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



A Distance Learning Module

WOMEN'S COMMISSION
for refugee women & children

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The Women's Commission for Refugee Women and Children (Women's Commission) works to improve the lives and defend the rights of refugee and internally displaced women, children and adolescents.

- We advocate for their inclusion and participation in programs of humanitarian assistance and protection.
- We provide technical expertise and policy advice to donors and organizations that work with refugees and the displaced.
- We make recommendations to policy makers based on rigorous research and information gathered on fact-finding missions.
- We join with refugee women, children and adolescents to ensure that their voices are heard from the community level to the highest councils of governments and international organizations.
- We do this in the conviction that their empowerment is the surest route to the greater well-being of all forcibly displaced people.

The Women's Commission was established in 1989 to address the particular needs of refugee and displaced women and children. The Women's Commission is legally part of the International Rescue Committee (IRC), a non-profit 501(c)(3) organization. The Women's Commission receives no direct financial support from the IRC.

This MISP distance learning module was principally developed by Julia Matthews, formerly of the Women's Commission for Refugee Women and Children. Sandra Krause, Sarah Chynoweth and Diana Quick provided project and editorial oversight. The module is primarily based on *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*, WHO/UNHCR/UNFPA, 1995. Many thanks to the Inter-agency Working Group on Reproductive Health in Refugee Situations' MISP taskforce for providing feedback and to the following humanitarian workers for editing and providing comments: Ribka Amsalu, Cholpon Asambaeva, Meriwether Beatty, Stephanie Chaban, Carmen Crow, Pamela Delargy, Wilma Doedens, Sathyanarayanan Doraiswamy, Michelle Hynes, Pholaphat Charles Inboriboon, Maqsooda Kasi, Rob Kevlihan, Renee King, Rashmi Kukreja, Heidi Lehmann, Florame Magalong, Fatou Mbow, Siobhan McNally, Jennifer Miquel, Gabrielle Oestreicher, Sinead O'Reilly, Susan Purdin, Dorcas Robinson, Marian Schilperoord, Melissa Sharer, Basia Tomcyk and Elena Vuolo.

This module was made possible by the generous support of the The Bill & Melinda Gates Foundation.

Concept, Design & Production:
Green Communication Design: www.greencom.ca

Publication Date September 2006

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Acronym List

AIDS	Acquired Immunodeficiency Syndrome
BPRM	Bureau for Population, Refugees and Migration
CBR	Crude birth rate
CDC	Centers for Disease Control and Prevention
CoC	Code of conduct
DHS	Demographic Health Survey
EC	Emergency contraception
ECHO	Humanitarian Aid Office of the European Commission
EmOC	Emergency obstetric care
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HRU	Humanitarian Response Unit
IAWG	Inter-agency Working Group (on Reproductive Health in Refugee Situations)
IEC	Information, education and communication
MISP	Minimum Initial Service Package (for Reproductive Health)
MOH	Ministry of Health
NGO	Nongovernmental organization
OFDA	Office of Foreign Disaster Assistance
PHC	Primary health care
RH	Reproductive health
RHRC	Reproductive Health Response in Conflict (Consortium)
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization
WRA	Women of reproductive age

About the MISP Distance Learning Module

The 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 neonatal mortality and morbidity; and plan for comprehensive RH services in the early days and weeks of an emergency. The MISP distance learning module aims to increase humanitarian actors' knowledge of these priority RH services to initiate at the onset of a crisis situation.

The MISP was first articulated in 1996 in the field–test version of *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*[1] *(Field Manual)*, a resource developed by the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations. The IAWG is a group of approximately 40 United Nations (UN), academic research, governmental and nongovernmental organizations (NGOs) that came together in 1995 to address RH for refugees. Unless a specific reference is given, the information provided in the MISP module is based on the *Field Manual*, which provides specific guidelines on how to address the RH needs of displaced populations from the initial emergency stage of a crisis through to reconstruction and development phases. The MISP outlines the initial RH response and will be explained in detail in this module. **The MISP is also a standard in the 2004 revision of the** *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*[2] **for humanitarian assistance providers**.

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 first humanitarian responders in crisis situations. The module 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 used as a minimum standard post-crisis to ensure that priority RH activities are established.

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

Approximately three to four hours.

How do I use the MISP Module?

The module is a self-instructional learning module. The module should be read in order of chapters and later can be used as a reference. The user reads through each chapter and completes the chapter quizzes and final quiz. The online version of the module is interactive and also includes quizzes and provides links to additional Web-based resources. The online module can be downloaded or printed for offline review.

[1] www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/full_text.pdf

[2] www.sphereproject.org

OBJECTIVE

OF THE MISP MODULE IS FOR READERS TO:

- define and understand each component of the MISP;
- grasp the importance of implementing the MISP in emergency settings;
- understand the role and functions of the RH Coordinator/Focal Point;
- be able to order MISP supplies internationally or obtain them locally;
- know the most important things to do in the immediate days and weeks of a new emergency to prevent and respond to sexual violence;
- know the priority interventions for reducing HIV transmission in the earliest phase of crisis situations;
- understand the best ways to reduce maternal and neonatal death and disability at the onset of an emergency;
- be able to plan for comprehensive RH programming once the crisis has stabilized.

In what format and languages is the MISP Module?

The module is available online on the Women's Commission's Web site at www.womenscommission.org and the Reproductive Health Response in Conflict (RHRC) Consortium Web site at www.rhrc.org. Print copies can be ordered by emailing info@womenscommission.org. The module is currently available in English and French; other languages may be available in the future.

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

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

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

Yes, once you've completed the post-test online with 80 percent correct answers, you will automatically receive a certificate of completion that you can print out directly. The certificate of completion also verifies 3.5 hours of continuing education credits for nurses in the USA.

Introduction

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a set of priority activities to be implemented during the onset of an emergency (conflict or natural disaster). When implemented in the early days of an emergency, 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 and subsequent unwanted pregnancies and unsafe abortions; and the spread of HIV.

The MISP is a standard for humanitarian actors, outlining which RH components are most important in preventing death and disability, particularly among women and girls, in emergency settings. Although comprehensive RH services should be available to the entire population once the situation stabilizes, reducing the transmission of HIV, preventing sexual violence, providing care for survivors of sexual violence, ensuring clean deliveries and access to emergency obstetric care in the first days of a crisis are a priority because these actions will save lives and prevent illness.

Yet, assessments undertaken by the Women's Commission during 2004 and 2005 demonstrated that many humanitarian actors working in emergencies did not know the priority RH services of the MISP that should be implemented in every emergency setting. A 2004 MISP assessment of Sudanese refugees in Chad revealed that most humanitarian actors were not familiar with the MISP and consequently did not know the MISP's overall goal, key objectives and priority activities. There was no overall RH coordinator and only one agency had an identified RH focal point.[3] In 2005, the Women's Commission MISP assessment during the tsunami crisis in Indonesia showed that while half the humanitarian staff interviewed were aware of the MISP, only one of 25 humanitarian workers could define its priority objectives and activities.[4]

The MISP also builds the foundation for comprehensive RH services as the situation stabilizes and all components of the MISP have been implemented. However, assessment findings in the post-crisis phase demonstrate that the MISP is not a priority in humanitarian settings, even once a situation reaches a relatively stable phase. For instance, an assessment of reproductive health care services undertaken in 2003 among Afghan refugees in Pakistan found that only six of the 18 refugee camps surveyed had an RH focal point.[5] Although women and girls represent 55 percent of the 2 million people displaced in Colombia, RH focal points were non-existent and agencies were not planning to implement the MISP.[6] Based on these findings, the Women's Commission has developed the *MISP for Reproductive Health in Crisis Situations: A Distance Learning Module* to raise awareness about and provide guidance on addressing RH in crisis situations.

[3] Women's Commission for Refugee Women and Children 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.

[4] Women's Commission for Refugee Women and Children, *Reproductive Health Priorities in an Emergency: Assessment of the Minimum Initial Service Package in Tsunami-affected Areas in Indonesia*, February/March 2005.

[5] Women's Commission for Refugee Women and Children, *Still in Need: Reproductive Health Care for Afghan Refugees in Pakistan*, October 2003.

[6] Marie Stopes International and Women's Commission on behalf of the RHRC Consortium, *Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Person*, February 2003.

Chapter 1

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 neonatal and maternal morbidity and mortality; reduce HIV transmission; and plan for comprehensive RH services in the early days and weeks of an emergency. See "About the Distance Learning Module" on p. 2 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 a new needs assessment because documented evidence already justifies its use. The MISP is a standard in the 2004 revision of the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*.[7] 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 implementation of the MISP requires essential equipment and supplies, which are available in pre-packaged kits for emergency deployment.

[7] www.sphereproject.org.

Goal

The goal of the MISP is to reduce mortality, morbidity and disability among populations affected by crises, particularly women and girls. These populations may be refugees, internally displaced persons (IDPs) or populations hosting refugees or IDPs.

Objectives and Activities

1. Identify an organization(s) and individual(s) to facilitate the **coordination** and **implementation** of the MISP by:
   - ensuring the overall RH Coordinator is in place and functioning under the health coordination team;
   - ensuring RH focal points in camps and implementing agencies are in place;
   - making available material for implementing the MISP and ensuring its use.
2. **Prevent sexual violence** and provide appropriate assistance to survivors by:
   - ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence;
   - ensuring medical services, including psychosocial support, are available for survivors of sexual violence.
3. **Reduce the transmission of HIV** by:
   - enforcing respect for universal precautions;
   - guaranteeing the availability of free condoms;
   - ensuring that blood for transfusion is safe.
4. **Prevent excess maternal and neonatal mortality and morbidity** by:
   - providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries;
   - providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility;
   - initiating the establishment of a referral system to manage obstetric emergencies.
5. Plan for the **provision of comprehensive reproductive health services**, integrated into primary health care (PHC), as the situation permits by:
   - collecting basic background information (see Appendix A on monitoring and evaluation);
   - identifying sites for future delivery of comprehensive RH services;
   - assessing staff and identifying training protocols;
   - identifying procurement channels and assessing monthly drug consumption.

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

The MISP includes a pre-packaged set of kits containing drugs and supplies aimed at facilitating the implementation of priority RH services in the early phase of a crisis. UNFPA is in charge of assembling and delivering these RH Kits. As logistical problems are common in crisis settings, agencies should prepare by including RH supplies within their overall medical supply procurement. Please see Chapter 7 for more information on ordering supplies.

Why is the MISP a priority?

While resources should not be diverted from dealing with other major health threats, implementing the MISP is essential to reducing mortality and morbidity experienced particularly by women and girls. There are multiple competing health priorities in an emergency, such as addressing diarrhea, measles, acute respiratory infections, malaria and malnutrition, but specific aspects of RH, as expressed in the MISP, also must be addressed. Rather than trying to implement a broad range of RH activities, limiting the scope of RH in the emergency phase to the MISP ensures focused attention on essential actions in emergencies where human and material resources are scarce.

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

The lives of the displaced, particularly women and girls, are put at risk when the MISP is not implemented. For example, women and girls can be placed at risk of sexual violence when attempting to access food, firewood, water and latrines. Their shelter may 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. Not observing universal precautions in a health care setting may allow the transmission of HIV to patients or health workers. Without a referral system in place to transfer patients in need of emergency obstetric care services (e.g., cesarean section) to an equipped health facility, women may die or suffer long-term injuries (e.g., obstetric fistula). The MISP provides an outline of the basic steps to be taken in order avoid these negative consequences.

Who is responsible for implementing the MISP?

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

Is this the stable phase or not?

It is often unclear when the crisis or emergency phase is over and the stable phase begins. The UN High Commissioner for Refugees' working definition of an emergency is *any situation in which the life or well-being of the refugees will be threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures*. The World Health Organization (WHO) and the Centers for Disease Control and Prevention define the emergency phase as the period where the crude mortality rate is above one death per 10,000 per day. This phase is often characterized by internal or cross-border population displacement, a change in authority at local or national levels, a breakdown in infrastructure (such as health and legal institutions), impaired access to food and increased mortality rates. The post-crisis phase begins when mortality rates return to the level of the surrounding population and basic needs are met. Confidence in security rises, health services are normalized, long-term approaches can be introduced and capacity building and reconstruction can be initiated. The emergency phase may last only a few months, although the post-emergency phase can deteriorate to an acute phase again if the conflict resumes. Chronic emergency settings are often characterized by political deadlock and certain areas may stay in an acute phase while others move towards the post-emergency phase.[8]

How can an agency obtain funding to support MISP activities?

Nongovernmental organizations (NGOs) responding to a humanitarian crisis should include funding for MISP activities in proposals to donors such as the Office of Foreign Disaster Assistance (OFDA), United States Bureau for Population, Refugees and Migration (BPRM), the United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), Humanitarian Aid Office of the European Commission (ECHO) or private donors who may support emergency response activities. 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 also may be helpful to cite the Sphere standards in proposals. In the 2004 edition of the *Sphere Handbook*, the MISP is listed under Control of non-communicable diseases (standard 2, reproductive health, p. 288) within the health services section. See Annex B in this module on sample funding proposals for examples of narratives and budgets for submission to government, United Nations and other donors.

[8] WHO, *Outline Strategy for Malaria Control in Complex Emergencies*, 2000.

Chapter 2

Coordination *of the* MISP

Coordination of MISP activities is necessary at multiple levels, including within each agency responding to the emergency as well as at the local/camp, agency, sub-regional, country and international levels. Coordination within and among these various levels and across sectors is aimed at ensuring that efforts are not duplicated, useful data and information are shared among humanitarian actors and scarce resources are used efficiently.

A qualified and experienced person should be identified to coordinate RH activities at the start of the emergency response. The overall leading agency should be responsible for designating this **RH Coordinator** (also known as **RH Focal Point** or **MISP Coordinator/Focal Point**) and this person should be supervised by the overall Health Coordinator. Ideally, there should not only be an overall RH Coordinator for each displaced setting but each agency should also have an RH Coordinator on its response team or a designated health person responsible for the MISP. Emergency RH professionals should be in their post for a minimum of six months, as it typically takes at least this amount of time to implement the MISP and make the transition to providing comprehensive RH services.

The following is a broad terms of reference to be undertaken by an overall RH Coordinator. (See the MISP Fact Sheet in Appendix D for a user-friendly summary and check list to assist an RH Coordinator in her/his work.)

OBJECTIVE

To identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP.

The RH Coordinator should:

- be the focal point for RH services and provide technical advice and assistance on RH to the displaced communities and all organizations working in health and other sectors as needed;
- liaise with national and regional authorities when planning and implementing RH activities in camps, settlements and among the surrounding population;
- liaise with other sectors (protection, community services, camp management, education, etc.) to ensure a multi-sectoral approach to RH;
- assure that RH is a standard item on the health coordination meeting agenda;
- create or adapt and introduce national and other standardized policies that support the MISP and ensure that they are integrated with primary health care, for example, policies relating to emergency obstetric care or gender-based violence;
- initiate and coordinate audience-specific orientation sessions on the MISP (e.g., for health workers, community services officers, the beneficiary population, security personnel, etc.);
- introduce standardized protocols for selected areas (such as medical response to survivors of sexual violence and referral of obstetric emergencies; and, when planning for comprehensive RH services: syndromic case management of STIs and family planning);
- adapt and introduce simple forms for monitoring RH activities during the emergency phase that can become more comprehensive once the program is expanded (see monitoring and evaluation in Appendix A of this module);
- use standard indicators to monitor MISP outcomes;
- collect, analyze and disseminate data for use;
- report regularly to the health coordination team.

Good practices in facilitating the coordination and implementation of the MISP observed in *Darfur* [9]

- In West Darfur, the sub-grantee established a good relationship with the Ministry of Health (MOH), which they noted was crucial to implementing all the components of the MISP.
- Successful advocacy was achieved by UNFPA with the MOH in South Darfur to allow emergency obstetric care (EmOC) at the peripheral levels (in camps and villages).
- Different agencies noted that working with a national counterpart is also important to promote sustainability.
- UNFPA is successfully working with the Advisory Council on Human Rights to train judges, doctors, lawyers, police and others on Form 8—a form that was previously mandatory for women who had experienced sexual violence before they could receive medical care.

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

Why is putting in place an RH Coordinator a priority?

Without an individual or agency leading RH activities in emergency settings, evidence has shown that RH is typically overridden by the other emergency concerns such as ensuring that the population has access to sufficient food, water and shelter. An RH Coordinator has the ability to make RH a priority and facilitate implementation of the MISP.

The diagram on the following page provides an example of the various levels of coordination at the site/camp, agency, sub-regional, country and international levels in three separate settings. It should be kept in mind that this is an ideal scenario and, in reality, the situation may not be as organized. However, the point of the example is to demonstrate coordination at all levels.

