2

CHAPTER TWO

Minimum Initial Service Package

Contents

1 Introduction

This chapter describes the Minimum Initial Service Package (MISP) to address reproductive health (RH) needs of populations at the onset of an emergency. The MISP defines which RH services are most important in preventing morbidity and mortality, particularly among women and girls, in humanitarian settings. Neglecting reproductive health in humanitarian settings has serious consequences: maternal and newborn deaths; sexual violence and subsequent complications such as trauma, sexually transmitted infections (STIs), unwanted pregnancies and unsafe abortions; and the possible spread of HIV. All activities of the MISP need to be implemented simultaneously. The MISP is a Sphere standard.

The MISP was developed based on well-documented evidence of RH needs in humanitarian settings and therefore can be implemented without an initial needs assessment. However, some basic demographic and health information of the affected population must be collected through the health coordination mechanism for optimum delivery of MISP activities.

It is important to note that the components of the MISP form a **minimum** requirement. *Plan for and implement comprehensive RH services, as outlined in Chapters 4 to 10 in this Field Manual, as soon as the situation allows. Even in circumstances where other components of reproductive health are provided, ensure that the MISP objectives are also implemented as they are priority.*

Minimum Initial Service Package

Objectives of the MISP

- **ENSURE** the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:
  - nominates an RH officer to provide technical and operational support to all agencies providing health services
  - hosts regular stakeholder meetings to facilitate implementation of the MISP
  - reports back to the health sector/cluster meetings on any issues related to MISP implementation
  - shares information about the availability of RH resources and supplies
- **PREVENT AND MANAGE** the consequences of sexual violence:
  - Put in place measures to protect affected populations, particularly women and girls, from sexual violence
  - Make clinical care available for survivors of rape
  - Ensure the community is aware of the available clinical services
- **REDUCE** HIV transmission:
  - Ensure safe blood transfusion practice
  - Facilitate and enforce respect for standard precautions
  - Make free condoms available
- **PREVENT** excess maternal and newborn morbidity and mortality:
  - Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:
    - ▷ At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications
    - ▷ At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies
  - Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and hospital
  - Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- **PLAN** for comprehensive RH services, integrated into primary health care (PHC) as the situation permits. Support the health sector/cluster partners to:
  - Coordinate ordering RH equipment and supplies based on estimated and observed consumption
  - Collect existing background data
  - Identify suitable sites for future service delivery of comprehensive RH services
  - Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff

Note: It is also important to ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). In addition, ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in "hygiene kits") are distributed to women and girls.

2 Objectives

The objective of this chapter is to provide information and guidance for RH officers, programme managers and service providers working in humanitarian settings on:

- the role and functions of the lead RH agency and RH officer;
- prevention of sexual violence and clinical management of the consequences of rape;
- priority interventions for reducing HIV transmission;
- priority interventions for reducing maternal and newborn morbidity and mortality;
- planning for comprehensive RH services integration into primary health care as the situation stabilizes;
- the supplies needed to implement the MISP.

3 Programming

3.1 RH lead agency and RH officer

From the beginning of the response in each humanitarian setting, the health sector or health cluster must identify a lead RH organization. This can be an international NGO, the Ministry of Health (MOH) or a UN agency. The nominated organization, which is the one identified as having the most capacity to fulfil this role, immediately dedicates a full-time RH officer for a minimum period of three months to provide operational and technical support to the health partners and to ensure the prioritization of reproductive health and achieve good coverage of MISP services.

To ensure MISP implementation the following must be done:

- The health sector/cluster identifies a lead RH organization.
- The lead RH organization puts in place an RH officer (see Box 4, p. 24, for RH officer terms of reference), who functions within the health sector/cluster. The RH officer, supported by the lead RH organization, ensures that:
  - all health agencies working in each of the crisis areas address reproductive health;
  - regular RH stakeholder meetings are held to correctly establish the MISP;
  - information from these meetings is shared and discussed in the general health sector/cluster coordination meetings.
  - Operational and technical support is provided for health partners to implement the MISP in all locations affected by the emergency. This includes:
  - giving guidance on and technical support for the coordinated procurement of RH supplies;
  - identifying skilled staff to implement MISP services.

3.2 Prevention of and response to sexual violence

In order to prevent sexual violence and respond to the needs of survivors from the onset of an emergency, put in place:

- mechanisms to protect the affected population from sexual violence;
- clinical services to care for survivors of rape
- community awareness of the available services for rape survivors.

3.2.1 Prevent sexual violence

Sexual violence has been reported from most humanitarian settings, including those caused by natural disasters. All actors in humanitarian settings must be aware of the risk of sexual violence and coordinate multisectoral activities to prevent it and protect the affected population, in particular women and girls. The RH officer must discuss the issue of sexual violence in health coordination meetings. In collaboration with the overall health sector/cluster mechanism, the RH officer and RH programme staff must:

- ensure women, men, adolescents and chil-

Box 4: RH Officer - Terms of Reference

The RH officer is responsible for supporting health sector/cluster partners to implement the MISP and plan for comprehensive RH service delivery. The RH officer's role is to:

- coordinate, communicate and collaborate with the health sector or health cluster coordinator and actively participate in health coordination meetings, providing information and raising strategic and technical issues and concerns;
- support the coordinated procurement of reference materials and supplies;
- host regular RH stakeholder meetings at relevant (national, sub-national/regional, local) levels to problem solve and strategize the implementation of the MISP and to provide MISP resource materials;
- ensure regular communication among all levels and report back on key conclusions, challenges requiring resolution (e.g. policy or other barriers that restrict the population's access to RH services) to the overall health coordination mechanism. Identify synergies and gaps and avoid duplication of efforts and parallel structures;
- provide technical and operational guidance on MISP implementation and audience-specific orientation sessions when and where feasible (e.g. for service providers, community health workers, programme staff and the affected population, including adolescents)
- liaise with other sectors (protection, water and sanitation, community services, camp coordination, etc.) addressing RH-related concerns;
- support health partners to seek RH funding through humanitarian planning processes and appeals in coordination with the health sector/cluster.

The RH officer must identify and understand and provide information about:

- the elements of national and host country policies, regulations and customary laws that:
  - support RH services for the affected population
  - create barriers and restrict access to RH services
- relevant MOH protocols for standardized care (e.g. protocols for clinical management of rape survivors; referral mechanisms for obstetric emergencies; and, when planning for comprehensive RH services, STI syndromic management and family planning protocols).

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

- Use the MISP checklist (see page 50) to monitor services. Collect service delivery information, analyse findings and act on identified gaps and overlaps.
- Collect or estimate basic demographic and RH information of the affected population to support MISP implementation and planning for comprehensive RH service delivery (see Chapter 2).

dren have access to basic health services, including sexual and RH services;
- design and locate health facilities to enhance physical security, in consultation with the population, in particular women and adolescents;
- consult with service providers and patients about security in the health facilities;
- locate separate male and female latrines and washing areas in the health facility in a secure location with adequate path lighting at night, and ensure doors lock from the inside;
- ensure all ethnic subgroup languages are represented among service providers or interpreters are available;
- hire female service providers, community health workers, programme staff and interpreters;
- inform service providers of the importance of maintaining confidentiality and have them sign and abide by a code of conduct against sexual exploitation and abuse (SEA);
- ensure that codes of conduct and reporting mechanisms on SEA by health staff are in place, as well as relevant punitive measures to enforce them.

