Frequently Asked Questions

1. *Humanitarian staff do not have time for activities that are not imperative for saving lives. Are RH services important to reducing mortality and morbidity?*
   Yes, providing RH services saves lives. The MISP has been created to prioritize which of the many RH activities should be undertaken and are the most important to reduce morbidity and mortality in emergencies, particularly among women and girls. The MISP is also recognized as a life-saving intervention and is included in the CERF life-saving criteria.

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

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

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

5. *Wouldn't it be offensive to offer condoms to a displaced population that is very conservative?*
   It could be offensive to undertake a mass distribution of condoms in the early days and weeks of new emergencies without knowing people's knowledge and attitudes. And, though it is not easy to judge

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

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

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

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

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

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

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

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

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