Site Level

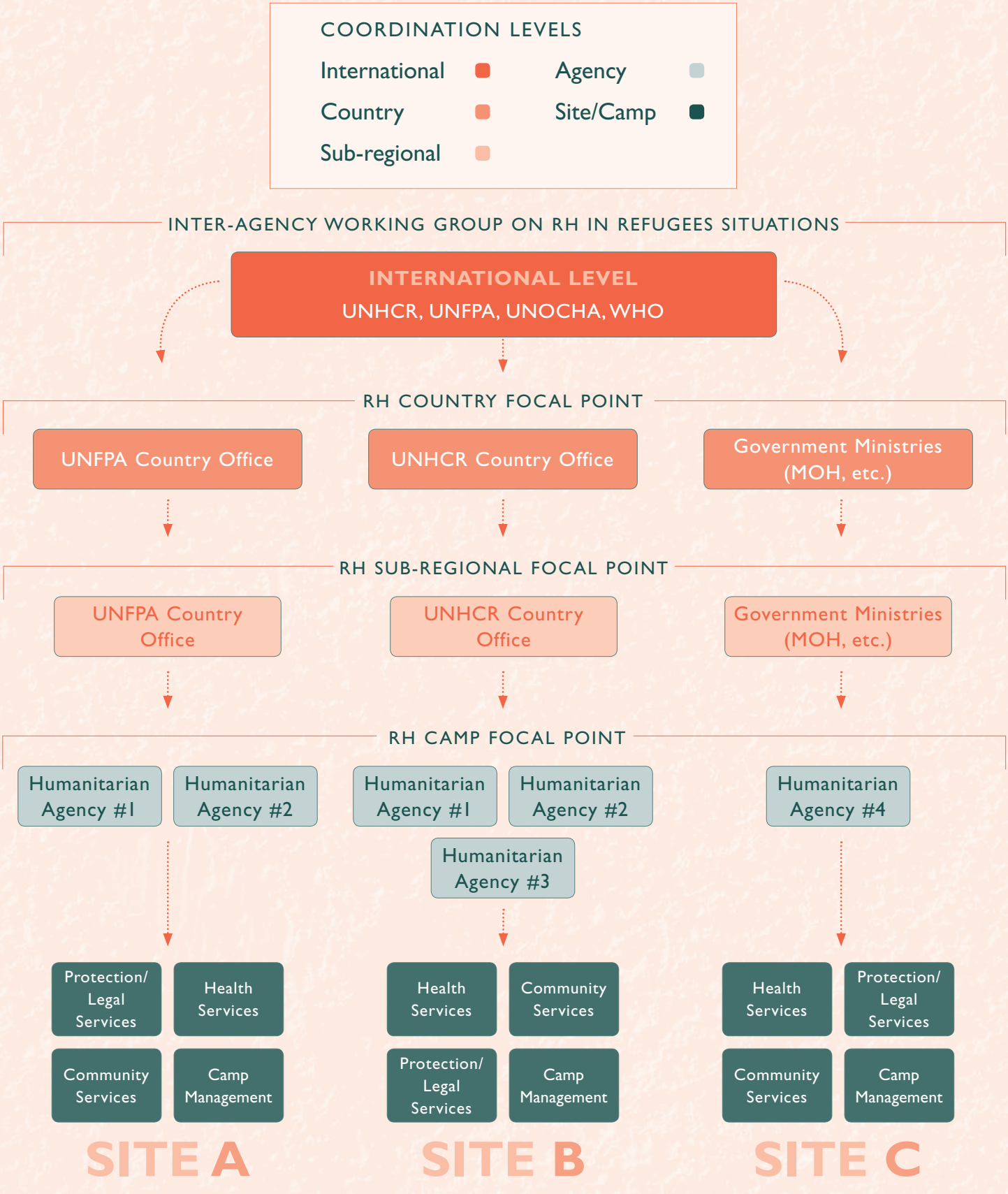
At the site level, the diagram shows a variety of configurations to demonstrate the different ways in which humanitarian agencies may be organized to serve the needs of the displaced population housed in such setting.

Site A has two humanitarian agencies providing the services in the site which include health, protection/legal, community services and site management. (For this example, services have been divided into these four main areas, but this may vary depending upon setting.) Site B has three agencies providing these same services, while in Site C all of the services are provided by one agency.

Here are a few examples of how coordination activities may occur:

- Site A: Agency #1, which manages the protection/legal sector, receives a report of a rape incident and refers the survivor immediately to health services, provided by Agency #2. Having this case addressed and coordinated among both agencies allows the survivor to access clinical services and also seek legal recourse if she chooses to do so.
- Site B: Agency #2, which is responsible for community services, collaborates with Agency #1, the health services provider, to obtain condoms. The community service manager places the condoms in appropriate venues such as offices and community meeting spaces and distributes them to her staff to ensure that condoms are free and visible to the displaced population and agency staff alike. The community services manager also requests Agency #3, the site manager, to place condoms in other appropriate areas where staff and the displaced assemble. Coordination in this setting may be a more challenging endeavor because of the number of agencies involved in providing services to the displaced population in this site.
- Site C: Agency #4, although it is the lone service provider in the camp and therefore coordination with other agencies is not an issue, should be aware of the good practices and developments that have occurred in the other sites. For example, the agencies working in Sites A and B recently performed a health facility assessment of the two local referral hospitals. They found that one facility was so badly damaged in the local conflict that they decided to abandon this facility and focus on fully equipping and staffing the other facility which was also closer to the sites. This is important information for Agency #4 to know so that it refers patients to the most appropriate health facility.

Example of **MISP Coordination Levels**



Despite the different configurations in these examples of site settings, each agency is responsible for coordinating MISP activities.

Sub-regional Level:

It is important for all agencies responding to emergencies to participate in the coordination activities occurring among sites, whether this is weekly, bi-weekly or monthly meetings. The role of the RH Coordinator at this level is to work with the host government MOH where possible to provide RH technical assistance to these agencies; ensure that coordination is happening among the various sectors to ensure a multi-sectoral implementation of MISP activities; and provide specific orientation sessions on the MISP for the agency staff, which may include health workers, community services officers, security officers, the displaced, etc. In addition, the RH Coordinator can ensure that standardized protocols are being used by the agencies to facilitate MISP implementation.

Example:

The RH Coordinator can ensure that each agency is using WHO/UNHCR's *Clinical Management of Rape Survivors*[10] or other standard protocols for medical management of rape survivors (e.g., protocol from Médecins Sans Frontières or MOH) and that staff are trained on the protocol. Site health surveillance forms should also be adapted to document the number of survivors of sexual violence treated and maternal and neonatal deaths. The RH Coordinator also can introduce simple forms for monitoring MISP activities (or adapt ones already familiar to agency staff). These forms can include more information once the situation moves to a stable phase and comprehensive RH services are being established. Although maternal and neonatal deaths are relatively rare, unless they are documented, maternal and neonatal mortality may not be addressed. In addition, the RH Coordinator is responsible for collecting information from each site setting and compiling it in a report that can be shared at the country level with UN and government agencies.

Country Level:

As the diagram shows, an RH Coordinator should also be appointed at the country level to collect information from all the sub-regions. This person has the full picture of RH issues for the displaced population in the country.

Example:

In response to the tsunami crisis, UNFPA fielded RH Coordinators in Indonesia and Sri Lanka. The RH Coordinators initiated coordination meetings in each country at the start of the crisis which spurred more agencies than were initially interested in RH to participate and share information about their RH service provision activities. This coordination also provided the entry point to monitor the supply needs of agencies as well as to facilitate data collection.

International Level:

On the international level, the IAWG is a mechanism where collaboration occurs among UN and government agencies, donors and NGOs. The group provides a forum in which local and international partners share activities and resources, initiate collaborative efforts and analyze issues in the field to be addressed. For more details on joining IAWG, please email info@rhrc.org.

[10] www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/clinical_mngt_survivors_of_rape.pdf

Example:

From 2002 to 2004, the IAWG undertook the global evaluation, *Reproductive Health Services for Refugees and Internally Displaced Persons*,[11] which assessed how the reproductive health field had progressed in the past decade. This led to the formation of six working groups to tackle the most pressing topics, one of which was the lack of proper implementation of the MISP. Since the formation of the working groups in December 2004, the MISP working group has been meeting by teleconference to share findings from the crisis response on the tsunami in Indonesia, Sri Lanka, the Maldives and other affected regions. These activities have informed response activities and helped to support a more coordinated and effective response to tsunami-stricken areas. This is an example of how action at the global level can support activities in the field.

The Reality of Implementing the MISP in *Thailand*

From the end of September to mid-November 1997, a steady stream of Cambodian refugees poured across the border into Thailand. The American Refugee Committee (ARC) was the only NGO on the scene to offer emergency relief and primary health care, including RH services, to some 40,000 refugees in two camps. It was one of the few occasions since the RHRC Consortium began its work that the MISP was deployed at the height of a refugee influx. Sterile medical supplies were readily available, both from ARC's own stocks and from the refugee community itself. ARC supplied gloves, obtained condoms and held training sessions on universal precautions[12] for HIV/AIDS prevention for health workers in both camps. Refugee women with emergency obstetric complications benefited from an established camp referral system that provided transportation to a provincial hospital, where a full range of obstetric services was available to the refugees. Though camp midwives denied knowledge of any incidents of gender-based violence in flight or in the camps, ARC offered the midwives training sessions on emergency post-coital contraceptives and on identifying and treating women who are victims of sexual violence. "In the first days, the refugees went through a shock phase. Their priorities were shelter, food and water," said the international health advisor at ARC who coordinated the MISP along the Thai-Cambodian border. "But day by day, more health workers came forward to work in the community and in the clinics. They were motivated and eager to learn." Rapid responses in similar crisis situations would be more assured if field offices of international agencies, such as UNICEF, UNHCR and UNFPA, stocked MISP supplies or knew how to obtain them quickly. "We were fortunate in Thailand," the ARC advisor said, "because you can buy medical supplies in most large towns and assemble essential materials and basic kits, and that's what we did. But UN organizations should stock emergency supplies regionally. You need them on the first day." Essential to the success of MISP is the presence of a focal person, experienced in emergency settings, to oversee the program. "You need someone who can set up the MISP in the environment of a potential cholera or measles epidemic," said the international health advisor, "someone who can see how the MISP fits into the situation, but doesn't compromise the response to other emergency needs; who sees what can be done and does it."[13]

[11] www.rhrc.org/resources/iawg

[12] Universal precautions are simple 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. See Chapter 4 for further information.

[13] RHRC Consortium, *Refugees and Reproductive Health Care: The Next Step*, 1998.

MISP Coordination Monitoring

It is the RH Coordinator's role to monitor and evaluate the MISP activities. She/he should collect or estimate basic demographic and health information of the affected population. (See Chapter 9 of the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual.*)[14]

- 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

To monitor and evaluate the implementation of the MISP, the following data should be collected every month as a minimum (see Appendix A on monitoring and evaluation):

- Number of condoms distributed
- Number of clean delivery packages distributed
- Number of sexual violence cases reported in all sectors (confidential and anonymous reporting is essential)
- Number of health facilities with adequate supplies for universal precautions

Indicators to monitor overall coordination

- Overall RH Coordinator in place and functioning under the health coordination team
- RH focal points in camps and implementing agencies in place
- Material for implementation of the MISP available and used

Which supplies are required for coordinating the implementation of the MISP?[15]

Number	Name	Color
Kit 0:	*Administration sub-kit*	*Orange*

[14] www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/full_text.pdf

[15] The Reference and Training Package, a library of resource materials, is included with each kit order. Please visit Chapter 7 for the list of materials in this package. The *RH Kits for Crisis Situations* booklet is available at www.rhrc.org/pdf/rhrkit.pdf.

Challenges and Solutions

1. *Sometimes a lack of understanding and/or prioritization of RH by humanitarian actors can make coordination difficult. How can one counteract such apathy and dismissal of RH issues?*

   In the short term, one could point to the fact that the MISP is a Sphere standard and is thus an internationally recognized, universal minimum standard in disaster response to which each humanitarian agency is obligated to adhere. One could emphasize that it is a lifesaving intervention. From a longer-term perspective, agencies should be encouraged—based on the Sphere standard—to prioritize RH in their emergency preparedness planning. One could also encourage staff to complete the MISP module as well as use the module to educate and advocate to relevant agency staff and others about the importance of implementing the MISP.

2. *At the beginning of an emergency, UNFPA and other 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 assuming responsibility in the health sector, it should ensure the MISP is included in its response. Your agency or another agency could volunteer to establish regular meetings to coordinate implementation of the MISP. Contacting UNFPA in Geneva or New York could also help to identify in-country support.

   The next three chapters focus on the technical areas of the MISP, including preventing and responding to sexual violence, reducing HIV transmission and preventing excess maternal and neonatal mortality and morbidity.

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 87)

1 *The goal of the MISP is to:*

- **a.** prevent sexual violence and respond to survivors
- **b.** reduce unwanted pregnancies
- **c.** reduce HIV transmission
- **d.** prevent excess maternal mortality and morbidity

2 *Addressing _____ is part of the MISP.*

- **a.** family planning
- **b.** malnutrition
- **c.** emergency obstetric care
- **d.** antenatal care

3 *Reproductive health workers are solely responsible for ensuring that MISP priority activities are implemented.*

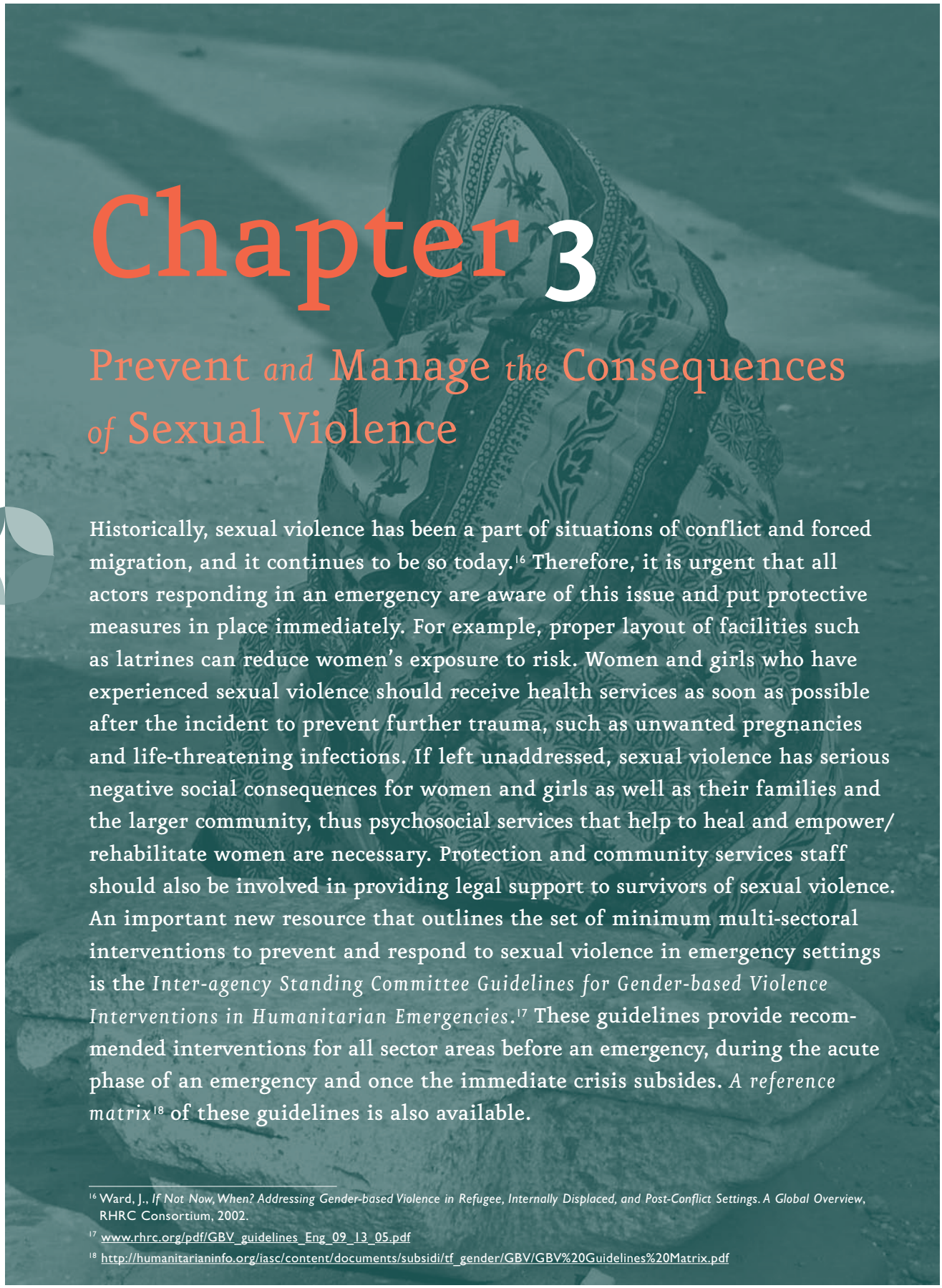
- ○ True
- ○ False

4 *The RH Coordinator should determine the following demographic and health information:*

- **a.** The number of people with sexually transmitted infections
- **b.** The number of people living with HIV/AIDS
- **c.** The number of sexually active men
- **d.** The number of pregnant women

5 *The RH Coordinator should:*

- **a.** be able to order MISP supplies internationally or obtain them locally
- **b.** initiate and coordinate orientation sessions for humanitarian workers on the MISP
- **c.** adapt and introduce simple forms for monitoring RH activities
- **d.** conduct trainings on how to prevent the transmission of HIV



Chapter 3

Prevent *and* Manage *the* Consequences *of* Sexual Violence

Historically, sexual violence has been a part of situations of conflict and forced migration, and it continues to be so today.[16] Therefore, it is urgent that all actors responding in an emergency are aware of this issue and put protective measures in place immediately. For example, proper layout of facilities such as latrines can reduce women's exposure to risk. Women and girls who have experienced sexual violence should receive health services as soon as possible after the incident to prevent further trauma, such as unwanted pregnancies and life-threatening infections. If left unaddressed, sexual violence has serious negative social consequences for women and girls as well as 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 providing legal support to survivors of sexual violence. An important new resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to sexual violence in emergency settings is the *Inter-agency Standing Committee Guidelines for Gender-based Violence Interventions in Humanitarian Emergencies*.[17] 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*[18] of these guidelines is also available.