3.2.2 Respond to the needs of rape survivors

In order to prevent and manage possible health consequences, rape survivors must have access to clinical care, including supportive counselling, as soon as possible after the incident. Ensure health-care services can provide such care at the onset of a humanitarian response.

Survivors may also need protection and psychosocial and legal support. As soon as possible, support a process to identify clear division of roles and responsibilities among health partners and between all sector/cluster programmes responding to needs of survivors (health, protection, security and community services) in order to ensure a coordinated, survivor-centered, confidential referral mechanism for survivors. The outcome document of this process is sometimes referred to as GBV Standard Operating Procedures (SOPs) (see Chapter 8: GBV).

Box 5: Guiding Principles When Responding to the Needs of Survivors of Rape

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

3.2.3 Clinical services for survivors of rape

When setting up clinical management services for rape survivors, RH officers and programme staff must:

- establish a private consultation area with a lockable filing cabinet;
- put in place clear protocols and sufficient supplies and equipment;
- hire male and female service providers fluent in local languages, or where this is not possible, trained male and female chaperones and translators;
- involve women and male and female adolescents in decisions on accessibility to services and on an appropriate name for the service;
- ensure services and a referral mechanism to a hospital in case of life-threatening complications are available 24 hours a day/7 days a week;
- once services are established, inform the community why, where and when (as soon as possible after a rape) these services should be accessed. Use communication

channels appropriate to the setting (e.g. through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets);
- ensure service providers are skilled. Where needed, organize information sessions or short refresher training on clinical care for survivors of rape. Clinical management of survivors of rape includes the following components:
  - supportive communication
  - history and examination
  - forensic evidence collection as relevant
  - compassionate and confidential treatment, including:
    - emergency contraception
    - treatment of STIs
    - postexposure prophylaxis (PEP) to prevent HIV transmission
    - care of wounds and prevention of tetanus
    - prevention of hepatitis B
    - referral for further services, e.g. health, psychological and social.

Supportive communication

Ensure service providers are able to extend compassionate and confidential support to the survivor through communication that is accurate, clear, nonjudgemental and involves active listening.

History and examination

A detailed history and a thorough medical examination are conducted after ensuring the survivor understands and consents to each step. Preprinted history and examination forms must guide the process and all findings must be thoroughly documented.

The primary purpose of the history and examination is to determine the clinical care that is needed. Taking the history and conducting the examination are done at the survivor's own pace. She or he is 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 or not to be examined.

Forensic evidence collection

- Local legal requirements, laboratory and storage facilities determine if and what forensic evidence should be collected.
- Evidence is collected during the medical examination if the survivor consents to it.
- At a minimum, a careful written record should be kept of all findings during the medical examination that can support the survivor's story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence (with the survivor's consent) if the case goes to court. It must be kept confidential in a secure place.
- If a microscope is available, a trained health-care provider or laboratory worker can examine wet-mount slides for the presence of sperm, which proves penetration took place. Further evidence (such as clothes, foreign materials, semen or blood for DNA or urine for toxicology testing) is only collected if local capacity for processing (storage, laboratory analysis) exists and if the evidence can be used in court.
- When requested by the survivor, the service provider can prepare a medical certificate or a police form. Depending on the law applicable in the setting, this form may be used for legal purposes, such as redress or asylum. Two copies of the document are made. One copy is kept locked away at the health centre or by the programme manager. The other copy is provided to the survivor if she wants it after careful counselling on the risk of further violence if the document is found in her possession.
- The survivor is the only one who decides when and where to use the medical certificate.

Compassionate and confidential treatment

Treatment can be started without examination if that is the survivor's choice. Treat life-threatening complications first and refer to higher-level health facilities if appropriate.

Emergency Contraceptive Pill Regimens

1. The levonorgestrel-only regimen: 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen, it is more effective and has fewer side effects); or

2. The combined estrogen-progestogen regimen (Yuzpe): a dose of 100 microgram ethinyl estradiol plus 0.5 mg of levonorgestrel, taken as soon as possible, followed by the same dose 12 hours later.

Emergency contraception

Emergency contraceptive pills (ECPs) can prevent unwanted pregnancies if used *within 120 hours* (up to 5 days) of the rape. There are two ECP regimens that can be used (see box above).

- Treatment with either regimen should be started as soon as possible after the rape because efficacy declines with time. Both regimens are effective when used up to 72 hours after the rape, and continue to be moderately effective if started within 72 to 120 hours. The effectiveness after longer delays has not been investigated.
- There are products that are specially packaged for emergency contraception, but they are not available in all countries. If prepackaged ECPs are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills (see Table 1, p. 28).
- Counsel the survivor about how to take the pills, what side effects may occur and the effect the pills may have on her next period. ECPs do not prevent pregnancy from sexual acts that take place after their use. Provide her with condoms for use in the immediate future.
- Make it clear to the survivor that there is a small risk that the pills will not work. Menstruation should occur around the time when she would normally expect it. It may be up to a week early or a few days late. If she has not had a period within a week after it was expected, she should return to have a pregnancy test and/or to discuss the options in case of pregnancy. Explain to her that spotting or slight bleeding is common with the levonorgestrel regimen. This should not be confused with a normal menstruation.
- Side effects: Up to 50% of users report nausea with ECP. Taking the pills with food decreases nausea. The levonorgestrel-only regimen has been shown to cause significantly less nausea and vomiting than the combined estrogen-progestogen regimen (Yuzpe). If vomiting occurs within two hours of taking a dose, repeat the dose. In cases of severe vomiting, ECPs can be administered vaginally.
- Precautions: ECPs can safely be used by any woman or girl, even those who cannot use hormonal methods on a continuous basis, as the dose of hormones used is relatively small and the pills are used for a short time. ECPs will not be effective in the case of an established pregnancy. ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

Table 1: Emergency Contraception Regimens

Regimen	Pill composition *(per dose)*	Common brand names	First dose *(number of tablets)*	Second dose 12 hours later *(number of tablets)*
Levonorgestrel only	750 μg	Levonelle, NorLevo,Plan B, Postinor-2, Vikela	2	0
	30 μg	Microlut, Microval, Norgeston	50	0
	37.5 μg	Ovrette	40	0
Combined	EE 50 μg plus LNG 250 μg or EE 50 μg plus NG 500 μg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, Tetragynon/ PC-4, Preven, E-Gen-C, Neo-Primovlar 4	2	2
	EE 30 μg plus LNG 150 μg or EE 30 μg plus NG 300 μg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4	4

a EE = ethinylestradiol; LNG = levonorgestrel; NG =norgestrel.

(Adapted from: Consortium for Emergency Contraception, Emergency contraceptive pills, medical and service delivery guidelines, Second Edition. Washington, DC, 2004).

Insertion of a copper-bearing IUD is an effective method of emergency contraception if the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle). It will prevent more than 99% of expected subsequent pregnancies. When the time of ovulation can be estimated (the risk of ovulation is low up to day seven of the menstrual cycle), she can have a copper-bearing IUD inserted beyond five days after the rape, as long as insertion does not occur more than five days after ovulation.

Offer survivors counselling on this service so they can make an informed decision. A skilled provider should counsel the survivor and insert the IUD.

