MISP: Coordination Fact Sheet for Adolescent Sexual and Reproductive Health

The implementation of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations requires coordination among humanitarian actors at the local, regional, national and international levels. Effective coordination will help to ensure that resources are used efficiently, that services are distributed equally without gap or duplication, and that information is shared among all of the actors involved.

Some key elements of coordination and examples of how they can be applied to ensure that MISP implementation is adolescent-inclusive are listed below.

Cluster-level coordination:

Coordination of RH activities during an acute emergency is the responsibility of the Global Health Cluster and the Lead RH Agency, which is designated by the Health Cluster. The Lead RH Agency appoints a full-time RH Officer for a minimum period of three months, during which technical and operational support is provided to partners to ensure that RH is prioritized and that there is good coverage of MISP services. The RH Officer oversees the implementation of the MISP and liaises with field-level RH representatives and stakeholders.

The key coordination activities that should take place during MISP implementation are outlined in the following *Terms of Reference (TOR)* for the RH Officer. The table below has been adapted from a table in Chapter 2 of the IAFM. The text in black is taken directly from the table in Chapter 2 and the text in **bold orange** highlights additional responsibilities that should be added to make MISP interventions and planning for comprehensive RH services more adolescent-inclusive. While these ASRH-related interventions should ideally be mainstreamed into the regular responsibilities of the RH Officer, they have been listed separately here to highlight them.

Lead Agency: RH Officer Terms of Reference	
Coordinate, communicate and collaborate:	• Work in close collaboration with the health sector/cluster coordinator(s) and actively participate in and provide information to the health sector/cluster meetings; • Host regular RH stakeholder meetings at relevant (national, sub-national/ regional, local) levels to discuss, problem-solve, strategize and coordinate to ensure the MISP is implemented. • Ensure regular communication among all levels and that key conclusions, issues and activities are reported back to the overall health coordination mechanism to identify synergies and avoid duplication of efforts and parallel structures; • Liaise with other sectors (Protection, GBV, HIV/AIDS) addressing RH; • Procure reference/resource materials and supplies for implementing the MISP; • Provide technical and operational guidance on implementing the MISP and audience-specific orientation on the MISP when and where it is feasible (e.g., for service providers, community health workers, program staff and the beneficiary population including adolescents); • Inform the health sector/cluster lead(s) of issues requiring response (EG, policy or other barriers that restrict the population's access to MISP services); • Disseminate MISP Summary to main stakeholders • Obtain RH funding within the health sector/cluster through humanitarian planning processes and appeals.

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Lead Agency: RH Officer Terms of Reference	

Coordinate, communicate and collaborate: (continued)	• **Advocate for RH attention to adolescents during implementation of the MISP;**
	• **Identify the most vulnerable adolescents through multi-sectoral collaboration and ensure that they are able to access RH services;**
	• **Provide adolescents with information about what RH services are available and where they can be accessed;**
	• **Engage government entities on ASRH to ensure national leadership and ownership;**
	• **During planning for comprehensive RH services:**
	• **Continue multi-sectoral approaches to RH, to ensure that adolescent needs are identified and addressed;**
	  ◦ **Collaborate with other stakeholders (agencies, MOH) to ensure that adolescent RH needs are covered, without duplication of services;**
	  ◦ **Continue engaging government entities on ASRH to ensure national leadership and ownership;**
	  ◦ **Advocate with leadership of uniformed services (police, military) for establishment and enforcement of zero-tolerance policies for GBV**

Identify, familiarize and understand:	• The elements of national and host country policies, regulations and customary laws that support MISP activities; • The elements of national and host country policies, regulations and customary laws that create barriers and restrict access of the affected population to MISP services; • Relevant MOH standardized protocols for selected areas (such as clinical management of rape and referral of obstetric emergencies; and, when planning for comprehensive RH services, syndromic case management of STIs and FP). If MOH policies do not exist, defer to and apply WHO protocols; • **Review and update standardized RH protocols to ensure they address the needs of adolescents.**

Obtain basic demographic and health information:	• Work within the health sector/cluster to ensure collection or estimation of basic demographic and health information of the affected population including:
	  ◦ Total population;
	  ◦ Number of women of reproductive age (ages 15 to 49, estimated at 25 percent of the population);
	  ◦ Number of sexually active men (estimated at 20 percent of the population);
	  ◦ Crude birth rate (estimated at 4 percent of the population);
	  ◦ Age-specific mortality rate (including newborn mortality rate newborn deaths 0 to 28 days);
	• Use MISP checklist to monitor services. Work within context of overall health coordination structure to collect services delivery information, analyze findings, and to respond to identified service-delivery gaps;
	• **Incorporate indicators that capture adolescent demographic data as well as utilization of RH services;**
	• **During planning for comprehensive RH services:**
	  ◦ **Monitor, analyze and report on adolescent RH services using standardized indicators on a monthly basis.**

SRH interventions, including implementation of the MISP, should be discussed in the Health Cluster (or within the health sector, in situations in which the Cluster is not activated). This will allow coordination of activities among NGOs, UN agencies, and national authorities and will ensure coverage of services without duplication or gaps. All RH staff should advocate for inclusion of adolescents during MISP implementation.

