UNIT 1: WHAT IS THE MISP FOR SRH?

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is a coordinated set of lifesaving priority SRH activities and services to be implemented at the onset (within 48 hours whenever possible) of every humanitarian emergency.

The goal of the MISP for SRH is to prevent SRH-related morbidity and mortality while protecting the right of the affected community to life with dignity. Its objectives are to ensure identification of an organization to lead the implementation of the MISP for SRH, prevent sexual violence and respond to the needs of survivors, prevent the transmission of and reduce morbidity and mortality due to human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancies, and plan for comprehensive SRH services integrated into primary health care as soon as possible. Other priority activities of the MISP for SRH include access to safe abortion care (SAC) to the full extent of the law.

This set of priority activities must be implemented at the onset of a crisis in a coordinated manner by trained staff. The MISP for SRH can be implemented without an in-depth SRH needs assessment because documented evidence already justifies its use. However, some initial situational, demographic, and health information about the crisis-affected population must be determined with the health coordination mechanism for the optimum delivery of MISP for SRH activities and advocacy. It is important to note that these activities form a minimum requirement, and it is expected that they be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming as soon as the situation allows.

At the end of the unit, learners will be able to:

- list the objectives and priorities of the MISP for SRH;
- explain why the MISP for SRH is a priority in humanitarian emergencies;
- explain the importance of involving crisis-affected populations in the planning and implementation of MISP for SRH services; and
- explain how to monitor and obtain funding for the MISP for SRH.

MISP for SRH objectives and activities

There are six MISP for SRH objectives and one other priority. These include:

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP. The lead SRH organization:[14]

- nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services;
- hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP for SRH;
- reports back to the health sector/cluster, gender-based violence (GBV) sub-sector/cluster, and/or HIV national coordination meetings on any issues related to MISP implementation;
- in tandem with health/GBV/HIV coordination mechanisms, ensures mapping and analysis of existing SRH services;
- shares information about the availability of SRH services and commodities in coordination with the health and logistics sectors/clusters; and
- ensures the community is aware of the availability and location of SRH services.

Prevent sexual violence and respond to the needs of survivors by:

- working with other clusters, especially the protection cluster and GBV sub-cluster, to put in place preventative measures at community, local, and district levels, including health facilities, to protect affected populations, particularly women and girls, from sexual violence;
- making clinical care and referral to other supportive services available for survivors of sexual violence; and
- putting in place confidential and safe spaces within health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

14 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2018 Revision* (Inter-Agency Working Group on Reproductive Health in Crises, 2018), http://iawg.net/wp-content/uploads/2018/11/IAFM-web.pdf.

Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs by:

- establishing safe and rational use of blood transfusion;
- ensuring application of standard precautions;
- guaranteeing the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population before the crisis), ensure provision of female condoms;
- supporting the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an antiretroviral therapy (ART) program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs;
- providing post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure;
- supporting the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV; and
- ensuring the availability in health facilities of syndromic diagnosis and treatment of STIs.

Prevent excess maternal and newborn morbidity and mortality by:

- ensuring availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services, including:
  - at referral hospital level: skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC);
  - at health facility level: skilled birth attendants and supplies for vaginal births and provision of basic emergency obstetric and newborn care (BEmONC);
  - at community level: provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities; clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible;
- establishing a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital;
- ensuring the availability of lifesaving post-abortion care in health centers and hospitals; and
- ensuring availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable.

Prevent unintended pregnancies by:

- ensuring availability of a range of long-acting, reversible and short-acting contraceptive methods (including male and female [where already used] condoms and emergency contraception [EC]) at primary health care facilities to meet demand;
- providing information, including existing information, education, and communication materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and nondiscrimination; and
- ensuring the community is aware of the availability of contraceptives for women, adolescents, and men.

Plan for comprehensive SRH services integrated into primary health care as soon as possible.

- Work with the health sector/cluster partners to address the six health system building blocks: service delivery, health workforce, health information system, medical commodities, financing, and governance and leadership.

Other Priority

- It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

What is sexual and reproductive health (SRH)?