[16] Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings. A Global Overview*, RHRC Consortium, 2002.

[17] www.rhrc.org/pdf/GBV_guidelines_Eng_09_13_05.pdf

[18] http://humanitarianinfo.org/iasc/content/documents/subsidi/tf_gender/GBV/GBV%20Guidelines%20Matrix.pdf

OBJECTIVE

To prevent and manage the consequences of sexual violence.

What are the key actions that should be taken:

1) to reduce the risk of sexual violence?

- Design and locate settlements for the displaced population, in consultation with the population and women in particular, to enhance physical security.
- Locate latrines, hygiene and water points in accessible, secure places.
- Provide latches to lock latrines and washing facilities.
- Provide adequate lighting on paths used at night.
- Provide security patrols.
- Provide direct transport to firewood collection sites or patrol collection routes in close collaboration with displaced women and girls.
- Ensure the inclusion of female workers in food distribution, registration and other services.
- Ensure the presence of female protection officers.
- Discuss sexual violence issues during health coordination meetings.
- Identify individuals or groups that may be at higher risk of sexual violence (e.g., single female-headed households, unaccompanied minors, etc.) and, in consultation with these persons themselves, address their protection and assistance needs. For example, make special arrangements for housing unaccompanied women, girls and boys and women-headed households.
- Ensure confidential reporting system (so beneficiaries have the possibility of reporting suspicious and threatening behaviors before incidents occur).

2) to respond appropriately to survivors?

- Ensure a standard medical response to sexual violence survivors, including the option of emergency contraception, preventive treatment for STIs, post-exposure prophylaxis for prevention of transmission of HIV, and tetanus and hepatitis B vaccinations and wound care as appropriate.
- Ensure privacy and confidentially of the survivor.
- Ensure the presence of same-sex, same-language health worker or chaperone and, if the survivor wishes, a friend or family member, present for any medical examination.
- Ensure the physical safety of the survivor immediately following an incident of sexual violence.[19]
- Ensure the displaced population is informed of the availability and location of services for sexual violence survivors.
- Ensure the availability of appropriate, culturally appropriate *psychosocial* support.
- Ensure that locations where incidents of sexual violence have occurred are identified and documented and relevant preventive measures are established.

A useful resource that provides guidance to health care providers for medical management after rape of women, men and children is *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations.*[20]

What is sexual violence?

Sexual violence is any non-consented action of a sexual nature, including rape and sexual exploitation among other acts. 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.[21]

The focus of addressing sexual violence in the MISP is the prevention of rape, provision of medical care for rape survivors and ensuring the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISP 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 pregnancy, forced or coerced prostitution, trafficking of women, girls and boys and additional forms of GBV.

[19] In circumstances where sexual violence occurs between individuals who are in frequent contact, such as family members, additional protection strategies may be necessary.

[20] www.rhrc.org/pdf/Clinical_Management_2005_rev.pdf

[21] Ward, J., *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-Conflict Settings. A Global Overview*, RHRC Consortium, 2002.

Why is preventing sexual violence a priority?

Although sexual violence is common even during peacetime, war and conflict increase incidents 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 weapon of war has been documented in several conflicts as an effective means of controlling, degrading and humiliating a community.[22]

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

A multi-sectoral team approach is required to prevent and respond appropriately to sexual violence. A committee or task force should be formed to design, implement and evaluate sexual violence programming at the field level. The purview of the task force should encompass all technical sectors and all geographic areas. Representatives of the displaced community, UNHCR, UN partners, NGOs and government authorities should be members of this task force. Each member of the task force, including displaced women and girls, representing relevant sectors/partners (such as protection, health, education, community services, security/police, site planning, etc.) should identify her/his role and responsibilities in preventing and responding to sexual violence.

The Reality of Implementing the MISP in *Pakistan*[23]

The Women's Commission conducted a year-long MISP assessment in Pakistan from 2002 to 2003 to advocate for improved RH services for Afghan refugees who had fled their country from the bombings following the September 11 attacks on the United States. Most staff had not received refresher training and lacked proper equipment and supervision to adhere to universal precautions to prevent the spread of HIV. Condoms were available in most settings but were not always free. Prevention and management of sexual violence went largely unaddressed. Emergency obstetric care was available, but many women did not have the means to access services due to high transportation costs. The assessment revealed that while isolated efforts had been made to improve the quantity and quality of RH care for Afghan refugees, many programs were limited to traditional maternal and child health services, and the quality of RH care was a significant concern.

[22] 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 (Avega), *Survey on Violence Against Women in Rwanda*, 1999.

[23] Full assessment available at www.rhrc.org/pdf/pk_rh.pdf

Who is impacted most by sexual violence?

Most reported cases of sexual violence among displaced people—and in most settings around the world—involve male perpetrators committing violent acts against females.[24] However, men and boys may also be at risk of sexual violence, particularly when they are subjected to detention or torture. While all women in situations of conflict are susceptible to sexual violence, female adolescents are exceptionally vulnerable as they are often targeted for sexual exploitation and rape. In addition, systematic 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.

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 or NGO agencies; members of the host population; or family members. Rape may be used as a strategy of war to intimidate and traumatize a population, in which case the perpetrators are enemy combatants; perpetrators of opportunistic rape can be anyone acting with impunity in the climate of lawlessness that accompanies armed conflict.

When does sexual violence occur?

Sexual violence can happen during all phases of displacement: prior to fleeing one's home area, during flight, while in the country of asylum and during repatriation and reintegration. In addition, sexual and domestic 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.

Good practices in preventing and managing the consequences of sexual violence observed in *Darfur* [25]

- Clinic staff in North Darfur distributed emergency contraception (EC) to village midwives in addition to a flyer (in Arabic) developed by the MISP Coordinator on why and where women and girls can access care for rape.
- African Union (AU) commanders in North Darfur were informed by the MISP Coordinator to refer all rape survivors 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 MISP Coordinator 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 internally displaced women could approach these focal points confidentially; the focal points referred women to receive medical care. ►

[24] United Nations High Commissioner for Refugees, *Sexual Violence against Refugees: Guidelines on Prevention and Response*, Geneva, 1995.

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

- 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 which provide a safe place for women and girls and provide a space for survivors of sexual violence to receive confidential, holistic care in an environment that minimizes the social stigma.

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 are dependent on males for their daily survival and may be forced to provide sexual favors to obtain these essential items. It also has been demonstrated that when men (fellow displaced persons or humanitarian actors) are responsible for distributing food and other essential goods, women may be subject to sexual exploitation, that is, they may be forced to perform sexual favors for men 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 also be unlocked and unprotected. Lighting may be poor. Male and female latrines and washing facilities may not be separate. All of these circumstances leave women vulnerable to attack or abuse.

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 acts of abuse or exploitation. If there are no independent organizations, such as UNHCR or NGOs, to ensure personal security within a camp, the number of incidents often increases. It is important that female protection officers are available since often women and girls are 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 services, lack of trust in the health services and the lack of confidentiality and unfamiliarity with the services. All of these circumstances are exacerbated in displaced settings, increasing the likelihood that incidents of sexual violence among the population will go unreported. Therefore, addressing sexual violence goes beyond the clinical management and must also include an environment where women are supported and able to access this care.

Code of Conduct

The *Code of Conduct*[26] (CoC) against sexual exploitation and abuse is a set of agency guidelines that promote respect for fundamental human rights, social justice, human dignity and respect for the equal rights of women, men and children. Implementing MISP activities appropriately means that each agency has a CoC in place and all humanitarian actors are committed to adhering to the guidelines and have been oriented to their responsibilities to prevent sexual abuse and exploitation. The CoC is not only for staff of international agencies. International agencies must also ensure that any staff hired from local organizations or people contracted from the local community or displaced population are oriented to the CoC. All humanitarian actors who have been oriented should sign their agency's CoC.

Good Practice

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 the local context.

[26] www.medair.org/press/codeconducten.pdf

MISP Sexual Violence Monitoring

- Coordinated multi-sectoral systems to prevent sexual violence are in place
- Confidential health and psychosocial services to manage cases of sexual violence are available and accessible
- Number of staff trained in sexual violence prevention and response

Indicators to monitor sexual violence coordination:

- Monitor the number of incidents of sexual violence anonymously reported to health and protection services and security officers
- Monitorthe number of survivors of sexual violence who seek and receive health care (anonymous reporting is of utmost importance)

Which supplies are needed or which Interagency RH Kit(s) could be ordered to address this issue?[27]

Number	Name	Color
Kit 3:	*Post-Rape sub-kit*	*Pink*
Kit 9:	*Suture of Tears and Vaginal Examination sub-kit*	*Purple*

Challenges and Solutions

1. *The provision of psychosocial services can be challenging to implement in the early stages of an emergency. What if 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 need to communicate 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. A good resource that focuses on engagement strategies for work with GBV survivors is the *GBV Communication Skills Manual*.[28]

2. *In certain insecure settings, individual agencies that strongly advocate around the issue of GBV may put their own staff and the operation of the program at risk. How can this be addressed?*

   It is essential to work in a culturally appropriate way while giving women and girls the opportunity and space to name the violence they have experienced. Because GBV can be a culturally taboo subject, it is necessary that links with key community members who help legitimize talking about GBV are established. If this is not possible, agencies may choose to identify programs as providing more general "women's health services" to avoid sensitivities to GBV and to avoid community advocacy on GBV in the earliest days and weeks of emergencies. The key focus at this time is finding ways to inform the community about the benefits and availability of care for survivors of sexual violence. Later, when better relations have been established with the community and more is understood about GBV in the local context, information, education and communication (IEC) campaign planning and community advocacy should be established.

[27] 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 *RH Kits for Crisis Situations* booklet is available at www.rhrc.org/pdf/rhrkit.pdf.

[28] www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 87)

1 *The RH Coordinator should:*

- **a.** Coordinate multi-sectoral systems to prevent sexual violence
- **b.** Ensure confidential health and psychosocial services to manage cases of sexual violence are available and accessible
- **c.** Conduct a community-wide education campaign on ways to prevent sexual violence
- **d.** Ensure women and girls at increased risk for trafficking are identified

2 *Who are the potential perpetrators of sexual violence?*

- **a.** UN personnel
- **b.** Family members
- **c.** Armed militia groups
- **d.** Police officers

3 *The code of conduct applies to:*

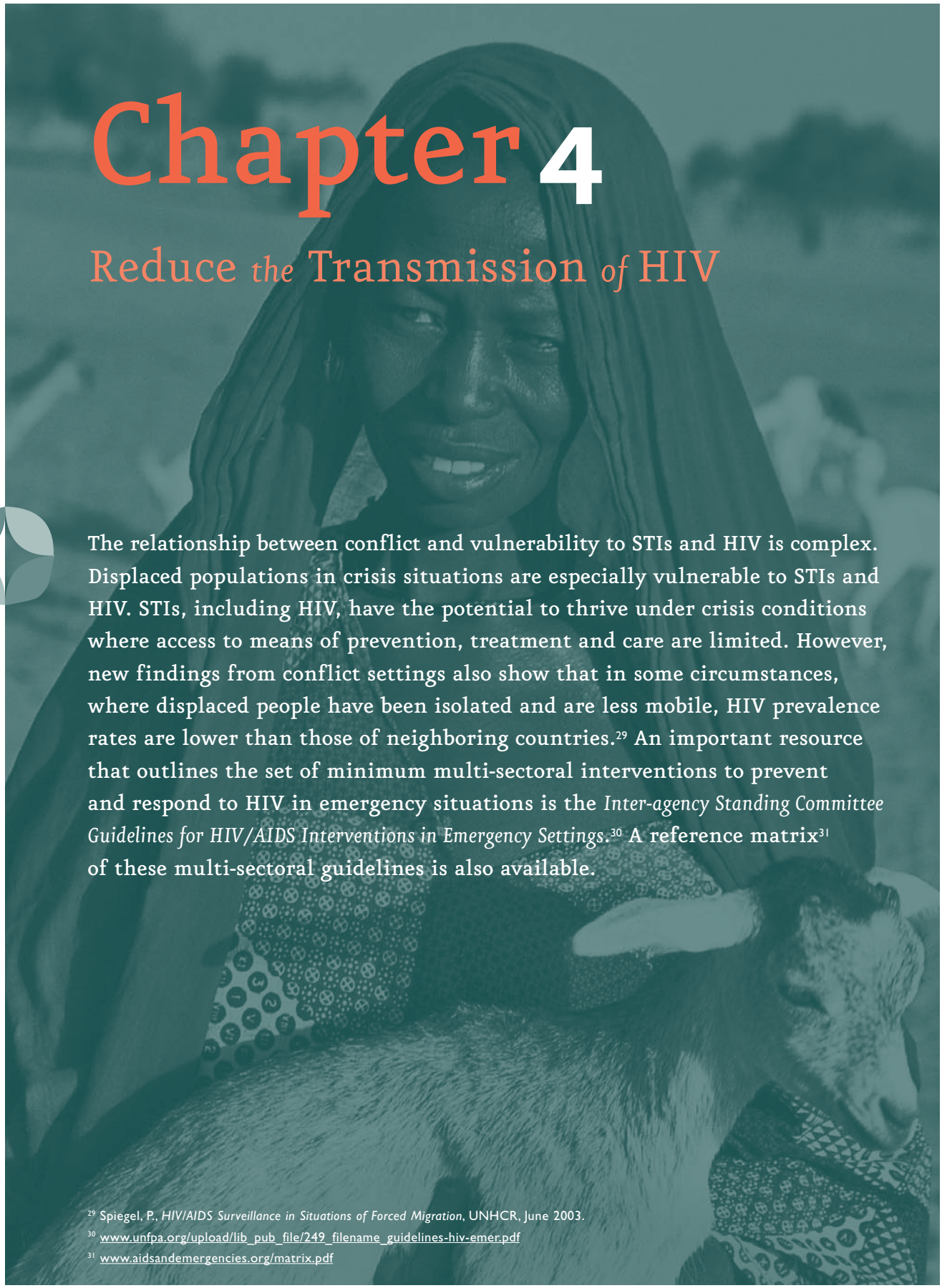
- **a.** International NGO staff
- **b.** Local humanitarian staff
- **c.** UN personnel
- **d.** Individuals contracted from the host population

4 *Which situation puts women at risk of sexual violence?*

- **a.** Men distribute food and other goods
- **b.** Well-lighted paths to nearby latrines
- **c.** Lack of fuel available in or near settlement/camp
- **d.** Most, but not all, protection officers are female

5 *What 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 and post-exposure prophylaxis



Chapter 4

Reduce *the* Transmission *of* HIV

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, new findings from conflict settings also show that in some circumstances, where displaced people have been isolated and are less mobile, HIV prevalence rates are lower than those of neighboring countries.[29] An important resource that outlines the set of minimum multi-sectoral interventions to prevent and respond to HIV in emergency situations is the *Inter-agency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings*.[30] A reference matrix[31] of these multi-sectoral guidelines is also available.

