



WOMEN'S
REFUGEE
COMMISSION



INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

MINIMUM INITIAL
SERVICE PACKAGE
MISP

**FOR SEXUAL AND
REPRODUCTIVE
HEALTH (SRH) IN CRISIS
SITUATIONS: A DISTANCE
LEARNING MODULE**



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The current Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) module is based on the 2018 revision of the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises' *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, "Chapter 3: Minimum Initial Service Package." This version of the distance learning module, as led by the Women's Refugee Commission and IAWG on RH in Crises, was revised by Heather Lorenzen, an independent consultant, and designed by Little Man Project. A volunteer task team also provided overall direction and guidance. Task team members include Raya Alchukr (United Nations Population Fund [UNFPA]), Melissa Garcia (International Consortium for Emergency Contraception/Management Sciences for Health), Alison Greer (IAWG on RH in Crises Secretariat/Women's Refugee Commission), Virginie Jouanicot (Save the Children), Sandra Krause (Women's Refugee Commission), and Chelsea L. Ricker (independent consultant). The task team thanks Luna Mehraïn from the International Planned Parenthood Federation (IPPF), Danielle Jurman and Nadine Cornier from UNFPA, and Sarah Rich, Hilary Wartinger, and Lily Jacobi from the Women's Refugee Commission for their contributions. The following IAWG on RH in Crises Sub-Working Groups also contributed to the review and finalization of this module: Adolescent SRH, Gender-Based Violence, Supplies, Maternal and Newborn Health, MISP for SRH, Safe Abortion Care, and Voluntary Contraception.

The original 2007 MISP for SRH distance learning module was principally developed by Julia Matthews, formerly of the Women's Refugee Commission; Sandra Krause of the Women's Refugee Commission; and Sarah Chynoweth of IPPF. Diana Quick of the Women's Refugee Commission provided project and editorial oversight. The 2011 revision of the module was updated to reflect the 2010 revised *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* by Sandra Krause and Sarah Chynoweth and was edited by Diana Quick with thanks to the following IAWG on RH in Crises colleagues: Ribka Amsalu, Wilma Doedens, Brad Kerner, Cecile Mazzacurati, Chen Reis, Marian Schilperoord, and Mihoko Tanabe.

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About the Women’s Refugee Commission and IAWG on Reproductive Health in Crises

The Women’s Refugee Commission improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice. Since our founding in 1989, we have been a leading expert on addressing the needs of refugee women and children and the policies that can protect and empower them. The Women’s Refugee Commission is the host of the IAWG on RH in Crises.

The IAWG on RH in Crises is a broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for people affected by conflict and natural disasters. Formed in 1995 as the Inter-Agency Working Group on RH in Refugee Situations, the coalition works to document gaps, accomplishments, and lessons learned; evaluate the state of SRH in the field; establish technical standards for the delivery of SRH services; build and disseminate evidence to policy makers, managers, and practitioners; and advocate for the inclusion of crisis-affected persons in global development and humanitarian agendas. The IAWG on RH in Crises is led by a 19-member Steering Committee that includes United Nations agencies and nongovernmental humanitarian, development, research, and advocacy organizations and had over 2,800 individual members from 450 agencies in 2018.

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ACRONYM LIST

AIDS	Acquired immunodeficiency syndrome
BEmONC	Basic emergency obstetric and newborn care
CBR	Crude birth rate
CEmONC	Comprehensive emergency obstetric and newborn care
CERF	Central Emergency Response Fund
EC	Emergency contraception
EmONC	Emergency obstetric and newborn care
GBV	Gender-based violence
HeRAMS	Health Resources Availability Monitoring System
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IAFM	Inter-Agency Field Manual
IARH	Inter-Agency Emergency Reproductive Health (Kits)
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group (on Reproductive Health in Crises)
IEHK	Inter-Agency Emergency Health Kit
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LGBTQIA	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual

MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
NGO	Nongovernmental organization
PAC	Post-abortion care
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission (of HIV)
RH	Reproductive health
SAC	Safe abortion care
SitRep	Situation report
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme 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
WFP	World Food Programme

ABOUT THE MISP FOR SRH DISTANCE LEARNING MODULE

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) distance learning module aims to increase humanitarian actors' and stakeholders' knowledge of the priority SRH services that must be initiated at the onset of a humanitarian crisis and scaled up for equitable coverage throughout protracted crises and recovery. This includes planning for and implementing comprehensive SRH services as soon as possible following a crisis.

The MISP for SRH was first articulated in 1996 in the field-test version of the *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual*, a resource developed by the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises. *The Inter-Agency Field Manual (IAFM)* was finalized in 1999 and widely disseminated.¹ The MISP for SRH was then updated and revised in the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review* and again in *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018*. The 2018 version of the *IAFM* represents the consensus of representatives from agencies working on SRH in the humanitarian sector and reflects the best available evidence on clinical practice and program implementation at the end of 2017. The revision process was led by the *IAFM* Revision Taskforce, a body comprising more than 50 individuals from 21 United Nations agencies, international nongovernmental organizations, and academic institutions and guided by a consultant with subject matter expertise.

Unless a specific reference is given, the information provided in this learning module is based on the 2018 revision of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*.

¹ *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* (Inter-Agency Working Group on Reproductive Health in Crises, 1999).

What is new in the 2018 version of the MISP for SRH?

In the latest revision of the MISP for SRH, a new objective on prevention of unintended pregnancy was added, which includes the following priority activities:

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

Another change to the MISP for SRH chapter involves explicit references to safe abortion care to the full extent of the law. In addition to incorporating pregnancy options counseling and the provision of or referral for abortion services to the full extent of the law into clinical care for survivors of sexual violence, safe abortion care to the full extent of the law is now included in the MISP for SRH chapter as a standalone “other priority activity.” Lastly, guidance has been strengthened on maternal and newborn care, prevention and treatment of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), clinical care for survivors of sexual violence, and planning for comprehensive SRH services.

Who is the MISP for SRH distance learning module designed for?

The module incorporates a multisectoral set of activities to be implemented by humanitarian workers operating in health, camp design and management, logistics, community services, protection, and other sectors. The module is most relevant to members of emergency response teams and other humanitarian first responders as it focuses on populations affected by crises, such as armed conflicts and natural disasters. However, it can also be referenced as part of emergency preparedness efforts and when scaling up services to ensure more comprehensive and equitable coverage in protracted crises and throughout recovery.

How long will it take to complete the module?

The module will take approximately 5 to 7 hours to complete.

At the end of the MISP for SRH distance learning module, learners should be able to:

- ▶ define and understand each component of the MISP for SRH;
- ▶ explain the importance and lifesaving aspects of implementing the MISP for SRH in humanitarian settings;
- ▶ explain the importance of addressing SRH as a core part of the overall health response, health sector/cluster coordination, and coordination with other sectors, such as the protection sector/cluster;
- ▶ list the role and functions of the SRH lead agency/coordinator within the health sector/cluster;
- ▶ explain the most important actions for the health sector/cluster to do in a humanitarian crisis to prevent sexual violence and respond to the needs of survivors;
- ▶ describe the priority interventions for preventing the transmission of, and reducing the morbidity and mortality due to HIV and other STIs in the earliest phase of crisis situations;
- ▶ explain the priority interventions to reduce preventable maternal and newborn morbidity and mortality at the onset of an emergency;
- ▶ list priority interventions to prevent unintended pregnancies;
- ▶ describe how to plan for comprehensive SRH programming services integrated into primary health care as soon as the situation permits;
- ▶ explain how to ensure access to safe abortion care to the full extent of the law; and
- ▶ describe how to order MISP for SRH supplies internationally or obtain them locally.

How should the MISP for SRH distance learning module be taken?

The module is a self-instructional learning module. It should be read in order of the learning units and can later be used as a reference. The learner reads through each unit, completes the unit quizzes, and takes the post-test that includes questions from all units. **The online version of the distance learning module is interactive; it includes e-learning exercises to reinforce the material in the units and links to additional web-based resources.**² Case studies and lessons learned from previous humanitarian responses undertaken by members of the IAWG on RH in Crises are incorporated throughout this version of the module.

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Further guidance and information: Learners should refer to the complete 2018 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, which can be accessed at www.iawg.net/iafm.

² The website for the Inter-Agency Working Group on Reproductive Health in Crises is available from <http://www.iawg.net>.

Please Keep in Mind...

Throughout the training you will see references to the Interagency Emergency Reproductive Health (IARH) Kits. The revised 2019 IARH Kits will be available for procurement in early 2020. If you are taking this distance learning module **before the 2019 IARH Kits are available** please see information on the currently available IARH Kits at the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011).³

In what format and languages is the MISP for SRH module available?

The module is available online on the IAWG on RH in Crises' website (www.iawg.net) and the Women's Refugee Commission's website (www.womensrefugeecommission.org). Print copies can be ordered by emailing info@wrcommission.org or info.iawg@wrcommission.org. This version of the MISP for SRH module is currently available in English and will be available in French, Arabic, and Spanish in 2020.



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

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

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

Is there a way to certify completion the MISP for SRH module?

Learners who have completed the online post-test with a score of at least 80% will automatically receive a certificate of completion that can be printed and saved.

³ An online version of this resource can be accessed by visiting iawg.net/resource/inter-agency-reproductive-health-kits-2011.

INTRODUCTION

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is a set of lifesaving priority activities to be implemented from the onset of a crisis. These services are to be scaled up and sustained to ensure equitable coverage throughout protracted crises and recovery while planning to integrate comprehensive SRH into primary health care as soon as possible.

Morbidity and mortality related to SRH are significant issues, and women and girls in humanitarian emergencies suffer disproportionately from life threatening conditions due to increased barriers to health services.⁴ Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy, such as unsafe abortion; and preventable cases of sexual violence and their consequences, including unintended pregnancies, increased acquisition of sexually transmitted infections (STIs), increased transmission of human immunodeficiency virus (HIV), and ongoing mental health problems, including depression.

The MISP defines which SRH services are most important in preventing morbidity and mortality, while protecting the right to life with dignity in humanitarian settings. It is a standard for humanitarian actors and is supported by the international legal obligations of states to respect and ensure basic human rights, including SRH. All people, including those affected by crises, have a fundamental human right to SRH. To exercise this right, affected populations must have an enabling environment and access to SRH information and services so that they can make free and informed choices. The MISP for SRH services provided during a humanitarian emergency must be based on the needs of the crisis-affected populations, must respect their religious and ethical values and cultural backgrounds, and must conform to international human rights and humanitarian standards.

Despite being an internationally recognized standard, assessments undertaken by the Women's Refugee Commission and partners in 2003^{5,6}, 2004⁷, and 2005⁸ showed that

4 *Maternal Mortality in Humanitarian Crises and Fragile Settings* (United Nations Population Fund, November 2015), <https://www.unfpa.org/resources/maternal-mortality-humanitarian-crises-and-fragile-settings>.

5 *Still in Need: Reproductive Health Care for Afghan Refugees in Pakistan* (Women's Refugee Commission, October 2003), <https://www.womensrefugeecommission.org/resources/document/359-still-in-need-reproductive-health-care-for-afghan-refugees-in-pakistan>.

6 *Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Persons*, Marie Stopes International and Women's Refugee Commission, (Reproductive Health Response in Crises Consortium, February 2003), <https://www.womensrefugeecommission.org/srh-2016/resources/72-displaced-and-desperate-assessment-of-reproductive-health-for-colombia-s-internally-displaced>.

7 *Lifesaving Reproductive Health Care: Ignored and Neglected, Assessment of the Minimum Initial Service Package (MISP) for Reproductive Health for Sudanese Refugees in Chad* (Women's Refugee Commission and United Nations Population Fund, August 2004), <https://www.womensrefugeecommission.org/resources/photo-essays/60-our-fuel-and-firewood-team-in-kenya>;

8 *Reproductive Health Priorities in an Emergency: Assessment of the Minimum Initial Service Package in Tsunami-Affected Areas in Indonesia* (Women's Refugee Commission, February, 2005) https://www.womensrefugeecommission.org/images/zdocs/id_misp_eng.pdf.

implementation of the MISP for SRH was often overlooked during emergencies and few humanitarian workers were familiar with its objectives and activities. Since then, progress has been made in advancing awareness of the MISP for SRH. In September 2009, the Granada Consensus was agreed upon through an inter-agency consultation convened by the United Nations Population Fund, World Health Organization, and the Andalusian School of Public Health, providing a new commitment and framework for action. A key component of the Granada Consensus was scaling up equitable coverage of the MISP for SRH and sustaining these services in protracted crises and throughout recovery while integrating comprehensive SRH services through health systems strengthening.⁹ Inter-agency assessments in 2007 and 2010 demonstrated an increased awareness of the priority SRH services of the MISP for SRH that should be implemented; however, the services were not systemically available.¹⁰

In 2013 and 2015, inter-agency assessments of crisis settings found consistent availability of MISP for SRH services and high awareness of the MISP for SRH as a standard among responders.¹¹ An inter-agency MISP for SRH assessment in Jordan in 2013, following the influx of Syrian refugees, demonstrated increased recognition and support of the MISP for SRH through strong leadership by the Ministry of Health, United Nations agencies, and nongovernmental organizations. Coordination was appropriate at the national and camp levels but insufficient in urban areas where beneficiary participation and knowledge of services was lacking.¹² Two years later, in the 2015 assessment in Nepal following the earthquake, sizeable advances had occurred; the SRH working group (SRH sub-cluster) was established within days of the earthquake, funding and supplies were sufficient, and there was strong awareness of the MISP for SRH among humanitarian practitioners. Commitments and investments in SRH before the crisis, the existence of the MISP for SRH in preparedness activities, and the pre-positioning of Inter-Agency Emergency Reproductive Health Kits were key factors to the success. The main limitations of the Nepal MISP for SRH response included a slower activation of district-level coordination and a lack of community knowledge about SRH issues, including the benefits of seeking care and the locations of services for sexual violence, STIs, and HIV. Following the assessment, the Nepal National Family Planning Costed Implementation Plan (2015–2020) was established, and central- and district-level MISP for SRH trainings were held to mainstream the MISP for SRH into district disaster preparedness and response plans.¹³

9 *Sexual and Reproductive Health During Protracted Crises and Recovery: Report on an Expert Consultation Held in Granada, Spain, 28–30 September 2009*, Preliminary Publication (World Health Organization, 2010).

10 *Four Months On: A Snapshot of Priority Reproductive Health Activities in Haiti: An Inter-Agency MISP Assessment Conducted by CARE, International Planned Parenthood Federation, Save the Children and the Women's Refugee Commission May 17–21, 2010* (Women's Refugee Commission, October 2010).; *Reproductive Health Coordination Gap, Services Ad Hoc: Minimum Initial Service Package (MISP) Assessment in Kenya* (Women's Commission for Refugee Women and Children, September 2008), https://www.womensrefugeecommission.org/images/zdocs/ken_misp.pdf.

11 Sandra K. Krause, Sarah K. Chynoweth, and Mihoko Tanabe, "Sea-Change in Reproductive Health in Emergencies: How Systemic Improvements to Address the MISP Were Achieved," *Reproductive Health Matters*, 25, no. 51, (December 13, 2017): 7–17, DOI: 10.1080/09688080.2017.1401894.

12 Sandra Krause, Holly Williams, Monica A Onyango, Samira Sami, Wilma Doedens, Noreen Giga, Erin Stone and Barbara Tomczyk, "Reproductive Health Services for Syrian Refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: An Evaluation of the Minimum Initial Services Package," *Conflict and Health* 9, Suppl 1 (February 2, 2015): S4, <http://www.conflictandhealth.com/content/9/S1/S4>.

13 Anna Myers, Samira Sami, Monica Adhiambo Onyango, Hari Karki, Rosilawati Anggraini, and Sandra Krause "Facilitators and Barriers in Implementing the Minimum Initial Services Package (MISP) For Reproductive Health in Nepal Post-Earthquake," *Conflict and Health* 12, no. 35 (August 15, 2018), <https://doi.org/10.1186/s13031-018-0170-0>.

These are some examples of the achievements made over the years in ensuring the availability of the MISP for SRH at the onset of humanitarian responses. Although much progress has been made, more effort is required to guarantee its universal implementation in acute crises. The Women's Refugee Commission and the IAWG on RH in Crises' *Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module* is a resource and tool that provides guidance on the implementation of quality MISP for SRH services and raises awareness about the importance of addressing priority SRH services in crisis settings.





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

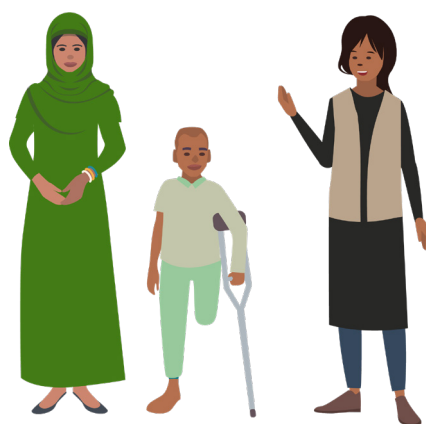
There are six MISP for SRH objectives and one other priority. These include:

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

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

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, Fortunata 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.

24 Additional information on remote programming and mobile and migrant populations include: *To Stay and Deliver, Good practice for humanitarian 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.html/>.

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.

i

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.

UNIT 2: ENSURE THE HEALTH SECTOR/CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP



Coordination of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) activities as part of the overall health sector/cluster response is essential at multiple levels, including within each agency responding to the emergency, as well as at sub-national, national, and international levels. Coordination within and among these various levels and across sectors is crucial to ensure the effectiveness of the SRH response. This is because coordination helps to identify and fill gaps in service delivery, prevent overlapping programming, strengthen advocacy, and support the application of standards and accountability to ensure crisis-affected populations access to lifesaving SRH services.

From the beginning of the response in each humanitarian setting, the health sector/cluster must identify a lead SRH organization to ensure coordination. This can be the Ministry of Health, a United Nations agency, and/or a national or international nongovernmental organization (NGO). The nominated organization, which is the one identified as having the greatest capacity to fulfill this role, immediately dedicates a full-time SRH Coordinator for a minimum period of three to six months. The SRH Coordinator provides operational and technical support to health partners and facilitates coordinated planning to ensure the prioritization of SRH and the effective provision of MISP for SRH services. It is important that this individual has sufficient technical knowledge of all MISP for SRH components and coordination skills to provide this support.

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

- ▶ describe the importance of having a lead SRH agency and SRH Coordinator and
- ▶ identify the roles and functions of the SRH Coordinator.



MISP for SRH objectives and activities

ENSURE THE HEALTH SECTOR/CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- ▶ 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;
- ▶ reports back to the health cluster, gender-based violence (GBV) sub-sector/cluster, and/or human immunodeficiency virus (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.

What are the activities of the SRH Coordinator?

At the onset of a humanitarian response, the health sector/cluster must identify a lead SRH organization. The lead SRH organization should then put into place an SRH Coordinator who functions within the health sector/cluster.

The following are broad terms of reference to be undertaken by the SRH Coordinator:

SRH Coordinator: Terms of Reference

The SRH Coordinator is responsible for supporting health sector/cluster partners to implement the MISP for SRH and plan for the provision of comprehensive SRH services. The SRH Coordinator's role is to:

- ▶ coordinate, communicate, and collaborate with the health, GBV, and HIV sector/ cluster/actors and actively participate in health and other intersectoral coordination meetings, providing information and raising strategic and technical issues and concerns;
- ▶ host regular SRH coordination meetings at national and relevant sub-national/ regional and local levels with all key stakeholders, including the Ministry of Health, local and international NGOs (including development organizations working on SRH), relevant United Nations agencies, civil society groups, intersectoral (protection, GBV, and HIV) representatives, and community representatives from often-marginalized populations, such as adolescents, persons with disabilities,

and lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) individuals to facilitate implementation of the MISP for SRH;

- ▶ compile basic demographic and SRH information of the affected populations to support MISP for SRH advocacy, implementation, and planning for comprehensive SRH service delivery;
- ▶ identify, understand, and provide information about the elements of national and host-country policies, protocols, regulations, and customary laws that:
 - support SRH services for the affected population and
 - create barriers and restrict access to SRH services;
- ▶ with health, GBV, and HIV coordination mechanisms, support a mapping exercise/ situation analysis of existing SRH services (including specialized local service providers that are already working with sub-populations such as LGBTQIA individuals and those engaged in sex work); identify SRH program needs, capacities, and gaps; and conduct a planning exercise in coordination with all relevant stakeholders for effective, efficient, and sustainable SRH services;
- ▶ support health partners in seeking SRH funding through humanitarian planning processes and appeals, including the flash appeals process (Central Emergency Relief Fund [CERF] and Country-based Pooled Funds) and the Humanitarian Response Plan, in coordination with the health sector/cluster;
- ▶ provide technical and operational guidance on MISP for SRH implementation, as well as orientation for health partners on the MISP for SRH, Inter-Agency Emergency Reproductive Health (IARH) Kits,³¹ and other resources; and
- ▶ support coordinated procurement and distribution of IARH Kits and supplies, support partners in basic data collection on consumption of supplies and plan for long-term, stable SRH procurement and distribution systems.

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

- ▶ ensure MISP for SRH services are monitored to facilitate quality and sustainability; utilize the MISP for SRH Checklist (see Appendix B) to monitor services;
- ▶ ensure regular communication among all levels and report back on key conclusions and challenges requiring resolution to the overall health coordination mechanism;
- ▶ collect and apply service delivery data, analyze findings, identify solutions to service gaps, and plan for the provision of comprehensive SRH services;
- ▶ facilitate planning meetings with all stakeholders to identify synergies, needs, gaps, and opportunities; and
- ▶ support the establishment of client-centered comprehensive SRH services as soon as possible and within three to six months of the onset of the emergency.

³¹ See Unit 9 for more information about IARH Kits.

Adolescents

The MISP for SRH may not address all adolescents' needs, and it may not be possible to incorporate all adolescent SRH principles when implementing the MISP for SRH. Given this situation, the SRH Coordinator should meaningfully engage adolescents in SRH coordination, project design, and implementation and should support the provision of adolescent-friendly SRH services. One helpful resource to refer to is the *Adolescent SRH Toolkit for Humanitarian Settings* developed by Save the Children and the UNFPA for additional guidance on the establishment and provision of adolescent-friendly MISP for SRH services.³² See Appendix E for an updated version of the adolescent-friendly SRH service checklist from the toolkit.

Why is putting an SRH Coordinator in place a priority?

Evidence shows that without appropriate technical expertise and coordination to support the SRH response, the critical services of the MISP for SRH are often ignored, deprioritized, or isolated in their implementation.

Who should participate in SRH working group meetings?

Regularly hosting SRH coordination meetings is one of the responsibilities of the SRH Coordinator. Relevant actors in the humanitarian health response should participate in these meetings, including:

- ▶ the Ministry of Health and any other relevant ministries;
- ▶ local and international development, humanitarian, and civil society organizations and private sector actors with SRH expertise and experience;
- ▶ donors;
- ▶ the protection working group or cluster and its GBV Area of Responsibility;
- ▶ representatives from the affected communities; and
- ▶ United Nations agencies, such as the United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), United Nations Office on the Coordination of Humanitarian Affairs (UNOCHA), and the World Health Organization (WHO).

As partners in the coordination mechanism, agencies are responsible for raising SRH-related issues for discussion within the overall health sector/cluster meetings.

³² *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Save the Children and UNFPA, September 2009), https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf.

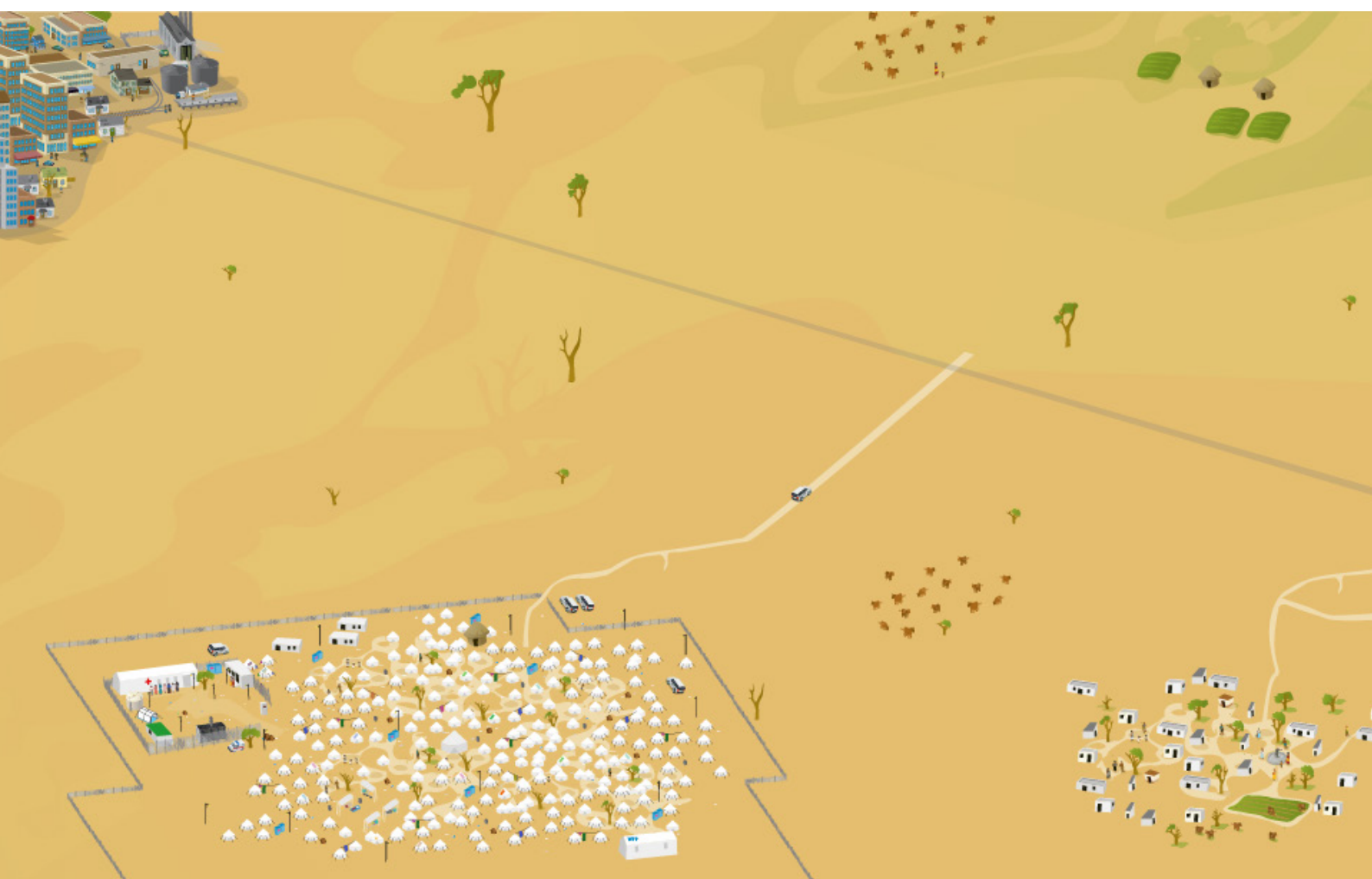
SRH coordination at the national and sub-national levels

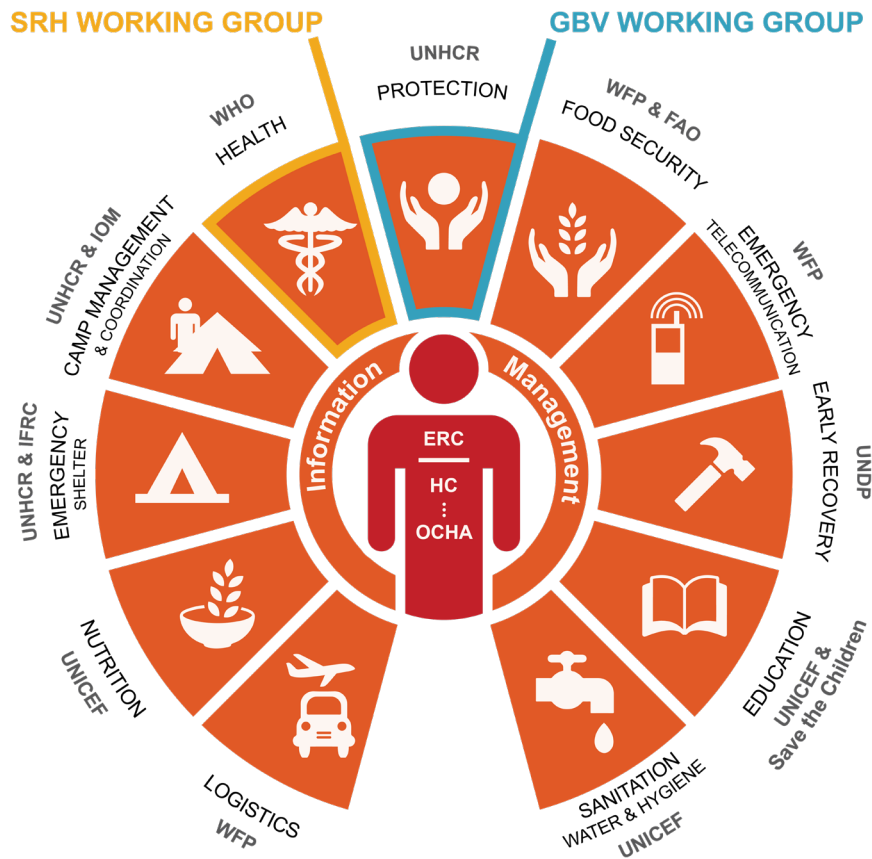
In order to understand SRH coordination at the national and sub-national level, it is important to remember that coordination mechanisms in a refugee setting are different from those in an internally displaced populations setting.

- ▶ If you are operating in a **refugee setting**, UNHCR is responsible for the overall coordination of the response.
- ▶ If you are operating in an **internal displacement setting**, UNOCHA is responsible for the overall coordination using the 'Cluster Approach' (described on page 26).

While these coordination structures differ operationally, it is important to remember that the obligations for partners to ensure the implementation of the MISRP for SRH at the onset of every emergency remain the same.

For more information on the differences between the coordination mechanisms of refugees and internally displaced populations responses please see the *Building A Better Response* training on humanitarian coordination (<https://www.buildingabetterresponse.org>) or go to the UNOCHA and UNHCR websites.





Source: "What Is the Cluster Approach?" Humanitarian Response, accessed April 8, 2019
<https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach>.

Global cluster lead acronyms

FAO	Food and Agriculture Organization
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
OCHA	Office for the Coordination of Humanitarian Affairs
UNAID	Joint United Nations Program on HIV/AIDS
UNDP	UN Development Program
UNEP	UN Environment Program
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
WFP	World Food Program
WHO	World Health Organization

Note that at the national level, responsibility for leadership and coordination may be placed with different agencies that have more competencies on the ground.

What support does the SRH Coordinator need?

The SRH Coordinator should be supported with administration, communications, and logistics personnel to:

- ▶ help arrange SRH coordination meetings;
- ▶ identify and ensure meaningful inclusion of local civil society groups including networks and organizations representing women, adolescents, LGBTQIA individuals, people living with disabilities, and other crisis-affected community members;
- ▶ maintain and post meeting minutes;
- ▶ share situational updates, trainings, and related resources; and
- ▶ work with the health and logistics sectors/clusters to order, stockpile, and distribute SRH supplies.

Useful MISP for SRH-related resources for the SRH Coordinator and others can be found at iawg.net.

What are some of the attributes of strong and successful SRH coordination meetings or working groups?

Strong and successful SRH coordination meetings or working groups:

- ▶ have agreed-upon terms of reference (focused on implementing and building upon the MISP for SRH);
- ▶ are well-facilitated and used for strategic planning and problem-solving to ensure service coverage of the MISP for SRH;
- ▶ have active engagement of the Ministry of Health in leading or co-leading the coordination effort;
- ▶ are advertised to all stakeholders and open to all relevant agencies and members of affected communities—including representation from often-marginalized populations (e.g., adolescents, persons with disabilities, LGBTQIA individuals);
- ▶ are held in an accessible location and hosted on a regular basis—usually once per week at the onset of an emergency; and
- ▶ are time efficient and based on an action-oriented agenda to ensure equitable and comprehensive coverage of MISP for SRH activities.

Facilitation of the meetings should:

- ▶ support equal participation, effective listening, and notetaking;
- ▶ be reinforced through the distribution of minutes post-meeting; the meeting minutes should also be posted on the Humanitarian Response website (humanitarianresponse.info), and the SRH Coordinator should ensure that key points are included in the health cluster situation reports (sitreps) and communicated to UNOCHA for its sitreps as part of the health sector/cluster contribution;

- ▶ accommodate new agencies and the rotation of staff by reviewing the MISP for SRH and the action plan for the working group at the start of each meeting; different organizations could take the lead at the beginning of the meeting to distribute and review the MISP for SRH advocacy sheet and synopsis (also referred to as the “cheat sheet”) (Appendices E and F).

How can SRH coordination be sustained through post-acute/protracted crises?

International SRH Coordinators should, at the onset of their work, actively engage the Ministry of Health or identify a local counterpart to lead or co-lead the coordination effort. This will ensure a smooth transition during any staff turnover that occurs while aiming for the Ministry of Health to assume SRH coordination.



Nepal Post-2015 Earthquake(s): Preparedness and Coordination of the MISP for SRH

Before the 2015 earthquake(s) in Nepal, the Government and partners had made commitments to and investments in SRH, and the MISP for SRH was included in preparedness activities, including the coordination and pre-positioning of IARH Kits. Within two days of the devastating earthquake, an SRH coordination mechanism was initiated under the health cluster in Kathmandu.³³ This effort was led by the Department of Health Services, Family Health Division, and UNFPA.