The International Conference on Population and Development defined SRH as "a state of complete physical, mental, and social well-being in all matters relating to the reproductive system and its functions and processes."[15]

This definition implies that women, men, and adolescents, including those living in humanitarian settings, have the right to:

- a satisfying and safe sex life;
- freedom to decide if, when, and how often to reproduce;
- information about and access to quality, safe, effective, affordable, and acceptable contraceptive methods of their choice;
- appropriate health care services that enable safe pregnancies and deliveries and protect the health of their infants;
- information on HIV and STI prevention and treatment; and
- interventions and strategies for fertility regulation to the full extent of the law.

15 United Nations, *"Programme of Action"* (adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994), paragraph 7.2, https://unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.

Why is the MISP for SRH a priority?

The components of the MISP for SRH represent critical, lifesaving health actions that must be implemented simultaneously with other lifesaving activities. The MISP for SRH is essential to reducing death, illness, and disability while protecting the right to life with dignity. Crisis-affected communities have a right to access these services and a right to comprehensive SRH information so that they can make free and informed choices.

If the MISP for SRH is ignored or not prioritized in a humanitarian response, use these points in your advocacy with United Nations (UN), national policy makers, nongovernmental organizations (NGOs), and others.

The MISP for SRH is:

- an internationally recognized, universal minimum standard of disaster response;
- a Central Emergency Response Fund (CERF) minimum lifesaving criterion eligible for CERF funding;
- integrated in the global health cluster guidance; and
- integrated into the 2018 revision of the Sphere Minimum Standards in Disaster Response SRH and HIV standards.

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

The lives of people affected by crises are put at risk when the MISP for SRH is not implemented. For example, women and girls can be at risk of sexual violence when attempting to access food, firewood, water, and latrines. Their shelter may 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 individuals, especially women and girls, by withholding access to essential goods in exchange for sex.

If the MISP for SRH is ignored, health facilities may not have services available to provide clinical management for survivors of sexual violence. In addition, not observing standard precautions in a health care setting may allow the transmission of HIV and other infections to patients or health workers, and not ensuring medications for HIV prevention and treatment (PEP and ART) and treatment for STIs in clinics may increase transmission rates. Moreover, a lack of contraceptive methods may lead to unintended pregnancies and, without a referral system in place to transfer patients in need of basic or comprehensive EmONC services in an equipped health facility, women and newborns may die or suffer long-term injuries (e.g., obstetric fistula) or illness.

The MISP for SRH provides an outline of the basic steps to be taken in order to save lives, preserve health, and avoid these and other negative consequences.

Who is responsible for implementing the MISP for SRH?

The health sector/cluster and the Ministry of Health are responsible for ensuring that MISP for SRH priority activities are implemented. However, not all MISP for SRH activities are limited to the health sector/cluster. For example, activities to prevent and respond to sexual violence cut across the protection, food/nutrition, education, water, sanitation and hygiene, and shelter sectors/clusters. The critical role that must be played by the health sector/cluster in implementing the MISP for SRH is reflected in the Inter-Agency Standing Committee (IASC) health cluster tools and guidance.[16]

What are the fundamental principles of SRH programming in humanitarian settings?

The principles are values developed through consultations with stakeholders in the humanitarian and SRH sectors and should be used to help guide action. These include:

- working in respectful partnership with people receiving care, providers, and local and international partners;
- ensuring equality by meeting people's varied SRH needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality;
- providing comprehensive, evidenced-based, and accessible information and choice about the supplies and services;
- ensuring effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities;
- ensuring privacy and confidentiality for everyone and treating people with dignity and respect;
- promoting equity with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g., rural/urban), disability, race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth, or other characteristics;
- recognizing and addressing gender and power dynamics in health care facilities to ensure that people do not experience coercion, discrimination, or violence/ mistreatment/disrespect/abuse in receiving or providing health services;
- engaging and mobilizing the community, including often-marginalized populations, such as adolescents, in community outreach to inform the community about the availability and location of MISP services and commodities; and
- monitoring services and supplies and sharing information and results with the aim of improving quality of care.

16 *Health Cluster Guide: A Practical Guide for Country-Level Implementation of the Health Cluster* (Inter-Agency Standing Committee, 2009), https://www.who.int/health-cluster/resources/publications/hc-guide/en/.

How are crisis-affected populations and communities involved?

Though it may be difficult in the earliest days of a crisis, every effort should be made to ensure crisis-affected populations, including women, adolescents, and men, are involved in the program planning and implementation of MISP for SRH services from the onset of an emergency. To ensure all members of the population are involved, it is important to reach out to groups with particular vulnerabilities, including lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) people and persons with disabilities, while taking care to safeguard their protection. At minimum, affected communities must be informed of the benefits of seeking services—such as clinical care for survivors of sexual violence, contraception, and EmONC—and how and where to access these services.