[29] Spiegel, P., *HIV/AIDS Surveillance in Situations of Forced Migration*, UNHCR, June 2003.

[30] www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf

[31] www.aidsandemergencies.org/matrix.pdf

OBJECTIVE

To reduce the transmission of HIV by:

- ensuring safe blood transfusions;
- enforcing respect for universal precautions;
- 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 and reverse the increase of new infections.

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

STIs, including HIV infections, if not addressed or checked, may increase among displaced populations for many reasons:[32]

- Poor or destroyed health infrastructures.
- Protective supplies in health centers, such as clean needles and syringes and gloves, may not be available.
- No access to condoms.
- Peacekeeping forces, military and police, groups which may have higher rates of STIs, can facilitate the spread of HIV in refugee situations.[33]
- Women and children may be coerced into transactional sex to obtain their survival needs.
- During civil strife and flight, displaced persons, especially women and girls, are at increased risk of sexual violence, including rape.
- The disturbance of community and family life among displaced populations may disrupt social norms governing sexual behavior.
- Adolescents may begin sexual relations at an earlier age, take sexual risks, such as having sexual intercourse without using a condom, and face exploitation in the absence of traditional socio-cultural constraints.
- In forced displacement situations, populations from low-HIV–prevalence areas may mix with populations from high-prevalence areas, with the risk of increasing the HIV prevalence among the lower prevalence group.

[32] See p. 30 of *Protecting the Future: A guide to incorporating HIV prevention and care in refugee settings* for additional risk factors.

[33] McGinn, T., "Reproductive Health of War-Affected Populations: What Do We Know?", *International Family Planning Perspectives*, December 2000.

HIV Transmission

The main transmission routes of HIV are 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 region.

Enforce respect for universal precautions

Universal precautions are essential to prevent the spread of infections within health care settings. This must be emphasized during the first health coordination meeting. Under the pressure of an emergency situation, there is a possibility of lack of supplies, and due to the workload, humanitarian staff may be tempted to take shortcuts in procedures, which can jeopardize the safety of patients and staff alike. Therefore, it is essential that universal precautions are respected. In addition, very limited attention is paid to support staff such as cleaners, who are often newly recruited and may not have worked in health setting environments before.

What are universal precautions?

Universal precautions are simple 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 "universal precaution" principle, *blood and body fluids from all persons should be considered as infected with HIV*, regardless of the known or suspected status of the person. Improving the safety of injections is an important component of universal precautions. See the WHO's Web site for further information on universal precautions.[34]

Why are universal precautions particularly important in an emergency setting?

Universal precautions are essential in any setting but in an emergency, infrastructures and supplies may be destroyed or not available. In addition, due to high work pressure or other reasons, health staff are more likely to have work-related accidents and cut corners in sterilization techniques. Therefore, infection–control measures must be enabled and enforced during crisis.

[34] www.who.int/hiv/topics/precautions/universal/en/

The Reality of Implementing the MISP in *Chad*[35]

The Women's Commission conducted an assessment of the MISP among Darfuri refugees in Chad in March 2004. At the time, most humanitarian actors in Chad were not familiar with the MISP and there was no overall RH focal point and only one agency with an identified RH focal point. While several protection activities supporting the prevention of sexual violence had been implemented in some camps, the protection needs of the majority of refugees living in spontaneous refugee sites on the dangerous border areas were unmet. There were no UN protection officers, focal points or reporting mechanisms for sexual abuse and exploitation, in addition to a lack of systematic interventions to address the needs of vulnerable groups such as female-headed households and unaccompanied minors. Priority activities to prevent the transmission of HIV/AIDS in this setting were nonexistent or limited at best. One humanitarian worker remarked, "Condoms would probably melt here," and another stated, "We need to concentrate on basic activities—not complicated activities like HIV." None of the three priority interventions to prevent excess maternal and neonatal mortality and morbidity were fully established. Specific planning for comprehensive reproductive health services was not evident. Over all, this assessment demonstrated a widespread lack of awareness among humanitarian actors about the MISP and a lack of emergency preparedness by UN agencies and donors to implement the MISP in this emergency setting.

What are the minimum requirements for infection control?

- Ensure all staff (both medical and support staff) in health care settings understand universal precautions.
- Ensure clean health center environment.
- Reduce unnecessary procedures.
- Ensure facilities for frequent hand washing.
- Use protective barriers, such as disposable gloves, for all procedures involving contact with blood or other potentially infected body fluids, and protective clothing, such as waterproof gowns or aprons, masks and eye shields, where appropriate.
- Use of new, disposable injection equipment for all injections is highly recommended; sterilizable injection should only be considered if single-use equipment is not available and if the sterility can be documented with Time, Steam and Temperature indicators.[36]
- Ensure space for an incinerator and sterilization facilities.
- Clean, disinfect and sterilize medical equipment[37] using the most appropriate techniques for the setting (e.g., pressure-steam, high-level disinfection, boiling in water for at least 20 minutes or soaking in chemical solutions).

[35] Full assessment available at www.rhrc.org/pdf/cd_misp_final.pdf

[36] For further information on Time, Steam and Temperature indicators, visit www.who.int/vaccines-documents/DocsPDF/www9512/e10-9512.pdf.

[37] For further information on disinfecting and sterilizing medical equipment, visit www.engenderhealth.org/res/offc/safety/ip-ref/pdf/ip-ref-eng.pdf.

- Treat injuries at work, including thorough washing of wounds, rinsing of eye or mouth splashes and providing post-exposure therapy where warranted.
- Ensure safe handling of sharp objects, including the provision of puncture-resistant containers for sharps disposal.
- Ensure that disposal grounds are fenced and not accessible to the public. Dispose of medical waste by burning and burying sharp objects in a protected pit within the grounds of the health facility and not in the communal dump.
- Properly handle contaminated waste, including human waste and corpses.[38]

What information should health workers and support staff receive about universal precautions?

Health workers and support staff should be supervised to ensure their compliance and should receive guidelines on:

- potential risks in the environment, how to protect against those risks, and what to do in case of accidents such as needle-stick injuries, cuts or blood spattering;
- what does NOT constitute a risk;
- when it is appropriate to use protective clothing and why;
- how to avoid unnecessary injections and other procedures involving sharp objects handling and disposal.

Safe blood transfusion

Safe blood transfusion is an essential part of preventing the transmission of HIV. If conducted properly, blood transfusion can save lives and improve health. However, if used inappropriately, it carries the risk of transmission of infectious agents, such as HIV, hepatitis viruses and syphilis. Improperly screened or unscreened blood and the incorrect use of blood and blood products increase the risk of HIV to recipients. In addition, it can contribute to shortages of blood and blood products for patients who need transfusion. Therefore, decreasing unnecessary blood transfusion is critical to avoid the risks of infection. Unnecessary transfusion can be reduced by appropriate clinical use of blood, avoiding the needs for transfusion and use of alternatives to transfusion. Use the standard criteria for blood transfusions[39] as outlined by WHO.

- Reduce the need for blood transfusion by training health care workers to use volume replacement solutions where possible.
- Avoid blood transfusions as much as possible at night, when there is often insufficient light.
- When blood transfusions are implemented at camp level, develop proper systems and hold appropriate medical staff accountable for the transfusions.

[38] For further information on the proper handling of contaminated waste, visit www.who.int/water_sanitation_health/medicalwaste/emergmedwaste/en/.

[39] www.who.int/bloodsafety/en/

- Blood transfusions should ideally be done in health facilities where laboratory facilities exist to screen donors for HIV and other infections diseases, to cross-match blood and to manage complications due to blood transfusions.
- All health workers should be trained to ensure that blood transfused in their facility and/or the blood supply in the facility to which they refer patients is safe.[40]
- Select safe donors.[41]
- Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases.[42]
- Ensure that blood banks have sufficient supplies for screening blood.
- Provide sufficient HIV and other *tests* and supplies for screening blood where needed.[43]

Good practices in preventing and managing the consequences of HIV observed in *Darfur* [44]

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

Guarantee the availability of free condoms

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 to them. Sufficient supplies should be ordered immediately. (See exercise box on how to calculate the correct number of condoms to order.)

[40] For further information on blood safety, visit www.who.int/bloodsafety/clinical_use/en/.

[41] For further information on selecting safe donors, visit www.who.int/bloodsafety/voluntary_donation/en/.

[42] For further information on screening blood for HIV, visit www.who.int/bloodsafety/testing_processing/donation_testing/en/index.html.

[43] For further information on testing of donated blood, visit www.who.int/bloodsafety/testing_processing/donation_testing/en/index.html.

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

Exercise

Calculate a 3-month supply of male condoms for a population of 10,000	
SEXUALLY ACTIVE MALE POPULATION = 20%	10,000 x .2 = 2,000
PERCENTAGE OF SEXUALLY ACTIVE MEN WHO USES CONDOMS = 20%*	2,000 x .2 = 400
CONDOMS USED PER MONTH PER MALE = 12	400 x 12 = 4,800
WASTAGE OR LOSS = 20%	4,800 x .2 = 960
CONDOMS USED PER MONTH + WASTAGE/LOSS	4,800 + 960 = 5,760
CALCULATE FOR A 3-MONTH SUPPLY**	5,760 x 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 can be ordered through UNFPA (RH Kit 1, Part B. For more information, see Chapter 7). Female condoms provide women and girls with a female-initiated method of preventing HIV as well as protection from other STIs and pregnancy. This can be very 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 they are usually not as well known as male condoms among the population. If it is possible to secure a stable supply of female condoms, efforts could be made once a stable phase of the emergency is reached to provide information to the population on this method and provide training for women, girls 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 local MOH and local NGOs that work in the family planning and HIV prevention or treatment sector, as they may also be able to help with condom procurement and may be able to do so more rapidly than the UN agencies. If an agency does not have experience in procuring condoms, contact UNFPA,[45] which procures for the whole UN system, to facilitate the purchase of bulk quantities of good-quality condoms at low cost. Condoms are also available as part of Interagency RH Kits in Kit 1, part A. (See Chapter 7 for more information on RH Kits.)

[45] Contact information available at www.unfpa.org/procurement/contact.htm

How should condoms be made available?

As well as providing condoms upon request, 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 a range of other sites such as food distribution points, 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.

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. Do NOT distribute condoms to the population, which could be offensive, or conduct a mass IEC campaign on condom distribution until all components of the MISP have been implemented, when more comprehensive HIV/AIDS and family planning programs can be carefully designed.

Good Practice

When asked by national staff why there were condoms in the toilet area, the 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.

MISP HIV Monitoring

- Sufficient materials in place for adequate practice of universal precautions
- Number of condoms procured and made available
- Health workers knowledgeable on and practice universal precautions

Indicators to monitor HIV coordination:

- Supplies for universal precautions: Percentage of health facilities with sufficient supplies for universal precautions, such as disposable injection materials, gloves, protective clothing and safe disposal protocols for sharp objects
- Safe blood transfusion: Percentage of referral level hospitals with sufficient HIV tests to screen blood and consist use of them
- Estimate of condom coverage: Number of condoms distributed in a specified time period

Which supplies are needed or which Interagency RH Kit(s) could be ordered to address this issue?[46]

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

[46] Most kits include supplies to ensure universal 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 RH Kits for Crisis Situations* booklet is available at www.rhrc.org/pdf/rhrkit.pdf.

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 UN agencies, such as WHO and UNFPA, or an NGO, 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. However, it is still important to make condoms visible and available because such an assumption may not necessarily 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.

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 88)

1 *Which is **not** a risk factor for HIV transmission in displaced settings?*

- **a.** Social norms are not enforced
- **b.** People living with HIV/AIDS participate in food distribution
- **c.** Adolescents may initiate sexual relations at an earlier age
- **d.** Uniformed services surround the displacement camp

2 *Which is a requirement for infection control?*

- **a.** Facilities for frequent hand washing
- **b.** Safe handling of sharp objects
- **c.** Cleaning, disinfecting and sterilizing medical equipment
- **d.** Disposal of medical waste by burning materials and burying sharp objects outside the grounds of the health facility

3 *Condoms should not be ordered until the community leaders request them.*

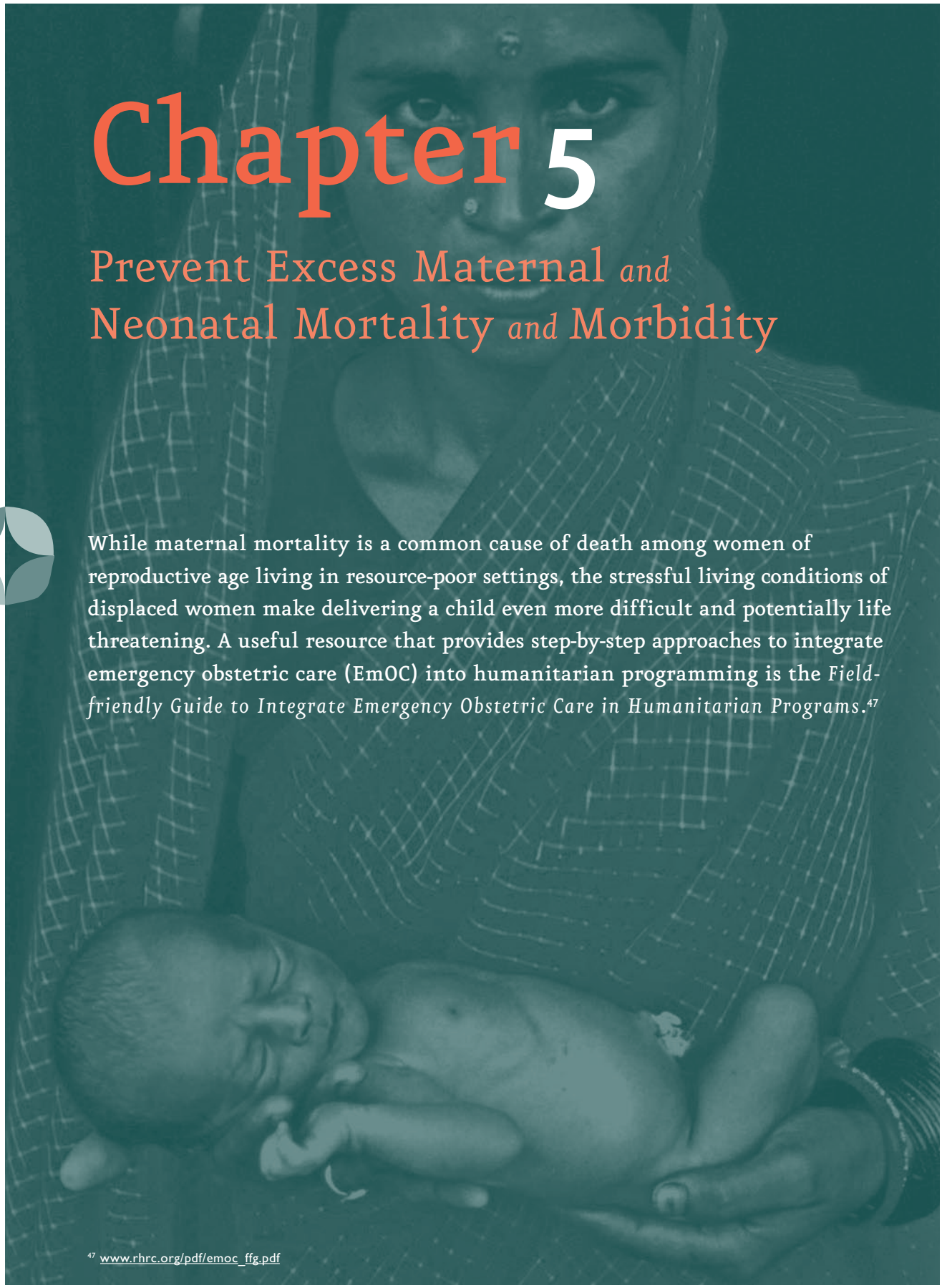
- True
- False

4 *Condoms can be made available at:*

- **a.** Health facilities
- **b.** Food distribution points
- **c.** Community service offices
- **d.** Latrines

5 *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 blood-borne diseases
- **b.** Avoid blood transfusions for non-serious medical conditions
- **c.** Select donors from the displaced community
- **d.** Ensure sufficient HIV and other tests and supplies for screening blood where needed



Chapter 5

Prevent Excess Maternal *and* Neonatal Mortality *and* Morbidity

While maternal mortality is a common cause of death among women of reproductive age living in resource-poor settings, the stressful living conditions of displaced women make delivering a child even more difficult and potentially life threatening. A useful resource that provides step-by-step approaches to integrate emergency obstetric care (EmOC) into humanitarian programming is the *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*.[47]

[47] www.rhrc.org/pdf/emoc_ffg.pdf

OBJECTIVE

PREVENT EXCESS NEONATAL AND MATERNAL MORTALITY AND MORBIDITY BY:

- providing clean delivery kits to visibly pregnant women or birth attendants to promote clean deliveries;
- providing midwife delivery kits (UNICEF [48] or equivalent) to facilitate clean and safe deliveries at the health facility;
- initiating the establishment of a referral system to manage obstetric emergencies.