Leadership and collaboration among partners occurred immediately to successfully secure donor support and reach the affected communities. At the national level, Nepal designated its SRH working group as an RH sub-cluster. The meetings in Kathmandu were reported to have had a rapid start; key stakeholders, including the Department of Health Services, United Nations agencies, local and international NGOs, and adolescents, were involved in the RH sub-cluster coordination meetings. In rural areas, the District Public Health Office led the response efforts, including establishing temporary hospitals, mobile RH camps, and supplies distribution mechanisms, which allowed the MISP for SRH to be integrated into efforts to reach more rural and remote communities.

³³ Myers, et al., “Facilitators and Barriers in Implementing the Minimum Initial Services Package.”

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

Global Health Cluster: The Global Health Cluster, led by the WHO, comprises approximately 700 partners at the country level, 55 of which engage strategically at the global level. These organizations work collaboratively to ensure predictable and accountable health action, including for SRH in crises settings.³⁴ For refugee crises, UNHCR is the lead coordinating agency, including for SRH.

IAWG on RH in Crises: The IAWG on RH in Crises is a broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for people affected by conflict and natural disasters. The group is led by a 19-member Steering Committee comprised of United Nations agencies and nongovernmental humanitarian, development, research, and advocacy organizations. With over 2,800 individual members from 450 agencies in 2018, the group collaborates with members through biennial meetings (as of 2017) where local and international partners share activities and resources, initiate collaborative efforts, and analyze issues in the field to be addressed.³⁵ The IAWG on RH in Crises has 12 active sub-working groups through which members address critical SRH topics. Sub-working groups develop their own terms of reference, which are updated annually. The MISP for SRH sub-working group meets regularly by teleconference to address its terms of reference, share findings, and identify areas for improvement. The findings from these meetings and actions implemented from the terms of reference support a more coordinated and effective MISP for SRH response in new emergencies. This is an example of how action at the global level can support activities in the field. For more details on joining the IAWG on RH in Crises, please go to iawg.net.

Logistics Cluster: The Logistics Cluster, led by the World Food Programme (WFP), provides coordination and information management to support operational decision-making and improve the predictability, timeliness, and efficiency of the humanitarian emergency response. Where necessary, the Logistics Cluster also facilitates access to common logistics services.

GBV Area of Responsibility (The GBV AoR): The GBV Area of Responsibility, led by UNFPA, brings together NGOs, United Nations agencies, academics, and others under the shared objective of ensuring life-saving, predictable, accountable, and effective GBV prevention, risk mitigation, and response in humanitarian contexts. It also works to strengthen system wide preparedness and the technical capacity to respond to humanitarian emergencies. The GBV Area of Responsibility sits within the Global Protection Cluster.³⁶

³⁴ The Global Health Cluster website is found at http://www.who.int/hac/global_health_cluster.

³⁵ More information on the IAWG meetings can be found at http://iawg.net/event_type/annual-meeting.

³⁶ "What we do" Gender-Based Violence AoR (website), accessed June 19, 2019, <http://gbvaor.net>.



The Reality of Implementing the MISP for SRH in Jordan

In March 2011, civil unrest in Syria led to a mass exodus of Syrians into neighboring countries, including Jordan.³⁷ Relief agencies ensured the SRH needs of refugees were factored into the humanitarian response, relying on the Jordanian Ministry of Health guidelines on maternal, newborn, and post-abortion care; HIV prevention and treatment; and family planning.

In 2013, a joint evaluation of MISP for SRH services was conducted by the Women's Refugee Commission, UNFPA, and the Centers for Disease Control and Prevention to determine the status of MISP implementation for Syrian refugees in the Zaatari refugee camp and the urban area of Irbid, Jordan, as part of a global evaluation of RH in crisis-affected settings. The results revealed that lead health agencies addressed the MISP by securing funding and supplies and establishing RH focal points, services, and coordination mechanisms.

UNFPA held weekly coordination meetings in Zaatari, which focused specifically on refugees within the camp, and monthly meetings in Amman, Jordan, which focused on the refugee influx and the crisis as a whole. However, coordination was lacking in Irbid and other urban areas, which had larger numbers of refugees. Maternal and newborn health services, including safe blood transfusions, were functioning in urban areas. This was possibly due to the pre-existing level of maternal and newborn care in Jordan.

The challenge was that refugees hosted in the urban areas were not as visible as those in Zaatari camp, which made them more vulnerable. For example, there was a lack of information about the types and locations of services that were available to them. In Zaatari, regional partners offered advanced maternal and newborn care, but there were gaps in the prevention of sexual violence and the provision of clinical care for survivors. This was thought to be due to health providers' lack of attention to preventing and responding to sexual violence.

Overall, this assessment revealed that there was an increased awareness of the MISP for SRH in the response at the field level. It also highlighted the challenges of working in an urban context and the importance of ensuring all crisis-affected people have knowledge of and access to services.

³⁷ Krause, et al., "Reproductive Health Services for Syrian Refugees."

Unit 2: Key Points

- ▶ It is important to have a lead SRH agency and SRH Coordinator because without appropriate technical expertise and stakeholder coordination to support the SRH response, the critical, lifesaving services of the MISP for SRH are often ignored, and interventions are isolated or deprioritized. This can lead to life-threatening consequences for affected populations.
- ▶ The role of the SRH Coordinator, with the support of the SRH lead agency, is to provide operational and technical support, host regular meetings with all relevant stakeholders, share information about the availability of SRH services and commodities, ensure the community is aware of SRH services, work with the health and logistics sectors/clusters for supplies, and with the health/GBV/HIV coordination mechanisms ensure a mapping and analysis of existing SRH services and gaps and challenges related to MISP for SRH implementation.
- ▶ All relevant actors in the humanitarian health response should participate in the SRH coordination meetings (Ministry of Health, international NGOs, civil society organizations, the private sector working in SRH, donors, the protection working group/cluster—including the GBV Area of Responsibility—representatives from the affected communities, and United Nations agencies).



Challenges and Solutions

Challenges	Solutions
<p>Sometimes a lack of understanding and/or prioritization of SRH by humanitarian actors can make implementation of the MISP for SRH within the overall health response difficult. How can one ensure that SRH and the MISP for SRH are prioritized and integrated appropriately?</p>	<p>Emphasize that the MISP for SRH is an accepted international minimum standard reflected in <i>The Sphere Handbook</i>, the CERF lifesaving criteria, the <i>Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings</i>, and the <i>Health Cluster Guide</i>.</p> <p>Encourage all technical and managerial staff involved in humanitarian response to complete the MISP for SRH distance learning module and share relevant resources, such as the MISP for SRH Advocacy and Synopsis Sheets (Appendices C and E).</p> <p>Conduct trainings on the lifesaving SRH services of the MISP for SRH as part of preparedness efforts and collaborate with the Ministry of Health and other relevant governmental organizations prior to an emergency, if possible.</p> <p>Undertake a MISP for SRH emergency preparedness assessment.</p>
<p>At the beginning of an emergency, UNFPA and other SRH specialist agencies may not yet be operational in the field. Security may be poor and staff capacity may be weak. In such a setting, what can an agency do to address SRH?</p>	<p>If your agency is involved in the health response, it should ensure the MISP for SRH is included in its programming. Your agency or another agency could volunteer in the health sector/ cluster meetings to lead on SRH and to establish regular SRH working group meetings to facilitate implementation of the MISP for SRH.</p> <p>If your agency cannot provide all MISP for SRH recommended activities, assess other health/SRH actors' service capacity, and establish an effective referral system for those services that your agency cannot provide.</p>
<p>How can a local counterpart be identified to lead or co-lead the SRH coordination effort?</p>	<p>If capacity exists, the Ministry of Health should lead or co-lead the coordination effort. The Ministry of Health could advise on existing local organizations and their capacities. Conduct a mapping of existing local actors implementing SRH programming to identify candidates to lead or co-lead the coordination effort.</p>

How can marginalized populations be included in coordination initiatives?

With the SRH working group, identify representatives of local adolescents, women, persons with disabilities and LGBTQIA, and other often marginalized groups from among the crisis-affected populations. Extend an invitation for representation in the SRH working group meetings to these leaders.

What can be done about members of the SRH working group who have never heard of the MISP for SRH?

In the early weeks and months of the SRH working group meetings, begin with a brief orientation to the MISP for SRH. Share the MISP for SRH Synopsis (also known as the “cheat sheet”) and explain that the overall objective of the SRH working group is to work collaboratively to ensure the full MISP for SRH is accessible to all crisis-affected populations. If there is a high rotation of staff and new agencies joining the SRH working group meetings, review the MISP for SRH and the action plan for the working group at the start of each meeting.

MISP FOR SRH MONITORING CHECKLIST: COORDINATION

The MISP for SRH Monitoring Checklist below, can be used to monitor SRH service provision in humanitarian settings.

1. SRH Lead Agency and SRH Coordinator			
		Yes	No
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly ³⁸	Yes	No
	National (MONTHLY)		
	Sub-national/district (BIWEEKLY)		
	Local (WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH working group meetings	Yes	No
	Ministry of Health		
	UNFPA and other relevant United Nations agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
	Civil society organizations, including marginalized (adolescents, persons with disabilities, LGBTQIA people)		
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensure mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		
2.2	Number of women of reproductive age (ages 15–49, estimated at 25% of population)		
2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population, estimated at 4% of the population)		

³⁸ Meetings are more frequent at the immediate onset of a crisis.

MATERIALS AND SUPPLIES

Which supplies are needed for coordinating the implementation of the MISP for SRH?

IARH Kits (2019)

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Complementary commodities

The first objective of the MISP does not have an IARH Kit associated with it. However, there is an administration and training complementary commodity kit available that should only be procured where administrative supplies can not be procured in-country.

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Coordination	Kit 0 Administration and training	All Kits

Unit 2 Quiz: Coordination of the MISP for SRH

1. The lead SRH agency should immediately dedicate a full-time SRH Coordinator for a minimum period of one year to provide operational and technical support to the health partners and facilitate coordinated planning to ensure the prioritization of SRH and effective provision of MISP for SRH services.

True or False

2. In the MISP for SRH, the lead SRH organization is responsible for all the below **except**:
 - a. Hosting regular meetings with all relevant stakeholders
 - b. Mapping existing SRH services alone and separate from health/GBV/HIV coordination mechanisms
 - c. Nominating an SRH Coordinator
 - d. Sharing information about the availability of SRH services and commodities
 - e. Ensuring the community is aware of the availability and location of SRH services
3. Who should participate in the SRH working group meetings?
 - a. Representatives from the affected community
 - b. NGOs
 - c. Civil society organizations
 - d. GBV coordinator
 - e. All of the above
4. Components of successful SRH coordination include all **except**:
 - a. Having an agreed-upon terms of reference
 - b. Engaging the Ministry of Health in leading or co-leading the coordination effort
 - c. Having appropriate administrative, communications, and logistics support
 - d. Meeting on a monthly or bimonthly basis at the beginning of an emergency
5. The MISP for SRH Checklist can be used to monitor SRH service provision and coordination in humanitarian emergencies.

True or False



UNIT 3: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS

Sexual violence is among the most pervasive forms of violence and is a major public health concern. It is exacerbated in situations of conflict, forced migration, and natural disasters, with an estimated one in five women and girls experiencing sexual violence in complex humanitarian settings.³⁹ Anyone can experience sexual violence, including women, men, adolescents, persons with disabilities, young children, the elderly, lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) people, ethnic and religious minorities, and sex workers, among others. All actors responding in an emergency should be aware of the risks of sexual violence and coordinate multisectoral activities to prevent them and protect the affected populations—particularly women, girls, and other at-risk populations.

Examples of protective measures include:

- ▶ safe access to health facilities;
- ▶ sex-segregated latrines and bathing facilities with locks on the inside;
- ▶ adequate lighting around the camp and in the health facilities; and
- ▶ partitioned homes or individual family tents to allow privacy.

Humanitarian actors must also ensure that women, girls, men, and boys, in all their diversity, who have experienced sexual violence receive clinical care and psychosocial, protection, and other supportive services as soon as possible after the incident. Sexual violence is a traumatic experience that may have a variety of serious and negative short- and long-term physical, psychological, personal, and social consequences for survivors that must be addressed. Sexual violence diminishes the ability of women and girls, along with other at-risk populations, to meaningfully participate in development, peacekeeping, educational opportunities, and economic activities. Entire families and communities suffer deeply due to the multilayered impacts of sexual violence.

An important resource that outlines the set of minimum multisectoral interventions to prevent and respond to sexual violence in emergency settings is the Inter-Agency Standing Committee (IASC) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*.⁴⁰ These guidelines provide recommended interventions for all sector areas before an emergency, during the acute phase of an emergency, and once the immediate crisis subsides. A reference matrix of these guidelines is also available.

³⁹ Alexander Vu, Atif Adam, Andrea Wirtz, Kiemanh Pham, Leonard Rubenstein, Nancy Glass, Chris Beyrer, and Sonal Singh “The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: A Systematic Review and Meta-Analysis,” *PLOS Currents Disasters*, March 18, 2014, DOI: 10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7.

⁴⁰ Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (website), accessed April 8, 2019, <https://gbvguidelines.org>.

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

- ▶ explain what sexual violence is and why preventing sexual violence and responding to the needs of survivors is a priority;
- ▶ list what actions should occur to prevent sexual violence;
- ▶ describe the components of clinical care for survivors of sexual violence;
- ▶ explain who is responsible for preventing and managing incidents of sexual violence;
- ▶ describe the reasons sexual violence goes unreported; and
- ▶ understand what a Code of Conduct and complaints mechanism are.

MISP for SRH objectives and activities:

TO PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS.

To prevent sexual violence and respond to the needs of survivors from the onset of an emergency, the Sexual and Reproductive Health (SRH) Coordinator, program managers, and service providers must collaborate with the health sector/cluster to:

- ▶ work with other clusters, especially the protection cluster and gender-based violence (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;
- ▶ make clinical care and referral to other supportive services available for survivors of sexual violence; and
- ▶ ensure confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

What is sexual violence?

Sexual violence is a violation of fundamental human rights and takes many forms, including rape, sexual harassment, forced pregnancies/abortions, sexual exploitation, and sex trafficking. It is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person sexually, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. The Minimum Initial Service Package (MISP) for SRH mainly addresses the following three areas of sexual violence:

Rape/attempted rape: Rape is an act of nonconsensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape.

Sexual abuse: Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

Sexual exploitation: Any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another.

Why is preventing sexual violence and responding to the needs of survivors a priority?

During emergencies such as conflicts or natural disasters, the risk of violence, exploitation, and abuse is heightened, and pre-existing gender and other social inequalities may be exacerbated. Individuals may experience a loss of secure housing, limited economic opportunities, and instability, leading to opportunistic sexual violence by known and unknown perpetrators. In some conflict or post-conflict settings, sexual violence is used as a tactic of war. Further, national systems and community and social support networks may be weakened, and in an environment of impunity perpetrators may not be held accountable.

Survivors of sexual violence may suffer from depression and anxiety, attempt/complete suicide, contract human immunodeficiency virus (HIV) or other sexually transmitted infections (STIs), become pregnant, or be shunned or even killed, a practice that is sometimes referred to as an “honor killing,” by their families or members of their communities. Moreover, the impact of sexual violence is multifold: it impacts the survivor’s physical and mental health and social well-being while having possible consequences for the survivor’s family and wider community. The heightened risk for and fear of sexual violence can also lead to increases in harmful practices designed to ‘protect’ women and girls such as early and/or forced marriage, increased incidents of domestic and intimate partner violence, and loss of mobility for women and girls.

Once a situation stabilizes and all components of the MISP for SRH have been implemented, attention can be given to addressing the wider array of GBV issues, including domestic violence, intimate partner violence, early and/or forced marriage, female genital mutilation/cutting, forced sterilization or forced pregnancy, forced or coerced prostitution, and the trafficking of women, girls, and boys.

Who is affected most by sexual violence?

People of any sex, gender, age, or ability can experience sexual violence. Most reported cases of sexual violence among crisis-affected communities—and in most settings around the world—involve male perpetrators committing violent acts against women and girls.⁴¹ Perpetrators are often intimate partners (including spouses) or others known to the individual (relatives, friends, or community members). However, men and boys are also at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture.⁴² Adolescent girls, persons with disabilities (especially intellectual

⁴¹ “Violence Against Women,” WHO, November 29, 2017, <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

⁴² Sarah Chynoweth, *Sexual Violence Against Men and Boys in the Syria Crisis* (UNHCR, October 2017), <https://data2.unhcr.org/en/documents/download/60864>.

disabilities), and LGBTQIA individuals are exceptionally vulnerable because they are often targeted for sexual exploitation and rape while social protections are weakened.⁴³

It is important to recognize that anyone can experience sexual violence and to ensure that comprehensive and quality services are available and accessible to all.

When does sexual violence occur during crises?

Sexual violence can happen anytime during displacement, including prior to fleeing one's home, during flight, while in the country of asylum, during repatriation and reintegration, and in temporary shelters for internally displaced populations. It can occur in crisis-affected communities after a natural disaster or conflict, even among those who were not displaced from their homes.

Who is responsible for preventing and responding to incidents of sexual violence?

All humanitarian actors are responsible for preventing sexual exploitation, reporting abuse, and ensuring humanitarian assistance is provided impartially, without bias or discrimination on the basis of age, sex, gender or gender identity, marital status, sexual orientation, location (e.g., rural/urban), disability, race, color, language, political or other opinion, religion, national, ethnic or social origin, property, birth, or other characteristics. Humanitarian actors are also responsible for ensuring that survivors have access to clinical care and other supportive services.

A multisectoral, multilevel approach is required to protect the crisis-affected population and respond appropriately to sexual violence. The global protection cluster, under the leadership of the United Nations High Commissioner for Refugees (UNHCR), is responsible for ensuring that protection is mainstreamed and integrated with other sectors and that support is provided as requested to the country-level protection cluster. The protection cluster working group is subdivided into five additional Areas of Responsibility, including child protection, under the leadership of the United Nations Children's Fund (UNICEF), and GBV, under the leadership of the United Nations Population Fund (UNFPA). The stated overarching objective of the GBV Area of Responsibility is "to develop effective and inclusive protection mechanisms which promote a coherent, comprehensive, and coordinated approach to GBV at the field level, including regarding prevention, care, support, recovery, and works to hold perpetrators accountable."⁴⁴

At the field level, coordination to address sexual violence should encompass all technical sectors (e.g., protection; health; education; logistics; water, sanitation and hygiene [WASH]; community services; security/police; site planning; etc.) and all geographic areas affected by crises. Clinical care for survivors of sexual violence falls within the purview and accountability

⁴³ *Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence* (Women's Refugee Commission, February 2016), <https://www.womensrefugeecommission.org/gbv/resources/document/download/1455>.

⁴⁴ More information on the GBV AoR can be found at <http://gbvaor.net>.

of the health sector/cluster with the designated lead SRH agency.⁴⁵ The SRH Coordinator, SRH working group, and the health sector/cluster should work with the GBV Area of Responsibility lead agency to support a process to identify a clear division of roles and responsibilities among health partners and between all sector/cluster programs responding to the needs of survivors. This includes justice/legal, protection, security, psychosocial, and community services. Representatives of the affected community, United Nations partners, nongovernmental organizations (NGOs), and government authorities should inform and/or participate in this process and relevant sector/cluster coordination meetings.

Further, to ensure a coordinated, survivor-centered, and confidential referral mechanism for survivors, there should be linkages to community self-help groups, including those formed by adolescents, persons with disabilities, LGBTQIA populations, and sex workers.

The MISP for SRH activity:

Put in place preventative measures at community, local, and district levels to protect affected populations from sexual violence

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

Women and girls who have been displaced or are living in conflict or other emergency settings may be put at an increased risk of sexual violence in the following situations:

- ▶ If they are without personal documentation for collecting food rations, assistance, or essential services and dependent on males for their daily survival;
- ▶ When men (fellow affected persons, members of host communities, or humanitarian actors) alone are responsible for distributing food and other essential goods;
- ▶ If they have to travel to remote distribution points for food, firewood for cooking fuel, and water without security or other protection;
- ▶ If their sleeping quarters are unlocked and unprotected or the lighting is poor; and
- ▶ If male and female latrines and washing facilities are not separate, if they do not have internal locks, or are located in insecure areas of a camp or settlement.

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

⁴⁵ Inter-Agency Standing Committee, Humanitarian Response, <https://www.humanitarianresponse.info/en>.

What are the key actions that should be taken to prevent sexual violence?

Health and protection coordination meetings should consistently address sexual violence to ensure coordination in the response between the SRH Coordinator and other sectoral actors. Confidential operating and coordination procedures should be agreed upon and implemented to assess and respond to at-risk situations or for risk mitigation.⁴⁶

As part of the work of the overall health sector/cluster mechanism, the SRH Coordinator and SRH program staff must ensure that the humanitarian health sector/cluster and health actors do the following:

- ▶ Ensure safe access to basic health services, including SRH services, for women, men, adolescents, and children.
- ▶ Design and locate health facilities to enhance physical security and safety and be accessible to persons with disabilities, in consultation with the population, in particular, women, adolescents, persons with disabilities, and other marginalized populations.
- ▶ Consult with service providers and clients about security and safety concerns regarding access to and within health facilities.
- ▶ Ensure health facilities are in secure locations and have adequate path lighting at night.
- ▶ Ensure health facilities have confidential spaces, trained health providers and the essential supplies to provide clinical care for survivors of sexual violence.
- ▶ Consider the need for security personnel at facility entrances.
- ▶ Locate separate male and female latrines and washing areas in the health facility and ensure doors lock from the inside.⁴⁷
- ▶ Hire and train female service providers, community health workers, program staff, and interpreters.⁴⁸
- ▶ Ensure all ethnic subgroup languages are represented among service providers, or ensure interpreters are available.
- ▶ Inform service providers and all other facility staff of the importance of maintaining confidentiality, including protecting survivor information and data.
- ▶ Ensure health workers and all other facility staff have signed and abide by a Code of Conduct against sexual exploitation and abuse.
- ▶ Ensure that Code of Conducts and reporting mechanisms on sexual exploitation and abuse (which ensure whistleblower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct.

⁴⁶ See the GBV Responders Network at <https://gbvresponders.org/resources> for existing tools and resources to facilitate operationalization.

⁴⁷ WASH, *Protection and Accountability: Briefing Paper* (UNHCR, 2017), <http://wash.unhcr.org/download/wash-protection-and-accountability>.

⁴⁸ *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook* (WHO, September 2014), http://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf?sequence=1.

The MISP for SRH activity:

Make Clinical Care and Referral to Other Supportive Services Available for Survivors

Guiding Principles When Responding to the Needs of Survivors of Sexual Violence

The following guiding principles should be respected at all times by all humanitarian actors who are responding to the needs of survivors:

- ▶ Safety
- ▶ Confidentiality
- ▶ Respect
- ▶ Nondiscrimination

Why is addressing sexual violence a critical concern for health professionals?

Health services are often the first—and sometimes the only—point of contact for survivors of sexual violence. The quality of care provided can have short- and long-term impacts on the well-being of the survivor and the willingness of the survivor to report the incident. Therefore, all health providers (even those not working in a facility that provides clinical care for survivors of sexual violence) must be prepared to provide the first line of psychosocial support.

First line psychosocial support includes:

- ▶ empathetic listening and validation;
- ▶ identifying immediate emotional, psychological, and physical needs;
- ▶ attending to the survivor's immediate and ongoing safety (protection) and health, including mental health needs through referral to psychosocial support;
- ▶ reassuring the survivor that they are not at fault or to blame;
- ▶ inquiring about the survivor's needs and concerns;
- ▶ identifying and offering information about other support services; and
- ▶ supporting the survivor's decisions.

What is a survivor-centered approach?

A survivor-centered approach means that survivors' rights, needs, and wishes are prioritized. This approach can guide health providers in their engagement with persons who have experienced sexual violence. It aims to create a supportive environment in which the

survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect.

What are the key actions that should be taken when setting up clinical services?

All humanitarian actors must respect a sexual violence survivor's rights to life, self-determination, good-quality health care, nondiscrimination, privacy, confidentiality, information, and respect. Survivors must have access to clinical care, including supportive psychosocial counseling, as well as emergency contraception and post-exposure prophylaxis (PEP) for HIV, as soon as possible after the incident.

To ensure health services can provide such care at the onset of a humanitarian response, SRH Coordinators and program staff must:

- ▶ establish a private, non-stigmatizing consultation area with a lockable filing cabinet;
- ▶ put in place clear protocols and a list of patient rights in the languages of providers and patients;
- ▶ have sufficient supplies and equipment available;
- ▶ hire male and female service providers fluent in local languages, and train male and female chaperones and interpreters;
- ▶ involve women, adolescent girls and boys, and other at-risk populations, such as persons with disabilities and LGBTQIA groups, in decisions on accessibility and acceptability of services;
- ▶ with the health cluster lead, ensure that services and a referral mechanism, including transport to a hospital in case of life-threatening complications, are available 24 hours a day, 7 days a week.

What can be done to inform the community about available services?

Once services are established, SRH Coordinators and program staff should inform the community about:

- ▶ the hours and location of the services;
- ▶ the importance of seeking immediate medical care following sexual violence no later than 72 hours for prevention of HIV and 120 hours for prevention of pregnancy—the sooner the more effective for both; and
- ▶ what health services are offered to survivors who are unable to seek immediate care.

To ensure accessibility, multiple formats and languages should be used (e.g., Braille, sign language, pictorial formats) and distributed through community-led outreach (women, youth, LGBTQIA, and persons with disabilities groups) and other appropriate communication channels (e.g., schools, midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines).

What are the key actions that should be taken to ensure service providers are skilled and able to provide nondiscriminatory, unbiased, and survivor-centered services?

Where needed and feasible, the SRH Coordinator, with the SRH working group and health sector/cluster, should organize information sessions or short refresher trainings on clinical care for survivors of sexual violence.

What are the components of clinical care for survivors of sexual violence?

Supportive communication: Ensure service providers can extend compassionate and confidential support to the survivor through communication that is accurate, clear, and nonjudgmental and that involves empathetic active listening without pressuring the survivor to respond. They should inform the survivor about available care options, encourage and address the survivor's questions and concerns, and obtain written or verbal consent for all aspects of care. Service providers must take care not to make promises or misrepresentations (particularly regarding security) that cannot be guaranteed.

History and examination:⁴⁹ The primary purpose of the history and examination is to determine the clinical care that is needed. During this process, the health and well-being of the survivor is the main priority. Allow the survivor to choose a trusted person to be present at the examination if they so desire. For children, this may be their (nonoffending) guardian or, where they are not available, a trained support person. The survivor should always be able to choose the sex of the support person; this is obligatory for children. A history and thorough medical examination (avoiding invasive procedures as much as possible in accordance with World Health Organization [WHO] guidelines⁵⁰) are conducted. Providers must ensure the survivor understands and consents to each step. The history-taking includes:

- ▶ questions about the assault limited to what is needed for medical care and, where appropriate (capacity exists to test and use the evidence), the collection of samples for forensic evidence;
- ▶ general medical information;
- ▶ medical and gynecological history for women and girls; and
- ▶ an assessment of mental state by asking how the survivor is feeling and noting the survivor's emotions during the exam.

Keep a carefully written record of all actions and referrals (medical, psychosocial, security, legal, community-based support) to facilitate follow-up care. Ensure the documentation is

49 An example of a history and exam form can be found on p. 44–47 of the *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (WHO, 2004), http://iawg.net/wp-content/uploads/2016/08/Clinical_Management_2005_rev-1.pdf.

50 *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (WHO, 2004), http://iawg.net/wp-content/uploads/2016/08/Clinical_Management_2005_rev-1.pdf.

available for prosecution if the survivor chooses to pursue it.

During this process, survivors should be assured that they are in control, do not have to talk about anything they are uncomfortable with, and can stop the process at any time. It is the survivor's right to decide whether to be examined and refuse any part of the exam. All aspects of the exam should be explained, and consent obtained prior to touching the survivor. Allow the survivor to ask questions and agree to or refuse any aspect of the examination and treatment at any time.

The medico-legal system and forensic evidence collection,⁵¹ where feasible and when needed:

- ▶ The SRH Coordinator, together with the GBV Area of Responsibility lead and legal experts, should determine the status of the national medico-legal system, including the relevant laws and policies about sexual violence, and share this information with stakeholders.
- ▶ Forensic evidence collection, where feasible and when it can be used, should be collected, stored, analyzed, and used only if the survivor consents after a full explanation of each procedure. Clinical management of survivors of sexual violence takes priority over the medico-legal process.

Compassionate and confidential treatment and counseling: Clinical treatment for survivors of sexual violence can be started without examination if that is the survivor's choice. This will be explored in more detail in this section but will include:

- 1. Emergency contraception;**
- 2. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care to the full extent of the law;**
- 3. Presumptive treatment of STIs;**
- 4. PEP to prevent HIV transmission;**
- 5. Prevention of hepatitis B and human papillomavirus (HPV);**
- 6. Care of wounds and prevention of tetanus;**
- 7. Referral for further services, such as other health, psychological, and social services; and**
- 8. Follow-up care.**

Treat life-threatening complications first and refer to higher-level health facilities, if appropriate. A useful resource that provides guidance to health care providers for medical management after rape of women, men, and children is the 2004 *Clinical Management of Rape Survivors: A Guide to the Development of Protocols for Use in Refugee and Internally Displaced Persons*.⁵²

⁵¹ More information on forensic collection can be found in the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018 (IAWG, November 2018), p.27, <http://iawg.net/wp-content/uploads/2018/11/IAFM-web.pdf>.

⁵² *Clinical Management of Rape Survivors: A Guide to the Development of Protocols for Use in Refugee and Internally Displaced Persons* (WHO, 2004), <https://www.unhcr.org/protection/health/403a0b7f4/clinical-management-rape-survivors-developing-protocols-use-refugees-internally.html>.

In addition, the WHO, UNHCR, and UNFPA have an e-learning program for health care providers on the *Clinical management of rape survivors*, which is available online in English and French.⁵³

1. Emergency contraception

Emergency contraception can prevent unintended pregnancies and should be provided to survivors as soon as possible and within 120 hours after experiencing sexual violence.⁵⁴

Common Emergency Contraceptive Methods

Progestin-only emergency contraceptive (EC) pills: are the most widely available form of EC and contain 1.5 mg of levonorgestrel.

Timeframe: EC pills can be used up to 120 hours (5 days) after unprotected sex but are more effective the sooner they are taken.

Safety: Progestin-only EC pills are safe for all women, girls, and adolescents of reproductive age, even for those who are advised not to use combined oral contraceptives for ongoing contraception, as the dose of hormones is relatively small and the pills are used for a short time.

Clinical screening: No clinical examinations or tests (including a pregnancy test) are needed before providing progestin-only EC pills.

Mechanism of action: EC pills delay or prevent ovulation. An additional postulated mechanism is that they may stop the egg and sperm from meeting. EC pills do not have any effect after fertilization and cannot terminate or interfere with an established pregnancy. In other words, progestin-only EC does not induce an abortion.

Side effects: EC pills are safe, and there is no situation in which the risks of using them outweigh the benefits. Side effects are minor and may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. If vomiting (rare) occurs within two hours of taking a dose, the dose should be repeated and, if available, an antiemetic can be given.

Counseling: There is a small chance that the pills will not work. Inform the client that menstruation should occur around the time when it would normally be expected but may be up to a week early or late. If she has not had a period within a week after it was expected, she should return for a pregnancy test and/or to discuss options in case of pregnancy.⁵⁵

Repeated use: EC pills remain safe and effective in preventing pregnancy if taken more than once, even within the same menstrual cycle, and there are no lifetime limits on the

53 "Clinical Management of Rape Survivors," WHO, accessed April 8, 2019, <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en>.

54 More information about emergency contraception and medical eligibility can be found at the International Consortium for Emergency Contraception's website: <http://www.ec-ec.org/ecmethod>.

55 How to Be Reasonably Certain a Client Is Not Pregnant (checklists)," FHI360, 2015, <https://www.fhi360.org/resource/how-be-reasonably-sure-client-not-pregnant-checklists>.

number of times a woman can take progestin-only EC pills. However, using an ongoing contraceptive method is recommended as the most effective way to prevent pregnancy.

Copper-bearing intrauterine devices (IUDs) can also be inserted in medically eligible women up to five days after unprotected sex, including in cases of sexual violence. This is a highly effective form of post-coital contraception and will prevent more than 99% of expected pregnancies. As the risk of ovulation is low through the seventh day of the menstrual cycle, a woman can have a copper-bearing IUD inserted beyond five days after the sexual violence occurred, when ovulation can be estimated, and as long as insertion does not occur more than five days after ovulation.

Providers should offer survivors full information and counseling about this service (taking care to avoid further traumatization), so they can make a voluntary and informed decision about whether to use EC pills or have an IUD inserted. Counseling should include information about risks, benefits, side effects, and complications. Only a skilled provider should insert the IUD and only after performing a pelvic exam.

If an IUD is inserted, make sure to give a full STI treatment, including antibiotics to empirically treat possible STIs and/or pelvic inflammatory disease. The IUD may be removed at the time of the woman's next menstrual period or left in place as ongoing contraception.

If progestin-only EC pills are not available in the country, **combined hormonal oral contraceptives** can be used (the Yuzpe method).

- ▶ Two doses of combined oral contraceptive pills are needed. Combined oral contraceptive pills contain different dosages; the provider must calculate to ensure that each dose contains estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel or 1.0–1.2 mg norgestrel).
- ▶ The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days), and the second dose should be taken 12 hours later.
- ▶ If vomiting occurs within two hours of taking a dose, the dose should be repeated.
- ▶ Combined hormonal EC pills are less effective and have more side effects than progestin-only EC pills and ulipristal acetate.

2. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care to the full extent of the law

Provide pregnancy testing at the time of the initial presentation, but do not withhold EC if this is not available. Provide additional pregnancy testing at the two-week and one-month follow-up visits. Provide accurate information about pregnancy options, including continuing the pregnancy and parenting, continuing the pregnancy and placing the child for adoption, and having an abortion, as applicable, and nonbiased counseling to facilitate informed decision-making. If the survivor is pregnant as a result of sexual violence and an abortion is desired, provide safe abortion care or a referral for that care to the full extent of the law.