To improve and enhance community access and equity and to support inclusive services, organizations can examine program data to understand service utilization and partner with local groups to provide education and information to underrepresented groups. By encouraging involvement from diverse community groups, respectful partnerships can develop and improve SRH service coverage and quality.

LGBTQIA Definitions

Lesbian	A woman who is emotionally, romantically, or sexually attracted to other women.
Gay	A person who is emotionally, romantically, or sexually attracted to members of the same gender.
Bisexual	A person who is emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity, though not necessarily simultaneously, in the same way, or to the same degree.
Transgender	An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
Queer	A term often used to express fluid identities and orientations.
Questioning	A term often used to describe people who are in the process of exploring their sexual orientation or gender identity.
Intersex	An umbrella term often used to describe a wide range of natural bodily variations. In some cases, these traits are visible at birth, and in others they are not apparent until puberty. Some chromosomal variations of this type may not be physically apparent at all.
Asexual	The lack of a sexual attraction or desire for other people.

Source: "Glossary of Terms," Human Rights Campaign, accessed April 8, 2019, https://www.hrc.org/resources/glossary-of-terms.

What tools are available to support service providers in delivering information to communities on the MISP for SRH?

The Women's Refugee Commission has developed *Universal and Adaptable Information, Education, and Communication Templates on the MISP for SRH* for crisis-affected populations on the importance of seeking care after sexual assault and accessing care for obstetric complications, as well as *Family Planning Information, Education, and Communication Templates* to support service providers in providing information to clients.[17] These templates speak to three MISP for SRH objectives and are intended to aid service providers in their efforts to inform communities in diverse crisis settings about the available services and the benefits of seeking care.

Where can I find these and other resources for MISP for SRH implementation?

On the IAWG on RH in Crises website's "MISP for SRH Area of Focus" resource page you will find materials and resources for implementation, including the information, education, and communication materials, MISP for SRH process evaluation tools, checklists, the MISP for SRH calculator—which calculates the SRH statistics necessary for advocacy, programming, and fundraising (see Appendix C)—and more.

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

In the immediate aftermath of a crisis, the disruption of families and communities, coupled with the loss of educational opportunities, jobs, and other meaningful activities are common challenges for adolescents and can greatly affect their ability to protect themselves. As a result of displacement, they may have lost access to family, peer networks, religious institutions, social supports, and health services, which can lead to environments that are violent or unhealthy. With the breakdown of law and order, adolescents, particularly girls, are especially vulnerable to sexual coercion, exploitation and violence, and early and forced marriages, which further increases the risks of unintended pregnancy, complications during pregnancy and childbirth, unsafe abortions, and STIs, including HIV.

Adolescents' resilience and resourcefulness can help them cope with their circumstances and support their communities. They should be provided with opportunities to participate in designing, coordinating, and implementing accessible, acceptable, and appropriate MISP for SRH services to help ensure their needs are considered and addressed from the onset of the emergency.[18]

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17 Download the information, education, and communication templates at http://iawg.net/resource/universal-adaptable-information-education-communication-iec-templates-misp and the family planning templates at http://iawg.net/resource/universal-and-adaptable-information-education-and-communication-templates-on-family-planning/.

18 Save the Children and United Nations Population Fund, *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (UNFPA, 2010), https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf.

Why is it important to consider urban populations, mobile populations, and remote programming for MISP for SRH implementation?

In each of these situations, providing health services can be challenging due to security, logistical, or communication challenges.

Urban: The world is undergoing a rapid global urbanization process. Today, 55% of the world's population is living in urban areas, and it is predicted that by 2050, 68% of the global population will be living in urban areas.[19] Approximately 60% of all refugees and 80% of internally displaced persons live in urban areas where opportunities, such as employment, are more accessible.[20] However, health systems in urban settings are often already stretched and may not be able to support an influx of crisis-affected persons.

Mobile populations: In recent years, we have seen a rise in mobile populations and migration. Some barriers preventing migrants from accessing health services include a lack of information, language, costs, and fear of arrest or deportation.[21]

Remote programming: The shifting characteristics of crises have led to security and logistical challenges that can restrict humanitarian organizations' ability to safely and effectively provide relief to some conflict and disaster-affected populations.[22] Remote programming has become more common in protracted, fragile, and conflict-affected settings where access is severely restricted.