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

In any displaced population, approximately 4 percent of the total population will be pregnant at a given time.[49] Of these pregnant women, 15 percent will experience an unpredictable obstetric complication, such as obstructed or prolonged labor, pre-eclampsia or eclampsia, sepsis, ruptured uterus, ectopic pregnancy or complications of abortion.[50] In the early phase of an emergency, births will often take place outside the health facility without the assistance of trained health personnel. Without access to emergency obstetric services, many women will die or suffer long-term health consequences that are preventable (for example, obstetric fistula).

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

All displaced populations will include women who are in the later stages of pregnancy and who will therefore deliver during the emergency phase; the crude birth rate (CBR) is estimated at 4 percent. Simple, clean delivery packages for home use should be made available to all visibly pregnant women. These are packages that the women themselves or TBAs can use to help women when they are giving birth. The packages contain very basic materials: one sheet of plastic, two pieces of string, one clean (new and wrapped in its original paper) razor blade, one bar of soap, a pair of gloves and a cotton cloth.

What is the best way to get clean delivery kits?

Because these materials 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 kits, which could provide an income generation project for local women. However, clean delivery kits can be ordered from *UNFPA*.[51] Sometimes this may be a quicker alternative, and the sooner the materials are available, the better it is for pregnant women. In addition, contacting UNFPA at the start of a crisis to establish a relationship and to determine the availability of MISP supplies will likely facilitate better emergency preparedness.

[48] Contact information available at www.supply.unicef.dk/catalogue/bulletin4.htm

[49] UNFPA, *State of the World Population 2002*, 2002.

[50] UNICEF, WHO, UNFPA, *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 1997.

[51] Contact information available at www.unfpa.org/procurement/contact.htm

Exercise

Use the 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 .25[52] =	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 shoulders bags, flashlights with batteries, gloves, plastic aprons and rain ponchos.

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

Fifteen percent of women will develop a potentially life-threatening complication during pregnancy or at the time of delivery. At the primary health care level, basic EmOC[53] should be available for these women 24 hours per day, seven days per week. Therefore, it is important to provide midwives and other skilled birth attendants at the primary health center level with materials and drugs to safely conduct deliveries, to deal with complications and to stabilize women prior to transport to the referral level. Supplies to address obstetric emergencies are included in the Interagency RH Kits and can be ordered through UNFPA.

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

According to the UN Process Indicators of Emergency Obstetric Services,[54] 5 to 15 percent of all deliveries require a c-section. These women, and other women suffering from obstetric emergencies, such as those requiring blood transfusion and surgery, may need to be referred to a hospital that is capable of performing comprehensive EmOC.[55] Obstetric complications that cannot be managed at the health center should be stabilized and transported to the referral hospital.

Estimates 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

[52] Three months are 25 percent (.25) of one year.

[53] Basic emergency obstetric care functions, performed in a health center without an operating theatre, include: assisted vaginal delivery, manual removal of the placenta and retained products to prevent infection, and administering antibiotics to treat infection and drugs to prevent or treat bleeding, convulsions and high blood pressure.

[54] www.amdd.hs.columbia.edu/docs/unguidelines.finalversion.pdf

[55] Comprehensive EmOC services require an operating theater and are usually provided in a district hospital. These include all the functions of a basic emergency facility, plus the ability to perform surgery (c-section) to manage obstructed labor and to provide safe blood transfusion to respond to hemorrhages.

The Reality of Implementing the MISP in *Indonesia* [56]

The Women's Commission conducted an assessment of the MISP in tsunami-affected areas of Aceh, Indonesia in February 2005. While slightly more than half of humanitarian workers interviewed had actually heard of the MISP, only one of 25 people could accurately describe its overall goal, objectives and priority activities. Coordination of the MISP was led by UNFPA, which fielded a designated RH focal point in Banda Aceh within one week of the tsunami and initiated working group meetings among the numerous local and international organizations, as well as the Indonesian health authorities. Women and girls in focus groups expressed concern with the lack of privacy and security in some settings and, in some camps, men and women shared latrines. No MOH personnel and few organizations were able to state that they had a sexual violence protocol in place to respond to the clinical needs of rape survivors. MOH and WHO representatives reported that health workers failed to practice universal precautions, such as cleaning, disinfection and sterilization of medical supplies to prevent the spread of infections, including HIV/AIDS. Most supplies to support the MISP, such as clean delivery kits and midwife kits for health centers, were available to international agencies within or shortly after the first month of the emergency. The need to plan for comprehensive RH services as part of the MISP, including ordering RH supplies, was evident in the demand that women affected by the tsunami had for contraceptive supplies. The demand was quickly addressed through collaborative efforts of donors, the National Family Planning Coordinating Board (BKKBN) and UNFPA.

[56] Full assessment available at www.rhrc.org/pdf/id_misp_eng.pdf

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

As soon as possible, a referral system, including the means of communication and transport, that supports the management of obstetric complications must be available for use by the displaced population 24 hours a day, seven days a week. The referral system should ensure that women with complications of pregnancy or delivery are referred from the community to a primary health care facility where basic EmOC is available and to a facility with comprehensive EmOC services, if necessary.

Is it better to support an already existing referral facility or set up new one?

Where feasible, a local referral facility (e.g., district hospital) should be used and supported with personnel, medical equipment and supplies as needed to meet the needs of the displaced population. If this is not feasible because of the distance or the inability of the host facility to meet the increased demand, then an appropriate emergency referral facility for the displaced population could be established. In either case, it will be necessary to coordinate with local health authorities concerning the policies, procedures and practices to be followed in the referral facility. The protocols of the country should be followed, although some variation may have to be negotiated.

What are the 24/7 requirements of an effective referral system?

A referral system should have transport at all times. For example, if the NGO staff leave the camp and take the vehicle or ambulance with them, a communication system must be established so that if a woman goes into labor and experiences complications, such as obstructed labor, she can get to the health care facility. It may be necessary to negotiate with camp security personnel to allow the transport of emergency patients at night. In addition, a qualified medical person who can address obstetric complications and perform a c-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.

Which type of activity related to maternal care is not a priority in a crisis?

Most maternal deaths occur from complications during or after delivery. The majority of these complications cannot be predicted earlier in pregnancy. Of all pregnant women in whom a health problem is identified during antenatal care, most will not develop a life-threatening complication during or after delivery. Therefore, although providing antenatal care and training midwives are appropriate activities once all the components of the MISP are implemented and the crisis phase is over, these interventions are not vital and could divert attention from the more urgent need of access to quality EmOC in the emergency phase. It is not necessary to train TBAs and midwives before providing them with clean delivery kits as these kits should reach pregnant women without delay. Organizing discussions with TBAs and midwives to exchange information and provide supplies to the community can be done early in an emergency. However, training existing TBAs and/or midwives on clean and safe deliveries should wait until a more stable phase has been reached.[57]

[57] Note that WHO no longer recommends training new TBAs, but rather recommends informing all women in the community about danger signs during delivery and providing a professional training curriculum for village midwives. For more information, visit www.who.int/reproductive-health/publications/2004/skilled_attendant.pdf.

Good practices in excess neonatal and maternal mortality and morbidity observed in *Darfur* [58]

- At the time of the Women's Commission's field team visit, UNFPA reported that it had recently completed an EmOC assessment of five of the eight referral hospitals (three were not accessible due to insecurity) in North Darfur and recruited national staff to conduct the assessment in order to build local capacity. It reported at the time that EmOC assessments were underway in South Darfur and West Darfur as well. These assessments built on EmOC assessments undertaken by the MOH in November 2005.
- The MISP Coordinator in North Darfur enlisted AU forces to provide emergency transport for obstetric complications by helicopter if necessary (due to travel insecurity or time constraints).
- In North Darfur, the sub-granting agency requested 3,000 delivery kits from UNFPA and distributed an average of 1,000 per month (with a flyer on instructions in Arabic) through home visits by village midwives.
- The MISP Coordinator in North Darfur trained two local NGOs to create locally made delivery kits, which they are distributing to their communities.
- The sub-grantee in West Darfur was able to quickly establish basic EmOC services at the peripheral level–in part due to a establishing a good relationship with the MOH.
- In South Darfur, to navigate security restrictions, the sub-grantee's RH unit coordinated with other internal units, e.g., the water and sanitation unit, to provide MISP supplies.
- In South Darfur, one NGO's midwives followed up on each referral at the hospital to ensure women and girls received the appropriate care.
- In South Darfur, UNFPA worked with MOH to provide training to humanitarian actors in manual vacuum aspiration.

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

Neonatal Care

Approximately two-thirds of infant deaths occur within the first 28 days.[59] The majority of these deaths are preventable by initiating essential actions that can be taken by health care workers, mothers or other community members:[60]

Immediate care after birth

- Be sure that attendants use gloves or wash hands with soap and water before the delivery and before tying and cutting the cord.
- Keep delivery room warm and ensure baby is dried and warmly wrapped immediately after birth. Keep the head covered. Delay bathing for at least six hours.
- Use a clean (preferably sterile) instrument to cut the umbilical cord, and check frequently for bleeding.
- Keep the baby with the mother to ensure warmth and frequent breastfeeding.
- Pay attention to frequent hand washing by anyone handling the baby.
- Clean baby's eyes immediately after birth, and if prophylaxis is country policy, instill drops or ointment.
- Encourage Kangaroo Mother Care.[61]
- Help mother with the first (within one hour) breastfeeding.[62]

Continuing postnatal care

- Keep the baby with the mother. Avoid putting two babies in the same cot.
- Clean the cord with soap and water and keep it dry. Do not cover the cord with any bandage or cloth.
- Tell the mother what danger signs to look for in the condition of the cord and in her baby. Be sure she knows when and where to go for help.
- Teach the mother how to keep the baby warm.
- Take the baby to the health center at six weeks for immunizations.
- Advise the mother to give her child nothing but breast milk for the first sixmonths and to continue breastfeeding up to two years or longer.[63]

Useful resources include *Care of the Newborn: Reference Manual, Every Newborn's Health: Recommendations for Care for all Newborns* and *Managing Newborn Problems: A Guide for Doctors, Nurses and Midwives*.[64]

[59] WHO, *Perinatal and Neonatal Mortality: Global, Regional and Country Estimates*, 2001.

[60] Moore, J. and J. McDermott, *Every Newborn's Health: Recommendations for Care for All Newborns*, Save the Children US, 2004.

[61] Kangaroo Mother Care is a universally available and biologically sound method of care for all newborns, but in particular for premature babies, with three components: skin-to-skin contact; exclusive breastfeeding; and medical, emotional, psychological and physical support of mother and baby without separating them. For more information, visit www.kangaroomothercare.com/ref_oprefs.htm.

[62] For more information on breastfeeding in emergencies, visit www.who.int/reproductive-health/publications/conflict_and_displacement/RH_conflict_appendix2.en.html.

[63] This recommendation applies in all settings for women who do not know their status and HIV-negative women, including in areas with high HIV prevalence and low acceptance or availability of interventions to prevent HIV transmission to infants. For women who have been tested and are HIV-positive, UN guidelines state "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life" and should then be discontinued. For further information, see WHO's *HIV and Infant Feeding: A guide for health-care manager and supervisors*.

[64] *Care of the Newborn: Reference Manual* available at www.savethechildren.org/publications/snl/00%20-%20Care%20of%20the%20Newborn%20Reference%20Manual%20(3.6MB).pdf; *Every Newborn's Health: Recommendations for Care for all Newborns* available at www.savethechildren.org/publications/EveryNewbornsHealth.pdf; and *Managing Newborn Problems: A Guide for Doctors, Nurses and Midwives* available at www.who.int/reproductive-health/publications/mnp/mnp.pdf

What causes women to die from obstetric complications?

Often women experience delays in accessing life-saving care that cost them their lives. The situations that hinder women from seeking care can be divided into three categories ("the three delays"):

- delay in deciding to seek care;
- delay in reaching care due to transportation difficulties; and
- delay in having appropriate care available at the facility once reached.[65]

Therefore, after EmOC services are in place, the immediate focus should be on preventing delays in timely access to good quality EmOC for women suffering from emergency obstetric complications.

Good practice

If the situation permits, assembling clean delivery packages locally may be a good opportunity to identify and organize TBAs and to talk with them about referring women suffering from obstetric complications or requiring medical care for rape. TBAs can be organized to make up the simple packages and then distribute them to visibly pregnant women. Because TBAs 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, and may also know which women and girls have survived rape.

[65] Thaddeus, S. and D. Maine, *Too far to walk: maternal mortality in context,* Soc Sci Med, April 1994.

MISP Safe Motherhood Monitoring

- Clean delivery kits available and distributed. Compare the number of clean delivery packages distributed to the estimated number of births in a given period of time.
- Midwife kits available at the health center.
- Hospital staff competency and capacity to provide EmOC assessed and support provided.
- Referral system for obstetric emergencies functioning 24 hours per day, seven days per week.

Indicators to monitor safe motherhood coordination:

- Estimate of coverage of clean delivery kits
- Number and type of obstetric complications treated at the PHC level and the referral level
- Number of maternal and neonatal deaths in health facilities

Which supplies are needed or which UNFPA RH Kit(s) could be ordered to address this issue?[66]

Number	Name	Color
Kit 2:	*Clean Delivery (Individual) (Part A + B)*	*Dark blue*
Kit 6:	*Delivery (Health Facility)*	*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 12:	*Blood Transfusion*	*Dark green*

Challenges and Solutions

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

Without access to adequate 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 where to immediately refer women with dangers signs of pregnancy and delivery including: heavy bleeding, high fever, convulsions, prolonged labor, retained placenta and loss of consciousness. It is important to plan and implement training and capacity-building for all staff once the emergency is stable and the MISP has been fully implemented.

[66] 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 *RH Kits for Crisis Situations* booklet is available at www.rhrc.org/pdf/rhrkit.pdf.

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 89)

1 *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

2 *Clean delivery kits should be provided to all women over 20 years of age.*

- ○ True
- ○ False

3 *What activities are part of proper postnatal care?*

- **a.** Ensure the baby is dried and warmly wrapped keeping its head covered immediately after birth
- **b.** Clean the cord with soap and water
- **c.** Advise the mother to give her child nothing but breast milk for the first six months and to continue breastfeeding no longer than one year
- **d.** Encourage Kangaroo Mother Care

4 *Approximately what proportion of the displaced population will be pregnant at a given time?*

- ○ 25 percent
- ○ 20 percent
- ○ 15 percent
- ○ 4 percent

5 *It is usually better to construct a new health facility than use an already existing one.*

- ○ True
- ○ False

Chapter 6

Planning *for* Comprehensive RH Services

This section outlines the steps to be taken to be ready to expand RH services when a crisis situation stabilizes and when all the components of the MISP have been implemented. It is important to ensure that drug supplies, including contraceptives and drugs to treat STIs, are available and ordered in a rational and sustainable manner so that the displaced population can have access to comprehensive RH services as soon as possible.

OBJECTIVE

Plan for the provision of comprehensive RH services, integrated into primary health care, as the situation permits.

This includes:

- collecting existing background data on maternal and neonatal 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;
- 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 primary health care during the initial phase. If not, the provision of these services may be delayed unnecessarily which may increase the risk of unwanted pregnancies, complications of pregnancy and delivery and sexually transmitted infections, including HIV. By having data collected, an appropriate service site selected, staff prepared and supplies ordered, comprehensive RH services will be up and running quickly when the stable phase of the emergency has been reached.

When should planning for comprehensive RH services take place?

It is essential to plan, in collaboration with displaced women, youth and men, for the integration of comprehensive, good quality RH activities into PHC as soon as possible during the initial phase. If not, the provision of these services may be delayed unnecessarily.

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 expanded RH services.

