them.

The original 2007 MISP distance learning module was principally developed by Julia Matthews, formerly of the Women's Refugee Commission, Sandra Krause of the Women's Refugee Commission and Sarah Chynoweth of the International Planned Parenthood Foundation (IPPF); Diana Quick of the Women's Refugee Commission provided project and editorial oversight.

The current MISP module is based on the *Inter-agency Working Group (IAWG) on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review, Chapter 2: Minimum Initial Service Package (MISP)*. This version of the MISP distance learning module was revised by Sandra Krause and Sarah Chynoweth, and edited by Diana Quick. Many thanks to the following IAWG colleagues for their contributions to the 2011 revision of the MISP Distance Learning Module: Ribka Amsalu, Wilma Doedens, Brad Kerner, Cecile Mazzacurati, Chen Reis, Marian Schilperoord and Mihoko Tanabe.

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Acronym List

AIDS	Acquired Immunodeficiency Syndrome	MISP	Minimum Initial Service Package (for Reproductive Health)
AMPATH	Academic Model for the Prevention and Treatment of HIV	MoH	Ministry of Health
AoR	Area of responsibility	MoU	Memorandum of Understanding
ARHA	Australian Reproductive Health Alliance	NGO	Nongovernmental organization
BPRM	Bureau for Population, Refugees and Migration	OFDA	Office of Foreign Disaster Assistance
CAP	Consolidated Appeals Process	PAHO	Pan American Health Organization
CBR	Crude birth rate	PEP	Post-exposure prophylaxis
CDC	Centers for Disease Control and Prevention	PHC	Primary health care
CERF	Central Emergency Response Fund	PCWG	Protection cluster working group
CIVPOL	Civilian police	PMTCT	Prevention of mother-to-child transmission (of HIV)
CoC	Code of conduct	RH	Reproductive health
CHAP	Common Humanitarian Action Plan	RHRC	Reproductive Health Response in Crises (Consortium)
DHS	Demographic Health Survey	SOP	Standard operating procedure
ESEAOR	East South-East Asia and Pacific Region	SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
EC	Emergency contraception	STI	Sexually transmitted infection
ECHO	Humanitarian Aid Office of the European Commission	TBA	Traditional birth attendant
EmOC	Emergency obstetric care	TP	Training Partnership (IAWG Initiative)
GBV	Gender-based violence	UN	United Nations
HIS	Health Information System	UNAIDS	Joint United Nations Program on HIV/AIDS
HIV	Human Immunodeficiency Virus	UNFPA	United Nations Population Fund
HLD	High level disinfection	UNHCR	United Nations High Commissioner for Refugees
HRB	Humanitarian Response Branch	UNICEF	United Nations Children's Fund
IASC	Inter-Agency Standing Committee	UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
IAWG	Inter-agency Working Group (on Reproductive Health in Crises)	UNSW	University of New South Wales
ICRC	International Committee of the Red Cross	VCT	Voluntary counseling and testing (for HIV)
IEC	Information, education and communication	WG	Working group
IEHK	Interagency Emergency Health Kit	WHO	World Health Organization
IFRC	International Federation of the Red Cross and Red Crescent Societies	WRA	Women of reproductive age
IUD	Intrauterine devices		
MSF	Médecins Sans Frontières		

About the MISP Distance Learning Module

The Minimum Initial Service Package (MISP) for reproductive health (RH) is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; and plan for comprehensive RH services. Additional priority activities of the MISP include making contraceptives available to meet demand, syndromic treatment for sexually transmitted infections (STIs) and ensuring antiretrovirals (ARVs) for continuing users. The MISP distance learning module aims to increase humanitarian actors' knowledge of these priority RH services to initiate at the onset of a crisis and to scale up for equitable coverage throughout protracted crises and recovery, while planning for comprehensive RH services and implementing them as soon as possible.

The MISP was first articulated in 1996 in the field-test version of *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*,¹ a resource developed by the IAWG on Reproductive Health in Crises. The MISP was then updated and revised in the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review (Field Manual)*. Founded in 1995 and formerly known as the IAWG on Reproductive Health in Refugee Situations, the IAWG seeks to advance the RH of women, men and adolescents in humanitarian settings. IAWG is currently led by a steering committee of 12 agencies that includes representatives of UN agencies, national and international non-governmental organizations (NGOs) and academic organizations. It has more than 800 members on its listserv. Unless a specific reference is given, the information provided in the MISP module is based on the IAWG's 2010 *Field Manual*, which provides specific guidelines on how to address the RH needs of displaced populations from the initial emergency through to reconstruction and development.

The MISP is a standard in the *Sphere Minimum Standards in Disaster Response*² and is integrated into the Inter-agency Standing Committee (IASC) Health Cluster tools and guidance.³

Who is the MISP Module designed for?

The module incorporates a multi-sectoral set of activities to be implemented by humanitarian workers operating in health, camp design and management, community services, protection and other sectors. The MISP module is particularly useful for members of emergency response teams and other humanitarian first responders in crisis settings as it focuses on populations displaced by crises, such as armed conflict and natural disasters. Although the MISP module is most relevant to those working in emergency settings, it can also be referenced when scaling up services to ensure equitable coverage in protracted crises and recovery.

How long will it take me to complete the MISP Module?

Approximately 4 hours.

¹ Inter-agency Working Group on Reproductive Health in Crises, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, 1999. Available from http://iawg.net/resources/iawg_Field%20Manual_1999.pdf.

² The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. Available from www.sphereproject.org.

³ An example is: World Health Organization, *Health Cluster Guide*, June 2009. Available from http://www.who.int/hac/global_health_cluster/en/.

THE OBJECTIVE

OF THE MISP MODULE IS FOR READERS TO:

- ➊ Define and understand each component of the MISP;
- ➋ Grasp the importance of implementing the MISP in humanitarian settings;
- ➌ Understand the importance of addressing RH as a core part of overall health response and health sector/cluster coordination;
- ➍ Understand the role and functions of the RH lead agency/officer within the health sector/cluster;
- ➎ Be able to provide information on how to order MISP supplies internationally or obtain them locally;
- ➏ Know the most important things for the health sector/cluster to do in a humanitarian crisis to prevent and respond to sexual violence;
- ➐ Know the priority interventions for reducing HIV transmission in the earliest phase of crisis situations;
- ➑ Understand the best ways to reduce maternal and newborn death and disability at the onset of an emergency;
- ➒ Be able to plan for comprehensive RH programming services integrated into primary health care (PHC) as the situation permits; and
- ➓ Ensure contraceptives are available to meet demand; that syndromic treatment of sexually transmitted infections (STIs) is available to patients presenting with symptoms; and that antiretrovirals (ARVs) are available to continue treatment for people already on ARVs. In addition, the MISP will ensure that culturally appropriate menstrual protection materials are distributed to women and girls.


How do I use the MISP Module?

The module is a self-instructional learning module. It should initially be read in order of chapters and can later be used as a reference. The user reads through each chapter and completes the chapter quizzes, and takes the final quiz. The online version of the module is interactive and also includes quizzes and links to additional web-based resources from the IAWG website.⁴

In what format and languages is the MISP Module available?

The module is available online on the Inter-agency Working Group (IAWG) on Reproductive Health in Crises website at www.iawg.net, the Women's Refugee Commission's website at www.womensrefugeecommission.org and the Reproductive Health Response in Crises (RHRC) Consortium website at www.rhrc.org. The dedicated website is <http://misp.rhrc.org>.

⁴ Inter-agency Working Group on Reproductive Health in Crises website is available from <http://www.iawg.net>.



Disclaimer: Please note that the MISP distance learning module can be completed free of charge. There is no guarantee of employment with any humanitarian agency upon completion of the MISP module.

Print copies can be ordered by emailing info@wrcommission.org or info@iawg.net. The 2011 module is available in Arabic, French and Spanish.

Are there ways to provide feedback for improving or asking questions about the MISP Module?

Yes, send an email to info@wrcommission.org.

Is there a way to certify that I've completed the MISP Module?

Yes, once you have completed the post-test online with 80 percent correct answers, you will automatically receive a certificate of completion that you can print out directly.

Introduction

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a set of priority activities to be implemented from the onset of a humanitarian crisis (conflict or natural disaster), and further scaled up and sustained to ensure equitable coverage throughout protracted crisis and recovery⁵ while planning is undertaken to implement comprehensive RH as soon as possible. RH problems are a leading cause of women's death and ill-health globally.⁶ The priority RH services contained within the MISP are essential services because all people, including people affected by humanitarian emergencies, have a fundamental human right to RH. To exercise their right, displaced communities need to be informed about RH and the availability of MISP services.

Good quality MISP services must be based on the needs of the population and abide by human rights and humanitarian standards with respect for the religious, ethnic and cultural backgrounds of the affected communities. When implemented in a crisis, the MISP saves lives and prevents illness, especially among women and girls. Neglecting RH in emergencies has serious consequences: preventable maternal and infant deaths; sexual violence; unwanted pregnancies and unsafe abortions; and the spread of HIV and other STIs.

The MISP is a standard for humanitarian actors. It outlines which RH components are most important in preventing death and disability—particularly among women and girls—in emergency settings while also building the foundation for the comprehensive RH services that should be initiated as soon as the situation stabilizes and all components of the MISP have been implemented and can be sustained.

Assessments undertaken by the Women's Refugee Commission in 2003, 2004 and 2005⁷ showed that the MISP was often overlooked during emergencies and few humanitarian workers were familiar with its activities and objectives. Since then, progress has been made in advancing awareness of the MISP. However, assessments in 2007 and 2010 demonstrated that while many more humanitarian actors, donors and others are increasingly aware of the priority RH services of the MISP that should be implemented in every emergency setting, the services are not yet systemically available or adequately sustained. In many settings, the minimum services in the MISP are not available prior to the humanitarian crisis, which raises implementation challenges. Beneficiaries are often unaware of the benefits of seeking these services.

A 2008 MISP assessment in Kenya following the post-election crisis in December 2007 showed that, compared to previous assessments undertaken by the Women's Refugee Commission, there was more, albeit limited, awareness among humanitarian practitioners about the MISP. Lack of RH coordination, however, was a glaring gap in the response. An inter-agency assessment of the MISP following the January 12, 2010 earthquake in Haiti demonstrated a possible "tipping point" in recognition of the MISP in greatly increased efforts by donors, humanitarian responders and others to address the MISP at the onset of a crisis. Overall, the assessment team found an unprecedented awareness of the MISP among international organizations about the need for priority RH services and stronger efforts to address them in Haiti—more so than any previous emergency assessed by


⁵ World Health Organization, *Sexual and Reproductive Health During Protracted Crises and Recovery: Report on an expert consultation held in Granada, Spain 28-30 September, 2009* Preliminary Publication, 2010.

Granada Consensus available from http://www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf.

⁶ World Health Organization, *Women's health, Fact sheet N°334*, November 2009. Last accessed March 12, 2011.

Accessible from <http://www.who.int/mediacentre/factsheets/fs334/en/index.html>.

⁷ Women's Refugee Commission, *Still in Need: Reproductive Health Care for Afghan Refugees in Pakistan*, October 2003; Marie Stopes International and Women's Refugee Commission on behalf of the RHRC Consortium, *Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Person*, February 2003; Women's Refugee Commission and United Nations Population Fund, *Lifesaving Reproductive Health Care: Ignored and Neglected, Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad*, August 2004; Inter-agency Working Group on Reproductive Health in Crises, *Reproductive Health Services for Refugees and Internally Displaced Persons: Report of an Inter-agency Global Evaluation*, 2004; Women's Refugee Commission, *Reproductive Health Priorities in an Emergency: Assessment of the Minimum Initial Service Package in Tsunami-affected Areas in Indonesia*, February, 2005. All reports available from <http://www.womensrefugeecommission.org/reports>.



the Women's Refugee Commission. The efforts to address the MISP were further reflected in funding appeals, with one-third of appeals addressing the MISP specifically or broader RH. Four months post-earthquake, however, the quality of RH coordination appeared to be lagging at the national level, due to rapid turnover of staff. In addition, coordination of RH was slow to start at the sub-national level and beneficiaries were unaware of the benefits of seeking medical services for rape survivors.⁸

Providing a new commitment and framework for action for RH in protracted crises and recovery, the Granada Consensus was agreed through an inter-agency consultation convened by the United Nations Population Fund (UNFPA), World Health Organization (WHO) and the Andalusian School of Public Health in September 2009. A key component of the Granada Consensus is scaling up equitable coverage of the MISP and sustaining these services in protracted crisis and recovery, while integrating comprehensive RH services through health systems strengthening.⁹

The Women's Refugee Commission has developed the *MISP for Reproductive Health in Crisis Situations: A Distance Learning Module* primarily for humanitarian workers to raise awareness about and provide guidance on addressing RH in crisis situations.

⁸ Women's Refugee Commission, *Four Months On: A Snapshot of Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment conducted by CRE, International Planned Parenthood Federation, Save the Children and the Women's Refugee Commission May 17-21, 2010*, October 2010. Available from http://www.rhrc.org/resources/haiti_interagency_assessment_05_2010_final.pdf.

⁹ World Health Organization, *Sexual and Reproductive Health During Protracted Crises and Recovery: Report on an expert consultation held in Granada, Spain 28-30 September, 2009* Preliminary Publication, 2010.

Chapter I

The Minimum Initial Service Package (MISP) for Reproductive Health

What is the MISP?

The Minimum Initial Service Package (MISP) for Reproductive Health (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 HIV transmission; and plan for comprehensive RH services beginning in the early days and weeks of an emergency. See “About the Distance Learning Module” on page 3 for further information.

This set of activities must be implemented at the onset of an emergency in a coordinated manner by trained staff. The MISP can be implemented without an in-depth RH needs assessment because documented evidence already justifies its use. The MISP is a standard in the 2011 revision of the Sphere *Minimum Standards in Disaster Response* as well as in Inter-agency Standing Committee (IASC) Health Cluster tools and guidance.¹⁰ The MISP also meets the life-saving criteria for the Central Emergency Response Fund (CERF).¹¹ The components of the MISP form a minimum requirement and it is expected that scale-up and an expansion to comprehensive RH services will occur as soon as the situation stabilizes.

¹⁰ The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. Available from <http://www.sphereproject.org>. Inter-agency Standing Committee, *Health Cluster Guide: A practical guide for country-level implementation of the Health Cluster*, June 2009. Available from http://www.who.int/hac/network/global_health_cluster/guide. Inter-agency Standing Committee, *Health Resources Availability Mapping System (HeRAMS)*, 2009. Available from http://www.iawg.net/resources/Graph_RAM5_5aug09.pdf.

¹¹ Central Emergency Response Fund, CERF Lifesaving Criteria and Sectoral Activities, 2010. Available from <http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1163693>.

GOAL

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.

OBJECTIVES AND ACTIVITIES

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:
 - ❶ Nominates an RH Officer to provide technical and operational support to all agencies providing health services;
 - ❷ Hosts regular stakeholder meetings to facilitate implementation of the MISP;
 - ❸ Reports back to the health sector/cluster meetings on any issues related to MISP implementation; and
 - ❹ Shares information about the availability of RH resources and supplies.
2. Prevent and manage the consequences of sexual violence by:
 - ❶ Putting in place measures to protect affected populations, particularly women and girls, from sexual violence;
 - ❷ Making clinical care available for survivors of rape; and
 - ❸ Ensuring the community is aware of the available clinical services.
3. Reduce HIV transmission by:
 - ❶ Ensuring safe blood transfusion practice;
 - ❷ Facilitating and enforcing respect for standard precautions; and
 - ❸ Making free condoms available.
4. Prevent excess maternal and newborn morbidity and mortality by:
 - ❶ Ensuring availability of emergency obstetric care (EmOC) and newborn care services, including:
 - ❖ At health facilities: Ensure there are skilled birth attendants and supplies for normal births and management of obstetric and newborn complications;
 - ❖ At referral hospitals: Ensure there are skilled medical staff and supplies for management of obstetric and newborn emergencies;
 - ❷ Establishing a referral system to facilitate transport and communication from the community to the health center and between health center and hospital; and
 - ❸ Providing clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

5. Plan for comprehensive RH services, integrated into primary health care (PHC) as the situation permits. Support the health sector/cluster partners to:
 - Coordinate ordering RH equipment and supplies based on estimated and observed consumption;
 - Collect existing background data;
 - Identify suitable sites for future service delivery of comprehensive RH services; and
 - Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff.

Note: It is also important to ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and, as per 2010 IASC Guidelines on Addressing HIV in Humanitarian Settings,¹² antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). In addition, it is important to ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in “hygiene kits”) are distributed to women and girls.

What supplies are necessary to implement the MISP and where can an agency get them?

Essential drugs, equipment and supplies to implement the MISP have been assembled into a set of specially designed prepackaged kits: the Inter-Agency Reproductive Health Kits.¹³ The kits complement the objectives in the *Inter-agency Field Manual for Reproductive Health in Humanitarian Settings*.¹⁴ As the kits are designed for the early phase of a crisis and logistical problems are common in crisis settings, RH service provider agencies should, as part of the overall health sector/cluster, prepare by including RH supplies within their overall medical supply procurement. The lead RH agency should support the inclusion of RH supplies in the process of transition to re-establish normal supply chains. Please see Chapter 8 for more information on ordering supplies.

Why is the MISP a priority?

The components of the MISP represent critical, life-saving health actions that must be implemented simultaneously with other life-saving activities. The MISP is essential to reducing death, disability and illness, particularly among women and girls. Crisis-affected communities have a right to access these services.

¹² Inter-agency Standing Committee, *Guidelines for Addressing HIV in Humanitarian Settings*, 2010. Accessible from <http://www.aidsandemergencies.org/cms/>.

¹³ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations* (Fourth edition), January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

¹⁴ Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review*, 2010. Available from http://www.iawg.net/resources/field_manual.html.

What are the possible consequences of ignoring the MISIP in an emergency setting?

The lives of people affected by crises, particularly women and girls, are put at risk when the MISIP is not implemented. For example, women and girls can be at risk of sexual violence when attempting to access food, firewood, water and latrines. Their shelter may also not be adequate to protect them from intruders or they may be placed in a housing situation that deprives them of their privacy. Those in power may exploit vulnerable women and girls by withholding access to essential goods in exchange for sex. In addition, not observing standard precautions in a health care setting may allow the transmission of HIV to patients or health workers and, without a referral system in place to transfer patients in need of basic or comprehensive EmOC services to an equipped health facility, women may die or suffer long-term injuries (e.g., obstetric fistula). The MISIP provides an outline of the basic steps to be taken in order to save lives, preserve health and avoid these negative consequences.

Who is responsible for implementing the MISIP?

The health sector/cluster and the Ministry of Health (MoH) are responsible for ensuring that MISIP priority activities are implemented. However, not all MISIP activities are limited to the health sector/cluster; specifically, activities to prevent and respond to sexual violence cut across the protection, food/nutrition, water and sanitation and shelter sectors. The critical role that must be played by the health sector/cluster in implementing the MISIP is reflected in IASC Health Cluster tools and guidance.¹⁵

How are displaced populations and affected communities involved?

Though it may be difficult in the earliest days of a crisis, every effort should be made to ensure crisis-affected populations, including men, women and adolescents, are involved in the program planning and implementation of MISIP services from the onset of an emergency. It is also important to reach out to other groups with particular vulnerabilities, including persons with diverse sexual orientations and persons with disabilities. At minimum, affected communities must be informed of the benefits of seeking services, such as clinical care for survivors of sexual violence and EmOC services, and how and where to access these services. On behalf of the RHRC Consortium, the Women's Refugee Commission has developed information, education, communication (IEC) "universal templates" for crisis-affected populations on the importance of seeking care after sexual assault and accessing care for obstetric complications. The templates currently speak to two of the MISIP objectives (additional templates are planned), and are intended to aid service providers in their efforts to inform communities in diverse crisis settings on the available services and the benefits of seeking care.¹⁶

Why is it important to ensure the needs and capacities of adolescents are addressed?

In the immediate aftermath of a crisis, the disruption of families and communities, and, often the loss of educational opportunities, jobs and other meaningful activity are common challenges for adolescents

¹⁵ Inter-agency Standing Committee, *Health Cluster Guide: A practical guide for country-level implementation of the Health Cluster*. 2009. Available from www.who.int/hac/network/global_health_cluster/guide; Inter-agency Standing Committee, *Health Resources Availability Mapping System (HeRAMS)*, 2009. Available from http://iawg.net/resources/Graph_RAM5_5aug09.pdf.

¹⁶ The templates are available from the Reproductive Health Response in Crises (RHRC) Consortium website: <http://rhrc.org/members/iec/>.

affected by crises. Adolescents are often idle and their needs and capacities go unrecognized at a time when they face new risks. They may have lost access to family, social supports and health services as a result of displacement. Adolescents, particularly girls, are especially vulnerable to sexual violence with the breakdown of law and order, which further increases the risks of unwanted pregnancy, unsafe abortions and STIs including HIV. Yet, although adolescents face numerous challenges to their sexual and reproductive health, they are typically a healthy cohort with strength that can be garnered to cope with their circumstances and help their communities. Adolescents should therefore be provided with opportunities to participate in designing and implementing accessible, acceptable and appropriate MISP services. See Appendix G for an Adolescent-Friendly Sexual and Reproductive Health Service Checklist from Save the Children/UNFPA's *Adolescent Sexual and RH Toolkit for Humanitarian Settings: A Companion to the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.¹⁷

Why is the urban context important to consider for MISP implementation?

The world is undergoing a rapid global urbanization process, and it is predicted that an estimated 60 percent of the global population will be living in urban areas by 2030.¹⁸ Statistics from the United Nations High Commissioner for Refugees (UNHCR) have shown that, currently, more than half of the world's refugee populations are living in cities and towns, and this is likely to continue to increase over the next years for refugees and IDPs alike.¹⁹ Conversely, only one-third of refugees currently live in traditional camp settings.²⁰ In urban settings, health systems are often already stretched and an influx of displaced persons compounds the situation. Further, providing health care to refugees and IDPs is often difficult in urban settings. Transport to health facilities is often a challenge, and displaced people may have cultural, social and economic barriers for accessing health care and other services. It is important to ensure that under these challenges the immediate access to the priority RH services of the MISP is guaranteed. Since scenarios for the provision of health care in urban settings differs by country, it is important to conduct a rapid mapping of the available health facilities and systems, including the MoH, NGOs and faith-based services. These facilities also must be supported directly through the MoH and the international community to ensure that RH services are readily accessible, utilized by IDPs and the crisis-affected community, and that they meet the required quality standards adapted to the specific context of the displaced situation.

Is the MISP only for acute emergencies?

The MISP is not just applicable to acute crises. In some protracted and/or post-crisis settings, the priority services of the MISP are still not in place. The new framework for action for RH in protracted crisis and recovery includes ensuring the clinical components of the MISP, achieving equitable coverage and sustaining services as they are integrated into comprehensive RH care.²¹ Existing RH programming should not be suspended or reduced, but immediately improved to include all priority activities of the MISP that form the basis for comprehensive RH programming.

¹⁷ Save the Children/United Nations Population Fund, *Adolescent Sexual and RH Toolkit for Humanitarian Settings: A Companion to the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. Available from <http://www.iawg.net/resources/ARH/index.html>.

¹⁸ Population Bulletin, "World Population Highlights: Key Findings from PRB's 2007 World Population Data Sheet." <http://www.prb.org/pdf07/62.3Highlights.pdf>.

¹⁹ United Nations High Commissioner for Refugees. *Urban Refugees: Trying to get by in the city*. Accessible from <http://www.unhcr.org/pages/4b0e4cba6.html>.

²⁰ United Nations High Commissioner for Refugees. *Urban Refugees: Trying to get by in the city*. Accessible from <http://www.unhcr.org/pages/4b0e4cba6.html>.

How can MISP implementation be monitored?

The MISP Checklist (see Appendix A) can be used to monitor RH service provision in each humanitarian setting. In some cases, this may be done by verbal reporting from RH Officers and/or through observation visits. At the onset of the humanitarian response, weekly monitoring is done. Once services are fully established, monthly monitoring is sufficient. Another tool to monitor MISP implementation is the Health Resources Availability and Mapping System (HeRAMS). HeRAMS is a software-based information system developed by the IASC Health Cluster to support the collection, collation and analysis of information on the availability of health resources in different areas and locations, and by type of service delivery point and level of care. Health resources include health facilities (infrastructure), personnel and services provided, including those specific to the MISP. In addition, the emergency Health Information System (HIS), developed by UNHCR, includes the collection of key RH indicators at health facility level from the onset of an emergency. Data can be used to discuss gaps and overlaps in service coverage within the health sector/ cluster coordination mechanisms to find and implement solutions.

How can an agency obtain funding to support MISP activities?

NGOs responding to a humanitarian crisis should include funding for MISP activities in proposals to donors such as the Office of U.S. Foreign Disaster Assistance (OFDA), U.S. Bureau for Population, Refugees and Migration (BPRM), UNHCR, UNFPA, Humanitarian Aid Office of the European Commission (ECHO), AusAID or private donors who may support emergency response activities (see Appendix C for a sample of a funding proposal). The MISP also meets the life-saving criteria of the UN Central Emergency Response Fund (CERF).²² NGOs can access CERF funds from the UN by submitting proposals for projects that are part of the humanitarian planning and appeals processes (e.g., flash appeals, consolidated appeals process (CAP) and other humanitarian appeals). (See Appendix D for a sample of a CAP proposal). It is important that the proposals describe the priority RH activities as outlined in the MISP as the first RH components to be addressed, followed by an expansion of RH programming once the MISP has been fully implemented. It may be helpful to cite the life-saving criteria and the Sphere standards in proposals. In the 2011 edition of the *Sphere Handbook*, the MISP is included within the section on *Minimum Standards in Health Action, Essential Health Services Standard 3.1 Reproductive Health*.²³


What can be done to prepare for an emergency in disaster- and conflict-prone countries?

Local communities, district and state representatives, and humanitarian and disaster agencies should prioritize RH in health emergency management policies, including emergency preparedness and contingency plans. Such plans could include: training national, local and community-based health workers in the MISP; identifying a system to map available services at the onset of an emergency; identifying coordination and communication strategies; emergency human resource planning; and developing logistic plans for stockpiling, ordering and disseminating MISP supplies.

²¹ World Health Organization, *Sexual and Reproductive Health During Protracted Crises and Recovery: Report on an expert consultation held in Granada, Spain 28-30, September, 2009*; Preliminary Publication, 2010. Granada. Consensus available from http://www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf.

²² Central Emergency Response Fund (CERF), *Lifesaving Criteria and Sectoral Activities*, 2010. Available from <http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1163693>.

²³ The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. Available from www.sphereproject.org.