3. Presumptive treatment of STIs

Provide survivors antibiotics to presumptively treat gonorrhea, chlamydial infection, and syphilis, as warranted and if desired.⁵⁶ If other STIs are prevalent in the area (e.g., trichomoniasis or chancroid), give presumptive treatment for these infections as well.

4. Post-exposure prophylaxis to prevent HIV transmission

The likelihood of HIV transmission after sexual violence can be reduced through the prompt administration of post-exposure prophylaxis (PEP).⁵⁷ PEP should be offered and initiated as soon as possible (no later than 72 hours following exposure and continued for 28 days) for all individuals with an exposure that has potential for HIV transmission. Pregnancy is not a contraindication (condition for which treatment should not be provided) for PEP.

5. Prevention of hepatitis B and HPV

Provide a hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. Consider providing the HPV vaccine to anyone age 26 or younger, unless the survivor has been fully vaccinated.

6. Care of wounds and prevention of tetanus

Clean any tears, cuts, and abrasions and suture clean wounds within 24 hours. Give tetanus prophylaxis if there are any breaks in skin or mucosa and if the survivor is not vaccinated against tetanus or the vaccination status is uncertain.

7. Referral for further crisis intervention

With a survivor's consent or upon their request, offer referral to:

- ▶ a hospital in case of life-threatening complications or complications that cannot be dealt with at the health facility level;
- ▶ protection or social services if the survivor does not have a safe place to go when leaving the health facility; and
- ▶ psychosocial or mental health services where available; liaise with GBV and protection focal points to identify psychosocial services in the setting. This may include services offered by the affected populations, women's centers, and other support groups.

8. Follow-up care

- ▶ If feasible, follow-up post-rape care is recommended at two weeks, one month, three months, and six months following the incident.
- ▶ Continue first-line support and care, monitor mental health needs, and refer for psychosocial and/or mental health support as needed.

⁵⁶ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 30–31.

⁵⁷ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 32–33.

- ▶ Offer pregnancy testing at two and four weeks following the incident.
- ▶ Monitor wounds for healing and follow up on a tetanus vaccination schedule as needed.
- ▶ Where relevant, discuss adherence to STI prophylaxis or treatment, including PEP and hepatitis B vaccination (additional doses at one month and six months), HIV testing at three months and six months, and pregnancy status and options.



The Reality of Implementing the MISP for SRH in Jordan

The Women's Refugee Commission's 2013 MISP for SRH assessment in Jordan showed that planning to respond to sexual violence was inadequate in both camp and urban settings.⁵⁸ Challenges were related to a low number of trained providers, the lack of a national clinical management of rape protocol, and challenges around the use of EC and PEP. It was also taboo to talk about sexual violence in the community and many people did not know what services were available. These factors and the fear of retribution made it difficult for survivors to make an informed choice about seeking care.



Noted Practice: Preventing and Managing the Consequences of Sexual Violence in Cox's Bazar, Bangladesh

- ▶ In the early phase of the emergency, organizations used incentives, such as transport vouchers, to promote the use and locations of facility-based services. An early rollout of a community volunteer program also helped to inform communities about the availability and location of services for survivors of sexual violence.⁵⁹
- ▶ There was strong coordination between the SRH sub-cluster and the protection cluster/GBV sub-sector, which helped to quickly put in place measures to protect affected populations, particularly women and girls, from sexual violence.
- ▶ Clinical management of survivors of sexual violence training sessions were co-facilitated by the SRH sub-cluster and GBV sub-sector experts early on in the response.
- ▶ Women's safe spaces were immediately established near health facilities, which provided a close linkage and allowed for quick and easy referrals.

⁵⁸ Krause, et al., "Reproductive Health Services for Syrian Refugees."

⁵⁹ Site visit, Women's Refugee Commission, February 2018.

Special Considerations for Specific Populations

Children	The SRH Coordinator must understand and disseminate information about country-specific laws with regard to the age of consent for treatment, the professional who can give legal consent for clinical care if a parent or guardian is the suspected offender (for instance, a representative from the police, community services, or the court), and mandatory reporting requirements and procedures when service providers suspect, or are informed of, a case of child abuse. Digital or speculum vaginal or anal examinations should not be conducted on children unless absolutely necessary. In those cases, children should be referred to a specialist. Protocols showing appropriate drug dosages must be posted or easily available to service providers.
Male survivors	Male survivors are less likely to report an incident because of shame, criminalization of same-sex relations, negative or dismissive provider attitudes, and the lack of recognition regarding the extent of the problem. Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and nondiscriminatory services that provide comprehensive care.
Persons with disabilities (intellectual and physical)	Persons with disabilities including women, girls, boys, and men living with disabilities are at a higher risk of sexual violence and often face extreme discrimination by service providers. Caregivers (usually women or girls) of persons with disabilities can also be vulnerable to violence and exploitation due to isolation, which can limit their access to social, economic, and material support. Organizations of people with disabilities within the host community often have information that health providers can use to ensure clinical care is provided to this often-hidden population.
LGBTQIA individuals	LGBTQIA individuals face a variety of different risk factors for sexual violence, and it is important to acknowledge that each population has separate needs and faces different risks. LGBTQIA individuals may face discrimination by health providers, which prevents them from seeking SRH services. Engaging with LGBTQIA or rights groups and making health facilities more respectful of diversity would allow critical health services to become more accessible to these populations.
People who engage in sex work	People who engage in sex work often face stigmatization and discrimination by health providers, who may be less likely to take sexual violence against this population as a serious concern. Humanitarian actors should engage with this population to develop SRH care programming.
Ethnic and religious minorities	Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence, including oppression and harassment. It is important to train caregivers, health providers, and other duty bearers on nondiscriminatory practices related to SRH service provision.

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 knowledge about the benefits of seeking services and support, the unreliability of public health and other services, lack of trust in the services, and a lack of confidentiality. All of these circumstances are exacerbated in humanitarian settings, increasing the likelihood that incidents of sexual violence within the population will go unreported. While ensuring clinical management of sexual violence and other services is an essential part of the response, addressing sexual violence must also include an environment where women are protected, supported, and able to access this care.

Even in the absence of any reported cases, services should be put in place. ***All humanitarian personnel have the responsibility to assume sexual violence is taking place, to treat it as a serious and life-threatening protection issue, and to take action as described to minimize risks of sexual violence through their sectoral interventions, regardless of the presence or absence of concrete evidence.***

What are some mechanisms to address sexual violence by agencies?

Code of Conduct

A Code of Conduct against sexual exploitation and abuse is a set of agency guidelines that promotes respect by the agency's staff for fundamental human rights, social justice, human dignity, and the rights of women, men, and children. It also informs staff that their obligation to show this respect is a condition of their employment. An enforceable Code of Conduct is a critical component of humanitarian accountability to beneficiaries. All humanitarian agencies, including those involved in MISP for SRH implementation, should have a Code of Conduct and policies in place to prevent sexual exploitation and abuse. Agencies should ensure that all staff are committed to adhering to the guidelines and have been oriented on their responsibilities. A good resource for agencies to develop these guidelines is the Core Humanitarian Standards Alliance's *Protection from Sexual Exploitation and Abuse Implementation Quick Reference Handbook*.⁶⁰ An additional resource is the *IASC Champion on Sexual Exploitation and Abuse and Sexual Harassment*.⁶¹

A Code of Conduct is relevant for all staff—international as well as local. Agencies must

60 Corinne Davey and Lucy Heaven Taylor, *PSEA Implementation Quick Reference Handbook* (Core Humanitarian Standards Alliance, July 2017), <http://www.pseataskforce.org/uploads/tools/1499958998.pdf>.

61 IASC Champion on Sexual Exploitation and Abuse and Sexual Harassment, <https://interagencystandingcommittee.org/iasc-champion-sexual-exploitation-and-abuse-and-sexual-harassment>.

ensure that any staff hired from local organizations or persons contracted from the local community sign and receive an orientation to and opportunities for discussion about the Code of Conduct. Beneficiaries and affected communities should also be informed and become familiar with the rules and the relevant site-specific systems so they can use them in case of a violation. The SRH Coordinator should support the development of a system for confidential reporting and follow-up of sexual exploitation and abuse.

The IASC Task Force on Protection from Sexual Exploitation and Abuse's Six Principles for Inclusion in United Nations and NGO Code of Conducts

- ▶ Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- ▶ Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defense.
- ▶ Exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading, or exploitative behavior, is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- ▶ Any sexual relationship between those providing humanitarian assistance and protection and a person benefitting from such humanitarian assistance and protection that involves improper use of rank or position is prohibited. Such relationships undermine the credibility and integrity of humanitarian aid work.
- ▶ Where humanitarian workers develop concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, they must report such concerns via established agency reporting mechanisms.
- ▶ Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their Code of Conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.⁶²

Complaints Mechanism

Complaints of sexual exploitation and abuse must be taken very seriously. Agencies should develop a response system to correctly handle any complaints that are brought to the attention of the agency. These mechanisms should be safe, confidential, transparent, and accessible. They include the following:

- ▶ **Clear and established internal complaints procedures** so that staff, communities, and people affected by crisis know how and when to confidentially report cases of

⁶² Cited in *Protection from Sexual Exploitation and Abuse (PSEA) Inter-Agency Cooperation in Community-Based Complaint Mechanisms: Global Standard Operating Procedures* (IASC, May 2016), <https://fscluster.org/document/iasc-psea-Inter-Agency-cooperation>.

sexual exploitation and abuse. This is particularly important if your agency is the only organization providing services in the community. Beneficiaries/people affected by crisis should be a part of the process to develop a system that is safe and accessible for everyone.

- ▶ **A workplace culture that encourages discussion and questioning of appropriate behavior regarding the protection of beneficiaries from sexual exploitation and abuse.** Such a culture allows staff to bring questionable behavior to a supervisor's attention.
- ▶ **Quick and proper reference of sexual exploitation and abuse reports for investigation.** Agencies can make sure they are prepared to provide strong and committed investigations when cases are reported. They must respond quickly to provide help to the survivors of these cases.⁶³
- ▶ **Appropriate discipline and penalization of acts of sexual exploitation and abuse,** which may include termination of contract, demotion, fine, and suspension without pay. If it constitutes a criminal offense, it may be referred to the proper law enforcement authorities.⁶⁴
- ▶ **An agreement that the agency office will keep all original documents of allegations in the appropriate files for the record.** The documents must be kept confidential and only accessible to relevant personnel.



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

Unit 3: Key Points

- ▶ Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person sexually, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. The MISP for SRH mainly addresses rape/attempted rape, sexual abuse, and sexual exploitation. Once the situation stabilizes and all components of the MISP for SRH have been implemented, attention can be given to addressing a wider array of GBV issues.
- ▶ Sexual violence is a human rights violation that affects the survivor's physical and mental health and social well-being while also having possible consequences for the survivor's family and the wider community.
- ▶ During emergencies such as conflicts or natural disasters, the risk of violence, exploitation, and abuse is heightened, particularly for women and girls.

⁶³ For example incident forms see Annex 4 in *Inter-Agency PSEA-CBCM Best Practice Guide* (Inter-Agency Standing Committee, 2016), <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-50>.

⁶⁴ *Inter-Agency PSEA-CBCM Best Practice Guide*.

- ▶ Adolescent girls, persons with disabilities (especially intellectual disabilities), and LGBTQIA populations are exceptionally vulnerable to sexual violence because they are often targeted for sexual exploitation and rape.
- ▶ All humanitarian actors are responsible for preventing and reporting sexual exploitation and abuse and ensuring humanitarian assistance is provided impartially, without bias or discrimination on the basis of age, sex, gender and gender identity, marital status, sexual orientation, location (e.g., rural/urban), disability, race, color, language, political or other opinion, religion, national, ethnic or social origin, property, birth, or other characteristics.
- ▶ A multisectoral approach following a standard operating procedure in each setting is required to prevent and protect the affected population and respond appropriately to sexual violence.
- ▶ The guiding principles when responding to the needs of survivors of sexual violence include safety, confidentiality, respect, and nondiscrimination.
- ▶ A survivor-centered approach means that survivors' rights, needs, and wishes are prioritized.
- ▶ Components of clinical care for survivors of sexual violence includes supportive communication; history and examination; medico-legal system and forensic evidence collection where feasible and when needed; and compassionate and confidential treatment and counseling, including EC, pregnancy testing, pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law, presumptive treatment for STIs, PEP, prevention of Hepatitis B and HPV, care of wounds and prevention of tetanus, and referral for further services, such as other health, psychological, and social services.
- ▶ The SRH Coordinator and program staff should inform the community about the importance of seeking immediate medical care following sexual violence and the type, location, and hours of services available for survivors of sexual violence.
- ▶ Reasons sexual violence often goes unreported include fear of retribution, shame, stigma, powerlessness, lack of knowledge about the benefits of seeking care and support, the unreliability of public health and other services, lack of trust in the services, and the lack of confidentiality.
- ▶ All humanitarian agencies, including those involved in MISP for SRH implementation, should have a Code of Conduct and policies for handling sexual exploitation and abuse in place.
- ▶ Agencies should develop a safe, confidential, transparent, and accessible response mechanism to correctly handle any complaints of sexual exploitation and abuse that are brought to the attention of the agency.

Challenges and Solutions

Challenges	Solutions
<p>What if staff members have low capacity and lack the basic skills to provide psychosocial services?</p>	<p>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.</p> <p>It is crucial that all staff who 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.</p> <p>Staff members need to communicate with the survivor in a way that both ensures accurate information sharing and reflects a caring, nonjudgmental attitude.</p> <p>Training programs on psychosocial support can be established once the situation is stable. In-service training programs can be provided during the acute phase of an emergency, as necessary. Undertaking this training as part of emergency preparedness would also be useful.</p> <p>Recommended resources that focus on engagement strategies for work with survivors of sexual violence include:</p> <ul style="list-style-type: none"> • <i>IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings</i>⁶⁵ • <i>Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings (1st ed.)</i>⁶⁶

⁶⁵ IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, June 2007), http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf. Additional tools can be found on IASC’s webpage “Mental Health and Psychosocial Support,” <https://interagencystandingcommittee.org/product-categories/mental-health-and-psychosocial-support>.

⁶⁶ *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings* (IRC and UNICEF, 2012), <http://gbvaor.net/wp-content/uploads/2012/10/Caring-for-Child-Survivors-of-Sexual-Abuse-Guidelines-for-Health-and-psychosocial-service-providers-in-Humanitarian-settings-IRC-UNICEF-2012-ENGLISH.pdf>.

- *Responding to Children and Adolescents Who Have Been Sexually Abused*⁶⁷
- *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*⁶⁸
- *Establishing GBV Standard Operating Procedures Guide*⁶⁹

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

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

What if staff have not been trained in clinical care for survivors of sexual violence?

It is important for organizations to deploy SRH staff trained in clinical management of survivors of sexual violence.

Work with the existing capacities of local staff and plan trainings on clinical care for survivors of sexual violence as soon as possible.

It is also useful to include training on clinical care of survivors of sexual violence as a component of emergency preparedness.

⁶⁷ *Responding to Children and Adolescents Who Have Been Sexually Abused: WHO Clinical Guidelines* (WHO, 2017), <http://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf?sequence=1>.

⁶⁸ *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (IASC, 2015), https://gbvguidelines.org/wp/wp-content/uploads/2016/10/2015_IASC_Gender-based_Violence_Guidelines_full-res.pdf.

⁶⁹ *Gender-Based Violence Resource Tools: Establishing Gender-Based Violence Standard Operating Procedures* (IASC Sub-Working Group on Gender and Humanitarian Action, May 2008), <https://www.k4health.org/toolkits/igwg-gender/establishing-gbv-standard-operating-procedures-sops>.

CHECKLIST: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

3. Prevent Sexual Violence and Respond to Survivors Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	Yes	No
	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100		%
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		
3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100		%
3.5	Information on the benefits and location of care for survivors of sexual violence		

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide clinical care to survivors of sexual violence?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.⁷⁰

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISIP to comprehensive care.

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 5	STI Treatment
Community/health post	Kit 8	Management of Complications of Miscarriage or Abortion
Community/health post	Kit 9	Repair of Cervical and Vaginal Tears

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Primary health care facility (BEmONC)	Mifepristone	Kit 8

*Misoprostol can also be procured to complement Kits 6A and 8 for the primary health care facility level.

Where feasible, it is important to pre-register IARH Kits and commodities prior to a crisis and to avoid procuring medicines that are not registered or allowed in a country during a humanitarian emergency.

⁷⁰ The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>.

Unit 3 Quiz: Prevent Sexual Violence and Respond to the Needs of Survivors

1. If a survivor does not feel comfortable with an examination and refuses to have one, the health provider should explain that treatment and medication can only be provided after an exam.

True or False

2. Clinical care for survivors of sexual violence includes all **except** for:
 - a. History and examination
 - b. Supportive communication
 - c. Presumptive treatment of STIs
 - d. Pregnancy test, and if negative only then give PEP
 - e. Emergency contraception as soon as possible and within 120 hours after the rape
 - f. Pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law

3. Male survivors are more likely to report an incident of sexual violence.

True or False

4. Perpetrators of sexual violence are often intimate partners or others known to survivor.

True or False

5. What should you do if you suspect that a staff member is violating the protection against sexual exploitation and abuse core principles?
 - a. Investigate to see if the staff member is in violation
 - b. Speak to the staff member and tell them to stop
 - c. Report the staff member to your supervisor or focal point for protection against sexual exploitation and abuse
 - d. Do nothing

UNIT 4: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs



1.6 million people living with human immunodeficiency virus (HIV) were affected by humanitarian emergencies in 2013, of whom 68% had no access to treatment.⁷¹ The relationship between HIV transmission in humanitarian settings is complex and dependent on the dynamic interaction of a variety of factors, which include:

- ▶ HIV prevalence and the vulnerability of some groups within the population in the region of origin and the host population;
- ▶ the level of interaction between displaced and surrounding populations;
- ▶ the duration of displacement; and
- ▶ the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees).

Sexually transmitted infections (STIs), including HIV, have the potential to thrive under crisis conditions where access to means of prevention, treatment, and care are limited. However, findings from conflict settings also show that in some circumstances, where displaced people have been isolated and are less mobile, HIV prevalence is lower than in neighboring countries.⁷² An important resource that outlines the set of minimum multisectoral interventions to prevent and respond to HIV in humanitarian settings is the *Inter-Agency Standing Committee Guidelines for Addressing HIV in Humanitarian Settings*.⁷³

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

- ▶ explain what safe and rational use of blood transfusion is and how to make it available;
- ▶ describe what standard precautions are, why they are important, and how to ensure they are used;
- ▶ explain the importance of ensuring the availability of free, lubricated condoms;
- ▶ explain the importance of continuing antiretrovirals and providing co-trimoxazole prophylaxis for opportunistic infections;
- ▶ identify people who should receive post-exposure prophylaxis (PEP); and
- ▶ describe the syndromic management of STIs.

⁷¹ *HIV in Humanitarian Emergencies* (UNAIDS, 2015), <https://www.unhcr.org/566961609.pdf>.

⁷² Brady W. Bennett, Brandon D. L. Marshall, Annie Gjelsvik, Stephen T. McGarvey, and Mark N. Lurie, "HIV Incidence Prior To, During, and After Violent Conflict in 36 Sub-Saharan African Nations, 1990–2012: An Ecological Study," *PLoS One* 10, no. 11 (November 12, 2015), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0142343>.

⁷³ *IASC Guidelines for Addressing HIV in Humanitarian Settings, 2010* (IASC, September 2, 2010), <https://interagencystandingcommittee.org/hiv-humanitarian-situations/documents-public/iasc-guidelines-addressing-hiv-humanitarian-settings>.

MISP for SRH objectives and activities

TO PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs.

To prevent the transmission of HIV and other STIs, the SRH Coordinator, program managers, and service providers must work with the health sector/cluster to:

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

Why is preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs a priority?

STIs cause a large proportion of the global burden of ill health. Addressing HIV remains an ongoing challenge, particularly in humanitarian contexts, despite the significant progress made over the last three decades in response to the HIV epidemic globally. Although a significant proportion of people affected by humanitarian emergencies are people at risk of or living with HIV, access to HIV prevention, treatment, and care may not often be prioritized during emergencies. The characteristics that define a complex emergency, such as conflict, mass displacement, loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV. It is necessary to do everything possible to contribute to the efforts to stop new infections and provide treatment to those in need.

What are some risk factors for the spread of HIV in crisis-affected settings?

STIs, including HIV infections, if not addressed or checked, may increase among crisis-affected populations for many reasons:^{74,75,76}

- ▶ There may be reduced access to HIV prevention, treatment, and care services due to the breakdown in health infrastructure (e.g., lack of personal protective equipment, clean needles/syringes, etc.).
- ▶ Staff may feel they are too busy to adhere to, or are not aware of the importance of, standard precautions.
- ▶ A breakdown of social and community structures can increase the incidence of rape, sexual exploitation, and transactional sex to obtain survival needs, and the disruption of social norms governing sexual behavior.
- ▶ Existing inequalities, stigmatization, and marginalization of key populations at risk of HIV and those living with HIV may be exacerbated.
- ▶ The population may move to an area of higher HIV prevalence.
- ▶ There is a limited or no access to condoms, or there is a lack of prioritization of condoms as part of the emergency response.
- ▶ Crisis-affected persons have an increased vulnerability to STIs for many reasons, including poverty, food insecurity, lack of access to health services, mobility, and lack of protection against violence and/or exploitation by the military, peacekeeping forces, and others.
- ▶ Adolescents may begin sexual relations at an earlier age.
- ▶ People may be more likely to take sexual risks, such as having sexual intercourse without condoms.

It is important to note, however, that HIV transmission among crisis-affected populations is complex. The common assumption that these populations' increased vulnerability necessarily translates into more HIV infections is not supported by data. Various competing and interacting factors affect HIV transmission during conflict and displacement.⁷⁷

HIV Transmission

HIV is transmitted through four body fluids: blood, semen, vaginal secretions, and breastmilk. The main transmission routes of HIV are through the entrance of infected fluids into the bloodstream of an uninfected individual, most commonly through unprotected sex, infected blood, and mother-to-child transmission. While the majority of infections are generally a result of unprotected sex, the proportion of transmission routes varies by setting.

⁷⁴ IASC *Guidelines for Addressing HIV in Humanitarian Settings*, 2010.

⁷⁵ *Strategies to Support the HIV-Related Needs of Refugees and Host Populations* (UNAIDS and UNHCR, October 2005) http://data.unaids.org/publications/irc-pub06/jc1157-refugees_en.pdf.

⁷⁶ *Guidelines for HIV/AIDS Interventions in Emergency Settings* (IASC, 2004), <https://www.unfpa.org/sites/default/files/resource-pdf/guidelines-hiv-emergencies.pdf>.

⁷⁷ Bennett, et al., "HIV Incidence ... in 36 Sub-Saharan African Nations, 1990–2012."

The MISP for SRH activity:

Safe and rational use of blood transfusion

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

Use the standard criteria for blood transfusions as outlined by the World Health Organization (WHO):⁷⁸

Rational blood transfusion includes the following:

- ▶ Transfusing blood only in life-threatening circumstances and when there is no other alternative.
- ▶ Using medicines to prevent or reduce active bleeding (e.g., oxytocin and misoprostol).
- ▶ Using blood substitutes to replace lost volume, such as crystalloid-based substitutes (Ringer's lactate, normal saline) wherever possible.

Safe blood transfusion includes the following:

- ▶ Screening all blood for transfusion for at least HIV 1 and 2, hepatitis B and C, and syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine HIV status. Although blood donation services should not be seen as a way for people to access HIV testing, if someone donating blood has a reactive test result, this should be communicated to them. They should then be encouraged to link with clinical services for further testing to confirm their HIV status and, if confirmed, be linked to appropriate services.
- ▶ Collecting blood only from voluntary, unpaid blood donors at low risk of acquiring transfusion-transmissible infections and developing stringent blood donor selection criteria.
- ▶ Linking blood transfusion services with HIV counseling and testing services as soon as these are established as part of the comprehensive response, and referring donors for HIV counseling and testing prior to screening their blood.
- ▶ Conducting ABO grouping and Rhesus D typing and, if time permits, cross-matching.

⁷⁸ The WHO blood transfusion safety webpage is found at <http://www.who.int/bloodsafety/en>.

- ▶ Only transfusing blood to women of reproductive age with appropriate Rhesus type blood.
- ▶ Ensuring safe transfusion practice at the bedside and safe disposal of blood bags, needles, and syringes.⁷⁹

What must the SRH Coordinator and program manager do to make rational and safe blood transfusion available?

The SRH Coordinator and program manager must work with the health sector/cluster partners to ensure that:

- ▶ Referral-level hospitals have sufficient supplies for safe and rational blood transfusion.
- ▶ Staff have appropriate knowledge of safe blood transfusion practices and have access to supplies to reduce the need for blood transfusion.
- ▶ Safe donors are recruited. Safe donors can be selected through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety. Recruit voluntary donors and do not request staff to donate blood.
- ▶ Standard operating procedures for blood transfusion are in place. These are essential components of a quality system in any organization and are used to ensure consistency in performing an activity. The use of standard operating procedures is mandatory for all staff members performing blood transfusions. Keep copies in all local languages in a central location and post them at a place where each procedure is performed so they are available for easy reference.
- ▶ Responsibility for the decision to transfuse is assigned and medical staff are held accountable.
- ▶ Staff are informed of protocols and follow procedures at all times to ensure safe blood transfusion practice at the bedside.
- ▶ Waste products, such as blood bags, needles, and syringes, are safely disposed of.
- ▶ Sites where blood is screened and where transfusion is performed have reliable light sources. To minimize the risk of errors, avoid blood transfusion at night as much as possible, unless sufficient lighting is available.⁸⁰

The MISP for SRH activity:

Ensure application of standard precautions

It is important for the SRH Coordinator to emphasize the importance of standard precautions during the first health and SRH coordination meetings. Keep in mind especially that cleaners and other support staff, who are often newly recruited, may not have worked in health setting environments before and therefore may not have received adequate training.

⁷⁹ For further information on selecting safe donors, visit http://www.who.int/bloodsafety/voluntary_donation/en.

⁸⁰ For further information on blood safety, visit http://www.who.int/bloodsafety/clinical_use/en.

What are standard precautions?

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens (e.g., HIV and hepatitis B and C) through exposure to blood or bodily fluids among patients and health care workers. Under the “standard precautions” principle, blood and body fluids, including semen, vaginal secretions, and breastmilk, from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person.

Why are standard precautions particularly important in humanitarian settings?

In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected. Regular supervision can help to reduce the risk of occupational exposure in the workplace.

What are the minimum requirements for infection control?

Standard precautions are the minimum requirements for infection control. It is critical to ensure that all staff (both medical and support) in health care settings understand standard precautions.⁸¹

The following are the standard precautions:

- ▶ Frequent hand washing:
 - Wash hands with soap and water before and after all patient contact.
 - Make facilities and supplies for hand washing easily available for all service providers.
- ▶ Wearing gloves:
 - Wear nonsterile single-use gloves for all procedures where contact with blood or other potentially infectious body fluids is anticipated.
 - Wash hands before putting on and after removing gloves. Discard gloves immediately after use. Require staff handling materials and sharp objects to wear heavy-duty gloves and to cover any cuts and abrasions with a waterproof dressing. Ensure sufficient supplies are available.

⁸¹ For further information on infection prevention, see the WHO’s “Evidence, Guidelines and Publications” at <http://www.who.int/infection-prevention/publications> and EngenderHealth’s Infection Prevention: A Reference Booklet for Health Care Providers at <https://www.engenderhealth.org/pubs/quality/infection-prevention.php>.

- **Note:** Ensure the availability of an adequate and sustainable supply of gloves to carry out all activities. Never reuse or re-sterilize single-use gloves; they become porous.
- ▶ Wearing protective clothing:
 - Waterproof gowns or aprons must be worn where blood or other body fluids might splash.
 - Require staff to wear masks and eye shields where there is possible exposure to large amounts of blood.
- ▶ Safe handling of sharp objects:
 - Minimize the need to handle needles and syringes.
 - Use a sterile, disposable syringe and needle for each injection.
 - Set up injection work area to reduce the risk of injury.
 - Use single-dose vials rather than multidose vials. If multidose vials are used, avoid leaving a needle in the stopper. Once opened, store multidose vials in a refrigerator.
 - Do not recap needles.
 - Position and inform patients correctly for injections.
 - Dispose needles and sharps in puncture- and liquid-proof safety boxes. Ensure puncture-resistant containers for sharps disposal are readily available, close at hand, and out of reach of children. Sharp objects should never be thrown into ordinary waste bins or bags.
- ▶ Disposal of waste materials:
 - Burn all medical waste in a separate area, preferably within the health facility grounds.
 - Bury items that still pose a threat, such as sharp objects, in a covered pit at least 10 meters from a water source.
- ▶ Used-instrument processing (in the following order):
 1. Decontaminate instruments to kill viruses (HIV and hepatitis B) and make items safer to handle.
 2. Clean instruments to remove debris before sterilization or high-level disinfection.
 3. Sterilize (eliminate all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. High-level disinfection (through boiling or soaking in a chlorine solution) may not eliminate spores.
 4. Use or properly store items immediately after sterilization.
- ▶ Housekeeping:
 - Promptly and carefully clean up spills of blood or other bodily fluids using a 0.5% chlorine solution.

What should SRH Coordinators do to support health sector/cluster workplace policies for occupational exposure?

Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. SRH Coordinators must advocate and provide assistance within the health sector/cluster to ensure that workplace policies for occupational exposure are established and implemented, including the following:

- ▶ Maintain confidentiality of the exposed health worker and the person who is the source of exposure at all times.
- ▶ Assess the risk of HIV transmission in case of occupational exposure: the type of exposure (percutaneous injury, mucous membrane splash, etc.), the type of exposed material (blood, other body fluids, etc.), and the likelihood of HIV infection of the source patient.
- ▶ Counsel the source patient regarding HIV testing and conduct an HIV test if consent is obtained.
- ▶ Provide counseling for the exposed worker on the implications of the exposure, the need for PEP, how to take it, and what to do in case of side effects.
- ▶ Only after receiving informed consent, take a medical history and conduct an exam of the exposed worker, recommend HIV voluntary counseling and testing, and provide PEP when appropriate. An HIV test is not required (neither for the source patient or the health worker) before prescribing PEP, and no one should be forcibly tested.
- ▶ Educate on risk reduction through a review of the sequence of events.
- ▶ Advise exposed worker to use condoms to prevent secondary transmission during the next three months.
- ▶ Provide HIV voluntary counseling and testing at three and six months after the exposure, whether or not the exposed worker received PEP.
- ▶ Complete an incident report.

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

- ▶ Ensure that protocols for standard precautions are posted in each health facility in all local languages and that supervisors enforce adherence to these.
- ▶ Ensure supplies are available to implement protocols for standard precautions at all health service delivery levels.
- ▶ Organize in-service orientation sessions on standard precautions for health care workers and auxiliary staff where needed.
- ▶ Establish supervisory systems such as simple checklists to ensure compliance with protocols.
- ▶ Ensure first-aid measures in case of occupational exposure are posted in all local

languages and staff are informed and know where to confidentially report and obtain PEP if needed.

- ▶ Review occupational exposure incident reports regularly to determine when and how exposure occurs, and to identify safety concerns and possible preventative measures.

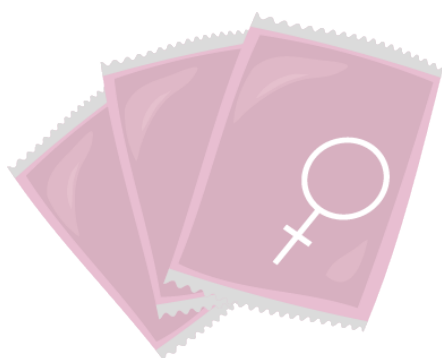
The MISP for SRH activity:

Guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms

Condoms are a key method of protection for the prevention of HIV, other STIs, and unintended pregnancy. Ensure lubricated male condoms and, where applicable (e.g., already used by the population prior to the crisis), female condoms are available in accessible and private areas, and promoted from the earliest days of a humanitarian response. Sufficient supplies of good-quality condoms should be ordered immediately. (See box below on how to calculate the correct number of male condoms to order.)

Female Condoms

Female condoms provide women and girls with a female-initiated method of protecting themselves against HIV and other STIs, as well as unintended pregnancy. This is especially important since many women and girls are unable to negotiate male condom use with their partners due to a lack of power in their relationship. Female condoms are typically more expensive and are usually not as well known as male condoms among the population. In most settings female condoms should not be procured at the onset of an acute-emergency. However, female condoms can be procured at the onset of an emergency if the affected community is known to use female condoms prior to the emergency. In planning for comprehensive SRH services, explore whether it is possible to secure a stable supply of female condoms, if the affected community is not familiar with them. Once a stable phase of the emergency is reached, provide information to the population about this method and provide training for women, girls, men, and boys on correct use.



Calculate a 3-month supply of male condoms for a population of 10,000

sexually active male population = 20%	$10,000 \times 0.2 = 2,000$ males
percentage of sexually active men who use condoms = 20%*	$2,000 \times 0.2 = 400$ users
condoms used per month per male = 12	$400 \times 12 = 4,800$ condoms
wastage or loss = 20%	$4,800 \times 0.2 = 960$ condoms
condoms used per month + wastage or loss	$4,800 + 960 = 5,760$ condoms
calculate for a 3-month supply**	$5,760 \times 3 = 17,280$ condoms

* Twenty percent is a general estimate that 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.

This is the content of one IARH Kit 1A.

Where can humanitarian staff order condoms?

The United Nations Population Fund (UNFPA) can rapidly ship bulk quantities of good-quality condoms to the field as part of the Inter-Agency Emergency Reproductive Health (IARH) Kits. Male condoms are available in the IARH Kit 1, and female condoms are in the IARH Complementary Commodity Kit 1B (starting in 2020). These IARH Kits contain sufficient supplies to cover the needs of a population of 10,000 people for three months (see calculations above). Leaflets explaining the appropriate use of male and female condoms are also included. For detailed information on ordering IARH Kits, see Unit 9.