Subject area	Minimum (MISP) RH services	Comprehensive RH services
FAMILY PLANNING[67]	None* **Although family planning is not part of the MISP, make contraceptives available for any demand, if possible.*	✦ Source and procure contraceptive supplies ✦ Offer sustainable access to a range of contraceptive methods ✦ Provide staff training ✦ Provide community IEC
GENDER-BASED VIOLENCE[68]	✦ Coordinate systems to prevent sexual violence ✦ Ensure health services available to survivors of sexual violence ✦ Assure staff trained (retrained) in sexual violence prevention and response systems	✦ Expand medical and psychological and legal care for survivors ✦ Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting, trafficking, etc. ✦ Provide community IEC
SAFE MOTHERHOOD[69]	✦ Provide clean delivery kits ✦ Provide midwife delivery kits ✦ Establish referral system for obstetric emergencies	✦ Provide antenatal care ✦ Provide postnatal care ✦ Train TBAs and midwives
STIs, INCLUDING HIV, PREVENTION AND TREATMENT[70]	✦ Provide access to free condoms* ✦ Ensure adherence to universal precautions ✦ Assure safe blood transfusions * *Although STI programming is not part of the MISP, it is important to make treatment available for patients presenting for care as part of routine clinical services.*	✦ Identify and manage STIs ✦ Raise awareness of prevention and treatment services for STIs/HIV ✦ Source and procure antibiotics and other relevant drugs as appropriate ✦ Provide care, support and treatment for people living with HIV/AIDS ✦ Collaborate in setting up comprehensive HIV/AIDS services as appropriate ✦ Provide community IEC

[67] "Family planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility." (Working definition used by the WHO Department of Reproductive Health and Research). For further information on family planning services in emergency settings, visit www.rhrc.org/resources/index.cfm?sector=fp.

[68] For further information on GBV in emergency settings, visit www.rhrc.org/resources/index.cfm?sector=gbv.

[69] For further information on safe motherhood in emergency settings, visit www.rhrc.org/resources/index.cfm?sector=safe.

[70] For further information on STIs, including HIV, in emergency settings, visit www.rhrc.org/resources/index.cfm?sector=sti.

Experience has shown that, in addition to providing the MISP, it is also important to respond to the displaced population's needs by initiating complementary RH services, if possible, including:

- antibiotics to treat people with symptoms of STIs (STI Treatment RH Kit 5);
- basic hygiene materials ordered locally and provided to all women and girls, including a 3-month supply of sanitary materials, underwear, soap and towels;
- the availability of basic contraceptives in order to respond to the demand of women with prior experience with contraceptives, who can no longer access their chosen method (Oral and Injectable Contraception, Interagency RH Kit 4 and IUD Kit 7).

Where can reliable data on the displaced population be found?

Part of planning for comprehensive RH services includes the collection of background information on maternal, infant and child mortality, HIV/STI prevalence and contraceptive prevalence data. This information can be obtained from such sources as WHO,[71] UNFPA,[72] the World Bank[73] and the Demographic and Health Survey[74] (DHS). It may be easier for staff at headquarters of implementing agencies to gather this information. For internally displaced people, the MOH may also have health statistics available. Useful tools for gathering data include the RHRC Consortium's *Refugee Reproductive Health Needs Assessment Field Tools*[75] and the *RHRC Monitoring and Evaluation Toolkit*.[76]

Good practices in planning for comprehensive RH services observed in *Darfur*[77]

- UNFPA maintains a comprehensive health information system in South Darfur.
- The MISP Coordinator in North Darfur developed statistical data collection forms for the safe motherhood unit and translated them into Arabic.

[71] www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htm

[72] www.unfpa.org/worldwide

[73] www.worldbank.org

[74] www.measuredhs.com

[75] www.rhrc.org/resources/general%5Ffieldtools/needs_menu.htm

[76] www.rhrc.org/resources/general%5Ffieldtools/toolkit/index.htm

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

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

It is important to address the following factors when selecting suitable sites:

- 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
- possibilities to maintain aseptic conditions[78]
- communications and transport for referrals
- tools for compiling and analyzing data
- locked storage facilities for supplies and files

What about staff and supplies?

An assessment of the capacity of staff to undertake comprehensive RH services should be made and plans put in place to train/retrain staff. Protocols and job aids should be provided to support quality service delivery according to evidence-based best practices.

Equipment and supplies for comprehensive RH services should be ordered through routine supply lines, based on estimated and observed consumption. Taking these actions will allow comprehensive services to begin as soon as the situation stabilizes and all the components of the MISP are in place.

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

MISP Comprehensive RH Monitoring

- Planning for the provision of comprehensive RH services initiated

  Indicators to monitor planning for comprehensive RH coordination:

  - Basic background information collected (see Appendix A on monitoring and evaluation)
  - Sites identified for future delivery of comprehensive RH services
  - Staff assessed, training protocols identified
  - Procurement channels identified and monthly drug consumption assessed

Which supplies are needed or which Interagency RH Kit(s) could be ordered to address this issue?[79]

Number	Name	Color
Kit 4:	*Oral and injectable contraception sub-kit*	*White*
Kit 5:	*STI sub-kit*	*Turquoise*
Kit 7:	*IUD sub-kit*	*Black*

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. Another option is to ensure a female attendant or friend accompanies the woman seeking medical care.

2. *Finding 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 may be available from the MOH. In addition, the agencies that attend the RH coordination meeting may be able to collectively obtain reliable data online from Web sites such as UNFPA,[80] WHO[81] and USAID.[82] If possible, try to collect data from the Internet before traveling or requesting headquarters to assist.

[79] These are very basic kits and supplies should be procured based on contraceptive prevalence data and STI prevalence. 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 *RH Kits for Crisis Situations* booklet is available at www.rhrc.org/pdf/rhrkit.pdf.

[80] www.unfpa.org/worldwide

[81] www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htm

[82] http://dolphn.aimglobalhealth.org

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 89)

1 *Which of the following activities are **not** part of planning for comprehensive RH services for displaced women, men and youth?*

- **a.** Preparing to prevent and address all forms of gender-based violence
- **b.** Preparing to establish antenatal and postnatal care
- **c.** Preparing to train health workers
- **d.** Establishing a referral system for emergency obstetric care

2 *Which activity needs to be undertaken to plan for expanded RH services?*

- **a.** Gather data on mortality rates, STI/HIV prevalence and contraceptive prevalence
- **b.** Establish medical care for rape survivors
- **c.** Assess staff capacity, develop training plans and order supplies
- **d.** Order equipment and supplies through routine supply lines

3 *Where can one find reliable data on the displaced population?*

- **a.** WHO
- **b.** World Bank
- **c.** UNFPA
- **d.** UNBST

4 *The MISP includes family planning services.*

- True
- False

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

- **a.** Privacy and confidentiality during consultations
- **b.** Possibilities to maintain aseptic conditions
- **c.** Communications and transport for referrals
- **d.** Locked storage facilities for supplies and files

Chapter 7

Ordering Reproductive Health Kits

Having the essential drugs, equipment and supplies available in a crisis is critical. To address 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 in the early phase of a crisis. UNFPA is in charge of assembling and delivering these Interagency RH Kits. However, logistics problems can occur in any setting; therefore, agencies should not be fully dependent on one source for supplies. Relief agencies should be prepared by including RH supplies within their overall medical supply procurement.

When should the Interagency RH Kits be ordered?

The RH Kits are intended for the early stage of an emergency as the contents of the kits are designed for a limited period of time (three months) for a particular number of people. Once basic RH services are established, the RH Coordinator should analyze the situation, assess the needs of the population and re-order disposables and other equipment as needed to ensure the sustainability of the RH program and to avoid shortage of some supplies and wasting of others that are not used in the setting. Follow-up orders for ongoing supply needs would be made through the regular supply lines in-country, procurement channels used by NGOs or through the UNFPA Procurement Services Section.[83] In other words, once the emergency phase has ended, continued ordering of the prepackaged RH Kits should be avoided.

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

Yes, the *Interagency Emergency Health Kit 2006*[84] (formerly the New Emergency Health Kit (NEHK)) is the most recent version of a standardized emergency health kit that contains essential drugs, supplies and equipment for the provision of primary health care services. This Emergency Health Kit was designed by WHO, UNHCR, UNICEF, UNFPA, Médecins Sans Frontières, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies. It contains a midwifery kit, emergency contraceptive pills, post-exposure prophylaxis treatment to prevent transmission of HIV after rape and supplies for the adherence to universal precautions. However, to provide the full range of priority RH services in an emergency situation, it is recommended that the Interagency RH Kits are ordered or other supply sources are identified to ensure all necessary equipment and materials are available.

What information do I need to order the Interagency RH Kits?

UNFPA needs to know where the kits will be used and which organization/individual will organize the distribution of the kits, along with the relevant 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 the:

- 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

[83] For further information, visit www.unfpa.org/procurement/contact.htm.

[84] www.who.int/medicines/publications/mrhealthkit.pdf

Knowing the following basic data can help you to order the correct supplies.
(Default estimates are provided in case requested data are not available.)

Kit number and helpful information when completing an order form to UNFPA	Default estimate %	Your estimate %
GENERAL		
Percentage of women of reproductive age (WRA, 15 to 49 years) in the population	25	
Crude birth rate	4	
Percentage of WRA who use modern contraceptives	15	
KIT 1		
Percentage of sexually active men in the population	20	
Percentage of sexually active men who use condoms	20	
Percentage of WRA who use female condoms	1	
KIT 3		
Prevalence of sexual violence (percent of WRA at risk of rape)	2	
KIT 4		
Percentage of women using modern methods of contraception who use combined oral contraceptive pills	30	
Percentage of women using modern methods of contraception who use injectable contraception	55	
KIT 6		
Percentage of all women who deliver who will give birth in a health center	15	
KIT 7		
Percentage of women using modern methods of contraception who use an IUD	5	
KIT 8		
Pregnancies that end in miscarriage or unsafe abortion (estimated as an additional percentage of live births)	15	
KIT 9		
Percentage of women who deliver who will need suturing of vaginal tears	15	
KIT 11		
Percentage of deliveries requiring a c-section	5-15	

How much do the Interagency 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 Interagency 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.

How are Interagency RH Kits packaged?

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

- are marked with the number of boxes and the weight and volume of each kit
- can be handled by one or two people
- are clearly marked with the kit number, description, contact person and contents
- 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 *Reproductive Health Kits for Crisis Situations*.[85] This booklet provides a list of contents of each kit as well as guidance on the type of training health personnel should have to use the contents of the kit appropriately.

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:

- *Clinical Management of Rape Survivors: A guide to the development of protocols for use in refugee and internally displaced person situations*.[86] WHO/UNHCR, (revised edition) 2004.
- *Distance Learning Module on the Minimum Initial Service Package (MISP) for Reproductive Health*.[87] Women's Commission for Refugee Women and Children, 2006.
- *Minimum Initial Service Package (MISP) Fact Sheet*.[88] Women's Commission for Refugee Women and Children, (revised) 2006.
- *Field-Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*.[89] Women's Commission for Refugee Women and Children/RHRC Consortium, 2005.
- *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*.[90] Inter-agency Standing Committee Task Force on Gender and Humanitarian Assistance, 2005.

[85] www.rhrc.org/pdf/rhrkit.pdf

[86] www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/clinical_mngt_survivors_of_rape.pdf

[87] www.womenscommission.org/pdf/MISP_tool.pdf

[88] www.rhrc.org/pdf/fs_misp.pdf

[89] www.rhrc.org/pdf/emoc_ffg.pdf

[90] www.rhrc.org/pdf/GBV_guidelines_Eng_09_13_05.pdf

- *Guidelines for HIV/AIDS interventions in emergency settings.*[91] IASC, 2005.
- *Guidelines for the Management of Sexually Transmitted Infections.*[92] WHO, 2003.
- *Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice.*[93] WHO, UNFPA, UNICEF, WB, 2003.
- *Reproductive Health during Conflict and Displacement: A Guide for Program Managers.*[94] WHO, 2000.
- *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual.*[95] UNHCR/UNFPA/WHO, 1999.
- *RHRC Monitoring and Evaluation Tool Kit.*[96] RHRC Consortium, 2004.
- *The Reproductive Health Kit for Emergency Situations.*[97] UNFPA/IAWG, (revised edition) 2006.

Some materials are available in various languages to be suited to the context of the crisis, but these are not automatically included and need to be requested specifically. For example, the Inter-agency Field Manual is available English, French, Spanish, Portuguese and Russian.

[91] www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf
[92] www.who.int/reproductive-health/publications/rhr_01_10_mngt_stis/guidelines_mngt_stis.pdf
[93] http://whqlibdoc.who.int/publications/2003/924159084X.pdf
[94] www.who.int/reproductive-health/publications/conflict_and_displacement/pdf/conflict_displacement.pdf
[95] www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/full_text.pdf
[96] www.rhrc.org/resources/general%5Ffieldtools/toolkit/index.htm
[97] www.rhrc.org/pdf/rhrkit.pdf

The RH Kits are designed for use for a 3-month period for a varying population number, depending on which block of sub-kits is ordered.[98] The RH Kits are divided into three blocks as follows:

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

Block 1 contains six sub-kits. Each sub-kit is designed for 10,000 persons for a 3-month period. The sub-kits contain mainly disposable items. Sub-kits 1 and 2 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five sub-kits to be used at the community and primary health care level for 30,000 persons / 3 months		
KIT NUMBER	**KIT NAME**	**COLOR CODE**
Sub-kit 6	Delivery sub-kit (Health Facility)	Brown
Sub-kit 7	IUD sub-kit	Black
Sub-kit 8	Management of Complications of Abortion sub-kit	Yellow
Sub-kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination sub-kit	Purple
Sub-kit 10	Vacuum Extraction for Delivery (Manual) sub-kit	Grey

Block 2 is composed of five sub-kits containing disposable and reusable material. In order to prevent wastage of expensive reusable equipment, these sub-kits are designed to be used for a population of 30,000 persons over a 3-month period. However, this certainly does not exclude the sub-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 sub-kits to be used at referral hospital level for 150,000 persons / 3 months		
KIT NUMBER	**KIT NAME**	**COLOR CODE**
Sub-kit 11	Referral level sub-kit for Reproductive Health (Part A + B)	Fluorescent green
Sub-kit 12	Blood Transfusion sub-kit	Dark green

Block 3 is composed of 2 sub-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.

[98] Please see table on pg. 57 for further ordering information.

How do I order Interagency RH Kits?

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

UNFPA/HRU
220 East 42nd Street
New York, NY 10017
USA

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

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

tel: +41 22 917 83 14
fax: +41 22 917 80 16
email: doedens@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: janssens@unfpa.org or dsmith@unfpa.org

How do I order the Interagency Emergency Health Kit?

A booklet describing the Interagency 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@ida.nl

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: psid@unicef.org

Exercise

How to place an order 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
LEVEL OF PERSONNEL:	1 medical doctor, 2 trained nurses, 1 trained midwife, traditional birth attendants and health workers
REFERRAL LEVEL:	local hospital is 10 km away, poorly equipped but with trained staff able to perform emergency obstetric procedures

Order		
KIT NUMBER	**NAME OF KIT**	**QUANTITY**
Sub-kit 0	Administration sub-kit	2
Sub-kit 1	Condom sub-kit (Part A + B)	2
Sub-kit 2	Clean Delivery sub-kit (Individual) (Part A + B)	2
Sub-kit 3	Post-Rape sub-kit	2
Sub-kit 4	Oral and Injectable Contraception sub-kit	2
Sub-kit 5	STI sub-kit	2
Sub-kit 6	Delivery sub-kit (Health Facility)	2
Sub-kit 7	IUD sub-kit	2
Sub-kit 8	Management of Complications of Abortion sub-kit	1
Sub-kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination sub-kit	1
Sub-kit 10	Vacuum Extraction for Delivery (Manual) sub-kit	1
To support the referral hospital		
Sub-kit 11	Referral level sub-kit for Reproductive Health (Part A + B)	1
Sub-kit 12	Blood Transfusion sub-kit	1

Chapter Quiz

Please note that multiple choice questions may have more than one correct answer. (Answers on page 90)

1 *Female condoms are available in the Interagency RH Kits.*

- ○ True
- ○ False

2 *To place an order for RH supplies, which of the following activities do* ***not*** *need to be undertaken?*

a. estimate the total population
b. identify the number of health personnel and their qualifications
c. conduct focus groups with an equal number of male and females
d. assess the condition of local referral facility

3 *For what time period are the RH Kits designed for use?*

a. 1 month
b. 3 months
c. 6 months
d. 1 year

4 *For which level of health care are the RH Kits designed?*

a. community level
b. primary health care level
c. referral level
d. country level

5 *At the beginning of an emergency, agencies should first try to secure supplies from 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 MISP 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.

2. *How do I advocate for the MISP to my colleagues?*
   Initially, some humanitarian actors may not see RH as a priority, but pointing out that the MISP is a Sphere standard and using the information contained in this module 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 can be very effective in getting people to give RH the attention it deserves in crisis situations.