With funding from AusAID, the SPRINT (Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations) Initiative in East, South East Asia and the Pacific was developed after the ninth IAWG annual meeting in October 2006 in Sydney to improve access to reproductive health services and information for populations living in humanitarian settings. The objectives are to:

- ✦ Increase the regional capacity of key stakeholders to coordinate and implement the MISP;
- ✦ Strengthen the coordination of the RH response in crisis situations;
- ✦ Raise awareness on RH in crises at national and regional levels; and
- ✦ Respond to RH needs in crises in a timely fashion.

The Initiative is coordinated by the International Planned Parenthood Federation (IPPF), and partners closely with the University of New South Wales (UNSW), UNHCR, UNFPA and the Women's Refugee Commission. For more information on the SPRINT Initiative, please visit the SPRINT Initiative website.²⁴

In addition, the IAWG Training Partnership (TP) for RH in Crises is an IAWG's sub-working group that was formed in 2006. It aims to establish partnerships between the IAWG and training institutions from crisis-prone countries in order to assure quality training on RH in emergency preparedness and response on a regular and sustainable basis. The objectives of the IAWG TP are to:

- ✦ Build the capacity of strategic partners;
- ✦ Improve the quality of RH training for (future) humanitarian workers; and
- ✦ Pilot new training modules.

The IAWG TP also aims to increase national capacity to effectively coordinate and deliver quality RH services from the onset of an emergency and to conduct effective national planning for and the implementation of integrated comprehensive RH services. For more information on the IAWG TP, go to www.iawg.net/2010/tp.html.


Where can I find Quick Resources for MISP Implementation?

From the IAWG website MISP resource page: <http://www.iawg.net/resources/misp.html>.

²⁴ The SPRINT Initiative website is accessible from <http://www.iawg.net/sprint.html>.

Chapter 2

Coordination of the MISP



Coordination of MISP activities as part of the overall health sector/cluster response is necessary at multiple levels, including within each agency responding to the emergency as well as at sub-national, national and international levels. Coordination within and among these various levels and across sectors is crucial to ensure effectiveness of the RH response as it helps to identify and fill gaps in service delivery, prevent overlapping programming, strengthen advocacy and support accountability and application of standards.

At the beginning of the response in each humanitarian setting, the health sector or health cluster must identify an organization to lead the RH response. This can be a national or international NGO, the Ministry of Health (MoH) or a UN agency. The nominated organization, which is the one identified as having the most capacity to fulfill this role, immediately dedicates a full-time RH Officer for a minimum of three months to provide operational and technical support to the health partners and to ensure the prioritization of RH and achieve good coverage of MISP services. It is important that this individual has sufficient technical knowledge of all MISP components to provide this support.

OBJECTIVE

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization then:

- ✦ Nominates an RH Officer to provide technical and operational support to all agencies providing health services;
- ✦ Hosts regular stakeholder meetings to facilitate implementation of the MISP;
- ✦ Reports back to the health sector/cluster meetings on any issues related to MISP implementation; and
- ✦ Shares information about the availability of RH resources and supplies.

The following is a broad terms of reference to be undertaken by an overall RH Officer.

RH Officer - Terms of Reference

The RH Officer is responsible for supporting health sector/cluster partners to implement the MISP and plan for comprehensive RH service delivery. The RH Officer's role is to:

- ✦ Coordinate, communicate and collaborate with the health sector or health cluster coordinator and actively participate in health coordination meetings, providing information and raising strategic and technical issues and concerns;
- ✦ Support the coordinated procurement of reference materials and supplies;
- ✦ Host regular RH stakeholder meetings at relevant (national, sub-national/regional, local) levels to problem solve and strategize the implementation of the MISP and to provide MISP resource materials;

Adolescents: The RH Officer advocates for an adolescent-inclusive implementation of the MISP and supports the identification of the most vulnerable adolescents and ensures they are able to access RH services.

- ✦ Ensure regular communication among all levels and report back on key conclusions and on challenges requiring resolution (e.g., policy or other barriers that restrict the population's access to RH services) to the overall health coordination mechanism. This includes identifying synergies and gaps and avoiding a duplication of efforts and parallel structures;
- ✦ Provide technical and operational guidance on MISP implementation and audience-specific orientation sessions when and where feasible (e.g., for service providers, community health workers, program staff and the affected population, including adolescents);
- ✦ Liaise with other sectors (protection, water and sanitation, community services, camp coordination, etc.) to address RH-related concerns; and
- ✦ Support health partners to seek RH funding through humanitarian planning processes and appeals in coordination with the health sector/cluster.

The RH Officer must identify, understand and provide information about:

- ✦ The elements of national and host country policies, regulations and customary laws that:

- ❖ support RH services for the affected population; and
 - ❖ create barriers and restrict access to RH services.
- ⊕ Relevant MoH protocols for standardized care (e.g., protocols for clinical management of rape survivors, referral mechanisms for obstetric emergencies and STI syndromic management and family planning protocols).

Urban Settings: The RH Officer must:

- Ensure that the MoH at the relevant (national, provincial, district, municipal or other) level participates in leading the RH working group;
- Work with the health sector/cluster to ensure a mapping of existing MISP activities and services, including those among the MoH, civil society and the private sector; and
- Aim to identify and support existing capacities among the variety of stakeholders to ensure there is equitable coverage of the MISP for the crisis-affected population.

The RH Officer works within the context of the overall health sector/cluster coordination mechanism to obtain and use information to:

- ⊕ Use the MISP checklist (see Appendix A) to monitor services, collect service delivery information, analyze findings and act on identified gaps and overlaps;
- ⊕ Collect or estimate basic demographic and RH information of the affected population to support MISP implementation and planning for comprehensive RH service delivery (see Appendix A).

Noted practices in facilitating the coordination and implementation of the MISP observed in Haiti²⁵

- ✦ Led by the UNFPA with Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population) of Haiti, an RH coordination mechanism was initiated under the health cluster in Port-au-Prince within two weeks of the earthquake.
- ✦ In Port-au-Prince, UNFPA led orientations to the MISP, disseminated supplies to NGOs and collected minimum data (condoms distributed, rape cases).
- ✦ In the early weeks of the crisis, UNFPA linked with the health and protection clusters, including the gender-based violence (GBV) area of responsibility (AoR).
- ✦ RH working group meetings in Port-au-Prince were reported to have had a rapid start in the midst of the chaos in the early weeks of the crisis and were viewed by many, including development organizations working in Haiti but not experienced in humanitarian crises, to be extremely valuable in accessing information and RH supplies. These meetings also provided an opportunity for development organizations to meet Ministry of Public Health and Population and UNFPA representatives.
- ✦ The majority of people interviewed by the assessment team who had heard of the MISP and were aware of the RH working group in Port-au-Prince had attended the RH working group meeting at least once, and many attended regularly.

²⁵ Women's Refugee Commission, *Four Months On: A Snapshot of Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment Conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission*, May 17-21, 2010, October, 2010. Available from <http://www.womensrefugeecommission.org/reports>.

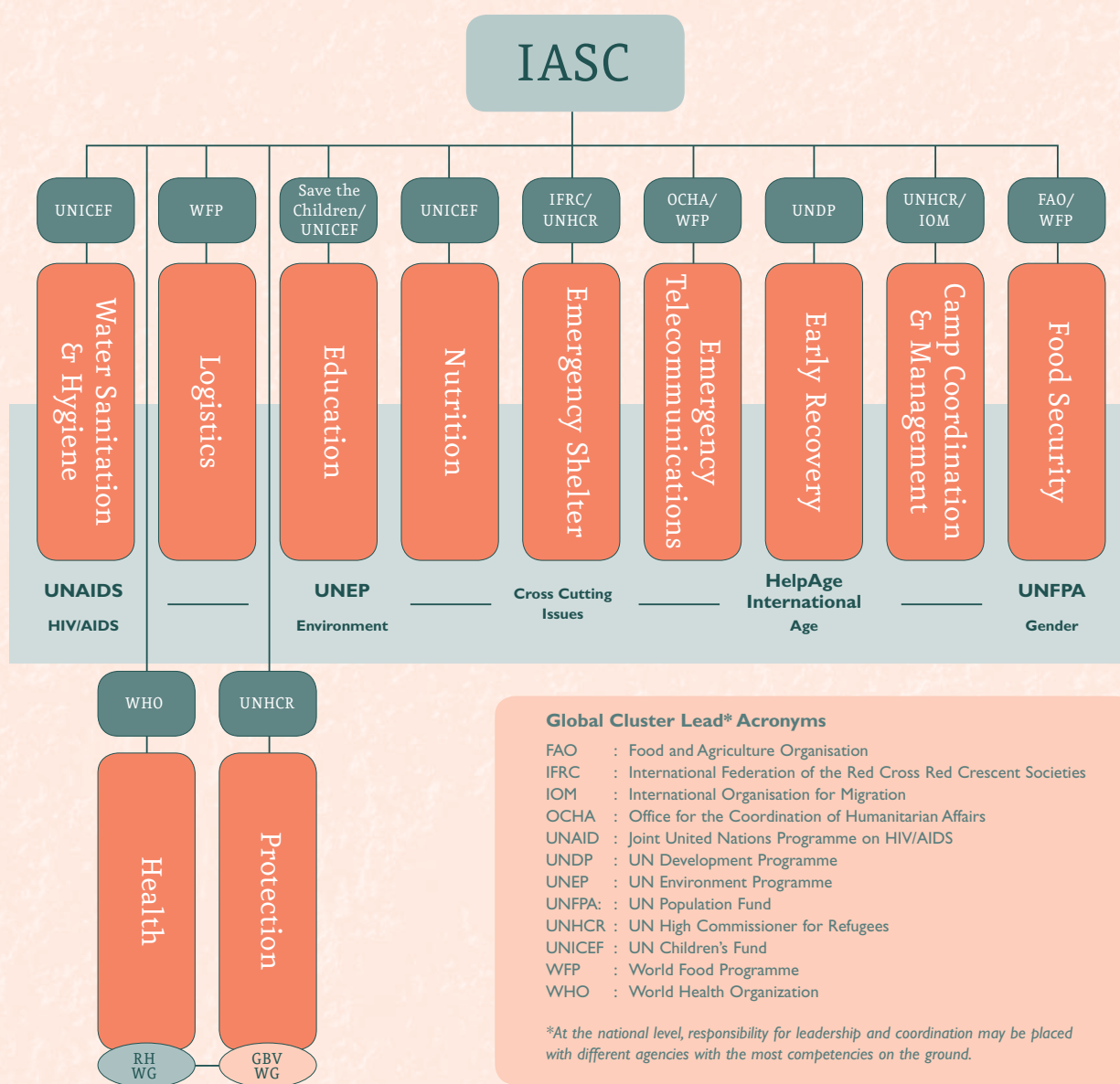
Why is putting an RH Officer in place a priority?

Evidence shows that, without appropriate technical expertise and coordination to support the RH response, the critical services of the MISp are often ignored or de-prioritized.

National or Sub-national Level:

It is important for all agencies responding to health needs in a crisis to participate in the health sector/ cluster coordination activities at national and/or sub-national levels, whether this is by attending weekly, bi-weekly or monthly meetings. As partners in the coordination mechanism, agencies are responsible for raising RH-related issues for discussion within the overall sector/cluster meetings.

RH Coordination at the National and Sub-national Levels ²⁶



²⁵ The diagram is dated March 2011. The RH working group must address the health-related sexual violence/GBV issues and raise this in the discussions, appeals planning, and other work of the health cluster/sector. The presence of a GBV working group under the protection cluster does not replace this function for the RH working group.

What support does the RH Officer need?

The RH Officer should be supported with administration and logistics personnel to help arrange RH working group meetings and to work with the health sector/cluster to order, stockpile and distribute RH supplies. Useful MISP-related resources for the RH Officer and others can be found at: www.iawg.net/resources/misp.html.

Who should participate in RH working group meetings?

Relevant actors in the humanitarian health response should participate, including the MoH and any other relevant ministries; local and international development, humanitarian and civil society organizations with RH expertise and experience; representatives from the affected communities; and UN agencies such as UNFPA, UNHCR, UNICEF and WHO.

What are some components of good RH coordination?

Successful RH working groups have an agreed-upon terms of reference (focused on implementing and building upon the MISP), are well facilitated, and are used for strategic planning and problem-solving to ensure good coverage of the MISP. Active engagement of the MoH in leading or co-leading the coordination effort is also critical for the success of the working group. In addition to appropriate administrative and logistics support, it is important to ensure that relevant agencies are aware of the RH working group and understand that the working group meetings are open to all.

Meetings should be held in an accessible location and should occur on a regular basis – usually once per week at the onset of an emergency. It is important to ensure that meetings are time-efficient. The RH Officer should facilitate meetings based on an action-oriented agenda to ensure equitable and comprehensive coverage of MISP activities. In addition, to accommodate new agencies and the rotation of staff, it is important to review the MISP and the action plan for the working group at the start of each meeting. Different organizations could take the lead at the beginning of the meeting to distribute and review MISP [cheat sheets](#) and [advocacy](#)²⁷ (see Appendices E and F). Facilitation of meetings should also support equal participation, effective listening, note-taking and distribution of minutes. Minutes should also be posted on the OneResponse website (www.oneresponse.info) and the RH Officer should ensure that key points from the RH working group are included in health cluster situation reports (sitreps) and are communicated to OCHA for their sitreps as part of the health sector/cluster contribution.

How can RH coordination be sustained through protracted crises?

International RH Officers should, at the onset of their work, identify a local counterpart to establish a “twinning” partnership. This will ensure a smooth transition during any staff turnover that occurs while aiming for the MoH to assume RH coordination.

What global mechanisms provide policy and technical support for the MISP?

Global Health Cluster: On the international level, the Global Health Cluster, led by WHO, comprises of more than 30 organizations that work collaboratively to ensure predictable and accountable health action

²⁷ MISP-related resources are available from www.iawg.net/resources/misp.html.

including RH in crises.²⁸ For refugee crisis, UNHCR is the lead coordinating agency, including for reproductive health.

IAWG on RH in Crises: The IAWG is a mechanism where RH-specific collaboration occurs among UN and government agencies, donors and NGOs. The group collaborates through an open membership volunteer steering committee comprised of representatives from 14 agencies and via annual meetings where local and international partners share activities and resources, initiate collaborative efforts and analyze issues in the field to be addressed. The IAWG has also established 12 sub-working groups to tackle the most pressing RH topics based on a specific terms of reference for each of those groups, which are updated at the annual IAWG meeting. The MISP sub-working group meets regularly by teleconference to address the terms of reference, share findings, and identify areas for improvement from crisis-affected settings in countries such as Burma/Myanmar, Haiti, Kenya and Pakistan. The findings from these meetings have formed the sub-working group's terms of reference and helped support a more coordinated and effective MISP response in new emergencies. This is an example of how action at the global level can support activities in the field. For more details on joining IAWG, please go to www.iawg.net.

The Reality of Implementing the MISP in Burma/Myanmar

In May 2008, Cyclone Nargis hit the Irrawaddy Delta in Burma/Myanmar. The cyclone affected 2.4 million people and caused up to 140,000 deaths. As in many emergency settings, the RH needs were high. Two representatives from UNFPA and UNHCR, who had recently completed a training on coordinating the implementation of the MISP by the SPRINT Initiative, immediately took action to address the MISP. Despite resistance from some agencies that did not deem RH a priority, they established an RH/HIV technical working group under the health cluster and helped spearhead a women's protection technical working group under the protection cluster. UNFPA Myanmar recruited new staff to support the coordination and implementation of the MISP. UNFPA and the members of the RH/HIV and women's protection working group conducted rapid orientations on the MISP, including prevention and response to sexual violence, which helped garner the buy-in from other agencies, with some agencies recruiting new staff to implement RH services after attending the awareness-raising sessions. UNFPA and partners included the MISP in humanitarian appeals, including the Flash Appeal and CERF, and distributed RH Kits throughout the affected area. Although there were barriers and constraints in the overall response, agencies noted that RH/HIV coordination had worked exceptionally well from the onset of the crisis. One RH Program Officer from an NGO remarked: "Before I attended the RH/HIV working group, I didn't know if what we were doing was right. And I didn't realize how many other agencies were working on RH. The working group helped us work together and ensure we were on the same page. It was very encouraging for us to have them at that time." One UN representative noted, "In these meetings we could really talk." After the acute phase passed, UNFPA Myanmar and partners rolled out hundreds of trainings on the MISP, GBV, gender and psychosocial care, reaching over 3,000 people throughout the country.

²⁸ The Global Health Cluster website is available at http://www.who.int/hac/global_health_cluster/en/.

MISP Coordination Monitoring Checklist

Lead Agency for RH

- ✦ Lead RH agency identified and RH Officer functioning within the health sector/cluster
- ✦ RH stakeholder meetings established and meeting regularly at national/sub-national levels

Demographics

- ✦ Total population
- ✦ Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)
- ✦ Number of sexually active men (estimated at 20% of population)
- ✦ Crude birth rate (estimated at 4% of the population)

Materials and Supplies

- ✦ Sufficient supplies for MISP implementation identified and procured

Which supplies are useful for coordinating the implementation of the MISP?²⁹

Number	Name	Color
Kit 0:	Administration Kit	Orange

Challenges and Solutions

1. *Sometimes a lack of understanding and/or prioritization of RH by humanitarian actors, and in particular sector/cluster leads and partners, can make implementation of the MISP within the overall health response difficult. How can one counteract such apathy and dismissal of RH issues?*

Point out that the MISP is an accepted international minimum standard reflected in the Sphere handbook, the CERF life-saving criteria, the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* and the *Health Cluster Guide*. Encourage all technical and managerial staff involved in humanitarian response to complete the MISP module and share relevant resources such as the [MISP advocacy sheet](#).

2. *At the beginning of an emergency, UNFPA and other RH specialist agencies may not yet be operational in the field. Security may be poor and capacity of staff may be very weak. In such a setting, the reality of trying to adequately implement all elements of the MISP can be very challenging. In what ways can an individual, small group or agency address this problem?*

If your agency is involved in the health response it should ensure the MISP is included in its programming. Your agency or another agency could volunteer in the health sector/cluster meetings to lead RH and to establish regular RH working group meetings to facilitate implementation of the MISP.

²⁹ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations* (Fourth edition), January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

Chapter 2 Quiz

(Answers on page 104)

- 1** *MISP and additional priority activities include:*
- Prevent sexual violence and respond to survivors
 - Reduce HIV transmission
 - Prevent excess maternal and newborn morbidity and mortality
 - Ensure contraceptives, ARVs and STI care are available
 - All of the above
- 2** *Addressing _____ is part of the MISP.*
- Emergency obstetric care
 - Early age of marriage
 - Antenatal care
 - Clinical care for survivors of rape
 - a and d
- 3** *RH Officers are solely responsible for ensuring that MISP priority activities are implemented.*
- True
- False
- 4** *The RH Officer should know the following demographic and health information:*
- The number of people with sexually transmitted infections
 - The approximate number of sexually active men
 - The approximate number of pregnant women
 - The number of people with HIV
 - b and c
- 5** *The RH Coordinator should:*
- Work within the health sector/cluster
 - Support the coordinated procurement of RH materials and supplies
 - Conduct orientation sessions on the MISP for the health sector/cluster and humanitarian workers
 - Utilize the MISP checklist for monitoring RH activities
 - All of the above

Chapter 3

Prevent and Manage the Consequences of Sexual Violence

Historically, sexual violence has consistently been a result of situations of conflict and forced migration, including natural disasters, and it continues to be so today.³⁰ It is therefore urgent that all actors responding in an emergency are aware of this issue and put protective measures in place immediately—proper layout of facilities such as latrines, for example, can reduce women’s exposure to risk. Women and girls who have experienced sexual violence should receive health care as soon as possible after the incident in order to avert preventable consequences, such as unwanted pregnancies and life-threatening infections. If left unaddressed, sexual violence may have serious negative personal and social consequences for women and girls, as well as for their families and the larger community. Thus, psychosocial services that help to heal and empower/rehabilitate women are necessary. Protection and community services staff should also be involved in offering legal support to survivors of sexual violence.

An important resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to sexual violence in emergency settings is the *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Emergencies*. These guidelines provide recommended interventions for all sector areas before an emergency, during the acute phase of an emergency and once the immediate crisis subsides. A reference matrix of these guidelines is also available.³¹

³⁰ Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings*. A Global Overview, RHRC Consortium, 2002. Available from <http://www.rhrc.org/resources/ifnotnow.pdf>.

³¹ Inter-agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005. Available from <http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402>.

THE OBJECTIVE

TO PREVENT AND MANAGE THE CONSEQUENCES OF SEXUAL VIOLENCE BY:

- Putting in place measures to protect affected populations from sexual violence;
- Making clinical care available for survivors of rape; and
- Ensuring the community is aware of the available clinical services.

What is sexual violence?

Sexual violence is any non-consented action of a sexual nature, including rape, attempted rape, sexual exploitation and sexual abuse. Sexual violence is a subset of the broader category of gender-based violence (GBV). GBV is an umbrella term for any harm that is perpetrated against a person's will that results from power inequities that are based on gender roles. Violence may be physical, sexual, psychological, economic or socio-cultural.³²

The reason for addressing sexual violence in the MISIP is to prevent rape and sexual exploitation and abuse, provide medical care for rape survivors and to ensure the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISIP have been implemented, attention can be given to preventing the wider array of violence issues, including domestic violence; early and/or forced marriage; female genital mutilation/cutting; forced sterilization or forced pregnancy; forced or coerced prostitution; trafficking of women, girls and boys; and additional forms of GBV.

Why is preventing sexual violence a priority?

Although sexual violence is common even during peacetime, natural disasters and conflict may increase the risk of rape and other forms of sexual violence. This dire reality is reflected in an increasing number of documented reports and research. Women and adolescents are especially vulnerable to sexual abuse committed by combatants. The use of rape as a strategy of war has been documented in several conflicts as an effective means of controlling, degrading and humiliating a community.³³ It is important to recognize that sexual violence may increase after natural disasters as well; it is therefore imperative to ensure that prevention and response mechanisms are also in place in these settings.

It is critical to prevent sexual violence because it is a human rights violation. Survivors may suffer from depression and anxiety, attempt/complete suicide, contract HIV or other STIs, become pregnant, or may be shunned by their families or communities. Moreover, the impact of sexual violence is multifold: it impacts the survivor's physical and mental health and social well-being, while also having possible consequences for the survivor's family and wider community.

³² Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings*. A Global Overview, RHRC Consortium, 2002. Available from <http://www.rhrc.org/resources/ifnotnow.pdf>.

³³ See, for example, Human Rights Watch, *Climate of Fear*, July 2003; UNFPA, *Women suffer brunt of conflict in western Sudan*, UNFPA warns, May 6, 2004; Human Rights Watch, *The War Within the War: Sexual violence against women and girls in Eastern Congo, 2002*; Hynes, M. et al., *Field test of GBV survey in East Timor and Kosovo: Lessons learned*, 2003; Physicians for Human Rights, *War-Related Sexual Violence in Sierra Leone: A Population-Based Assessment*, 2002; Shan Women's Action Network and Shan Human Rights Foundation, *License to Rape*, 2002; UNDP, *Situation of Gender-based Violence Against Women in Latin America and the Caribbean: National Report*, 2001; Association of Widows of the Genocide (Vega), *Survey on Violence Against Women in Rwanda*, 1999.

Who is impacted most by sexual violence?

Sexual violence in crisis-affected settings does not happen in a vacuum. Most reported cases of sexual violence among crisis-affected communities—and in most settings around the world—involve male perpetrators committing violent acts against females.³⁴ However, men and boys may also be at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture. While all women in crisis-affected settings are susceptible to sexual violence, adolescent girls are exceptionally vulnerable as they are often targeted for sexual exploitation and rape. In addition, sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community—including the fathers, brothers, husbands and sons of the survivor. It is important to recognize that anyone can be a survivor of sexual violence (women, girls, boys and men of all ages) and to ensure that services are available and accessible to all.

Who are the perpetrators of sexual violence?

Perpetrators may be others who have been displaced by the conflict or disaster; members of other clans, villages, religious groups or ethnic groups; military personnel; rebel forces; humanitarian workers from UN agencies or NGOs; members of the host population; the community; or family members. Perpetrators may also be male or female. In short, anyone can perpetrate sexual violence. Rape may be used as a strategy of warfare to intimidate and traumatize a population, in which case the perpetrators are enemy combatants, but perpetrators of opportunistic rape can be anyone acting with impunity in the climate of lawlessness that accompanies armed conflict and after natural disasters.

When does sexual violence occur?

Sexual violence can happen anytime during displacement, including prior to fleeing one's home area, during flight, while in the country of asylum and during repatriation and reintegration. It can occur in crisis-affected communities after a natural disaster, even among those not displaced from their homes. In addition, sexual violence frequently escalates in displaced settings as normal social structures are disrupted. Immediate prevention and response measures must be adapted to suit these different circumstances.

What are the key actions that should be taken to reduce the risk of sexual violence?

As part of the work of the overall health sector/cluster mechanism, the RH Officer and RH program staff must:

- ✦ Ensure women, men, adolescents and children have access to basic health services, including sexual and RH services;
- ✦ Design and locate health facilities to enhance physical security, in consultation with the population and in particular with women and adolescents;
- ✦ Consult with service providers and patients about security in the health facilities;

³⁴ United Nations High Commissioner for Refugees, *Sexual Violence against Refugees: Guidelines on Prevention and Response*, Geneva, 1995. Available from <http://www.unhcr.org/3b9cc26c4.html>

- ✦ Locate separate male and female latrines and washing areas in the health facility in a secure location with adequate lighting at night, and ensure doors lock from the inside;
- ✦ Ensure all ethnic subgroup languages are represented among service providers or interpreters are available;
- ✦ Hire female service providers, community health workers, program staff and interpreters;
- ✦ Inform service providers of the importance of maintaining confidentiality and have them sign and abide by a code of conduct against sexual exploitation and abuse; and
- ✦ Ensure that codes of conduct and reporting mechanisms on sexual exploitation and abuse by health staff are in place, as well as relevant punitive measures to enforce them.

Urban Settings: With all stakeholders to the humanitarian response, identify the specific risks for sexual violence in the setting and develop targeted protection measures. Displaced populations, particularly women and girls, may be at additional risk of rape and sexual exploitation and abuse in an unfamiliar urban setting as they struggle to obtain their basic and survival needs. As it may be difficult to identify and access displaced women in urban settings, it is important to discover creative ways to reach out to inform them of where and why to receive services after rape. Working with a local women's organization to establish a hotline where displaced women can speak to someone (in their own language) about sexual violence, for example, may be helpful.

Adolescents: Provide adolescent-friendly care for survivors of sexual violence at health facilities and encourage adolescent participation in any multi-sectoral GBV prevention task force.