If an organization would like to procure condoms in bulk, ensuring the quality of both male and female condoms is essential. There are many brands of condoms on the market. Ensure that the procurement office responsible for bulk purchases for emergencies sources only WHO- and UNFPA-approved condoms and adds a certificate in the relevant language to all shipments declaring that the condoms have been quality tested on a batch-by-batch basis by an independent laboratory. Agencies with limited experience in condom procurement can procure them in bulk through UNFPA.⁸²

⁸² Contact information is available at <https://www.unfpaprocedurement.org/home>.

Adolescents

Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices that could result in unintended pregnancy, unsafe abortion, STIs, and HIV. Provide discreet information and access to free condoms at adolescent-identified distribution points. Further, ensure adolescent-friendly health services are available and that health workers provide condoms to adolescents presenting to facilities.

How should condoms be made available?

In addition to providing condoms upon request in health facilities, humanitarian staff should make sure that condoms are made available in accessible, private areas in the community. Condoms can be set out at health facilities, as well as at various other sites, such as registration desks, food and non-food distribution points, youth and community service offices, and anywhere that people congregate or come to access services or supplies. It may be a good idea to make condoms available in private locations, such as latrines, and to supply hotels, coffee shops, and bars. Condoms should also be made available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, and others, along with culturally appropriate messages and information about correct use and disposal.

It is useful to discuss condom distribution with leaders and members of the crisis-affected community so they understand the need for and importance of condom use and to ensure distribution takes place in a culturally appropriate manner to increase community acceptance of condoms. Another option is consulting with local staff about how condoms can be made available in a culturally sensitive way, particularly for adolescents and key populations, such as sex workers and their clients, men who have sex with men, persons using injectable drugs, and transgender persons. Key populations and adolescents are helpful in identifying locations where their peers congregate, and these volunteers can be enlisted to distribute condoms to their peers.



Noted Practice: Making Condoms Available

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

The MISP for SRH activity:

Support the provision of antiretrovirals to continue treatment

Antiretroviral drugs reduce the transmission of HIV and excess mortality and morbidity from opportunistic infections and acquired immunodeficiency syndrome (AIDS)-defining illnesses.

Why is the continuation of antiretrovirals a priority?

Continuation of antiretrovirals for those already on treatment prior to the emergency is a priority because a sudden disruption of treatment can cause deterioration of an individual's health (by allowing opportunistic infection and immune-deficiency progression), potential transmission (due to viral rebound), and development of antiretroviral resistance. Antiretrovirals should be continued for people who were enrolled in a program prior to the emergency, including women who were enrolled in PMTCT of HIV and syphilis programs.

How can it be determined who has been on treatment and what regimen they were taking?

To determine who has been on treatment, examine health records or patient cards, ensuring that confidentiality is safeguarded. Where possible, existing networks of people living with HIV can be useful to disseminate information about the availability of antiretroviral therapy for continuation of treatment.

To determine the regimen, use patients' treatment cards where available. In general terms, first-line treatment will suffice. However, where the exact regimen (e.g., second-line regimen) is not available, the regimen should be matched with equivalent available first-line drugs, bearing in mind the national guidelines and WHO protocols for switching regimens.⁸³ Per WHO recommendations, people who are already taking antiretrovirals should not be retested for HIV. People on antiretroviral therapy should also be offered condoms.

What is the role of the SRH Coordinator in supporting the provision of antiretrovirals?

The SRH Coordinator should work with the HIV Coordinator (if one exists) or national HIV representative to support the health sector/cluster to rapidly:

1. Understand the HIV coordination system in the country. It is usually done through mechanisms led by the national HIV program, UNAIDS, the UN HIV coordination team, and civil society organizations.

⁸³ Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach (WHO, June 2016), <http://www.who.int/hiv/pub/arv/arv-2016/en>.

2. Ensure that the affected population is included in the national HIV program, including the national antiretroviral therapy program.
3. Inform the national HIV program about the urgent need to adjust its antiretroviral and co-trimoxazole distribution plans to address the needs of the crisis-affected population.
4. Quantify needs using rough total population estimates and pre-crisis statistics of prevalence and treatment rates (the MISIP for SRH Calculator can support this, see Appendix C).
5. Ensure that focal points are identified (primarily health care providers or networks of people living with HIV) and that the community is informed about how to reach focal points that will help them to get their treatment and care.
6. Facilitate the continuity of treatment of women and infants enrolled in the PMTCT of HIV and syphilis program prior to the crisis.
7. Ensure that HIV is included in needs assessments to inform scaling up HIV services once the situation stabilizes.

The SRH Coordinator should not take the responsibility for:

- ▶ the procurement of antiretrovirals for first- or second-line treatment and co-trimoxazole;
- ▶ active case identification and case management; or
- ▶ setting up the national monitoring system.

These responsibilities are under the remit of the national HIV Program, UNAIDS, and the United Nations HIV Coordination team.

The MISIP for SRH activity:

Provide PEP to survivors of sexual violence and for occupational exposure

Providing PEP to survivors of sexual violence is part of providing compassionate and confidential treatment and counseling, as outlined in Unit 3.⁸⁴ PEP treatment protocols for occupational exposure are the same as those for survivors of sexual violence.

⁸⁴ More information on PEP can be found in the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings 2018*, p. 32–33.

The MISIP for SRH activity:

Support the provision of co-trimoxazole prophylaxis for opportunistic infections

Why is it important to give co-trimoxazole prophylaxis to people living with HIV?

Co-trimoxazole prophylaxis is an antibiotic used to prevent pneumocystis pneumonia and toxoplasmosis, as well as other infectious and parasitic diseases in people living with HIV. It is a lifesaving, simple, well-tolerated, and cost-effective intervention and should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy. Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery.

Who is co-trimoxazole prophylaxis recommended for?

Co-trimoxazole prophylaxis is recommended for adults (including pregnant women) with severe or advanced HIV clinical disease and/or with a CD4 count of ≤ 350 cells/mm³. In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or clinical disease severity. Co-trimoxazole prophylaxis is recommended for infants, children, and adolescents with HIV, irrespective of clinical and immune conditions.⁸⁵ It is a priority to engage staff who are adolescents or members of key populations. These populations are also helpful to identify locations where their peers congregate including for the distribution of condoms.

The MISIP for SRH activity:

Ensure the availability of syndromic diagnosis and treatment of STIs

What is the syndromic management of STIs?

The syndromic management of STIs is a method built from algorithms (decision trees) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols. The guidelines and algorithms were developed by WHO and can be found in the WHO's *Guidelines for the Management of Sexually Transmitted Infections*.⁸⁶ Antibiotics recommended by WHO for syndromic treatment of STIs are available in the IARH Kits.

⁸⁵ *Guidelines on Post-Exposure Prophylaxis for HIV and the Use of Co-Trimoxazole Prophylaxis for HIV-Related Infections Among Adults, Adolescents and Children: Recommendations for a Public Health Approach* (WHO, December 2014) https://apps.who.int/iris/bitstream/handle/10665/145719/9789241508193_eng.pdf?sequence=1.

⁸⁶ *Guidelines for the Management of Sexually Transmitted Infections* (WHO, February 2004), <http://apps.who.int/medicinedocs/en/d/Jh2942e>.

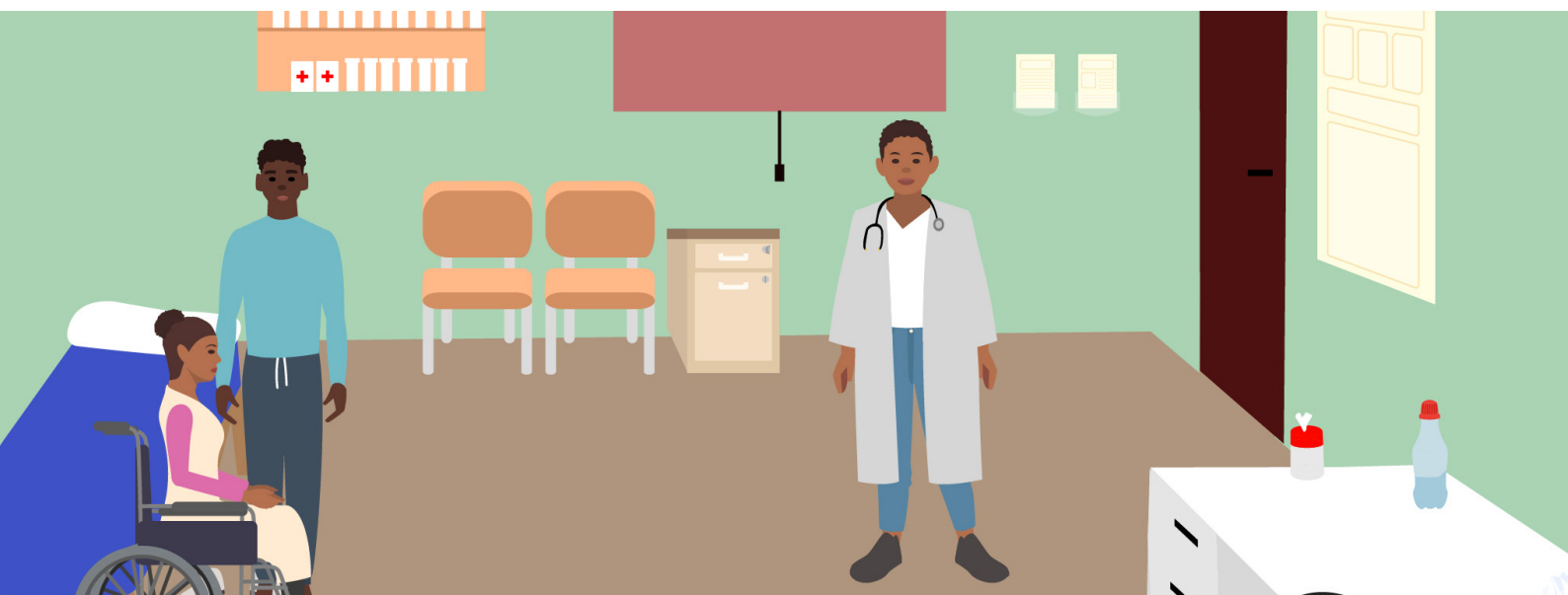
Why is syndromic management and treatment of STIs a priority?

The transmission of HIV and STIs are closely linked. Certain STIs facilitate the transmission of HIV, and the weakened immune systems of people living with HIV can make them more susceptible to STIs. Syndromic management is predictable, cost effective, satisfactory for the patients, and has a strong public health base and impact. This approach is particularly relevant at the onset of a crisis, where people are less likely to come for follow-up visits and where access to laboratories might be difficult, impossible, or expensive.



Noted Practice: Preventing the Transmission of and Reducing Morbidity and Mortality Due to HIV and Other STIs in Jordan

- ▶ There was an existing Jordanian HIV policy before the crisis, as well as accessible and stocked blood banks.⁸⁷
- ▶ Safe blood from a blood bank was available for transfusion in both the Zaatari camp and in Irbid.
- ▶ Most facilities enforced standard precautions, including use of disposable needles and syringes and sharps disposal boxes.
- ▶ In the event of a health worker's occupational exposure to HIV, occupational post-exposure treatment was available in Amman, although it was limited.
- ▶ In Zaatari camp, male condoms were available through clinics and in women's safe.



⁸⁷ Krause, et al., "Reproductive Health Services for Syrian Refugees." *Conflict and Health*, February 2, 2015.

Unit 4: Key Points

- ▶ STIs, including HIV infections, if not addressed or checked, may increase among crisis-affected populations where access to means of prevention, treatment, and care are limited.
- ▶ The SRH Coordinator and program managers must ensure that rational and safe use of blood is available to prevent the transmission of HIV and other transfusion-transmissible infections, such as hepatitis B and C and syphilis.
- ▶ The importance of standard precautions (frequent hand washing, wearing gloves and protective clothing, safe handling of sharp objects, disposal of waste materials, instrument processing, and cleaning up spills) should be emphasized and respected.
- ▶ Workplace policies for addressing occupational exposure should be established and implemented.
- ▶ Lubricated male condoms and, where applicable (e.g., already used in the population prior to the crisis), female condoms should be available in accessible and private areas in health facilities and the community and promoted from the earliest days of a humanitarian response.
- ▶ Antiretrovirals should be continued for people who were enrolled in a program prior to the emergency, including women who were enrolled in PMTCT of HIV and syphilis programs.
- ▶ It is important to give co-trimoxazole prophylaxis to prevent pneumocystis pneumonia and toxoplasmosis, as well as other infectious and parasitic diseases in people living with HIV.
- ▶ PEP should be provided to survivors of sexual violence and occupational exposure. An HIV test is not required (neither for the source patient or the health worker) before prescribing PEP, and no one should be forcibly tested.
- ▶ Syndromic management of STIs is a standardized treatment protocol based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions in a single visit.



Challenges and Solutions

Challenges	Solutions
What if the health facilities do not have the capacity to screen donors for HIV?	Do not administer blood that has not been screened. Strongly advocate to the Ministry of Health, United Nations agencies such as WHO and UNFPA, and/or a humanitarian organization such as the International Committee of the Red Cross to establish blood-screening services.
What if the culture of the crisis-affected population objects to condoms?	<p>It is important to guarantee the availability of condoms. Humanitarian workers sometimes assume that making condoms widely available may be frowned upon by some cultures. Because such an assumption may not be true or may not be true for everyone in the population, condoms are sometimes not made visible and available.</p> <p>There are creative ways to provide condoms for those who want to protect themselves or others from HIV transmission, such as placing condoms in less public yet still accessible areas. As an example, realizing people were reluctant to ask for condoms, doctors at a hospital in South Sudan placed a basket of condoms in an easily accessible location in the hospital (under a tree) where they could be taken without asking a health provider. The doctors informed the community where the basket was located. After some time, people started coming for the condoms, and now the basket needs to be refilled on a weekly basis.</p>
What if health records or patient treatment cards for individuals living with HIV are unavailable or have been destroyed?	Generally, first-line treatment will suffice for people living with HIV and whose treatment is unknown. Where the exact regimen (e.g., second-line regimen) is not available, the regimen prescribed should be matched with the equivalent available first-line drugs, bearing in mind the national guidelines and WHO protocols for switching regimens. ⁸⁸

⁸⁸ *Guidelines for the Management of Sexually Transmitted Infections*. (WHO, February 2004), <http://apps.who.int/medicinedocs/en/d/Jh2942e/>.

What if no one seems to be addressing HIV?

Speak to the SRH Coordinator to inquire directly or ask in the next health sector/cluster meeting about who the national representative is and what is being done to support the availability of antiretrovirals and co-trimoxazole for people living with HIV in the crisis-affected population. If services are not currently available, advocate within the health sector/cluster to support the Ministry of Health and others to establish services.

Request information about how the SRH working group can support any existing or new efforts to inform the community about the availability and location of services for people living with HIV.

Contacting UNAIDS or the national vertical HIV programme to ensure the inclusion of the target population in HIV services.



MISP FOR SRH MONITORING CHECKLIST: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

4. Prevent and Respond to HIV			
4.1	Safe and rational blood transfusion protocols in place	Yes	No
4.2	Units of blood screened/all units of blood donated x 100	%	
4.3	Health facilities have sufficient materials to ensure standard precautions in place	Yes	No
4.4	Lubricated condoms available free of charge	Yes	No
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	Persons with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period Specify locations:		
4.7	Antiretrovirals available to continue treatment for people who were enrolled in antiretroviral therapy prior to the emergency, including PMTCT		
4.8	PEP available for survivors of sexual violence; PEP available for occupational exposure		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to prevent the transmission of and provide treatment for HIV and other STIs?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.^{89,90}

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in PMTCT programs, **are not included in the IARH Kits**. Please go through the vertical HIV/AIDS program and/or contact UNAIDS for a sustainable source of supplies.

Health Care Level	Kit Number	Kit Name*
Community/health post	Kit 1	Male Condoms
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 5	Treatment of STIs
Referral hospital (CEmONC)	Kit 12	Blood Transfusion

*Additional standard precautions supplies are in kits 2, 4, 6, 8, 9, and 11

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Kit 1B, female condoms	Kit1

89 Most kits include supplies to ensure universal standard precautions. In addition, the Reference and Training Package, a library of resource materials, is included with each kit order. The Inter-Agency IARH Kit booklet is available at <https://www.unfpa.org/resources/emergency-reproductive-health-kits>.

90 The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>.

Unit 4 Quiz: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs

1. The syndromic management of STIs is a method used to treat STIs based on multiple visits to the clinic using standardized treatment protocols.

True or False

2. What is the role of the health provider in an emergency setting when a person presents for continued antiretroviral treatment? Select all that apply:

- a. Ensure confidentiality
- b. Provide condoms
- c. Provide co-trimoxazole, as recommended
- d. Provide antiretrovirals
- e. Advise the person to return for treatment in a couple of months when the emergency phase is over

3. Which of the following are minimum requirements for infection control (also known as standard precautions)?

- a. Safe handling of sharp objects
- b. Wearing of protective clothing
- c. Proper disposal of waste material
- d. Frequent hand washing
- e. All of the above

4. Condoms can be made available at:

- a. Health facilities
- b. Food and non-food distribution points
- c. Latrines
- d. Popular bars or coffee shops in urban areas
- e. All of the above

5. The SRH Coordinator should not take responsibility for the procurement of antiretrovirals.

True or False

UNIT 5: PREVENT EXCESS MATERNAL AND NEWBORN MORTALITY AND MORBIDITY



Two-thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflicts, natural disasters, or both.⁹¹ Stressful living conditions and limited access to skilled health providers and health facilities exacerbates the vulnerability of crisis-affected women and increases the risk of morbidity and mortality due to pregnancy-related complications.

There are several useful resources that provide step-by-step approaches to integrate emergency obstetric and newborn care (EmONC) into humanitarian programming, including the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, and the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises Training Partnership Initiative's series of clinical outreach refresher trainings.⁹² Useful resources for providing and enhancing national strategies and programs for newborn care include *Newborn Health in Humanitarian Settings: Field Guide and Operational Guidelines on Improving Newborn Health in Refugee Operations*.⁹³

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

- ▶ explain why preventing maternal and newborn morbidity and mortality is a priority;
- ▶ explain what clean and safe delivery, essential newborn care, and basic and comprehensive EmONC services must be made available and accessible in crises;
- ▶ define the requirements for an effective referral system;
- ▶ list ways to ensure post-abortion care is available and what to do if a woman presents for care; and
- ▶ explain how to make supplies and commodities available for clean delivery and immediate newborn care if access to a health facility is not possible.

91 Sarah Zeid, Flavia Bustreo, Maha Taysir Barakat, Peter Maurer, and Kate Gilmore, "For Every Woman, Every Child, Everywhere: A Universal Agenda for the Health of Women, Children, and Adolescents," *The Lancet* May 16, 2015, [https://doi.org/10.1016/S0140-6736\(15\)60766-8](https://doi.org/10.1016/S0140-6736(15)60766-8).

92 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. Assisted Vaginal Delivery via Vacuum Extraction — Refresher Training; Uterine Evacuation in Crisis Settings Using MVA — Refresher Training; and BEmONC in Humanitarian Settings: Select Signal Functions*, IAWG, accessed April 8, 2019, <http://iawg.net/tpi-home/resources>.
Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors. (WHO, UNFPA, and UNICEF, 2017), <http://apps.who.int/iris/bitstream/10665/255760/1/9789241565493-eng.pdf?ua=1>.

93 *Newborn Health in Humanitarian Settings: Field Guide* (Save the Children, WHO, and UNICEF, January 1, 2018). <http://iawg.net/resource/newborn-health-humanitarian-settings>; *Operational Guidelines on Improving Newborn Health in Refugee Operations* (UNHCR, 2015), <http://www.unhcr.org/protection/health/54bd0dc49/operational-guidelines-improving-newborn-health-refugee-operations.html>.

MISP for SRH objectives and activities

PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY.

To prevent excess maternal and newborn morbidity and mortality from the onset of an emergency, the SRH Coordinator, program managers, and service providers must work with the health sector/cluster to:

- ▶ ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving EmONC services;
- ▶ establish 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;
- ▶ ensure the availability of post-abortion care in health centers and hospitals; and
- ▶ ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable.

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

In any crisis-affected population, approximately 4% of the total population will be pregnant at any given time. Of these pregnant women, approximately 15% will experience an obstetric complication, such as obstructed or prolonged labor, pre-eclampsia/eclampsia, infection, or severe bleeding. The World Health Organization (WHO) estimates that 9% to 15% of newborns will require lifesaving emergency care.⁹⁴ Most maternal and newborn deaths occur around the time of labor, delivery, and the immediate postpartum period. The first day of life is the highest risk for newborns. In humanitarian situations, the breakdown of health systems can cause increases in maternal and newborn deaths due to untreated complications that can be prevented in stable situations (e.g., obstructed labor). This objective addresses the main causes of maternal and newborn mortality and morbidity and the lifesaving interventions that must be available in any humanitarian crisis.

What causes women to die from pregnancy complications?

The common causes of maternal mortality are hemorrhage (antepartum and postpartum), postpartum sepsis, pre-eclampsia or eclampsia, complications of abortion, ectopic pregnancy, and prolonged or obstructed labor. Delays in accessing lifesaving care, which can be caused by many factors, can cost women their lives. The delays that contribute to the likelihood of maternal death can be grouped using a simple model called the Three Delays:

- ▶ **Delay 1:** Delay in the decision to seek care;
- ▶ **Delay 2:** Delay in reaching care (inability to get transport, poor road conditions, insecurity, check points, curfews, etc.); and

⁹⁴ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.*

- ▶ **Delay 3:** Delay in receiving quality care (absence or lack of qualified staff, lack of equipment/supplies, high costs of treatment, need for down payment prior to receiving care, etc.).

The emergency team needs to make sure that basic and comprehensive EmONC services are in place and that there is an immediate focus on preventing delays in accessing quality services for women during labor and childbirth and in the immediate postpartum period.

What are some ways to manage intrapartum complications?

The WHO estimates that in any given population, 5% to 15% of all deliveries may require a caesarean section. If the percentage is high, it may mean that there is use of nonindicated caesarean sections. If it is low, the provision of EmONC may not be adequate for the population. Women with obstetric emergencies and those requiring blood transfusion and surgery will need to be referred to a hospital that is capable of providing CEmONC.

Where Type III female genital cutting is common, SRH Coordinators and health program managers should ensure that SRH service providers are trained in deinfibulation as needed for childbirth or that a referral system is established for trained providers. Providers should ensure that women and girls have information on all aspects of the procedure and obtain consent.

Estimates of C-sections needed based on a population of 150,000 with a crude birth rate (CBR) of 4%

expected number of live births in a 3-month period	$150,000 \times 0.04 \text{ (CBR)} \times .25$	1500 Births
number of deliveries that require a c-section in a 3-month period	1500×0.05	75 Deliveries

Ensuring Maternal and Newborn Care in Urban and Mobile Settings

Work within the health sector/cluster to identify and support health facilities with medical supplies and human resources to ensure provision of care for normal deliveries, basic and comprehensive EmONC, essential newborn care, and an emergency referral system 24 hours per day, 7 days per week. In circumstances where a “user fee” is a barrier to health care service, advocate with governments where feasible and with United Nations agencies such as the WHO, United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), and United Nations Children’s Fund (UNICEF) for free access for maternal and newborn health care services, including EmONC services.

Women and communities also need to be informed about the danger signs of pregnancy and where to seek immediate care. For mobile populations and in urban settings, crisis-affected populations are unlikely to know where women can go for care during childbirth or for complications of childbirth. Ensure that explicit information is available to inform pregnant women and the crisis-affected community when and where women can access care. Further, identify how communities are currently gaining information, if at all, such as through the radio, cell phones, or other means of communications. To inform communities, consider using these methods and the adaptable information, education, and communication templates available at iawg.net/resource/universal-adaptable-information-education-communication-iec-templates-misp.

The MISP for SRH activity:

Ensure availability and accessibility of clean and safe delivery, essential newborn care, and EmONC services

Where should clean and safe deliveries, essential newborn care, and EmONC services be made accessible?

Past experience has shown that at the onset of an emergency there may be an increase in births that will take place outside of the health facility without the assistance of trained health personnel. As birth complications are difficult to predict, the WHO recommends that **all births** are attended by skilled health personnel and take place in health institutions that are equipped and staffed to manage complications.

What needs to be in place within the different health levels to prevent excess maternal and newborn morbidity and mortality?

Health providers should promote the skilled attendance of all births in a health facility to prevent maternal and newborn morbidity and mortality, where feasible. They should also ensure that sufficient skilled birth attendants, equipment, and supplies (especially lifesaving medicines) are available and women are informed of the location of health facilities.

At the community level, information should be provided 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 given to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible. When distributing clean delivery kits, remind women that it is still important for them to give birth in a health facility, if possible.

Primary health care facilities should provide skilled birth attendants (including midwives) and supplies for vaginal births, essential newborn care, and provision of basic EmONC (BEmONC).

Referral hospitals should provide all the above health facility activities, as well as skilled medical staff and supplies for provision of comprehensive EmONC (CEmONC).

Adolescents

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



Signal Functions of Basic and Comprehensive EmONC*

Ensure basic EmONC at all health centers. This means that staff are skilled and have the resources to do the following:

1. Administer parenteral antibiotics for treatment of maternal sepsis.
2. Administer parenteral anticonvulsant drugs (e.g., magnesium sulfate) to manage severe pre-eclampsia and eclampsia.
3. Perform assisted vaginal delivery (e.g., vacuum extraction).
4. Manually remove the placenta.
5. Remove retained products of conception after delivery or an incomplete abortion.
6. Perform basic neonatal resuscitation (e.g., with bag and mask).
7. Administer uterotonic drugs (e.g., parenteral oxytocin or misoprostol tablets) for treatment of postpartum hemorrhage and administer intravenous tranexamic acid in addition to standard care for women with clinically diagnosed postpartum hemorrhage.

Ensure comprehensive EmONC at hospitals. This means that staff are skilled and have the resources to support all interventions 1–7 above, plus:

8. Perform surgery (e.g., caesarean section).
9. Perform safe blood transfusion, observing universal infection prevention precautions.

**Signal functions are key medical interventions that are used to treat the direct obstetric complications that cause the vast majority of maternal deaths around the globe.*

Basic EmONC

Basic emergency obstetric and newborn care (BEmONC) must be provided at the health center level to address the main complications of childbirth, including newborn complications. While skilled attendance at all births in a health facility is ideal because it can help reduce morbidity and mortality associated with pregnancy and childbirth, it may not be feasible at the start of a humanitarian response. However, at a minimum, ensure that BEmONC interventions and capacity to refer to the hospital for comprehensive EmONC are available 24 hours per day, 7 days per week at each health center.

Comprehensive EmONC

Comprehensive emergency obstetric and newborn care (CEmONC) must be provided at referral hospitals to address obstetric complications. Where feasible, support host-country hospitals with skilled staff, infrastructure, and medical commodities, including medicines and surgical equipment, as needed to provide CEmONC. If this is not feasible because of the hospital's location or inability to meet the increased demand, the SRH Coordinator should work with the health sector/cluster and an agency such as the

International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, or other nongovernmental organizations (NGOs) to provide CEmONC. Services can be made available, for example, by establishing a temporary field or referral hospital close to the crisis-affected population.

Key Danger Signs of Pregnancy

- ▶ Vaginal bleeding
- ▶ Severe abdominal pain
- ▶ Convulsions
- ▶ Severe headache
- ▶ Fever
- ▶ Fast or difficult breathing

What are some lifesaving medicines and supplies needed to address maternal and newborn complications?

Provide midwives and other skilled birth attendants in health centers with materials and medicines to conduct deliveries, provide newborn care, treat complications, and stabilize women prior to transport to the hospital if needed.

Lifesaving medicines and supplies that must be available include:

- ▶ **antibiotics** for prevention and management of maternal infections;
- ▶ **uterotonics** (oxytocin, misoprostol, and tranexamic acid) for prevention and management of postpartum hemorrhage;
- ▶ **anticonvulsants** (magnesium sulfate) for prevention and treatment of severe pre-eclampsia and eclampsia;
- ▶ **newborn resuscitation supplies**, including a bag and mask;
- ▶ **antibiotics** (gentamycin and ampicillin) for treatment of newborn infections; and
- ▶ **antenatal steroids** (dexamethasone) for preterm labor and **antibiotics** (penicillin and erythromycin) for premature pre-labor rupture of membrane, at specialized referral hospitals only. Skilled medical providers at specialized referral hospitals should have the ability to manage obstetric complications, provide neonatal intensive care, accurately estimate gestational age, and administer steroids (dexamethasone for fetal lung maturity).

Newborn care

Essential newborn care is the basic care required for every baby. Approximately two-thirds of infant deaths occur within the first 28 days of life. The majority of these deaths are preventable by initiating essential actions that can be taken by health workers, mothers, or other community members. One major challenge is that approximately 5% to 10% of newborns do not breathe spontaneously at birth and require assistance to breathe. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

Newborn Danger Signs

The following danger signs indicate a newborn should be referred to a health facility by family members and community health workers:

- ▶ Not feeding well
- ▶ Fits or convulsions
- ▶ Reduced activity or lack of movement
- ▶ Fast breathing (more than 60 breaths per minute)
- ▶ Severe chest in drawing
- ▶ Temperature above 37.5°C or below 35.5°C
- ▶ Very small size at birth

Formally trained medical staff are able to identify additional danger signs.

What are the essential services for all newborns?

Newborn care is part of the continuum of care for a mother and baby. In humanitarian settings, essential newborn care is provided at the community, health center, and hospital levels and includes the following:

- ▶ **Thermal care:** Drying, warming, skin-to-skin contact, and delayed bathing.
- ▶ **Infection prevention/hygiene:** Clean birth practices, hand washing, and clean cord, skin, and eye care.
- ▶ **Feeding support:** Skin-to-skin contact, support for immediate and exclusive breastfeeding, and not discarding colostrum (i.e., first milk).
- ▶ **Monitoring:** Frequent assessment for danger signs of serious infections and other conditions that require extra care outside of the household or health post.
- ▶ **Postnatal care checks:** Care given at or as close to home as possible in the first week of life. The first 24 hours are the most critical time, and a postnatal visit should be a priority. Every effort should be made to reach newborn babies at home as soon as possible after delivery.

Chlorhexidine for Clean Cord Care at Home

Daily application of 7.1% chlorhexidine digluconate to the umbilical cord stump during the first week of life is recommended for newborns who are born at home in settings with high neonatal mortality. It is a low-cost, acceptable, and feasible intervention shown to reduce newborn morbidity and mortality related to infection and sepsis. Where women have been trained on the application of chlorhexidine for cord care prior to the emergency, chlorhexidine can be procured as an Inter-Agency Emergency Reproductive Health (IARH) Kit complementary commodity (early 2020).

Clean, dry cord care is recommended for newborns born in health facilities and at home in low neonatal mortality settings.

Important to note: The WHO has issued a warning that chlorhexidine 7,1% digluconate aqueous solution or gel (10ml) has caused serious harm when mistakenly applied to the eyes. This has resulted in severe eye injuries, including blindness.⁹⁵



⁹⁵ Information Exchange System, Alert No. 133 Chlorhexidine 7,1% digluconate (CHX) aqueous solution or gel (10ml) Reports of serious eye injury due to errors in administration (World Health Organization, February 2019), https://www.healthynewbornnetwork.org/hnn-content/uploads/alert133_chlorhexidine.pdf.

What newborn care should be provided at the health facility level and the hospital level?

Newborn Care at the Health Facility Level	Newborn Care at the Hospital Level
<p>Address intrapartum complications and ensure labor monitoring using partograph with appropriate action for complications.</p> <p>Be prepared for newborn resuscitation at every birth, including drying, clearing airway as needed, stimulation, and bag and mask ventilation.</p> <p>Provide essential newborn care for every newborn.</p> <p>For preterm and low birth weight /small newborns where babies and mothers are clinically stable, initiate skin-to-skin contact, support immediate breastfeeding, and refer to a hospital as soon as possible.</p> <p>Manage signs of possible serious bacterial infections in newborns, including diagnosing, classifying, providing the first dose of antibiotics, and referring to a hospital as soon as possible.</p>	<p>Ensure space for newborn resuscitation in the labor ward and capacity and supplies to provide bag and mask ventilation.</p> <p>Ensure space for newborn resuscitation in the labor ward and capacity and supplies to provide bag and mask ventilation.</p> <p>Address intrapartum complications and ensure labor monitoring using partograph with appropriate action for complications.</p> <p>Provide newborn resuscitation, including drying, clearing airway as needed, stimulating, and ventilating with bag and mask. Continue to manage newborns with respiratory distress.</p> <p>Provide essential newborn care for every newborn.</p> <p>Establish a kangaroo mother care unit for babies and mothers that are clinically stable, support immediate breastfeeding, and follow WHO guidelines for preterm infants, including management of serious signs of bacterial infections in newborns.</p>

Kangaroo Mother Care for Preterm and Low Birthweight Babies

Kangaroo mother care is one of the most promising ways to save preterm and low birthweight babies in all settings. This form of care, initiated in health facilities, involves teaching health workers and caregivers how to keep newborns warm through continuous, 24-hours-per-day, skin-to-skin contact on the mother or caregiver's chest. Kangaroo mother care may significantly enhance other well-known treatments for prematurity, such as thermal care, breastfeeding support, infection prevention and management, and neonatal resuscitation.



The Reality of Implementing the MISP for SRH in Nepal

Following the earthquake in Nepal in April 2015, UNFPA estimated that 1.4 million women of reproductive age were affected, including 93,000 pregnant women, of which 1,000 to 1,500 were likely to experience complications.⁹⁶ The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) was immediately initiated by government, international, and local actors.