ASRH EXAMPLE: CLUSTER-LEVEL COORDINATION

After an escalation in fighting in the region, there is a massive influx of internally displaced persons (IDPs) into a camp where your agency provides health services. Your agency has been designated by the Global Health Cluster to take the lead on RH coordination for implementation of the MISP and you are designated as the RH Program Officer. You have been informed that there is a large number of unaccompanied adolescents among the new arrivals. Knowing that these adolescents are at high risk for RH and social problems, you advocate with the Health and Protection Clusters to designate stakeholders responsible for addressing the needs of the most-at-risk adolescents in the camp.

Multi-sectoral approaches to SRH:

Multi-sectoral approaches to SRH, involving health, protection, mental health and psychosocial support services, community services, camp management and education, promote coordination and increase the likelihood that vulnerable adolescents will have access to RH information and services. SRH (including ASRH) concerns are discussed at multi-sectoral coordination meetings, so that integrated approaches can be identified to address the problems.

ASRH EXAMPLE: MULTI-SECTORAL APPROACHES TO SRH

After recent political elections, there is widespread civil unrest and massive displacement of the population. There are reports that many young girls have been raped during the violent protests that have swept through the villages. A multi-sectoral GBV working group is formed, comprising adolescents and representatives from the various sectors. The working group develops strategies to ensure that adolescent-friendly health services are in place for survivors of sexual assault and establishes an inter-sectoral referral network for survivors. The group works with each sector to identify vulnerable adolescents and ensure that they have information regarding the RH services that are available, and it evaluates prevention measures to ensure that they adequately protect the most-at-risk adolescents.

Orientation to the MISP:

Audience-specific orientations should be conducted to introduce relevant stakeholders, including health workers, the beneficiary population, community service staff and uniformed personnel to the MISP.

ASRH EXAMPLE: MISP ORIENTATION

MISP orientation sessions are held with adolescent clubs, at schools, and other places where adolescents gather, to inform them about the ASRH services being provided and where and how they can be accessed. It also provides a forum for their participation and ability to educate other adolescents on the services available through the MISP as well as informing about potential adolescent-oriented sites for free condom distribution.

Use of standardized RH protocols:

To promote quality service provision, standardized RH protocols should be used (either MOH protocols, or if these do not exist, WHO protocols) and should be revised to meet the specific needs of adolescents. Standardized MISP protocols could include (1) adolescent-friendly clinical services, (2) clinical management of survivors of sexual violence, (3) treatment and referral of clients with obstetric emergencies, (4) standard precautions[13], and (5) condom distribution. As the situation stabilizes, program managers should also review comprehensive standardized protocols to see that they address the specific needs of adolescents and that they reflect adolescents' rights to access to RH information and services.

ASRH EXAMPLE: USING STANDARDIZED RH PROTOCOLS

After the acute crisis has stabilized, the RH program manager reviews the FP protocols at a health facility and notes that they state that *FP services will be available to all married women Monday through Friday from 8 am to 12 pm*. She realizes that this will exclude not only unmarried adolescents, but also those who attend school. After discussion with the clinic director and the RH staff, this is changed to state that *FP services will be available during all hours of clinic operation and are offered to all women and men, including adolescents, regardless of their marital status.*

Monitoring MISP services:

MISP outcomes should be monitored using the MISP service availability checklist, which is available in Chapter 2 of the Inter-agency Field Manual. In addition, the Adolescent-Friendly Services checklist found in this toolkit can be used to assess health facilities.

Further information about the MISP can be found in the MISP chapter *Reproductive Health in Refugee Situations: An Inter-agency Field Manua*l and the Minimum Initial Service Package Distance Learning Module, available at www.misp.rhrc.org.

ASRH EXAMPLE: MONITORING MISP SERVICES

As part of its emergency response to an earthquake, an agency monitored the services provided through implementation of the MISP. The program manager found that there was information lacking about adolescent reproductive health services and incorporated the following revisions to the data collection tools:

- *Total population, disaggregated by age and sex:* (under 10 years, 10-14 years and 15-19 years)
- *Number of condoms distributed + Number of condoms distributed at adolescent-friendly locations*
- *Number of sexual violence cases reported in all sectors, disaggregated by age and sex (under 10 years; 10-14 years; 15-19 years; 20 years or above)*