If an IUD is inserted, make sure to give full STI treatment, as recommended below. The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Presumptive treatment for sexually transmitted infections (STIs)

- Offer survivors of rape antibiotics to presumptively treat gonorrhoea, chlamydial infection and syphilis (see Tables 2 and 3). If other STIs are prevalent in the area (such as trichomoniasis or chancroid), give presumptive treatment for these infections as well.
- Give the shortest courses available in the local protocol which are easy to take. For instance, if the survivor presents within 30 days of the incident, 400 mg of cefixime plus 1 g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and incubating syphilis.
- Be aware that women who are pregnant or who have known allergies should not take certain antibiotics, and modify the treatment accordingly (see Table 2).
- Presumptive STI regimens can start on the same day as emergency contraception and postexposure prophylaxis for HIV (PEP). To reduce side effects, such as nausea, the doses can be spread out (and taken with food).
- Provide hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. A total of three doses are needed, the second dose four weeks after the first and the third dose eight weeks after the second dose.

Table 2: WHO-recommended STI Treatment Protocols for Adults

*Note: These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow **local** treatment protocols for sexually transmitted infections.*

STI	Treatment
Gonorrhoea	**cefixime** 400 mg orally, single dose or **ceftriaxone** 125 mg intramuscularly, single dose
Chlamydial infection	**azithromycin** 1 g orally, in a single dose *(This antibiotic is also active against incubating syphilis (within 30 days of exposure)* or **doxycycline** 100 mg orally, twice daily for 7 days *(contraindicated in pregnancy)*
Chlamydial infection in pregnant women	**azithromycin** 1 g orally, in a single dose *(This antibiotic also active against incubating syphilis (within 30 days of exposure)* or **erythromycin** 500 mg orally, 4 times daily for 7 days or **amoxicillin** 500 mg orally, 3 times daily for 7 days
Syphilis	**benzathine benzylpenicillin*** 2.4 million IU, intramuscularly, once only *(give as two injections in separate sites)* or **azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)* *(This antibiotic is also active against chlamydial infections)*
Syphilis, patient allergic to penicillin	**azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)* or **doxycycline** 100 mg orally twice daily for 14 days *(contraindicated in pregnancy)* *Both azithromycin and doxycycline are also active against chlamydial infections*
Syphilis in pregnant women allergic to penicillin	**azithromycin** 2 g orally as a single dose (for treatment of primary, secondary and early latent syphilis of < 2 years duration) or erythromycin 500 mg orally, 4 times daily for 14 days Both azithromycin and erythromycin are also active against chlamydial infections

STI	Treatment
Trichomonas	**metronidazole** 2 g orally as a single dose or **tinidazole** 2 g orally as a single dose or **metronidazole** 400 or 500 mg orally, 2 times daily for 7 days *Avoid metronidazole and tinidazole in the first trimester of pregnancy*

**** Note:** If the survivor presents within 30 days of the incident, **benzathine benzylpenicillin** can be omitted if the treatment regimen includes **azithromycin 1 g as a single dose**, which is effective against incubating syphilis as well as chlamydial infection. If the survivor presents more than 30 days after the incident, **azithromycin 2 g as a single dose** is sufficient presumptive treatment for primary, secondary and early latent syphilis of < 2 years duration and also covers chlamydial infections.*

Table 3: WHO-recommended STI Treatment Protocols for Children and Adolescents

Note: These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow local treatment protocols for sexually transmitted infections and use drugs and dosages that are appropriate for children.

STI	Weight or age	Treatment
Gonorrhoea	< 45 kg	**ceftriaxone** 125 mg intramuscularly, single dose or **spectinomycin** 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose or (if > 6 months) **cefixime** 8mg/kg of body weight orally, single dose
	> 45 kg	Treat according to adult protocol
Chlamydial infection	< 45 kg	**azithromycin** 20 mg/kg orally, single dose or **erythromycin** 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	> 12 years	Treat according to adult protocol
	> 45 kg but < 12 years	**erythromycin** 500 mg orally, 4 times daily for 7 days or **azithromycin** 1 g orally, single dose
Syphilis		**benzathine penicillin*** 50 000 IU/kg IM (up to a maximum of 2.4 million IU), single dose

STI	Weight or age	Treatment
Syphilis, patient allergic to penicillin		**erythromycin** 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days
Trichomoniasis	< 12 years	**metronidazole** 5 mg/kg of body weight orally, 3 times daily for 7 days
	> 12 years	Treat according to adult protocol
Note: If the survivor presents within 30 days of the incident, **benzathine penicillin presumptive treatment for syphilis can be omitted if the treatment regimen includes **azithromycin,** which is effective against incubating syphilis as well as chlamydial infection.*		

PEP to prevent HIV transmission

The likelihood of HIV transmission after a rape can be reduced through the prompt administration of PEP. PEP must be initiated within 72 hours following exposure and continued for 28 days. PEP needs to be started as soon as possible after exposure as studies suggest that PEP is more effective the sooner it is initiated. WHO recommends a 28-day combination therapy with two nucleoside-analogue reverse-transcriptase inhibitors, preferably in a fixed-dose combination. (This guidance is current at the time of publication. As this is a rapidly evolving field, it may change. Please check www.iawg.net for updates.)

For survivors of sexual violence:

- Assess the risk of exposure to HIV before prescribing PEP. Take the history of the event (including whether there were multiple attackers), vaginal or anal penetration and the type of injuries sustained.
- Offer voluntary counselling and testing for HIV (see Chapter 10: VCT) in the first two weeks after the incident. However, an HIV test is not mandatory before prescribing PEP.
- Offer PEP to all eligible survivors, including those who do not want to undergo HIV testing. Start the first dose of PEP as soon as possible. Do not delay starting PEP while waiting for a VCT result.

Do not offer PEP to survivors who are known or found to be HIV-positive. While it is not likely to harm, there is no expected benefit. Refer HIV-positive survivors to HIV treatment, support and care services where available.

Table 4: Recommended Two-drug Combination Therapies for HIV-PEP in Adults

Weight or age	Treatment	Prescribe	28 days supply
Adult	Combined tablet containing **Zidovudine** (300 mg) and **Lamuvidine** (150 mg) or **Zidovudine** (ZDV/AZT) 300 mg tablet plus **Lamuvidine** (3TC) 150 mg tablet	1 tablet twice/day or 1 tablet twice/day plus 1 tablet twice/day	60 tablets or 60 tablets plus 60 tablets

Table 5: Recommended Two-drug Combination Therapies for HIV-PEP in Children

Weight or age	Treatment	Prescribe	28 days supply
< 2 years or 5-9 kg	**Zidovudine (ZDV/AZT) syrup*** 10 mg/ml plus **Lamivudine (3 TC) syrup** 10 mg/ml	7.5 ml twice a day plus 2.5 ml twice a day	= 420 ml (i.e. 5 bottles of 100 ml or 3 bottles of 200 ml) plus = 140 ml (i.e. 2 bottles of 100 ml or 1 bottle of 200 ml)
10 – 19 kg	**Zidovudine (ZDV/AZT)** 100 mg capsule plus **Lamivudine** (3 TC) 150 mg tablet	1 capsule three times a day plus ½ tablet twice a day	90 capsules plus 30 tablets
20 – 39 kg	**Zidovudine (ZDV/AZT**) 100 mg capsule plus **Lamivudine** (3 TC) 150 mg tablet	2 capsule three times a day plus 1 tablet twice a day	120 capsules plus 60 tablets

** Discard a bottle of syrup 15 days after opening*

Box 6: Three-drug ARV PEP

A regimen comprising a three-drug regimen is only recommended where:

- The source person is HIV-positive, taking antiretroviral therapy and is known to have signs of, or a personal history of a proven, antiretroviral therapy resistance

or

- The background prevalence of antiretroviral therapy resistance in the community exceeds 15% (where this is known).