What are the key actions that should be taken to respond appropriately to survivors?

RH Officers and program staff must:

- ✦ Establish a private consultation area with a lockable filing cabinet;
- ✦ Put in place clear protocols and sufficient supplies and equipment;
- ✦ Hire male and female service providers fluent in local languages, or, where this is not possible, hire trained male and female chaperones and translators;
- ✦ Involve women and male and female adolescents in decisions on accessibility to services and on an appropriate name for the services;
- ✦ Ensure that services and a referral mechanism to a hospital for life-threatening complications are available 24 hours a day/seven days a week;
- ✦ Once services are established, inform the community why, where and when (as soon as possible after a rape) these services should be accessed. Use communication channels appropriate to the setting (e.g., through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets); and

✦ Ensure service providers are skilled. Where needed, organize information sessions or short refresher trainings on clinical care for survivors of rape. Clinical management of survivors of rape should include the following components:

- ❖ Supportive communication
- ❖ History and examination
- ❖ Forensic evidence collection as relevant
- ❖ Compassionate and confidential treatment, including:
 - ▶ Emergency contraception
 - ▶ Treatment of STIs
 - ▶ Post-exposure prophylaxis (PEP) to prevent HIV transmission
 - ▶ Care of wounds and prevention of tetanus
 - ▶ Prevention of hepatitis B
 - ▶ Referral for further services, e.g., health, psychological and social.

A useful resource that provides guidance to health care providers for medical management after rape of women, men and children is the 2004 *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*.³⁵ In addition, the WHO, UNHCR and UNFPA e-learning *Program on Clinical Management of Rape Survivors* is a complementary online tool which is available in English and French.

Who is responsible for preventing and managing incidents of sexual violence?

A multi-sectoral approach is required to prevent and respond appropriately to sexual violence. The global protection cluster under the leadership of UNHCR is responsible for ensuring that protection is mainstreamed and integrated with other sectors and that support is provided as requested to the country-level protection cluster. The protection cluster working group (PCWG) is sub-divided with five additional AoR, including child protection under the leadership of UNICEF and GBV under the leadership of UNFPA/ UNICEF. The stated overarching objective of the GBV AoR is “to develop effective and inclusive protection mechanisms which promote a coherent, comprehensive and coordinated approach to GBV at the field level, including regarding prevention, care, support, recovery, and works to hold perpetrators accountable.” Clinical care for survivors of rape falls within the purview and accountability of the health sector/cluster with the designated lead RH agency.³⁶

Coordination at the field level to address sexual violence should encompass all technical sectors (such as protection, health, education, community services, security/police, site planning, etc.) and all geographic areas. Representatives of the displaced community, including women and girls, UN partners, NGOs and government authorities, should inform and/or participate in relevant sector/cluster coordination meetings and identify her/his role and responsibilities in preventing and responding to sexual violence. It is important for the RH Officer to participate in GBV coordination mechanisms and collaborate with the GBV focal point, if one is appointed, to prevent and respond to sexual violence.

³⁵ World Health Organization, United Nations High Commissioner for Refugees, *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*, 2004. Available from http://www.rhrc.org/resources/Clinical_Management_2005_rev.pdf.

³⁶ Inter-agency Standing Committee, One Response, available from <http://oneresponse.info/COUNTRIES/Pages/default.aspx>.

The Reality of Implementing the MISP in Kenya³⁷

The Women's Refugee Commission's 2008 MISP assessment in Kenya showed that planning to prevent sexual violence, including sexual exploitation and abuse, were strong at the national level but still inadequate at the field level. Poor security measures were noted at all but one camp and the assessment team received numerous disturbing reports of sexual exploitation and abuse by humanitarian workers, police and others.

Mechanisms to respond to sexual violence, including sexual exploitation and abuse, were also weak at the field level. Displaced persons and representatives of humanitarian organizations reported a general atmosphere of impunity toward perpetrators of sexual violence. Health workers also suggested that many of the displaced did not know the importance of seeking treatment for sexual assault or where it was offered. Many displaced women slowly sought care several months after the height of the violence.

Noted Practices in Preventing and Managing the Consequences of Sexual Violence Observed in Darfur³⁸ include:

- ◆ Clinic staff in North Darfur distributed emergency contraception (EC) to village midwives in addition to a flyer (in Arabic) developed by the RH Officer on why and where women and girls can access care for rape.
- ◆ African Union (AU) commanders in North Darfur were informed by the RH Officer to refer all rape survivors who reported to them to a local clinic for treatment. The AU civilian police (CIVPOL) patrol also distributed information flyers (in Arabic) on the benefits and availability of care for survivors of sexual violence after an attack.
- ◆ In North Darfur, the RH Officer conducted meetings with CIVPOL members about the importance of the clinical management of rape survivors.
- ◆ In West Darfur, midwives were identified as sexual violence protection "focal points" and let internally displaced women know they could approach these focal points confidentially; these focal points then referred women to receive medical care.
- ◆ In North Darfur, traditional birth attendants (TBAs) delivered messages on sexual violence to the community.
- ◆ In South Darfur, women's health teams conducted community outreach to survivors of sexual violence.
- ◆ Some agencies immediately established women's centers in camps to provide a safe place for women and girls. These camps also provided a space for survivors of sexual violence to receive confidential, holistic care in an environment that minimized the social stigma.

³⁷ Women's Refugee Commission, Reproductive Health Coordination Gap, Services Ad hoc: Minimum Initial Service Package (MISP) Assessment in Kenya, September 2008. Available from http://www.womensrefugeecommission.org/docs/ken_misp.pdf.

³⁸ The Women's Refugee Commission sub-granted to international agencies to coordinate the implementation of the MISP in the three states of Darfur, North Sudan from 2005 to 2006. Some practices observed by the Women's Refugee Commission's field team are listed.



What are some situations that put women and girls at risk of sexual violence?

It has been shown that women without their own personal documentation for collecting food rations or shelter materials are vulnerable because they may be dependent on males for their daily survival. It also has been demonstrated that when men (fellow displaced persons or humanitarian actors) alone are responsible for distributing food and other essential goods, women and children may be forced to perform sexual favors in order to obtain their survival needs.

Women and girls may have to travel to remote distribution points for food, firewood for cooking fuel and water. Their living quarters may be far from latrines and washing facilities. Their sleeping quarters may be unlocked and unprotected. Lighting may be poor. Male and female latrines and washing facilities may not be separate or these facilities may be located in insecure areas of a camp. Given the stressful circumstances of displacement, women and girls may also be at increased risk of intimate partner violence. All of these circumstances leave women and girls vulnerable to abuse and sexual assault.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, humanitarian workers, camp administrators or other government officers may themselves be involved in forcing women and girls to engage in sexual activity for security, services or other support. If there are no independent organizations, such as UNHCR or NGOs, to help ensure personal security within a camp, the number of incidents often increases. It is important that female protection officers are available since women and girls are often more comfortable reporting protection concerns and incidents of violence to another woman.

Why are incidents of sexual violence often not reported?

Even in non-crisis settings, sexual violence often goes unreported due to a range of factors, including fear of retribution, shame, stigma, powerlessness, lack of support, the unreliability of public health and other services, lack of trust in the services and the lack of confidentiality and unfamiliarity with the services. All of these circumstances are exacerbated in humanitarian settings, increasing the likelihood that incidents of sexual violence within the population will go unreported. While ensuring that clinical management and other services is an essential part of the response, addressing sexual violence goes beyond this and must also include an environment where women are protected, supported and able to access this care.

Code of Conduct

A Code of Conduct (CoC) against sexual exploitation and abuse (SEA) is a set of agency guidelines that promotes respect by staff of the agency for fundamental human rights, social justice, human dignity and respect for the rights of women, men and children. The CoC also informs staff that their obligation to show this respect is a condition of their employment. An enforceable CoC is a critical component of humanitarian accountability to beneficiaries. A good resource for agencies to develop these guidelines is the *InterAction Step by Step Guide to Addressing Sexual Exploitation and Abuse*.³⁹ Agencies involved in MISP implementation (and indeed any aspect of humanitarian response) should have a CoC in place. Agencies should ensure that all staff are committed to adhering to the guidelines and have been oriented to their responsibilities to prevent SEA. A CoC is relevant for international staff. Agencies must also ensure that any staff hired from local organizations or persons contracted from the local community sign the CoC and receive regular orientation to and opportunities for discussion about the CoC. Beneficiaries/persons of concern also need to be informed and become familiar with the CoC rules and the relevant site-specific systems so they can invoke them in case of violation. The RH Officer should support the development of a system for confidential reporting and follow-up of SEA.

The IASC Task Force on Protection from Sexual Exploitation and Abuse has developed six core principles for inclusion in UN and NGO CoCs. They are:

- ✦ Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- ✦ Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
- ✦ Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior, is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- ✦ Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- ✦ Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- ✦ Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.⁴⁰

³⁹ InterAction, *Step by Step Guide to Addressing Sexual Exploitation and Abuse*, June 2010. Available from <http://www.interaction.org/document/interaction-step-step-guide-addressing-sexual-exploitation-and-abuse>.

⁴⁰ Cited in InterAction, *Step by Step Guide to Addressing Sexual Exploitation and Abuse*, June 2010. Available from <http://www.interaction.org/document/interaction-step-step-guide-addressing-sexual-exploitation-and-abuse>.

Complaints Mechanism

Complaints of sexual exploitation and abuse must be taken very seriously. Agencies should develop a response system to correctly handle any complaints that are brought to the attention of the agency. These mechanisms should be safe, confidential, transparent and accessible. Often, such systems are best situated in broader response mechanisms for employee misbehavior.⁴¹

- ✦ The agency office can have clear and established internal complaints procedures so that staff and beneficiaries know how and when to confidentially report cases of sexual exploitation and abuse. This is particularly important if your agency is the only organization providing services in the community. Beneficiaries/persons of concern should be a part of the process to develop a system that is safe and accessible for everyone.
- ✦ Agencies should create a workplace culture that encourages discussion and questioning of appropriate behavior regarding protection of beneficiaries from exploitation and abuse. Such a culture allows staff to bring questionable behavior to a supervisor's attention.
- ✦ Staff and beneficiaries need to be informed that making a false complaint of sexual exploitation and abuse may constitute misconduct, just as the failure to report suspected sexual exploitation and abuse may also constitute misconduct.⁴²
- ✦ Reports of sexual exploitation and abuse must be quickly and properly referred for investigation. Agencies can make sure they are prepared to provide strong, committed investigations when cases of sexual exploitation and abuse are reported. They must respond quickly to provide help to the survivors of these cases.⁴³
- ✦ Employees who are accused of sexual exploitation and abuse need to be disciplined and penalized appropriately.⁴⁴ This can include termination of contract, demotion, fine and suspension without pay, among other sanctions.
- ✦ The agency office should keep all original documents of allegations of sexual exploitation and abuse in the appropriate files for the record. The documents must be kept confidential in locked file cabinets and only accessible by relevant personnel.

If you know someone who has been sexually exploited or abused, report the incident in a confidential manner to a relevant authority as predetermined in the established complaints mechanism.

Noted Practices

One agency conducts an orientation on its CoC for its entire staff and then six weeks later provides a brief refresher session so that staff may share examples from their work of issues discussed during the orientation. This is a promising way to ensure that staff do understand the CoC and can assist the agency in making any necessary modifications to it in relation to the local context.

An agency in Darfur had a focal point that conducted orientations on the CoC and was also the go-to person for all staff with questions and concerns.

⁴¹ United Nations, "Addressing Sexual Exploitation and Abuse," *Protection from Sexual Exploitation and Abuse*. 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

⁴² United Nations, Interpretation Guide for ST/SGB/2003/13: *Secretary-General's Bulletin on special measures for protection from sexual exploitation and abuse*. Draft under review, 2010.

⁴³ United Nations, *Comprehensive Strategy on Assistance and Support to Victims of Sexual Exploitation and Abuse by United Nations Staff and Related Personnel*. March 7, 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

⁴⁴ United Nations, "Addressing Sexual Exploitation and Abuse," *Protection from Sexual Exploitation and Abuse*. 2008. Available from <http://cdu.unlb.org/Portals/0/Documents/KeyDoc13.pdf>.

MISP Coordination Monitoring Checklist

- ✦ Multisectoral coordinated mechanisms to prevent sexual violence are in place
- ✦ Confidential health services to manage survivors of rape are in place, including:
 - Emergency contraception
 - PEP
 - Antibiotics to presumptively treat STIs
 - Care of wounds and prevention of tetanus (tetanus toxoid/tetanus immunoglobulin)
 - Hepatitis B vaccine
 - Wound care
 - Referrals to health, psychological and social support services
- ✦ Number of incidents of sexual violence reported to health services
- ✦ Information on post-rape care and access to services has been disseminated to community

Which supplies are needed or which Inter-agency RH Kit(s) could be ordered to address this issue?⁴⁵

Number	Name	Color
Kit 3:	Rape Treatment Kit	Pink
Kit 9:	Suture of Tears and Vaginal Examination Kit	Purple

** At times drugs in the kits may not be the same as those that are in the relevant national medical protocol. This should be discussed in the health sector/cluster meeting.*

⁴⁵ The Reference and Training Package, a library of resource materials, is included with each kit order. Please see Chapter 8 for the list of materials in this package. The RH Kits booklet is available from <http://www.rhrc.org/resources/rhrkit.pdf>.

Challenges and Solutions

1. *The provision of psychosocial services can be challenging to implement in the early stages of an emergency. What if the members of the staff have low capacity and lack the basic skills to provide these services?*

Local staff will likely be able to help identify the most appropriate local persons with nonjudgmental, supportive attitudes and good communication skills for this role. It is crucial that all staff that come into contact with a survivor respect the survivor's wishes and ensure that all related medical and health status information is kept confidential and private, including from the survivor's family members. Staff members need to communicate with the survivor in a way that both ensures accurate information and reflects a caring, uncritical attitude. Training programs on psychosocial support can be established once the situation is stable. Good resources that focus on engagement strategies for work with GBV survivors include: *Clinical Management of Rape Survivors*,⁴⁶ *Caring for Survivors Training Module*,⁴⁷ *Communication Skills in Working with Survivors of Gender-Based Violence*,⁴⁸ *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*,⁴⁹ *Establishing GBV Standard Operating Procedures (SOP) Guide*⁵⁰ and the *Workshop Package for the Gender-based Violence Standard Operating Procedures Guide*.⁵¹

2. *What can be done in settings where talking about sexual violence is taboo and/or where there is strong resistance to addressing sexual violence by local health workers and community members?*

Even in settings where discussing sexual violence is strongly discouraged, it is important to find innovative ways to address it as it is a life-saving intervention. For example, one local NGO working with an extremely conservative refugee population organized "family health" workshops for refugee women that covered a wide variety of health issues, including sexual violence. In this way, the community gained knowledge on sexual violence, including why, where and when to seek medical care if they or someone they know is assaulted.

⁴⁶ World Health Organization, United Nations High Commissioner for Refugees, United Nations Population Fund, *Clinical Management of Rape Survivors*, 2009. Available from <http://iawg.net/cmor>.

⁴⁷ United Nations Children's Fund, *Caring for Survivors Training Manual*, 2010. Part One of this series of training modules focuses on how multi-sectoral actors can engage with survivors in a supportive and ethical way. Part Two addresses medical interventions for sexual assault survivors and is based on the WHO Guidelines. Available from <http://www.rhrc.org/resources/index.cfm?sector=gbv#209>.

⁴⁸ Family Health International (FHI), *Communication Skills in Working with Survivors of Gender-Based Violence*, RHRC Consortium, 2004. Available from http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html.

⁴⁹ Global Protection Cluster Gender-based Violence Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, 2010. Available from [http://onerresponse.info/GlobalClusters/Protection/GBV/publicdocuments/GBV%20Handbook%20Long%20Version\[1\].pdf](http://onerresponse.info/GlobalClusters/Protection/GBV/publicdocuments/GBV%20Handbook%20Long%20Version[1].pdf).

⁵⁰ Inter-agency Standing Committee Sub-Working Group on Gender and Humanitarian Action, *Establishing GBV Standard Operating Procedures (SOP) Guide*, May 2008. Available in English and in French from the Protection cluster website at <http://onerresponse.info/GlobalClusters/Protection/GBV/Pages/Gender-Based%20Violence.aspx>.

⁵¹ Global Protection Cluster Gender-based Violence Area of Responsibility Working Group, *Workshop Package for the Gender-based Violence Standard Operating Procedures Guide*. GBV SOP Guide. Available in English and in French from the Protection Cluster website at <http://onerresponse.info/GlobalClusters/Protection/GBV/Pages/Gender-Based%20Violence.aspx>.

Chapter 3 Quiz

(Answers on pages 104-105)

1 The RH Officer should:

- a. Support multi-sectoral/inter-cluster coordination of actions to prevent (and respond to) sexual violence.
- b. Conduct a community-wide IEC campaign about gender-based violence.
- c. Ensure communities are informed about the benefits of seeking clinical care for rape as well as the location and hours of clinical care service.
- d. Identify and support the development and functioning of systems to address sexual exploitation and abuse.
- e. a, c and d

2 Which of the following groups are potential perpetrators of sexual violence?

- a. UN personnel
- b. Family and community members
- c. Armed militia groups
- d. Women
- e. All of the above

3 A good resource for guiding agencies on how to address sexual exploitation and abuse is:

- a. CERF *Life-saving Criteria and Sectoral Activities*
- b. IEC Universal Templates
- c. InterAction's *Step by Step Guide*
- d. MISP cheat sheet
- e. RHRC Consortium *Field Friendly Guide to Emergency Obstetric Care*

4 Which situation may put women at risk for sexual violence?

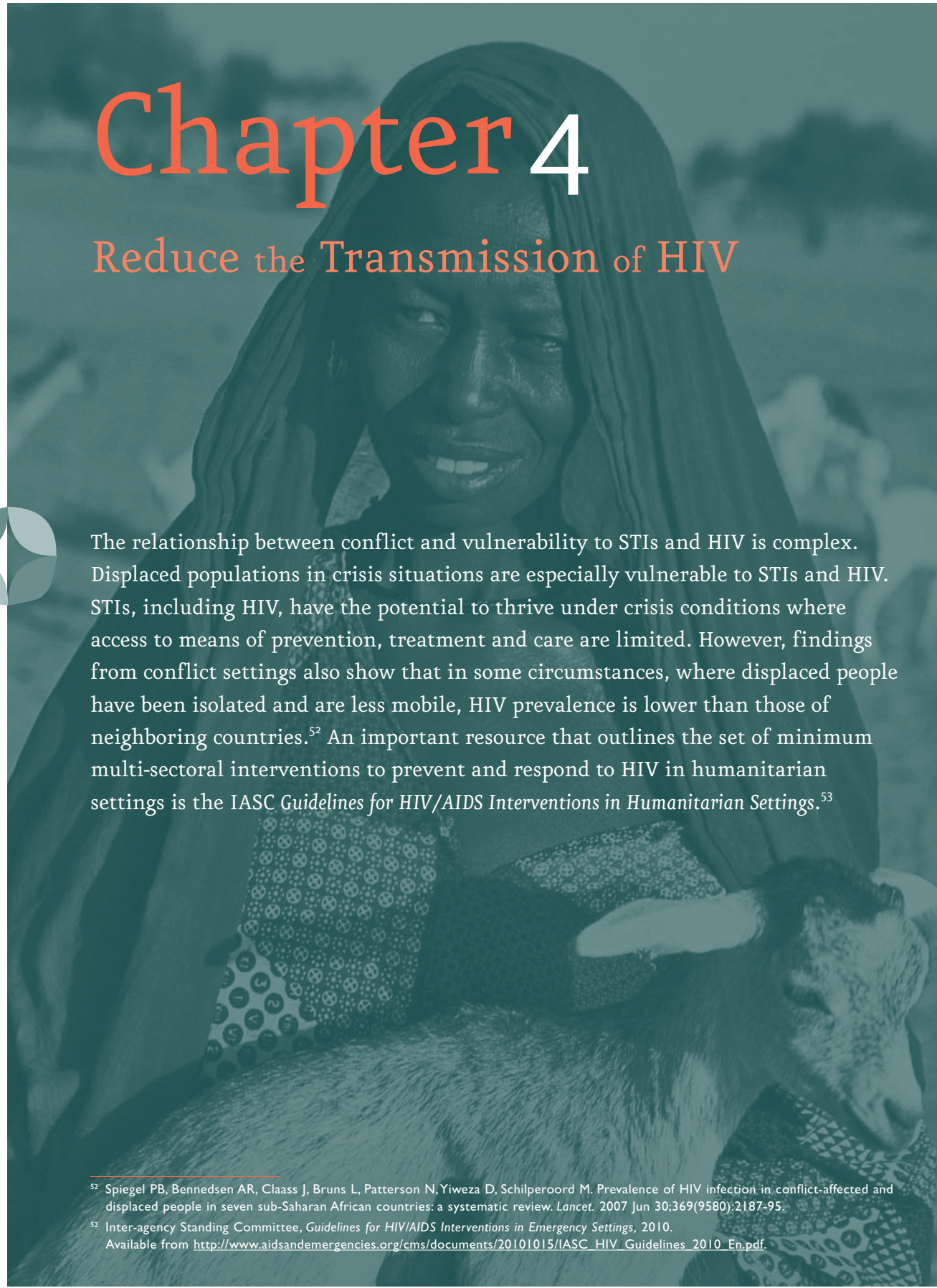
- a. Women participating in distribution of food and other goods
- b. Latrines that lock from the inside
- c. Lack of cooking fuel available in or near households
- d. Most, but not all, on-site protection officers being female
- e. International and local NGOs abiding by CoC against sexual exploitation and abuse

5 Which of the below is **not** a MISP-related service for women and girls who survive sexual violence?

- a. Psychosocial care
- b. Antenatal care
- c. Ensured physical safety
- d. Access to emergency contraception
- e. Access to post-exposure prophylaxis to prevent HIV

Chapter 4

Reduce the Transmission of HIV

A photograph of a woman with long dark hair, wearing a patterned headscarf and a patterned top, holding a small goat. The image is overlaid with a semi-transparent teal filter. The woman is looking slightly to the right with a gentle expression. The background is blurred, suggesting an outdoor setting.

The relationship between conflict and vulnerability to STIs and HIV is complex. Displaced populations in crisis situations are especially vulnerable to STIs and HIV. STIs, including HIV, have the potential to thrive under crisis conditions where access to means of prevention, treatment and care are limited. However, findings from conflict settings also show that in some circumstances, where displaced people have been isolated and are less mobile, HIV prevalence is lower than those of neighboring countries.⁵² An important resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to HIV in humanitarian settings is the IASC *Guidelines for HIV/AIDS Interventions in Humanitarian Settings*.⁵³

⁵² Spiegel PB, Bennedsen AR, Claass J, Bruns L, Patterson N, Yiweza D, Schilperoord M. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: a systematic review. *Lancet*. 2007 Jun 30;369(9580):2187-95.

⁵³ Inter-agency Standing Committee, *Guidelines for HIV/AIDS Interventions in Emergency Settings*, 2010. Available from http://www.aidsandemergencies.org/cms/documents/20101015/IASC_HIV_Guidelines_2010_En.pdf.

THE OBJECTIVE

TO REDUCE THE TRANSMISSION OF HIV BY:

- Ensuring safe and rational blood transfusions;
- Enforcing respect for standard precautions; and
- Guaranteeing the availability of free condoms.

Why is reducing HIV transmission a priority?

In most settings, HIV and other STIs spread faster where there is poverty, powerlessness and instability—all characteristics of displaced settings. In this environment, it is necessary to do everything possible to contribute to the efforts to stop new infections.

What are some risk factors for the spread of HIV in displacement settings?⁵⁴

STIs, including HIV infections, if not addressed or checked, may increase among displaced populations for many reasons:

- ◆ Poor or destroyed health infrastructure.
- ◆ Protective supplies in health centers, such as clean needles, syringes and gloves, may not be available.
- ◆ Staff may feel they are too busy to adhere to, or are not aware of, the importance of standard precautions.
- ◆ Limited or no access to condoms.
- ◆ Increased vulnerability to STIs for refugees and displaced persons for reasons including poverty; food insecurity; lack of access to health services; mobility; and lack of protection against violence and/or exploitation by military, peacekeeping forces and others.⁵⁵
- ◆ Women and children coerced into transactional sex to obtain their survival needs.
- ◆ Gender-related factors, such as increased GBV due to the breakdown of social and community structures.⁵⁶
- ◆ Power imbalances that make girls and women disproportionately vulnerable to the infection become more pronounced during conflict and displacement.⁵⁷
- ◆ Disturbance of community and family life among displaced populations can disrupt social norms governing sexual behavior.
- ◆ Adolescents may begin sexual relations at an earlier age and/or are more likely to take sexual risks, such as having sexual intercourse without using a condom.

⁵⁴ International Rescue Committee, *Protecting the Future: A guide to incorporating HIV prevention and care in refugee settings*, 2002.

⁵⁵ United Nations Joint Programme on HIV/AIDS, United Nations High Commissioner for Refugees, *Strategies to support the HIV-related needs of refugees and host populations*, 2005. Available from http://data.unaids.org/publications/irc-pub06/JCI1157-refugees_en.pdf.

⁵⁶ United Nations Joint Programme on HIV/AIDS Inter-Agency Task Team on Gender and HIV/AIDS, *Operational Guide on Gender and HIV/AIDS*, 2005. Available from <http://www.unfpa.org/hiv/docs/rp/op-guide.pdf>.

⁵⁷ United Nations Joint Programme on HIV/AIDS Inter-Agency Task Team on Gender and HIV/AIDS, *Operational Guide on Gender and HIV/AIDS*, 2005. Available from <http://www.unfpa.org/hiv/docs/rp/op-guide.pdf>.

- ✦ Adolescents face exploitation in the absence of traditional socio-cultural constraints.
- ✦ Due to forced displacement, populations from low HIV prevalence areas may mix with populations from high prevalence areas.

It is important to note, however, that HIV transmission among conflict-affected and displaced populations is complex. The common assumption that these populations' increased vulnerability *necessarily* translates into more HIV infections is not supported by data. Various competing and interacting factors affect HIV transmission during conflict and displacement.⁵⁸

HIV Transmission

The main transmission routes of HIV are through unprotected sex, infected blood and mother-to-child transmission. While the majority of infections are generally a result of unprotected sex, the proportion of transmission routes varies by setting.