In September 2015, a MISP for SRH assessment was conducted by a team from the IAWG on RH in Crises. Regarding the objective on the prevention of maternal and newborn morbidity and mortality, the assessment revealed that facilities visited were providing normal delivery services and BEmONC was available. To increase facility-based deliveries in the Sindhupalchowk district, a temporary hospital was set up for CEmONC with an emergency referral system, and radio and television campaigns were conducted to provide women with information about the services.

However, after the closure of this temporary hospital, CEmONC was not reliably available in Sindhupalchowk. Focus group discussion participants reported bypassing nearby health posts or the district hospital when experiencing complications and going directly to the neighboring district hospital or Kathmandu for quality care. Ongoing barriers to accessing delivery care in the facilities included direct and indirect costs associated with reaching facilities, particularly in faraway districts.

Clean delivery kits were distributed to pregnant women in Sindhupalchowk and there were newborn care services provided in both Kathmandu and Sindhupalchowk districts, with well-established comprehensive care in higher-level hospitals in Kathmandu. Sindhupalchowk reported that barriers to implementing comprehensive newborn care included a lack of or malfunctioning equipment.

⁹⁶ Myers, et al., "Facilitators and Barriers in Implementing the Minimum Initial Services Package."

The MISP for SRH activity:

Establish a 24 hours per day, 7 days per week referral system

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

Because most maternal and perinatal deaths are due to a failure to get skilled help in time for complications of childbirth, it is critical to have a well-coordinated system to identify obstetric complications and ensure their immediate management and/or referral to a health center with BEmONC or a hospital with CEmONC capacity as needed. SRH Coordinators must coordinate with the health sector/cluster and host-country authorities, as well as communities, to ensure a referral system (including means of communication and transport) is established in the first days in a humanitarian setting.

The referral system must support the management of obstetric and newborn complications 24 hours per day, 7 days per week. It should ensure that women, girls, and newborns who require emergency care are referred from the community to a health center where BEmONC is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health center must be stabilized and transported to the nearest available hospital with CEmONC services.

What are the requirements for an effective and efficient referral system?

To ensure an effective and efficient referral system:

- ▶ Develop policies, procedures, and practices to be followed in health centers and hospitals to ensure efficient referral.⁹⁷
- ▶ Assess the referral facilities to ensure adequate supplies, staffing and infrastructure to provide CEmONC.
- ▶ Determine distances from the affected community to functioning health centers and to the hospital, as well as transport options for referrals—including drivers, sufficient fuel, and cellphones/radio/sat phones—available 24 hours per day, 7 days per week.
- ▶ Post protocols in every health center, specifying when, where, and how to refer patients with obstetric and newborn emergencies to the next level of care.
- ▶ In a camp setting, negotiate with camp security personnel for lifesaving access to the referral hospital in order to allow for transport of emergency patients at night.
- ▶ Inform communities about the danger signs of pregnancy and where to seek emergency care for complications of pregnancy and childbirth:

⁹⁷ Ideally hospitals and health centers should have referral policies and procedures in place prior to a humanitarian crisis to ensure the health system is ready to respond.

- Messages should be shared in multiple formats and languages (e.g., Braille, sign language, pictorial formats) to ensure accessibility and in discussion groups through community-led outreach (with women’s, lesbian, gay, bisexual, transgender, queer, intersex, and asexual [LGBTQIA], and persons with disabilities groups) and other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women’s latrines).
- ▶ Where 24 hours per day, 7 days per week referral services are impossible to establish, make sure that qualified staff are available at all times at health centers to provide BEmONC. For example, establish a system of communication, such as the use of radios or cell phones, to get medical guidance and support from more qualified personnel. The SRH Coordinator should also work through the health sector/cluster to resolve the problem and ensure that the populations have access to basic and comprehensive EmONC.



Noted Practice: Establishing a Referral System in Cox’s Bazar, Bangladesh

In Cox’s Bazar, Bangladesh, access and transportation to health facilities and referral hospitals were challenging due to the difficult terrain.⁹⁸ In addition to mobilizing ambulances, over 20 Tom Toms (a motorbike with seats) were used to bring pregnant women and others in need to health facilities. The phone number of the Tom Tom coordinator was shared, and the service was available day and night. One Tom Tom per facility was also stationed for any emergency referral.

The MISP for SRH activity:

Ensure the availability of post-abortion care in health centers and hospitals

Post-abortion care is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion (also called a miscarriage) and is a lifesaving intervention. Death and injury from unsafe abortion continues to be a serious public health problem that affects women, girls, families, and entire communities. Globally, unsafe abortion, defined as an abortion performed either by persons lacking the necessary skills or in an environment lacking the minimum medical standards, or both, accounts for nearly 8% of maternal deaths, 97% of which occur in the developing world.⁹⁹ Women and girls in humanitarian settings may be at an increased risk of unintended pregnancy and unsafe abortion.

⁹⁸ Site visit, Women’s Refugee Commission, February 2018.

⁹⁹ “Induced Abortion Worldwide,” Guttmacher Institute, March 2018, <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>; and *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 48.

Most countries allow abortion to be performed for one or more of the following reasons, including when the pregnancy:

- ▶ endangers the woman's life;
- ▶ threatens the woman's physical and/or mental health;
- ▶ is the result of rape or incest; or
- ▶ involves a fetus with a severe impairment.

All countries allow for legal access to emergency post-abortion care, regardless of the legal status of access to abortion. Women and girls are also at risk of spontaneous abortion, and some will require timely and appropriate care.

What should be done if a woman presents for post-abortion care?

Typically, women presenting for post-abortion care are ambulatory and have symptoms that may include vaginal bleeding, abdominal pain, fever, or chills.¹⁰⁰ Women who have suffered more severe complications may present with shock, hemorrhage, sepsis, and intra-abdominal injury. Severe complications are more likely in settings where access to safe and legal abortion care is limited.

If a woman presents for post-abortion care, a skilled health provider should do the following:

- ▶ **Conduct a rapid initial assessment.** If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization.
- ▶ **Once the initial assessment and stabilization are underway, conduct a more complete clinical assessment to determine the cause and begin treatment.** This includes a history and directed physical exam with concurrent urgent treatment for definitive management of underlying causes. Shock in post-abortion care clients is usually either hemorrhagic or septic:
 - *Hemorrhagic shock* is the result of severe blood loss, which may be caused by an incomplete abortion, uterine atony, or vaginal, cervical, uterine, or intra-abdominal injury.
 - *Septic shock* is the end result of infection, which may come from incomplete abortion, endometritis, or intra-abdominal injury.
- ▶ **Provide immediate uterine evacuation, if treatment requires.** In the first trimester this is typically done through vacuum aspiration or the use of misoprostol. If the woman requires treatment beyond the capability of the facility where she is seen, stabilize her condition before transferring her to a higher-level service.
- ▶ **Provide or refer the patient for tetanus prophylaxis.** Women who have had unsafe abortions with nonsterile instruments are at risk of tetanus, particularly in communities where tetanus after abortion has been reported.
- ▶ **Provide all women who present for post-abortion care with contraceptive information, counseling, and services once their immediate medical needs are met.**

¹⁰⁰ More information on post-abortion care is available in Unit 8 on safe abortion care to the full extent of the law.



Noted Practice: Provision of Post-abortion Care in Cox's Bazar, Bangladesh

In Cox's Bazar, Bangladesh, a partnership with Ipas supported the immediate rollout of post-abortion care services.¹⁰¹ The deployment of trained health workers and availability of adequate commodities facilitated service provision. Referral facilities were equipped with human resources and commodities to provide post-abortion care in a systematic manner.

The MISP for SRH activity:

Ensure availability of supplies and commodities for clean delivery and basic newborn care

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

In all humanitarian settings, there are women and girls who are in the advanced stages of pregnancy and will therefore deliver during the emergency. At the onset of a humanitarian response, births will often take place outside of a health center without the assistance of skilled birth attendants. In many places home deliveries are common. It is important to make clean delivery kits available to all visibly pregnant women to improve birth and essential newborn care practices when access to a health facility is not possible. Be sure to include information—in the local language—on how to use the kit, to emphasize the importance of giving birth at a health facility in the presence of a skilled provider, and about how to access nearby health facilities. Distribution can be done at registration sites or via community health workers where there is an established network. In settings where access to facilities is not possible and traditional birth attendants are assisting home deliveries, they can be given clean delivery packages.

What is the best way to obtain clean delivery packages?

Clean delivery kit (IARH Kit 2A) packages and supplies for community-level distribution can be ordered from UNFPA through the IARH Kit procurement process.¹⁰² Because these materials are often easily obtained locally and do not expire, it is possible to assemble these kits on site and pre-stock them in settings where they do not need to be immediately available. If possible, consider contracting with a local NGO to produce the kits, which could provide an income-generation project for local women. If a decision is made to locally procure the items as a preparedness measure, it is essential to ensure the quality of the individual items being procured; the UNFPA country office or Procurement Services Branch can support in this effort.

¹⁰¹ Site visit, Women's Refugee Commission, February 2018.

¹⁰² To order kits, go to <https://www.unfpaprocurement.org/humanitarian-supplies>.



Noted Practice: Ensuring the Availability of Clean Delivery Supplies

If the situation permits, assembling clean delivery packages locally may be a good opportunity to identify and organize women's groups and traditional birth attendants. This provides an opportunity to talk about informing and encouraging all pregnant women to deliver in a health facility and the early recognition and referral of those suffering from obstetric complications. The women's groups can make the packages and then distribute them to visibly pregnant women free of charge. This is particularly helpful because, as the women's groups are part of the crisis-affected population, they most likely already know which women are close to their delivery times and are in need of the materials. Those responsible for distributing the kits should also be informed about the nearest facilities, the danger signs in pregnancy, and the importance of delivering with a skilled attendant so that they can pass this information on to the women they visit.

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

Setting up services to provide antenatal care and training midwives are appropriate activities that need to be established as soon as possible. However, these interventions are not a priority in the immediate emergency and should not divert attention from the more urgent need for access to quality facility-based delivery, basic and comprehensive EmONC services, and newborn care.

Training existing midwives on clean and safe deliveries can wait until the situation has stabilized. Identifying midwives, however, and ensuring they are informed about the referral system should be undertaken from the onset of a crisis. It is important to note the definition of "skilled personnel" has been updated to reflect new evidence and a focus on being competent in providing care during childbirth. The WHO does not recommend training new traditional birth attendants but rather informing all women and the community about danger signs of pregnancy and facilitating referrals to health facilities and, in the stable phase of humanitarian emergencies, supporting professional training for midwives.



Noted Practice: Preventing Excess Maternal and Newborn Mortality and Morbidity in Cox's Bazar, Bangladesh

- ▶ UNFPA and partners were able to deploy obstetricians and anesthesiologists (a combination of national and international staff) to the referral facilities to provide CEmONC.¹⁰³
- ▶ Midwives, who were the first responders at all levels of the health system, were trained in initial stabilization and supported with commodities and supplies.
- ▶ An adequate number of midwives to provide services 24 hours per day, 7 days per week was assured, in addition to having midwife mentors to support new recruits and encourage them to provide evidence-based care.
- ▶ Clean delivery kits were distributed very early on in the emergency through mobile SRH clinics, static clinics, and community health workers. A contingency stock was kept at all times to ensure there were enough supplies available to meet the needs of new Rohingya arrivals over weeks.

Unit 5: Key Points

- ▶ To prevent excess maternal and newborn morbidity and mortality, the WHO recommends that all births be attended by skilled health personnel and take place in health institutions that are equipped and staffed to manage complications.
- ▶ Each health center should have skilled birth attendants and supplies for vaginal births, essential newborn care, and BEmONC interventions, as well as the capacity to refer to the hospital for CEmONC 24 hours per day, 7 days per week.
- ▶ The essential services for all newborns include thermal care, infection prevention/hygiene, feeding support, monitoring, and postnatal care checks.
- ▶ Midwives and other skilled birth attendants should be provided with materials and medicines to conduct deliveries, provide newborn care, treat complications, and stabilize women prior to transport to the hospital, if needed.
- ▶ A referral system must be established to facilitate transport and communication from the community to the health center and hospital to manage obstetric and newborn complications 24 hours per day, 7 days per week.
- ▶ Community members must be informed about the danger signs of pregnancy and childbirth and where to seek emergency care for complications of pregnancy and childbirth.
- ▶ Post-abortion care should be available in the health centers and hospitals because women and girls in humanitarian settings may be at increased risk of spontaneous abortions, unintended pregnancies, and unsafe abortions.
- ▶ Clean delivery packages should be made available to all visibly pregnant women to improve birth and essential newborn care practices when access to a health facility is not possible.

103 Site visit, Women's Refugee Commission, February 2018.

Challenges and Solutions

Challenges	Solutions
What if ensuring 24/7 referral services is not possible due to insecurity in the area?	Without access to adequate basic and comprehensive EmONC, women, girls, and newborns will die unnecessarily. Therefore, it is important to attempt to negotiate access to an appropriate referral facility within any emergency referral system. Where 24/7 referral services are impossible to establish, it is essential that qualified staff are available at all times to stabilize patients with BEmONC. 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.
What if the crisis-affected population does not have a history of routinely accessing services for assisted delivery?	<p>As many women in developing countries routinely deliver in their homes, an essential activity to undertake is to ensure the community—especially midwives and existing traditional birth attendants—knows the danger signs and where to immediately refer women, as needed. It is also important to refer newborns to a health facility if they show any of the danger signs.</p> <p>Provide incentives for deliveries in health facilities, such as transport vouchers and newborn kits.</p> <p>Plan and implement trainings and other capacity development opportunities for all trained health staff once the emergency is stable and the MISP for SRH has been fully implemented to ensure respectful, quality care.</p>
What else can be used for transportation besides an ambulance?	Not all health facilities have ambulances. Depending on the context, other solutions could include, but are not limited to, donkey carts, stretchers, rented vehicles, and bicycles.
What can be done if a referral hospital lacks the lifesaving supplies needed for BEmONC and CEmONC?	<p>Discuss the issue during the SRH and health sector/cluster coordination meeting.</p> <p>Work with UNFPA to determine if IARH kits are already available in country.</p> <p>Work with United Nations agencies, including WHO, UNHCR, and UNFPA, World Food Programme (WFP), and the logistics cluster to see if they can support with supplies procurement and management.</p> <p>Discuss the issue with the Ministry of Health and/or advocate for available supplies to be sent to the referral hospitals.</p>

MISP FOR SRH MONITORING CHECKLIST: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY

The MISP for SRH Checklist, below, can be used to monitor SRH service provision in humanitarian emergencies.

5. Prevent Excess Maternal and Newborn Morbidity and Mortality			
5.1	Availability of EmONC basic and comprehensive per 500,000 population	Yes	No
	Health center with basic EmONC, five per 500,000 population		
	Hospital with comprehensive EmONC, one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
5.3	Hospital (to ensure comprehensive EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	One team of doctor, nurse, midwife, and anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care (PAC)		
	Coverage of PAC: (number of health facilities where PAC is available/number of health facilities) x 100		%
	Number of women and girls receiving PAC		
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 (means of communication [radios, mobile phones])	Yes	No
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		
5.4	Functioning cold chain (for oxytocin, blood-screening tests) in place		
5.5	Proportion of all births in health facilities: (number of women giving birth in health facilities in specified period/expected number of births in the same period) x 100		%
5.6	Need for EmONC met: (number of women with major direct obstetric complications treated in EmONC facilities in specified period/expected number of women with severe direct obstetric complications in the same area in the same period) x 100		%
5.7	Number of caesarean deliveries/number of live births at health facilities x 100		%
5.8	Supplies and commodities for clean delivery and newborn care		
5.9	Clean delivery kit coverage: (number of clean delivery kits distributed where access to health facilities is not possible/estimated number of pregnant women) x 100		%
5.10	Number of newborn kits distributed including clinics and hospitals		
5.11	Community informed about the danger of signs of pregnancy and childbirth complications and where to seek care		

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide clean and safe delivery, essential newborn care, and EmONC services?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.¹⁰⁴

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 2A, 2B	Clean Delivery (A: mother, B: birth attendant)
Primary health care facility (BEmONC)	Kit 6A, 6B	Clinical Delivery Assistance—Midwifery Supplies (A: Reusable, B: Consumable)
Primary health care facility (BEmONC)	Kit 8	Management of Complications of Miscarriage or Abortion
Primary health care facility (BEmONC)	Kit 9	Repair of Cervical and Vaginal Tears
Primary health care facility (BEmONC)	Kit 10	Assisted Delivery with Vacuum Extraction
Referral hospital (CEmONC)	Kit 11A, 11B	Obstetric Surgery and Severe Obstetric Complications Kit (A: Reusable, B: Consumable)
Referral hospital (CEmONC)	Kit 12	Blood Transfusion

* Where there is a kit A and B, it means that these kits may be used together, but they can also be ordered separately.

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

104 The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>.

Service Delivery Level	Item	To Complement
Community/health post	Chlorhexidine	Kit 2A
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Community/health post	Inter-Agency Newborn Care Supply Kit (Community)**	Kit 2A, 2B
Primary health care facility (BEmONC)	Non-Pneumatic Anti-Shock Garment	Kit 6A
Primary health care facility (BEmONC)	Oxytocin	Kit 6B
Primary health care facility (BEmONC)	Inter-Agency Emergency Health Kit (Basic Malaria Module)	Kit 6B
Primary health care facility (BEmONC)	Inter-Agency Newborn Care Supply Kit (Primary Health Facility)**	Kit 6A, 6B
Primary health care facility (BEmONC)	Mifepristone*	Kit 8
Primary health care facility (BEmONC)	Handheld Vacuum-Assisted Delivery System	Kit 10
Referral hospital (CEmONC)	Inter-Agency Newborn Care Supply Kit (Hospital)**	Kit 11A, 11B

*Misoprostol can also be procured to complement Kits 6A and 8 for the primary health care facility level.

**At the time of printing the 2018 IAFM, Newborn Care Supply Kits were not yet available.



Unit 5 Quiz: Prevent Excess Maternal and Newborn Morbidity and Mortality

1. Which of the below is **not** an essential service for all newborns?
 - a. Drying, warming, skin-to-skin contact, and delayed bathing
 - b. Infection prevention/hygiene
 - c. Feeding support: discarding colostrum (or first milk) and then supporting breastfeeding or formula if available
 - d. Monitoring for danger signs of serious infections
 - e. Postnatal care checks
2. Where should BEmONC and/or CEmONC services be made accessible?
 - a. In referral hospitals
 - b. In health centers
 - c. At the community level
 - d. a and b
3. Newborns should be referred to a health facility if they have reduced activity or lack of movement.

True or False

4. If a woman presents for post-abortion care, the **first** thing a skilled health provider should do is refer her to a hospital.

True or False

5. Who should the SRH Coordinator work with to establish an effective referral system at the onset of a humanitarian crisis? Select all that apply:
 - a. Health sector/cluster
 - b. Communities
 - c. Host-country authorities

UNIT 6: PREVENT UNINTENDED PREGNANCIES



Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. Global data suggests that an additional 29% of maternal deaths could be reduced through the provision of contraception for women who desire to prevent or delay pregnancy at that time.¹⁰⁵ However, as health systems are compromised during natural disasters and conflicts, access to contraception decreases. It is critical that the importance of the provision of contraception and its lifesaving effects are understood by Sexual and Reproductive Health (SRH) Coordinators, health program managers, and service providers to be part of essential health programming from the earliest phase of an emergency through recovery.

There are several useful resources that provide in-depth information on contraceptive methods and medical eligibility criteria, including the *Contraceptive Delivery Tool for Humanitarian Settings*¹⁰⁶ and *Family Planning: A Global Handbook for Providers*.¹⁰⁷

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

- ▶ explain why preventing unintended pregnancies is a lifesaving priority;
- ▶ list what contraception methods should be available in primary health care centers;
- ▶ explain what information should be available and how to ensure women, adolescents, and men are aware of the availability of contraceptives; and
- ▶ list ways to share information about the availability of contraceptives with the community.

105 Saifuddin Ahmed, Qingfeng Li, Li Liu, and Amy O Tsui, "Maternal Deaths Averted by Contraceptive Use: An Analysis of 172 Countries," *The Lancet* 380, no. 9837 (July 14, 2012), p. 111–125, [https://doi.org/10.1016/S0140-6736\(12\)60478-4](https://doi.org/10.1016/S0140-6736(12)60478-4).

106 *Contraceptive Delivery Tool for Humanitarian Settings* (WHO, 2018), <https://apps.who.int/iris/handle/10665/276553>.

107 *Medical Eligibility Criteria for Contraceptive Use* (WHO, 2015), https://apps.who.int/iris/bitstream/handle/10665/181468/9789241549158_eng.pdf?sequence=1; and *Family Planning: A Global Handbook for Providers* (WHO, Johns Hopkins Bloomberg School of Public Health, and USAID 2018), <http://www.fphandbook.org>.

MISP for SRH objectives and activities

PREVENT UNINTENDED PREGNANCIES.

To prevent unintended pregnancies from the onset of an emergency, it is important to ensure contraceptives are available. The SRH Coordinator, program managers, and services providers must work to:

- ▶ ensure 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;
- ▶ provide information, including existing information, education, and communications materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination;
- ▶ ensure the community is aware of the availability of contraceptives for women, adolescents, and men.

Why is preventing unintended pregnancies a priority?

Women, men, and adolescents' SRH needs do not disappear when they are forced to flee their homes and communities; this includes the need for contraception. Displacement and insecurity may even increase people's desire and need for contraception, at the same time as they experience increased barriers to access. Those fleeing an emergency may not be able to bring their contraceptives with them or obtain contraceptives at their site of refuge. Conflict and natural disasters also expose women and girls to increased risks of sexual violence and subsequent unwanted pregnancy. Further, people continue to have sex lives during an emergency. Women may wish to postpone or cease bearing children in emergencies for many reasons, including to avoid exposing newborns to the risks of displacement. The disruption of family and social support structures can further pose challenges, particularly for adolescents who, without access to adequate information and services, can be more at risk of exposure to unsafe sexual practices. It is therefore vital that contraception is properly integrated into humanitarian response and that services and supplies are made available to meet the demand in the affected population from the onset of an emergency.





The Reality of Implementing the MISP for SRH in Nigeria

Boko Haram violence forced people to flee from their homes into internally displaced persons camps and host communities.¹⁰⁸ To respond to the health needs of women and girls, the International Rescue Committee's Emergency Response Team deployed an SRH Coordinator to launch the Minimum Initial Service Package (MISP) for SRH in the newly liberated government areas. The international nongovernmental organization (NGO) recruited midwives and skilled staff to augment and support existing Ministry of Health providers. Inter-Agency Emergency Reproductive Health (IARH) Kits were ordered and delivered, including SRH equipment, medications, contraceptives, and supplies for six months. The SRH Coordinator also conducted on-the-job training to provide clinical care for survivors of sexual violence, contraception, and post-abortion care. The International Rescue Committee supported a total of five clinics. Within four weeks, it set up the only RH clinic in the Bakassi internally displaced persons camp, which included family planning services—registering 134 new contraception acceptors within the first month.

Lessons learned: Emergency responders must anticipate and prepare for a low number of available skilled health staff, long lead times for procurement and recruitment, and a low priority placed on SRH.

The MISP for SRH activity:

Ensure availability of a range of long-acting, reversible, and short-acting contraceptive methods at primary health facilities

A range of long-acting, reversible (implants and intrauterine devices [IUDs]), and short-acting (oral contraceptive pills, hormonal injectables, male condoms, female condoms where applicable, e.g., already used by the population prior to the crisis, and EC pills) contraceptive methods should be made immediately available to meet the demand of the affected population where providers are trained and skilled to provide and, in the case of long-term reversible contraception, remove the method.

Providers with existing competency should begin providing all available methods at the onset of the crisis. All forms of contraception should be provided on a confidential basis, without requiring the consent of a partner, parent, or caregiver. Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection (to prevent pregnancy and sexually transmitted infections [STIs], including human immunodeficiency virus [HIV]). More information on delivering contraceptive services in humanitarian settings and the World Health Organization (WHO) medical eligibility criteria can be found at who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/ and srhr.org/mecwheel/.

¹⁰⁸ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, case study MISP chapter, 2018.

As part of the planning for comprehensive SRH programming after the acute phase of the emergency, it is important to work on expanding the method mix available to the target population. Work with the Ministry of Health, the United Nations Population Fund (UNFPA) and other partners nationally to register methods, expand method mix, and train providers. A range of contraceptive methods beyond what is offered in the IARH kits can be procured through UNFPA Procurement Services Branch.



Noted Practice: Preventing Unintended Pregnancies in Cox's Bazar, Bangladesh

- ▶ Negotiations with the government took place at the beginning of the emergency for the government to provide short-acting methods temporarily for refugees—this was later replenished with humanitarian procurement by UNFPA.¹⁰⁹
- ▶ Existing information, education, and communications materials were used among partners and from the country of origin rather than designing new materials (language similarity, although not the same, between refugees and host communities helped to an extent).

What are some factors to consider in determining appropriate method mix in an acute humanitarian setting?

When determining what contraceptive methods to offer in the initial acute humanitarian response, some factors to consider include what methods were available to, and used by, the target population prior to the emergency and what methods are registered in the country of operation. Methods that were available to the target population before the emergency and for which demand exists should be provided. However, in an acute emergency setting, the ethical roll out of a new method, that was previously not available to the displaced population or not provided in the specific context, to a distressed population may be difficult to guarantee. Local providers may be unfamiliar with the new method, which may compromise high-quality counseling and service provision during an acute emergency. If a product was not registered in the country of operation before an emergency, there may be issues for arrival and customs clearance even when humanitarian import exemptions are in place. If a product is not registered but is necessary to implement lifesaving MISP for SRH services, work with the SRH Coordinator to anticipate and address potential import challenges. Further, when providing long-acting methods of contraception that require removal, it is important to consider if the affected population has a high likelihood of onward migration, in which case they may not have ongoing access to removal services. Consider prioritizing new method uptake (registration and rollout) in preparedness planning, to enable smooth import and use in the event of an acute emergency, and in post-acute emergency settings as part of expanding on the MISP to achieve comprehensive SRH programming.

¹⁰⁹ Communications, Chief, Health, United Nations Population Fund, September 2018.

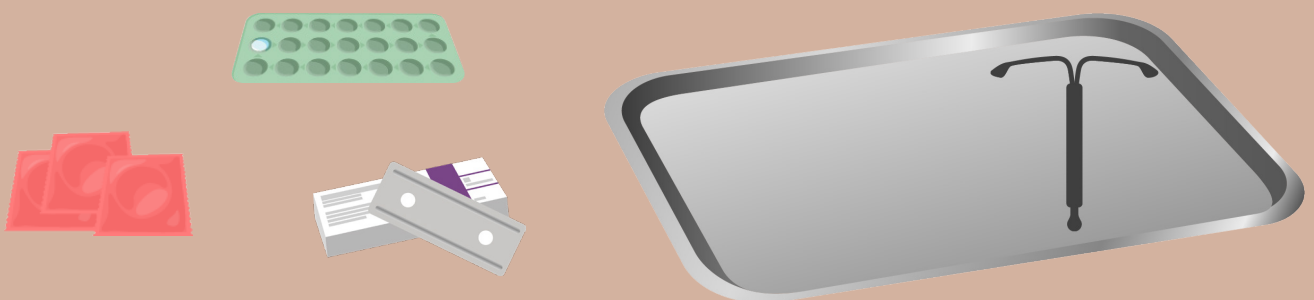
Why is it important to provide long-acting contraceptive methods?

Women have the right to access a safe, effective, and acceptable method of contraception of their choice. It is important that long-acting contraceptive methods, such as the IUD and implants, are available because they are highly effective, repeat visits to a health facility are not necessary (this is especially important in unstable environments), and they do not require user action (e.g., taking a pill) when there are competing priorities for their time. In addition, the evidence shows that when more methods are available, more women find a method they like and use it.

How can a provider ensure quality of care?

Quality contraceptive service delivery emphasizes clients' confidentiality, privacy, voluntary and informed choice and consent. Counseling should also include information about method eligibility, effectiveness, possible side effects management and follow-up, guidance on method removal and return to fertility after method discontinuation. Women of all ages, including adolescent girls, should receive full information and services. With the important exception of emergency contraceptive pills and condoms, it is important to ensure the client is not pregnant before providing contraceptives.

If a client is pregnant, inform her of her options: giving birth and raising the child, putting the child up for adoption, or providing or referring for safe abortion care to the full extent of the law.



The MISIP for SRH activity:

Provide information that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and nondiscrimination

Ensuring Contraceptive Use Is Voluntary

All persons have the human right to reproductive self-determination and, thus, to make decisions regarding their reproductive health without being subjected to violence, coercion, or discrimination. Consequently, a human rights–based approach to providing contraception requires that all contraceptive services be offered on a voluntary and informed basis.

Providers must ensure that clients are provided with accurate information and are free to choose their preferred method without being subjected to undue influence or coercion.

The key tenets of voluntarism in providing contraception include the following:

- ▶ People have the opportunity to choose voluntarily whether to use a specific contraceptive method or not.
- ▶ Individuals have access to information on a wide variety of contraceptive choices, including the benefits, side effects and any health risks of particular methods.
- ▶ Clients are offered, either directly or through referral, a broad range of contraceptive methods and services.
- ▶ The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client.

What essential information should be provided to a client seeking contraception?

It is important that providers share the following information with clients who are seeking contraception:

- ▶ How the method works
- ▶ Effectiveness of the method
- ▶ Correct use of the method
- ▶ Benefits of the method
- ▶ Common side effects
- ▶ Other side effects and any health risks associated with the method
- ▶ How to overcome the side effects of the method

- ▶ Signs and symptoms that would necessitate a return to the clinic
- ▶ Return to fertility after method discontinuation
- ▶ STI prevention
- ▶ The right to get the method removed if desired (e.g., long-acting, reversible contraception)

The MISP for SRH activity:

Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

What can be done to ensure women, adolescents, and men are aware of the availability of contraceptives?

Ensure the community—including unmarried and adolescent community members—is aware of where and how to seek contraception. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms, and pictures). Community leaders and local volunteers, including peer promoters, can also be engaged to distribute information about the availability of contraceptive services. To aid service providers in providing family planning information, the Women’s Refugee Commission developed “universal” information, education, and communications materials on family planning topics. The templates can be found at iawg.net/resource/universal-and-adaptable-information-education-and-communication-templates-on-family-planning/.

What is emergency contraception?

Emergency contraceptives (EC) are medications or devices that can prevent pregnancy when used up to five days (120 hours) after intercourse.¹¹⁰ They should be used as quickly as possible for greater effectiveness. EC options include EC pills and insertion of the copper-bearing IUD (see Unit 3 for more information on EC). They can be used after unprotected intercourse, in cases of possible contraceptive failure and incorrect use of contraceptives, and following sexual violence. EC pills work by preventing ovulation and do not interfere with an existing pregnancy. A pregnancy test is not required in order to provide EC pills.

As part of the MISP for SRH, EC should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual. More information about EC and medical eligibility can be found at ec-ec.org/ecmethod/.

Overview of emergency contraceptive pill options

There are multiple regimens that can be used, including progestin-only, ulipristal acetate, and combined hormonal EC pills (the Yuzpe method, in which the client takes a higher dose

¹¹⁰ *Emergency Contraceptive Pills: Medical and Service Delivery Guidance (International Consortium for Emergency Contraception and FIGO, 2018)*, https://www.cecinfo.org/wp-content/uploads/2018/12/ICEC-guides_FINAL.pdf.

of regular oral contraceptive pills).¹¹¹ Globally, progestin-only EC pills are the most widely available dedicated EC pill; however, dedicated progestin-only EC pills may not be available in all countries.

<p>Progestin-Only EC Pills</p>	<ul style="list-style-type: none"> ▶ One dose of Levonorgestrel (LNG) 1.5 mg taken within five days (120 hours) of unprotected intercourse ▶ Greatest efficacy when used closer to the time of sexual intercourse ▶ More effective and with fewer side effects than combined hormonal pills ▶ Most widely available type of dedicated emergency Contraceptive pill
<p>Ulipristal Acetate</p>	<ul style="list-style-type: none"> ▶ One dose of ulipristal acetate 30 mg taken within five days (120 hours) of unprotected intercourse ▶ More effective than progestin-only pills in the 73–120 hours after unprotected intercourse ▶ More effective and with fewer side effects than combined hormonal pills
<p>Combined Hormonal EC Pills</p>	<ul style="list-style-type: none"> ▶ Two doses of combined oral contraceptive pills, each containing estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel) ▶ The first dose taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) ▶ The second dose taken 12 hours later ▶ If vomiting occurs within two hours of dose, dose should be repeated ▶ Less effective and with more side effects than progestin-only EC pills and ulipristal acetate

¹¹¹ *Emergency Contraception, Fact Sheet*, (WHO 2018), <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>.

UNIT 6: Key Points

- ▶ Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities.
- ▶ Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection (to prevent pregnancy and STIs/HIV).
- ▶ EC should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual.
- ▶ All forms of contraception should be provided on a confidential basis without requiring the consent of a partner, parent, or caregiver.
- ▶ Some considerations for selecting method mix in acute onset emergencies include what methods were available to, and used by, the target population prior to the emergency and what methods are registered in the country of operation.
- ▶ Providers should ensure quality of care that emphasizes clients' confidentiality, privacy, voluntary and informed choice and consent.
- ▶ Information about contraceptive methods should be given, including how the method works, effectiveness of the method, correct use of the method, benefits of the method, common side effects, other side effects and any health risks associated with the method, how to overcome the side effects of the method, signs and symptoms that would necessitate a return to the clinic, return to fertility after method discontinuation, and STI prevention.
- ▶ Ensure the community, including unmarried and adolescent community members, is aware of how and where to access contraception:
 - ▶ Information about contraception should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms, and pictures).
 - ▶ Community leaders and local volunteers, including peer promoters, can also be engaged to distribute information about the availability of contraceptive services.