Recommended three drug combination therapies			
Zidovudine (AZT)	+ Lamuvidine (3TC)	+ Lopinavir	with a Ritonavir boost

Adherence to the triple-drug regimen may be more difficult than to the two-drug regimen. Because of the potentially dangerous side-effects, refer the survivor to a clinician or medical doctor with experience in HIV treatment.

From: *Post-exposure Prophylaxis to Prevent HIV Infections, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.* WHO/ILO. 2007.

Important to know:

- Pregnancy is not a contraindication for PEP. Inform women who are less than 12 weeks pregnant that the possible effects of the drug on the fetus are not known.
- Counsel the survivor on common side effects of the drugs such as tiredness, nausea and flu-like symptoms. These side effects are temporary and can be relieved with ordinary analgesics such as paracetamol.
- Survivors may be given a one-week supply of PEP with the remaining three weeks' supply given upon follow-up visits.
- Provide the full 28-day dose to survivors who cannot return for any reason or in settings where there is likely to be ongoing displacement.

Care of wounds and prevention of tetanus

Clean any tears, cuts and abrasions and suture clean wounds within 24 hours. Do not suture dirty wounds. Consider giving appropriate antibiotics and pain relief if there are large dirty wounds.

Give tetanus prophylaxis if there are any breaks in skin or mucosa and the survivor is not vaccinated against tetanus or the vaccination status is uncertain. Advise survivors to complete the vaccination schedule (second dose at four weeks, third dose at six months to one year).

Referral for further crisis intervention

With the survivor's consent or upon her or his request, offer referral to:

- a **hospital** in case of life-threatening complications or complications that cannot be dealt with at the health centre level;
- **protection or social services** if the survivor does not have a safe place to go to when she or he leaves the health centre;
- **safe abortion care** where it is legal. Determine the legal indications for safe abortion care. In many countries the law allows termination of pregnancy resulting from rape. Termination of pregnancy may also be allowed in relation to the mental and physical health of the woman. Trained service providers can provide abortions in the first trimester:

- through manual vacuum aspiration (MVA) for up to 12 weeks since the last menstrual period (LMP), or
- with medical methods for up to nine weeks since LMP. WHO recommends a combination of **200 mg mifepristone orally followed by 800 µg misoprostol vaginally 36 to 48 hours later**. Where mifepristone is not available, evidence supports use of misoprostol alone 800 µg vaginally repeated every 12 hours up to three doses, although it is less effective than when used in combination with mifepristone.
  - Provide pain relief; e.g. ibuprofen 800 mg three times a day or as needed.
  - Advise women to return for one or more follow-up visits after 10-14 days. Cases of ongoing pregnancy should be referred for MVA; cases of incomplete abortion are managed either expectantly, with an additional dose of misoprostol or with an MVA procedure.
- Dilatation and curettage (D & C) with metal instruments should be used only where vacuum or medical methods of abortion are not available. MVA is quicker and associated with less blood loss than D&C. Therefore, every effort should be made to replace D&C with MVA.

- Psychosocial services where available. Liaise with GBV and protection focal points to identify psychosocial services available in the humanitarian setting. This may include initiatives offered by the affected population, women's centres and other support groups.

Special considerations for children

The RH officer must understand country-specific laws with regard to the age of consent; the professional (for instance a representative from the police, community services or the court) who can give legal consent for clinical care if a parent or guardian is the suspected offender; and mandatory reporting requirements and procedures when service providers suspect, or are informed of, a case of child abuse.

Digital vaginal or anal or speculum examination should never be conducted in young children.

Protocols showing appropriate drug dosages must be posted or easily available to service providers.

Special considerations for male survivors

Male survivors are less likely to report an incident because of embarrassment, shame, criminalization of same sex relationships or the lack of recognition of the extent of the problem by service providers and programme managers. Male survivors suffer physical and psychological trauma similar to female survivors and should have access to confidential, respectful and non-discriminatory services that provide all relevant treatments.

3.2.4 Inform the community of the available services

Use appropriate communication channels (e.g. leaflets, radio messages, information sessions by TBAs and health workers) to inform the affected population of the availability of confidential services, and the importance of survivors attending these as soon as possible after an incident.

3.3 Reduce the transmission of HIV

To reduce the transmission of HIV from the onset of the humanitarian response, the RH officer must work with the health sector/cluster partners to:

- establish safe and rational blood transfusion practice;
- ensure application of standard precautions;
- guarantee the availability of free condoms.

Although not a component of the MISP, it is important to make antiretrovirals (ARV) available to continue treatment for people who were enrolled in an ART programme prior to the emergency,

including women who were enrolled in PMTCT programmes.

3.3.1 Safe blood transfusion

The rational and safe use of blood for transfusions is essential to prevent the transmission of HIV and other transfusion-transmissible infections (TTIs) such as hepatitis B, hepatitis C and syphilis. 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.

Rational blood transfusion includes:

- 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);
- using blood substitutes to replace lost volume such as crystalloid-based substitutes (Ringer's lactate, normal saline) or colloid-based substitutes (haemaccel, gelofusin) wherever possible.

Safe blood transfusion includes:

- collecting blood only from voluntary, unpaid blood donors at low risk of acquiring TTIs and developing stringent blood donor selection criteria;
- screening all blood for transfusion for at least HIV 1 and 2, hepatitis B, hepatitis C, and syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine HIV status (see Chapter 10: HIV). Do not reveal the results of a positive screening test to donors where they cannot be referred to voluntary counselling and testing (VCT) services. In this case screen blood for transfusion and discard it if it cannot be used. Link blood transfusion services with VCT services as soon as these are established as part of the comprehensive response and refer donors for VCT prior to screening their blood;
- conducting ABO grouping and Rhesus D (RhD) typing and, if time permits, cross-matching;
- ONLY transfusing blood to women of reproductive age with appropriate RhD type blood;
- ensuring safe transfusion practice at the bedside and safe disposal of blood bags, needles and syringes.

In order to make rational and safe blood transfusion available, RH officers and programme managers must work with the health cluster/sector partners to ensure that:

- referral-level hospitals have sufficient supplies for safe and rational blood transfusion;
- staff know how 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 (SOPs) for blood transfusion are in place. SOPs are essential components of a quality system in any organization and are used to ensure consistency in performing an activity. The use of SOPs is mandatory by all staff members dealing with blood transfusions every time they perform an activity. Keep copies of SOPs in a central location, and post them at the 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.

3.3.2 Standard precautions

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure of blood or body fluids among patients and health-care workers. Under the "standard precautions" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person. Standard precautions prevent the spread of infections such as HIV, hepatitis B and hepatitis C and other pathogens within health-care settings.

In humanitarian settings there may be a lack of health sector 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.

Emphasize the importance of standard precautions during the first health coordination meeting.

Standard precautions are:

- **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 non-sterile single use gloves for all procedures where contact with blood or other potentially infected 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.
  - Note: Ensure the availability of an adequate and sustainable supply of gloves to carry out all activities. NEVER reuse or resterilize single use gloves; they become porous.
- **Wearing protective clothing,** such as waterproof gowns or aprons, 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 the work area where injections are given to reduce the risk of injury.
  - Use single-dose vials rather than multi-dose vials. If multi-dose vials are used, avoid leaving a needle in the stopper. Once opened, store multi-dose vials in 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 metres from a water source.
- **Instrument processing:** Process used instruments in the following order:
  1. *Decontaminate* instruments to kill viruses (HIV and hepatitis B) and make items safer to handle.
  2. *Clean* instruments before sterilization or high-level disinfection (HLD) to remove

debris.
3. *Sterilize* (eliminates all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. HLD (through boiling or soaking in a chlorine solution) may not eliminate spores.
4. *Use or properly store* items immediately after sterilization.