Safe and Rational Blood Transfusion

The rational and safe use of blood is essential to preventing the transmission of HIV and other transfusion-transmissible infections such as Hepatitis B and C and syphilis. If conducted properly, blood transfusion can save lives, but it does carry the risk of the transmission of infectious agents such as HIV, malaria, hepatitis viruses and syphilis. If HIV-contaminated blood is transfused, transmission of HIV to the recipient is almost 100 percent. Improperly screened or unscreened blood and the incorrect use of blood and blood products increase the risk of HIV to recipients. Blood transfusions must not be undertaken if the facilities, supplies and appropriately qualified staff do not exist. Decreasing unnecessary blood transfusion is also critical to avoid the risks of infection and preventing blood shortages. Unnecessary transfusion can be reduced by ensuring the appropriate clinical use of blood, avoiding the needs for transfusion and use of alternatives to transfusion.

Urban Settings: Determine national policies and practices on safe blood transfusion. In collaboration with the health sector/cluster, distribute blood test kits and supplies for safe blood transfusion and the practice of standard precautions to health facilities as needed. Ensure that condoms are available in health facilities, mobile clinics, throughout the urban area in community centers, popular bars, and at food and non-food item distribution points. Advocate for the displaced community to have full access to the national HIV programs, including prevention standard precautions, voluntary counseling and testing (VCT), PMTCT, antiretroviral therapy and PEP programs. Early detection and prevention with culturally appropriate HIV IEC materials, translated into the language of displaced persons is important. These services also must be targeted for groups engaged in high-risk behaviors.

⁵⁸ Spiegel, PB., "HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action," *Disasters* 2004; 28: 322-39

Use the standard criteria for blood transfusions⁵⁹ as outlined by WHO:

Reduce the need for blood by:

- ✦ Transfusing blood only in life-threatening circumstances and when there is no other alternative—using medicines to prevent or reduce active bleeding and using standard blood substitutes to replace lost blood.

Safe blood transfusion includes:

- ✦ Developing stringent blood donor selection criteria and collecting blood only from voluntary, unpaid blood donors at low risk of acquiring transfusion-transmissible infections; and
- ✦ Using the most appropriate assays to screen all blood for at least HIV 1 and 2, hepatitis B, hepatitis C and syphilis.⁶⁰

In order to make rational and safe blood transfusion available, RH Officers and staff must work with the health sector/cluster partners to ensure that:

- ✦ Referral-level hospitals have sufficient supplies for safe and rational blood transfusion;
- ✦ Staff know how and have access to supplies to reduce the need for blood transfusion;
- ✦ Safe, voluntary donors are recruited;
- ✦ SOPs for blood transfusion are in place;
- ✦ Responsibility for the decision to transfuse is assigned and medical staff are held accountable;
- ✦ Staff are informed of protocols and follow SOPs at all times to ensure safe blood transfusion practice at the bedside;
- ✦ Waste products, such as blood bags, needles and syringes, are safely disposed of; and
- ✦ Sites where blood is screened and where transfusion is performed have reliable light sources. To minimize the risk of errors, blood transfusion at night should be avoided as much as possible.⁶¹

What are standard precautions?

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure of blood or body fluids among patients and health care workers. Under the standard precautions principle, blood and body fluids from all persons should be considered potentially infectious and handled accordingly. Standard precautions prevent the spread of infections such as HIV, hepatitis B and C and other pathogens in health care settings.

Why are standard precautions particularly important in an emergency setting?

Standard precautions are essential in any setting but, in an emergency, infrastructures and supplies may be destroyed or unavailable. Due to high work pressure, among other reasons, health care staff are more likely to have work-related accidents and may resort to taking shortcuts in procedures, which endangers the safety of both patients and staff. Therefore, infection control measures must be enabled and enforced during a crisis.

⁵⁹ WHO blood transfusion safety website is accessible from <http://www.who.int/bloodsafety/en/>.

⁶⁰ For further information on selecting safe donors, visit http://www.who.int/bloodsafety/voluntary_donation/en/.

⁶¹ For further information on blood safety, visit http://www.who.int/bloodsafety/clinical_use/en/.

Enforce Respect for Standard Precautions

Standard precautions must be emphasized during the first health coordination meeting. Keep in mind especially that cleaners and other support staff, who are often newly recruited, may not have worked in health setting environments before and therefore may not have received adequate training.

What are the minimum requirements for infection control?⁶²

Ensure all staff (both medical and support staff) in health care settings understand standard precautions.

Standard precautions are:

- ✦ Frequent hand washing:
 - ❖ Wash hands with soap and water before and after all patient contact.
 - ❖ Make facilities and supplies for hand washing easily available for all service providers.
- ✦ Wearing gloves:
 - ❖ Wear non-sterile single use gloves for all procedures where contact with blood or other potentially infected body fluids is anticipated.
 - ❖ Wash hands before putting on and after removing gloves.
- ✦ Wearing protective clothing:
 - ❖ Waterproof gowns or aprons must be worn where blood or other body fluids might splash.
 - ❖ Require staff to wear masks and eye shields where there is possible exposure to large amounts of blood.
- ✦ Safe handling of sharp objects:
 - ❖ Minimize the need to handle needles and syringes.
 - ❖ Use a sterile disposable syringe and needle for each injection.
 - ❖ Set up a work area where injections are given to reduce the risk of injury.
 - ❖ Do not recap needles.
 - ❖ Position and inform patients correctly for injections.
 - ❖ Dispose needles and sharps in puncture-and liquid-proof safety boxes. Ensure puncture-resistant containers for sharps disposal are readily available, close at hand and out of reach of children. Sharp objects should never be thrown into ordinary waste bins or bags.
- ✦ Disposal of waste materials:
 - ❖ Burn all medical waste in a separate area, preferably within the health facility grounds.
 - ❖ Bury items that still pose a threat, such as sharp objects, in a covered pit at least 10 meters from a water source.

⁶² For further information on infection prevention, visit <http://www.engenderhealth.org/files/pubs/qi/ip/ip-ref-eng.pdf>.

- ✦ Using single-dose vials rather than multi-dose vials and:
 - ❖ If multi-dose vials are used, avoid leaving a needle in the stopper.
 - ❖ Once opened, store multi-dose vials in refrigerator.
- ✦ Instrument processing: Process used instruments in the following order:
 1. *Decontaminate* instruments to kill viruses (HIV and hepatitis B) and make items safer to handle.
 2. *Clean* instruments before sterilization or high-level disinfection (HLD) to remove debris.
 3. *Sterilize* (eliminates all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. HLD (through boiling or soaking in a chlorine solution) may not eliminate spores.
 4. *Use or properly store* items immediately after sterilization.
- ✦ Housekeeping:
 - ❖ Clean up spills of blood or other body fluids promptly and carefully.

What should RH Officers do to support health sector/cluster workplace policies for occupational exposure?

Despite putting standard precautions in place and adhering to them, occupational exposure to HIV may occur. RH Officers must advocate and provide assistance within the health sector/cluster to ensure that workplace policies for occupational exposure are established and implemented, including:

- ✦ Ensure PEP⁶³ is available within the health sector as part of a comprehensive standard precautions package for reducing staff exposure to infectious hazards at work.
- ✦ Post first aid measures in relevant workspaces and inform all staff how to access treatment for exposure.
- ✦ Maintain confidentiality of the exposed health worker and the person who is the source of exposure at all times.
- ✦ Counsel the source patient regarding HIV testing and conduct an HIV test if consent is obtained.
- ✦ Assess the risk of HIV transmission in case of occupational exposure: the type of exposure (percutaneous injury, mucous membrane splash, etc.); the type of material exposed to (blood, other body fluids, etc.); and the likelihood of HIV infection of the source patient.
- ✦ Provide counseling for the exposed worker on the implications of the exposure, the need for PEP, how to take it and what to do in case of side effects.
- ✦ Take a medical history and conduct an exam of the exposed worker only after informed consent; recommend HIV voluntary counseling and testing and provide PEP when appropriate. An HIV test is not required before prescribing PEP and no one should be forcibly tested.
- ✦ Educate on risk reduction through review of sequence of events and advise exposed worker to use condoms to prevent secondary transmission during the next three months.

⁶³ World Health Organization, *Post-exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to prevent HIV infection*, 2007.

- ✦ Provide HIV voluntary counseling and testing at three and six months after the exposure, whether or not the exposed worker received PEP.
- ✦ Complete an incident report.

How can RH Officers work with the health sector/cluster partners to ensure the application of standard precautions?

- ✦ Ensure that protocols for standard precautions are posted in each health facility and that supervisors enforce adherence to these.
- ✦ Organize in-service orientation sessions on standard precautions for health care workers and auxiliary staff where needed.
- ✦ Establish supervisory systems such as simple checklists to ensure compliance with protocols.
- ✦ Ensure first-aid measures in case of occupational exposure are posted and staff are informed and know where to report and obtain PEP if needed.
- ✦ Review occupational exposure incidence reports regularly to determine when and how exposure occurs, and to identify safety concerns and possible preventive measures.

Noted Practices in Preventing and Managing the Consequences of HIV from Darfur⁶⁴

At a clinic in North Darfur, a medical assistant was identified who was specifically responsible for ensuring standard precautions. Trainings on standard precautions were held with village midwives, and necessary supplies were distributed, including condoms.

Adolescents: Provide discreet access to free condoms at adolescent-oriented distribution points, and ensure that health workers provide condoms to adolescents presenting with symptoms of STIs. Ensure that adolescent-friendly health services are available for adolescents presenting to facilities.

Make Free Condoms Available

Condoms are a key method of protection for the prevention of HIV and other STIs. Although not all of the population will be 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 ordered immediately. (See exercise box, page 42, on how to calculate the correct number of condoms to order.)

⁶⁴ The Women's Refugee Commission sub-granted to international agencies to coordinate the implementation of the MISIP in the three states of Darfur, Sudan from 2005 to 2006. Some practices observed by the Women's Refugee Commission's field team are noted..

Exercise

Calculate a 3-month supply of male condoms for a population of 10,000	
SEXUALLY ACTIVE MALE POPULATION = 20%	$10,000 \times .2 = 2,000$
PERCENTAGE OF SEXUALLY ACTIVE MEN WHO USES CONDOMS = 20%*	$2,000 \times .2 = 400$
CONDOMS USED PER MONTH PER MALE = 12	$400 \times 12 = 4,800$
WASTAGE OR LOSS = 20%	$4,800 \times .2 = 960$
CONDOMS USED PER MONTH + WASTAGE/LOSS	$4,800 + 960 = 5,760$
CALCULATE FOR A 3-MONTH SUPPLY**	$5,760 \times 3 = 17,280$

* Twenty percent is a general estimate which can be modified if additional information from previous surveys or studies indicate a higher or lower condom usage rate.

** Condoms usually come in boxes of 144.

Female condoms

Female condoms provide women and girls with a female-initiated method of preventing HIV and protection against other STIs and pregnancy. This is especially important since many women and girls are unable to negotiate male condom use with their partners due to a lack of power in their relationship. Female condoms are typically more expensive and are usually not as well known as male condoms among the population. If, however, the affected community is known to use female condoms, then they can be procured at the onset of an emergency. If the affected community is not familiar with them, explore whether it is possible to secure a stable supply of female condoms; then once a stable phase of the emergency is reached, provide information to the population about this method and provide training for women, girls, boys and men on correct use.

Where can humanitarian staff order condoms?

There are many brands of condoms on the market. It may be useful to check with the national MoH and local NGOs that work in the family planning and HIV prevention or treatment sectors, as they may also be able to help with condom procurement and may be able to do so more rapidly than UN agencies. If an agency does not have experience in procuring condoms, contact UNFPA,⁶⁵ the organization that procures for the whole UN system, to facilitate the purchase of bulk quantities of good-quality condoms at low cost. Male condoms are available as part of Inter-agency RH Kits in Kit 1, part A. Female condoms are available in the Inter-agency RH Kit 1, part B. (See Chapter 7 for more information on RH Kits.)

⁶⁵ Contact information is available at <http://www.unfpa.org/public/contact>.

The Reality of Implementing the MISP in Chad⁶⁶

The Women's Refugee Commission and UNFPA conducted an assessment of the MISP among Darfuri refugees in Chad in March 2004. At the time, priority activities to prevent the transmission of HIV in this setting were nonexistent or limited at best. One humanitarian worker remarked, "Condoms would probably melt here." Another worker stated, "We need to concentrate on basic activities—not complicated activities like HIV."

How should condoms be made available?

In addition to providing condoms upon request in health facilities, humanitarian staff should make sure that condoms are made visible to the displaced population and provide information that condoms are available at various locations. Condoms can be set out at health facilities as well as at a range of other sites such as registration; food and non-food distribution points; youth and community service offices; and anywhere that people congregate or come to access services or supplies. It may be a good idea to make condoms available in private locations, such as latrines and to supply hotels and bars with condoms. Discuss with people from the affected population (men, women and youth) about how condoms can be made available in a culturally sensitive way—particularly for individuals who engage in behavior that increases their risk of transmission, such as sex workers and their clients, men who have sex with men, injecting drug users and young people. Adolescents may also be helpful in identifying locations where their peers congregate.

Designing and implementing an appropriate IEC condom distribution campaign is time and resource consuming and is thus not a priority intervention at the beginning of an emergency. It is best not to conduct a mass IEC campaign on condom distribution until after all components of the MISP have been implemented, when more comprehensive HIV, AIDS and family planning programs can be carefully designed.

Noted Practice

When asked by a national staff why there were condoms in the toilet area, an international organization representative explained: "X agency is an international organization and, wherever we work in the world, we make condoms available to prevent HIV transmission in the region we are working." The staff person was satisfied with this answer and condoms slowly began to be taken from the condom basket located in the staff toilet.

⁶⁶ Women's Refugee Commission and UNFPA, *Lifesaving Reproductive Health Care: Ignored and Neglected: Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad*, 2004. Available from http://www.rhrc.org/resources/cd_misp_final.pdf.

MISP HIV Monitoring

- ✦ Safe and rational blood transfusion protocols in place
- ✦ Units of blood screened/all units of blood donated x 100 ____
- ✦ Sufficient materials and checklists to ensure standard precautions in place
- ✦ Condoms available free of charge at:
 - ✦ Health facilities
 - ✦ Community level
- ✦ Approximate number of condoms taken this period _____
- ✦ Number of condoms replenished in distribution sites this period (specify locations)

Which supplies are needed or which Inter-agency RH Kit(s) could be ordered to address this issue?⁶⁷

Number	Name	Color
Kit 1:	Condom Kit (Part A + B)	Red
Kit 12:	Blood Transfusion Kit	Dark green

* *It is important that supplies are procured in collaboration with the overall health sector/cluster procurement to ensure coordinated supply procurement, management and distribution.*

Challenges and Solutions

1. What if the health facilities do not have the capacity to screen donors for HIV?

Do not administer blood that has not been screened. Strongly advocate to the MoH, UN agencies such as WHO and UNFPA, or a humanitarian organization such as International Committee of the Red Cross, to establish blood screening services.

2. What if the culture of the displaced population objects to condoms?

Humanitarian workers sometimes assume that the wide availability of condoms may be frowned upon by some cultures. It is still important to make condoms visible and available, however, because such an assumption may not be true or may not be true for everyone in the population. There are creative ways to provide this life-saving material for those who want to protect themselves or others from HIV transmission, such as placing condoms in less public yet still accessible areas. In one displaced setting in Indonesia, for example, an agency engaged local kiosks to keep a bowl of condoms available for the community free of charge.

⁶⁷ Most kits include supplies to ensure universal standard precautions. In addition, the Reference and Training Package, a library of resource materials, is included with each kit order. Please see Chapter 7 for the list of materials in this package. The Inter-agency RH Kit booklet is available at <http://www.rhrc.org/resources/rhrkit.pdf>.


Chapter 4 Quiz

(Answers on page 105)

- 1** Which is **not** a risk factor for HIV transmission in displaced settings?
- a. Exploitative relationships among women and girls who are in need of money, goods or services
 - b. People living with HIV participating in food distribution
 - c. Adolescents who may initiate sexual relations at an earlier age
 - d. Armed forces and other uniformed services surround the displacement area
 - e. Making condoms available only to married couples
- 2** Which of the following activities should be undertaken in order to ensure safe blood transfusion?
- a. Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other transfusion transmissible infections such as hepatitis B and C and syphilis
 - b. Avoid unnecessary blood transfusions
 - c. Ensure there are sufficient HIV and other tests and supplies available for screening blood where needed
 - d. Ensure that an appropriate facility, supplies and qualified staff are in place
 - e. All of the above
- 3** Which is a requirement for infection control?
- a. Facilities for frequent hand washing
 - b. X-ray services
 - c. Decontaminating, cleaning, disinfecting and sterilizing used instruments
 - d. Safe handling of sharp objects
 - e. a, c and d
- 4** PEP should **not** be provided if HIV testing is unavailable or the patient refuses a test.
- True
 - False
- 5** Condoms can be made available at:
- a. Health facilities
 - b. Food and non-food distribution points
 - c. Latrines
 - d. Popular bars in urban areas
 - e. All of the above

Chapter 5

Prevent Excess Maternal and Newborn Mortality and Morbidity



Maternal mortality is a leading cause of death among women of reproductive age living in resource poor settings. The stressful living conditions and limited access to skilled health providers and health facilities exacerbate the vulnerability of displaced women during pregnancy, labor and delivery with high risk for morbidity and mortality due to pregnancy-related complications. There are several useful resources that provide step-by-step approaches to integrate EmOC into humanitarian programming, including the *Field Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*⁶⁸ and the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.⁶⁹

⁶⁸ Women's Refugee Commission, *Field Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*, RHRC Consortium, 2005. Available from http://www.rhrc.org/resources/emoc/EmOC_ffg.pdf.

⁶⁹ Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010. Available from http://www.iawg.net/resources/field_manual.html.

OBJECTIVES

PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY THROUGH PROVISION OF PRIORITY ACTIVITIES:

- ❖ Ensuring availability and accessibility of EmOC and newborn care services at:
 - ❖ Health facilities, where skilled birth attendants, supplies for normal births, and basic emergency obstetric care for the management of obstetric and newborn complications (basic EmOC) should be available 24 hours per day 7 days per week.
 - ❖ Referral hospitals, where skilled medical staff and supplies for comprehensive emergency obstetric care for management of obstetric and newborn emergencies (basic and comprehensive EmOC) should be available 24 hours per day 7 days per week.
- ❖ Establishing a referral system for transportation and communication from the community to the health center or hospital, and between the health center and the hospital.
- ❖ Providing clean delivery kits to visibly pregnant women and birth attendants for clean home deliveries when access to a health facility is not possible.

Ensure basic EmOC and newborn care at all health centers. This means that the staff is skilled and has the resources to:

1. Administer *parenteral* antibiotics
2. Administer *parenteral* uterotonics
3. Administer *parenteral* anticonvulsants
4. Perform manual removal of the placenta
5. Perform removal of retained products of conception
6. Perform assisted vaginal delivery
7. Perform neonatal resuscitation

Ensure comprehensive EmOC and newborn care at hospitals. This means that the staff is skilled and has the resources to support all of the interventions above, plus to:

8. Perform cesarean and laparotomy under anesthesia
9. Perform blood transfusions

Why is preventing maternal and newborn morbidity and mortality a priority?

In any displaced population, approximately 4 percent of the total population will be pregnant at a given time.⁷⁰ Of these pregnant women, approximately 15 percent will experience an obstetric complication such as obstructed or prolonged labor, pre-eclampsia/eclampsia, sepsis, ectopic pregnancy or complications of abortion.⁷¹ At the onset of an emergency, past experience has shown that births tend to take place outside the health facility without the assistance of trained health personnel. As birth complications are difficult to predict, the WHO recommends that all births are attended by skilled health personnel and take place in health institutions that are equipped and staffed to manage complications. Without access to emergency obstetric services, many women will die or suffer long-term health consequences that are preventable (e.g., obstetric fistula).

Urban Settings: Work within the health sector/cluster to identify and support health facilities with medical supplies and human resources to ensure provision of care for normal deliveries, basic and comprehensive EmOC, newborn care and an emergency referral system 24 hours per day, 7 days per week. In circumstances where a "user fee" is a new barrier to health care service, advocate for free access for maternal and newborn health care services, including EmOC services. In urban settings, crisis-affected populations are unlikely to know where women can go for free care during childbirth or complications of childbirth. Ensure that explicit information is available to inform pregnant women and the affected urban community when and where women can access free delivery care and care for complications of child birth. Also identify how communities are currently gaining information, if at all, such as through the radio, cell phones or other means of communications and consider using adaptable IEC templates to inform communities. (See <http://rhrc.org/members/iec>.)

What basic materials can help pregnant women have a clean birth in an emergency?

In all humanitarian settings, there are women and girls who are in the later stages of pregnancy and who will therefore deliver during the emergency. It is important to make clean delivery packages available to all visibly pregnant women to support clean home deliveries (when access to a health facility is not possible). Be sure to include information on how to use the clean delivery kit, to emphasize the importance of giving birth at a health facility in the presence of a skilled provider, and about how to access nearby health facilities. Distribution can be done at registration sites and can be provided to skilled personnel who are attending to births at the community level.

Adolescents: Identify pregnant adolescents in the community and link them to health facilities to encourage facility-based deliveries. Facilitate new adolescent mothers' participation in peer support networks following the delivery.

⁷⁰ United Nations Population Fund, *State of the World Population 2002*, 2002.

⁷¹ United Nations Children's Fund, World Health Organization, United Nations Population Fund, *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997.

Clean Delivery Package

The package contains very basic materials: one sheet of plastic (for the woman to deliver on), a bar of soap, a pair of gloves, one clean razor blade (new and wrapped in its original paper, to cut the umbilical cord), three pieces of string (to tie the umbilical cord), two pieces of cotton cloth (one to dry and the other to warm the baby), explanatory leaflets with pictures.

What is the best way to obtain clean delivery packages?

Because the materials included in a clean delivery package are often easily obtained locally, it is possible to assemble these packages on site. In fact, it may be possible to contract with a local NGO to produce the packages, which could also provide an income generation project for local women. Clean delivery packages can also be ordered from UNFPA, which may sometimes be a quicker alternative—and the sooner the materials are available, the better it is for pregnant women. In addition, contacting UNFPA⁷² before the start of a crisis to establish a relationship and to ensure the availability of supplies will likely facilitate better emergency preparedness.

Exercise

Use the Crude Birth Rate (CBR) (4%) to calculate the supplies and services needed for a population of 10,000 for 3 months to ensure pregnant women have a safe delivery.

CBR =	4% per year
10,000 X .04 =	400 births per year
400 X .25⁷³ =	100 births in a 3-month period
ORDER	One RH Kit 2, Part A which contains 200 clean delivery packages to be used by women. This is sufficient for more than a 3-month period. One RH Kit 2, Part B which contains 5 sets of supplies for use by TBAs, including shoulder bags, flashlights with batteries, gloves, plastic aprons and rain ponchos.

How can we ensure that pregnancy and delivery complications are dealt with efficiently at the health center level?

Support and promote for all childbirth to take place at health facilities. You should also disseminate information to the community and to service providers at the location about working hours and ambulance services for health centers and hospitals that can manage normal and complicated pregnancy and delivery. In addition, provide midwives and other skilled birth attendants at the primary health center level with materials and drugs to safely conduct deliveries, to provide basic EmOC and to stabilize women prior to transport to the referral hospital.

⁷² Contact information available at <http://www.unfpa.org/public/contact>.

⁷³ Three months are 25 percent (.25) of one year.

Ensure access to basic and comprehensive EmOC and newborn care services. According to the UN Process Indicators of the Emergency Obstetric Services, an estimated 15 percent of women will develop a potentially life-threatening complication during pregnancy or at the time of delivery.⁷⁴ In order to prevent maternal and newborn morbidity and mortality resulting from complications, RH Officers must ensure that basic and comprehensive EmOC and newborn care services are available 24 hours a day 7 days a week. These services include provision of drugs and medical supplies, and recruitment/retention of skilled health personnel. Supplies to address obstetric emergencies are included in the Inter-agency RH Kits and can be ordered through UNFPA (see Chapter 8 for Ordering RH Kits).

How many deliveries require a cesarean section (c-section)?

About five to 15 percent of all deliveries will require a cesarean section.⁷⁵ Women with obstetric emergencies, and those requiring blood transfusion and surgery will need to be referred to a hospital that is capable of providing comprehensive EmOC.

Estimates of c-sections needed based on a population of 20,000 with a CBR of 4%		
EXPECTED NUMBER OF BIRTHS IN A 3-MONTH PERIOD	20,000 x .04 (CBR) x .25	200
PREGNANT WOMEN WHO WILL FACE COMPLICATIONS AT DELIVERY	15%	30
COMPLICATED DELIVERIES THAT REQUIRE A C-SECTION	5-15%	10-30

The Reality of Implementing the MISP in Haiti⁷⁶

Four months following the earthquake in January 2010 in Haiti, basic and comprehensive EmOC was available to varying extents in the three settings assessed, but the quality and availability of free care was not consistently available 24 hours per day 7 days per week. In Port-au-Prince, several facilities offered free comprehensive EmOC but mobile clinics, serving many displaced settlements and camps, were not able to provide basic EmOC. Referral pathways also appeared to be problematic for communities without access to communications networks or affordable transport options—particularly those in the more remote camps and settlements in Léogane and Jacmel. Women also appeared to have very limited access to clean delivery kits, in spite of agencies reporting distribution in the thousands. Care for complications in newborns was also raised as a major concern in all three locations.

⁷⁴ United Nations Children's Fund, World Health Organization, United Nations Population Fund, *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997. www.amdd.hs.columbia.edu/docs/unguidelines.finalversion.pdf.

⁷⁵ UNICEF, WHO and UNICEF *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997.

⁷⁶ Women's Refugee Commission, *Four Months On: A Snapshot of Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment Conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission*, May 17-21, 2010, October, 2010. Available from <http://www.womensrefugeecommission.org/reports>.

What is included in newborn care?

Approximately two-thirds of infant deaths occur within the first 28 days of life.⁷⁷ The majority of these deaths are preventable by initiating essential actions that can be taken by mothers or health care workers.⁷⁸ One major challenge is that approximately five to ten percent of newborns do not breathe spontaneously at birth and require stimulation;⁷⁹ about half of those who have difficulty initiating breathing require resuscitation.⁸⁰ To prevent and address these complications:

- ✦ Provide midwives and other skilled birth attendants in health facilities with materials and drugs for essential newborn care. This will include materials for newborn resuscitation, antibiotics for the treatment of sepsis, and supplies for the care of low birth weight/preterm babies.
- ✦ Ensure skilled birth attendants are able to provide competent essential newborn care, including:
 - ❖ Initiation of breathing;
 - ❖ Resuscitation;
 - ❖ Thermal protection (delayed bathing, drying, skin-to-skin contact);
 - ❖ Prevention of infection (cleanliness, hygienic cord cutting and care, eye care);
 - ❖ Immediate and exclusive breastfeeding; and
 - ❖ Management of newborn sepsis and care for preterm/low birth weight babies.

Establish a Referral System

When should a referral system for obstetric emergencies be made available?

