CHAPTER 3
MINIMUM INITIAL SERVICE PACKAGE (MISP)

3.1 INTRODUCTION

Providing comprehensive sexual and reproductive health (SRH) care to all members of a crisis-affected population is an overarching goal of the health sector and if financial, human, and material resources are available at the onset of an emergency, it should be the aim of the SRH response. Yet, the nature of crisis-affected settings often results in the disruption of the population's access to many, if not all, of their basic and survival needs. These include security, water, food, shelter, and sanitation for their health and well-being. The situation is often further compounded by limited resources. While attention should not be diverted from humanitarian efforts to address these needs and help prevent infectious diseases, neglecting SRH needs in humanitarian settings has serious consequences. These include: preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy such as unsafe abortion; and preventable consequences of sexual violence such as unintended pregnancies, increased acquisition of sexually transmitted infections (STIs), increased transmission

of HIV, mental health problems including depression, and the sequelae of trauma. It is within this context that the Inter-agency Working Group on Reproductive Health in Crises (IAWG) established the Minimum Initial Service Package (MISP) for SRH.

This chapter describes the humanitarian response to the SRH needs of populations at the onset of an emergency (within 48 hours wherever possible). In addition, this chapter provides recommendations on how to transition from the MISP to comprehensive SRH services for the recovery phase or during chronic or protracted crisis situations.

The MISP defines which SRH services are most important in preventing morbidity and mortality, while protecting the right to life with dignity, particularly among women and girls, in humanitarian settings. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners. The MISP for SRH is a health standard within the Sphere Minimum Standards in Humanitarian Response.

Based on well-documented evidence of SRH needs in humanitarian settings and World Health Organization (WHO) normative standards, the MISP can be implemented without an in-depth SRH needs assessment. However, some initial situational, demographic, and health information of the affected population must be determined with the health coordination mechanism for advocacy for and optimum delivery of MISP activities. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. Even where other components of SRH care are already provided, we should also implement MISP services as they are priority.

BOX 3.1: OBJECTIVES OF THE MISP

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

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

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

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 supplies for uncomplicated vaginal births 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

PREVENT UNINTENDED PREGNANCIES:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female 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

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.

Note: 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 MISP states that as soon as possible (ideally within 3-6 months, but it could be within weeks), national and international organizations and stakeholders should work toward the provision of comprehensive SRH services as outlined in Chapters 6 through 12 of this manual.

3.2 OBJECTIFS

The objective of this chapter is to provide information for and guidance to SRH Coordinators, health program managers, and service providers working in humanitarian settings on:

- The role and functions of the lead SRH agency and SRH Coordinator
- Prevention of sexual violence and clinical management to prevent or mitigate the consequences of sexual violence
- Priority interventions to prevent HIV and other STIs and reduce related morbidity and mortality
- Priority interventions to reduce maternal and newborn morbidity and mortality
- Prevention of unintended pregnancies
- Planning for comprehensive SRH service integration into primary health care as the situation stabilizes, including procurement of commodities and supplies

3.3 MISP PROGRAMMING

3.3.1 Ensure the health sector/cluster identifies an organization to lead implementation of the MISP

From the beginning of the response in each humanitarian setting, the health sector or health cluster must identify a lead SRH organization. This can be an international non-governmental organization (NGO), the Ministry of Health (MOH), or a United Nations (UN) agency. The nominated organization, which is the one identified as having the greatest capacity to fulfil this role, immediately dedicates a full-time SRH Coordinator for a minimum period of 3-6 months 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 services.

BOX 3.2: SRH COORDINATOR TERMS OF REFERENCE

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

- Coordinate, communicate, and collaborate within the health, GBV, and HIV cluster/sectors/actors and actively participate in health and other inter-sectoral 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 MOH, local and international NGOs including development organizations working on SRH, relevant UN agencies, civil society groups, inter-sectoral (protection, GBV, HIV) representatives, and community representatives from often marginalized populations such as adolescents, organizations of PWDs and LGBTQIA organizations to facilitate implementation of the MISP

- Compile basic demographic and SRH information of the affected populations to support MISP 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
  - 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), and 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 to seek SRH funding through humanitarian planning processes and appeals including the flash appeals process (Central Emergency Response Fund (CERF) and Country-based Pooled Funds (CBPFs)) and the Humanitarian Response Plan, in coordination with the health sector/cluster
- Provide technical and operational guidance on MISP implementation, as well as orientation for health partners on the MISP, RH Kits, and other resources
- Support coordinated procurement and distribution of RH Kits and supplies and plan for long-term sustainable SRH procurement and distribution systems

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

- Ensure MISP services are monitored to ensure quality and sustainability. Utilize the MISP checklist 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, to support establishment of client-centered comprehensive SRH services as soon as possible and within 3-6 months of the onset of the emergency

TO ENSURE MISP IMPLEMENTATION THE FOLLOWING MUST BE DONE:

- The health sector/cluster identifies a lead SRH organization
- The lead SRH organization puts in place the SRH Coordinator (see Box 3.2), who functions within the health sector/cluster. The SRH Coordinator, supported by the lead SRH organization, ensures:
  - All health agencies working in each of the crisis areas address SRH and implement or refer to SRH services
  - Regular SRH coordination meetings are held with all relevant stakeholders, including representatives working in SRH from the government, relevant UN agencies, local and international NGOs, the private sector, donors, and the protection working group or cluster and its gender-based violence Area of Responsibility (AoR) with members of the local affected populations to ensure the MISP is effectively implemented
  - Operational and technical support is provided for health partners to implement the MISP in all locations affected by the emergency. This includes:
- Providing guidance on and technical support for the coordinated procurement of SRH supplies (see Chapter 4)

- Identifying skilled health workers to implement MISP services
- Identifying effective and confidential referral mechanisms between health service delivery points and between health services and other service sectors
  - o Systems are established for regular data collection and analysis of data among partners implementing SRH services; at a minimum these data should be disaggregated by age and sex
  - o Clinical refresher trainings are conducted as needed and is feasible
  - o Once the situation allows, a mapping and analysis exercise of existing SRH services is undertaken in tandem with health, protection, gender-based violence (GBV), and HIV stakeholders. This exercise should include gaps and opportunities followed by a complete situation analysis and a planning exercise to support accessible, effective, efficient, equitable, and sustainable services
  - o Information from SRH working group meetings is shared and discussed in the general health sector/cluster, protection, GBV, and HIV coordination meetings
  - o The community is made aware of the availability and location of the SRH services. This should include:
    - Employing appropriate communication channels such as leaflets, radio, and text messages
    - Using community-led outreach, where possible, through adolescents, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) groups, people with disabilities (PWD), women's groups, sex workers, traditional birth attendants, and other community outreach workers to inform the affected population of the availability of SRH services and the importance of survivors of sexual violence seeking care as soon as possible after an incident

BOX 3.3: MISP COORDINATION AND ADOLESCENTS

- **Acknowledge that adolescents have unique concerns and needs and they may face further discrimination on the basis of age, sex, gender identity, disability, sexual orientation, and bodily diversity**
- **Engage adolescents meaningfully in SRH coordination, project design, and implementation**
- **Support the provision of adolescent-friendly SRH services including informed choices and outreach activities**

3.3.2 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, in the health sector/cluster:

- 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
- Ensure confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

PREVENT SEXUAL VIOLENCE

Sexual violence is often a frequent occurrence in all types of humanitarian settings and especially in conflict situations. Survivors of sexual violence can be of any sex, gender, or age. Survivors can be women, men, adolescents, people with disabilities, young children, LGBTQIA people, ethnic and religious minorities, and sex workers, among others. Women and girls are most affected. Perpetrators of sexual violence are often male intimate partners (including spouses) or others known to survivors (family, friends, or community members) or may be from among people in uniform, including security/peacekeeping forces and combatants. All actors in humanitarian settings must be aware of the risks of sexual violence and those related to sexual exploitation and abuse and coordinate multi-sectoral activities to prevent these and protect the affected population, particularly women, girls, and other at-risk populations. 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 settings disclosed by survivors during clinical management (keeping personal identifiers confidential) for risk mitigation.