3. *My agency is not involved in the provision of health care services, so why should I be concerned about the MISP?*
   The MISP is not limited to the health sector. 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, and protection/legal sectors. To prevent sexual violence, all sectors should be involved in supporting the safety and security of displaced populations, particularly women and girls. To reduce HIV transmission, all agencies and sectors can assist in making condoms free, available and visible to the conflict-affected population and their staff. Emergency obstetric care services may require that the camp management agency support the transportation of pregnant women to a referral facility. Multi-sectoral implementation of the MISP objectives will help to reduce death and disability as much as possible in the earliest days of an emergency.

4. *Is emergency contraception (EC) part of the MISP?*
   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 sub-kit 3, the post-rape sub-kit and sub-kit 4, the oral and injectable contraceptives sub-kit. EC may also be available locally: *Not-2-Late.com*, a website on EC, provides a list of locally available EC in countries worldwide. It can also be given using regular contraceptive pills and procured through agencies' usual medical supply systems. A useful resource that provides detailed information on EC regimes is *Emergency Contraception for Conflict-affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module*.[99]

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. It is not easy to judge whether a population is conservative. However, there may be some segments of the population who are less conservative. Therefore, it is better to make condoms available in a crisis setting even if condoms are offered in less public places where they can be obtained privately (for example, 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.

[99] www.rhrc.org/resources/general_fieldtools/er_contraception/welcome.htm

6. *Why should condoms be made available if the displaced population doesn't know how to use them and the HIV prevalence rate is very low?*
   Even if the percentage of people in the community that is knowledgeable about condoms is low, ethically, condoms should still be made available so those who wish to can access them.

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 women who will develop unpredictable complications of pregnancy and delivery. Therefore, it is essential to ensure that all pregnant women can access EmOC services so 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 but may be available from other NGOs or UN agencies working in the area. It is the responsibility of all health workers to verify that all blood for transfusion in their facility, and facilities to which they refer patients for care, is safe. If needed, you can order RH Kit 12, which 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 to refer women who have complications at birth?*
   Once services for survivors of sexual violence and for EmOC are established, the health and community services sectors should inform the community about the availability of these services, and the urgency for survivors of sexual violence to present to these services as soon as possible, as well as about the procedures for referring women who develop complications of pregnancy and delivery.

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 TBAs should be encouraged to make appropriate referrals during the earliest days and weeks of new emergencies, it is not a good use of time and resources to train TBAs and midwives on how to perform clean and safe deliveries. This type of in-depth training should wait until a more stable phase has been reached.

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 this 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 *Clinical Management of Rape Survivors*[100] or another standard protocol for rape survivors (Médecins Sans Frontières, MOH, etc.) without delay. If the woman agrees, the incident should be reported to the protection officer in the camp in order to ensure her immediate safety. The woman should also be offered psychosocial services that are offered by the community services sector. Ensure that confidentiality is maintained throughout this process and do not do anything that the survivor does not consent to.

   It is also important to work with all organizations in the camp to find out how to prevent future rapes. Your team may consider identifying alternative fuel sources so the community is not dependent on wood for fuel, organizing armed or protective escorts to gather wood to increase safety, obtaining/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.

2. *You have been hired by UNFPA as the RH Coordinator in a region that received an influx of refugees from a neighboring country two days ago. What are some of the first steps you should take?*

   Call a meeting with all of the implementing partners of UNFPA as well as other local or national agencies that are responding to the needs of the refugees. During the meeting, you will identify which organizations already have an RH Coordinator/Focal Point in place and which ones still need to make RH a priority. This meeting also provides the opportunity to facilitate ordering supplies for the agencies and initiate a plan for monitoring and sharing data on mortality, births, etc.

3. *You are a newly arrived supervisor at a camp-level health facility. 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?*

   Conduct a refresher lesson for all health center staff on respect for universal precautions and ensure that necessary supplies are available by taking an inventory and ordering materials that are lacking. Also, during the session you can work with staff to develop a system to self-monitor compliance with cleaning, disinfection and sterilization of equipment and supplies and to identify staff responsible for daily medical waste management, such as burning or burying refuse in a protected pit specifically for medical waste. If staff feel overwhelmed and feel that they don't have time to ensure adherence to universal precautions, you can determine whether more staff are needed, if it is possible to hire more staff, or help staff determine how to prioritize adherence to universal precautions over other tasks that may be less important. Ultimately, most trained health workers should be aware how basic and critical universal precautions are and understand the principle of preventing the transmission of infections in the healthcare setting. Therefore, it may be sufficient to remind and support staff in any way necessary to ensure universal precautions are respected.

[100] www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/clinical_mngt_survivors_of_rape.pdf

4. *You are a health worker in a remote area. Due to the ongoing conflict in the local area, you and your colleagues leave the camp 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 the camp at 9 a.m. 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 at the camp in the future?*

   It may be necessary to negotiate emergency transport with security personnel, camp managers and other relevant actors. If it is deemed within security protocol, one alternative is to find out if any people in the local area have a vehicle they would be willing to use to transport women from the camp to the health facility. This individual could be registered with camp security to travel at night. A radio communication system could be set up in the camp health center to link with the local person who could be immediately alerted when a woman needed to get transported to the referral health facility. Alternatively, another vehicle could be procured that would stay at the health center in camp 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?*

   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 facility is and whether there is a country-level UNFPA office. You can use this information to determine essential resources needed, including personnel, supplies and equipment. It is best to anticipate these needs prior to an emergency and include appropriately trained personnel in your emergency staff rosters and supplies and equipment in your medical supply procurement orders. You can also work with UNFPA, at the country office or the New York or Geneva office, to determine the kits to 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 had 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?*

   Use the data that you have collected on maternal, infant and child mortality, HIV prevalence and contraceptive prevalence to determine what additional RH services would be suited to this population. Determine whether the sites identified for expanded RH services remain suitable in terms of security, accessibility, privacy and confidentiality during visits, access to water and sanitation, adequate room for patients to wait and 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 three months. Review supply needs to see what orders can now be made through normal procurement channels to supplement the inventory that has been ordered through Interagency RH Kits.

MISP Module Post-Test

Please note that multiple choice questions may have more than one correct answer.

1 *When should the MISP be implemented?*

- **a.** In the first days of a crisis situation
- **b.** Once approval from UNFPA has been given
- **c.** Once early mortality rates have stabilized
- **d.** After the displaced population has been settled into camps

2 *The activities of the RH Coordinator's job 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.** Adapting and introducing simple forms for monitoring RH activities
- **d.** Ensuring the provision of family planning services

3 *What health and demographic data should the RH Coordinator determine/estimate and collect?*

- **a.** Malnutrition rate
- **b.** Number of sexually active men using condoms
- **c.** Crude birth rate
- **d.** Age-specific mortality rate

4 *MISP supplies can be procured by:*

- **a.** Ordering the Interagency Reproductive Health Kit 2006
- **b.** Ordering the New Emergency Health Kit
- **c.** Contracting with a local NGO to assemble the kits
- **d.** Contacting UNHCR for RH supplies

5 *What activities should be undertaken for newborn care immediately after birth?*

- **a.** Help mother to establish breastfeeding within the first hour
- **b.** Ensure that attendants use gloves or wash hands with soap and water before tying and cutting the cord
- **c.** Ensure baby is dried and warmly wrapped immediately after birth
- **d.** Encourage mother to supplement breastfeeding with formula

6 *Which of the following activities should* **not** *be undertaken in the early days of an emergency?*

- **a.** Carry out a community-wide condom sensitization campaign
- **b.** Ensure that women have their own ration cards for food distribution
- **c.** Inform the community about where rape survivors can receive care
- **d.** Provide midwifery kits to visibly pregnant women

7 *What type of services should be offered to a rape survivor?*

a. Clinical services
b. Additional food rations for her extended family
c. Protection for her physical safety
d. Psychosocial care

8 *Which of the following is a way that does* ***not*** *help to prevent sexual violence in a crisis situation?*

a. Involve women in distribution of materials and supplies
b. Ensure that women have their own individual registration cards
c. Communal bathing facilities for both men and women
d. Involve women in the decision-making process regarding the layout of the site/camp

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

- True
- False

10 *What are* ***not*** *the requirements of a referral-level facility for obstetric complications?*

a. Communication system
b. Safe blood transfusion
c. Antenatal care
d. Medical staff that can perform c-sections available 24 hours per day, seven days per week

11 *A civil war has recently displaced tens of thousands of people and approximately 500 refugees are arriving in Camp XYZ per week. You are responsible for health services at Camp XYZ. What are some of the priority RH activities you immediately undertake?*

a. ensuring survivors of domestic violence have access to psychosocial services
b. providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries
c. ensuring blood for transfusion is safe
d. ensuring safe access to fuel

12 *You are a newly assigned RH Coordinator and have recently arrived in an emergency situation. You contact UNFPA to:*

a. Find out how to participate in the RH coordination meetings
b. Co-host trainings on HIV/AIDS
c. Discuss supply needs
d. Coordinate community outreach on STI prevention

13 *You are trying to ensure that transport is available in the camp clinic for obstetric emergencies 24 hours per day, seven days a week. You have consulted with security personnel and the surrounding area is too insecure to provide transport at night. What alternative activities can you undertake?*

a. Ensure qualified staff are available at all times to stabilize the patient with basic EmOC
b. Establish trainings for medical staff on comprehensive EmOC
c. Second qualified international physicians to support the referral hospital as needed
d. Establish a communication system to consult qualified providers for guidance

14 *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. Order supplies from another source abroad and wait until they arrive
d. Discuss during the RH coordination meeting where to procure supplies

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Appendix A:

Monitoring and Evaluation (X – implemented O – reviewed)

COORDINATION	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Overall RH Coordinator in place and functioning under the health coordination team												
RH focal points in camps and implementing agencies in place												
Material for implementation of the MISP available and used												
Basic demographic and health data collected												
SEXUAL VIOLENCE												
Coordinated multi-sectoral systems to prevent sexual violence in place												
Confidential health services to manage cases of sexual violence in place												
Staff trained (retrained) in sexual violence prevention and response												
HIV TRANSMISSION												
Sufficient materials in place for practice of universal precautions by trained, knowledgeable health workers												
Condoms procured and made available												
Blood for transfusion consistently screened												
MATERNAL AND NEONATAL MORTALITY AND MORBIDITY												
Clean delivery kits available and distributed												
Calculate the number of clean delivery packages needed to cover for births for 3 mo. (estimated population x .04 x .25)												
Midwife kits available at the health center												
Referral hospital assessed and supported for adequate number of qualified staff, equipment and supplies												
Referral system for obstetric emergencies functioning 24/7												
PLANNING FOR COMPREHENSIVE RH												
Basic background information collected												
Sites identified for future delivery of comprehensive RH services												
Staff assessed, training protocols identified												
Procurement channels identified and monthly drug consumption assessed												

Monthly data collection												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Number of condoms distributed												
Number of clean delivery packages distributed												
Number of sexual violence cases reported in all sectors												
Number of health facilities with supplies for universal precautions												
Basic demographic and health data collected												

Basic demographic and health information												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
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												

Appendix B:

Sample Project Proposal for an international NGO to submit to government, United Nations, 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 AND REASON FOR PROJECT OR PROBLEM TO BE ADDRESSED:	The MISP for Reproductive Health 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. The MISP is a set of priority activities designed to: prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services. 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 a new needs assessment because documented evidence already justifies its use. The components of the MISP form a minimum requirement and it is expected that comprehensive reproductive health services will be provided as soon as the situation allows. The MISP is a minimum standard in the 2004 Sphere guidelines. An RH Coordinator is essential to ensuring coordination of MISP activities among all health implementing agencies. Under the auspices of the overall health coordination framework, the RH Coordinator 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; introduce standardized strategies for RH which are fully integrated with primary health care (PHC), standardized protocols and simple forms for monitoring RH activities; and report regularly to the health coordination team. [Insert brief background on emergency situation.]
OBJECTIVES:	✦ Identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP ✦ Prevent and manage the consequences of sexual violence ✦ Reduce HIV transmission by enforcing respect for universal precautions against HIV/AIDS and guaranteeing the availability of free condoms ✦ Prevent excess maternal and neonatal mortality and morbidity by: providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries; providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility; and initiating the establishment of a referral system to manage obstetric emergencies ✦ Plan for the provision of comprehensive RH services, integrated into PHC, as the situation permits

ACTIVITIES:	Identify an organization(s) and individual(s) to facilitate the MISP ✦ ensuring overall RH Coordinator is in place and functioning under the health coordination team ✦ ensuring RH focal points in camps and implementing agencies are in place ✦ making available material for implementing the MISP and ensuring its use Prevent and manage the consequences of sexual violence ✦ ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence ✦ ensuring medical services, including psychosocial support, are available for survivors of sexual violence Reduce HIV transmission ✦ enforcing respect for universal precautions ✦ guaranteeing the availability of free condoms ✦ ensuring that blood for transfusion is safe Prevent excess maternal and neonatal mortality and morbidity ✦ providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries ✦ providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility ✦ initiating the establishment of a referral system to manage obstetric emergencies Plan for provision of comprehensive RH services ✦ collecting basic background information (see below) ✦ identifying sites for future delivery of comprehensive RH services ✦ assessing staff and identifying training protocols ✦ identifying procurement channels and assessing monthly drug consumption 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

INDICATORS:	✦ Incidence of sexual violence: Monitor the number of incidents of sexual violence anonymously reported to health and protection services and security officers and the number of survivors of sexual violence who seek and receive health care. ✦ Supplies for universal precautions: Percentage of health facilities with sufficient supplies for universal precautions, such as disposable injection materials, gloves, protective clothing and safe disposal protocols for sharp objects. ✦ Safe blood transfusion: Percentage of referral level hospitals with sufficient HIV tests to screen blood and consistent use of them. ✦ Estimate of condom coverage: Number of condoms distributed in a specified time period. ✦ Estimate of coverage of clean delivery kits: Calculate the number of clean delivery kits available to cover the estimated births in a given period of time. ✦ Number and type of obstetric complications treated at the PHC level and the referral level and number of maternal and neonatal deaths in health facilities.
TARGETED BENEFICIARIES:	(Total number of) displaced, of whom (xx) are women 15 to 49 yrs old
PROJECT DURATION:	6 months to one year
PROJECT BUDGET:	✦ Salary for RH Coordinator ✦ RH supplies and infrastructure support (coordinate with UNFPA to obtain supplies) ✦ Travel ✦ Indirect costs (xx %)

Appendix C:

Sample project proposal for UNFPA country offices to submit to the Consolidated Appeals Process (CAP)

Appealing Agency	UNFPA
PROJECT TITLE:	Implementing the Minimum Initial Service Package (MISP) for Reproductive Health (RH) in a Crisis Setting
PROJECT CODE:	(number assigned by OCHA's Financial Tracking Unit)
SECTOR:	Health
THEMES:	Safe Motherhood, Sexual Violence–prevention and management, HIV/AIDS, Displacement, Refugees
OBJECTIVE:	To reduce reproductive health-related morbidity and mortality, through making a minimum set of reproductive health interventions available as early as possible and through planning for the provision of more comprehensive RH services as the situation permits
TARGETED BENEFICIARIES:	110,000 displaced persons, of whom 22,000 are women 15 to 49 yrs old
IMPLEMENTING PARTNERS:	xxxxx
PROJECT DURATION:	6 months
TOTAL PROJECT BUDGET:	xxxxx
FUNDS REQUESTED:	USD xxxxx

The Project Description

In the early phase of an emergency situation, morbidity and mortality related to reproductive health (RH) continue and, in fact, often increase. The risk for complications of pregnancy and delivery and maternal and neonatal mortality is increased through the lack of access to emergency obstetric care, the increased risk of malnutrition and epidemics, and the increased incidence of childbirth under unhygienic circumstances. Furthermore, the risk of sexual violence may increase during social instability and population movement; and sexually transmitted infections and HIV transmission are more likely in areas of high population density. The lack of family planning methods increases risks associated with unwanted pregnancy. Some aspects of RH must therefore be addressed in the early phase of an emergency to reduce morbidity and mortality, particularly among women. This is best done through the widely accepted Inter-Agency standard of the Minimum Initial Service Package (MISP) for Reproductive Heath. This strategy assures that basic, limited RH services are delivered to the population as soon as possible, without spending time on a site-specific needs assessment. The strategy includes coordination of RH activities, essential drugs, supplies and equipment and planning for comprehensive RH services.