RH Officers must coordinate with the health sector/cluster and host-country authorities to ensure a referral system (including means of communication and transport) is established immediately (in the first days) in a humanitarian setting. The referral system must support the management of obstetric and newborn complications in the displaced population available 24 hours per day 7 days per week. It should ensure that women, girls and newborns that require emergency care are referred from the community to a health center where basic EmOC is available, or a hospital where basic and comprehensive EmOC and newborn care is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health center must be stabilized and transported to a hospital with comprehensive EmOC and newborn care services.

What are the requirements of an effective referral system?

A referral system should have transport—including drivers, sufficient fuel and cell phones/radio/sat phones—available 24 hours per day 7 days per week. In a camp setting, it is extremely important to attempt to negotiate access to the referral hospital with camp security personnel in order to allow for the transport of emergency patients at night. Where available 24 hours per day 7 days per week transportation services are impossible to establish, the RH Officer should work through the health sector/cluster to resolve the problem and to ensure that the populations have access to basic and comprehensive EmOC.

⁷⁷ World Health Organization, *Perinatal and Neonatal Mortality: Global, Regional and Country Estimates*, 2001.

⁷⁸ Moore, J. and J. McDermott, *Every Newborn's Health: Recommendations for Care for All Newborns, Save the Children USA*, 2004.

⁷⁹ World Health Organization. *Basic Newborn Resuscitation: Practical Guide*, WHO/RHT/MSM/98.1, 1-32, 1998.

⁸⁰ World Health Organization. *Basic Newborn Resuscitation: Practical Guide*, WHO/RHT/MSM/98.1, 1-32, 1998.

For there to be a functional referral mechanism, it is critical that qualified staff are available at all times at health centers to provide basic EmOC and newborn care. These staff members must have a means of communication to call for transportation as soon as possible and to contact the hospital to inform them that they are sending a referral patient. The communication system is also important for staff to contact the referral hospital for support and guidance on stabilizing the patient if she has an obstetric complication, particularly if transport to the hospital is not possible. A qualified medical person who can address obstetric complications and perform a cesarean section if necessary must be available at the referral facility at all times. Finally, the referral facility must have qualified staff, medical equipment and supplies to cope with the extra demands put on it by the displaced population. Where needed, it is important to support existing hospitals in areas with the affected populations with skilled staff, infrastructure and medical commodities, including medicines and surgical equipment, and to provide comprehensive EmOC and newborn care.

Are there any types of activities related to maternal care that are not a priority in a crisis?

Most maternal deaths occur from complications during labor, delivery and in the immediate postpartum period. The majority of these complications cannot be predicted during pregnancy. Setting up the ability to provide antenatal care and training midwives are appropriate activities that need to be established as soon as possible; however, these interventions are not a priority in the immediate emergency and should not divert attention from the more urgent need of access to quality facility-based delivery, basic and comprehensive EmOC and newborn care. Training existing midwives on clean and safe deliveries should wait until more stability has been reached; identifying midwives, however, and ensuring they are informed about the referral system, should be undertaken from the onset of a crisis. It is also important to inform community members on danger signs during pregnancy and where to refer women with these symptoms from the onset of a crisis.

It is important to note that WHO does not recommend training new TBAs, but rather informing all women in the community about danger signs during delivery and providing a professional training curriculum for village midwives.⁸¹

Noted Practices in Preventing Excess Maternal and Newborn Mortality and Morbidity from Burma/Myanmar

After Cyclone Nargis devastated Burma/Myanmar in May 2008, UNFPA, MSI, Relief International and other groups prioritized ensuring referral systems were established for EmOC. Agencies used creative transport mechanisms for women with obstetric emergencies, including transportation by boat to referral hospitals since roads were severely obstructed. Agencies pooled their funds to support the costs of EmOC and also established maternity waiting homes during the more stable times, reflecting exceptional coordination among agencies supporting EmOC and newborn care.

⁸¹ WHO, *Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO*, 2004. Available from <http://whqlibdoc.who.int/publications/2004/9241591692.pdf>.

What causes women to die from pregnancy complications?

The common causes for maternal mortality are hemorrhage (ante-and postpartum), postpartum sepsis, pre-eclampsia or eclampsia, complications of abortion, ectopic pregnancy and prolonged or obstructed labor. While there are many factors that can cause the delays in accessing life-saving care that cost women their lives, those delays can be grouped using a simple model called The Three Delays. Those three types of delays that contribute to the likelihood of maternal death are:

- ✦ Delay at the household level in identifying complications and deciding to seek care;
- ✦ Delay in reaching a treatment facility (inability to get transport, poor road conditions, insecurity, check points, curfews, etc.); and
- ✦ Delay in receiving adequate treatment at the facility once reached (absence or lack of qualified staff, lack of equipment/supplies, high costs of treatment, need for down payment prior to receiving care, etc.).⁸²

Therefore, the emergency team needs to make sure that basic and comprehensive EmOC services are in place, and that there is immediate focus on preventing delays for timely access to good quality basic and comprehensive EmOC services for women during labor, delivery and in the immediate postpartum period.

Noted Practice

If the situation permits, assembling clean delivery packages locally may be a good opportunity to identify and organize women's groups and TBAs with whom you can then talk about encouraging all pregnant women to deliver in a health facility, and about early recognition and referral of those suffering from obstetric complications. The women's group can make up the simple packages and then distribute them to visibly pregnant women free of charge. This is particularly helpful because, as the women's groups are part of the displaced population, they most likely already know which women are close to their delivery times and are in need of the materials. Those provided with the kits should also be informed about the nearest facilities and the importance of delivering with a skilled attendant so that they can pass this information on to the women they visit.

⁸² Thaddeus, S. and D. Maine, "Too far to walk: maternal mortality in context," *Social Science and Medicine*, April 1994.

MISP Maternal and Newborn Checklist Monitoring

- ✦ Health center (to ensure basic EmOC and newborn care 24/7) with:
 - ❖ One qualified health worker on duty per 50 outpatient consultations per day
 - ❖ Midwife supplies, including newborn supplies, available
- ✦ Hospital (to ensure comprehensive EmOC and newborn care 24/7) with:
 - ❖ One qualified service provider on duty per 20-30 inpatient beds for the obstetric wards
 - ❖ One team of doctor/nurse/midwife/anesthetist on duty
 - ❖ An adequate amount of drugs and other supplies to support comprehensive EmOC and newborn care 24/7
- ✦ Referral system for obstetric and newborn emergencies functioning 24 hours per day/seven days per week with:
 - ❖ Means of communication (radios, mobile phones) available 24/7
 - ❖ Transport from community to health center available 24/7
 - ❖ Transport from health center to hospital available 24/7
- ✦ Functioning cold chain (for oxytocin, blood screening tests) in place
- ✦ Number of caesarean deliveries/number of births x 100
- ✦ Number of clean delivery kits distributed/estimated number of pregnant women x 100

Which supplies are needed or which UNFPA RH Kit(s) could be ordered to address this issue?⁸³

Number	Name	Color
Kit 2:	Clean Delivery Subkit (Individual) (Part A + B)	Dark blue
Kit 6:	Clinical Delivery Assistance (Part A + B)	Brown
Kit 8:	Management of Complications of Miscarriage	Yellow
Kit 9:	Suture of Tears (cervical and vaginal) and Vaginal Examination	Purple
Kit 10:	Vacuum Extraction for Delivery (Manual)	Grey
Kit 11	Referral level for RH (Part A + B)	Fluorescent Green
Kit 12:	Blood Transfusion	Dark green

Challenges and Solutions

1. What if ensuring 24/7 referral services are not possible due to insecurity in the area?

Without access to adequate basic and comprehensive EmOC, women and girls will die unnecessarily. Therefore, it is extremely important to attempt to negotiate women and girls' access to an appropriate referral facility. Where 24/7 referral services are simply impossible to establish, it is particularly essential that qualified staff are available at all times to stabilize patients with basic EmOC. In this situation, establishing a system of communication, such as the use of radios or cell phones, would be helpful to communicate with more qualified personnel for medical guidance and support.

2. What if the displaced population does not have a history of routinely accessing services for assisted delivery?

As many women in developing countries routinely deliver in their homes, an essential activity to undertake is to ensure the community, especially midwives and TBAs, knows the danger signs and where to immediately refer women with danger signs of pregnancy and delivery, including: heavy bleeding, high fever, severe headache, blurry vision, swelling of face/hands, convulsions, prolonged labor, retained placenta and loss of consciousness. It is important to plan and implement training and capacity-building for all trained health staff once the emergency is stable and the MISP has been fully implemented.

⁸³ The Reference and Training Package, a library of resource materials is included with each kit order. Please see Chapter 8 for the list of materials in this package. Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.


Chapter 5 Quiz

(Answers on page 106)

- 1** Which of the below is **not** an activity of emergency obstetric care?
- a. Manually removing the placenta
 - b. Resuscitating the newborn
 - c. Distributing clean delivery kits
 - d. Performing cesarean section
 - e. Performing blood transfusion
- 2** Which activity is **not** a part of essential newborn care?
- a. Initiation of breathing (resuscitation)
 - b. Ensuring the baby is dried and warmly wrapped, keeping its head covered immediately after birth
 - c. Identification and treatment of sepsis
 - d. Prevention of infection (hygienic cord cutting and care, eye care)
 - e. Blood transfusions
- 3** Approximately what proportion of the displaced population will be pregnant at a given time?
- a. 25 percent
 - b. 20 percent
 - c. 15 percent
 - d. 4 percent
 - e. 10 percent
- 4** It is usually better to construct a new health facility than to support an already existing one.
- True
 - False
- 5** Which material is not part of a clean delivery kit?
- a. A new razor blade
 - b. A sheet of plastic
 - c. Two pieces of string
 - d. Sutures
 - e. A bar of soap

Chapter 6

Planning for Comprehensive RH Services



This section outlines the steps to take to be ready to expand RH services when all the components of the MISP have been implemented. It is important to ensure that supplies or RH medicines and other commodities are available and ordered in a rational and sustainable manner so that the affected population can have access to comprehensive RH services as soon as possible.

OBJECTIVES

PLAN FOR THE PROVISION OF COMPREHENSIVE RH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE, AS THE SITUATION PERMITS.

THIS INCLUDES, AS PART OF AND IN COORDINATION WITH THE HEALTH SECTOR/CLUSTER, THE FOLLOWING:

- ❖ Collecting existing background data on maternal and newborn mortality; STI and HIV prevalence; contraceptive prevalence and preferred methods; and RH knowledge, attitudes and behavior of the affected population, if available;
- ❖ Identifying suitable sites for future service delivery of comprehensive RH services;
- ❖ Assessing staff capacity to provide comprehensive RH services and a plan for training/retraining staff; and
- ❖ Ordering equipment and supplies through routine supply lines, based on estimated and observed consumption.

Why is planning for comprehensive RH a priority?

It is essential to plan for the integration of RH activities into PHC from the onset of the humanitarian response; if not, the provision of these services may be delayed unnecessarily. Delays may increase the risk of unwanted pregnancies, complications of pregnancy and delivery, and sexually transmitted infections, including HIV. By collecting data, selecting appropriate service sites and preparing staff and ordering supplies, comprehensive RH services can be faster and more efficiently operationalized once the MISP has been implemented.

When should planning for comprehensive RH services take place?

It is essential to plan, in collaboration with health sector/cluster partners as well as affected women, youth and men, for the integration of comprehensive, good quality RH activities into PHC as soon as possible. When humanitarian appeals processes and agencies start longer-term planning (for 6-12 months), comprehensive services must be integrated into funding and planning processes, such as the Common Humanitarian Action Plan (CHAP) and the CAP. Otherwise the provision of these services may be delayed unnecessarily. Implementation of comprehensive RH programming should not negatively affect the availability of MISP services.

What is the difference between minimum (MISP) and comprehensive RH services?

The chart on the following page shows which RH technical activities are part of the MISP and which are elements of comprehensive services.

MISP and Comprehensive RH Services

**In addition to the MISP, the IAWG has identified additional priority activities related to RH that should be undertaken from the onset of an emergency. These additional priority activities are further explained in Chapter 7.*

RH Components (not in order of priority/importance)	Priority RH Services (MISP)	Comprehensive RH Services
FAMILY PLANNING	<p>None*</p> <p><i>*Provide contraceptives such as condoms, pills, injectables and IUDs to meet demand.</i></p>	<ul style="list-style-type: none"> ✦ Source and procure contraceptive supplies. ✦ Provide staff training. ✦ Establish comprehensive family planning programming. ✦ Provide community education.
GENDER-BASED VIOLENCE	<ul style="list-style-type: none"> ✦ Coordinate mechanisms to prevent sexual violence with health, protection and other sectors/clusters. ✦ Provide clinical care for survivors of rape. 	<ul style="list-style-type: none"> ✦ Expand medical, psychological, social and legal care for survivors. ✦ Prevent and address other forms of GBV, including domestic violence, forced/early marriage and female genital mutilation. ✦ Provide community education. ✦ Engage men and boys in GBV programming.
MATERNAL AND NEWBORN CARE	<ul style="list-style-type: none"> ✦ Ensure availability of emergency obstetric and newborn care services. ✦ Establish a 24/7 referral system for obstetric emergencies. ✦ Provide clean delivery packages to visibly pregnant women and birth attendants. 	<ul style="list-style-type: none"> ✦ Provide antenatal care. ✦ Provide postnatal care. ✦ Train skilled attendants (midwives, nurses, doctors) in performing EmOC and newborn care. ✦ Increase access to basic and comprehensive EmOC and newborn care.
STIS, INCLUDING HIV PREVENTION AND TREATMENT	<ul style="list-style-type: none"> ✦ Ensure safe blood transfusion practice. ✦ Facilitate and enforce respect for standard precautions. ✦ Make free condoms available. <p><i>* Make syndromic treatment available as part of routine clinical services for patients presenting for care.</i></p> <p><i>* Make treatment available for patients already taking ARVs, including for PMTCT, as soon as possible.</i></p>	<ul style="list-style-type: none"> ✦ Establish comprehensive STI prevention and management services, including partner tracing and STI surveillance systems. ✦ Collaborate in establishing comprehensive HIV services as appropriate. ✦ Provide care, support and treatment for people living with HIV/AIDS. ✦ Raise awareness of prevention, care and treatment services for STIs, including HIV. ✦ Provide community education.

In addition to the services mentioned above, comprehensive RH also includes gynaecological care, including the management of infertility and fistula; screening/treatment of cervical and breast cancer; and urology services for male sexual dysfunction and male reproductive cancers.

Comprehensive RH services must be accessible for all affected populations, including adolescents; unmarried as well as married women and men; the elderly; sex workers/clients; gay, lesbian, bisexual and transgendered persons; ex combatants; uniformed staff; and injecting drug users. RH must be integrated into public health packages and linked to other service sectors.

Where can reliable data on the displaced population be found?

Part of planning for comprehensive RH services includes conducting needs assessments and monitoring and evaluation of the MISP services. Background information on maternal, infant and child mortality, HIV/STI prevalence and contraceptive prevalence data can be obtained from such sources as WHO, UNFPA, the World Bank, the Demographic and Health Survey and the MoH. Useful tools for gathering data as part of needs assessments include the health cluster's HeRAMS and the RHRC Consortium's *Refugee Reproductive Health Needs Assessment Field Tools*.⁸⁴ The *RHRC Monitoring and Evaluation Toolkit*⁸⁵ and the *UNHCR's Health Information System*⁸⁶ for health facility-based data collections are also useful tools to monitor and evaluate RH services.

What are the characteristics of a suitable site for delivering comprehensive RH services?

Collaborate with local authorities and the health sector/cluster partners to identify possible sites for comprehensive RH services, such as family planning clinics, STI outpatient rooms and adolescent RH services. It is important to consider the following factors when selecting suitable sites:

- ✦ Number, type and quality of existing health facilities and RH services;
- ✦ Availability of health staff;
- ✦ Capacity of health staff and any implications of additional services on current services;
- ✦ Security both at the point of use and while moving between home and the service delivery point;
- ✦ Accessibility to all potential users;
- ✦ Privacy and confidentiality during consultations;
- ✦ Easy access to water and sanitation facilities;
- ✦ Appropriate space;
- ✦ Possibility of maintaining aseptic conditions;⁸⁷
- ✦ Communications and transport for referrals; and
- ✦ Locked storage facilities for supplies and files.

⁸⁴ Reproductive Health Response in Crises Consortium, *Refugee Reproductive Health Needs Assessment Toolkit*, 2004. Available from http://www.rhrc.org/resources/general_fieldtools/needs_menu.htm.

⁸⁵ Reproductive Health Response in Crises Consortium, *Monitoring and Evaluation Toolkit*, 2004. Available from http://rhrc.org/resources/general_fieldtools/needs_menu.htm.

⁸⁶ UNHCR's HIS website is available from <http://his.unhcr.org>.

⁸⁷ For further information on maintaining aseptic conditions, visit www.surgeryencyclopedia.com/A-Ce/Aseptic-Technique.html.

What about staff and supplies?

Make an assessment of the capacity of staff to undertake comprehensive RH services and establish plans to train/retrain staff. Staff capacity can be measured through supervisory activities (e.g., monitoring checklists, direct observation, client exit interviews) and through formal examinations of knowledge and skills. When planning for training or retraining of staff, work with the health sector/cluster to engage with national authorities and academic and training institutes and take into consideration existing curricula and other training needs (including complementary needs). Where possible, use national trainers and plan training sessions carefully, in order not to leave health facilities without in-service staff. Provide protocols and job aids to support quality service delivery according to evidence-based best practices.

See www.iawg.net/resources/jobaids.html.

Once minimum initial RH services are established, work through the health sector/cluster with health authorities to analyze the situation, estimate the use of medicines and disposable supplies, assess the needs of the population and reorder supplies as needed. Avoid continued ordering of the prepackaged RH Kits—ordering RH supplies based on demand will ensure the sustainability of the RH program and avoid the shortage of some supplies and the wasting of others not used in the setting. Place follow-up orders for RH supplies through regular medical supply lines in-country and consider procurement channels used by NGOs or through UNFPA Procurement Services Branch (see Chapter 8). When ordering supplies for comprehensive RH services, coordinate RH commodity management with health authorities and the health sector/cluster in order to ensure uninterrupted access to RH commodities and to avoid waste.

Monitoring planning for comprehensive RH service delivery

Examples of indicators to monitor planning for comprehensive RH coordination:

- ✦ MISRP service indicators monitored and evaluated (see MISRP Checklist in Appendix A)
- ✦ RH background information collected
- ✦ Number and type of sites identified for future delivery of comprehensive RH services
- ✦ Number and type of staff assessments conducted
- ✦ Number and type of trainers and training protocols identified
- ✦ RH commodities consumption monitored and analyzed and further RH supply needs assessed
- ✦ Medical commodities procurement channels identified

Which supplies are needed or which Inter-agency RH Kit(s) could be ordered to address this issue?⁸⁸

No additional RH Kits are needed to address this issue; the RH Kits are designed to meet the needs of the first four objectives of the MISRP.

⁸⁸ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

Challenges and Solutions

1. *What if there appears to be a lack of female health workers?*

Efforts should be made to identify and engage female health workers, particularly in contexts where religious or cultural norms bar male health workers from examining female patients. The lack of female staff, however, should not prevent women and girls from accessing care. Another option is to ensure a female attendant or friend accompanies the woman seeking medical care.

2. *Background information on maternal, infant and child mortality, HIV/STI prevalence and contraceptive prevalence of the displaced population can be challenging to access, especially for an NGO trying to find this information without the assistance of WHO and UNFPA. What can an agency do to obtain reliable data on the displaced population?*

This information should be collected through the health sector/cluster and should be available through its members, including the MoH. In addition, the agencies that attend health sector/cluster and RH working group meetings may be able to collectively obtain reliable data online from agencies such as UNFPA, WHO and USAID. If possible, try to collect data from the Internet before travelling or request headquarters to assist and ensure that data are shared and compared with that available to the health cluster more broadly. Where there are inconsistent data, there should be discussions within the health sector/cluster to agree which should be used.


Chapter 6 Quiz

(Answers on pages 106-107)

- 1** Which of the following activities are part of the planning process for comprehensive RH services for displaced women, men and youth?
- a. Preparing to prevent and address all forms of gender-based violence
 - b. Identifying suitable sites for delivery of comprehensive RH
 - c. Identifying training needs
 - d. Establishing a referral system for emergency obstetric care
 - e. a, b and c
- 2** Which activities need to be undertaken to plan for comprehensive RH services?
- a. Gathering data on mortality rates, STI/HIV prevalence and contraceptive prevalence
 - b. Establishing medical care for rape survivors
 - c. Assessing staff capacity and developing training plans
 - d. Ordering equipment and supplies through routine supply lines
 - e. a, c and d
- 3** Where may one find reliable data on the displaced population?
- a. WHO
 - b. World Bank
 - c. UNFPA
 - d. Demographic and Health Survey (DHS)
 - e. All of the above
- 4** Planning for comprehensive RH service provision should start after the other components of the MISP have been implemented.
- True
 - False
- 5** What are the characteristics of a suitable site for delivering comprehensive RH services?
- a. The capacity for privacy and confidentiality during consultations
 - b. Possibilities to maintain aseptic conditions
 - c. Communications and transport available for referrals
 - d. Locked storage facilities for supplies and files
 - e. All of the above

Chapter 7

Priority Activities in Addition to the MISP



In the revised 2010 field-test version of the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, additional priority minimum activities were identified beyond the priority objectives of the MISP. Specifically, the manual states it is important to ensure that: contraceptives are available to meet the demand; syndromic treatment of STIs is available to patients presenting with symptoms; and ARVs are available to continue treatment for people already on ARVs, including for PMTCT. In addition, culturally appropriate menstrual protection materials (usually packed with other toiletries in “hygiene kits”) should be distributed to women and girls.

Ensuring Contraceptives Are Available to Meet Demand

Why is it important to make contraceptives available from the onset of a humanitarian crisis?

Women, men and adolescents' reproductive health needs do not disappear when they are forced to flee their homes and communities as a result of conflict or natural disaster. Displacement can even increase people's desire and need for contraception while they simultaneously experience increased barriers to access. Those fleeing an emergency may not be able to bring their contraceptives with them or obtain them at their site of refuge. Women may also wish to postpone or cease bearing children in emergencies to avoid exposing newborns to the risks of displacement. The disruption of family and social support structures can further pose challenges for adolescents, who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices.

It is therefore vital that family planning is properly integrated into humanitarian response and existing supply systems to ensure that contraceptives, such as condoms, pills, injectables, emergency contraceptive pills and intrauterine devices (IUDs), are available to meet demand from the onset of an emergency.

Comprehensive family planning programming should be initiated as the situation stabilizes. This involves training staff, offering community education, establishing client follow-up, providing permanent methods and maintaining a contraceptive supply chain system.

Noted Practices in Haiti

One international NGO used existing funding to address the high demand for contraceptives at the beginning of the emergency response by making free contraceptives available through mobile clinics in 15 camps in Cité Soleil. The agency noted that the availability of funds was a key factor in its ability to provide contraceptives, reflecting the importance of preparedness and contingency planning. Another international NGO reported providing contraceptives at all facilities and establishing an active network of community health workers providing contraceptives from tent to tent.

Adolescents: Health staff should be aware that adolescents requesting contraceptives have a right to receive these services, regardless of age or marital status. Adolescents presenting to facilities for family planning should be asked about STI symptoms, and family planning should be discussed with those who come to STI clinics.

Syndromic Treatment of Sexually Transmitted Infections Available at Health Facilities

Why is syndromic treatment of STIs important in humanitarian settings?

STIs are a common health problem with potentially serious consequences, including infertility, chronic illness and death. STIs may also enhance the transmission of HIV infection. The circumstances caused by many humanitarian crises—such as sudden abject poverty; food insecurity; lack of access to health services; mobility; and lack of protection against violence and/or exploitation by military, peacekeeping forces and others—increase people’s vulnerability to STIs.

What can the RH Officer do to ensure treatment is available?

The RH Officer should work within the health sector/cluster to identify national treatment protocols for diagnosis and treatment of STIs and to determine whether they are in line with international standards. If there are no national protocols or if the existing protocols do not meet international standards, WHO protocols should be used. The RH Officer can also work to ensure that people presenting to all health care facilities with symptoms of STIs receive syndromic treatment as well as condoms to prevent future infections.

Noted Practice

One international NGO in Haiti hung a list of syndromic protocols on a line in a mobile clinic while another NGO put posters of the protocols on the wall.

Ensure Antiretrovirals (ARVs) Are Available to Continue Treatment for People Already on ARVs, Including for Prevention of Mother-to-Child Transmission (PMTCT)

It is important for RH Officers to work within the health sector/cluster to ensure that treatment is not interrupted for people already taking ARVs, including for PMTCT.

Why is continuation of ARVs important?

Following a crisis, facilities where people received ARVs may have been destroyed or providers may no longer be available. People previously on treatment may therefore suddenly be unable to access their ongoing regimen. This is a serious problem because, in order to be effective, ARVs must be taken in

adequate doses at the correct time intervals; in addition, interrupting drug therapy can lead to drug resistance.⁸⁹

What can be done to facilitate people's, including pregnant women's, access to ARVs?

The RH Officer can work within the health sector/cluster to ensure there is a coordinated effort among people with HIV, the MoH, and local and international organizations addressing HIV. Efforts should be made to identify people, including pregnant women, who were on ARVs before the crisis, and to inform them through communications campaigns and health workers where they can receive treatment. In some emergencies, an HIV focal point is identified; in these cases it is important for the RH Officer to coordinate with this focal point to address ARVs for continuing users.

It is important to note that the Inter-agency RH Kits do not contain ARVs, apart from those for PEP following rape (RH Kit 3) which is also available in the Inter-agency Emergency Health Kit (IEHK). In addition, first line treatment regimens vary from country to country, and thus a global kit is not currently available. RH Officers should ensure that the health sector/cluster obtains the relevant information from the MoH, WHO, the UN Joint Programme on HIV/AIDS (UNAIDS) or the national Red Cross to ensure that ARVs are available.

Urban Settings: Determine the channels of communication among the urban displaced and provide contact information for them regarding how to access information on continuing treatment with ARVs. It is also important to share this information with service providers.

Noted Practices in Kenya

Following the Kenya post-election crisis, international and local institutions and the government responded robustly to ensure that people on ARVs did not miss their ARV doses and develop drug resistance. Organizations used innovative ways to coordinate and reach clients and other displaced people; telephone hotlines and cell phone networks enabled agencies such as Médecins Sans Frontières (MSF)-France and the Academic Model for the Prevention and Treatment of HIV (AMPATH) to spread the word and locate clients.