In collaboration with the overall health sector/cluster mechanism, the SRH Coordinator and program staff must ensure that the humanitarian health sector/cluster and health actors:

- Ensure safe access to basic health services, including sexual and reproductive health services, for women, men, adolescents, and children

PROGRAMMATIC EXAMPLE 3.1: MISP COORDINATION IN NEPAL

ORGANIZATIONS: Family Health Division (FHD)/Department of Health Services (DoHS) Nepal and the Reproductive Health Sub-cluster, Boston University School of Public Health, Johns Hopkins University School of Public Health, UNFPA, Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations (SPRINT) Initiative, Family Planning Association Nepal, Women's Refugee Commission

LOCATION: Nepal

INTRODUCTION: An inter-agency evaluation was undertaken to document the implementation of the MISP within 5 months after the April 2015 earthquake in Nepal in one urban (Kathmandu) and one rural (Sindhupalchowk) district. The study explored awareness of the MISP, implementation of the standards, and factors that influenced implementation using both quantitative and qualitative methods. Methods included secondary data review, focus group discussions, key informant interviews, and health facility assessments.

FINDINGS: MISP priority activities were largely available in both districts. The quality of certain services was low when they were available, specifically clinical care for survivors of sexual violence, syndromic management of sexually transmitted infections (STIs) and standard precautions in some settings. Community knowledge about culturally sensitive SRH issues, the benefits of seeking care, and the location of services for sexual violence and STIs including HIV were a major gap when compared to contraception or maternal health services. In addition, many key informants were not aware of available services such as emergency contraception and post-exposure prophylaxis for sexual violence survivors.

LESSONS LEARNED: Availability of the MISP in the two study districts appears to be associated with three key factors:

1) Commitments and investments in SRH by the Government of Nepal and partners pre-crisis;
2) Existence of emergency and disaster risk management for health initiatives that include the MISP in preparedness activities and pre-positioning of RH kits; and
3) Leadership and collaboration among partners in the immediate response to secure donor support and to implement coordinated and innovative strategies to reach affected communities. Community engagement in the initial response is critical including informing communities about the benefits for sexual violence survivors seeking timely health care and the location of services.

- 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, PWDs, 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
- 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
- Hire and train female service providers, community health workers, program staff and interpreters
- Ensure all ethnic subgroup languages are represented among service providers, or 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 (SEA)
- Ensure that codes of conduct and reporting mechanisms on SEA (which ensure whistle blower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct

RESPOND TO THE NEEDS OF SURVIVORS OF SEXUAL VIOLENCE

For the health sector to prevent and manage possible health consequences, survivors of sexual violence must have access to clinical care, including supportive psychosocial counseling, as soon as possible after the incident. Ensure health services can provide such care at the onset of a humanitarian response.

As soon as possible, the SRH Coordinator, together with the GBV AoR lead or GBV sub-cluster, should obtain information about the national medico-legal system and share it with the health and protection sectors/clusters during coordination meetings. The SRH Coordinator, with the SRH working group and the health sector/cluster, should work with the GBV AoR 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. These include health, justice/legal, protection, security, psychosocial, and community services. It is important to link to community self-help groups, including those formed by adolescents, persons with disabilities, LGBTQIA populations, and sex workers to ensure a coordinated, survivor-centered, and confidential referral mechanism for survivors. The outcome document of this process is sometimes referred to as GBV Standard Operating Procedures (SOPs) (see Chapter 10).

All humanitarian actors must respect a sexual violence survivor's rights to life, self-determination, high quality health care, non-discrimination, privacy, confidentiality, information, and respect. All health providers must follow a standard examination and treatment protocol and ensure survivors are informed of mandatory reporting laws that may limit confidentiality of the information they disclose to health care providers and influence their decision to seek care. Survivor-centered care also ensures the survivors' right to choose the services they want and the sex of the providers. As soon as possible child survivors of sexual violence should be treated by providers trained in post-rape care for children and children should also be allowed to choose the sex of the service provider.

A health care provider may be the first or only person a survivor ever approaches and the quality of the care provided can have short and long-term impacts on the well-being of the survivor and the survivor's willingness to disclose. Therefore, all health providers (including those who are not working in facilities equipped to provide clinical care for survivors of sexual violence) must be prepared to provide the first-line of support, which includes empathetic listening and validation, identifying the survivor's immediate emotional, psychological, and physical needs, and identifying available support services. This also includes attending to the survivor's immediate and ongoing safety (protection) and health, including mental health needs. Providers should respectfully listen with empathy to the survivor's story without judgment.

BOX 3.4: 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**
- **Non-discrimination**

Reassure the survivor she or he is not at fault or to blame. Inquire about the survivor's needs and concerns, offer information about other support services, and always support the survivor's decisions.

CLINICAL SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE

When setting up clinical services for survivors of sexual violence, 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 people 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

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

- The importance of seeking immediate medical care following sexual violence:
  - No later than 72 hours for prevention of HIV
  - No later than 120 hours for prevention of pregnancy
- The hours and locations of services

This information should be provided in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (women, youth, and LGBTQIA and PWD groups) and other setting-appropriate channels (e.g., through schools, midwives, community health workers, community leaders, radio messages or informational leaflets in women's latrines). Messaging should also include information about what health services are offered to survivors who are unable to seek immediate care.

The SRH Coordinator, with the SRH working group and health sector/cluster, should ensure service providers are skilled and able to provide non-discriminatory and unbiased services. Where needed, organize information sessions or brief refresher trainings on clinical care for survivors of sexual violence that includes the following components:

- Supportive communication
- History and examination
- The medico-legal system and forensic evidence collection, where feasible and when needed
- Compassionate and confidential treatment and counseling, including:
  - Emergency contraception
  - Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care, to the full extent of the law
  - Presumptive treatment of STIs

- Post-exposure prophylaxis (PEP) to prevent HIV transmission
- Prevention of hepatitis B and human papillomavirus (HPV)
- Care of wounds and prevention of tetanus
- Referral for further services, such as other health, psychological, and social services

Supportive communication

Ensure service providers can extend compassionate and confidential support to the survivor through communication that is accurate, clear, non-judgmental, and involves empathetic active listening without pressuring the survivor to respond. 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

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 she or he so desires. For children, this may be their (non-offending) 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 and this is obligatory for children. Inform the survivor that the person is there to give the survivor support, but only at the survivor's request.

A history and a thorough medical examination (avoiding invasive procedures as much as possible in accordance with WHO guidelines) are conducted after ensuring the survivor understands and consents to each step. The history-taking includes:

- Questions about the assault limited to what is needed for medical care (e.g., type of penetration, injuries) and, where appropriate, the collection of samples for forensic evidence. Do not ask the survivor to repeat information that is already noted on a referral form
- General medical information
- Medical and gynecological history for women and girls
- Assessment of mental state, by asking how the survivor is feeling and noting the survivor's emotions during the exam

Preprinted history and examination forms should guide the process and all findings should be thoroughly documented.

The primary purpose of the history and examination is to determine the clinical care that is needed. History-taking and the examination are to be done at the survivor's own pace. The survivor should be assured that she or he is in control, does not have to talk about anything she or he is 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, where feasible and when needed

Medico-legal system

An important part of the response to sexual violence is ending impunity of perpetrators and supporting justice for survivors. Together with the protection and health cluster/sectors and in coordination with legal experts, the GBV AoR lead and the SRH Coordinator should determine the status of the national medico-legal system, including the relevant laws and policies about sexual violence. They should share this information with respective national and international stakeholders (including health providers, GBV experts, psychosocial workers, and civil society organizations addressing GBV, such as women's, youth, LGBTQIA, PWD, and ethnic minority community groups). In crisis settings, various aspects of an existing system comprised of health and social services, forensic medicine, forensic lab services, police/investigative services, and the legal system could be compromised due to a lack of qualified personnel or insufficient/damaged facilities, equipment, supplies, and resources.

Clinical management of survivors of sexual violence takes priority over the medico-legal process. However, if the survivor agrees, the exam and forensic evidence can be collected together. Collection of forensic evidence should only occur if that evidence can be tested, analyzed, and used.