- **Housekeeping:** Clean up spills of blood or other body fluids promptly and carefully.

Establish and implement workplace policies for occupational exposure

Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. Ensure PEP is available within the health sector as part of a comprehensive standard precautions package reducing staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces (see Box 7) and inform all staff how to access treatment for exposure. When managing occupational exposure:

- Maintain **confidentiality** 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 material exposed to (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 counselling 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.
- Take a medical history and conduct an exam of the exposed worker only after informed consent, recommend HIV voluntary counselling and testing and provide PEP when appropriate. PEP treatment protocols are the same as those for survivors of sexual violence (see Table 4). **An HIV test is not required before prescribing PEP.**
- Educate on risk reduction through review of sequence of events and advise the exposed worker to use condoms to prevent secondary transmission during the next three months.
- Provide HIV voluntary counselling and testing at three and six months after the exposure, whether or not the exposed worker received PEP.
- Complete an incident report.

In order to ensure application of standard precautions, RH officers and RH programme managers must work with the health cluster/ sector partners and:

- ensure protocols for standard precautions are posted in each health facility and supervisors enforce adherence to these;
- 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 and staff are informed and know where to report and obtain PEP if needed;
- review occupational exposure incidence reports regularly to determine when and how exposure occurs and to identify safety concerns and possible preventive measures.

Box 7: First Aid

Occupational Exposure: First Aid

Injury with a used needle or sharp instrument and broken skin

- Do not squeeze or rub.
- Wash immediately using soap and water or chlorhexidine gluconate solution.
- Do not use strong solutions. Bleach or iodine irritate the wound.

Splash of blood or body fluids on unbroken skin

- Wash the area immediately. Do not use strong disinfectants.

Splash of blood or body fluids in the eye

- Irrigate the exposed eye immediately with water or normal saline.
- Tilt the head back and have a colleague pour water or normal saline.
- Do not use soap or disinfectant on the eye.

Splash of blood or body fluids in the mouth

- Spit the fluid out immediately.
- Rinse mouth thoroughly with water or saline. Repeat several times.
- Do not use soap or disinfectant in the mouth.

Report the incident to *(insert name here)* and take PEP if indicated.

3.3.3 Make free condoms available

Condoms are key protection methods to prevent transmission of HIV and other STIs. Although not everyone will know about them, in most populations some people will use condoms. Ensure male and female condoms are available from the earliest days of a humanitarian response and order sufficient supplies of good-quality male and female condoms immediately (see Box 8).

Box 8: Ordering Condoms

- Ensure that the procurement office responsible for bulk purchases for emergencies 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 through UNFPA. UNFPA can rapidly ship bulk quantities of good-quality condoms to the field as part of the Interagency RH Kits (see paragraph 3.5).
- Male condoms are available in the Interagency RH Kit 1, part A. Female condoms are in the Interagency RH Kit 1, part B. These kits contain sufficient supplies to cover the needs of a population of 10 000 people for three months (see calculations below). Leaflets explaining appropriate use of male and female condoms are also included.

Calculations for condom supplies for 10 000 population over 3 months

Male condoms	**Female condoms**
Assume:	*Assume*:
20% of population are sexually active males	25% of population are sexually active females
Therefore:	*Therefore:*
20% x 10 000 persons = 2000 males	25% x 10 000 persons = 2,500 females
Assume:	*Assume:*
20% of these will use condoms	1% of these will use female condoms
Therefore:	*Therefore:*
20% x 2000 = 400 users	1% x 2,500 = 25 users
Assume:	*Assume:*
Each user needs 12 condoms per month	Each user needs 6 condoms per month
Therefore:	*Therefore:*
400 x 12 x 3 months = 14,400 male condoms	25 x 6 x 3 months = 450 female condoms
Assume:	*Assume:*
20% wastage (2,880 condoms)	20% wastage (90 female condoms)
Therefore:	*Therefore:*
TOTAL = 14,400 + 2,880 = 17,280 (or 120 gross)	TOTAL = 450 + 90 = 540 (or 3.8 gross)

Provide condoms on request and ensure that condoms are available in all heath facilities and in accessible private areas in the community such as in latrines, in bars, at non-food distribution points and in youth and community centres. Consult with local staff about how condoms can be made available in a culturally sensitive way, particularly for most at-risk groups, such as sex workers and their clients, men who have sex with men, injecting drug users and young people. Adolescents may be helpful in identifying locations where their peers congregate. Ensure condoms are also available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, etc.

Condom uptake should be monitored by conducting regular checks (and stock-ups where needed) of distribution points.

3.4 Prevent excess maternal and newborn morbidity and mortality

Priority activities to prevent excess maternal and newborn morbidity and mortality are:

- Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:
  - At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications
  - At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies.
- Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and the hospital.
- Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

Box 9:
Basic and Comprehensive EmOC and Newborn Care

- Ensure basic EmOC and newborn care at all health centres. This means that staff are skilled and have the resources to provide:
  - parental antibiotics
  - parental uterotonic drugs (oxytocin)
  - parental anticonvulsant drugs (magnesium sulfate)
  - manual removal of retained products of conception using appropriate technology
  - perform manual removal of placenta
  - assisted vaginal delivery (vacuum or forceps delivery)
  - maternal and newborn resuscitation

- Ensure comprehensive EmOC and newborn care at hospitals. This means that staff are skilled and have the resources to support all of the interventions above, as well as to:
  - perform surgery under general anaesthesia (caesarean delivery, laparotomy)
  - provide rational and safe blood transfusion

(See Chapter 6 for additional information.)

3.4.1 Ensure availability of EmOC and newborn care services

According to the UN Process Indicators of Emergency Obstetric Services, an estimated 15% of women will develop a potentially life-threatening complication during pregnancy or at the time of delivery and 5% to 15% of all deliveries will require a caesarean section. WHO estimates that 9% to 15% of newborns will require lifesaving emergency care. In order to prevent maternal and newborn morbidity and mortality resulting from complications, RH officers must ensure that basic

and comprehensive EmOC and newborn care services are available 24 hours per day, seven days per week (see Box 9).

Basic EmOC and newborn care

While skilled attendance at all births in a health facility is ideal because it can help reduce maternal 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 at each health facility basic EmOC and newborn care interventions (as outlined in Box 9), as well as capacity to refer to the hospital if needed, are available 24 hours per day, seven days per week.

Among the 15% of women with life-threatening obstetric complications, the most common problems are severe bleeding, infection, eclampsia and obstructed labour.

Approximately two-thirds of infant deaths occur within the first 28 days. The majority of these deaths are preventable by initiating essential actions that can be taken by health-care workers, mothers or other community members. Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation. About half of those who have difficulty initiating breathing, require resuscitation. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

To prevent and address these complications:

- Provide midwives and other skilled birth attendants in health centres with materials and drugs to conduct deliveries, to deal with complications and to stabilize women prior to transport to the hospital if needed.
- Ensure skilled birth attendants are competent to provide emergency and routine newborn care, including:
  - initiation of breathing;
  - resuscitation;
  - thermal protection (delayed bathing, drying, skin-to-skin contact);
  - prevention of infection (cleanliness, hygienic cord cutting and care, eye care);
  - immediate and exclusive breastfeeding;
  - management of newborn illness and care for preterm/low birth weight babies.