Noted Practices in Haiti

Haiti's strong HIV programs prior to the earthquake appeared to facilitate a largely successful effort to ensure ARVs were available to the displaced populations from the earliest days and weeks following the earthquake. This demonstrates how strong programming—including pre-positioned supplies and drugs prior to a humanitarian crisis—can mitigate the impact on people during and following the crisis.⁹⁰

⁸⁹ Women's Refugee Commission, *HIV/AIDS Prevention and Control: A short course for humanitarian workers: Facilitators Manual*, RHRC Consortium, 2004. Available from <http://www.rhrc.org/resources/sti/hivaidmanual/>.

⁹⁰ Women's Refugee Commission, *Four Months On: A Snapshot of Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment Conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission*, May 17-21, 2010, October, 2010. Available from <http://www.womensrefugeecommission.org/reports>.

Ensure that culturally appropriate menstrual protection materials are distributed to women and girls

As a result of crisis and displacement, women and girls may no longer have access to menstrual hygiene supplies. To help address this, it is important to first talk with women and girls to learn what they typically use for menstrual protection. Culturally appropriate menstrual hygiene protection materials should then be a part of hygiene non-food item (NFI) packages and distributed to women and girls of reproductive age.

Additional Priority Activities Monitoring Checklist

- ◆ Percentage of health facilities providing basic contraceptive methods available to meet demand ____
- ◆ Percentage of health facilities providing ARVs for patients on ART, including PMTCT ____
- ◆ Percentage of health facilities providing STI treatment ____
- ◆ Number of hygiene kits distributed ____

Which supplies are needed or which Inter-agency RH Kit(s) could be ordered to address this issue?⁹¹

Number	Name	Color
Kit 1:	Condom (Part A + B)	Red
Kit 4:	Oral and Injectable Contraception	White
Kit 5:	STI	Turquoise

⁹¹ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008.


Chapter 7 Quiz

(Answers on page 107)

- 1** Which are the priority activities in addition to the MISP?
- a. Ensure contraceptives are available
 - b. Ensure syndromic treatment of STIs is available
 - c. Ensure ARVs are available
 - d. Ensure menstrual protection materials are provided
 - e. All of the above
- 2** The disruption of family and social support structures can pose challenges for adolescents who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices.
- True
 - False
- 3** Which contraceptive methods should be available at the onset of an emergency?
- a. Condoms and pills
 - b. Injectables
 - c. IUDs
 - d. Emergency contraceptive pills
 - e. All of the above
- 4** What can be done to ensure syndromic treatment of STIs is available at health facilities?
- a. Ensure the baby is dried and warmly wrapped, keeping its head covered immediately after birth
 - b. Identify national STI treatment protocols
 - c. Make STI treatment protocols available at health facilities
 - d. Coordinate community outreach on food distribution
 - e. b and c
- 5** Whom should the RH Officer contact to ensure ARVs are available?
- a. MoH
 - b. WHO
 - c. UNAIDS
 - d. National Red Cross
 - e. All of the above

Chapter 8

Ordering Reproductive Health Kits



Having the essential drugs, equipment and supplies available in a crisis is critical. To support the objectives of the MISP, the IAWG has specifically designed a pre-packaged set of kits containing drugs and supplies aimed at facilitating the implementation of priority RH services—the Inter-agency Reproductive Health Kits (RH Kits). UNFPA is in charge of assembling and delivering the RH Kits. However, because logistics problems can occur in any setting, agencies should not be fully dependent on one source for these supplies. Relief agencies should be prepared by prepositioning supplies wherever feasible and including RH supplies within their overall medical supply procurement.

When should the Inter-agency RH Kits be ordered?

The RH Kits are intended for use at the onset of the humanitarian response and contain sufficient supplies for a three-month period for different population numbers, depending on the population coverage of the health care setting for which the kits are designed. When planning to order RH Kits, prepare a plan for in-country distribution of the kits. This plan outlines how many of which kits go to which partners in which geographical setting. It also includes detailed plans for in-country transport and storage, including provisions for items that need to be kept cool (cold-chain).

Once basic RH services are established, the RH Officer should coordinate within the health sector/cluster to analyze the situation, assess the needs of the population and re-order disposables and other equipment as needed. This will serve to ensure the sustainability of the RH program and to avoid the shortage of some supplies and the wasting of others that are not used in the setting. Follow-up orders for ongoing supply needs should be made through the regular supply lines in-country used by NGOs and through the MoH and its procurement channels, or through the UNFPA Procurement Services Section.⁹² In other words, continued ordering of the Inter-agency RH Kits should be avoided.

Are there other agencies that provide pre-packed kits with RH supplies in addition to UNFPA?

The Inter-agency RH Kits complement the Inter-agency Emergency Health Kit 2006 (IEHK)—a standardized emergency health kit that contains essential drugs, supplies and equipment for the provision of primary health care services. The IEHK was designed by WHO, UNHCR, UNICEF, UNFPA, MSF, the International Committee of the Red Cross (ICRC) and the International Federation of Red Cross and Red Crescent Societies (IFRC). It contains a midwifery kit, EC pills, PEP and supplies for the adherence to standard precautions. The IEHK does not, however, have all the supplies needed to implement the MISP. To provide the full range of priority RH services in an emergency situation, it is recommended that the Inter-agency RH Kits are ordered in a way that is complementary to what may already have been procured or that other supply sources are identified to ensure all necessary equipment and materials are available.

What information do I need to order the Inter-agency RH Kits?

UNFPA needs to know where the kits will be used and which organization/individual will organize the distribution of the kits. They also need the relevant detailed contact, delivery and financing information. In addition, information about the type of setting, number of target population, time period of operation and the number of health centers and referral hospitals helps to calculate the amount of supplies needed to address the situation. It may also help to have information about personnel, including:

- ✦ Number of doctors
- ✦ Number of doctors qualified for obstetrical surgery
- ✦ Number of nurses
- ✦ Number of nurses trained in obstetrics
- ✦ Number of qualified midwives
- ✦ Number of traditional birth attendants
- ✦ Number of community health workers

For some agencies, particularly local NGOs, it may be helpful to develop an MoU with UNFPA before a crisis strikes to avert delays in procurement.

⁹² Contact procurement@unfpa.dk.

How much do the Inter-agency RH Kits cost?

The cost of the kits changes periodically. It is best to contact UNFPA directly to facilitate ordering, discuss budgeting questions and ensure that contact and delivery information is correct.

How quickly will Inter-agency RH Kits arrive at my site?

In crisis situations, kits should arrive at the country port of entry within two to seven days after an order is placed and the funds are transferred. Transport to field sites is dependent upon the ordering agency's local transport and storage arrangements.

Be prepared to receive the goods as soon as they arrive at the port of entry to the country and ensure that all relevant forms for customs clearance have been prepared ahead of time so there are no unnecessary delays with importing the kits. The health cluster and logistics cluster, where they exist, are often able to help facilitate this, as well as further distribution.

How are Inter-agency RH Kits packaged?

To facilitate logistics in-country, UNFPA has arranged that the boxes containing each kit:

- ✦ Are clearly marked with the kit number, description, consignee, contact person and detailed list of contents;
- ✦ Are marked with the number of boxes per kit and the weight and volume of each kit;
- ✦ Can be handled by one or two people; and
- ✦ Are branded on all sides with one color representing a particular kit.

How can I find out the exact contents of each RH Kit?

Contact UNFPA to obtain a copy of the booklet *Inter-agency Reproductive Health Kits for Crisis Situations*.⁹³ This booklet provides a list of contents of each kit as well as guidance on the type of training health personnel should have in order to use the contents of a kit appropriately. You can also find the booklet on the IAWG website, which also includes downloadable treatment guidelines in English.

Are any reference or training materials included with my RH Kit order?

Yes, a Reference and Training Package is provided with each kit order. The following documents and manuals are included:

- ✦ In Kit 3: *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*. WHO/UNHCR, (revised edition) 2004.⁹⁴

⁹³ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

⁹⁴ World Health Organization/United Nations High Commissioner for Refugees, *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*, 2004. Available from <http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/index.html>.

⁹⁵ U.S. Agency for International Development, Johns Hopkins Bloomberg School of Public Health, *Family Planning, A Global Handbook for Providers*, 2007. Available from <http://info.k4health.org/globalhandbook/>.

⁹⁶ World Health Organization, *Sexually transmitted and other reproductive tract infections. A guide to essential practice*, 2005. Available from <http://www.who.int/reproductivehealth/publications/rtis/9241592656/en/index.html>.

⁹⁷ EngenderHealth, *Infection prevention, 2001. A reference booklet for health care providers*. Available from <http://www.engenderhealth.org/pubs/quality/infection-prevention.php>.

- ✦ In Kit 4: Chapters 1, 2, 3 and 4 from: *Family Planning, A Global Handbook for Providers*.⁹⁵ USAID/Johns Hopkins Bloomberg School of Public Health/WHO 2007.
- ✦ In Kit 5: *Sexually transmitted and other reproductive tract infections. A guide to essential practice*. WHO 2005.⁹⁶
- ✦ In Kit 6: *Infection prevention. A reference booklet for health care providers*, EngenderHealth, 2001.⁹⁷
- ✦ In Kit 8: *Guidelines on MVA procedures*. Ipas, in development.
- ✦ In Kit 11B: *Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice*. WHO, UNFPA, UNICEF, World Bank, 2006.⁹⁸

The documents in the Kits are available in English and French. Other languages and documents to suite the context of the crisis are not included and need to be requested specifically. For example, the 2010 Field Manual is available in Arabic, Bahasa Indonesia, English, Farsi, French and Spanish.

Other useful documents to download include:

General

- ✦ *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review*. IAWG on RH in Crises, 2010.⁹⁹
- ✦ *Reproductive Health during Conflict and Displacement: A Guide for Program Managers*. WHO, 2000.¹⁰⁰
- ✦ *Inter-agency Reproductive Health Kit for Emergency Situations*. UNFPA/IAWG on RH in Crises, revised 2006.¹⁰¹
- ✦ *RHRC Monitoring and Evaluation Tool Kit*. RHRC Consortium, 2004.¹⁰²
- ✦ *MISP Cheat Sheet* (Available in Bahasa Indonesia, French and Spanish). IPPF/Women's Refugee Commission, revised 2011.¹⁰³

Prevention and Response to Sexual Violence

- ✦ *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. IASC, 2005.¹⁰⁴

⁹⁸ World Health Organization, United Nations Population Fund, United Nations Children's Fund, World Bank, *Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice*, 2006. Available from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/924159084X/en/index.html.

⁹⁹ Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review*, 2010. Available from http://www.iawg.net/resources/field_manual.html.

¹⁰⁰ World Health Organization, *Reproductive Health during Conflict and Displacement: A Guide for Program Managers*, 2000. Available from http://whqlibdoc.who.int/hq/2001/WHO_RHR_00.13.pdf.

¹⁰¹ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

¹⁰² Reproductive Health Response in Crises Consortium, *Monitoring and Evaluation Toolkit*, 2004. Available from http://rhrc.org/resources/general_fieldtools/needs_menu.html.

¹⁰³ International Planned Parenthood Federations, Women's Refugee Commission, *MISP Cheat Sheet*, 2011. Available from <http://misp.rhrc.org/>.

¹⁰⁴ Inter-agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, 2005. Available from <http://www.humanitarianinfo.org/iasc/downloadDoc.aspx?docID=4402>.

¹⁰⁵ World Health Organization/United Nations High Commissioner for Refugees, *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*, 2004. Available from <http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/index.html>.

¹⁰⁶ World Health Organization, United Nations High Commissioner for Refugees, United Nations Population Fund, *Clinical Management of Rape Survivors*, 2009. Available from <http://iawg.net/cmor>.

¹⁰⁷ United Nations Children's Fund, *Caring for Survivors Training Manual*, 2010. Part One of this series of training modules focuses on how multi-sectoral actors can engage with survivors in a supportive and ethical way. Part Two addresses medical interventions for sexual assault survivors and is based on the WHO Guidelines. Available from <http://www.rhrc.org/resources/index.cfm?sector=gbv#209>.

- ✦ *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations.* WHO/UNHCR, 2004.¹⁰⁵
- ✦ *Clinical Management of Rape Survivors (e-learning tool).* WHO/UNHCR/UNFPA, 2009.¹⁰⁶
- ✦ *Caring for Survivors Training Manual.* UNICEF, 2010.¹⁰⁷
- ✦ *Emergency Contraception for Conflict-Affected Settings: Distance Learning Module.* Women's Refugee Commission/RHRC Consortium, updated 2008.¹⁰⁸

Maternal and Newborn Care

- ✦ *Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice.* WHO/UNFPA/UNICEF World Bank 2006.¹⁰⁹
- ✦ *Field-Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs.* Women's Refugee Commission/RHRC Consortium, 2005.¹¹⁰

HIV

- ✦ *Guidelines for Addressing HIV in Humanitarian Settings.* IASC, revised 2010.¹¹¹
- ✦ *HIV/AIDS Prevention and Control: A short course for humanitarian workers.* Women's Refugee Commission/RHRC Consortium, 2004.¹¹²

STIs

- ✦ *Guidelines for the Management of Sexually Transmitted Infections.* WHO, 2003.¹¹³
- ✦ *Guidelines for the Care of Sexually Transmitted Infections.* Women's Refugee Commission/RHRC Consortium, 2004.¹¹⁴

If you are procuring RH supplies locally, ensure that you include the relevant treatment guidelines, which are available for download from the IAWG website.¹¹⁵

¹⁰⁸ Women's Refugee Commission, *Emergency Contraception for Conflict-affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module, on behalf of the RHRC Consortium*, revised 2008. Available from http://www.rhrc.org/resources/general_fieldtools/er_contraception/welcome.html.

¹⁰⁹ World Health Organization, United Nations Population Fund, United Nations Children's Fund, World Bank, *Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice*, 2006. Available from http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/924159084X/en/index.html.

¹¹⁰ Women's Refugee Commission, *Field-Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*, RHRC Consortium, 2005. Available from http://www.rhrc.org/resources/emoc/EmOC_ffg.pdf.

¹¹¹ Inter-agency Standing Committee, *Guidelines for Addressing HIV in Humanitarian Settings*, 2010. Accessible from <http://www.aidsandemergencies.org/cms/>.

¹¹² Women's Refugee Commission, *HIV/AIDS Prevention and Control: A short course for humanitarian workers: Facilitators Manual*, RHRC Consortium, 2004. Available from <http://www.rhrc.org/resources/sti/hivaidsmanual/>.

¹¹³ World Health Organization, *Guidelines for the Management of Sexually Transmitted Infections*, 2003. Available from <http://www.who.int/hiv/pub/sti/en/STIGuidelines2003.pdf>.

¹¹⁴ Women's Refugee Commission, *Guidelines for the Care of Sexually Transmitted Infections*, RHRC Consortium, 2004. Available from <http://www.rhrc.org/resources/index.cfm?sector=sti#51>.

¹¹⁵ Inter-agency Working Group on Reproductive Health in Crises, *Inter-Agency Reproductive Health Kits for Crisis Situations (Fourth edition)*, January 2008. Available from <http://www.iawg.net/resources/rhkits.html>.

The consumable supplies in the RH Kits are calculated to last for a 3-month period for a varying population number, depending on the population coverage of the health-care setting for which each block of kits is designed. The RH Kits in each of the blocks are as follows:

Block 1: Six kits to be used at the community and primary health care level for 10,000 persons/ 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 0	Administration Kit	Orange
Kit 1	Condom Kit (Part A is male condoms + B is female condoms)	Red
Kit 2	Clean Delivery Subkit (Individual) (Part A + B)	Dark Blue
Kit 3	Rape Treatment Kit	Pink
Kit 4	Oral and Injectable Contraception Kit	White
Kit 5	STI Kit	Turquoise

Block 1 contains six kits. Kits 1 and 2 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance (Part A: reusable equipment, Part B: drugs and disposable supplies)	Brown
Kit 7	IUD Kit	Black
Kit 8	Management of Complications of Abortion Kit	Yellow
Kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination Kit	Purple
Kit 10	Vacuum Extraction for Delivery (manual) Kit	Grey

Block 2 is composed of five kits containing disposable and reusable material. In order to prevent the waste of expensive reusable equipment, these kits are designed to be used for a population of 30,000 persons over a 3-month period. This does not, however, exclude the kits from being ordered for a setting with fewer than 30,000 persons—in this case the supplies in the kits would last longer.

Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 11	Referral level Kit for Reproductive Health (Part A: reusable equipment + B: drugs and disposable supplies)	Fluorescent green
Kit 12	Blood Transfusion Kit	Dark green

Block 3 is composed of two kits containing disposable and reusable material for the referral (surgical obstetrics) level. In most countries, this level normally serves a population of approximately 150,000 persons over a 3-month period. In displaced situations, patients are generally referred to the nearest hospital, which will often require support in terms of equipment and supplies to be able to provide the necessary services for this additional population.

How do I order Inter-agency RH Kits?

Information on the kits and assistance with ordering can be provided by UNFPA field offices, agency partners or the UNFPA Humanitarian Response Branch (HRB) in New York or Geneva:

UNFPA/HRB
220 East 42nd Street
New York, NY 10158
USA

tel: +1 212 297 5245
fax: +1 212 297 4915
email: hrb@unfpa.org
website: www.unfpa.org

UNFPA/HRB
11-13, chemin des Anémones
1219 Chatelaine, Geneva
Switzerland

tel: +41 22 917 83 14
fax: +41 22 917 80 16
email: hrb@unfpa.org

Kits can also be directly ordered from:

UNFPA Procurement Services Section
Midtermolen 3
2100 Copenhagen
Denmark

tel: +45 3546 7368 / 7000
fax: +45 3546 7018
email: procurement@unfpa.dk

How do I order the Inter-agency Emergency Health Kit?

A booklet describing the Inter-agency Emergency Health Kit and how it can be ordered is available from the International Dispensary Association (IDA) Foundation:

IDA Foundation
P.O. Box 37098
1030 AB Amsterdam
The Netherlands

tel: +31 20 403 30 51
fax: +31 20 403 18 54
email: info@idafoundation.org

Booklet:

www.idafoundation.org/fileadmin/user_upload/Documenten/PDF/Product_Library/IEHK_2006_from_IDA_Foundation.pdf

You can also contact UNICEF directly at:

Procurement Services Centre
UNICEF Supply Division
UNICEF Plads, Freeport
DK-2100 Copenhagen
Denmark

tel: +45 35 27 32 21
fax: +45 35 26 94 21
email: supply@unicef.org

Exercise

How many kits should be ordered for a camp or settlement with 20,000 persons?

(A basic assessment was carried out and the following information was documented).

TOTAL POPULATION	20,000 persons
SPECIAL OBSERVATIONS	Female condoms are known and used
NUMBER AND TYPE OF HEALTH CARE SETTINGS	<ul style="list-style-type: none"> ✦ Two health posts ✦ One PHC clinic ✦ One referral hospital
LEVEL OF PERSONNEL	One medical doctor, two trained nurses, one trained midwife and several traditional birth attendants and health workers

Order		
KIT NUMBER	NAME OF KIT	QUANTITY
Kit 0	Administration Kit	0
Kit 1	Condom Kit (Part A + B)	2
Kit 2	Clean Delivery Subkits (Individual) (Part A + B)	2
Kit 3	Rape Treatment Kit ¹¹⁶	2
Kit 4	Oral and Injectable Contraception Kit	2
Kit 5	STI Kit	2
Kit 6	Clinical Delivery Assistance (Part A + B) Kit	1
Kit 7	IUD Kit	1
Kit 8	Management of Complications of Abortion Kit	1
Kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination Kit	1
Kit 10	Vacuum Extraction for Delivery (manual) Kit	1
<i>To support the referral hospital</i>		
Kit 11	Referral level Kit for Reproductive Health (Part A + B)	1
Kit 12	Blood Transfusion Kit	1

¹¹⁶ It would also be important to determine if any IEHK orders have been made and whether the post-rape supplies have been included.

Chapter 8 Quiz

(Answers on pages 107-108)

- 1** *Female condoms are available in the Inter-agency RH Kits.*
- True
 - False
- 2** *To place an order for RH supplies, which of the following activities do not need to be undertaken?*
- a. Estimating kit needs based on basic demographic data
 - b. Coordinating within the health sector/cluster
 - c. Conducting focus groups with an equal number of males and females
 - d. Determining the number of health personnel and their qualifications
 - e. Preparing a plan for distribution of the kits
- 3** *For what time period are the supplies in the RH Kits calculated to last?*
- a. One month
 - b. Three months
 - c. Six months
 - d. One year
 - e. Nine months
- 4** *For which level of health care are the RH Kits designed?*
- a. International level
 - b. Primary level
 - c. Referral level
 - d. Community level
 - e. b, c and d
- 5** *The Inter-agency RH Kits are managed by UNHCR*
- True
 - False

Frequently Asked Questions

1. *Humanitarian staff do not have time for activities that are not imperative for saving lives. Are RH services important to reducing mortality and morbidity?*

Yes, providing RH services saves lives. The MISIP has been created to prioritize which of the many RH activities should be undertaken and are the most important to reduce morbidity and mortality in emergencies, particularly among women and girls. The MISIP is also recognized as a life-saving intervention and is included in the CERF life-saving criteria.

2. *How do I advocate for the MISIP to my colleagues?*

Initially, some humanitarian actors may not see RH as a priority so, if needed, point out that including the MISIP is a Sphere and Health Cluster standard and is not optional. Use the information contained in this module and the MISIP advocacy sheet (Appendix F) to educate colleagues about the risks women and girls face in emergencies and some of the basic tasks that can be undertaken to reduce these risks. This can be very effective in getting RH responses prioritized and funded in crisis situations.

3. *My agency is not involved in the provision of health care services, so why should I be concerned about the MISIP?*

While the bulk of work to implement the MISIP is a health sector/cluster responsibility, the MISIP is not limited to this group. For example, comprehensive prevention of sexual violence requires action not only on the part of health staff but also from the community services, site planning, water and sanitation, protection/legal and other sectors/clusters. To prevent sexual violence, all sectors should be involved in supporting the safety and security of displaced populations, particularly women and girls. In addition, all agencies and sectors can assist in reducing HIV transmission by making condoms free, available and visible to the crisis-affected population and their staff. And EmOC services may require that the camp management agency support the transportation of pregnant women to a referral facility. In general, multi-sectoral implementation of the MISIP objectives will help to reduce death and disability as much as possible in the earliest days of an emergency.

4. *Is EC part of the MISIP?*

Yes, EC should be made available to rape survivors and women and girls who want to avoid an unintended pregnancy following unprotected sexual intercourse. EC is available in the Inter-agency RH Kits in Kit 3, the post-rape Kit, and Kit 4, the oral and injectable contraceptives Kit. EC may also be available locally—www.Not-2-Late.com, a website on EC, provides a list of locally available EC in countries worldwide. EC can also be given using regular contraceptive pills and therefore procured through normal agency medical supply systems. It is important to note that EC pills do not disrupt or damage an established pregnancy following implantation and thus they are not considered a form of abortion by authoritative agencies such as the WHO.¹¹⁷ A useful resource that provides detailed information on EC regimens is the 2008 *Emergency Contraception for Conflict-affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module*.¹¹⁸

5. *Wouldn't it be offensive to offer condoms to a displaced population that is very conservative?*

It could be offensive to undertake a mass distribution of condoms in the early days and weeks of new emergencies without knowing people's knowledge and attitudes. And, though it is not easy to judge

¹¹⁷ World Health Organization, Johns Hopkins Bloomberg School of Public Health and U.S. Agency for International Development, *Family Planning: A Global Handbook for Providers*, 2007.

¹¹⁸ Women's Refugee Commission, *Emergency Contraception for Conflict-affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module*, on behalf of the RHRC Consortium, revised 2008. http://www.rhrc.org/resources/general_fieldtools/er_contraception/welcome.html.

whether a population is conservative or not, even in conservative populations there can be some segments which are less so. It is therefore better to make condoms available in a crisis even if condoms must be offered in less public places where they can be obtained privately (i.e., in toilet areas). As soon as the situation stabilizes and the MISP is fully implemented, more in-depth assessments can be done to determine how to conduct IEC and condom distribution campaigns.

6. *Why should condoms be made available if the displaced population doesn't know how to use them and the HIV prevalence is very low?*

Even if the percentage of people in the community knowledgeable about condoms is low, ethically, condoms should still be made available so those who wish to access them. Humanitarian staff also have a right to access condoms.

7. *Will setting up antenatal care services help health workers identify women at risk of emergency obstetric complications?*

No, screening women during antenatal care visits will not identify most cases in which women will develop complications of pregnancy and delivery, as these complications are unpredictable. It is therefore essential to ensure that all pregnant women can access basic and comprehensive EmOC services so that those who experience complications can get the life-saving services they need.

8. *As a health worker, how do I know whether the blood supply I'm providing patients is screened?*

This information should be available at the health facility or from the MoH. If you have any concerns or do not know, raise this in the health sector/cluster meetings, as the information may be available from other NGOs or UN agencies working in the area. Blood transfusions must not be undertaken if the facilities, supplies and appropriately qualified staff do not exist. The health sector/cluster should then work to ensure a safe blood supply. RH Kit 12 includes tests to screen blood prior to transfusion, for HIV and other blood-borne diseases.

9. *How does the community know where and how to report incidents of sexual violence? Or how and where to refer women who have complications at birth?*

Once services for survivors of sexual violence and for basic and comprehensive EmOC are established, the health and community services sectors should inform the community about the availability of these services immediately. The community should also be informed about the urgency for survivors of sexual violence to present themselves to these service providers as soon as possible, and about the procedures available for referring women who develop complications of pregnancy and delivery. Depending on the context, the community can be informed through postcards, flyers, radio, word of mouth (i.e., informing community leaders, midwives and TBAs) or other means.

10. *Isn't training TBAs and midwives on how to perform clean and safe deliveries an important part of reducing maternal and neonatal death and disability?*

Although it is important to engage TBAs and encourage them to make appropriate referrals, WHO does not recommend training TBAs.¹¹⁹ Retraining midwives on how to perform clean and safe deliveries is also not recommended at the onset of an emergency, as it is not a good use of time and resources. This type of in-depth training should wait until a more stable phase has been reached.

¹¹⁹ World Health Organization, *Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO*, 2004. Available from http://www.who.int/making_pregnancy_safer/documents/9241591692/en/index.html.

Scenarios for Implementing the MISP

1. *You are a health worker based in a camp for internally displaced persons. A woman presents to you at the health facility and says she was raped while gathering firewood outside the perimeter of the camp. How would you address her needs?*

First, you should assure her that it was not her fault and that she did not deserve to have this happen to her. Provide her with information about her right to receive care and what these services entail. If she accepts care, provide her with services as outlined in the national post-rape protocol (if available and up to international standards). Other protocols/guidance can be used without delay if there is no national protocol, such as *Clinical Management of Rape Survivors*¹²⁰ or MSF's *Clinical Guidelines: Diagnosis and Treatment Manual*.¹²¹ The survivor should be informed about other services as well (protection, psychosocial and so on) and a referral should be made with the consent of the survivor. Ensure that confidentiality is maintained throughout this process and do not do anything to which the survivor does not consent.