Forensic evidence collection

- Only evidence that can be collected, stored, analyzed, and used should be collected and only if the survivor consents after a full explanation of each procedure
- Local legal requirements, available laboratory and storage facilities, the survivor's report of when the sexual violence occurred, and the survivor's actions after the assault (for instance whether she/he/they washed, changed clothing, urinated or defecated), will determine if and what forensic evidence should be collected
- A non-specialized health care provider should, at a minimum, keep a careful written record of all findings during the medical examination that can support the survivor's story, including the state of the survivor's clothes, location of the incident, and a detailed description of any injuries. The medical chart is part of the legal record and a summary of it 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
- Only providers explicitly trained and supervised in the collection of forensic evidence should undertake the collection of other samples of forensic evidence
- It is the role of the health provider to document the exam and the findings consistent with the survivor's description of what happened, but it is not the role of the provider to establish whether, legally, a rape happened
- If a microscope is available and no more than 5 days have passed since the incident, a trained health provider or laboratory worker can examine wet-mount slides for the presence of sperm
- Systematically offer a medical certificate to the survivor with a clear explanation of risks in keeping this document. 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 facility or by the program manager. The other copy is provided to the survivor if she or he wants it after careful counseling of the risk of further violence if the document is found in the survivor's possession. These documents should be provided free-of-charge
- 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 contraception

Emergency contraception (EC) can prevent unintended pregnancies after sexual violence. EC should be provided as soon as possible to a sexual violence survivor seeking care within 120 hours after the rape. There are multiple regimens of emergency contraceptive pills (ECPs) that can be used. Insertion of a copper-bearing intrauterine device (IUD) is also a highly effective method of EC.

Progestin-only ECPs

Globally, progestin-only ECPs are the most widely available form of EC; pills containing 1.5 mg of levonorgestrel are often packaged specifically for post-coital use.

- Timeframe: Progestin-only ECPs should be provided as soon as possible to survivors of sexual violence because their efficacy declines with time. ECPs can be used up to 120 hours (5 days) after unprotected sex, but are more effective the sooner they are taken
- Safety: Progestin-only ECPs 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 are needed before providing progestin-only ECPs. A pregnancy test is not required, as ECPs will neither cause any harm if the woman is already pregnant, nor affect a pre-existing pregnancy
- Mechanism of action: Progestin-only ECPs work by preventing pregnancy. They delay or prevent ovulation or stop the egg and sperm from meeting. ECPs 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

BOX 3.5: OVERVIEW OF EMERGENCY CONTRACEPTIVE PILL OPTIONS

PROGESTIN-ONLY ECPS

- One dose of levonorgestrel 1.5 mg
- Taken within 5 days (120 hours) of unprotected intercourse; efficacy is greatest 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

ULIPRISTAL ACETATE (UPA)

- 1 dose of ulipristal acetate 30 mg
- Taken within 5 days (120) 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

COMBINED HORMONAL ECPS

- 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)
- 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 2 hours of taking a dose, the dose should be repeated
- Less effective and with more side effects than progestin-only ECPs and UPA

- Side effects: Side effects are generally short-term, mild, and easily managed. These side effects may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. If vomiting occurs within two hours of taking a dose, the dose should be repeated and, if available, an antiemetic can be given. Notably, there are no long-term side effects of progestin-only ECPs; they are not associated with any serious medical complications and do not affect future fertility

- Regimens: Progestin-only ECPs are more effective and have fewer side effects than combined hormonal pills (the Yuzpe method). However, dedicated progestin-only ECPs are not available in all countries. If dedicated progestin-only ECPs are not available in your setting, first see if progestin-only oral contraceptive pills that can be used to create a 1.5 mg dose of levonorgestrel are available. If not, combined-hormonal oral contraceptive pills should be used to make EC

- Counseling: Counsel the survivor on how to take progestin-only ECPs and what to expect after taking them. There is a small chance that the pills will not work. Inform the survivor that menstruation should occur around the time when it would normally be expected, but may be up to a week early or late. If the survivor 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. Survivors should also be informed that progestin-only ECPs do not prevent pregnancy from sexual acts that take place after their use

- Repeated use: ECPs 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 number of times a woman can take progestin-only ECPs. However, using an ongoing contraceptive method is recommended as the most effective way to prevent pregnancy. Progestin-only ECPs do not need to be taken more than once in a 24-hour period if unprotected sex occurs more than once during that timeframe

TABLE 3.1 EMERGENCY CONTRACEPTIVE PILL REGIMENS

TYPE	PILL COMPOSITION (PER PILL)[a]	COMMON BRAND NAMES	FIRST DOSE: TAKE AS SOON AS POSSIBLE, UP TO 120 HOURS	SECOND DOSE: TAKE 12 HOURS LATER
Levonorgestrel-only ECPs	1.5 mg LNG	NorLevo 1.5 (available in RH Kits), Escapelle, Plan B One-Step, Postpill, Pregnon 1.5, Vikela, Postinor 1	1 tablet	0 tablets
	0.75 mg LNG	Postinor 2, Levonelle-2, NorLevo 0.75, Pregnon, Next Choice	2 tablets[b]	0 tablets
Levonorgestrel-only oral contraceptive pills	30 µg	Microlut, Microval, Norgeston	50 tablets	0 tablets
	37.5 µg	Ovrette	40 tablets	0 tablets
Ulipristal acetate ECPs	30 mg UPA	ella, ellaOne	1 tablet	0 tablets
Ulipristal acetate	5 mg	Fibristal	6 tablets	0 tablets
Combined oral contraceptive pills	EE 50 µg plus LNG 250 µg or NG 500 µg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, Tetragynon, E-Gen-C, Neo-Primovlar 4	2 tablets	2 tablets
	EE 30 µg plus LNG 150 µg or NG 300 µg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4 tablets	4 tablets
	EE 20 µg plus LNG 100 µg or NG 200 µg	Loette	5 tablets	5 tablets

Copper-bearing IUD

A copper-bearing IUD can also be inserted in medically eligible women through 5 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 day 7 of the menstrual cycle, the woman can have a copper-bearing IUD inserted beyond 5 days after the sexual violence occurred, when ovulation can be estimated and as long as insertion does not occur more than 5 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 ECPs 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 full STI treatment, including antibiotics to empirically treat possible STIs and/or pelvic inflammatory disease (PID). The IUD may be removed at the time of the woman's next menstrual period or left in place as ongoing contraception (see Chapter 7).

a EE = ethinylestradiol; LNG = levonorgestrel; NG =norgestrel; UPA = ulipristal acetate.

b The labels on two-pill ECP packages specify that the second pill should be taken 12 hours after the first. However, these labels do not reflect current scientific information. Both pills should be taken at the same time.

Presumptive treatment for sexually transmitted infections

- Provide survivors antibiotics to presumptively treat gonorrhea, chlamydial infection, and syphilis, as warranted and if desired. 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. For instance, if the survivor presents within 30 days of the incident, 400 mg of cefixime plus 1g of azithromycin orally will be sufficient presumptive treatment for gonorrhea, chlamydial infection, and incubating syphilis

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

TABLE 3.2: WHO RECOMMENDED STI TREATMENT PROTOCOLS FOR ADULTS

STI	TREATMENT		
Chlamydial infection	Option 1) azithromycin	1 g orally, in a single dose	This antibiotic is also active against incubating syphilis (within 30 days of exposure)
	Option 2) doxycycline	100 mg orally, twice daily for 7 days	Contraindicated in pregnancy
Chlamydial infection in pregnant women	Option 1) azithromycin	1 g orally, in a single dose	This antibiotic is also active against incubating syphilis (within 30 days of exposure)
	Option 2) erythromycin	500 mg orally, 4 times daily for 7 days	
	Option 3) amoxicillin	500 mg orally, 3 times daily for 7 days	
Gonorrhea	Option 1) cefixime	400 mg orally, single dose	
	Option 2) ceftriaxone	125 mg intramuscularly, single dose	
Syphilis	Option 1) benzathine benzylpenicillin*	2.4 million IU, intramuscularly, once only	Give as two injections in separate sites
	Option 2) 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	Option 1) 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
	Option 2) doxycycline	100 mg orally twice daily for 14 days	Contraindicated in pregnancy. This antibiotic is also active against chlamydial infections
Syphilis in pregnant women allergic to penicillin	Option 1) 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
	Option 2) erythromycin	500 mg orally, 4 times daily for 14 days	This antibiotic is also active against chlamydial infections
Trichomoniasis	Option 1) metronidazole	2 g orally as a single dose	Avoid metronidazole and tinidazole in the first trimester of pregnancy
	Option 2) tinidazole	2 g orally as a single dose	
	Option 3) metronidazole	400 or 500 mg orally, 2 times daily for 7 days	

* 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.