For crisis-affected women and adolescents, obtaining health and other services is often a challenge in these settings because of cultural, social, economic, and safety/security barriers. Further, they may not have information about what services exist and where. Studies have found that pregnant women living in conflict-affected areas or who are mobile have higher rates of pregnancy-related complications leading to higher rates of maternal and neonatal death, often due to reduced access to and lower standards of care.[23]

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19 *World Urbanization Prospects: The 2018 Revision* (United Nations, Department of Economic and Social Affairs, Population Division, 2018), https://population.un.org/wup/Publications/Files/WUP2018-KeyFacts.pdf.

20 Hans Park, "The Power of Cities," The UN Refugee Agency, November 25, 2016, https://www.unhcr.org/innovation/the-power-of-cities.

21 *New Walled Order: How Barriers to Basic Services Turn Migration into a Humanitarian Crisis* (International Federation of Red Cross and Red Crescent Societies, July 2018), http://media.ifrc.org/wpcontent/uploads/sites/5/2018/07/Migration-policy-Report-Final-LR.pdf.

22 Simran Chaudhri, Kristina Cordes, and Nathan Miller, *Humanitarian Programming and Monitoring in Inaccessible Conflict Settings: A Literature Review* (WHO, February 2017), https://www.who.int/health-cluster/resources/publications/remote-lit-review.pdf.

23 Olivia Tulloch, Fortunate Machingura, and Claire Melamed, *Health, Migration and the 2030 Agenda for Sustainable Development* (Overseas Development Institute, July 2016), https://www.odi.org/sites/odi.org.uk/files/resource-documents/10761.pdf; A.D. Akol, S. Caluwaerts, and A.D. Weeks, "Pregnant Women in War Zones," BMJ (April 20, 2016), 353, https://doi.org/10.1136/bmj.i2037.

All actors should work together to address these challenges and protect the safety and well-being of people living in these contexts.[24] Since the provision of health care differs by country and situation, one recommended approach is to conduct a rapid mapping of the available health facilities and systems, including the Ministry of Health, NGOs, and faith-based services. In the case of mobile populations, services should be mapped in the clusters'/sectors' location and in other areas/countries along common migration routes. Provide accurate information to women, adolescents, and other groups with specific vulnerabilities about how and where to access the services they may need when there's a comprehensive list to consult. Another approach is to establish partnerships with local organizations that are part of a community structure and that are better able to find local solutions to ensure that no one is left behind and that all those who are affected by the crisis and in need of services are reached.

How can MISP for SRH implementation be monitored?

The MISP for SRH Checklist (see Appendix B) can be used to monitor SRH service provision in each humanitarian emergency. This may be done through verbal reporting by SRH Coordinators and/or through observation visits. At the onset of the humanitarian response, weekly monitoring should be implemented. Once services are fully established and agreed upon, routine monitoring and evaluation should be conducted to determine progress toward quality MISP and comprehensive SRH services.

The Health Resources Availability Monitoring System (HeRAMS) is another tool to monitor MISP for SRH implementation and support coordination and decision-making among health actors.[25] HeRAMS is a software-based information system developed to support the monitoring and assessment of the status of health facilities and the availability of health services and resources in different areas affected by emergencies by the type of service and level of care. The four areas monitored by HeRAMS are health facilities, resources for health services, services provided (including those specific to the MISP for SRH), and reasons why services are unavailable.

The Emergency Health Information System Toolkit, developed by United Nations High Commissioner for Refugees (UNHCR), includes key SRH indicators to inform data collection at the health facility level to be collected from the onset of an emergency.[26] This data can be used to discuss gaps and overlaps in service coverage within the health sector/cluster coordination mechanisms and to find and implement solutions.