Supplies to support basic EmOC and newborn care are included in the Interagency RH Kits (see paragraph 3.5). Newborn resuscitation supplies are available in Interagency RH Kit 6. When ordering supplies from other sources, make sure the midwifery package includes newborn resuscitation supplies.

Comprehensive EmOC and newborn care

Where feasible, support host-country hospitals with skilled staff, infrastructure, medical commodities, including medicines and surgical equipment, as needed to provide comprehensive EmOC and newborn care (see Box 9). If this is not feasible because of the host-country hospital's location or inability to meet the increased demand, the RH officer should work with the health sector/cluster and an agency such as ICRC or IFRC to resolve the problem, such as establishing a referral hospital close to the affected population.

3.4.2 Establish a referral system to manage obstetric and newborn emergencies

Coordinate with the health sector/cluster and host-country authorities to ensure a referral system (including means of communication and transport) as soon as possible in a humanitarian setting. Such a referral system must support the management of obstetric and newborn complications 24 hours a day, seven days a week. It should ensure that women, girls and newborns who require emergency care are referred from the community to a health centre where basic EmOC and newborn care is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health centre must be stabilized and transported to a

hospital with comprehensive EmOC and newborn care services.

- Determine policies, procedures and practices to be followed in health centres and hospitals to ensure efficient referral.
- Determine distances from the affected community to functioning health centres and to the hospital, as well as transport options for referral.
- Post protocols in every health centre, specifying when, where and how to refer patients with obstetric emergencies to the next level of care.
- Inform communities when and where to seek emergency care for complications of pregnancy and childbirth as soon as possible. Meet and inform community leaders, traditional birth attendants and others to distribute illustrative brochures or undertake other creative information, education and communication (IEC) approaches.

Without access to adequate EmOC and newborn care, women and newborns will die unnecessarily. Therefore it is extremely important to attempt to negotiate access to the referral hospital. Where 24/7 referral services are impossible to establish, it is particularly essential that qualified staff are available at all times at health centres to provide basic EmOC and newborn care (see paragraph 3.4.1). In this situation, it is helpful to establish a system of communication, such as the use of radios or cell phones, to communicate with more qualified personnel for medical guidance and support.

3.4.3 Clean delivery kits

In all humanitarian settings there are women and girls who are in the later stages of pregnancy and who will therefore deliver during the emergency. At the onset of a humanitarian response, births will often take place outside of a health centre without the assistance of skilled birth attendants. Make a clean delivery package available to all visibly pregnant women to promote clean home deliveries when access to a health facility is not possible. Distribution can be done at registration sites for instance.

In communities where traditional birth attendants (TBAs) are assisting home deliveries, they can be given clean delivery packages and additional basic supplies. Link these TBAs to a health clinic with skilled birth attendants where they can register and replenish their supplies. This is a first step to integrating them in the comprehensive RH programme where they may be able to play a

Box 10: Encourage Childbirth in Health Centres

It is important to emphasize that where health centres with skilled birth attendants and sufficient equipment and supplies are available, all women should be told where these clinics are and should be encouraged to deliver there. This information can be provided when the clean delivery packages are distributed, as well as through communication with the community.

Box 11: Clean Delivery Package

The packages contain very basic materials:

- one sheet of plastic (for the woman to deliver on)
- a bar of soap
- a pair of gloves
- one clean razor blade (new and wrapped in its original paper) (to cut the umbilical cord)
- three pieces of string (to tie the umbilical cord)
- two pieces of cotton cloth (one to dry and the other to warm the baby)
- explanatory leaflets with pictures

role as a link between families, communities and local authorities and the RH services see Chapter 6: Maternal and Newborn Health.

Clean delivery packages and supplies for traditional birth attendants can be ordered through UNFPA (Interagency RH Kit 2A and B, see paragraph 3.5). Because these materials are often easily obtained locally and do not expire, it is possible to assemble these packages on-site and prestock them as a preparedness measure in settings where they do not need to be immediately available. It may be possible to contract with a local NGO to produce the packages, which could provide an income generation project for local women.

3.5 Supplies to implement the MISP

To implement the service delivery components of the MISP (provide clinical care for survivors of rape; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality), the Inter-agency Working Group on Reproductive Health in Crises (IAWG) designed a set of kits containing drugs and supplies aimed at facilitating the implementation of these priority RH services: the Interagency Reproductive Health Kits (RH Kits). The RH Kits complement the Interagency Emergency Health Kit 2006 (IEHK), which is a standardized emergency health kit that contains essential drugs, supplies and equipment for the provision of primary health-care services. In a humanitarian setting, the IEHK is often rapidly available; however, although it contains a midwifery kit, emergency contraceptive pills (ECPs), PEP treatment to prevent transmission of HIV after rape and supplies for the adherence to standard precautions, the IEHK does not have all supplies needed to implement the MISP.

The RH Kits are designed for use at the onset of the humanitarian response and contain sufficient supplies for a three-month period for different population numbers, depending on the population coverage of the health-care setting for which the kits are designed.

The 13 RH Kits are divided into three blocks; each block targets a different health service delivery level:

- Block 1: Community and primary health-care level: 10 000 persons/3 months
- Block 2: Primary health care and referral hospital level: 30 000 persons/3 months
- Block 3: Referral hospital level: 150 000 persons/3 months

Block 1
Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at community and primary health care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

Block 2
Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health-care providers with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3
In humanitarian settings, patients from the affected population 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. Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive EmOC and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150 000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

3.5.1 RH Kit procurement and logistics

UNFPA is in charge of assembling and delivering the Interagency RH Kits. However, agencies should not be dependent on one source for

Table 6: Inter-Agency Reproductive Health Kits

Block 1

Kit No.	Kit Name	Colour Code
Kit 0	Administration	Orange
Kit 1	Condom (Part A: male condoms plus Part B: female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A: clean delivery packages plus part B: supplies for birth attendants)	Dark Blue
Kit 3	Post-Rape Part A: ECP and STI treatment plus Part B: PEP	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	STI treatment	Turquoise

Block 2

Kit No.	Kit name	Colour Code
Kit 6	Delivery kit (Health Facility)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Miscarriage and Abortion	Yellow
Kit 9	Suture of Tears (cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction Delivery (Manual)	Gray

Block 3

Kit No.	Kit name	Colour Code
Kit 11	Referral level (Part A plus B)	Fluorescent green
Kit 12	Blood Transfusion	Dark green

supplies and should include RH supplies in their overall medical supply procurement. Order the Interagency RH Kits through UNFPA or identify other quality supply sources to ensure all necessary equipment and materials are available to provide the full range of priority RH services. Coordinate the ordering of health supplies within the health sector/cluster to avoid waste.

When planning to order RH Kits, prepare a plan for in-country distribution of the kits. This plan outlines how many of which kits go to which partners, in which geographical setting. It also includes detailed plans for in-country transport and storage, including provisions for items that need to be kept cool (cold-chain).