- Be aware that women who are pregnant or who have known allergies should not take certain antibiotics; modify the treatment accordingly
- Presumptive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV
- To reduce side effects such as nausea, the doses can be spread out (and taken with food) and if available, an antiemetic can be given

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 2 week and 1 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 non-biased 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

Women can seek post-rape care any time after the event. Survivors who present with a pregnancy at any gestational age due to sexual violence should receive information about all options open to them, including safe abortion care or a referral for that care, to the full extent of the law.

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

TABLE 3.3: WHO RECOMMENDED STI TREATMENT PROTOCOLS FOR CHILDREN AND ADOLESCENTS

STI	WEIGHT OR AGE	TREATMENT	
Chlamydial infection	< 45 kg	Option 1) azithromycin	20 mg/kg orally, single dose
		Option 2) doxycycline	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	Option 1) erythromycin	500 mg orally, 4 times daily for 7 days
		Option 2) azithromycin	1 g orally, single dose
Gonorrhea	< 45 kg	Option 1) ceftriaxone	125 mg intramuscularly, single dose
		Option 2) spectinomycin	40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose
		Option 3) cefixime	8mg/kg of body weight orally, single dose
	> 45 kg	Treat according to adult protocol	
Syphilis	All children	Option 1) benzathine benzylpenicillin*	50,000 IU/kg IM (up to a maximum of 2.4 million IU), single dose
Syphilis, patient allergic to penicillin	All children	Option 1) 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	Option 1) metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	> 12 years	Treat according to adult protocol	

* If the survivor presents within 30 days of the incident, benzathine benzylpenicillin can be omitted if the treatment regimen includes azithromycin, which is effective against incubating syphilis as well as chlamydial infection.

Post-exposure prophylaxis (PEP) to prevent HIV transmission

HIV post-exposure prophylaxis should be offered and initiated as early as possible for all individuals with an exposure that has potential for HIV transmission. The likelihood of HIV transmission after sexual violence can be reduced through the prompt administration of PEP. PEP must be initiated as soon as possible and no later than 72 hours following exposure and continued for 28 days. Studies suggest that PEP is more effective the sooner it is initiated. WHO recommends a 28-day combination therapy. This guidance is current at the time of publication. As this is a rapidly evolving field please check the IAWG website for updates.

Although PEP is ideally provided within 72 hours of exposure, people may not be able to access services within this time. Provide other relevant post-rape care and refer clients presenting after 72 hours for voluntary HIV counseling and testing services, as appropriate.

FOR SURVIVORS OF SEXUAL VIOLENCE:

- Assess the risk of exposure to HIV before prescribing PEP. Take the history of the event, type of penetration (vaginal, anal, and/or oral), and the type of injuries sustained into consideration
- Discuss with the survivor the risks for transmission of HIV based on type of exposure and PEP therapy and side effects and stress the need for adherence to the regimen
- Offer counseling and testing for HIV in the first 2 weeks after the incident. However, an HIV test is not a prerequisite for prescribing PEP within the first 72 hours of exposure
- Offer PEP to all eligible survivors, including those who decline HIV testing. Start the first dose as soon as possible. Do not delay starting PEP while waiting for a HIV test result

Note: Do not offer PEP to survivors who are known to be HIV-positive. Refer HIV-positive survivors to HIV treatment, support, and care where available.

TABLE 3.4: RECOMMENDED COMBINATION THERAPIES FOR HIV-PEP

AGE	TREATMENT	COMMENTS
Adults and adolescents	Backbone regimen: Tenofovir (TDF) + Lamivudine (3TC) or Emtricitabine (FTC) Recommended third drug: Lopinavir/ritonavir (LPV/r) or Atazanavir/ritonavir (ATV/r) Where available Raltegravir (RAL), Darunavir + ritonavir (DRV/r), or Efavirenz (EFV) can be considered as alternative options for the third drug	Post-exposure prophylaxis for HIV with two drugs is effective. A third drug is recommended by the WHO Use the 2-drug regimen if a 3rd drug is not available Provide the full 28-days prescription of PEP following risk assessment Enhanced adherence counseling is recommended for all individuals initiating HIV PEP
Children 10 years and younger	Backbone regimen: Zidovudine (AZT) + Lamivudine (3TC) Alternative regimen: Abacavir ABC + Lamivudine (3TC) or Tenofovir (TDF) + Lamivudine (3TC) or Emtricitabine (FTC) Recommended third drug: Lopinavir/ritonavir (LPV/r) is recommended as third drug for HIV PEP in children) An age-appropriate alternative regimen can be identified among Atazanavir/ritonavir (ATV/r), Raltegravir (RAL), Darunavir + ritonavir (DRV), Efavirenz (EFV) and Nevirapine (NVP)	

TABLE 3.5: RECOMMENDED TWO-DRUG COMBINATION THERAPIES FOR HIV-PEP FOR USE BY CHILDREN

WEIGHT OR AGE	TREATMENT	PRESCRIBE	28-DAY SUPPLY
< 2 years or 5-9 kg	Zidovudine(AZT) syrup* 10 mg/ml plus Lamivudine (3 TC) sup 10 mg/ml	7.5 ml twice a day plus 2.5 ml twice a day	420 ml (i.e. five 100 ml bottles or three 200 ml bottles) plus 140 ml (i.e. two 100 ml bottles or one 200 ml bottle
10-19 kg	Zidovudine (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
20-39 kg	Zidovudine (AZT) 100 mg capsule plus Lamivudine (3 TC) 150 mg tablet	2 capsules three times a day plus 1 tablet twice a day	120 capsules plus 60 tablets

*Discard a bottle of syrup 15 days after opening

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
- Provide enhanced adherence counseling. 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
- Provide the full 28-day supply of PEP but schedule a return visit in 1 week to discuss adherence and offer return visits at any time in case survivor is concerned about side effects or other issues

Prevention of hepatitis B and human papillomavirus (HPV)

Provide hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. A total of 3 doses are needed, the second dose 4 weeks after the first, and the third dose 8 weeks after the second dose.

Consider providing the HPV vaccine to anyone age 26 or younger, unless the survivor has been fully vaccinated. In most cases, a total of 3 doses need to be given over a 6-month period.

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 unclean 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 4 weeks, third dose at 6 months to 1 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 facility level
- Protection or social services if the survivor does not have a safe place to go when she or he leaves the health facility

- 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

Follow-up care

- If feasible, follow-up care is recommended at 2 weeks, 1 month, 3 months, and 6 months following the incident
- Continue first-line psychosocial support and care, monitor mental health needs and refer for psychosocial and/or mental health support as needed
- Offer pregnancy testing at 2 and 4 weeks following the incident
- Monitor wounds for healing and follow-up on tetanus vaccination schedule as needed
- Where relevant, discuss adherence to STI prophylaxis or treatment including PEP and hepatitis B vaccination (additional doses at 1 month and 6 months), HIV testing at 3 months and 6 months, and pregnancy status and options

Special considerations for 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 vaginal or anal or speculum examinations should not be conducted in 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.

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

To reduce the transmission of HIV and other STIs from the onset of the humanitarian response, the SRH Coordinator, health program managers, and service providers must work with the health sector/cluster partners 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 (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 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

ESTABLISH SAFE AND RATIONAL USE OF 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

BOX 3.6: SPECIAL CONSIDERATIONS FOR SPECIFIC POPULATIONS

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 by service providers and program 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 comprehensive care.

PERSONS WITH DISABILITIES

Women, girls, men, and boys living with disabilities are at a higher risk of sexual violence. They also often face extreme discrimination by service providers; it is important to train and mentor health providers to reflect on their own attitudes related to disability, clinical care, and sexual violence. Host community organizations of persons with disabilities often have resources 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 each population as having separate needs and facing different risks. More generally, LGBTQIA individuals, particularly transwomen, face discrimination by health providers and other duty bearers that prevents them from seeking SRH services, including clinical care for sexual violence. Engaging with LGBTQIA self-help or rights groups and making health facilities more respectful of diversity in gender identity and sexual orientation 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. Respectful care by these duty bearers is essential to ensuring critical health services to this population. Humanitarian actors should engage with sex worker populations to develop SRH care programming. Organizations led by refugees and people who engage in sex work often have the expertise and connections necessary to effectively provide clinical services to these groups.

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. These specific barriers must be considered when designing programs to reach survivors of sexual violence and provide clinical care. It is important to train caregivers, health providers, and other duty bearers on non-discriminatory practices related to SRH service provision.