It is also important to work with all organizations in the camp to find out how to prevent future rapes. Your team may recommend identifying alternative fuel sources so the community is not dependent on wood for fuel; organizing armed or protective escorts to increase safety while gathering wood; obtaining or producing fuel-efficient cook stoves; or discussing the possibility of changing the type of rations that are provided to a kind that does not require long cooking times. In April 2009, the IASC task force on Safe Access to Firewood and Alternative Energy (SAFE) published guidance on safe cooking fuel for refugees and IDPs that is designed to support these activities, including a matrix on agency roles and responsibilities for developing a coordinated fuel strategy and decision tree diagrams on factors affecting the choice of fuel strategy.¹²²


2. *The health sector/cluster has identified UNFPA as the lead agency for RH and you have been hired by UNFPA as the RH Officer in an urban area impacted by a major earthquake one week ago. The natural disaster resulted in massive loss of life and displacement. What are some of the first steps you should take?*

Ensure that RH is included in sector/cluster assessments, data collection, planning, procurement and appeals. Establish an RH working group within the health sector/cluster that includes any local or national agencies that are responding to the needs of the displaced. Ensure that local organizations are able to access the RH working group meeting. Work with the health sector/cluster to undertake a rapid mapping of the available MoH, NGO and other community health facilities and systems to determine the specific needs and capacities to provide good quality MISP services. During the RH working group meeting, you will learn which organizations already have an RH strategy in place and which ones still need to make RH a priority. Then, as a group, you can strategize how to address each objective of the MISP and begin to map out “who is doing what where” and share this with the health sector/cluster. This meeting also provides the opportunity to identify RH supply needs, coordinate the ordering of supplies (though this needs to be done in conjunction with overall health sector/cluster procurement) and to initiate a plan for monitoring

¹²⁰ World Health Organization/United Nations High Commissioner for Refugees, *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*, 2004. Available from http://www.rhrc.org/resources/Clinical_Management_2005_rev.pdf.

¹²¹ Médecins Sans Frontières, *Clinical Guidelines: Diagnosis and Treatment Manual*, 2010. Available from http://www.refbooks.msf.org/MSF_Docs/En/Clinical_Guide/CG_en.pdf.

¹²² Inter-agency Standing Committee, *Matrix on agency roles and responsibilities for developing a coordinated fuel strategy*, 2009; Inter-agency Standing Committee, *Decision Tree Diagrams on factors affecting the choice of fuel strategy*, 2009. Available from <http://www.fuelnetwork.org/index.php/Formal-Launch-of-IASC-Task-Force-SAFE-Outputs>.



and sharing RH data among yourselves and with all health sector/cluster partners. You should also continue, along with other RH partners, to provide feedback to health sector/cluster members in the meetings on key issues and concerns identified in the RH meeting, and collectively develop solutions. Ensure RH information is included in health sector/cluster situation reports as well as in health cluster submission for overall OCHA situation reports.

3. *You are a newly arrived supervisor at a primary health care facility in a crowded urban area. You notice that your staff members do not use gloves or wear protective clothing and there is an open waste pit of used medical supplies, including needles, behind the health center. How would you address these concerns?*

Work with the health sector/cluster to ensure that necessary supplies to practice standard precautions are available by taking an inventory and ordering materials that are lacking and conduct refresher lessons for health center staff on respect for standard precautions as needed. During the session you can work with the staff to develop a system to self-monitor compliance with disinfection, cleaning, and sterilization of equipment and supplies and to identify staff responsible for daily medical waste management, such as burning and burying refuse in a protected pit specifically for medical waste. If staff feel overwhelmed and do not have time to ensure adherence to standard precautions, you can determine whether more staff and what type of staff are needed and whether it is possible to hire more staff. Alternately, you can help staff determine how to prioritize adherence to standard precautions over other tasks that may be less important. Ultimately, most trained health workers should be aware of basic, critical, standard precautions and understand the principle of preventing the transmission of infections in the health care setting. It may therefore be sufficient to remind and support the staff in any way necessary to ensure standard precautions are respected.

4. *You are a health worker in a remote area. Due to the ongoing local conflict, you and your colleagues leave the crisis-affected area at 4 p.m. to arrive back in your living quarters before dark and the time of the imposed curfew. The night before, a young woman went into labor early in the morning before your staff arrived at work. She had an obstructed labor and needed to get to the referral health facility to have a cesarean section. Luckily, she reached the referral facility in time to have a safe birth. What would you do now to prevent another pregnant woman from being stranded without transport during the night and early morning hours in the future?*

It is extremely important to raise this issue in the broader health sector/cluster early, to identify possible mechanisms for emergency transport, including negotiating for curfew exemptions with security personnel, MoH and other relevant actors. It is also necessary to identify practical arrangements for vehicles, drivers and communication. If it is deemed within security protocol, one possible alternative is to find out whether any people in the local area have a vehicle they would be willing to use to transport women from the crisis-affected setting to the health facility. If it is a camp environment, this individual could be registered with camp security to travel at night. A radio communication system should be set up in the camp health center to link with the local person designated to be immediately alerted when a woman requires transport to the referral health facility. Alternatively, another vehicle could be procured that would stay at the health center in the crisis-affected setting overnight so that women could be transported directly from there when she presents, at any time of the day or night.

5. *You've arrived in a crisis setting and are in charge of getting RH supplies in place. What are your first steps?*

In collaboration with the health sector/cluster (including key partners involved in RH response, such as UNFPA), do a quick situation analysis to find out the total population; how many and what type of personnel are working in this setting; where and in what condition the referral facilities are; what the national policies and mechanisms are; what the regulations on RH medicines are; and what supplies are already available in the setting or pre-positioned in the area. You can feed this information into sector/cluster assessments and planning to determine essential resources needed, including personnel, supplies and equipment. It is best to also anticipate these needs prior to an emergency and undertake contingency planning, including: identifying appropriately trained personnel in your emergency staff rosters; considering stockpiling supplies and equipment; and preparing local communities. You can also work with UNFPA, at the country and regional offices or the New York or Geneva offices, to determine which kits should be ordered and how to finance the purchase through your organization.

6. *You've been working in a camp for four months where a steady influx of refugees from the conflict in the neighboring country ended one month ago and all components of the MISP are well established. At the most recent health coordination meeting, it was reported that the crude mortality rate had stabilized at less than 1/10,000 population per day and that the number of refugees registering has dramatically declined. What do you do now that the situation seems to be reaching a more stable phase?*

In discussion with health sector/cluster and based on data on maternal, infant and child mortality, STI prevalence, contraceptive prevalence and health system capacity, determine what additional RH services would be suited to this population. Then determine how those services can be implemented without a negative impact on MISP service availability. Within the overall health sector/cluster, identify sites for expanded RH services and whether they are suitable in terms of need; security; accessibility; privacy and confidentiality during visits; access to water and sanitation; and adequate room for patients to wait where sufficient provisions can be made for health workers to maintain aseptic conditions. Begin training staff on the needs that have been identified during the past four months. Review supplies to see what orders can now be made through normal procurement channels to supplement the inventory that has been ordered through Inter-agency RH Kits.

7. *You are working as a health focal point with an NGO in a crisis setting. You are concerned about RH in this emergency and want to ensure it is addressed. You have requested that identifying a lead RH agency is added to the agenda of the next health cluster meeting. During the meeting, however, there is resistance from some health cluster partners to address the issue and a lead agency is not appointed. What do you do?*

If you are not able to speak during the meeting, talk directly to the health cluster co-chairs and explain that identifying a lead RH agency is part of the responsibility of the health cluster as outlined in the IASC Health Cluster Guide. Use the points in the MISP Advocacy Sheet (Appendix F) to highlight that the MISP is a live-saving intervention and is not optional in an emergency. If there is continued resistance, follow up with your agency's headquarters to see if they can address the issue at a global level (if you are working with an international agency), or write to the IAWG to see if they can assist: info@iawg.net.

MISP Module Post-Test

- 1** *When should the MISP be implemented?*
 - a. At the onset of a crisis situation
 - b. Once mortality rates have stabilized
 - c. In any humanitarian setting when the set of minimum RH service requirements are not in place
 - d. a and c

- 2** *The activities expected of an RH Officer facilitating the implementation of the MISP include:*
 - a. Training/retraining staff to provide comprehensive RH services
 - b. Ensuring the presence of a same-sex, same-language health worker or chaperone during any medical examination of a survivor of sexual violence
 - c. Utilizing the MISP check-list for monitoring MISP activities
 - d. b and c

- 3** *What are some components of good intergration of RH in health coordination in urban areas?*
 - a. Ensuring communities know where to go for priority RH services
 - b. Addressing transport challenges related to the community's access to RH services
 - c. Including MoH, NGOs, private sector in rapid mapping of RH services
 - d. All of the above

- 4** *MISP supplies can be obtained by:*
 - a. Ordering the Inter-agency Emergency Health Kit (IEHK) 2006
 - b. Ordering from one's own organization
 - c. Ordering the Inter-agency RH Kits from UNFPA
 - d. All of the above

- 5** *Which of the following activities should be undertaken in the early days of an emergency?*
 - a. Carry out a community-wide condom sensitization campaign
 - b. Support protection measures to prevent sexual violence
 - c. Inform the community about where and when rape survivors can receive care
 - d. b and c

- 6** *What type of services should be offered to a rape survivor?*
 - a. Clinical services
 - b. Protection for her physical safety
 - c. Psychosocial care
 - d. All of the above

7 Which of the following **does not** help to prevent sexual violence in a crisis situation?

- a. Involving women in the distribution of materials and supplies
- b. Ensuring that women have their own individual registration cards
- c. Communal latrines and bathing facilities for both men and women
- d. Involving women in the decision-making process regarding protection strategies

8 Which of the following will support adolescent RH?

- a. Identifying pregnant adolescent girls and linking them to health facilities
- b. Not providing contraceptives to adolescents because they are too young to have sex
- c. Adolescent peer groups identifying their protection risks and solutions
- d. a and c

9 Condoms should only be procured from UN agencies to ensure quality

- True
- False

IO What are the requirements of a referral-level facility for comprehensive emergency obstetric care?

- a. Safe blood transfusion capabilities
- b. Medical staff that can perform c-sections available 24 hours per day, seven days per week
- c. Skilled staff and resources for normal births and basic emergency obstetric care and newborn care
- d. All of the above

II A natural disaster has suddenly displaced hundreds of thousands and you are the RH Program Officer for your organization. What are some of the priority RH activities you immediately undertake?

- a. Ensuring survivors of domestic physical violence have access to psychosocial services
- b. Ensuring that you are coordinating with other RH actors within the health sector/cluster
- c. Identifying and discuss RH supply needs with the health sector/cluster lead RH agency and/or UNFPA
- d. b and c

I2 Which one of these is **not** a priority activity in addition to the MISIP?

- a. Ensuring contraceptives are available to meet demand
- b. Establishing comprehensive GBV programs
- c. Ensuring ARVs are available to continue treatment for people already taking ARVs
- d. Ensuring syndromic treatment for STIs is available for people presenting with symptoms

I3 You are the RH officer in the lead RH agency in the health cluster/sector and are trying to ensure skilled birth attendance and emergency obstetric care and newborn care are available. Which of the following activities below is **not** a component of the MISIP?

- a. Ensuring qualified staff are available for safe deliveries, newborn care and to stabilize the patient with basic emergency obstetric care
- b. Ensuring qualified physicians are available at the referral hospital
- c. Establishing a communication system at health centers to enable staff to consult qualified providers about referrals
- d. Implementing trainings for medical staff on comprehensive maternal and newborn care

I4 You have tried to procure clean delivery kits through UNFPA, but logistical challenges have significantly delayed the arrival of these supplies. Given this reality, what can you do to address this situation?

- a. Contract with a local agency to produce kits
- b. Procure kit contents locally and assemble on site
- c. Discuss during the health cluster/sector coordination meeting where to procure supplies
- d. All of the above

I5 Which agency can act as the “lead RH agency” in an emergency?

- a. UNFPA only
- b. WHO only
- c. MoH only
- d. Any agency that has the capacity to lead RH

		YES	NO
3.2	Number of incidents of sexual violence reported to health services:	_____	
3.3	Information on post-rape care and access to services disseminated to community.	<input type="checkbox"/>	<input type="checkbox"/>
4. Reduce the transmission of HIV			
4.1	Safe and rational blood transfusion protocols in place	<input type="checkbox"/>	<input type="checkbox"/>
4.2	Units of blood screened /all units of blood donated X 100:	_____	
4.3	Sufficient materials and checklists to ensure standard precautions in place	<input type="checkbox"/>	<input type="checkbox"/>
4.4	Condoms available free of charge at: <ul style="list-style-type: none"> ▶ Health facilities ▶ Community level 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4.5	Approximate number of condoms taken this period:	_____	
4.6	Number of condoms replenished in distribution sites this period (specific locations): _____ _____ _____	_____ _____ _____	
5. Prevent excess maternal and newborn morbidity and mortality			
5.1	Health center (to ensure basic EmONC 24/7) has: <ul style="list-style-type: none"> ▶ One qualified health worker on duty per 50 outpatient consultations per day ▶ Midwife supplies, including newborn supplies, available Hospital (to ensure comprehensive EmONC 24/7) has: <ul style="list-style-type: none"> ▶ One qualified service provider on duty per 20-30 inpatient beds for the obstetric wards ▶ One team of doctor/nurse/midwife/anesthetist on duty ▶ Adequate drugs and supplies to support comprehensive EmONC 24/7 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5.2	Referral system for obstetric and newborn emergencies functioning 24 hours per day/7days per week (24/7) including <ul style="list-style-type: none"> ▶ Means of communication (radios, mobile phones) ▶ Transport from community to health center available 24/7 ▶ Transport from health center to hospital available 24/7 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5.3	Functioning cold chain (for oxytocin, blood screening tests) in place	<input type="checkbox"/>	<input type="checkbox"/>
5.4	Number of caesarean deliveries / number of births x 100:	_____	
5.5	Number of clean delivery kits distributed / Estimated number of pregnant women x 100:	_____	
6. Planning for transition to comprehensive RH services			
6.1	Sites identified for future delivery of comprehensive RH services (e.g., family planning, STI management, adolescent RH): _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>



6.2	Staff training needs (for FP provision, STI management, etc) assessed and training tools identified:		
		YES	NO
6.3	RH commodities consumption (medicines and renewable supplies) monitored	<input type="checkbox"/>	<input type="checkbox"/>
6.4	Procurement channels identified: _____		

7. Special notes

7.1	Basic contraceptives available to meet demand	<input type="checkbox"/>	<input type="checkbox"/>
7.2	ARV available for patients on ART, including PMTCT	<input type="checkbox"/>	<input type="checkbox"/>
7.3	STI treatment available at health facilities	<input type="checkbox"/>	<input type="checkbox"/>
7.4	Hygiene kits distributed	<input type="checkbox"/>	<input type="checkbox"/>

8. Actions (For the “No” checks, explain barriers and proposed activities to resolve them.)

Number	Barrier	Proposed solution

Appendix B:

MISP Calculator

The example shows estimates for a population of 300,000. The default estimates are based on the default Inter-agency RH Kit proportions, while the column on site-specific estimates uses the site-specific figures in the dark pink cells.

	Default Figures	Site-specific Estimate using Default Figures	Site-specific Estimate using Site-specific Figures	Units
Total Population	-	300,000	300,000	persons
Crude Birth Rate (per 1,000 population)	40	40	30	persons per 1,000 population
Contraceptive Prevalence Rate (%)	15%	15%	30%	percent
STI Prevalence Rate (% of adults)	5%	5%	5%	percent
Maternal Mortality Ratio (per 100,000 live births)	-	-	320	persons per 100,000 live births
Population Figures				
Live births per year	-	12,000	9,000	births
Live births per month	-	1,000	750	births
Number of currently pregnant women (excluding the additional 15% of pregnancies that will end in miscarriage)	-	9,000	6,750	pregnant women
Number of pregnancies that end in miscarriage or unsafe abortion in one month (estimated as an additional percentage of live births)	15%	200	150	pregnancies
Number of pregnancies that end in miscarriage or unsafe abortion in the next 9 months (estimated as an additional percentage of live births)	15%	1,800	1,350	pregnancies
Number of currently pregnant women who will experience complications in one month	15%	150	113	pregnant women
Number of currently pregnant women who will experience complications in the next 9 months	15%	1,350	1,013	pregnant women
Number of currently pregnant women who will have access and be able to give birth in a health center in one month	15%	150	113	pregnant women
Number of currently pregnant women who will have access and be able to give birth in a health center in the next 9 months	15%	1,350	1,013	pregnant women
Number of currently pregnant women who deliver who will need suturing of vaginal tears in one month	15%	150	113	pregnant women
Number of currently pregnant women who deliver who will need suturing of vaginal tears in the next 9 months	15%	1,350	1,013	pregnant women
Number of deliveries requiring a c-section in one month (Min)	5%	50	38	deliveries

Number of deliveries requiring a c-section in the next 9 months (Min)	5%	450	338	deliveries
Number of deliveries requiring a c-section in one month (Max)	15%	150	113	deliveries
Number of deliveries requiring a c-section in the next 9 months (Max)	15%	1,350	1,013	deliveries
Number of maternal deaths averted in the next 9 months if MISP is fully implemented and all pregnant women have access to EmOC services	100%	-	26	deaths
Number of women of reproductive age (WRA)	25%	75,000	75,000	WRA
Number of sexually active men in the population	20%	60,000	60,000	men
Number of sexually active men who use condoms	20%	12,000	12,000	men
Number of WRA who use modern contraceptives	15%	11,250	22,500	WRA
Number of WRA who use female condoms	1%	750	750	WRA
Number of WRA using modern methods of contraception who use combined oral contraceptive pills	30%	3,375	6,750	WRA
Number of WRA using modern methods of contraception who use injectable contraception	55%	6,188	12,375	WRA
Number of WRA using modern methods of contraception who use an IUD	5%	563	1,125	WRA
Number of cases of sexual violence (percent of WRA at risk of rape)	2%	1,500	1,500	WRA

Appendix C:

Sample Project Proposal for an international NGO to submit to governments, United Nations groups such as UNFPA and UNHCR, or other donors

PROJECT TITLE	Implementing the Minimum Initial Service Package (MISP) for Reproductive Health
ORGANIZATION	Description of the organization and its work, including reproductive health activities, in the region
BRIEF BACKGROUND, REASON FOR PROJECT AND PROBLEM TO BE ADDRESSED	<p>The MISP for Reproductive Health (RH) will save lives if implemented at the onset of an emergency. Neglecting RH in emergencies has serious consequences: preventable maternal and infant deaths; unwanted pregnancies and subsequent unsafe abortions; and the spread of sexually transmitted infections, including HIV/AIDS.</p> <p>The MISP is a set of priority activities designed to: prevent excess maternal and newborn morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services.</p> <p>Additional Priority Activities include ensuring contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). Another important activity is to ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in “hygiene kits”) are distributed to women and girls.</p> <p>The MISP includes a kit of equipment and supplies to complement a set of priority activities that must be implemented in the early days and weeks of an emergency in a coordinated manner by trained staff. The MISP can be implemented without an in-depth needs assessment because documented evidence already justifies its use.</p> <p>The components of the MISP form a minimum requirement and it is expected that comprehensive RH services will be provided as soon as the situation allows. The MISP is a minimum standard in the Sphere <i>Minimum Standards in Disaster Response</i> and in the <i>Health Cluster Guide</i>. An RH lead agency with a designated RH Officer is essential to ensuring coordination of MISP activities within the health sector/cluster. Under the auspices of the overall health coordination framework, the RH Officer should: be the focal point for RH services and provide technical advice and assistance on RH; liaise with national and regional authorities of the host country; liaise with other sectors to ensure a multi-sectoral approach to RH; identify standard protocols for RH which are fully integrated with primary health care, as well as simple forms for monitoring RH activities; and report regularly to the health sector/cluster.</p> <p>[Insert brief background on emergency situation.]</p>



OBJECTIVES	<ol style="list-style-type: none">1. Identify lead RH organization and individual(s) to facilitate the coordination and implementation of the MISP.2. Prevent and manage the consequences of sexual violence.3. Reduce HIV transmission.4. Prevent excess maternal and newborn mortality and morbidity.5. Plan for comprehensive RH services, integrated into primary health care as the situation permits. Notes: It is also important to ensure contraceptives are available to meet demand, treatment of STIs is available and that ARVs are available to continuing users.
ACTIVITIES	<p>ACTIVITIES</p> <ol style="list-style-type: none">1. ENSURE the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:<ol style="list-style-type: none">a. Nominates an RH Officer to provide technical and operational support to all agencies providing health services;b. Hosts regular stakeholder meetings to facilitate implementation of the MISP;c. Reports back to the health sector/cluster meetings on any issues related to MISP implementation; andd. Shares information about the availability of RH resources and supplies.2. PREVENT AND MANAGE the consequences of sexual violence by ensuring that:<ol style="list-style-type: none">a. Measures are put in place to protect affected populations, particularly women and girls, from sexual violence;b. Clinical care, including psychosocial support, is made available for survivors of rape; andc. The community is aware of the available clinical services.3. REDUCE HIV transmission by:<ol style="list-style-type: none">a. Ensuring there is a safe blood transfusion practice;b. Facilitating and enforcing respect for standard precautions; andc. Making free condoms available.4. PREVENT excess maternal and newborn morbidity and mortality by:<ol style="list-style-type: none">a. Ensuring the availability of emergency obstetric and newborn care services, including:<ol style="list-style-type: none">i. At health facilities: ensure there are skilled birth attendants and supplies for normal births and management of obstetric and newborn complicationsii. At referral hospitals: ensure there are skilled medical staff and supplies for management of obstetric and newborn emergencies



	<ul style="list-style-type: none">b. Establishing a referral system to facilitate transport and communication from the community to the health center and between health center and hospital; andc. Providing clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible. <p>5. PLAN for comprehensive RH services, integrated into primary health care as the situation permits. Support the health sector/cluster partners to:</p> <ul style="list-style-type: none">a. Coordinate ordering RH equipment and supplies based on estimated and observed consumption;b. Collect existing background data;c. Identify suitable sites for future service delivery of comprehensive RH services; andd. Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff. <p><i>Ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and that antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). In addition, ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in “hygiene kits”) are distributed to women and girls.</i></p> <p>MONITOR & EVALUATE project implementation</p> <p>Regularly complete the MISP checklist as found in the revised <i>Inter-Agency Field Manual: Reproductive Health in Humanitarian Situations</i> for all project implementation areas.</p> <p>Collect or estimate basic demographic information; total population number; of women of reproductive age (ages 15 to 49, estimated at 25 percent of population); number of sexually active men (estimated at 20 percent of population); crude birth rate (estimated at 4 percent of the population); age-specific mortality rate (including neonatal deaths 0 to 28 days); sex-specific mortality rate.</p>
INDICATORS	<ul style="list-style-type: none">1. Availability of clinical management of rape survivors: defined as the percentage of health facilities with clinical management of rape survivors, including EC, PEP and presumptive STI treatment. Calculate the number of health facilities offering clinical management of rape survivors divided by all health facilities x 100.2. Number of reported rape cases: defined as the number of rape cases reported to health facilities over a specific time period. Calculate the number of rape cases reported to health facilities divided by the time period.3. Coverage of supplies for standard precautions: defined as the percentage of health delivery sites with sufficient supplies to ensure standard precautions can be practiced. Calculate the number of health service delivery points with



	<p>adequate supplies to carry out standard precautions divided by the number of health service delivery points x 100.</p> <ol style="list-style-type: none"> 4. Coverage of HIV rapid tests for safe blood transfusion: defined as the percentage of referral hospitals that have sufficient HIV rapid tests to ensure all blood destined for transfusion is screened. Calculate: number of hospitals with sufficient HIV rapid tests to screen blood for transfusion divided by the total number of hospitals x 100. 5. Condom distribution rate: defined as the rate of condom distribution among the population. Calculate the number of male condoms distributed divided by the total population divided by month. 6. EmOC needs met: defined as the proportion of women with major direct obstetric complications who are treated in EmOC facilities. Calculate the number of obstetric complications (antepartum hemorrhage, post-partum hemorrhage, obstructed labor, pre-eclampsia, eclampsia or puerperal sepsis) treated at an EmOC facility divided by expected number of deliveries x 100 per month. 7. Coverage of clean delivery kits: defined as rate of distribution of clean delivery kits among pregnant women in their third trimester. Calculate the number of clean delivery kits distributed divided by the estimated number of pregnant women x 100 per month. 8. Percentage of health facilities providing basic contraceptive methods available to meet demand. 9. Percentage of health facilities providing STI treatment available at health facilities. 10. Total number of hygiene kits distributed.
TARGETED BENEFICIARIES	(Total number of) displaced, of whom (xx) are women 15 to 49 years old.
PROJECT DURATION	Six months to one year.

Appendix D:

Sample Proposal for the Consolidated Appeals Process (CAP) on Adolescent Sexual and Reproductive Health

Note: annotations in **red** are from OCHA/On-Line Project System

Appealing Agency(ies)	XX
PROJECT TITLE	Ensuring Adolescent Sexual and Reproductive Health in the Aftermath of the Crisis/Disaster
PROJECT CODE	[Assigned automatically by OCHA's OPS after the draft project is saved.]
SECTOR OR CLUSTER	Health
OBJECTIVE	<ul style="list-style-type: none"> ❖ To increase availability of and access to adolescent-friendly sexual and reproductive health services in the affected area(s). ❖ To provide psychosocial support and reproductive health education to affected adolescent girls and boys.
BENEFICIARIES	<p>TOTAL : XXX [number of individuals, not households]</p> <p>Children : XXX Women : XXX</p> <p>Other group (specify): [number of adolescents/young people and age bracket]</p>
IMPLEMENTING PARTNER(S)	List partners <i>ONLY</i> in the sense of those to whom you will subcontract, <i>NOT</i> those with whom you will coordinate, such as the MoH, Oxfam. (It is assumed your agency will coordinate laterally with the rest of the sector/cluster.)
PROJECT DURATION	
LOCATION	
PRIORITY	(Will be assigned by sector/cluster)
PROJECT CONTACT NAME	<i>Warning: This information will eventually be published to allow interested donors to contact the appropriate person in your organization. Do not provide confidential contact information, but use a generic contact if preferable (e.g.; ReproductiveHealth@xyz.org).</i>
PROJECT CONTACT E-MAIL	<i>Warning: This information will eventually be published to allow interested donors to contact the appropriate person in your organization. Do not give confidential contact information, but use a generic contact if preferable (e.g.; ReproductiveHealth@xyz.org).</i>
PROJECT CONTACT PHONE	<i>Warning: This information will eventually be published to allow interested donors to contact the appropriate person in your organization. Do not give confidential contact information, but use a generic contact if preferable (e.g.; ReproductiveHealth@xyz.org).</i>

Needs – TO BE TAILORED TO SPECIFIC EMERGENCY!