Challenges and Solutions

Challenges	Solutions
What if there are no health providers trained in providing and removing long-acting methods (e.g., IUDs and implants)?	In partnership with national authorities, international NGOs should deploy staff trained in providing and removing long-acting methods of contraception, and women and girls who request these methods should be referred to a facility with the capacity to provide services until local staff are trained and skilled to provide these methods.
What if providers are reluctant to offer contraception to some clients (adolescents, unmarried women, etc.)?	In planning to expand services from the MISP for SRH to comprehensive SRH, undertake values clarification exercises and trainings on SRH rights. Continue these at various stages of service delivery in consideration of staff turnover. ¹¹²
What if providers lack knowledge of the full range of contraceptive methods?	International NGOs should deploy staff trained in all methods of contraception. When planning for comprehensive SRH services beyond the MISP for SRH, integrate trainings on contraceptive methods. If providers are not trained on long-acting, reversible contraception, a referral system can be established to guarantee that clients have access to the method of their choice.
What if emergency contraception is not available?	Health providers can use combined oral contraceptive pills as EC (the Yuzpe Method): This consists of two doses of combined oral contraceptive pills. Each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel [LNG] or 1.0–1.2 mg norgestrel). ¹¹³ The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) and the second dose should be taken 12 hours later.

¹¹² Undertaking values clarification exercises and trainings on SRH rights should also be done during the preparedness phase.

¹¹³ *Emergency Contraception, Fact Sheet*, (WHO 2018), <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>.

CHECKLIST: PREVENT UNINTENDED PREGNANCIES

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

6. Prevent Unintended Pregnancies			
6.1	Short-acting methods available in at least one facility	Yes	No
6.2	Condoms		
6.3	EC pills* ¹¹⁴		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine devices (IUDs)		
6.8	Number of health facilities that maintain a minimum of a three-month supply of each	Number	
	Condoms		
	EC pills		
	Combined oral contraceptive pills		
	Progestin-only contraceptive pills		
	Injectables		
	Implants		
	IUDs		

¹¹⁴ It is important to note the different emergency contraceptive pills that are available, including progestin-only EC pills, combined oral EC pills, and ulipristal acetate.

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide contraceptive services?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.¹¹⁵

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 1A	Male Condoms
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 4	Oral and Injectable Contraceptives

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Kit 1B Female Condoms	Kit 14
Community/health pos	Depot-Medroxyprogesterone Acetate–Subcutaneous (DMPA-SC)	Kit 4
Primary health care facility (BE _m ONC)	Kit 7A Intrauterine Device (IUD)	Kit 4
Primary health care facility (BE _m ONC)	Kit 7B Contraceptive Implant	Kit 4

¹¹⁵ The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org/>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>.

Unit 6 Quiz: Prevent Unintended Pregnancies

1. What are some considerations for determining a comprehensive method mix in acute onset emergency? Select all that apply:
 - a. Registration of the contraceptive method in country of operation
 - b. Use by the crisis-affected populations
 - c. Potential for further migration
 - d. Crude birth rate
 - e. Religion

2. Unmarried adolescents should **not** be given contraception.

True or False

3. Which statement about emergency contraception (EC) is **not** true?
 - a. EC will not harm an existing pregnancy
 - b. EC needs to be taken within 120 hours and the earlier it is taken the more effective it is
 - c. Adolescent girls cannot take EC
 - d. Where dedicated EC pills are not available, oral contraceptive pills in the correct dosage can be used
4. What three things should be emphasized to ensure quality of care when providing contraception? Select all that apply:
 - a. Confidentiality
 - b. Privacy
 - c. Informed choice
 - d. Approval from family members or partner
5. What information should be provided to all clients during contraceptive counseling? Select all that apply:
 - a. Effectiveness of the method
 - b. Common side effects of the contraceptive method
 - c. Antenatal counseling
 - d. How the method works
 - e. STI protection

UNIT 7: PLAN TO INTEGRATE COMPREHENSIVE SRH SERVICES INTO PRIMARY HEALTH CARE



The implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) not only entails coordination to make lifesaving SRH services available, it is also essential to start addressing comprehensive SRH as soon as possible. This requires vision, leadership, effective coordination skills, and a sound understanding of the local situation and opportunities related to health system reconstruction. This section outlines the steps to take to be ready to expand to comprehensive SRH services integrated into primary health care.

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

- ▶ explain the importance of planning for comprehensive SRH services;
- ▶ understand the process for expanding SRH services toward achieving comprehensive care; and
- ▶ explain the World Health Organization (WHO) health system building blocks.

MISP for SRH objectives and activities

PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE, AS SOON AS POSSIBLE.

This includes working with the health sector/cluster partners to address the six health system building blocks:

- ▶ Service delivery
- ▶ Health workforce
- ▶ Health information system
- ▶ Medical commodities
- ▶ Financing
- ▶ Governance and leadership

Why is planning for comprehensive SRH services a priority?

Providing comprehensive SRH care to all members of a crisis-affected population is an overarching goal of the health sector. If neglected, gaps in the provision of comprehensive SRH services will lead to increased morbidity and mortality. By collecting data, selecting appropriate service sites, preparing staff, ensuring the availability of supplies, and identifying long-term funding mechanisms, comprehensive SRH services can be more quickly and efficiently operationalized once the MISP for SRH has been implemented.

What are comprehensive SRH services?

According to a report from the Guttmacher-Lancet Commission, comprehensive SRH services are “essential sexual and reproductive health services that must meet public health and human rights standards, including the ‘Availability, Accessibility, Acceptability, and Quality’ framework of the right to health.”¹¹⁶ The services should include the following, as quoted in the commission’s report:

- ▶ Accurate information and counseling on SRH, including evidence-based, comprehensive sexuality education.
- ▶ Information, counseling, and care related to sexual function and satisfaction.
- ▶ Prevention, detection, and management of sexual and gender-based violence and coercion.
- ▶ A choice of safe and effective contraceptive methods.
- ▶ Safe and effective antenatal, childbirth, and postnatal care.
- ▶ Safe and effective abortion services and care, to the full extent of the law.
- ▶ Prevention, management, and treatment of infertility.
- ▶ Prevention, detection, and treatment of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), and of reproductive tract infections.
- ▶ Prevention, detection, and treatment of reproductive cancers.

Who should have access to comprehensive SRH services?

As with the MISP for SRH, all people (women, girls, men, and boys) should have access to comprehensive SRH services. The best way to ensure that SRH services meet the needs of the affected population is to involve the community in every phase of the development of those services; only then will people benefit from services specifically tailored to their needs and demands and only then will they have a stake in the future of those services.

¹¹⁶ *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission* (The Lancet, May 9, 2018), <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>.

What are some considerations for specific populations when planning for comprehensive SRH services?

SRH services must be accessible for all crisis-affected populations, including often-marginalized populations such as adolescents, persons with disabilities, unmarried and married women and men, the elderly, sex workers and clients, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) persons, ex-combatants, uniformed staff, and injecting drug users. This chart demonstrates some of the special considerations for specific populations.

Adolescents	Adolescents in humanitarian emergencies face increased risks of sexual violence, abuse and exploitation, unintended pregnancy, and unsafe abortion. Health staff should be aware that adolescents requesting contraceptives have a right to receive a full range of contraceptive services, including emergency contraception (EC), regardless of age or marital status. Adolescents presenting to facilities for voluntary contraception should be asked about STI symptoms and HIV, and voluntary contraception should be discussed with those who come to STI clinics.
Persons Engaged in Sex Work	It is important to be mindful that persons engaged in sex work have the same SRH needs as their peers who are not engaged in sex work. It is important to ensure their needs are addressed through discussion and counseling on available methods of contraception, safe sex and STI/HIV protection, and instructions on the proper use of male and female condoms and lubricants. Service providers should also screen for HIV and other STIs, promote and provide condoms and lubricants in sufficient quantities, prescribe the client's preferred contraceptive method, and make EC available.
Persons with disabilities	The diverse SRH needs of persons with disabilities are rarely understood or addressed through SRH programming in emergency contexts. The SRH needs of persons with disabilities, their family planning intentions, increased risk of sexual violence in emergencies, and access to voluntary contraceptive services should be understood and mainstreamed within comprehensive SRH programming.
LGBTQIA Persons	Discriminatory laws, attitudes, and practices often produce health disparities and compromise the ability of LGBTQIA individuals to access quality SRH services. SRH care should focus on a person's specific needs, determined by their behavior rather than their identity. Providers should adopt a respectful and nonjudgmental attitude when providing contraceptive services, being mindful of the particular barriers that LGBTQIA persons may face when seeking care and should strive to address any concerns that may be specific to this population.

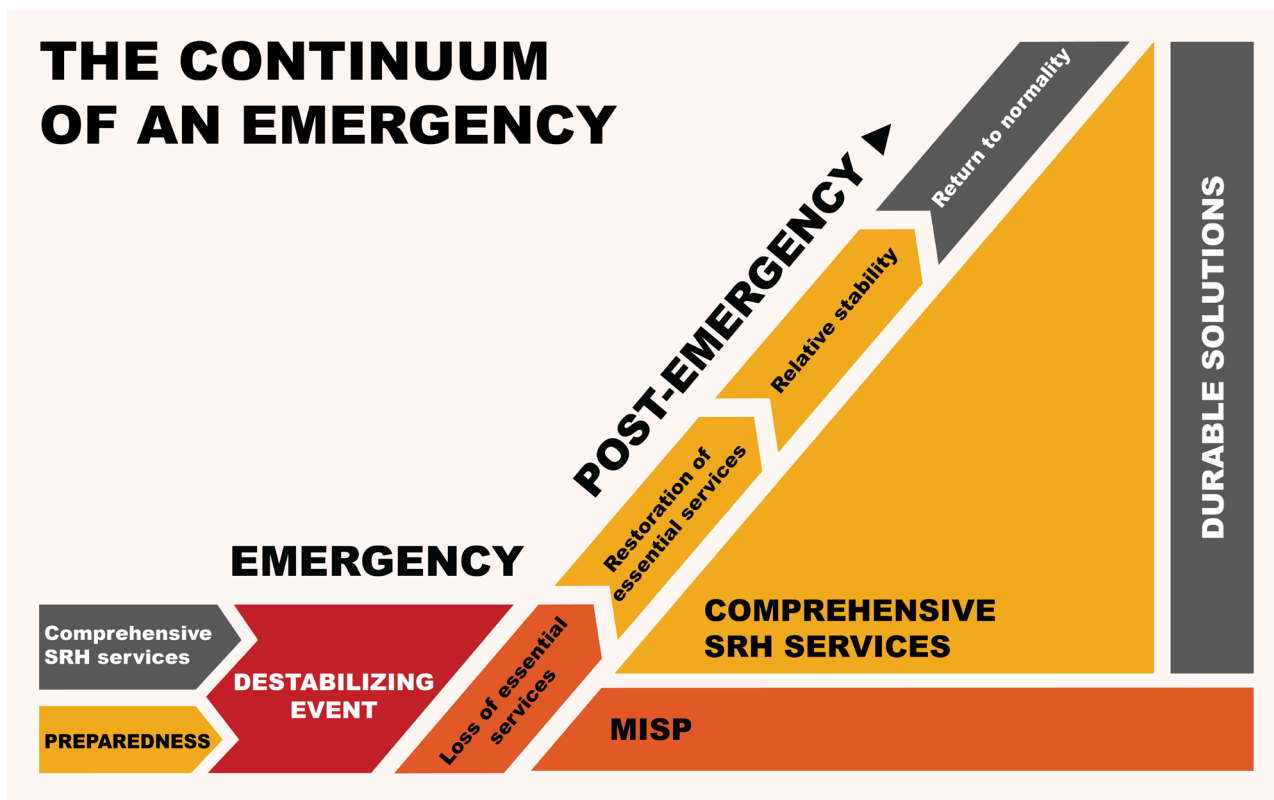
What aspects need to be considered when supporting local and international stakeholders in planning for delivery of comprehensive SRH services?

Providing comprehensive, high-quality SRH services in humanitarian settings requires a multisectoral, integrated approach. Protection, health, nutrition, and education, as well as water, sanitation, and hygiene and community service personnel all have a part to play in planning and delivering services. When planning, it is therefore important to consider the following:

- ▶ Communication among decision-makers and implementing partners
- ▶ Adequate financing
- ▶ Effective coordination
- ▶ Supply chain management
- ▶ Human resource management
- ▶ Monitoring and evaluation
- ▶ System of information sharing, feedback, and accountability to the affected community
- ▶ An exit strategy for humanitarian partners

When should planning start for comprehensive SRH services?

It is essential to start planning for the integration of comprehensive SRH activities, with health sector/cluster partners as well as with affected women, adolescents, and men, as soon as possible. This includes obtaining input/feedback on the initial response in order to identify gaps, successes, and avenues for improvement. When planning for the delivery of comprehensive SRH services, the priority services put in place as part of the MISP for SRH should be built upon, sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction.



How should planning for comprehensive SRH services take place?

Planning for comprehensive SRH services should take place through a participatory planning process among national stakeholders, national and international partners, relevant partners at provincial, regional, or local levels, and the affected population.¹¹⁷ The objective of the participatory planning process is to integrate comprehensive SRH programming into health system reconstruction efforts through a collective work plan for comprehensive SRH. As part of the participatory planning process, key stakeholders should do the following:

1. Assess the current situation, including the status of MISP for SRH implementation and the state of SRH among affected populations.
2. Based on this information and using the health system building blocks (see more information below) as a framework, identify SRH service needs and opportunities for expansion and integration into primary health care.
3. Referring to the activities and interventions seen as a group to be gaps and opportunities, identify and decide on planning priorities. Priorities for achieving comprehensive SRH services could include the broadening and strengthening of existing MISP for SRH services, as well as inclusion or strengthening of SRH services that fall outside the MISP for SRH.

¹¹⁷ A toolkit for implementing this participatory planning process is under development by the IAWG Training Partnership Initiative: "Integrating Sexual and Reproductive Health into Health System Reconstruction: A Workshop Toolkit to Catalyze Participatory Planning to Move from the Minimum Initial Service Package (MISP) for Sexual and Reproductive in Crisis Situations to Comprehensive Sexual and Reproductive Health Programming."

4. Develop a collective work plan for comprehensive SRH services to:
 - strengthen and build upon existing SRH implementation;
 - address service gaps and challenges;
 - be used as an advocacy tool to garner support and funding for programs; and
 - feed back into the overall reproductive, maternal, newborn, child and adolescent health program review.

Although initial planning starts at the onset of the response, this formal participatory process should begin as soon as the MISP for SRH indicators are reached and when humanitarian appeals processes and agencies begin longer-term planning processes. To avoid delays and ensure sustainability, it is essential that comprehensive service components are integrated into the national longer-term funding and planning processes, such as the Humanitarian Response Plans. *It is important to note that the implementation of comprehensive SRH programming should not negatively affect the availability of MISP for SRH services; on the contrary, it should improve and expand upon them.*

What should be assessed and planned for under the WHO health system building blocks?

1. Service delivery

Collaborate with national and local authorities, the affected community, and, where appropriate, camp management experts to identify possible new and existing sites to deliver comprehensive SRH services, such as family planning clinics, STI outpatient rooms, or focused adolescent-friendly SRH services. Consider the following factors (among others) when selecting suitable sites:

- ▶ Feasibility of communications and transport for referrals
- ▶ Number, type, quality, and distance to existing health facilities, SRH services, and other health services
- ▶ Accessibility to all potential users, in all their diversity, including the affected populations and the target group
- ▶ Possible integration with other services versus standalone services
- ▶ Security at the point of use as well as while moving between home and the service delivery point

2. Health workforce

Assess staff capacity to undertake comprehensive SRH services, establish plans to train or retrain staff, and ensure supportive supervision. Staff capacity can be measured through supervisory activities (e.g., monitoring checklists, direct observation, client exit interviews) or through formal examinations of knowledge and skills.

When planning for training or retraining of staff, work with national authorities, academic institutes, and training institutes and take into consideration existing curricula. Where possible, use national trainers and plan training sessions carefully in order not to leave health facilities without in-service staff. Training health workers on patients' rights and the provision of respectful, unbiased, equitable care is critical and should be incorporated into trainings, training schedules, and/or supportive supervision.

Consider ongoing capacity development opportunities outside of trainings, such as supportive supervision, mentorship programs, and opportunities to practice learned skills.

Provide protocols and job aids to support quality service delivery according to evidence-based best practices. For examples, see iawg.net/resource/job-aids-health-care-providers-humanitarian-settings/.

3. Health Information System

In order to move beyond the MISP for SRH and start planning for comprehensive SRH service delivery, SRH program managers, in close collaboration with the partners in the health sector/cluster, must collect existing information or estimate data that will assist in designing such a program.

Examples of information that assists with planning for comprehensive SRH include:

- ▶ Ministry of Health policies and protocols for standardized care (e.g., STI syndromic management, family planning protocols, and laws and regulations surrounding safe abortion care).
- ▶ MISP for SRH service indicators that are monitored and evaluated. The MISP for SRH Checklist in Appendix B and process evaluation tools are useful for ensuring the MISP for SRH components are in place.¹¹⁸ For gathering data as part of needs assessments, *Reproductive Health Assessment Toolkit for Conflict-Affected Women can be helpful*.¹¹⁹
- ▶ Services and supply consumption data at health facilities.
- ▶ SRH demographic information collected about the affected population, number of women of reproductive age, number of sexually active men, crude birth rate, age- and sex-specific mortality data, newborn mortality rate, and maternal mortality rate.
- ▶ STI and HIV prevalence, contraceptive prevalence and preferred methods, prevalence of unsafe abortion, and SRH knowledge, attitudes, and behaviors of the affected population.

118 IAWG. (2017). MISP Process Evaluation Tools. Retrieved from: www.iawg.net/resource/misp-process-evaluation-tools-2017.

119 Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention, & Department of Health and Human Services. (2007). *Reproductive Health Assessment Toolkit for Conflict-Affected Women*. Atlanta, GA. Retrieved from: https://www.unscn.org/web/archives_resources/files/ToolkitforConflictAffectedWomen.pdf.



Integrating Comprehensive SRH Services into Primary Health Care in the Rohingya Humanitarian Response in Bangladesh

A needs assessment was conducted with sound sampling, which allowed for analysis of real-time data and evidence to guide planning and programming.¹²⁰ However, one of the major challenges to integrating comprehensive SRH care was related to funding. Funding was for short, joint-response cycles, which made long-term planning difficult and the risk of service withdrawal high. This highlights a need to aim to identify long-term funding sources as soon as possible.

4. Medical commodities

The Inter-Agency Emergency Reproductive Health (IARH) Kits are not intended as re-supply kits and, if used as long-term, may result in the accumulation of items and medicines which are not needed. Although supplying medicines and medical devices in standard pre-packed kits is convenient early in an emergency, specific local needs must be assessed as soon as possible and further supplies must be ordered accordingly. This will help ensure the sustainability of the SRH program and national supply chain, reduce unnecessary costs, and avoid shortages of particular supplies, as well as the wasting of others not typically used in the specific context.

Once basic services have been established, work with the SRH Coordinator and other health partners to assess SRH needs and attempt to re-order bulk medicines, devices, and equipment based on consumption of these items, in order to ensure that the SRH program can be sustained and expanded. To make this shift, the SRH Coordinator should:

- ▶ strengthen or develop a medical supplies logistics management information system as soon as possible, in coordination with the United Nations Population Fund (UNFPA), WHO, United Nations Children’s Fund (UNICEF), and other health supplies partners;
- ▶ estimate the use of SRH supplies based on consumption, services, and demographic data and conduct a forecast; assess the changing SRH needs of the population and how this may affect supply needs; and
- ▶ reorder supplies as needed based on a supply plan; this can be a mix of IARH Kits and bulk item procurement.

When ordering supplies for comprehensive SRH services, coordinate SRH commodity management with health authorities and the health and logistics sectors/clusters in order to ensure uninterrupted access to SRH services and to avoid creating multiple health supply chains.

¹²⁰ Site visit follow-up, Women’s Refugee Commission, November 2018.

Some suggestions to strengthen national supply chains include the following:

- ▶ Hire staff trained in supply chain management and medical logistics.
- ▶ Develop the capacity of existing staff on supply chain management.
- ▶ Establish a health-logistics coordination sub-group under the health cluster in close partnership with the logistics cluster.
- ▶ Estimate monthly consumption and utilization of SRH commodities.
- ▶ Support the creation of, or reinforce an existing (if one exists) national logistics management information system.
- ▶ Identify medical supply channels. If local supply chains are inadequate (e.g., can not confirm quality standards), obtain SRH commodities through recognized global suppliers or with support from UNFPA (through the Procurement Services Branch¹²¹), UNICEF, or the WHO, which can facilitate purchasing bulk quantities of high-quality SRH supplies at lower costs.
- ▶ Place timely orders through identified supply lines.
- ▶ Store supplies as close to the target population as possible.



Always keep in mind the importance of utilizing and strengthening sustainable medical supply chains when planning for comprehensive SRH services. For more information and guidance, see Unit 9 in this publication and Chapter 4 in the 2018 Inter-Agency Field Manual (IAFM).

5. Financing

To ensure ongoing access to affordable, high-quality comprehensive SRH care, long-term financing mechanisms must be considered during the initial response to a crisis. A good health financing system is critical to sustaining comprehensive SRH care.^{122,123} Several financing options include, but are not limited to:

- ▶ Community financing and community-based health insurance
- ▶ Conditional and unconditional cash transfers
- ▶ Out-of-pocket payments or user fees
- ▶ Results-based financing
- ▶ Voucher subsidies to clients and reimbursements for health care workers
- ▶ Social marketing and franchising

¹²¹ www.unfpaprocurement.org.

¹²² Kutzin J., Witter S., Jowett M., Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Geneva: World Health Organization; 2017. (Health Financing Guidance No 3) Licence: CC BY-NC-SA 3.0 IGO, accessed: <https://apps.who.int/iris/bitstream/handle/10665/254757/9789241512107-eng.pdf?sequence=1>.

¹²³ *Health financing in post-conflict settings – a literature review*, (ReBUILD Consortium, 2011), <https://rebuildconsortium.com/media/1124/health-financing-in-post-conflict-settings-a-literature-review.pdf>.



UNHCR's Health Financing Efforts

- ▶ UNHCR has begun to implement successful cash-based interventions for health programs in refugee settings, such as a program offering Syrian refugee women short-term cash payments to offset the cost of maternal health care.¹²⁴
- ▶ The UN agency has had further success in integrating crisis-affected populations into the national health insurance structure of the country in which they are residing.

6. Governance and leadership

Leadership and governance for integrating SRH into health systems strengthening efforts can be driven from international, national, and community levels.

International and national levels: By identifying existing policies, guidelines, and protocols that do not support SRH and rights or meet international standards, international actors can advocate and support national leadership to implement an health systems strengthening plan to address excess SRH-related morbidity and mortality.

Community level: Communities should understand their rights and participate in the design and implementation of SRH services, creating demand and enforcing accountability (e.g., register complaints and seek remedies). They must be provided with the necessary resources to support these efforts.

Unit 7: Key Points

- ▶ Gaps in the provision of comprehensive SRH services to all members of a crisis-affected population will lead to increased morbidity and mortality.
- ▶ It is essential to start planning for the integration of comprehensive SRH activities with health sector/cluster partners, as well as affected women, adolescents, and men, from the onset of the humanitarian response.
- ▶ The implementation of comprehensive SRH programming should not negatively affect the availability of MISP for SRH services; on the contrary, it should improve and expand upon them.
- ▶ As with MISP for SRH services, comprehensive SRH services must be accessible for all crisis-affected populations, including adolescents, persons with disabilities, unmarried and married women and men, the elderly, sex workers and clients, LGBTQIA individuals, ex-combatants, uniformed staff, and injecting drug users.
- ▶ SRH must be integrated into public health packages and linked to other service sectors, including when strengthening SRH supply chain management.
- ▶ When planning for comprehensive SRH services, use the six WHO health system building blocks as a framework: service delivery, health workforce, health information system, supplies and medical commodities, financing, and governance and leadership.

¹²⁴ *Cash-Based Interventions for Health Programmes in Refugee Settings: A Review*, (UNHCR, 2015), <https://www.unhcr.org/568bce619.pdf>.

Challenges and Solutions

Challenges	Solutions
What if there appears to be a lack of female health workers?	<p>Efforts should be made to identify and engage female health workers, particularly in contexts where restrictive religious or cultural norms bar male health workers from examining female patients. Where feasible, engage and train female health workers in the emergency preparedness phase.</p> <p>The lack of female staff, however, should not prevent women and girls from accessing care. Another option is to ensure a female attendant or friend accompanies the woman seeking medical care.</p>
What can an agency do to obtain reliable data on the crisis-affected population (e.g., background information on maternal, infant, and child mortality, HIV/STI prevalence, and contraceptive use)?	<p>This information should be collected through the health sector/cluster and should be available to its members, including the Ministry of Health. In addition, the agencies that attend health sector/cluster and SRH working group meetings may be able to collectively obtain reliable data online from agencies such as UNFPA, WHO, United States Agency for International Development (USAID), the World Bank, the Demographic and Health Survey, and the Ministry of Health.</p> <p>If possible, try to collect data from credible online resources, or request headquarters to assist and ensure that data is shared and compared with that available to the health sector/cluster more broadly. Where there are inconsistencies in data, there should be discussions within the health sector/cluster to agree on which should be used.</p>
How can I initiate a participatory planning process to expand services from the MISP for SRH to comprehensive SRH?	<p>Field experience has shown that this MISP for SRH objective remains challenging to implement. In order to help address this gap, the IAWG on SRH in Crises Training Partnership Initiative is developing a workshop toolkit to support SRH Coordinators and key national and international stakeholders in their efforts to expand services from the MISP for SRH to comprehensive SRH services. This toolkit will be available on the IAWG website in 2020.</p>

MISP FOR SRH MONITORING CHECKLIST: PLANNING FOR THE TRANSITION TO COMPREHENSIVE SRH SERVICES

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

7. Planning for Transition to Comprehensive SRH Services			
7.1	Service delivery	Yes	No
	SRH needs in the community identified		
	Suitable sites for SRH service delivery identified		
7.2	Health workforce	Yes	No
	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		

MATERIALS AND SUPPLIES

Which supplies are useful for planning for comprehensive SRH services integrated into primary health care?

This objective does not have a kit associated with it.

Unit 7 Quiz: Plan to Integrate Comprehensive SRH Services into Primary Health Care as Soon as Possible

1. Which of the following is a core component/building block of the health system?
 - a. Health information system
 - b. Health workforce
 - c. Community awareness
 - d. Service delivery
 - e. a, b, and d
2. In order to ensure ongoing access to affordable comprehensive SRH care, long-term financing mechanisms must be considered at the initial response to a crisis.

True or False

3. Which one of the following should **not** be considered when selecting a site to deliver comprehensive SRH services?
 - a. Distance to existing health facilities, SRH services, and other health services
 - b. Accessibility to all potential users
 - c. Ability to have a standalone SRH service
 - d. Privacy and confidentiality during consultations
 - e. Feasibility of communications and transport for referrals
4. When planning for comprehensive SRH services, you must continue to order the prepackaged IARH Kits.

True or False

5. Which information or data should be collected to plan for comprehensive SRH services?
 - a. Individual organizations' protocols for standardized care
 - b. MISP for SRH service indicators that are monitored and evaluated
 - c. General health data and statistics on noncommunicable and communicable diseases, malnutrition rates, etc.
 - d. Chronic disease prevalence and health knowledge of the affected population
 - e. All of the above



UNIT 8: OTHER SRH PRIORITIES FOR THE MISP

Unsafe abortion is present in all countries where safe abortion care is not accessible.¹²⁵ Access to safe abortion care for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions account for nearly 8% of maternal deaths.¹²⁶ Safe abortion care should be available and accessible to all women and girls at the minimum for the indications permitted by law; post-abortion care has no legal restrictions and should always be available.

In the revised 2018 version of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, another priority activity was identified beyond the priority objectives of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH). Specifically, the manual states it is important to ensure that safe abortion care is provided to the full extent of the law.

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

- ▶ explain why safe abortion care to the full extent of the law is important in humanitarian settings;
- ▶ describe how to find information about national policies for the provision of safe abortion care; and
- ▶ explain how to facilitate access and ensure safe abortion care is available to the full extent of the law at the onset of an emergency and when planning for comprehensive SRH services.

Other MISP for SRH priority activities:

- ▶ 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.

¹²⁵ *Women and Girls Continue to Be at Risk of Unsafe Abortion* (WHO, September 2017), https://www.who.int/reproductivehealth/topics/unsafe_abortion/abortion-safety-estimates/en/.

¹²⁶ "Induced Abortion Worldwide"; and *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 48.

Why is safe abortion care important in humanitarian settings?

The need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of safe abortion care for women who are raped in crises; international human rights law supports access to safe abortion care across all settings.¹²⁷

In humanitarian situations, women and girls may also be at increased risk of unintended pregnancy due to loss of or decreased access to voluntary contraception. They may want to delay childbearing until their security and livelihoods are assured but may not have access to contraceptives due to disruptions in health supplies and services.

Unsafe Abortion

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy, carried out by persons lacking the necessary skills, in an environment that does not conform to minimal medical standards, or both.¹²⁸

How should safe abortion care be facilitated from the onset of an emergency?

Given its importance, it is critical that the SRH Coordinator, health program managers, and service providers ensure that safe abortion care to the full extent of the law is available at the onset of a crisis by direct service provision or referral to trained providers. When existing capacity is not present, safe abortion care to the full extent of the law should be made available once implementation of MISP for SRH priority activities are underway, ideally within three months after the onset of an emergency, if not sooner.

¹²⁷ International agreements supporting access to safe abortion care include the Geneva Convention, Article 3 (denial of safe abortion to a rape survivor can be considered in violation of her rights), UN Security Council, Resolution 2106 (supports access to complete RH services, including safe abortion for rape survivors), and the Maputo Protocol.

¹²⁸ *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO, 2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

Post-abortion Care

Post-abortion care is the global strategy to reduce death and suffering from complications of unsafe and spontaneous abortion. It comprises five elements:¹²⁹

- ▶ Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening
- ▶ Counseling to identify and respond to women's and girls' emotional and physical health needs and other concerns
- ▶ Voluntary contraceptive services to help women and girls prevent unintended pregnancy
- ▶ Reproductive and other health services that are preferably provided on site or via referrals to other accessible facilities in providers' networks
- ▶ Community and service provider partnerships for preventing unintended pregnancy, mobilizing resources (to help women and girls receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs

Comprehensive abortion care includes all the elements of post-abortion care as well as safe induced abortion.

Where can national policies for safe abortion care be found?

In most countries, induced abortion is legally permitted in at least some circumstances. In many countries, abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest. The SRH Coordinator should identify the conditions under which national policies, signed international agreements, and international humanitarian and human rights law permit the provision of safe abortion care. Additional resources on global abortion policies can be found at srhr.org/abortion-policies/.

What can be done to facilitate access and ensure safe abortion care to the full extent of the law is available?

It is essential that humanitarian responders collaborate to increase access to safe abortion care services. Promising entry points include but are not limited to:

- ▶ providing safe abortion care through health facilities run by organizations and/or staffed by willing, trained providers;
- ▶ offering technical support to qualified medical personnel already providing abortion services; and

¹²⁹ *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 146.

- ▶ reducing harm from unsafe abortion through the distribution of information and commodities for safe medication abortion.

Not all organizations will have the capability to provide safe abortion care, so it is important to identify and refer to providers and organizations that have capacity.

Who should provide safe abortion care services in an acute emergency?

At the onset of a crisis, services should be provided by health care providers already skilled in the provision of safe abortion care. In many cases, rapid, on-the-job training, in partnership with national counterparts where feasible, can be provided to qualified health care workers to build their skills when previously trained providers are not available. When transitioning to comprehensive SRH services, organizations should plan for competency-based training, ongoing clinical mentorship, and continued improvement of staff attitudes to support high-quality service provision.¹³⁰ Task shifting should also be integrated into comprehensive services. With appropriate training and support, nurses, midwives, and other trained health providers can safely provide first-line abortion and post-abortion care services, even in outpatient settings.¹³¹



Other MISP for SRH Priority: The Reality of Implementing Safe Abortion Care to the Full Extent of the Law

An organization recognized the need for greater access to safe abortion care and decided to introduce comprehensive abortion care services as part of services already offered by nurses and midwives in government health facilities in the affected setting.¹³² The organization conducted on-the-job training on misoprostol and manual vacuum aspiration for comprehensive abortion care and provided all the necessary supplies and equipment. To maintain client privacy and confidentiality, a system was devised to record safe abortion care clients in the post-abortion care register with a confidential mark. Information about comprehensive abortion care services was provided during one-on-one community outreach sessions to maintain a low profile within the community.

¹³⁰ *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences* (Ipas), accessed April 8, 2019, <https://ipas.org/resources/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences>.

¹³¹ *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception* (WHO, July 2015), http://apps.who.int/iris/bitstream/10665/181041/1/9789241549264_eng.pdf. See Chapter 8 in the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings* for further information.

¹³² *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 157.

Management of abortion and post-abortion care in the first trimester

	Lay health workers	Pharmacy workers	Pharmacist	Doctors of complementary system of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Vacuum aspiration for induced abortion	**	**	**						*	*
Vacuum aspiration for management of uncomplicated incomplete abortion/ miscarriage	**	**	**						*	*
Medical abortion in the first trimester	Recommendation for subtasks (see below)	**	Recommendation for subtasks (see below)						*	*
Management of uncomplicated abortion/ miscarriage with misoprostol		**	**						*	*

*considered within typical scope of practice; evidence not assessed

**considered outside of typical scope of practice; evidence not assessed

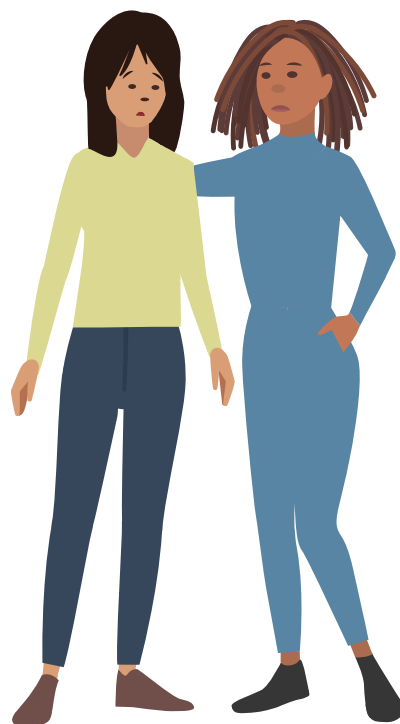
Recommendation category	Symbol	Explanation
Recommended		The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.
Recommended in specific circumstances		The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.
Recommended in the context of rigorous research		There are important uncertainties about this option (related to benefits, harms, acceptability, and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.
Recommended against		This option should not be implemented.