- 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:

- 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 11). 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 supported to link with clinical services for further testing to confirm their HIV status and, if confirmed, be linked to appropriate services
- Linking blood transfusion services with HIV counseling and testing services as soon as these are established as part of the comprehensive response and refer donors for HIV counseling and testing prior to screening their blood
- Conducting ABO grouping and Rhesus D typing and, if time permits, cross-matching
- 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

In order to make rational and safe blood transfusion available, the SRH Coordinator and health program 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 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

PROGRAMMATIC EXAMPLE 3.2: MISP IMPLEMENTATION IN JORDAN

ORGANIZATIONS: Boston University School of Public Health, UNFPA, US Centers for Disease Control and Prevention, Women's Refugee Commission

LOCATION: Jordan

INTRODUCTION: The purpose of this study was to describe the extent of the MISP for reproductive health services for Syrian refugees living in Zaatri refugee camp and one urban setting (Irbid City) in Jordan in March 2013. With local partners, the evaluation utilized mixed methods including focus group discussions, key informant interviews, and health facility assessments.

FINDINGS: Key elements to support MISP implementation were in place, including a dedicated lead agency and SRH focal point to coordinate MISP implementation, funding, and SRH supplies. Key informants reported that SRH coordination was insufficient for the urban areas and did not include participation from all key stakeholders, and clinical protocols for survivors of sexual violence and sexually transmitted infections were incomplete and missing, respectively. Clinical care for survivors of sexual violence was limited. Refugee women and adolescent girls were dissatisfied with available clinical services and their lack of participation in the humanitarian response.

LESSONS LEARNED: Leadership and coordination by the Ministry of Health with key UN agencies and NGOs to secure funding and SRH supplies are effective drivers to the availability of the MISP. High density refugee camps often garner more attention than urban settings where refugees are more disbursed within the host community. Concerted efforts are required to focus attention to less visible urban refugee settings. Gaps in pre-existing national SRH protocols need to be identified and addressed immediately. It is critical to engage and support the capacities of crisis-affected women and girls in the humanitarian response.

- Standard operating procedures 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 for all staff members performing blood transfusions. Keep copies of SOPs 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
- 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

ENSURE APPLICATION OF STANDARD PRECAUTIONS

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health 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, hepatitis C, and other pathogens within health care 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. Emphasize the importance of standard precautions during the first health coordination meeting.

<u>Standard precautions are:</u>

- ***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 re-sterilize 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 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
- ***Instrument processing:*** Process used instruments in the following order:
  - o Decontaminate instruments to kill viruses (HIV and hepatitis B) and make items safer to handle
  - o Clean instruments to remove debris before sterilization or high-level disinfection (HLD)
  - o 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
  - o Use or properly store items immediately after sterilization
- ***Housekeeping:*** Clean up spills of blood or other body fluids promptly and carefully with a 0.5% chlorine solution

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 to reduce staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces 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 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
- Take a medical history and conduct an exam of the exposed worker only after informed consent, recommend HIV voluntary counseling and testing, and provide PEP when appropriate. PEP treatment protocols are the same as those for survivors of sexual violence. ***An HIV test is not required (neither for the source patient nor the health care worker) before prescribing PEP***
- Educate on risk reduction through review of the sequence of events and advise the 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

In order to ensure application of standard precautions, SRH Coordinator and health program 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 workers and auxiliary staff where needed
- Establish supervisory systems, such as simple checklists, to ensure compliance with protocols
- Ensure first aid measures for 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 occurred and to identify safety concerns and possible preventive measures

BOX 3.7: OCCUPATIONAL EXPOSURE FIRST AID

INJURY WITH A USED NEEDLE OR SHARP INSTRUMENT AND BROKEN SKIN	SPLASH OF BLOOD OR BODY FLUIDS ON UNBROKEN SKIN	SPLASH OF BLOOD OR BODY FLUIDS IN THE EYE	SPLASH OF BLOOD OR BODY FLUIDS IN THE MOUTH
• 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	• Wash the area immediately. Do not use strong disinfectants	• 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	• 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 of relevant person-in-charge at health facility here) and take PEP if indicated

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 key protection methods to prevent transmission of HIV, other STIs, and unplanned pregnancy. Ensure lubricated male condoms and, where applicable (already used by the population), female condoms, are available and promoted from the earliest days of a humanitarian response. Order sufficient supplies of good-quality male and female condoms immediately. Condom supply in a humanitarian emergency should focus on the type of condoms used in the local context. It is useful to discuss condom distribution with leaders and members of affected communities, so they understand the need and importance of condom use, to ensure that distribution takes place in a culturally appropriate manner, and to increase community acceptance of condoms.

Provide lubricated condoms on request and ensure that condoms are available in all heath facilities and in accessible private areas in the community. These include latrines, bars, coffee shops, non-food distribution points, and youth and community centers. Consult 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. Where possible, community-led distribution of condoms within peer groups is useful. Key populations and adolescents will often know locations where their peers congregate and volunteers can be enlisted to distribute condoms to their peers. Ensure culturally appropriate messages are available to disseminate information on correct use and disposal of used condoms and educate key populations about correct use, as well as how to dispose of used condoms. Ensure condoms are also available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, and others.

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

BOX 3.8: ORDERING CONDOMS

Ensure that the procurement office responsible for bulk purchases for emergencies sources only WHO/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 through UNFPA. UNFPA can rapidly ship bulk quantities of good-quality condoms to the field as part of the Interagency Reproductive Health Kits (RH Kits).

Through 2018, male condoms are available in the RH Kit 1, Part A. Female condoms are in the RH Kit 1, Part B. These RH Kits contain sufficient supplies to cover the needs of a population of 10,000 people for 3 months (see calculations below). Leaflets explaining appropriate use of male and female condoms are also included.

SUPPORT THE PROVISION OF ARVS TO CONTINUE TREATMENT

Antiretroviral drugs reduce the transmission of HIV and excess mortality and morbidity from opportunistic infections and AIDS-defining illnesses.

Continuation of ART for those already on treatment prior to the crises

Antiretrovirals should be continued for people who were enrolled in an ART program prior to the emergency, including women who were enrolled in PMTCT of HIV and Syphilis programs. Continuation of ARVs for those already on treatment prior to the emergency is a priority because sudden disruption of ARVs can cause deterioration of individual health (by allowing opportunistic infection and immune-deficiency progression), potential transmission (due to viral rebound), and development of ARV resistance. The number and profile of people who were on ARVs prior to the emergency is likely to depend on the existing HIV epidemic (e.g., concentrated among key populations, generalized among the general population, or mixed).

To determine who has been on treatment, examine health records or patient cards, ensuring that confidentiality is safe-guarded. Where possible, existing networks of people living with HIV can be useful to disseminate information about the availability of ART for continuation of treatment. Use patients' treatment cards to determine the appropriate regimen. Many experienced patients can also identify which regimen they are using. 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. Per WHO recommendations, people who are already taking ARVs should not be re-tested for HIV. People on ART should also be offered condoms.

The SRH Coordinator, in concert with an HIV Coordinator if one exists, needs to support the health cluster/sector to rapidly:

- 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. In high prevalence countries and in countries with an important proportion of people living with HIV (PLWHIV) taking ARV, the "Inter-Agency Task Team to Address HIV in Emergencies" convened by UNHCR and the World Food Program should also provide support to the health coordination mechanism and/or

CALCULATIONS FOR CONDOM SUPPLIES FOR 10 000 POPULATION OVER 3 MONTHS

MALE CONDOMS

ASSUME: 20% of population are sexually active males

THEREFORE: 20% x 10 000 persons = 2000 males

ASSUME: 20% of these will use condoms

THEREFORE: 20% x 2000 = 400 users

ASSUME: Each user needs 12 condoms per month

THEREFORE: 400 x 12 x 3 months = 14,400 male condoms

ASSUME: 20% wastage (2,880 condoms)

THEREFORE: TOTAL = 14,400 + 2,880 = 17,280 (or 120 gross)

FEMALE CONDOMS

ASSUME: 25% of population are sexually active females

THEREFORE: 25% x 10 000 persons = 2,500 females

ASSUME: 1% of these will use female condoms

THEREFORE: 1% x 2,500 = 25 users

ASSUME: Each user needs 6 condoms per month

THEREFORE: 25 x 6 x 3 months = 450 female condoms

ASSUME: 20% wastage (90 female condoms)