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24 Additional information on remote programming and mobile and migrant populations include: *To Stay and Deliver, Good practice for humanitarians in complex security environments* (OCHA, 2011), https://www.unocha.org/sites/unocha/files/Stay_and_Deliver.pdf. *HUMANITARIAN PROGRAMMING AND MONITORING IN INACCESSIBLE CONFLICT SETTINGS*: *A Literature Review* (WHO Global Health Cluster, February 2017), http://www.who.int/health-cluster/resources/publications/remote-lit-review.pdf. Antonio Donini and Daniel Maxwell, "From face-to-face to face-to-screen: remote management, effectiveness and accountability of humanitarian action in insecure environments," *International Review of the Red Cross, 95, pp 383-413 doi:10.1017/S1816383114000265.* Peta Sandison, *Limited Access Humanitarian Programming Operational Guidance for Managing Programme Quality* Version 1 (Oxfam, January 2017), https://www.medbox.org/limited-access-humanitarian-programming/download.pdf. *Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants* (WHO African Region, 2018), www.who.int/migrants/publications/AFRO-Practices.pdf.

25 More information about HeRAMS can be accessed at https://www.who.int/hac/herams/en/.

26 "Health Information System Toolkit," UNHCR, accessed April 8, 2019, https://www.unhcr.org/protection/health/4a3374408/health-information-system-toolkit.htm/.

How can an agency obtain funding to support MISP for SRH activities?

Since the MISP for SRH meets the lifesaving criteria of the CERF,[27] NGOs can access CERF funds from the United Nations by submitting proposals for projects that are part of the humanitarian planning and appeals process. Country-based Pooled Funds provide another funding option as do Humanitarian Response Plans. Proposals should describe the priority SRH activities as outlined in the MISP as the first SRH components to be addressed, followed by an expansion of SRH programming as soon as the situation allows.

Organizations responding to a crisis should also include funding for MISP for SRH activities in proposals to donors, such as Australian Department of Foreign Affairs and Trade (DFAT), United States (U.S.) Bureau for Population, Refugees, and Migration (BPRM), Global Affairs Canada (GAC), Department for International Development (DFID) of the United Kingdom, European Civil Protection and Humanitarian Aid Operations (ECHO), Ministry of Foreign Affairs Denmark, Ministry of Foreign Affairs of the Netherlands, Norwegian Agency for Development Cooperation, Office of U.S. Foreign Disaster Assistance (OFDA), Swedish International Development Cooperation Agency (Sida), UNHCR, United Nations Population Fund (UNFPA), and private donors who may support emergency response activities (see Appendix D for a sample of a funding proposal).[28]

It may be helpful to cite the Sphere SRH and HIV standards in proposals. In the 2018 edition of *The Sphere Handbook*, priority activities of the MISP for SRH are included within the standards on sexual and reproductive health: "Standard 2.3.1 Reproductive maternal and newborn health care," "Standard 2.3.2 Sexual violence and clinical management of rape," and "Standard 2.3.3 HIV."[29]

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

Essential medicines, equipment, and supplies to implement the MISP for SRH have been assembled into specially designed prepackaged kits: The Inter-Agency Emergency Reproductive Health (IARH) Kits. These kits, managed by UNFPA on behalf of the IAWG on RH in Crises, are designed to be globally applicable in the initial phase of any acute emergency. Some of the medicines and medical devices contained in the kits, however, may not be appropriate for all settings. This is inevitable as these are standardized emergency kits, designed for worldwide use, prepacked and kept ready for immediate dispatch. Not all settings may need all kits, depending on the availability of supplies in the setting prior to the crisis and the capacity of the health facilities. Additionally, some essential commodities are not included in the IARH Kits but can be ordered as complementary commodities under specific circumstances to complement the main kits. Supplies should be discussed

27 *Lifesaving Criteria and Sectoral Activities* (Central Emergency Response Fund, 2010) https://cerf.un.org/.

28 "Guidelines for Proposals," USAID, accessed April 8, 2019, https://www.usaid.gov/what-we-do/working-crises-and-conflict/crisis-response/resources/guidelines-proposals; "Funding Opportunities," US Department of State, accessed April 8, 2019, https://www.state.gov/j/prm/funding; "Funding for Humanitarian Aid," European Civil Protection And Humanitarian Aid Operations, accessed April 8, 2019, http://ec.europa.eu/echo/funding-evaluations/funding-humanitarian-aid_en; Australian Government Department of Foreign Affairs and Trade (website), accessed April 8, 2019, https://dfat.gov.au.

29 *The Sphere Handbook 2018* (Sphere, 2018), https://www.spherestandards.org/handbook/.

in the health sector/cluster and/or the SRH sub-sector/working group meetings and in the emergency preparedness phase.