Table 7: Interagency RH Kit Points of Contact			
Address	**UNFPA** Humanitarian Response Branch 220 East 42nd Street New York, NY 10017 USA	**UNFPA** Humanitarian Response Branch 11-13 chemin des Anémones 1219 Chatelaine, Geneva, Switzerland	**UNFPA** Procurement Services Branch Midtermolen 3 2100 Copenhagen Denmark
Fax	+1 212 297 4915	+41 22 917 80 16	+45 35 46 70 18
E-mail	hrb@unfpa.org	hrb@unfpa.org	procurement@unfpa.dk
Website	www.unfpa.org		http://web.unfpa.org/procurement/form_request.cfm

Be prepared to receive goods as soon as they arrive at the port of entry to the country and ensure that all relevant forms for customs clearance have been prepared ahead of time so there are no unnecessary delays with importing the kits. The logistics cluster, where it exists, may be able to help facilitate this.

Information on the kits or assistance with ordering can be provided by UNFPA field offices, agency partners or UNFPA Procurement Services Branch (PSB) or UNFPA Humanitarian Response Branch (HRB).

3.6 Plan to integrate comprehensive RH services into primary health care

Start planning for the integration of comprehensive RH activities into primary health care at the onset of the humanitarian response. Failure to do so may unnecessarily delay the provision of these services, which increases the risk of unwanted pregnancies, the transmission of sexually transmitted infections, complications of gender-based violence and maternal and newborn morbidity and mortality.

Initiate comprehensive RH service delivery components as soon as the standards for the MISP indicators are reached (see Chapter 3: Assessment, Monitoring and Evaluation). When humanitarian appeals processes and agencies start longer-term planning (for 6-12 months), comprehensive services must be integrated into funding and planning processes, such as the Common Humanitarian Action Plan (CHAP), Consolidated Appeals Process (CAP) and applications to the Central Emergency Response Fund (CERF).

In order to design a comprehensive RH service delivery program, integrated into primary health care, RH officers and RH programme managers must work within the health sector/cluster to:

- order RH equipment and supplies
- collect existing background data
- identify suitable sites for future comprehensive RH service delivery
- assess staff capacity to provide comprehensive RH services and plan for training/retraining.

Box 12: MISP and Comprehensive RH Services		
RH Components (not in order of priority/ importance)	**Priority RH Services (MISP)**	**Comprehensive RH Services**
FAMILY PLANNING	** Provide contraceptives such as condoms, pills, injectables and IUDS to meet demand*	Source and procure contraceptive supplies Provide staff training Establish comprehensive family planning programming Provide community education
GENDER-BASED VIOLENCE	Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters Provide clinical care for survivors of rape	Expand medical, psychological, social and legal care for survivors Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital mutilation Provide community education Engage men and boys in GBV programming
MATERNAL AND NEWBORN CARE	Ensure availability of emergency obstetric and newborn care services Establish 24/7 referral system for obstetric emergencies Provide clean delivery packages to visibly pregnant women and birth attendants	Provide antenatal care Provide postnatal care Train skilled attendants (midwives, nurses, doctors) in performing EmOC and newborn care Increase access to basic and comprehensive EmOC and newborn care
STIs, INCLUDING HIV PREVENTION AND TREATMENT	Ensure safe blood transfusion practice Facilitate and enforce respect for standard precautions Make free condoms available **Make syndromic treatment available as part of routine clinical services for patients presenting for care* ** Make treatment available for patients already taking ARVs, including for PMTCT, as soon as possible*	Establish comprehensive STI prevention and treatment services, including STI surveillance systems Collaborate in establishing comprehensive HIV services as appropriate Provide care, support and treatment for people living with HIV/AIDS Raise awareness of prevention, care and treatment services for STIs, including HIV Provide community education

3.6.1 Order RH equipment and supplies

Once minimal initial RH services are established, work with health authorities and through the health sector/cluster to analyse the situation, estimate the use of medicines and disposable supplies, assess the needs of the population and reorder supplies as needed. Avoid continued ordering of the prepackaged RH Kits. Ordering RH supplies based on demand will ensure the sustainability of the RH programme and avoid shortage of some supplies and wasting of others not used in the setting.

Place follow-up orders for RH supplies through regular medical supply lines in-country. Also consider procurement channels used by NGOs or through UNFPA Procurement Services Branch (see paragraph 3.5.1).

When ordering supplies for comprehensive RH services, RH officers and RH programme managers must coordinate RH commodity management with health authorities and the health sector/cluster in order to ensure uninterrupted access to RH commodities and avoid waste.

- Hire staff trained in supply chain management.
- Estimate monthly consumption of RH medicines and disposables.
- Identify medical supply channels. Investigate the quality of local supply channels. If this is inadequate, obtain RH commodities through recognized global suppliers or with support from UNFPA, UNICEF or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality RH supplies at low cost.
- Place timely orders through identified supply lines based on your estimates in order to avoid stock-outs.
- Locate the supplies as close to the beneficiary population as possible.

3.6.2 Collect existing background data

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

- Identify relevant MOH policies and protocols for standardized care, such as STI syndromic management and family planning protocols.
- Collect or estimate demographic and RH information of the affected population, such as:
  - the number of women of reproductive age (15 to 49 years old) — estimated at 25% of the population; the number of sexually active men — estimated at 20% of the population; the crude birth rate — estimated at 4% of the population;
  - age- and sex-specific mortality data, for example the number of deaths in adolescent girls, the newborn mortality rate (the number of deaths during the first 28 completed days of life per 1000 live births in a given period), existing background data on maternal mortality;
  - STI and HIV prevalence, contraceptive prevalence and preferred methods, and RH knowledge, attitudes and behaviour of the affected population.

For more information, see Chapter 3: Assessment, Monitoring and Evaluation.

3.6.3 Identify suitable sites

Collaborate with local authorities and the health sector/cluster partners to identify possible sites for comprehensive RH service, such as family planning (FP) clinics, STI outpatient rooms or adolescent RH services. It is important to consider the following factors (among others) when selecting suitable sites:

- feasibility of communications and transport for referrals
- distance to other health services
- proximity to affected population and the target group

3.6.4 Assess staff capacity and plan for training

Staff capacity can be measured through supervisory activities (e.g. monitoring checklists, direct observation, client exit interviews) (see Chapter 1: Fundamental Principles and Chapter 3: Assessment, Monitoring and Evaluation) or through formal examinations of knowledge and skills.

When planning for training or retraining of staff, work with national authorities and academic and training institutes and take into consideration existing curricula. Where possible, use national trainers. Plan training sessions carefully, in order not to leave health facilities without in-service staff.

4 Human rights and legal considerations

The MISP as a standard for humanitarian actors is supported by the international legal obligations of States to respect and ensure basic human rights, including reproductive rights, in humanitarian settings. During times of conflict, States are obliged to ensure the provision of humanitarian assistance to the civilian population where food, medicine and other resources are inadequate. States also have a duty not to interfere with the provision of life-saving, health-related and other humanitarian assistance. Humanitarian assistance and protection of individual rights must be provided and ensured by States and other parties without discrimination.

Recognizing that certain categories of people have particular needs in times of conflict and/or displacement, international law grants special treatment and protection to children and women, especially expectant mothers and women with small children. States and relief workers are required to give special attention to the health needs of women, including ensuring access to reproductive health-care services, including prevention of HIV infection, and to female service providers. In addition, international refugee law requires that States treat refugees lawfully residing in their territory the same as their nationals with respect to social security schemes, including maternity and sickness benefits.