THEREFORE: TOTAL = 450 + 90 = 540 (or 3.8 gross)

the HIV country team

- Ensure that the affected population is included in the national HIV program, including the national ART program
- Inform the national HIV program about the urgent need to adjust their ARV and co-trimoxazole distribution plans to address the needs of the crisis-affected population
- Quantify needs using rough total population estimates and pre-crisis statistics of prevalence and treatment rates
- Ensure that focal points are identified (primarily health care providers or PLWHIV networks) and that the community is informed about how to reach focal points that will help them to get their treatment and care

The SRH Coordinator ***should*** as well take an active role in:

- Facilitating the continuity of treatment of women and infants enrolled in the PMTCT of HIV and Syphilis program prior to the crisis, through coordination with the health sector/cluster and the national program and through informing both pregnant women and birth attendants and supporting the supply chain
- Ensuring 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:

- Procurement of ARVs for first or second-line treatment and co-trimoxazole
- Active case identification and case management
- Setting up the national monitoring system

PROVIDE PEP TO SURVIVORS OF SEXUAL VIOLENCE AS APPROPRIATE AND FOR OCCUPATIONAL EXPOSURE

Provide PEP to survivors of sexual violence

Provision of PEP to survivors of sexual violence is part of providing compassionate and confidential treatment and counseling, as outlined in section 3.3.2. Recommended HIV-PEP combination therapies are outlined for women and children in Table 3.4 and Table 3.5.

Provide PEP as appropriate for occupational exposure

PEP treatment protocols for occupational exposure are the same as those for survivors of sexual violence. This

information is detailed in Section 3.3.2. See also the above section dedicated to ensuring standard precautions.

SUPPORT THE PROVISION OF CO-TRIMOXAZOLE PROPHYLAXIS FOR OPPORTUNISTIC INFECTIONS FOR PATIENTS FOUND TO HAVE HIV OR ALREADY DIAGNOSED WITH HIV

Co-trimoxazole prophylaxis is a life-saving, simple, well-tolerated, and cost-effective intervention for people living with HIV. It should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy care. Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery.

Co-trimoxazole prophylaxis is an antibiotic used to prevent pneumocystis pneumonia and toxoplasmosis in adults and children with HIV, as well as other infectious and parasitic diseases, demonstrating significant benefits in regions affected by malaria.

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.

ENSURE THE AVAILABILITY IN HEALTH FACILITIES OF SYNDROMIC DIAGNOSIS AND TREATMENT OF STIs

The transmission of HIV and STIs are closely linked. Certain STIs facilitate the transmission of HIV, such as STIs producing ulcers in the genital area, and those associated with discharge, such as chlamydia or gonorrhea. On the other hand, the weakened immune system of people living with HIV, in particular those who do not have access to ARVs, can make people more susceptible to become infected with STIs. The presence of HIV also increases the severity of symptoms for some STIs (such as genital herpes).

The syndromic management of STIs is an approach which is currently implemented in many countries and therefore might exist before the crisis. It 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. This approach is particularly relevant at the onset of a crisis, where people are less likely to come for follow-up visit and where access to laboratories might be difficult, impossible, or expensive. Antibiotics recommended by WHO for syndromic treatment of STIs are available in the Inter-Agency Reproductive Health Kits. Syndromic management is cost-effective, satisfactory for the patients, predictable (easing procurement and training), and has a strong public health base and impact.

3.3.4 Prevent excess maternal and newborn morbidity and mortality

During labor and the immediate postnatal period is when many maternal and newborn deaths occur. The first day of life is the highest risk period for newborns. This objective addresses the main causes of maternal and newborn mortality and morbidity, and the following ***life-saving interventions*** that must be available in any humanitarian crisis.

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services
- Establish a 24 hour per day 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure availability of 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 is unreliable

ENSURE AVAILABILITY AND ACCESSIBILITY OF CLEAN AND SAFE DELIVERY, ESSENTIAL NEWBORN CARE, AND EMERGENCY OBSTETRIC AND NEWBORN CARE SERVICES

- At referral hospitals: All the above health facility activities as well as skilled medical staff and supplies for provision of comprehensive EmONC (CEmONC)

- At health centers: Skilled birth attendants and supplies for vaginal births, essential newborn care, and provision of basic EmONC (BEmONC)
- At the community level: Provision of clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible

Where feasible, health providers should promote skilled attendance of all births in a health facility to prevent excess maternal and newborn morbidity and mortality. Ensure sufficient skilled birth attendants, equipment, and supplies (especially lifesaving medicines) are available, and inform women of the location of health facilities.

Management of intrapartum complications

WHO estimates that in any given population approximately 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 may 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, SRH Coordinators must ensure that basic and comprehensive EmONC services are available 24 hours per day, 7 days per week.

The partograph can be a useful tool for monitoring labor and detecting maternal or fetal complications. If complications are detected, relevant BEmONC interventions or referral to CEmONC are critical to saving the lives of the newborn and/or mother. By following the Helping Babies Breathe (HBB) flow chart, immediate and timely action can be taken for newborns in need of resuscitation.

Where Type III female genital cutting (FGC) 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.

Chlorhexidine cord care

Daily application of 7.1% chlorhexidine (CHX) 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. Clean, dry cord care is recommended for newborns born in health facilities and

BOX 3.9: ESSENTIAL SERVICES FOR ALL NEWBORNS

Thermal care: Drying, warming, skin-to-skin contact, and delayed bathing

Infection prevention/hygiene: Clean birth practices, hand washing, and clean cord/skin/eye care. Chlorhexidine cord care is recommended for newborns born at home and in settings where the neonatal mortality rate is above 30 per 1000 live births

Feeding support: Skin-to-skin contact, support for immediate and exclusive breastfeeding, and not discarding colostrum (or 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: Women and babies should receive care at or as close to home as possible in the first week of life. The first 24 hours are the most critical time and should be prioritized for a postnatal visit. Every effort should be made to reach newborn babies at home as soon as possible after delivery

BOX 3.10: CHLORHEXIDINE FOR CLEAN CORD CARE AT HOME

- Application of 7.1% chlorhexidine digluconate, delivering 4% chlorhexidine (CHX) to the umbilical cord, especially on the day of birth, is a low-cost intervention that has been shown to reduce newborn mortality
- Use CHX as a standard part of essential newborn care to prevent newborn morbidity and mortality related to infections and sepsis
- Chlorhexidine has an excellent safety record and is an acceptable, feasible, and cost-effective intervention. It can be easily administered by health professionals, including community health workers, as well as family members
- CHX was added to the 2013 WHO List of Essential Medicines for Children, specifically for umbilical cord care. In January 2014, WHO issued a new recommendation for umbilical cord care that prioritized daily CHX application to the umbilical cord stump during the first week of life for newborns born at home settings ***with high neonatal mortality*** (30 or more neonatal deaths per 1,000 live births)
- Clean, dry cord care is recommended for newborns born in health facilities and at home in ***low neonatal mortality settings***. Use of CHX in these situations may be considered only to replace application of a harmful traditional substance (such as cow dung) to the cord stump

at home in low neonatal mortality settings. Use of CHX in these situations may be considered only to replace application of a harmful traditional substance, such as cow dung, to the cord stump.

Basic EmONC

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 each health center has capacity to provide BEmONC and refer to a hospital for CEmONC, 24 hours per day, 7 days per week.

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

Comprehensive EmONC

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 host-country 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 (ICRC), the International Federation of the Red Cross and Red Crescent Societies (IFRC), or Médecins Sans Frontières (MSF) and other NGOs to provide CEmONC, such as establishing a temporary field or referral hospital close to the affected population.