To avoid the interruption of lifesaving SRH supplies during emergencies, humanitarian actors should keep in mind that strengthening locally sustainable supply chains is critical not only during the expansion of services toward comprehensive SRH programming but also in the acute phase of an emergency when the MISP for SRH is being implemented. Given that logistical problems are common in crisis settings, particularly for health supplies, partners in the SRH sub-subsector/working group and the health sector/cluster should work closely with the logistics sector/cluster and other health partners. Relevant humanitarian actors should work to ensure the integration of humanitarian health supplies into logistics planning and quickly identify and ensure needs-based SRH supplies are included within overall medical supply procurement to avoid shortages and stockouts.

For more information about supplies and logistics, please see Unit 9, Chapter 4 in the 2018 *IAFM*, and the *IARH Kit Manual* (2019) and accompanying materials.

Is the MISP for SRH only for acute emergencies?

The MISP for SRH is not only applicable to acute crises. The *Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery* framework includes ensuring the clinical components of the MISP for SRH, achieving equitable coverage, and sustaining services as they are integrated into comprehensive SRH programming in protracted crises and throughout recovery.[30] It is important to note that in some protracted and post-crisis settings, the priority clinical services of the MISP for SRH are not yet in place. In this case, existing SRH programming should not be suspended or reduced but immediately improved to include all priority services of the MISP for SRH.

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

Local communities, district and state representatives, and humanitarian, disaster and development agencies should prioritize SRH in health emergency management policies, including emergency preparedness and contingency plans. Such plans could include training national, local, and community-based health workers in the MISP for SRH; identifying a system to map available services both prior to and at the onset of an emergency; identifying coordination and communication strategies; planning emergency human resources; and developing logistics plans for stockpiling, managing, ordering, and disseminating MISP for SRH supplies. Here are two examples of resources to support such preparedness efforts:

The Sexual and Reproductive Health Program in Crisis and Post-Crisis Situations (SPRINT) Initiative in East and Southeast Asia and the Pacific was developed with funding

30 *Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery* (Andalusian School of Public Health, UNFPA, and WHO), accessed April 8, 2019, https://www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf.

from the Australian government after the ninth IAWG on RH in Crises meeting in October 2006, held in Sydney, Australia. The initiative's aim is to improve access to SRH services and information for populations living in humanitarian settings. It is now in its third phase and focuses on South and Southeast Asia and the Pacific, with the objectives to ensure that:

- the policy and funding environment is increasingly supportive of SRH and rights in humanitarian settings;
- there is increased national capacity to coordinate the implementation of the MISP for SRH in crises; and
- the MISP for SRH is implemented in a timely manner in crises.

The SPRINT Initiative is managed by International Planned Parenthood Federation (IPPF) and works closely with partners such as UNFPA, the Women's Refugee Commission, and other IAWG on RH in Crises members. For more information on the SPRINT Initiative and IPPF's humanitarian work, please visit www.ippf.org/our-priorities/humanitarian.

The IAWG on RH in Crises Training Partnership Initiative was formed in 2006 to address clinical service gaps in the implementation of MISP for SRH. The IAWG Training Partnership Initiative focuses on an integrated, inclusive, and comprehensive approach to increase regional, national, and local capacity to effectively coordinate and deliver quality SRH services from the onset of an emergency and to conduct effective planning for and the implementation of integrated comprehensive SRH services. For more information on the IAWG Training Partnership Initiative, please visit iawg.net.

Unit 1: Key Points

- The six objectives of the MISP for SRH include: ensure identification of an organization to lead the implementation of the MISP for SRH, prevent sexual violence and respond to the needs of survivors, prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs, prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancies, and plan for comprehensive SRH integrated into primary health care as soon as possible. Other priority activities of the MISP for SRH include access to safe abortion care to the full extent of the law.
- The MISP for SRH is essential to reducing death, illness, and disability while protecting the right to life with dignity.
- Every effort should be made to ensure crisis-affected populations, including women, adolescents, and men, are involved in the program planning and implementation of MISP for SRH services from the onset of an emergency. At minimum, affected communities must be informed of the benefits of seeking services—such as clinical care for survivors of sexual violence, contraception, and EmONC—and how and where to access these services.
- The MISP for SRH Checklist can be used to monitor SRH service provision and coordination in humanitarian emergencies.
- Organizations responding to a crisis should include funding for MISP for SRH activities in proposals to donors.