(maximum 4,000 characters, which is about 1.5 pages)

As they transition from childhood to adulthood, adolescents normally benefit from the influence of adult role models, social norms, structures and community groups (peer, religious or cultural).

During natural and man-made humanitarian emergencies, however, family and social structures are disrupted—adolescents may be separated from their families or communities as formal and informal educational programs are discontinued and community and social networks break down. Adolescents may feel fearful, stressed, bored or idle. They may find themselves in risky situations they are not prepared to confront and they may suddenly have to take on adult roles without preparation, positive role models or support networks.

The loss of livelihoods, security and the protection provided by families and communities places adolescents at risk of poverty, violence, and sexual exploitation and abuse. In crisis situations, adolescents, especially girls, are vulnerable to rape and sexual exploitation at the hands of fighting forces, community members, humanitarian workers and uniformed personnel due to girls' lack of power and resources, and because rape is often used as a strategy of warfare. In addition, many adolescents, including younger adolescents, resort to selling sex to meet their own or their families' needs. They may also be at risk of recruitment into armed forces or groups. Because of the high level of mobility, increased risk-taking behaviors and alcohol and drug abuse, these adolescents are even more vulnerable to sexual exploitation and abuse, sexually transmitted infections (STIs), including HIV, and unwanted pregnancies. Finally, adolescents who live through crises may not be able to visualize positive futures for themselves and may develop fatalistic views about the future. This may also contribute to high-risk sexual behaviors and poor health-seeking behaviors.

The disruption of families, education and health services, either due to infrastructure damage or due to increased demands placed on health and social service providers adds to the problem at a time when adolescents are most at risk.

Certain sub-groups of adolescents are at particularly high risk and require special attention. This is true of sub-groups of adolescents that are at risk by definition (very young adolescents, pregnant adolescent girls, adolescents with disabilities and marginalized adolescents, among others) and sub-groups that become at-risk during a crisis (adolescents separated from their families—parents or spouses; adolescent heads of households; survivors of sexual violence and other forms of gender-based violence; adolescent girls selling sex; and children associated with armed forces and groups). Regardless of the source of their vulnerability, all at-risk sub-groups of adolescents require particular attention and targeted interventions to ensure that their reproductive health needs are met.

Activities *(maximum 4,000 characters)*

Reproductive health interventions save lives and are critically important in the aftermath of a crisis. In addition, special efforts are required to ensure that the priority, life-saving reproductive health interventions are responsive to the needs of adolescents who will otherwise face increased risks of mortality and morbidity. This project aims to ensure that the implementation of the Minimum Initial Service Package (MISP) for Reproductive Health addresses adolescent sexual and reproductive health needs. The project will be carried out in close coordination with the Reproductive Health Working Group under the Health Cluster. This project will:

- ❖ Sensitize health providers on adolescent sexual and reproductive health needs and effective ways of working with adolescents, in order to ensure that the reproductive health services offered to affected populations are adolescent friendly and age responsive;
- ❖ Support the availability of health personnel specializing in adolescent sexual and reproductive health in outreach clinics and other facilities;
- ❖ Identify traditional birth attendants and community health workers to ensure they link pregnant adolescents and young adolescent mothers to health services and refer young survivors of sexual violence to such services;
- ❖ Mobilize peer educators and youth leaders to raise awareness of sexual and reproductive health issues among their peers and refer them to specialized services;
- ❖ Identify adolescent-oriented distribution points for condoms and ensure distribution; and
- ❖ Develop and disseminate youth-friendly sexual and reproductive health information materials.

Outcomes *(maximum 4,000 characters)*

- ❖ XX health providers trained on adolescent sexual and reproductive health.
- ❖ XX health providers placed in facilities to serve adolescents as a priority.
- ❖ XX traditional birth attendants and community health workers trained on referring adolescents to specialized services.
- ❖ XX peer educators and youth leaders mobilized and actively involved in outreach among their peers.
- ❖ XX male and female condoms distributed to XX adolescents.
- ❖ XX adolescents sensitized to reproductive health needs and threats in the aftermath of the emergency.

To be sure that adolescents are making use of available reproductive health services and receiving information, the following key indicators will be monitored in the framework of this project:

- ❖ Proportion of STIs among under-18 year olds.
- ❖ Proportion of births under 18 years of age.
- ❖ Condom use disaggregated by sex and age.

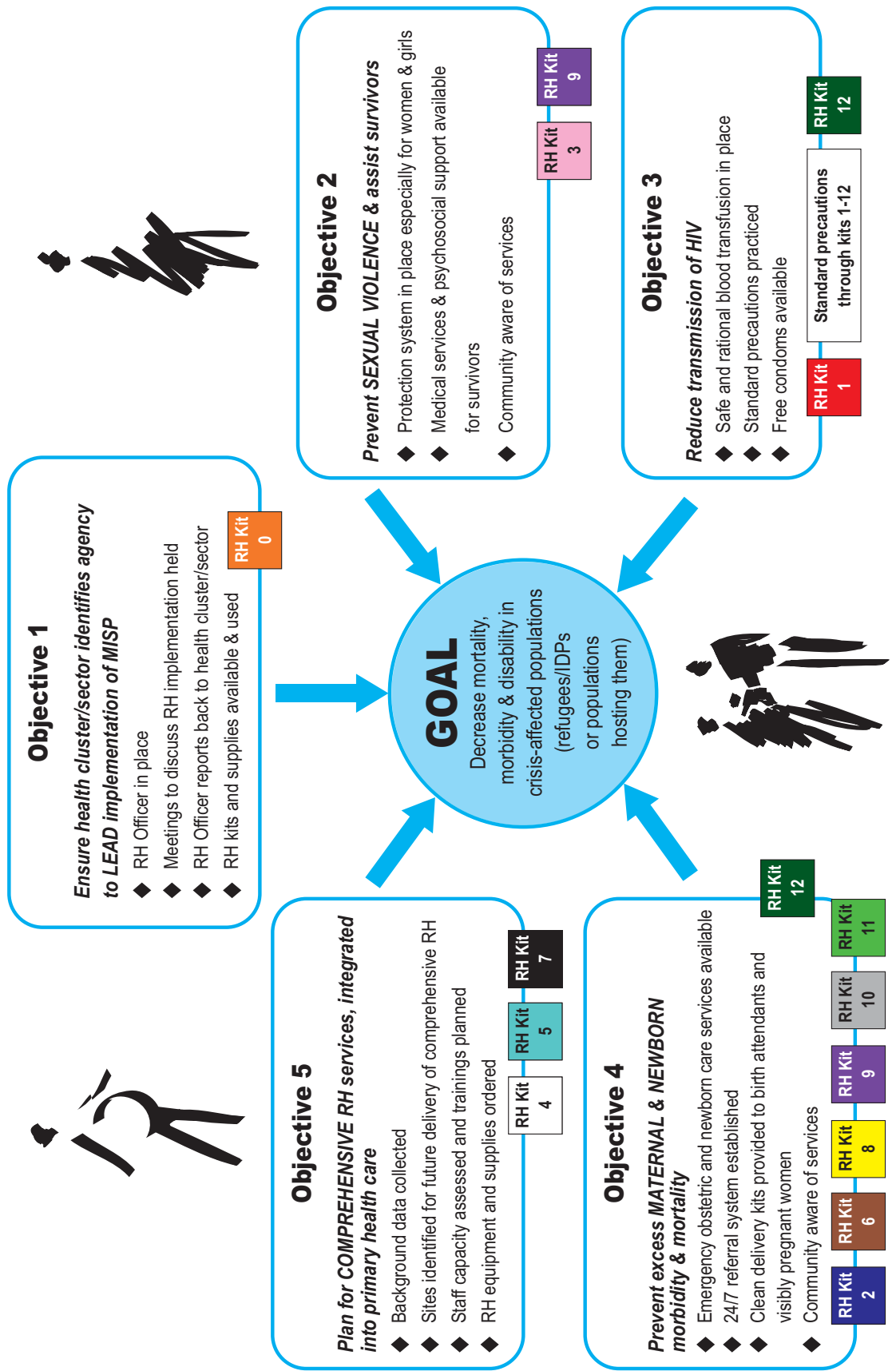
REQUESTED BUDGET	
<i>Note: If the project is longer than the CAP's common planning horizon—usually one year—this budget should only reflect the current year portion.)</i>	
Budget Items	\$
Cost A (e.g. staff)	
Cost B (e.g. inputs)	
Cost C (e.g. administration)	
TOTAL (OPS will calculate the total automatically from the lines above.)	

NOTE: OPS offers only five (5) budget lines, to keep the information manageable. If your organization's standard format has more than five, combine some of the smaller ones.

Appendix E:

MISP Cheat Sheet

Minimum Initial Service Package (MISP) for Reproductive Health



The RH Kit is designed for use for a 3-month period for a varying population number and is divided into three "blocks" as follows:

Block 1: Six kits to be used at the community and primary health care level for 10,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 0	Administration	Orange
Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
Kit 3	Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	STI	Turquoise

Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at the community and primary care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Abortion	Yellow
Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction for Delivery (Manual)	Grey

Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months		
KIT NUMBER	KIT NAME	COLOR CODE
Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

NOTE: Agencies should not depend solely on the Inter-agency RH Kits and should plan to integrate the procurement of MIS/RH supplies in their routine health procurement systems.

RESOURCES:

- Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual: http://www.iawg.net/resources/field_manual.html
- MISP Distance Learning Module: <http://misp.rhrc.org>
- SPRINT Facilitator's Manual for SRH Coordinators: www.ippfsear.org/en/Resources/Publications/SPRINTFacilitatorsManual.htm
- UNFPA/Save the Children Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings: A companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: www.unfpa.org/public/publications/pic/4169
- RHRC Monitoring and Evaluation Toolkit: www.rhrc.org/resources/general_fieldtools/toolkit/
- CDC RH Assessment Toolkit for Conflict-Affected Women: <http://www.cdc.gov/reproductivehealth/Refugees/RefugeesProjects.htm>
- Inter-agency Working Group on Reproductive Health in Crises: www.iawg.net
- Reproductive Health Response in Crises (RHRC) Consortium: www.rhrc.org

April 2011 © IAWG. Based on Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.

CRISIS		POST-CRISIS
SUBJECT AREA	Crude mortality rate >1 death/10,000/day	Mortality returns to level of surrounding populations
FAMILY PLANNING	<p>MINIMUM (MISP) RH SERVICES</p> <ul style="list-style-type: none"> Provide contraceptives, such as condoms, pills, injectables and IUDs, to meet demand 	<p>COMPREHENSIVE RH SERVICES</p> <ul style="list-style-type: none"> Source and procure contraceptive supplies Provide staff training Establish comprehensive family planning programs Provide community education
GENDER-BASED VIOLENCE	<ul style="list-style-type: none"> Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters Provide clinical care for survivors of rape Inform community about services 	<ul style="list-style-type: none"> Expand medical, psychological, social and legal care for survivors Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting, Provide community education Engage men and boys in GBV programming
MATERNAL AND NEWBORN CARE	<ul style="list-style-type: none"> Ensure availability of emergency obstetric and newborn care services Establish 24/7 referral system for obstetric and newborn emergencies Provide clean delivery packages to visibly pregnant women and birth attendants Inform community about services 	<ul style="list-style-type: none"> Provide antenatal care Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care Increase access to basic and comprehensive emergency obstetric and newborn care
STIs, INCLUDING HIV, PREVENTION & TREATMENT	<ul style="list-style-type: none"> Ensure safe and rational blood transfusion practice Ensure adherence to standard precautions Guarantee the availability of free condoms Provide syndromic treatment as part of routine clinical services for patients presenting for care Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible 	<ul style="list-style-type: none"> Establish comprehensive STI prevention and treatment services, including STI surveillance systems Collaborate in establishing comprehensive HIV services as appropriate Provide care, support and treatment for people living with HIV/AIDS Raise awareness of prevention, care, treatment services of STIs

How to order RH Kits for Crisis Situations booklet:
 UNFPA – Contact local country offices or
 220 East 42nd Street
 New York, NY 10017 USA
 Tel : +1 212 297 5245
 Fax : +1 212 297 4915
 Email: hru@unfpa.org
www.rhrc.org/resources/rhkit.pdf

How to order RH Kits:
 UNFPA Procurement Services Section
 Emergency Procurement Team
 Midtermolen 3
 2100 Copenhagen
 Denmark
 Tel : +45 3546 7368 / 7000
 Fax : +45 3546 7018
procurement@unfpa.dk

Appendix F:

MISP Advocacy Sheet: What is the MISP and Why Is It Important?

1. The Minimum Initial Service Package (MISP) for Reproductive Health is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. It forms the starting point for sexual and reproductive health programming and should be sustained and built upon with comprehensive sexual and reproductive health services throughout protracted crises and recovery.
2. Sexual and reproductive health problems are the leading cause of women's ill health and death worldwide.¹²³
3. The MISP saves lives and prevents illness, trauma and disability, especially among women and girls. As such, the MISP meets the life-saving criteria for the Central Emergency Response Fund (CERF).¹²⁴
4. Neglecting the MISP in humanitarian settings has serious consequences: preventable maternal and newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV.
5. Approximately 75 to 80 percent of all crisis-affected populations are women, children and youth who need and have a right to reproductive health services.¹²⁵
6. The MISP is an international standard as outlined in the Sphere Humanitarian Charter and Minimum Standards in Disaster Response.¹²⁶
7. The Global Health Cluster endorses the MISP as a minimum standard in health service provision in emergencies as outlined in the IASC Health Cluster Guide.¹²⁷
8. International laws support the rapid and unobstructed implementation of the MISP by humanitarian actors.¹²⁸ Reproductive health services are also vital to realizing United Nations Security Council Resolutions 1325, 1820, 1888 and 1889 on Women, Peace and Security.
9. In addition to health, activities of the MISP must be coordinated with other sectors/clusters, including protection, water, sanitation and hygiene (WASH) and early recovery.
10. As humanitarian actors become familiar with the priority activities of the MISP, they recognize that it can and should be provided within the context of other critical priorities, such as water, food, cooking fuel and shelter.

***Implementing the MISP is not optional:
it is an international standard of care that should be
implemented at the onset of every emergency.***

¹²³ United Nations Population Fund, *State of the World Population*, 2005.

¹²⁴ Central Emergency Response Fund, *CERF Lifesaving Criteria and Sectoral Activities*, 2010. Available from <http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1163693>.

¹²⁵ United Nations Population Fund, *State of the World Population*, 2000.

¹²⁶ The Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. Available from www.sphereproject.org.

¹²⁷ Inter-agency Standing Committee, *Health Cluster Guide: A practical guide for country-level implementation of the Health Cluster*, 2009.

¹²⁸ Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War (1948); Geneva Conventions, common art. 3; International Covenant on Civil and Political Rights, art. 6; Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War, arts. 23, 55, 59, 60 (1948); Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), art. 70; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), arts. 9-11; Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the International Covenant on Economic, Social and Cultural Rights (ICESCR).

What are the objectives of the MISP?

1. ENSURE the health sector/cluster identifies an organization to lead implementation of the MISP. The lead sexual and reproductive health (RH) organization:
 - a. Nominates an RH Officer to provide technical and operational support to all agencies providing health services;
 - b. Hosts regular stakeholder meetings to facilitate implementation of the MISP;
 - c. Reports back to health sector/cluster meetings on issues related to MISP implementation; and
 - d. Shares information about the availability of RH resources and supplies.

The MISP can be implemented without an initial needs assessment. Data on sexual violence, HIV and other RH issues are not required to implement the MISP.
2. PREVENT AND MANAGE the consequences of sexual violence by:
 - a. Putting in place measures to protect affected populations, particularly women and girls, from sexual violence;
 - b. Making clinical care available for survivors of rape; and
 - c. Ensuring the community is aware of available clinical services.
3. REDUCE HIV transmission by:
 - a. Ensuring safe blood transfusion practice;
 - b. Facilitating and enforcing respect for standard precautions; and
 - c. Making free condoms available.
4. PREVENT excess newborn and maternal morbidity and mortality by:
 - a. Ensuring availability of emergency obstetric care (EmOC) and newborn care services, including:
 - i. At health facilities: ensure there are skilled birth attendants and supplies for normal births and management of obstetric and newborn complications.
 - ii. At referral hospitals: ensure there are skilled medical staff and supplies for management of obstetric and newborn emergencies.
 - b. Establishing a referral system to facilitate transport and communication from the community to the health center and between health center and hospital; and
 - c. Providing clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
5. PLAN for comprehensive RH services, integrated into primary health care as the situation permits. Support the health sector/cluster partners to:
 - a. Coordinate ordering RH equipment and supplies based on estimated and observed consumption;
 - b. Collect existing background data;
 - c. Identify suitable sites for future service delivery of comprehensive RH services; and
 - d. Assess staff capacity to provide comprehensive RH services and plan for training of staff.

Note:

It is important to ensure that common contraceptive methods, such as condoms, pills, injectables and IUDs, are available to meet demand; antibiotics are available to provide syndromic treatment to patients with symptoms of a sexually transmitted infection; and antiretrovirals (ARVs) are available to continue treatment for people living with HIV who are already on ARVs, including for prevention of mother-to-child transmission.

Appendix G:

Adolescent-friendly Checklist

Characteristics	Yes	No	Feasible suggestions for improvement
Health Facility Characteristics			
1. Is the facility located near a place where adolescents—both female and male—congregate? (youth center, school, market, etc.)			
2. Is the facility open during hours that are convenient for adolescents—both female and male (particularly in the evenings or on the weekend)?			
3. Are there specific clinic times or spaces set aside for adolescents?			
4. Are RH services offered for free, or at rate affordable to adolescents?			
5. Are waiting times short?			
6. If both adults and adolescents are treated in the facility, is there a separate, discreet, entrance for adolescents to ensure privacy?			
7. Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
8. Is there a Code of Conduct in place for staff at the health facility?			
9. Is there a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility?			
Provider Characteristics			
1. Have providers been trained to provide adolescent-friendly services?			
2. Have all staff members been oriented to providing confidential, adolescent-friendly services (receptionist, security guards, cleaners, etc.)?			
3. Do staff members demonstrate respect when interacting with adolescents?			
4. Do the providers ensure the clients' privacy and confidentiality?			
5. Do the providers set aside sufficient time for client-provider interaction?			
6. Are peer educators or peer counselors available?			
7. Are health providers assessed using quality standard checklists?			
Program Characteristics			
1. Do adolescents (female and male) play a role in the operation of the health facility?			
2. Are adolescents involved in monitoring the quality of SRH service provision?			
3. Can adolescents be seen in the facility without the consent of their parents or spouses?			
4. Are a wide range of RH services available (FP, STI treatment and prevention, HIV counseling and testing, ante- and post-natal care, delivery care)?			
5. Are there written guidelines for providing adolescent services?			
6. Are condoms available to both young men and young women?			
7. Are the RH educational materials, posters or other job aids on site designed to reach adolescents?			
8. Are referral mechanisms in place (for medical emergencies, for mental health and psychosocial support, etc.)?			
9. Are adolescent-specific indicators monitored on a regular basis (e.g.; number of adolescent clients, disaggregated by age and sex)?			

MISP Module Answers

Chapter 2 Coordination of the MISP

1. **e.** All of the above

The MISP and additional priority activities include: prevent sexual violence and respond to survivors; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; and ensure contraceptives, ARVs and STI care are available.

2. **e.** A and D

Ensuring women and girls' access to emergency obstetric care is a priority activity for preventing maternal and newborn morbidity and mortality. Ensuring clinical care for rape survivors is an essential activity to respond to sexual violence.

Antenatal care is not part of priority RH services. Antenatal care should be initiated through comprehensive RH services once all components of the MISP have been implemented. Addressing early age at marriage is not part of the MISP.

3. **b.** False

Humanitarian workers are responsible for ensuring that MISP priority activities are implemented, not just the RH staff. MISP activities are not limited to RH staff or even the general health sector. The MISP cuts across all sectors in addition to health, including protection, food security, water/sanitation and shelter.

4. **e.** B and C

The RH Officer should know the following demographic and health information: the approximate number of sexually active men and the approximate number of pregnant women.

Determining the number of people living with HIV and sexually transmitted infections is not part of the MISP.

5. **e.** All of the above

The RH Officer should: work within the health sector/cluster; support the coordinated procurement of RH materials and supplies; conduct orientation sessions on the MISP for the health sector/cluster and humanitarian workers; and, utilize the MISP checklist for monitoring RH activities.

Chapter 3 Prevent and Manage the Consequences of Sexual Violence

1. **e.** A, C and D

The RH Officer should: support multi-sectoral/inter-cluster coordination of actions to prevent (and respond to) sexual violence; ensure communities are informed about the benefits of seeking clinical care for rape, as well as the location and hours of clinical care service; and identify and support the development and functioning of systems to address sexual exploitation and abuse.

A community-wide education campaign on gender-based violence (GBV) is not a component of the MISIP. The focus of the MISIP is the prevention of sexual violence, including sexual exploitation and abuse, provision of medical care for rape survivors and ensuring the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISIP have been implemented, attention can be given to preventing the wider array of GBV issues.

2. **e.** All of the above

Perpetrators can be *anyone*, including others who have been displaced by the conflict or disaster; members of the same or other clans, villages, religious groups or ethnic groups; military personnel; humanitarian workers from UN or NGO agencies; members of the host population; or family members. They can be male or female, old or young.

3. **c.** *InterAction Step by Step Guide to Addressing Sexual Exploitation and Abuse*

4. **c.** Lack of cooking fuel available in or near households

Women and girls who have to travel to gather firewood for cooking fuel are at increased risk for sexual assault.

5. **b.** Antenatal care

Chapter 4 *Reduce the Transmission of HIV*

1. **b.** People living with HIV participate in food distribution

The participation of people living with HIV in the distribution of food and other essential goods is not a risk factor for HIV transmission.

2. **e.** All of the above

All blood for transfusion should be safe by ensuring that it is screened for HIV and other transfusion transmissible infections such as hepatitis B, C and syphilis; avoiding unnecessary blood transfusions; ensuring there are sufficient HIV and other tests and supplies available for screening blood where needed; and ensuring that an appropriate facility, supplies and qualified staff are in place.

3. **e.** A, C and D

Requirements for infection control include: facilities for frequent hand washing; decontaminating, cleaning, disinfecting and sterilizing used instruments; and safe handling of sharp objects.

X-rays are not required for infection control.

4. **b.** False

An HIV test is not required before prescribing PEP.

5. **e.** All of the above

It is important to make condoms available in a variety of places so different segments of the population can access them comfortably.

Chapter 5 Prevent Excess Maternal and Newborn Morbidity and Mortality

1. **c.** Distributing clean delivery kits

The distribution of clean delivery kits is not a component of emergency obstetric care.

2. **e.** Blood Transfusion

Although safe blood transfusion is important, it is not part of essential newborn care.

3. **d.** 4 percent

The proportion of displaced women who will be pregnant at a given time is based on average estimates in developing countries at 4 percent of the total displaced population. National and sub-national or other locally available crude birth rate should be used when possible.

4. **b.** False

It is essential to assess the local health facility and work with the authorities in the region to determine whether it makes sense to support the current health center or hospital. However, if the facility is too far away or cannot handle the extra patients, NGOs and UN agencies must decide with the local health authorities whether it makes more sense to invest in building a new facility.

5. **d.** Sutures

Sutures are not part of a clean delivery kit.

Chapter 6 Planning for Comprehensive RH Services

1. **e.** A, B and C

The MISIP requires establishing a referral system for EmOC immediately versus planning for it as a component of comprehensive RH services.

2. **e.** A, C and D

The MISIP requires establishing medical care for survivors immediately versus planning for it as a component of comprehensive RH services.

3. **e.** All of the above

WHO, UNFPA, World Bank and Demographic and Health Surveys provide demographic and health data.

4. **b.** False

Planning for comprehensive RH service delivery should begin at the same time as the implementation of the other components of the MISIP. If not, provision of comprehensive RH services may be unnecessarily delayed. The actual implementation of comprehensive RH care, however, should wait until after the priority services of the MISIP are fully established.

5. **e.** All of the above

Characteristics of a suitable site for delivering comprehensive RH services include: the capacity for privacy and confidentiality during consultations; possibilities to maintain aseptic conditions; communications and transport availability for referrals; and locked storage facilities for supplies and files.

Chapter 7 Priority Activities in Addition to the MISp

1. **e.** All of the above

Priority activities in addition to the MISp include ensuring: contraceptives are available; syndromic treatment of STIs is available; ARVs are available; and menstrual protection materials are provided.

2. **a.** True

The disruption of family and social support structures can further pose challenges for adolescents who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices.

3. **e.** All of the above

Contraceptive methods that should be available at the onset of an emergency include: condoms and pills; injectables; IUDs; and emergency contraceptive pills.

4. **e.** B and C

To ensure syndromic treatment of STIs is available at health facilities, it is important to identify national STI treatment protocols and to make these protocols available at health facilities.

Although it is important to ensure a newborn is dried and warmly wrapped—keeping its head covered immediately after birth and to ensure community coordination around food distribution, these are not components of ensuring syndromic treatment of STIs at health facilities.

5. **e.** All of the above

To ensure ARVs are available, the RH Officer can contact the MOH, WHO, UNAIDS and the National Red Cross.


Chapter 8 Ordering RH Kits

1. **a.** True

Female condoms are available in Kit I, Part B.

2. **c.** Conducting focus groups with an equal number of male and females

To place an order for RH supplies, it is important to undertake the following activities: estimate kit needs based on basic demographic data; coordinate within the health sector/cluster; determine the number of health personnel and their qualifications; and prepare a plan for kit distribution.



Conducting focus groups in an emergency is not necessary because it would take too much time when it is critical to place an order to obtain supplies as soon as possible. Focus groups could be done when a stable phase is reached to better inform RH programming.

3. **b.** Three months

The RH Kits are designed for use for three months for varying levels of the population depending on which block of kits are ordered.

4. **e.** B, C and D

Block 1 is designed for the community and primary health care levels, Block 2 is for the primary health care level and Block 3 is for use at the referral hospital level.

The kits are not designed for the international level.

5. **b.** False

UNHCR does not provide Inter-agency RH Kits. The Inter-agency RH Kits are managed and supplied by UNFPA.

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