BOX 3.11: 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:

1. Administer parenteral antibiotics for treatment of sepsis
2. Administer uterotonic drugs (i.e., parental 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
3. Administer parenteral anticonvulsant drugs (i.e., magnesium sulfate) to manage severe preeclampsia and eclampsia
4. Perform assisted vaginal delivery (e.g., vacuum extraction)
5. Manually remove the placenta
6. Remove retained products of conception after delivery or an incomplete abortion
7. Perform basic neonatal resuscitation (e.g., with bag and mask)

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

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

Newborn care

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. Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation. About half of those that have difficulty initiating breathing require resuscitation. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

Newborn care is part of the continuum of care for mother and baby. In humanitarian settings, essential newborn care is provided at the community, health center, and

BOX 3.12: NEWBORN CARE

Newborn care at health facility level:

- Address intrapartum complications and ensure labor monitoring using partograph with appropriate action for complications
- Be prepared for newborn resuscitation at every birth including drying, clearing airway as needed, stimulation, and bag and mask ventilation
- Provide essential newborn care for every newborn
- For pre-term and LBW/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
- Manage signs of possible serious bacterial infections in newborns, including diagnosing, classifying, providing first dose of antibiotics, and referring to a hospital as soon as possible

Newborn care at hospital level:

- Be prepared. Ensure space for newborn resuscitation in the labor ward and capacity and supplies to provide bag and mask ventilation
- Address intrapartum complications. Provide monitoring using partograph with appropriate action for complications
- Provide newborn resuscitation including drying, clearing airway as needed, stimulation, and bag and mask ventilation. Continue to manage newborns with respiratory distress
- Provide essential newborn care for every newborn
- Establish Kangaroo Mother Care (KMC) unit for babies and mothers that are clinically stable, support immediate breastfeeding, and follow WHO guidelines for pre-term infants, including management of serious signs of bacterial infections in newborns

hospital levels and includes essential newborn care (ENC), prematurity and low birthweight (LBW) care, and treatment for newborn infections.

It is essential for health workers to be able to identify complications in order to accurately diagnose and provide timely treatment to a sick newborn. Newborns with the following danger signs should be referred by family members and community health workers to a health facility:

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

Formally trained medical staff are able to identify additional danger signs, including signs of possible serious bacterial infection.

BOX 3.13: SIGNS OF POSSIBLE SERIOUS BACTERIAL INFECTION IN NEWBORNS

The following danger signs can be used by formally trained medical staff to induce treatment of neonatal infection:

- **CRITICAL ILLNESS:** No movement/unconscious, history of convulsions, unable to feed, severe bleeding, or bulging fontanelle
- **CRITICALLY SEVERE INFECTIONS:** Fever (temperature greater than or equal to 38 degrees centigrade), poor feeding, reduced movement, or severe chest in-drawing
- **ISOLATED FAST BREATHING:** Respiratory rate greater than 60 breaths per minute

To prevent and respond to complications including provision of EmONC:

- Provide midwives and other skilled birth attendants in health centers with materials and drugs to conduct deliveries, provide newborn care, treat complications and stabilize women prior to transport to the hospital if needed. Life-saving drugs that must be available include:

  - Antibiotics for prevention and management of maternal infections
  - Uterotonics (oxytocin and misoprostol) for prevention and management of post-partum hemorrhage (PPH)
  - Anticonvulsants (magnesium sulphate) for prevention and treatment of eclampsia
  - Newborn resuscitation supplies, including a bag and mask
  - Antibiotics (gentamycin and ampicillin) for treatment of newborn infections
- Ensure skilled medical providers at specialized hospitals have the ability to manage obstetric complications, provide neonatal intensive care, accurately estimate gestational age, and administer steroids (dexamethasone for fetal lung maturity)
  - Antenatal steroids for preterm labor (dexamethasone) and antibiotics (penecillins and erythromycin) for premature re-labor rupture of membrane (PPROM) should be available
- Ensure skilled birth attendants are competent to provide EmONC and essential newborn care, including:
  - Initiation of breathing and resuscitation
  - Thermal protection (delayed bathing, drying, and wrapping and immediate and continued skin-to-skin contact)
  - Prevention of infection (hand washing, dry cord care or use of CHX, and eye care). Clean delivery practices as recommended by WHO including: clean hands, clean perineum, clean delivery surface, clean cord and tying instruments, and clean cutting surfaces
  - Immediate and exclusive breastfeeding
  - Identification of newborn danger signs and early referral (not feeding well, high or low temperature (≤36.5 or ≥37.5 Celsius), fits/convulsions, severe jaundice, fast or low breathing (≤30 or ≥60 breathe/min), reduced activity or low birth weight <2.5kg))
  - Management of newborn illness and care for preterm/low birth weight babies
  - Prevention and management of intrapartum and postpartum hemorrhage (PPH)
  - Prevention and management of postpartum infection
  - Provision of assisted delivery with vacuum extraction
  - Provision of post-abortion care
  - Provision of caesarean section
  - Provision of safe blood transfusion

Staff should be prepared to diagnose, prevent, and manage complications associated with prematurity and LBW according to the capacity and infrastructure needed to comprehensively support preterm infants. This includes provision of Kangaroo Mother Care (KMC), treatment of serious infections, and management of intrapartum complications.

Kangaroo Mother Care for preterm and low birth weight babies

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

ESTABLISH A 24 HOUR PER DAY 7 DAYS PER WEEK REFERRAL SYSTEM TO FACILITATE TRANSPORT AND COMMUNICATION FROM THE COMMUNITY TO THE HEALTH CENTER AND HOSPITAL

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. Such a referral system must support the management of obstetric and newborn complications 24 hours a day, 7 days a week (24/7). 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 a hospital with CEmONC services.

- Develop policies, procedures, and practices to be followed in health centers and hospitals to ensure efficient referral
- Determine distances from the affected community to functioning health centers and to the hospital, as well as transport options for referrals
- 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
- Inform communities when and where to seek emergency care for complications of pregnancy and childbirth. Messages should be shared in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (with women's, LGBTQIA, and PWD groups) and other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines). Meet with 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 EmONC, women and newborns will die unnecessarily. Therefore, it is vital to attempt to negotiate access to the referral hospital. Where 24/7 referral services are impossible to establish, it is essential that qualified staff are available at all times at health centers to provide basic EmONC. In this situation, it is helpful to establish a system of communication, such as the use of radios or cell phones, to get medical guidance and support from more qualified personnel.

BOX 3.14: HELPING SMALL NEWBORNS SURVIVE AND THRIVE WITH KMC

GETTING STARTED WITH KMC

- Not much is needed to start KMC other than designated beds with infection prevention measures, controlled access, and access to additional care if complications arise, which should be available at referral level hospitals
- Health workers should counsel mothers and families with stable small infants to initiate KMC as soon as possible after birth, particularly in the absence of intensive newborn care

POSITIONING

- Dress infant in only socks, diaper, and hat
- Place infant between mother's breasts, in vertical position, with head turned to side, slightly extended to protect airway
- Flex hips in frog position
- Flex arms
- Wrap/tie infant securely with cloth to mother

FEEDING

- Mother provides exclusive breastfeeding every 2-3 hours, and on demand
- If infant is unable to latch/suckle, feed expressed breast milk with cup or spoon

DURATION

- Low birth weight and premature infants should remain in KMC for at least 20 hours/day (with mother or surrogate) until the infant no longer tolerates KMC positioning
- Mother should sleep in half-sitting position, with infant tied in KMC
- If infant needs to be out of KMC position, care should be taken to keep infant warm

FOLLOW-UP

- Mother and infant should be sent home in KMC
- Position with counseling prior to discharge and follow-up monitoring as clinically indicated

ENSURE THE AVAILABILITY OF POST-ABORTION CARE IN HEALTH CENTERS AND HOSPITALS

Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects women, girls, families, and entire communities. Globally, unsafe abortion, that is abortions 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. Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion. Most countries now allow abortion to be performed on multiple grounds 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.

Post-abortion care (PAC) is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and is a life-saving intervention. Typically, women presenting for post-abortion care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. 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.

A rapid, initial assessment should be performed on all women presenting for care. 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, a more complete clinical assessment should be done to determine the cause and begin treatment. Shock in PAC 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. A history and directed physical exam with concurrent treatment should be done urgently for definitive management of underlying causes. Treatment may require immediate uterine evacuation; 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.

Women who have had unsafe abortions with non-sterile instruments are at risk of tetanus. Provide or refer the patient for tetanus prophylaxis for women presenting with post-abortion complications, particularly in communities where tetanus after abortion has been reported. All women who present for PAC should be provided with contraceptive information, counseling, and services.