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, p. 147.

If a woman chooses an abortion, what should a health provider do?

The health provider should:

- ▶ provide medically accurate unbiased information about abortion services in a format that the woman can understand and recall;
- ▶ explain any legal requirements for obtaining safe abortion care;
- ▶ explain where and how to obtain safe, legal abortion services and their costs;
- ▶ provide medication abortion with mifepristone/misoprostol if available or misoprostol alone if mifepristone is unavailable, vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by the WHO;
- ▶ provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method; and
- ▶ consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of sexually transmitted infections (STIs).



Special Considerations

Adolescents

There are many social, economic, logistical, policy, and health system barriers to safe abortion care for adolescent girls, including stigma and negative attitudes toward adolescent sexuality, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources/cost of care, transportation, third-party involvement laws, and concerns over privacy and confidentiality. These dynamics explain why young women often find no alternative other than resorting to unsafe abortion, even in settings where safe abortion is legal. Compassionate and confidential abortion services should be available and accessible to all adolescent girls regardless of their marital status.

Women Who Have Experienced Violence

It is likely that providers will encounter women who have experienced sexual violence. Women who have experienced such violence will often experience health-related conditions, such as physical injury, STIs, psychological distress, or unintended pregnancy. Physical or psychological violence during pregnancy may also contribute to miscarriage or the desire for an abortion. Abortion care visits may be the only contact that women who have experienced violence have with the health system. Counselors should develop a standard method for asking all clients about violence in their lives and incorporate those questions into routine counseling. Survivors of sexual violence should be offered compassionate abortion care if they wish to terminate a pregnancy, and abortion clients disclosing experiences of sexual violence should be referred for psychosocial support. See Unit 3 for more information.

Unit 8: Key Points

- ▶ Safe abortion care should be available and accessible to all women and girls to the full extent of the law. Post-abortion care has no legal restrictions and should always be available.
- ▶ Access to safe abortion care for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality.
- ▶ In most countries, induced abortion is legally permitted in at least some circumstances. In many countries, abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest.
- ▶ The SRH Coordinator should identify the conditions under which national policies, signed international agreements, and international humanitarian and human rights law permit the provision of safe abortion care.
- ▶ The SRH Coordinator, health program managers, and service providers should ensure that safe abortion care is available to the full extent of the law at the onset of a crisis by direct service provision or referral to trained providers.
- ▶ Rapid, on-the-job training can be provided to qualified health care workers, in partnership with national authorities where feasible, to build their skills in providing safe abortion care when previously trained providers are not available.
- ▶ If existing capacity is not present, safe abortion care to the full extent of the law, should be made available once implementation of the MISP for SRH priority activities is underway, ideally within three months after the onset of an emergency, if not sooner.



Challenges and Solutions

Challenges	Solutions
<p>What should be done from the beginning of an emergency to ensure safe abortion care to the full extent of the law is available?</p>	<p>Understand the law and when safe abortion care is legal.</p> <p>Undertake a mapping of existing providers in the host community or among international nongovernmental organizations. Support local providers with any additional human and financial resources, including supplies to support the facility and facilitate referrals as possible.</p>
<p>What should be done if the circumstances under which abortion is legally permitted are limited and do not meet the needs of women and girls?</p>	<p>Interpret legal indications for abortion as widely as the law allows, and take international humanitarian and human rights law into account to increase access to safe abortion care for as many women and girls as possible.</p> <p>All women seeking abortion may not meet the legal criteria for abortion. When women seeking abortion are turned away from services, they often seek unsafe methods that can result in injury or death. In these cases, providers may counsel clients seeking abortion on safer self-management of abortion using misoprostol alone or misoprostol in combination with mifepristone. Often referred to as “harm reduction,” this approach may be feasible in contexts where misoprostol is available and accessible in the local market.</p>
<p>What can be done if providers are not competent in WHO-recommended methods of safe abortion care?</p>	<p>In collaboration with national authorities where feasible, engage or refer to providers who are already competent in safe abortion care, where possible.</p> <p>Conduct rapid, on-the-job clinical coaching to improve provider skills.</p>
<p>What are ways to address providers’ and/or staff’s negative attitudes about abortion or women and girls who seek abortion?</p>	<p>Conduct abortion values clarification and attitudes transformation activities with providers, program staff, and support staff.¹³³ This should be done as part of preparedness efforts but can also be done rapidly during program implementation if needed.</p> <p>Screen for favorable attitudes toward safe abortion care access when hiring providers and staff.</p>

¹³³ *Abortion Attitude Transformation.*

What can be done if providers and staff lack knowledge about the circumstances under which safe abortion care can be provided?

In collaboration with national authorities where feasible, define the circumstances under which safe abortion care can be legally provided, and educate providers and other stakeholders about the legal criteria.

What can be done if community leaders and other key stakeholders are opposed to abortion?

In collaboration with national authorities where feasible, inform community leaders and other key stakeholders about the burden of unsafe abortion on women and girls in their communities.

Identify those who are supportive of your work and engage them to encourage the support of others. Abortion values clarification and attitudes transformation activities are also helpful to improve attitudes of community stakeholders.

THE MISP FOR SRH MONITORING CHECKLIST: OTHER PRIORITY ACTIVITY: SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

8. Other Priority Activity: SAC to the Full Extent of the Law		
8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to provide safe abortion care?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.¹³⁴

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Supplies for abortion and post-abortion care can be found in the IARH Kits below and include manual vacuum aspiration and misoprostol. The mifepristone/misoprostol regimen is the global gold standard for medication abortion and should be provided in settings where mifepristone is registered and available.

Health Care Level	Kit Number	Kit Name
Primary health care facility (BEmONC)	Kit 8	Management of Complications of Miscarriage or Abortion
Primary health care facility (BEmONC)	Kit 9	Repair of Cervical and Vaginal Tears

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Primary health care facility (BEmONC)	Misoprostol*	Kit 8

*Misoprostol can also be procured to complement Kits 6A and 8 for the primary health care facility level.

134 The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org/>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>.

Unit 8 Quiz: Other SRH Priorities to the MISP

1. Which of the following types of health care workers can provide first-line safe abortion care with manual vacuum aspiration and medication when properly trained and supported?
 - a. Physicians
 - b. Nurses
 - c. Pharmacists
 - d. a and b
2. What can be done to facilitate access to safe abortion care to the full extent of the law?
 - a. Provide safe abortion care to the full extent of the law through health facilities staffed by skilled providers
 - b. Offer technical support and resources to qualified medical personnel already providing abortion services to the full extent of the law
 - c. Distribute information and commodities for safe medication abortion
 - d. Identify and refer to providers and organizations that have capacity
 - e. All of the above
3. Cost of care, fear of negative repercussions, and stigma are barriers to safe abortion care for young women.

True or False

4. Safe abortion care is permitted for one or more circumstances in the majority of countries in the world.

True or False

5. At what point in a crisis should safe abortion care be prioritized?
 - a. After expanding SRH services from the MISP to comprehensive programming
 - b. In development settings—safe abortion care is not a priority during crises
 - c. In the MISP for SRH as a clinical component of care for survivors of sexual violence
 - d. When implementing the MISP for SRH as an other priority
 - e. c and d



UNIT 9: ORDERING INTER-AGENCY EMERGENCY REPRODUCTIVE HEALTH KITS

To ensure the implementation of Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) service objectives in an acute crisis, it is critical that the necessary SRH supplies are made available. However, the challenges to delivering timely, lifesaving medical supplies in the midst of an acute humanitarian crisis are vast. United Nations Population Fund (UNFPA), on behalf of the Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises, has specifically designed a prepackaged set of kits containing all the medicines, devices, and commodities necessary to facilitate the implementation of the MISP for SRH—the Inter-Agency Emergency Reproductive Health (IARH) Kits (sometimes referred to as the RH Kits or the Inter-Agency RH Kits). UNFPA manages these kits on behalf of the inter-agency community and updates them every few years to ensure compliance with the latest evidence and to address logistics bottlenecks. The IARH Kits are designed for use in the earliest phases of an acute humanitarian emergency, using assumptions made at the global level; they will therefore not be context specific or comprehensive.

This unit explains how to order and obtain the IARH Kits. However, it must be emphasized that while supplying medicines and medical devices in standardized prepacked kits is convenient early in a humanitarian response, specific, local needs must be assessed as soon as possible, and further supplies must be ordered accordingly. The IARH Kits are not intended as resupply kits. Using them as such may result in both accumulation of unneeded items and medicines and shortages of needed items and medicines.

Where possible, it is critical to work through national procurement channels and strengthen locally sustainable supply chains, especially in the post-acute expansion from the MISP for SRH to comprehensive SRH services. However, maintaining the quality of medical commodities being procured in humanitarian settings can be incredibly challenging; if you are unable to guarantee the quality of commodities in line with the World Health Organization (WHO) and UNFPA standards it is essential to procure internationally through prequalified suppliers, such as UNFPA or WHO.

There are also many activities related to logistics and supply chain management that can be done by organizations, in collaboration with national authorities, and where feasible, in the preparedness phase that will enable an effective, efficient, and lifesaving response during an acute crisis.

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

- ▶ describe what an IARH Kit is and explain how to order supplies;
- ▶ describe the different levels of the IARH Kits that target the three health service delivery levels; and
- ▶ explain when complementary commodities should be ordered.

When should the IARH Kits be ordered?

The IARH Kits are intended for use at the onset of an acute humanitarian response. Each kit contains sufficient supplies for a specific population size for a three-month period. Some of the medicines and medical devices contained in the kits may not be appropriate for all settings. This is inevitable as these are standardized, prepackaged emergency kits that are designed for worldwide use and are kept ready for immediate dispatch. Additionally, not all settings will need all kits, depending on the availability of supplies in the setting prior to the crisis and the capacity of the health facilities.

It must be emphasized that although supplying medicines and medical devices in standardized prepacked kits is convenient early in a humanitarian response, specific, local needs must be assessed as soon as possible, and further supplies must be ordered accordingly. After the acute phase of an emergency, the SRH Coordinator should assess the SRH needs of the affected population, coordinate with the health sector/cluster, and attempt to order supplies based on consumption. This will help avoid supply shortages and waste and will help ensure that the SRH program can be sustained. You can order supplies through regular channels (via the national procurement system, NGOs, or other agencies) or through the UNFPA Procurement Services Branch: unfpa.org/humanitarian-emergency-procurement. For more information on this transition, please see the *IARH Kit Management Guidelines for Field Offices*.

Are there other agencies that provide prepacked health kits with RH supplies in addition to UNFPA?

The IARH Kits complement the Inter-Agency Emergency Health Kit (IEHK), which is hosted by WHO and can be procured from the WHO or United Nations Children's Fund (UNICEF).¹³⁵ The IEHK is a standardized emergency health kit that contains essential medicines, supplies, and equipment for the provision of primary health care services. Particularly, the IEHK malaria module (basic and supplementary) can be procured in malaria prone settings to complement the IARH Kits. In a humanitarian setting, the IEHK is generally rapidly available. Additionally, there are a number of other emergency health kits that can be procured from the WHO, UNICEF, International Committee of the Red Cross, Médecins Sans Frontières, and other nongovernmental organizations (NGOs), depending on the specific emergency or need in a specific country. To provide the full range of priority SRH services in an

¹³⁵ For more information go to <https://www.who.int/emergencies/kits/iehk/en/> or https://www.unicef.org/supply/index_epe_health.html.

emergency situation, it is recommended that the IARH Kits be ordered in a way that complements what may already have been procured or that other supply sources are identified to ensure that all necessary equipment and materials are available.

What information is needed to order the IARH Kits?

Before ordering the kits, it is essential to undertake a rapid assessment of the local situation—the size of the population to be served, location and type of health facility, skills of providers—to confirm if IARH Kits are needed and what types are needed. The IARH Kit Calculator can be used to assist the process of determining what to order.¹³⁶

How much do the IARH 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. You can also use UNFPA's Budget Planner at unfpaprocurement.org/budget-planner to estimate the cost of your procurement. Funding for the kits can come from your own resources (e.g., government, NGO, or other resources) or UNFPA emergency funds. You can work with the UNFPA country office to determine if you are eligible to access UNFPA emergency funds for the IARH Kits needed in your context.

How quickly will IARH Kits arrive at my site?

The expected delivery of IARH Kits, once payments have been finalized, is a matter of days for acute emergency situations and 10–12 weeks for post-acute situations. Prepacked stock held with the supplier is prioritized for acute emergency operations; post-acute situations will receive kits packed from fresh stock. International transportation of the kits will be managed by UNFPA Procurement Services Branch, and transportation is factored into the delivery lead time. Please contact the UNFPA country office to determine if orders can be coordinated to facilitate import.¹³⁷

Transport to field sites is dependent upon the ordering agency's local transport and storage arrangements. If you are ordering the kits externally from the UNFPA country office, be prepared to receive the goods as soon as they arrive at the port of entry to the country. It is essential to have the documentation and approvals needed for customs clearance before the arrival of the commodities at the border, as well as warehouses and transportation methods identified. Additionally, designate staff to guarantee the smooth import, storage, and distribution of supplies to the implementing partners. UNFPA, the health sector/cluster, and the logistics sector/cluster are often able to help facilitate entry and customs clearance, storage, and onward distribution.

¹³⁶ The IARH Kit Calculator is available on the UNFPA website, IAWG on SRH in Crises website, and the UNFPA mobile application (by late 2019).

¹³⁷ UNFPA country office contact information can be found at <https://www.unfpa.org/worldwide>.

How are IARH Kits packaged?

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

- ▶ are clearly marked on the outside with the kit number and a description of the contents, consignee, and other relevant information;
- ▶ are marked with the number of boxes per kit and the weight and volume of each kit;
- ▶ can be handled by one or two people; and
- ▶ are branded on all sides with one color representing a particular kit.

UNFPA developed the *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings Manual* (2019) and the *IARH Kits Management Guidelines for Field Offices* to provide all the necessary information on management of the kits.

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

The IARH Kits are revised every few years to align with the most updated WHO guidance and address logistical bottlenecks. Contact UNFPA to obtain a copy of the most recent version of the *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings Manual*, or go on the UNFPA or IAWG for RH in Crises websites to find the most updated version.¹³⁸ This manual provides a list of contents for each kit, as well as guidance on ordering, management, the type of training health personnel should have in order to use the contents of a kit appropriately, and other key information. The manual is available in English, French, Arabic, and Spanish and there are downloadable treatment guidelines available in English and French. A repository of documents related to the use and management of the IARH Kits, including information, education and communications materials, will be available on the IAWG on RH in Crises website in 2019.

The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (unfpa.org) or IAWG for RH in Crises (iawg.net/resource/inter-agency-reproductive-health-kits-2011/) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations (5th ed., 2011)* at iawg.net/resource/inter-agency-reproductive-health-kits-2011/.

IARH Kits (2019)

The IARH Kits (2019) are categorized into three levels, targeting the three health service delivery levels.¹³⁹ The kits are designed for use for a three-month period for a specific target population size. Complementary commodities can be ordered based on basic pre-crisis information, according to the enabling environment and capacities of health care providers. As these kits are not context specific or comprehensive, organizations should not depend solely on the IARH Kits for long periods and should plan to integrate procurement of SRH

¹³⁸ *Inter-Agency Reproductive Health Kits for Crisis Situations* (IAWG, January 2011), <http://iawg.net/resource/inter-agency-reproductive-health-kits-for-crisis-situations>.

¹³⁹ The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org/>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations (5th ed., 2011)* at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011/>.

supplies in their routine health procurement systems as soon as possible. This will ensure the sustainability of supplies and enable the expansion of services from the MISIP for SRH to comprehensive SRH.

Community-level/health post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a three-month period. The kits contain mainly medicines and disposable items.

Primary health care facility level (BEmONC) kits contain both disposable and reusable material, for use by trained health care providers who have additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a three-month period. It is possible to order these kits for a population of less than 30,000 persons; this just means the supplies will last longer.

Referral hospital level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive EmONC at the referral (surgical obstetrics) level. In acute humanitarian settings, patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional caseload. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a three-month period.

Overview of Inter-Agency Emergency Reproductive Health Kits 2019

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 1A	Male Condoms
Community/health post	Kit 2A, 2B*	Clean Delivery (A: Mother, B: Birth Attendant)
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 4	Oral And Injectable Contraceptives
Community/health post	Kit 5	Treatment of STIs
Primary health care facility (BEmONC)	Kit 6A, 6B	Clinical Delivery Assistance—Midwifery Supplies (A: Reusable, B: Consumable)
Primary health care facility (BEmONC)	Kit 8	Management of Complications of Miscarriage or Abortion
Primary health care facility (BEmONC)	Kit 9	Repair of Cervical And Vaginal Tears
Primary health care facility (BEmONC)	Kit 10	Assisted Delivery With Vacuum Extraction
Referral hospital (CEmONC)	Kit 11A, 11B	Obstetric Surgery And Severe Obstetric Complications Kit (A: Reusable, B: Consumable)
Referral hospital (CEmONC)	Kit 12	Blood Transfusion

* Where there is a Kit A and B, it means that these kits may be used together, but they can also be ordered separately.

Complementary commodities are disposable and consumable items and/or kits that can be ordered under specific circumstances to complement the IARH Kits:

- ▶ Where providers or the population are trained to use the commodity
- ▶ Where the supplies were accepted and used prior to the emergency
- ▶ After the rapid first order of SRH supplies, in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels)
- ▶ Where the use of the supplies is allowed to the fullest extent of the national law

Complementary commodities with specific agency names can be ordered through their respective host organizations, including:

- ▶ IEHK Supplementary Malaria Module: WHO and UNICEF
- ▶ Inter-Agency Newborn Care Supply Kits: UNICEF*

Service Delivery Level	Item	To Complement
Coordination	Kit 0 Administration And Training	All Kits
Community/health post	Kit 1B, Female Condoms	Kit 8
Community/health post	Chlorhexidine	Kit 2A
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Community/health post	Inter-Agency Newborn Care Supply Kit (Community)**	Kit 2A, 2B
Community/health post	Depot-Medroxyprogesterone Acetate–Sub-cutaneous (DMPA-SC)	Kit 4
Primary health care facility (BEmONC)	Kit 7A – Intrauterine Device	Kit 4
Primary health care facility (BEmONC)	Kit 7B – Contraceptive Implant	Kit 4
Primary health care facility (BEmONC)	Non-Pneumatic Anti-Shock Garment	Kit 6A
Primary health care facility (BEmONC)	Oxytocin	Kit 6B
Primary health care facility (BEmONC)	Inter-Agency Emergency Health Kit (Malaria Module)	Kit 6B
Primary health care facility (BEmONC)	Inter-Agency Newborn Care Supply Kit (Primary Health Facility)**	Kit 6A, 6B
Primary health care facility (BEmONC)	Mifepristone*	Kit 8
Primary health care facility (BEmONC)	Handheld, Vacuum-Assisted Delivery System	Kit 10
Referral hospital (CEmONC)	Inter-Agency Newborn Care Supply Kit (Hospital)**	Kit 11A, 11B

* Misoprostol can also be procured to complement kits 6A and 8 for the primary health care facility level.

** At the time of printing the 2018 IAFM, Newborn Care Supply Kits were not yet available.

How can the IARH Kits be ordered?

In most acute emergencies UNFPA will provide IARH Kits on behalf of the SRH working group/sub-sector at the onset of an emergency. You can reach out to the SRH Coordinator to facilitate procurement of the IARH Kits.

The IARH Kits can also be ordered directly from UNFPA Procurement Services Branch in Copenhagen at unfpa.org/humanitarian-emergency-procurement. Before placing your own order, discuss with the UNFPA country office to determine what is already being ordered and if orders can be combined. UNFPA will need to know where the IARH Kits will be used and which organization or individual will organize the distribution of the kits. The UNFPA country office or UNFPA Humanitarian Office can provide information on the kits or help facilitate an order. The kits cannot be disbursed until funding is confirmed with UNFPA Procurement Services Branch.

When placing an order, provide the following information:

- ▶ The confirmation of availability of funds and the chargeable budget code; shipment cannot be made until funding issues are resolved
- ▶ The name and contact details of the person responsible for ordering and coordinating the delivery of the kits
- ▶ The name and complete contact details (address, telephone, fax, email) of the person responsible for receiving the kits in the field
- ▶ A detailed distribution plan

Having a distribution plan when placing an order is essential for both the disbursement of the kits and logistics planning and programming. This plan should outline how many of which kits should go to which partners in which geographical settings. It should also include detailed plans for in-country transport and storage, including provisions for items that need to be kept cool (cold chain). If multiple destinations in a county are involved, a detailed list outlining the respective destinations, types, and quantities of each kit to each destination, contact persons, and so forth, is required.



For more information, see the *IARH Kit Management Guidelines* and the *IARH Kit Manual* at iawg.net/resource/inter-agency-reproductive-health-kits-2011.

If you are a national NGO, using the SRH working group and ordering through the UNFPA country office can facilitate the customs and arrival procedures of the kits into the country as United Nations agencies are often covered in a blanket humanitarian import exemption. For some agencies, particularly local NGOs, it may be helpful to develop a memorandum of understanding with UNFPA before a crisis strikes to avert delays in procurement.

Information on the kits and assistance with ordering can be provided by UNFPA field offices, agency partners, or the UNFPA Humanitarian Office in Geneva:

Address	UNFPA Procurement Service Branch Marmovej 51 2100 Copenhagen Denmark	UNFPA Humanitarian Office Palais des Nations Avenue de la paix 8-14 1211 , Geneva 10, Switzerland
Email	procurement@unfpa.org	Humanitarian-SRHsupplies@unfpa.org
Website	unfpaprocurement.org	unfpa.org

How are the Inter-agency Emergency Health Kits (IEHK) ordered?

IEHKs can be ordered through WHO or UNICEF. A booklet describing the IEHK and how it can be ordered through WHO is available on the WHO emergency health kit website: who.int/emergencies/kits/en/.

You can also contact UNICEF directly at:

Address	Procurement Services Centre UNICEF Supply Division Oceanvej 10-12 DK — 2150 Nordhavn, Copenhagen Denmark
Email	supply@unicef.org
tel	+45 4533 5500
fax	+45 3526 9421



For more information about UNICEF services, partners, and supplies, please visit unicef.org/supply/index_procurement_services.html and supply.unicef.org.

What is an Example IARH Kit Order?

EXAMPLE: Acute Displaced Population, Migratory Cross-Borders

- ▶ **Number of displaced people:** 30,000
- ▶ **Special observations:** Administrative supplies are available locally; high rate of C-section in country of origin and high facility delivery (>75%); high likelihood of onward cross-border displacement; rape was known to be used in conflict at place of origin; Implants were used in the place of origin
- ▶ **Facilities and staff**
 - **Mobile Clinics:** 1 mobile clinic supported by UNFPA; outpatient daytime clinic
 - **Primary health care level:** 2 health centers with 2 medical doctors, 2 trained nurses, 1 trained midwife along the migration path
 - **Referral level:** 1 local hospital 10 km away, poorly equipped but with trained staff able to perform emergency obstetric procedures

Example Order:

Item	Quantity
Male Condoms (Kit 1)	3
Clean Delivery, Individual (Kit 2A)	3
Clean Delivery, Attendant (Kit 2B)	3
Post Rape Treatment (Kit 3)	4
Oral And Injectable Contraception (Kit 4)	4
Treatment Of Sexually Transmitted Infections (Kit 5)	4
Clinical Delivery Assistance (Kit 6A)	2
Clinical Delivery Assistance (Kit 6B)	2
Management Of Miscarriage And Complications Of Abortion (Kit 8)	4
Suture Of Cervical And Vaginal Tears (Kit 9)	3
Vacuum Extraction Delivery (Kit 10)	3
Referral Level Kit For Reproductive Health (Kit 11A)	1
Referral Level Kit For Reproductive Health (Kit 11B)	1
Blood Transfusion (Kit 12)	1
Complementary Commodities	
Oxytocin	1

Explanation of the IARH Kit order:

<p>Male Condoms (Kit 1)</p>	<p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be divided between primary and referral health centers.</p>
<p>Clean Delivery Kit Individual (Kit 2A)</p>	<p>Due to migratory nature of the emergency women may not have access to the health facilities.</p> <p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be distributed at the community, primary and referral health centers to visibly pregnant women.</p>
<p>Clean Delivery Kit Attendant (Kit 2B)</p>	<p>It is unknown if birth attendants and health care workers are in the community.</p> <p>Since there are not supplies in this kit which will expire you should order this kit.</p> <p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be distributed at the community, primary and referral health centers to visibly pregnant women.</p>
<p>Post-Rape Treatment (Kit 3)</p>	<p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be divided between primary and referral health centers.</p> <p>Since there are actually 4 primary and referral health centers and supplies are difficult to divide, we will procure 4 kits; one to be distributed to each primary and referral health center.</p>
<p>Oral and Injectable Contraceptives (Kit 4)</p>	<p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be divided between primary and referral health centers.</p> <p>Since there are actually 4 primary and referral health centers and supplies are difficult to divide, we will procure 4 kits; one to be distributed to each primary and referral health center.</p>
<p>Treatment of STIs (Kit 5)</p>	<p>This kit is designed for 10,000 people, therefore we need 3 kits which would then be divided between primary and referral health centers.</p> <p>Since there are actually 4 primary and referral health centers and supplies are difficult to divide, we will procure 4 kits; one to be distributed to each primary and referral health center.</p>

Clinical Delivery Assistance (Kit 6A and Kit 6B)

This kit is designed for 30,000 people; therefore, we would need 1 kit which would then be send to primary health centers.

Since there are 2 primary health care centers and supplies in this kit is not possible to divide. we will procure 3 kits and send one to each primary health care center.

Mobile clinics do not conduct deliveries themselves so they do not get this kit.

Management of complications of miscarriage and abortion (Kit 8)

This kit is designed for 30,000 people; therefore, we would need 1 kit which would then be send to primary and referral health centers.

Since there are 2 primary health care centers, 1 mobile clinic and 1 referral health center, and supplies in this kit is not possible to divide, we will procure 4 kits and send one to each primary and referral health care center.

All of these supplies may not be able to be used in the mobile clinic. It is recommended that the mobile clinic integrate the unusable supplies to a primary health care facility.

Suture of Cervical and Vaginal Tears (Kit 9)

This kit is designed for 30,000 people; therefore, we would need 1 kit which would then be send to primary and referral health centers.

Since there are 2 primary health care centers and 1 referral health center, and supplies in this kit is not possible to divide we will procure 3 kits and send one to each primary and referral health care center.

Mobile clinics do not conduct deliveries themselves so they do not get this kit.

Vacuum Extraction Delivery (Kit 10)

This kit is designed for 30,000 people; therefore, we would need 1 kit which would then be send to primary and referral health centers.

Since there are 2 primary health care centers and 1 referral health center, and the supplies in this kit is not possible to divide, we will procure 3 kits and send one to each primary and referral health care center.

Mobile clinics do not conduct deliveries themselves so they do not get this kit.

Referral level kit for reproductive health (Kit 11A and Kit 11B)	This kit is designed for 150,000 people; therefore, we would need 1 kit which would then be send to the 1 referral health center.
Blood Transfusion (Kit 12)	This kit is designed for 150,000 people; therefore, we would need 1 kit which would then be send to the 1 referral health center.
Oxytocin	<p>Populations coming from settings with high caesarean-section and high facility delivery will lead to more facility deliveries in primary health centers due to health seeking behavior.</p> <p>The amount of oxytocin may be more than the average than was used in the kit estimation.</p>

Unit 9: Key Points

- ▶ The IARH Kits are a prepackaged set of kits containing all the medicines, devices, and commodities necessary to facilitate the implementation of the MISIP for SRH for a three-month period.
- ▶ The IARH Kits are categorized into three levels, targeting the three health service delivery levels: community, primary health care, and referral hospital.
- ▶ Complementary commodities are disposable and consumable items that can be ordered under specific circumstances to complement the main kits. They should be ordered according to the enabling environment and capacities of health care providers.
- ▶ Reliance on and continued ordering of the IARH Kits should be avoided; follow-up orders for ongoing supply needs should be made through the regular supply lines in country.



Unit 9 Quiz: Ordering IARH Kits (2019)

1. When should an organization order complementary commodities? Select all that apply:
 - a. When providers or the population are trained to use the commodity
 - b. When the supplies were accepted and used prior to the emergency
 - c. If the supply is allowed to the fullest extent of the national law and is included on the national medicines list
 - d. At the beginning of every emergency
2. Which statement is not correct?
 - a. IARH Kits contain sufficient supplies for a seven-month period.
 - b. It is important to coordinate with partners and prepare a plan for in-country distribution of the kits.
 - c. It is important to have a plan for transport and storage, including a cold chain.
 - d. There should be continual coordination to analyze the situation, assess the needs of the population, and order disposables and other equipment.
3. _____, _____, and _____ are the different levels of health care for which the IARH Kits are designed.
 - a. International level
 - b. Primary health care
 - c. Referral hospital
 - d. Community/health post
 - e. Ministry of health level
4. Who manages the IARH Kits?
 - a. UNHCR
 - b. UNICEF
 - c. UNFPA
 - d. UNOCHA
5. What information is needed to order the IARH Kits? Select all that apply:
 - a. Detailed contact, delivery, and financing information
 - b. Information about the type of setting and the target population size
 - c. Where the kits will be used and which organization will organize the distribution of the kits
 - d. Why the kits are needed
 - e. The number of health centers and referral hospitals

MISP FOR SRH MODULE

POST-TEST

1. The MISP for SRH objectives and other priority activities include:
 - a. Prevent sexual violence and respond to the needs of survivors
 - b. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
 - c. Prevent excess maternal and newborn morbidity and mortality
 - d. Prevent unintended pregnancy and ensure safe abortion care is available, to the full extent of the law
 - e. All of the above

2. Which is a guiding principle for responding to the needs of survivors of sexual violence?
 - a. Safety
 - b. Confidentiality
 - c. Service delivery
 - d. Nondiscrimination
 - e. a, b, and d

3. What is **not** included as a MISP for SRH priority activity?
 - a. Antenatal care
 - b. Postnatal care
 - c. Comprehensive GBV services
 - d. HIV voluntary counseling and testing
 - e. All of the above

4. Which are WHO health system building blocks? Select all that apply:
 - a. Financing
 - b. Medical commodities
 - c. Service delivery
 - d. Marketing
 - e. Governance and leadership

5. Adolescents have the right to be informed about and to have access to safe, effective, affordable, and acceptable contraceptive methods of their choice.

True or False

6. It is two weeks after a natural disaster and the health coordination meetings have been established, but the SRH coordination meetings have not started. What should you do?
- a. Wait a little longer; once the health activities are established, the health sector/ cluster will focus on SRH
 - b. Advocate to the health cluster for immediate initiation of separate SRH meetings
 - c. Attend the nutrition coordination meetings
 - d. Both a and c
7. Which is **not** a principle of SRH programming in humanitarian settings?
- a. Advance human rights and reproductive rights
 - b. Ensure technical soundness and financial accountability
 - c. Share information and results only with attendees in the SRH working group
 - d. Work in respectful partnerships
8. The SRH Coordinator's role is:
- a. To coordinate, communicate, and collaborate within the health, GBV, HIV, and logistics sectors/cluster/actors
 - b. To support health partners to seek SRH funding through humanitarian planning processes and appeals and multiyear funding to transition to comprehensive SRH
 - c. To lead the active case identification and case management of HIV and procurement of antiretrovirals for first- or second-line treatment and co-trimoxazole
 - d. To utilize the MISP for SRH Checklist for monitoring MISP for SRH services
 - e. a, b, and d

9. Which is **not** a newborn danger sign?
- a. Fits or convulsions
 - b. Reduced activity or lack of movement
 - c. Breastfeeding
 - d. Fast breathing (more than 60 breaths per minute)
 - e. Very small size at birth
10. What essential services should skilled birth attendants be able to provide as part of emergency obstetric and newborn care (EmONC) and essential newborn care?
- a. Provision of post-abortion care
 - b. Management of newborn illness and care for preterm/low birthweight babies
 - c. Prevention and management of intrapartum and postpartum hemorrhage
 - d. Provision of assisted delivery with vacuum extraction
 - e. Thermal protection (drying, warming, immediate skin-to-skin contact, and delayed bathing)
 - f. All of the above
11. When should planning for the integration of comprehensive SRH activities take place?
- a. At the onset of a humanitarian response
 - b. Once mortality rates have stabilized
 - c. When the local health authorities inform the humanitarian community to start comprehensive services
 - d. b and c
12. What should be offered to all crisis-affected adults and adolescents living with advanced HIV who were on antiretrovirals prior to the emergency?
- a. Antiretrovirals
 - b. Co-trimoxazole
 - c. Condoms
 - d. Tetanus prophylaxis
 - e. a, b, and c

13. An effective referral system should have transport options available only during clinic operational hours.

True or False

14. Which of the following is **not** included in clinical care for female survivors of sexual violence?
- a. History and thorough medical exam following survivor's consent
 - b. Compassionate and confidential care and counseling with survivor's consent
 - c. Pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law
 - d. Forensic examination and collection done for all survivors in all contexts
 - e. Psychosocial or mental health services
15. Your organization is having logistical challenges and significant delays receiving supplies into the country. Given this reality, what can you do to address this situation?
- a. Discuss challenges during the SRH and health sector/cluster coordination meeting
 - b. Contact UNPFA and/or the logistics cluster to see if it can support you
 - c. Follow procurement processes and conduct quality assurance to obtain medications and supplies locally
 - d. All of the above
16. Progestin-only emergency contraceptive (EC) pills are safe for all women, girls, and adolescents of reproductive age, even for those who are advised not to use combined oral contraceptives for ongoing contraception.