In emergencies, States have collective and individual duties to ensure the right to health by cooperating to provide humanitarian assistance, including access to RH care. In their response to emergencies, States are instructed to give priority in "provision of international medical aid…safe and potable water, food and medical supplies…to the most vulnerable or marginalized groups of the population." *

Box 13: Advocacy

Use these points in your advocacy with UN and national policy makers, etc., when the MISP is dismissed or not prioritized in humanitarian response.

The MISP:

- is a Sphere standard and is thus an internationally recognized, universal minimum standard of disaster response;
- is a life-saving intervention and a CERF minimum life-saving criterion eligible for CERF funding;
- is integrated in the global health cluster guidance.

* Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 40 (2000).

5 Monitoring

The RH officer implements the MISP checklist to monitor service provision in each humanitarian setting. In some cases, this may be done by verbal reporting from RH managers and/or through observation visits. At the onset of the humanitarian response weekly monitoring is done. Once services are fully established, monthly monitoring is sufficient. Discuss gaps and overlaps in service coverage within the RH stakeholder meetings and at health sector/cluster coordination mechanisms to find and implement solutions.

Sample MISP Checklist			
Geographic area:	Reporting time period: _ _/ _ _/20 _ _ to _ _/ _ _/ 20 _ _	Start date of health response: _ _/ _ _/20 _ _	Reported by:
1. RH lead agency and RH officer			
		YES	NO
1.1	Lead RH agency identified and RH officer functioning within the health sector/cluster: Lead agency _____ RH officer _____	☐	☐
1.2	RH stakeholder meetings established and meeting regularly:		
	• National MONTHLY	☐	☐
	• Sub-national/District BIMONTHLY	☐	☐
	• Local WEEKLY	☐	☐
2. Demographics			
2.1	Total population	_____	
2.2	Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)	_____	
2.3	Number of sexually active men (estimated at 20% of population)	_____	
2.4	Crude birth rate (estimated at 4% of the population)	_____	

3. Prevent sexual violence and respond to the needs of survivors			
		YES	NO
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place	☐	☐
	Confidential health services to manage survivors of rape		
	• Emergency contraception	☐	☐
	• PEP	☐	☐
	• Antibiotics to prevent and treat STIs	☐	☐
	• Tetanus toxoid/Tetanus immunoglobulin	☐	☐
	• Hep B vaccine	☐	☐
	• Referral to health, psychological, social support services	☐	☐
3.2	Number of incidents of sexual violence reported to health services	_____	
3.3	Information on post-rape care and access to services disseminated to community	☐	☐
4. Reduce the transmission of 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	Sufficient materials and checklists to ensure standard precautions in place	☐	☐
4.4	Condoms available free of charge:		
	• Health facilities	☐	☐
	• Community level	☐	☐
4.5	Approximate number of condoms taken this period	_____	
4.6	Number of condoms replenished in distribution sites this period (specify locations)		
	_____	_____	
	_____	_____	
	_____	_____	
	_____	_____	

5. Prevent excess maternal and newborn morbidity and mortality			
		YES	NO
5.1	**Health centre** (to ensure basic EmOC and newborn care 24/7) • one qualified health worker on duty per 50 outpatient consultations per day • midwife supplies, including newborn supplies available **Hospital** (to ensure comprehensive EmOC and newborn care 24/7) • 1 qualified service provider on duty per 20-30 inpatient beds for the obstetric wards • 1 team of doctor/nurse/midwife/anaesthetist on duty • adequate drugs and supplies to support comprehensive EmOC and newborn care 24/7	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
5.2	Referral system for obstetric and newborn emergencies functioning 24 hours per day/7 days per week (24/7) • means of communication (radios, mobile phones) • transport from community to health centre available 24/7 • transport from health centre to hospital available 24/7	☐ ☐ ☐	☐ ☐ ☐
5.3	Functioning cold chain (for oxytocin, blood screening tests) in place	☐	☐
5.4	Number of caesarean deliveries/number of births x 100	☐	☐
5.5	Number of clean delivery kits distributed/estimated number of pregnant women x 100	_____	
6. Planning for transition to comprehensive RH services. Activities this period.			
6.1	Sites for future delivery of comprehensive RH services (e.g. FP, STI management, adolescent reproductive health)		
6.2	Staff training needs (for FP provision, STI management, etc.), training tools, facilitators:		
6.3	RH commodities consumption (medicines and renewable supplies) monitored?	☐	☐
6.4	Procurement channels identified: 1 _____ 2 _____ 3. _____		

7. Special notes			
		YES	NO
7.1	Basic contraceptive methods available to meet demand	☐	☐
7.2	ARV available for patients on ART, including PMTCT	☐	☐
7.3	STI treatment available at health facilities	☐	☐
7.4	Hygiene kits have been distributed	☐	☐

8. Further comments
Explain how this information was obtained (direct observation, report back from partner (name), etc.) and provide any other comments.

9. Actions (For the "No" checks, explain barriers and proposed activities to resolve them.)		
Number	**Barrier**	**Proposed solution**

6 Further reading

Essential reading

MISP

Minimum Initial Service Package (MISP) for Reproductive Health: A Distance Learning Module. Women's Commission for Refugee Women and Children (Women's Refugee Commission), 2006. http://misp.rhrc.org/content/view/26/45/lang,english/

MISP Cheat Sheet. International Planned Parenthood Federation, August 2007. http://iawg.net/resources/MISP%20cheat%20sheet%2003%2001%2010.pdf

Inter-Agency Reproductive Health Kits for Crisis Situations, 4th Edition. UNFPA/IAWG, 2008. http://www.rhrc.org/resources/rhrkit.pdf

Prevention of and response to sexual violence

Clinical Management of Rape Survivors: Developing Protocols for use with Refugees and Internally Displaced Persons, revised edition. WHO/UNHCR, 2004. http://www.who.int/reproductive-health/publications/emergencies/924159263X/en/index.html

Clinical Management of Rape Survivors e-learning tool, WHO, UNHCR, UNFPA, 2009: http://www.who.int/hac/techguidance/pht/womenshealth/en/index.html

Guidelines for Gender-based Violence Interventions in Humanitarian Settings, Focusing on

*Prevention of and Response to Sexual Violence in Emergencies. I*nter-agency Standing Committee, 2006. http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv

Emergency obstetric and newborn care

Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs. Women's Commission for Refugee Women and Children (Women's Refugee Commission), 2005. http://www.rhrc.org/resources/emoc/EmOC_ffg.pdf

Prevention of HIV transmission

Guidelines for addressing HIV in Humanitarian Settings, Interagency Standing Committee. 2009. http://www.aidsandemergencies.org/cms/documents/IASC_HIV_Guidelines_2009_En.pdf

Additional reading

Training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises: A Course for SRH Coordinators, Facilitator's Manual. IPPF ESAOR, UNFPA, UNSW, 2008. http://www.ippfeseaor.org/NR/rdonlyres/76E30209-A4F4-4A00-BD90-D1B810056168/0/SPRINTFacilitatorsManual-part1.pdf

Sexual and Gender-Based Violence Against Refugee, Returnee and Internally Displaced Persons, Guidelines for Prevention and Response. United Nations High Commissioner for Refugees, 2003. http://www.unhcr.org/3f696bcc4.html

More on emergency obstetric care: http://www.who.int/making_pregnancy_safer/documents/managing_complications/en/index.html

More on blood transfusion safety: www.who.int/bloodsafety/en/

More on standard precautions: www.engenderhealth.org/ip/index.html

Post-Exposure Prophylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. WHO/ILO, 2007. www.who.int/hiv/pub/guidelines/PEP/en/