UNFPA will work together with implementing partners, xxxxx. The project will provide for an RH Coordinator to work in collaboration with the Health Coordination team. RH supplies and medicines will be delivered in the form of RH kits. The RH Coordinator will be responsible for identifying health centers and health staff that can implement the objectives of the MISP; distributing the RH materials; and monitoring and evaluating the activities. The activities will focus on: 1) Preventing and managing the consequences of sexual violence through including the community in secure planning of the camp design, assuring a medical response for rape survivors and protecting at-risk groups; 2) Reducing HIV transmission through collaborating with the other health sector partners to enforce respect for universal precautions, making safe blood transfusions available and assuring the availability of free condoms; 3) Preventing excess maternal and neonatal mortality and morbidity through providing all pregnant women in the last trimester with clean birthing materials, assuring clean and safe deliveries at the health facility and initiating the establishment of a referral system for obstetric emergencies. Furthermore, the RH Coordinator, in collaboration with all partners and beneficiaries, will plan for provision of comprehensive RH services, integrated into primary health care, as soon as the situation permits.

Financial Summary:

Budget items	
SALARY RH COORDINATOR	xxxx
RH SUPPLIES AND INFRASTRUCTURE SUPPORT	xxxx
HARDWARE (VEHICLE, COMPUTER, ETC.)	xxxx
SOFTWARE (ADMIN., OFFICE HIRING, ETC.)	xxxx
TOTAL	xxxx

Appendix D:

MISP Fact Sheet and Checklist

WOMEN'S COMMISSION for refugee women & children

What is the MISP?

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) is a set of priority activities to be implemented during the early stages of an emergency (conflict or natural disaster). When implemented at the onset of an emergency, the MISP saves lives and prevents illness, especially among women and girls. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff at the beginning of a crisis. It can be implemented without a new needs assessment since documented evidence already justifies its use. The MISP prevents excess maternal and neonatal mortality and morbidity, reduces HIV transmission, prevents and manages the consequences of sexual violence, and includes planning for the provision of comprehensive RH services. The MISP is a standard in the 2004 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response. The components of the MISP form a minimum requirement and comprehensive RH services should be provided as soon as the situation allows.

Goal

The goal of the MISP is to reduce mortality, morbidity and disability among populations affected by crises, particularly women and girls. These populations may be refugees, internally displaced persons (IDPs) or populations hosting refugees or IDPs.

MISP Objectives & Activities

- Identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP by:
  - ensuring the overall RH Coordinator is in place and functioning under the health coordination team
  - ensuring RH focal points in camps and implementing agencies are in place
  - making available material for implementing the MISP and ensuring its use
- Prevent sexual violence and provide appropriate assistance to survivors by:
  - ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence
  - ensuring medical services, including psychosocial support, are available for survivors of sexual violence
- Reduce the transmission of HIV by:
  - enforcing respect for universal precautions
  - guaranteeing the availability of free condoms
  - ensuring that blood for transfusion is safe
- Prevent excess maternal and neonatal mortality and morbidity by:
  - providing clean delivery kits to all visibly pregnant women and birth attendants to promote clean home deliveries
  - providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility
  - initiating the establishment of a referral system to manage obstetric emergencies

This document is based on the *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* produced through a collaborative effort of United Nations agencies, governmental and nongovernmental organizations and displaced persons.

- Plan for the provision of comprehensive reproductive health services, integrated into Primary Health Care (PHC), as the situation permits by:
  - collecting basic background information identifying sites for future delivery of comprehensive RH services
  - assessing staff and identifying training protocols
  - identifying procurement channels and assessing monthly drug consumption

Broad Terms of Reference for a Reproductive Health Coordinator

- Under the auspices of the overall health coordination framework, the RH Coordinator should:
  - be the focal point for RH services and provide technical advice an d assistance on RH to the displaced communities and all organizations working in health and other sectors as needed;
  - liaise with national and regional authorities when planning and implementing RH activities in camps, settlements and among the surrounding population;
  - liaise with other sectors (protection, community services, camp management, education, etc.) to ensure a multi-sectoral approach to RH;
  - assure that RH is a standard item on the health coordination meeting agenda;
  - create or adapt and introduce national and other standardized policies that support the MISP and ensure that they are integrated with primary health care, for example, policies relating to emergency obstetric care or gender-based violence;
  - initiate and coordinate audience-specific orientation sessions on the MISP (e.g., for health workers, community services officers, the beneficiary population, security personnel, etc.);
  - introduce standardized protocols for selected areas (such as medical response to survivors of sexual violence and referral of obstetric emergencies; and, when planning for comprehensive RH services: syndromic case management of STIs and family planning);
  - adapt and introduce simple forms for monitoring RH activities during the emergency phase that can become more comprehensive once the program is expanded;
  - use standard indicators to monitor MISP outcomes;
  - collect, analyze and disseminate data for use;
  - report regularly to the health coordination team.

MISP Indicators

- Monitor incidence of sexual violence:
  - Monitor the number of incidents of sexual violence anonymously reported to health and protection services and security officers
  - Monitor the number of survivors of sexual violence who seek and receive health care (anonymous reporting is of utmost importance)
- Monitor HIV coordination:
  - Supplies for universal precautions: Percentage of health facilities with sufficient supplies for universal precautions, such as disposable injection materials, gloves, protective clothing and safe disposal protocols for sharp objects
  - Safe blood transfusion: Percentage of referral level hospitals with sufficient HIV tests to screen blood and consistently using them
  - Estimate of condom coverage: Number of condoms distributed in a specified time period
- Monitor safe motherhood coordination:
  - Estimate of coverage of clean delivery kits
  - Number and type of obstetric complications treated at the PHC level and the referral level
  - Number of maternal and neonatal deaths in health facilities

- Monitor planning for comprehensive RH coordination:
  - Basic background information collected
  - Sites identified for future delivery of comprehensive RH services
  - Staff assessed, training protocols identified
  - Procurement channels identified and monthly drug consumption assessed

Material Resources

1. What is in the Interagency Reproductive Health Kit?

The RH Kit is designed for use for a 3-month period for a varying population number, depending on which block of sub-kits are ordered. The RH Kit is divided into three "blocks" as follows:

Block 1: Six sub-kits to be used at the community and primary health care level for 10,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Sub-kit 0	Administration sub-kit	Orange
Sub-kit 1	Condom sub-kit (Part A is male condoms + Part B is female condoms)	Red
Sub-kit 2	Clean Delivery sub-kit (Individual) (Part A + B)	Dark Blue
Sub-kit 3	Post-Rape sub-kit	Pink
Sub-kit 4	Oral and Injectable Contraception sub-kit	White
Sub-kit 5	STI sub-kit	Turquoise

Block 1 contains six sub-kits. Each sub-kit is designed for 10,000 persons for a 3-month period. The sub-kits contain mainly disposable items. Sub-kits 1 and 2 are subdivided into parts A and B, which can be ordered separately.

Block 2: Five sub-kits to be used at the community and primary health care level for 30,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Sub-kit 6	Delivery sub-kit (Health Facility)	Brown
Sub-kit 7	IUD sub-kit	Black
Sub-kit 8	Management of Complications of Abortion sub-kit	Yellow
Sub-kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination sub-kit	Purple
Sub-kit 10	Vacuum Extraction for Delivery (Manual) sub-kit	Grey

Block 2 is composed of five sub-kits containing disposable and reusable material. In order to prevent wastage of expensive reusable equipment, these sub-kits are designed to be used for a population of 30,000 persons over a 3-month period. However, this certainly does not exclude the sub-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 sub-kits to be used at referral hospital level for 150,000 persons / 3 months

KIT NUMBER	KIT NAME	COLOR CODE
Sub-kit 11	Referral level sub-kit for Reproductive Health (Part A + B)	Fluorescent Green
Sub-kit 12	Blood Transfusion sub-kit	Dark Green

Block 3 is composed of 2 sub-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 to Order

Reproductive Health Kits for Crisis Situations is a booklet that describes the Inter-agency RH Kit. It can be ordered from UNFPA:

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
or downloaded directly: www.rhrc.org/pdf/rhrkit.pdf

2. What is in the Interagency Emergency Health Kit 2006 (formerly the New Emergency Health Kit (NEHK) to implement the MISP?

(For 10,000 people for three months)

- Materials for universal precautions for infection control
- Equipment, supplies and drugs for deliveries at health centers
- Equipment, supplies and drugs for some obstetric emergencies
- Equipment, supplies and drugs for post-rape management

How to Order

A booklet describing the Interagency Emergency Health Kit 2006 is available from the World Health Organization:

Marketing and Dissemination
World Health Organization
20 Avenue Appia
1211 Geneva 27, Switzerland
tel: +41 22 791 2476
fax: +41 22 791 4857;
email: bookorders@who.int
or downloaded directly: www.who.int/medicines/publications/mrhealthkit.pdf

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women, children, and adolescents. We advocate for their inclusion and participation in programs of humanitarian assistance and protection. We provide technical expertise and policy advice to donors and organizations that work with refugees and the displaced. We make recommendations to policy makers based on rigorous research and information gathered on fact-finding missions. We join with refugee and internally displaced women, children, and adolescents to ensure that their voices are heard from the community level to the highest levels of governments and international organizations. We do this in the conviction that their empowerment is the surest route to the greater well-being of all forcibly displaced people.

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Revised September 2006

Monitoring Implementation of the MISP: A Check List

❖ Identify an organization(s) and individual(s) to facilitate the MISP
- Overall RH Coordinator in place and functioning under the health coordination team
- RH focal points in camps and implementing agencies in place
- Material for implementation of the MISP available and used
- Basic demographic and health data collected:
  - 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)
  - Age-specific mortality rate (including neonatal deaths 0 to 28 days)
  - Sex-specific mortality rate

Notes:

❖ Prevent and manage the consequences of sexual violence
- Coordinated multi-sectoral systems to prevent sexual violence in place
- Confidential health services to manage cases of sexual violence in place
- Staff trained (retrained) in sexual violence prevention and response

Notes:

❖ Prevent HIV transmission
- Sufficient materials in place for adequate practice of universal precautions
- Condoms procured and made available
- Health workers knowledgeable on and practice universal precautions

Notes:

❖ Prevent excess maternal and neonatal mortality and morbidity
- Clean delivery kits available and distributed
- Calculate the number of clean delivery packages needed to cover for births for 3 months (estimated population x .04 x .25)
- Midwife kits available at the health center
- Referral hospital assessed and supported for adequate number of qualified staff, equipment and supplies
- Referral system for obstetric emergencies functioning 24 hours a day, 7 days a week

Notes:

❖ Plan for provision of comprehensive RH services
- Basic information collected (mortality, HIV prevalence, contraceptive prevalence, etc.)
- Sites identified for future delivery of comprehensive RH services

Notes:

❖ Plan for provision of comprehensive RH services
- Basic background information collected
- Sites identified for future delivery of comprehensive RH services
- Staff assessed, training protocols identified
- Procurement channels identified and monthly drug consumption assessed

Notes:

Follow-up Actions

MISP Module Answers

Chapter 2

1. **a.** prevent sexual violence and respond to survivors
   c. reduce HIV transmission
   d. prevent excess maternal mortality and morbidity

Family planning services, which may reduce the number of unwanted pregnancies, are *not* part of the MISP.

2. **c.** emergency obstetric care

Family planning and antenatal care are not part of priority RH services. They should be initiated through comprehensive RH services once all components of the MISP have been implemented. Malnutrition 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 workers. MISP activities are not limited to reproductive health staff or even the general health sector. The MISP cuts across all sectors in addition to health, including food security, water and sanitation services and shelter.

4. **c.** the number of sexually active men
   d. the number of pregnant women

Determining the number of people living with HIV/AIDS and sexually transmitted infections is not part of the MISP. In addition, more than 90 percent of HIV-positive individuals in the developing world do not know their status.

5. **a.** be able to order MISP supplies internationally or obtain them locally
   b. initiate and coordinate orientation sessions for humanitarian workers on the MISP
   c. adapt and introduce simple forms for monitoring RH activities

MISP activities do not include conducting trainings.

Chapter 3

1. **a.** coordinate multi-sectoral systems to prevent sexual violence
   c. conduct a community-wide education campaign on ways to prevent sexual violence

Although it is important to ensure that the displaced population is informed of the availability and location of services for sexual violence survivors, a community-wide education campaign is not appropriate in the very beginning days of an emergency. The focus of the MISP is the prevention of rape, provision of medical care for rape survivors and ensuring the availability of essential psychosocial services. Once a situation stabilizes and all components of the MISP have been implemented, attention can be given to preventing the wider array of GBV issues, including trafficking.

2. **a.** UN personnel
   b. family members
   c. armed militia groups
   d. police officers

Perpetrators can be *anyone*: others who have been displaced by the conflict or disaster; members of 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.

3. **a.** international NGO staff
   b. local humanitarian staff
   c. UN personnel
   d. individuals contracted from the host population

In addition to international UN and NGO staff, agencies must also train local staff and anyone contracted to work with the agency on the code of conduct to ensure that anyone in the agency's service is aware of his/her responsibility to prevent sexual exploitation and abuse.

4. **a.** men distribute food and other goods
   c. lack of fuel available in or near settlement/camp

Women and girls who have to travel outside of the camp or settlement to gather firewood for cooking fuel are at increased risk for sexual assault. Women should also be involved in distributing food and other essential goods since evidence has shown that when men are solely responsible for distributing these items, women may be subject to sexual exploitation.

5. **b.** antenatal care

Chapter 4

1. **b.** people living with HIV/AIDS participate in food distribution

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

2. **a.** facilities for frequent hand washing
   b. safe handling of sharp objects
   c. cleaning, disinfecting and sterilizing medical equipment

Disposing of medical waste by burning materials and burying sharp objects ***inside*** the grounds of the health facility help to prevent the spread of HIV infection in a health care setting.

3. **b.** false

Condoms should be ordered immediately and made available to anyone, including young people, through a range of distribution points so that people can collect them privately when they want to.

4. **a.** health facilities
   b. food distribution points
   c. community service offices
   d. latrines

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

5. **a.** ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases
   b. avoid blood transfusions for non-serious medical conditions
   d. ensure sufficient HIV and other tests and supplies for screening blood where needed

Selecting donors from the community does not ensure that blood for transfusion is safe.

Chapter 5

1. **d.** sutures

Clean delivery packages do not include suture materials. These packages consist of a bar of soap, a new razor blade, a sheet of plastic, a cotton cloth, a pair of gloves and two pieces of string.

2. **b.** false

Only visibly pregnant women and TBAs need to receive clean delivery kits. This can be done upon women's registration into the camp or settlement and TBAs as they are identified.

3. **a.** ensure the baby is dried and warmly wrapped keeping its head covered immediately after birth
   b. clean the cord with soap and water
   d. encourage Kangaroo Mother Care

Women should be advised to continue breast-feeding up to two years or *longer*.

4. **d.** 4 percent

The proportion of displaced women who will be pregnant at a given time based on average estimates in developing countries is 4 percent of the total displaced population.

5. **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 referral center.

Chapter 6

1. **a.** preparing to prevent and address all forms of gender-based violence
   b. preparing to establish antenatal and postnatal care
   c. preparing to train health workers

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

2. **a.** gather data on mortality rates, STI/HIV prevalence and contraceptive prevalence
   c. assess staff capacity, develop training plans and order supplies
   d. order equipment and supplies through routine supply lines

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

3. **a.** WHO
   b. World Bank
   c. UNFPA

4. **b.** false

The MISP does not include the provision of family planning services. Contraceptive choices are offered as part of comprehensive RH services. However, in planning for comprehensive RH services contraceptive supplies should be sourced and ordered or procured.

5. **a.** privacy and confidentiality during consultations
   b. possibilities to maintain aseptic conditions
   c. communications and transport for referrals
   d. locked storage facilities for supplies and files

It is important to address all of these factors when selecting suitable sites.

Chapter 7

1. **a.** true

Female condoms are available in sub-kit 1, Part B.

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

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 the RH services program. The other tasks should be completed rapidly.

3. **b.** 3 months

The RH Kits are designed for use for 3 months for a varying level of population depending on which block of sub-kits are ordered. However, if a camp only has 5,000 people, the sub-kits from Block 1 that are packaged for 10,000 persons could still be ordered and used over a six-month period.

4. **a.** community level
   b. primary health care level
   c. referral level

The sub-kits are divided into different blocks. Block 1 is designed for the community and primary health care level, Block 2 is for the primary health care or referral hospital level and Block 3 is for use at the referral hospital level.

5. **b.** false

UNHCR does not provide RH supplies. It is best to get in touch with UNFPA in New York and Geneva as soon as a crisis unfolds to learn more about where and when supplies will be available. Depending on the setting of the crisis, it may be possible to obtain some supplies locally. For example, it may be possible to obtain male and female condoms within the region, which may prove to be quicker than ordering them from UNFPA. This decision can be made in consultation with local officials and staff who are familiar with supply issues in the region. In addition, agencies should include RH supplies within their medical supply procurement.

Notes:

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How to Order Copies

The MISP Module is available online at www.womenscommission.org and www.rhrc.org as well as on CD-ROM and in print. To order CDs or print copies, please email info@womenscommission.org.

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