True or False

17. An example of infection control includes:
- a. Disposing of sharp objects into ordinary waste bins or bags
 - b. Cleaning up blood spills or other bodily fluids promptly and carefully with a 0.5% chlorine solution
 - c. Recapping needles
 - d. Soaking contaminated instruments in warm water

- 18.** Complementary commodities, such as female condoms or implants, should always be ordered at the onset of every emergency.

True or False

- 19.** Who should be involved in the program planning and implementation of MISIP for SRH services and comprehensive SRH services? Select all that apply:

- a.** LGBTQIA groups
- b.** Persons with disabilities
- c.** Adolescents
- d.** Community leaders
- e.** SRH Coordinator

- 20.** Contraceptive counseling and a range of short and long-acting methods should be offered to patients in all abortion services.

True or False

APPENDIX A: WHAT ARE THE OBJECTIVES OF THE MISP FOR SRH?

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP. The lead SRH organization:¹⁴⁰

- ▶ 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.

¹⁴⁰ *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.

APPENDIX B: MISP FOR SRH MONITORING CHECKLIST

The SRH Coordinator implements the MISP for SRH Monitoring Checklist to monitor service provision in each humanitarian setting as part of overall health sector/cluster monitoring and evaluation. In some cases, this might be done by verbal report from SRH managers and/or through observation visits. At the onset of the humanitarian response, monitoring is done weekly and reports should be shared and discussed with the overall health sector/cluster. Once services are fully established, monthly monitoring is sufficient. Discuss gaps and overlaps in service coverage during SRH stakeholder meetings and at the health sector/cluster coordination mechanism to find and implement solutions.

1. SRH Lead Agency and SRH Coordinator			
		Yes	No
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly	Yes	No
	National (MONTHLY)		
	Sub-national/district (BIWEEKLY)		
1.3	Local (WEEKLY)		
	Relevant stakeholders lead/participate in SRH working group meetings	Yes	No
	Ministry of Health		
	UNFPA and other relevant United Nations agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
1.4	Civil society organizations, including marginalized (adolescents, persons with disabilities, LGBTQIA people)		
	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensure mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		
2.2	Number of women of reproductive age (ages 15–49, estimated at 25% of population)		

2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population, estimated at 4% of the population)		
3. Prevent Sexual Violence and Respond to Survivor's Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	Yes	No
	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100		%
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		
3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100		%
		Yes	No
3.5	Information on the benefits and location of care for survivors of sexual violence		
4. Prevent and Respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		

4.4	Lubricated condoms available free of charge		
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	Persons with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period Specify locations:		
4.7	Antiretrovirals available to continue treatment for people who were enrolled in antiretroviral therapy prior to the emergency, including PMTCT		
4.8	PEP available for survivors of sexual violence; PEP available for occupational exposure		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		
5. Prevent Excess Maternal and Newborn Morbidity and Mortality			
5.1	Availability of EmONC basic and comprehensive per 500,000 population	Yes	No
	Health center with basic EmONC, five per 500,000 population		
	Hospital with comprehensive EmONC, one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
	Hospital (to ensure comprehensive EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	One team of doctor, nurse, midwife, and anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care (PAC)		
	Coverage of PAC: (number of health facilities where PAC is available/number of health facilities) x 100		
	Number of women and girls receiving PAC		
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 (means of communication [radios, mobile phones])	Yes	No
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		

5.4	Functioning cold chain (for oxytocin, blood-screening tests) in place		
5.5	Proportion of all births in health facilities: (number of women giving birth in health facilities in specified period/expected number of births in the same period) x 100		%
5.6	Need for EmONC met: (number of women with major direct obstetric complications treated in EmONC facilities in specified period/expected number of women with severe direct obstetric complications in the same area in the same period) x 100		%
5.7	Number of caesarean deliveries/number of live births at health facilities x 100		%
5.8	Supplies and commodities for clean delivery and newborn care		
5.9	Clean delivery kit coverage: (number of clean delivery kits distributed where access to health facilities is not possible/estimated number of pregnant women) x 100		%
5.10	Number of newborn kits distributed including clinics and hospitals		
5.11	Community informed about the danger of signs of pregnancy and childbirth complications and where to seek care		
6. Prevent Unintended Pregnancies			
6.1	Short-acting methods available in at least one facility	Yes	No
6.2	Condoms		
6.3	EC pills*		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine devices (IUDs)		
6.8	Number of health facilities that maintain a minimum of a three-month supply of each	Number	
	Condoms		
	EC pills		
	Combined oral contraceptive pills		
	Progestin-only contraceptive pills		
	Injectables		
	Implants		
	IUDs		
7. Planning for Transition to Comprehensive SRH Services			
7.1	Service delivery	Yes	No
	SRH needs in the community identified		
	Suitable sites for SRH service delivery identified		

7.2	Health workforce	Yes	No
	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		
8. Other Priority Activity: SAC to the Full Extent of the Law			
8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100		%
8.2	Number of women and girls receiving SAC		
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)		
9. Special Notes			
10. Further Comments			
Explain how this information was obtained (direct observation, report back from partner [name], etc.) and provide any other comments. ents .			
11. Actions (For the “No” Checks, Explain Barriers and Proposed Activities to Resolve Them.)			
Number	Barrier	Proposed solution	

APPENDIX C: MISP FOR SRH CALCULATOR

To access the MISP for SRH Calculator, visit:

<http://iawg.net/resource/misp-rh-kit-calculators/>.

MISP Calculator (2019) Guidance Note

What is the MISP calculator?

At the very onset of an acute humanitarian emergency, data on the affected population can range significantly depending on the quality of the information available before the emergency and based on the known demographic mix of the target population. The Minimum Initial Services Package for SRH in Humanitarian Settings (MISP) Calculator is a tool that can help coordinators and programme managers determine affected population demographics for advocacy, fundraising and programming at the very onset of an emergency.

The MISP calculator ONLY requires from the user affected population numbers. The MISP calculator works by automatically providing the user with a simple way to access the 'best available data' for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population.

How to use the MISP Calculator?

1. Click on the tab 'MISP calculator'
2. Select the country of origin of the target population (This may be different for IDPs, refugees, or host population)
3. Select the national or subnational level of the target population (in some settings you may be able to choose from provincial or municipal level)
4. Enter the number of persons affected
5. OPTIONAL: Enter any site specific information that you may have
6. Data will be calculated for MISP-related indicators including maternal and newborn health, contraceptives, sexual violence, HIV and other STIs
7. Click on the 'Visualizations' tab to see basic graphics on your data that can be used/ adapted for advocacy and fundraising

How is this version of the MISP Calculator (2019) different from previous versions?

This version of the MISP calculator has four major differences compared to previous versions.

1. The indicators provided are updated based on the revised MISP (2018).
2. There is a new functionality to allow for country specific data (if it exists) on the affected population to override the global constants if no site specific information is available.
3. There is now a basic visualization of the data that can be used for advocacy purposes.
4. The user should re-download the excel based tool every few months as UNFPA data branch will continuously update the national and sub-national data available for the tool to pull from.

What data will I receive from the MISP Calculator?

The MISP calculator works by automatically providing the user with a simple way to access the “best available data” for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. If there is national- or subnational-specific data, the online tool will automatically replace the global constants with the ‘best available data’ (based on available census, survey and other relevant data sources) at the applicable level of administrative boundary (i.e. country, region, province, or municipality). The source of this information can be found in the “sources” box of the tool.

Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population in the green boxes. This data will overwrite global constants and national- or subnational-specific data and replace it as the ‘best available data’.

What will the MISP Calculator not provide me?

The MISP encompasses a minimum set of lifesaving SRH interventions that must be available from the very onset of every humanitarian emergency and expanded on as soon as the situation allows. The MISP calculator is designed for use at the onset of an emergency where funding, advocacy and programming is targeted at providing the MISP interventions. It is important to remember that the MISP includes the minimum essential services, not the only services that should be provided to affected populations. As soon as possible it is essential to expand on the MISP to a more context specific, comprehensive, SRH response. The MISP calculator will not provide all of the information on indicators beyond those included in the MISP for this component of the response.

The MISP calculator is designed to be a supportive tool to help SRH coordinators and programme managers in the earliest phases of an emergency. It will never be 100% accurate

or the only programmatic guideline to base all decisions off of. The calculator outputs should be analyzed by SRH coordinators and programme managers together to take decisions about their response. Coordinators and programme managers need to think about their target populations and how the characteristics of that population may limit the applicability of the data provided in the MISP calculator. It is particularly important to consider how the emergency may have impacted demographics or changed pre-crisis data.

If there are multiple target populations for the programme (e.g. refugee populations and host population) keep in mind you may need to work with the MISP calculator separately for each population as their indicators may differ significantly. Additionally, it is important to remember that some affected populations around the world are left out of national data collection for political or social reasons; if these groups are included in your programme consider the limitations of the data and make adjustments accordingly.

Where does the national or subnational data come from and who updates it?

The national or subnational data comes from different sources depending on the context. It can come from available census, survey or other data collected by various national or international statistical collection agencies. The source and year of the data is always indicated on the top of the calculator when you choose a country and/or region. The United Nations Population Fund (UNFPA) Population and Data Branch is continuously updating the information that the tool pulls data from; it is important for the user to re-download the tool every few months or for each new response to ensure that you are getting the most updated information available.

Where do the global constants come from and who updates it?

The global constants are determined based on an expert group assessment of low- and middle-income countries and/or humanitarian and fragile countries' averages. For more information, please contact the UNFPA Humanitarian Office.

Who can help me use the tool or answer any other questions that I have?

UNFPA Humanitarian Office and the UNFPA Population and Development Branch conducted a webinar on how to use the tool which can be found which can be found on UNFPA's website.

Depending on the country you are operating in, the UNFPA regional humanitarian advisor can provide support on the use of the MISP calculator. Additionally please feel free to reach out to Humanitarian-SRHSupplies@unfpa.org for support from global UNFPA Humanitarian Office colleagues.

MISP calculator

Information can be overwritten manually in all green fields

No country specific data can be provided, if possible, provide site specific estimates, otherwise global constants are used

No data available

For more information on the functionality of the MISP calculator, please refer to the [Guidance note](#).

Country	Syria	
Region	Aleppo Governorate	Region/Province/Municipality incorrectly selected, please revise
Province		
Municipality		
Affected population	500,000	

Sources

United Nations Population Division - World Population Prospect: 2017 Revision

UN Population Division - World Contraceptive Use 2018

Global Burden of Disease Study 2017 (GBD 2017) Results

UN AIDS - AIDS Info - 2018 Estimates

United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 2018.

Trends in Maternal Mortality: 1990 to 2015, WHO, UNICEF, UNFPA, World Bank Group, UNFPA, 2015

Center for Reproductive Rights, The World's Abortion Laws, 2019

Basic statistics	Global constants	Country data	Site specific data	Best available data
Percentage of women of reproductive age (WRA)	26%	25%		25%
Percentage of adult population (18+)	63%	58%		58%
Percentage of young adolescent girls (10-14)	5%	6%		6%
Percentage of all adolescent girls (10-19)	9%	12%		12%
Percentage of adolescents (10-19)	19%	25%		25%
Percentage of adult men (18+)	31%	29%		29%
Crude birth rate (per 1,000 population)	23.9	20		20
STI prevalence	5%	3%		3%
Neonatal mortality rate (deaths per 1,000 live births)	-	8.7		8.7
Maternal mortality ratio (deaths per 100,000)				

Basic statistics	Estimates based on global	Country estimates	Site specific estimates
Number of women of reproductive age (WRA)	127,500	125,000	-
Number of adult population (18+)	313,150	287,885	-
Number of young adolescent girls (10-14)	24,350	30,000	-
Number of all adolescent girls (10-19)	47,150	60,000	-
Number of adolescents (10-19)	97,250	125,000	-
Number of adult men (18+)	157,350	145,000	-
Number of live births in the next 12 months	11,950	10,100	-
Number of live births in the next month	996	842	-
Number of currently pregnant women	8,963	7,575	-
Number of adults living with an STI	13,905	8,949	-

Best available estimates	Units
125,000	Women of reproductive age
287,885	Adults
30,000	Young adolescent girls (10-14)
60,000	Adolescent girls (10-19)
125,000	Adolescents (10-19)
145,000	Adult men
10,100	Live births in the next 12 months
842	Live births in the next month
7,575	Currently pregnant women
8,949	Adults living with an STI

Maternal and newborn health	Global constants (default)	Country data	Site specific data	Best available data
Number of pregnancies that end in miscarriage or unsafe abortion (estimated as an additional percentage of live births)	15%			15%
Number of still births	2%			2%
Number of currently pregnant women who will experience complications	15%			15%
Number of newborns who will experience complications	20%			20%
Number of newborns weighing less than 2,500 g	5%	-		5%
Number of currently pregnant women who will have access and be able to give birth in a health center	15%			15%
Number of currently pregnant women delivering who will need suturing of vaginal tears	15%			15%
Number of deliveries requiring a C-section (Min/Max)	5%	##		5% 15%
Number of maternal deaths averted if MISP is fully implemented and all pregnant women have access to EmOC services	100%			100%

Best available		Units
next 3 months	next month	
379	126	Pregnancies that end in miscarriage or unsafe abortion
58	19	Stillbirths
379	126	Currently pregnant women who will experience complications
505	168	Newborns who will experience complications
126	42	Babies who will weigh less than 2,500 g at birth
379	126	Currently pregnant women who will have access and be able to give birth in a health center
379	126	Currently pregnant women who will need suturing of vaginal tears
126/379	260/779	Deliveries requiring a C-section
2	1	Maternal deaths averted

Access to Sexual and Reproductive Health	Global	Country data	Site specific	Best available data
Number of sexually active men in the population	20%			20%
Number of sexually active men who use condoms	20%			20%
Number of WRA who use modern contraceptive	15%	45%		45%
Number of WRA who use female condoms	1%	-		9.0%
Number of WRA who use an implant	3%	-		9%
Number of WRA who use combined oral contraceptive pills	5%	-		13%
Number of WRA who use injectable contraception	8%	-		25%
Number of WRA who use an IUD	1%	-		2%
Number of people living with HIV	-	-		-
Number of people living with HIV, receiving ART	-	-		-
Number of people who will seek care for STI syndromes	3%			3%
Number of cases of sexual violence who will seek care	2%			2%
Status of abortion legislation	To save the woman's life			
Safe induced abortion rate	-		2%	2%

Best available	Units
100,000	Sexually active men
20,000	Sexually active men who use condoms
56,000	WRA who use modern contraceptives
11,200	WRA who use female condoms
11,200	WRA who use an implant
16,800	WRA who use combined oral contraceptive pills
30,800	WRA who use injectable contraception
2,800	WRA who use an IUD
-	People living with HIV
-	People living with HIV, receiving ART
7,917	People seeking care for STI syndromes
2,500	Number of cases of sexual violence who will seek care
Status of abortion	To save the woman's life
2,750	Abortions per 1,000 women of reproductive age

APPENDIX D: SAMPLE PROJECT PROPOSAL

This sample project proposal is for an NGO to submit to governments, United Nations agencies, such as UNFPA and UNHCR, or other donors.

PROJECT TITLE	Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)
ORGANIZATION	[Description of the organization and its work, including SRH activities, in the region]
BRIEF BACKGROUND, REASON FOR PROJECT AND PROBLEM TO BE ADDRESSED	<p>The MISP for SRH will save lives if implemented at the onset of an emergency. Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy, such as unsafe abortion; and preventable cases of sexual violence and their consequences, such as unintended pregnancies, increased acquisition of sexually transmitted infections (STIs), increased transmission of human immunodeficiency virus (HIV), and ongoing mental health problems, including depression.</p> <p>The MISP for SRH is a set of priority activities designed to 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 services integrated into primary health care. Another priority activity of the MISP for SRH includes ensuring that safe abortion care to the full extent of the law is provided.</p> <p>The MISP for SRH can be implemented without an in-depth needs assessment because documented evidence already justifies its use and it represents the minimum SRH services to be provided during emergencies. The components of the MISP for SRH form a minimum requirement and it is expected that comprehensive SRH services will be provided as soon as the situation allows. The priority activities of the MISP for SRH are included in the 2018 revision of the Sphere Guidelines within the standards on SRH: “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.”*</p> <p>An SRH lead agency with a designated SRH Coordinator is essential to ensuring coordination of MISP for SRH activities within the health sector/cluster. Under the auspices of the overall health coordination framework, the SRH Coordinator should be the focal point for SRH services and provide technical advice and assistance on SRH; liaise with national and regional authorities of the host country; liaise with other sectors to ensure a multisectoral approach to SRH; identify standard protocols for SRH that are fully integrated with primary health care, as well as simple forms for monitoring SRH activities; and report regularly to the health sector/cluster.</p> <p>[Insert brief background on emergency situation.]</p>

OBJECTIVES

1. Identify lead SRH organization and individuals to facilitate the coordination and implementation of the MISP for SRH.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care as the situation permits.

Other priority: It is also important to ensure safe abortion care to the full extent of the law.

ACTIVITIES

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP for SRH. The lead SRH organization does the following:

- ▶ 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, gender-based violence (GBV) sub-cluster/sector, and/or HIV national coordination meetings on any issues related to MISP for SRH 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
- ▶ Ensures the community is aware of the availability and location of SRH services

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

- ▶ Work with other clusters, especially the protection or 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
- ▶ Make clinical care and referral to other supportive services available for survivors of sexual violence
- ▶ Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

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

- ▶ Establish safe and rational use of blood transfusion
- ▶ Ensure application of standard precautions
- ▶ Guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population prior to the crisis), ensure provision of female condoms
- ▶ Support the provision of antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission programs

- ▶ Provide post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure
- ▶ Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- ▶ Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

Prevent excess maternal and newborn morbidity and mortality:

- ▶ Ensure 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 uncomplicated vaginal births and provision of basic emergency obstetric and newborn care (BEmONC)
 - 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
- ▶ Establish a 24/7 referral system to facilitate transport and communication from the community to the health center and hospital
- ▶ Ensure the availability of lifesaving post-abortion care in health centers and hospitals
- ▶ Ensure 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:

- ▶ Ensure availability of a range of long-acting, reversible and short-acting contraceptive methods (including male and female—where already used—condoms and emergency contraception) at primary health care facilities to meet demand
- ▶ Provide 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
- ▶ Ensure 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: Ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Monitor and evaluate project implementation:

- ▶ Regularly complete the MISP for SRH Checklist as found in the revised *Inter-Agency Field Manual: Reproductive Health in Humanitarian Situations* for all project implementation areas.

	Collect or estimate basic demographic information; total population; number of women of reproductive age (ages 15–49, 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 0–28 days); and sex-specific mortality rate.
INDICATORS	<ol style="list-style-type: none"> 1. Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception) 2. Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100 3. Percent of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100 4. Coverage of supplies for standard precautions, which is defined as the percentage of health delivery sites with sufficient supplies to ensure standard precautions can be practiced: (number of health service delivery points with adequate supplies to carry out standard precautions/number of health service delivery points) x 100 5. Coverage of HIV rapid tests for safe blood transfusion, which is defined as the percentage of referral hospitals that have sufficient HIV rapid tests to ensure all blood destined for transfusion is screened: (number of hospitals with sufficient HIV rapid tests to screen blood for transfusion/total number of hospitals) x 100 6. Condom distribution rate, which is defined as the rate of condom distribution among the population: number of male condoms distributed/total population/month 7. EmONC needs met, which is defined as the proportion of women with major direct obstetric complications who are treated in EmONC facilities: (number of obstetric complications [antepartum hemorrhage, postpartum hemorrhage, obstructed labor, pre-eclampsia, eclampsia or puerperal sepsis] treated at an EmONC facility/expected number of deliveries) x 100 8. Coverage of clean delivery kits, which is defined as the rate of distribution of clean delivery kits among pregnant women in their third trimester: (number of clean delivery kits distributed/estimated number of pregnant women) x 100 9. Percentage of health facilities providing long-acting reversible and short-acting contraceptive methods available to meet demand 10. Percentage of health facilities providing syndromic STI treatment available at health facilities
TARGETED BENEFICIARIES	(Total number of) crisis affected, of whom (xx) are women 15–49 years old.
PROJECT DURATION	Six months to one year.

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

APPENDIX E: MISP FOR SRH ADVOCACY SHEET

What is the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) and why is it important?

1. The MISP for SRH is a priority set of lifesaving activities to be implemented at the onset of every humanitarian crisis. It forms the starting point for SRH programming in humanitarian emergencies and should be sustained and built upon with comprehensive SRH services throughout protracted crises and recovery.
2. Two-thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflict, natural disaster, or both.¹⁴¹
3. The MISP for SRH saves lives and prevents illness, disability, and death. As such, the MISP for SRH meets the lifesaving criteria for the Central Emergency Relief Fund.
4. Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy, such as unsafe abortion; and preventable cases of sexual violence and their consequences, such as unintended pregnancies, increased acquisition of sexually transmitted infections, increased transmission of human immunodeficiency virus (HIV), and ongoing mental health problems, including depression.
5. The priority lifesaving SRH services in the MISP for SRH are integrated into the Sphere Minimum Health Standards in Humanitarian Response.¹⁴²
6. The Global Health Cluster endorses the MISP for SRH as a minimum standard in health service provision in emergencies, as outlined in the *Inter-Agency Standing Committee Health Cluster Guide*.¹⁴³
7. International laws support the rapid and unobstructed implementation of the MISP for SRH by humanitarian actors.¹⁴⁴ SRH services are also vital to realizing United Nations Security Council Resolutions 1325, 1820, 1888, and 1889 on Women, Peace and Security.
8. In addition to health, activities of the MISP for SRH must be coordinated with other sectors/ clusters, including protection; logistics; water, sanitation, and hygiene; and early recovery.
9. As humanitarian actors become familiar with the priority activities of the MISP for SRH, they recognize that it can and should be provided within the context of other critical priorities, such as water, food, cooking fuel, and shelter.

141 Zeid, et al., "For Every Woman, Every Child, Everywhere."

142 *The Sphere Handbook*.

143 *Health Cluster Guide: A Practical Guide for Country-Level Implementation*.

144 Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War (Geneva, August 12, 1949); Geneva Convention (III), Relative to the Treatment of Prisoners of War, Art. 3 (Geneva, August 12, 1949).; International Covenant on Civil and Political Rights, Art. 6 (UN General Assembly, December 16, 1966); Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War, Arts. 23, 55, 59, and 60 (Geneva, August 12, 1949); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), Art. 70 (June 8, 1977); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), Arts. 9–11 (June 8, 1977); Convention on the Elimination of All Forms of Discrimination Against Women (UN General Assembly, 1979); and the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, December 16, 1966).

APPENDIX F: MISP FOR SRH SYNOPSIS

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

- Work with other clusters especially the protection or gender based violence 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
- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral



OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs



Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- 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
- Reports back to the health cluster, GBV sub-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
- Ensures the community is aware of the availability and location of reproductive health services

GOAL PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 6: 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
- Governance and Leadership

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

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



OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure 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) to manage
 - At health facility level: Skilled birth attendants and provision of basic 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
- Establish 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
- Ensure the availability of life-saving, post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable



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.



The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

- Work in respectful partnership with people receiving care, providers, and local and international partners
- Ensure equality by meeting people's varied sexual and reproductive health needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality
- Provide comprehensive, evidence-based, and accessible information and choice about the supplies and services available
- Ensure effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities
- Ensure privacy and confidentiality for everyone and treat people with dignity and respect
- Promote 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
- Recognize and address gender and power dynamics in healthcare facilities to ensure that people do not experience coercion, discrimination, or violence/mistreatment/disrespect/abuse in receiving or providing health services
- Engage and mobilize 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
- Monitor services and supplies, and share information and results with the aim of improving quality of care

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEEmNC): Primary Health Care Facility Level (BEEmNC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order these kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmNC): Referral Hospital Level (CEmNC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

*** The new kit structure will only be available late 2019**

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEEmNC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level-CEmNC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

- where providers are trained to use the special supply;
- where the supplies were accepted and used prior to the emergency;
- after the rapid first order of SRH supplies in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels); and,
- where the use of the supplies is allowed to the fullest extent of the national law.

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpa.org/procurement

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

APPENDIX G: ADOLESCENT-FRIENDLY CHECKLIST

This adolescent-friendly SRH service checklist was adapted from the *Adolescent SRH Toolkit for Humanitarian Settings* developed by Save the Children and the UNFPA.

Characteristics	Yes	No	Feasible Suggestion for Improvement
Health Facility Characteristics			
1. Is the facility located near a place where adolescents—both female and male—congregate (e.g., youth center, school, market)?			
2. Is the facility open during hours that are convenient for adolescents—both female and male—particularly in the evenings or on the weekend?			
3. Are there specific clinic times for adolescents?			
4. Are drop-in clients (clients without appointments) welcomed?			
5. Are SRH services offered for free or at rate affordable to adolescents?			
6. Are waiting times short?			
7. If both adults and adolescents are treated in the facility, is there a separate, discreet entrance for adolescents to ensure privacy?			
8. Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
9. Is there a code of conduct in place for staff at the health facility?			
10. Is there a transparent, confidential mechanism for adolescents to submit complaints, feedback, or other accountability mechanisms for SRH services at the facility?			
11. Is the clinic accessible for those with disabilities?			
12. Are SRH services for boys and young men offered in places that welcome them?			
Provider Characteristics			
1. Have providers been trained to provide adolescent-friendly health services, which include nonjudgmental attitudes, empathy, active listening, and age-appropriate counseling?			
2. Have all staff members been oriented to providing confidential, adolescent-friendly services (e.g., receptionist, security guards, community health workers, cleaners)?			

3. Do staff members demonstrate respect for adolescents and their choices?			
4. Do the providers ensure the clients' privacy and confidentiality?			
5. Do the providers set aside sufficient time for client-provider interaction?			
6. Are peer educators or peer counselors available?			
7. Do providers approach every adolescent as an individual with different needs and concerns?			
8. Are there both male and female providers available (if possible)?			
Program Characteristics			
1. Do adolescents (female and male) play a role in the operation of the health facility?			
2. Are adolescents involved in monitoring the quality of SRH service provision?			
3. Can adolescents be seen in the facility without the consent of their parents or spouses?			
4. Are a wide range of SRH services available (contraception, STI treatment and prevention, HIV counseling and testing, ante- and postnatal care, delivery care)?			
5. Are there written guidelines for providing adolescent services?			
6. Are condoms available to both young men and young women in discrete locations?			
7. Are the SRH educational materials, posters, or other job aids/ information, education, and communications materials on site designed to reach adolescents?			
8. Are referral mechanisms in place for medical emergencies, mental health and psychosocial support, child protection, education, nutrition, social welfare programs, and so on?			
9. Are there mechanisms in place for adolescents to access SRH information and commodities at delivery points other than the health facility?			
10. Are adolescent-specific indicators monitored on a regular basis (e.g., number of adolescent clients, disaggregated by age and sex)?			

APPENDIX H: QUIZ ANSWERS

Unit 2 Quiz Answers: Coordination of the MISP for SRH

1. **False**

The lead SRH agency should dedicate an SRH Coordinator for a minimum of three to six months.

2. **b**

Mapping existing SRH services should be done in partnership with health, GBV, and HIV coordination mechanisms.

3. **e**

It is important that all stakeholders, including representatives from the affected community, NGOs, civil society organizations, and the GBV coordinator participate in the SRH working group meetings.

4. **d**

In order to ensure successful SRH coordination, meetings should occur in locations that are convenient for all stakeholders and should be held on a weekly or biweekly basis at the beginning of an emergency.

5. **True**

The MISP for SRH Checklist can be used to monitor the components of the MISP.

Unit 3 Quiz Answers: Prevent Sexual Violence and Respond to the Needs of Survivors

1. **False**

A survivor's rights, needs, and wishes should be prioritized and respected. Treatment and medication can be provided without an exam.

2. **d**

Clinical care for survivors of sexual violence includes history and examination, supportive communication, presumptive treatment of STIs, EC as soon as possible and within 120 hours after the rape, and pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law. It also includes PEP within 72 hours of exposure. Pregnancy testing is not required to provide EC or PEP.

3. **False**

Male survivors are less likely to report an incident because of shame, criminalization of same-sex relations, negative or dismissive provider attitudes, and the lack of recognition regarding the extent of the problem. Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and nondiscriminatory services that provide comprehensive care.

4. **True**

Perpetrators of sexual violence are often intimate partners or others known to survivor.

5. **c**

If you suspect that a staff member is violating the protection against sexual exploitation and abuse core principles, you should report the staff member to your supervisor or focal point for protection against sexual exploitation and abuse.

Unit 4 Quiz Answers: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs

1. **False**

Syndromic management of STIs is standardized treatment protocols based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions on a single visit.

2. **a, b, c, d**

Ensuring confidentiality and the provision of condoms, co-trimoxazole (as recommended), and antiretrovirals is the role of the health provider when a crisis-affected person presents for continued antiretroviral treatment.

3. **e**

Safe handling of sharp objects, wearing of protective clothing, disposal of waste material, and frequent hand washing are all minimum requirements for infection control.

4. **e**

Condoms can be made available at health facilities, food and non-food distribution points, latrines, and popular bars or coffee shops in urban areas.

5. **True**

The SRH Coordinator should not take responsibility for procurement of antiretrovirals. It is the role of the HIV Coordinator (if one exists) or national HIV representative to support the health sector/cluster to ensure adequate supplies of antiretrovirals.

Unit 5 Quiz Answers: Prevent Excess Maternal and Newborn Morbidity and Mortality

1. **c**

Feeding support includes promoting skin-to-skin contact, support for immediate and exclusive breastfeeding, and not discarding colostrum (or first milk).

2. **d**

BEmONC services should be accessible at the health facility level, and CEmONC services should be accessible at the referral hospital level.

3. **True**

Newborns should be referred to a health facility if they have reduced activity or lack of movement.

4. **False**

If a woman presents for post-abortion care, the first thing a skilled health provider should do is conduct a rapid, initial assessment. If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization.

5. **a, b, c**

The SRH Coordinator should work with health sector/cluster, communities and host-country authorities to establish an effective referral system at the onset of a humanitarian crises.

Unit 6 Quiz Answers: Prevent Unintended Pregnancies

1. a, b, c

Methods used by the target population prior to the crisis; methods registered in country; and potential for migration where removal of long-acted methods cannot be removed.

2. False

Contraceptive services must be accessible for all crisis-affected populations, including adolescents, unmarried and married women and men, sex workers and clients, LGBTQIA persons, ex-combatants, uniformed staff, and injecting drug users.

3. c

It is true that EC will not harm an existing pregnancy, EC needs to be taken within 120 hours and that it is more effective when taken earlier, and that the correct dosage of oral contraceptive pills can be used where dedicated EC pills are not available. It is not true that adolescent girls cannot take EC.

4. a, b, c

Confidentiality, privacy, and informed choice should be emphasized to ensure quality of care when providing contraception.

5. a, b, d, e

Effectiveness of the method, common side effects of the contraceptive method, how the method works, and STI protection should be provided to all clients during contraceptive counseling.

Unit 7 Quiz Answers: Plan to Integrate comprehensive SRH Services into Primary Health Care as Soon as Possible

1. e

Health information system, health workforce, service delivery, medical commodities, finance, and governance and leadership are the six WHO health system building blocks.

2. True

In order to ensure ongoing access to affordable comprehensive SRH care, long-term financing mechanisms must be considered at the initial response to a crisis.

3. **c**

When selecting a site to deliver comprehensive SRH services, it is preferable to integrate with other services versus standalone services.

4. **False**

When transitioning to comprehensive SRH services, avoid continual ordering of the prepackaged IARH Kits to avoid incurring costs and wastage. Ordering SRH supplies based on demand will help ensure the sustainability of the SRH program and avoid shortages of particular supplies, as well as the wasting of others not typically used in the setting.

5. **b**

In order to move beyond the MISP for SRH and start planning for comprehensive SRH service delivery, SRH program managers, in close collaboration with the partners in the health sector/cluster, must collect existing information or estimate data, including MISP for SRH service indicators.

Unit 8 Quiz Answers: Other SRH Priorities to the MISP

1. **d**

Physicians and nurse can provide first-line safe abortion care with manual vacuum aspiration and medication when properly trained and supported.

2. **e**

Providing safe abortion care through health facilities staffed by willing providers, offering technical support and resources to qualified medical personnel already providing abortion services, distributing information and commodities for safe medication abortion, and identifying and referring women to providers and organizations that have capacity are ways to facilitate safe abortion care to the full extent of the law.

3. **True**

Cost of care, fear of negative repercussions, and stigma are barriers to safe abortion care for young women.

4. **True**

Safe abortion care is permitted for one or more circumstances in the majority of countries in the world.

5. e

Safe abortion care should be prioritized in the MISP for SRH as a clinical component of care for survivors of sexual violence and as another priority of the MISP.

Unit 9 Quiz: Ordering IARH Kits

1. a, b, c

An organization should order complementary commodities when providers or the population are trained to use the commodity, when the supplies were accepted and used prior to the emergency and if the supply is allowed to the fullest extent of the national law and is included in the national drug list.

2. a

IARH Kits contain sufficient supplies for a three-month period.

3. b, c, d

Primary health care, referral hospital, and community/health post are the different levels of health care for which the IARH Kits are designed.

4. c

UNFPA manages the IARH Kits.

5. a, b, c, e

The information needed to order the IARH Kits includes detailed contact, delivery and financing information, information about the type of setting and the target population size, where the kits will be used and which organization will organize the distribution of the kits, and the number of health centers and referral hospitals.

How to Order Copies

The MISP for SRH module is available online on the IAWG on RH in Crises' website (www.iawg.net) and the Women's Refugee Commission's website (www.womensrefugeecommission.org). Print copies can be ordered by emailing info@wrcommission.org or info.iawg@wrcommission.org.

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