ENSURE AVAILABILITY OF SUPPLIES AND COMMODITIES FOR CLEAN DELIVERY AND BASIC NEWBORN CARE

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 center without the assistance of skilled birth attendants. Make a clean delivery package available to all visibly pregnant women to improve birth and essential newborn care practices when access to a health facility is not possible. For example, 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 (TBAs) are assisting home deliveries, they can be given clean delivery kits and additional basic supplies. The provision of supplies for the newborn will encourage essential newborn care practice. Where the community was trained in their use prior to the emergency, clean delivery kits can also include misoprostol tablets aimed at preventing PPH and a tube of chlorhexidine gel/solution 7.1% (delivering 4% chlorhexidine (CHX)) to prevent cord infection among newborns. The provision of these high impact interventions is part of community-based interventions that also include education to pregnant women in their use. Recent evidence from both stable and crisis settings suggests that self-administration of misoprostol can be done safely and effectively. Misoprostol has the potential to reach women who give birth, by choice or by necessity, at home or in health facilities that lack electricity, refrigeration, and/or skilled health providers. In settings with national protocols for advanced distribution of misoprostol tablets for PPH prevention and chlorhexidine for cord care, the SRH

Coordinator must discuss the inclusion of these essential life-saving commodities in the clean delivery and/or birth attendant kits. Both misoprostol and chlorhexidine may also be available in local pharmacies and can be procured at low cost.

Link 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 within a comprehensive SRH program where they may be able to play a role as a link between families, communities, and local authorities, and the SRH services or in referring or accompanying laboring women to the health facility for delivery after appropriate services have been established.

BOX 3.15: CLEAN DELIVERY AND NEWBORN KITS

CLEAN DELIVERY KIT

- One sheet of plastic (for the woman to deliver on)
- Bar of soap
- Pair of gloves
- One clean razor blade or other cutting instrument, new and wrapped in its original paper (to cut the umbilical cord)
- Three pieces of umbilical tape (to tie the umbilical cord)
- Two pieces of cotton cloth (to dry and to use as a nappy)

Contextual only: ***Misoprostol tablets (600 mcg) and CHX for cord care***

NEWBORN KIT

- Baby blanket, 50x75 cm,
- Polyester fleece
- Newborn cap, cotton
- Newborn romper suit, cotton
- Baby socks, size extra small
- Small, cotton towel

Contextual only: ***Chlorhexidine digluconate gel, 7.1% (delivering 4% base), 10cc; Tetracyline hydrochloride 1% (for eye care)***

Clean delivery kit packages and supplies for community-level distribution can be ordered through Inter-Agency Reproductive Health Kit procurement process. Because these materials are often easily obtained locally and do not expire, it is possible to assemble these packages onsite and pre-stock 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.

PROGRAMMATIC EXAMPLE 3.3: MISP IMPLEMENTATION IN TANZANIA

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Tanzania

INTRODUCTION: During a humanitarian crisis, women and children are often most affected, as was reflected among the Burundian population in Tanzania's Nyarugusu refugee camp. In mid-May 2015 thousands of Burundian refugees fled the civil unrest in Burundi and sought refuge in Tanzania's Nyarugusu camp which was originally built for a population of 50,000 but exceeded 100,000 by October 2015. There were critical SRH needs among women and girls arriving in the camp and a high demand for services.

PROJECT DESCRIPTION: In July 2015, the IRC's Emergency Preparedness Response Unit (EPRU) deployed an Emergency Reproductive Health Coordinator from their Emergency Response Team who, together with Tanzania country health programs, worked closely with the Tanzania Red Cross Society and other local health actors to launch the MISP for RH services in the camp.

RESULTS: The IRC established two fully functioning emergency reproductive health clinics and a maternity unit and filled staffing gaps in the clinics to ensure 24/7 access to RH services with an efficient medical referral system in place. RH Kits were then shipped from IRC's pre-positioned stock in Amsterdam to supply project sites with commodities and medicines. Urgent RH services to the displaced Burundian population were established with in-service clinical refresher training for staff. Community Health Workers were identified to raise community awareness of priority RH needs and available RH services. Results showed 64 new clients per week for family planning; 15 clients per month for management of abortion; an average of 3 survivors of sexual assault per week received clinical care; and an average of 215 deliveries were conducted per month in the maternity unit.

LESSONS LEARNED: The IRC's experience in Nyarugusu Camp demonstrates that sound investments in disaster preparedness such as dedicated staff to lead MISP implementation and pre-positioned SRH supplies can set the foundation for successful MISP implementation and effectively address the SRH needs of a crisis-affected population. Capacity-building and on-the-job training for health staff helped to build service quality and facilitated scale-up to comprehensive RH while community health workers worked with the community to generate increased awareness of and demand for SRH services.

3.3.5 Prevent unintended pregnancies

At the onset of an emergency, it is important to ensure contraceptives are available to prevent unintended pregnancy. The SRH Coordinator, health program managers, and service providers must work to:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
- Provide information, including information, education, and communication (IEC) materials, and, as soon as possible, ensure contraceptive counseling that emphasizes informed choice, effectiveness, and supports client privacy and confidentiality
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

ENSURE AVAILABILITY OF A RANGE OF LONG-ACTING REVERSIBLE AND SHORT-ACTING CONTRACEPTIVE METHODS (INCLUDING MALE AND FEMALE CONDOMS AND EMERGENCY CONTRACEPTION) AT PRIMARY HEALTH CARE FACILITIES TO MEET DEMAND

- A range of oral contraceptive pills, hormonal injectables and implants, IUDs, male and female condoms, and emergency contraceptive pills should be made available immediately to meet demand in the affected population where providers are trained and skilled to provide, and in the case of long-acting reversible contraceptive, remove the method
- Providers with existing competency should begin providing all 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 or parent

- Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection against STIs and HIV and pregnacy. Protection against pregnancy and STIs/HIV makes this "dual protection"
- Emergency contraception 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

PROVIDE INFORMATION, INCLUDING EXISTING IEC MATERIALS, AND CONTRACEPTIVE COUNSELING THAT EMPHASIZES INFORMED CHOICE AND CONSENT, EFFECTIVENESS, CLIENT PRIVACY AND CONFIDENTIALITY, EQUITY, AND NON-DISCRIMINATION

- Providers should ensure quality of care that emphasizes clients' confidentiality and privacy, clients' voluntary and informed choice and consent, method eligibility, effectiveness, possible side effects management, follow-up, and guidance on method removal as appropriate for women of all ages, including adolescent girls

ENSURE THE COMMUNITY IS AWARE OF THE AVAILABILITY OF CONTRACEPTIVES FOR WOMEN, ADOLESCENTS, AND MEN

- Ensure the community is aware of where and how to seek access to contraception, including unmarried and adolescent community members. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms and pictures)
- Engage community leaders to disseminate information about availability of contraceptive services

PROGRAMMATIC EXAMPLE 3.4: MISP IMPLEMENTATION IN NIGERIA

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Nigeria

INTRODUCTION: Boko Haram violence has forced some 1.82 million people from their home in Northeast Nigeria. As the uprooted continued to flee, internally displaced persons (IDP) camps and host communities swelled in Borno State. Health facilities in formal IDP camps and informal camps run by the Federal Ministry of Health were ill-equipped and lacking trained medical staff. Health services, including sexual and reproductive health, were almost non-existent in Maiduguri where health facilities had never recovered from Boko Haram insurgency, placing women and girls at increased risk of life-threatening health problems.

PROJECT DESCRIPTION: To respond to the health needs of women and girls specifically, the IRC Emergency Response Team deployed its RH Coordinator in August of 2016. The RH Coordinator worked work with her team to launch the MISP in the newly liberated government areas in Borno State, Nigeria.

RESULTS: The IRC conducted a situation analysis of existing structures and gaps, which informed the strategy and work plan. The IRC recruited midwives and skilled staff to augment and support existing Ministry of Health providers. RH Kits were ordered and delivered including SRH equipment, medications, contraceptives, and supplies for 6 months. The RH Coordinator also conducted on-the-job training for providers to provide clinical care for sexual violence, contraception, and post-abortion care. The IRC supported a total of 5 clinics, including 4 satellite clinics providing basic SRH and referrals. Within 4 weeks, the IRC set up the only reproductive health clinic in Bakassi IDP camp, providing antenatal and family planning services – seeing 134 new contraception acceptors within the first month. The clinic also provided basic primary healthcare services and emergency delivery services. In addition, the team set up SRH programming in multiple informal camp facilities led by the Federal Ministry of Health, offering antenatal consultations and SRH supplies to women and girls.

LESSONS LEARNED: The IRC's experience in Nigeria demonstrates that emergency responders must anticipate a low number of skilled health staff available, long lead times for procurement and recruitment, and low priority placed on SRH. To fill these gaps, responders must budget for more skilled staff including procurement staff, and prepare data and evidence to share with local authorities and in the health cluster to prioritize RH.

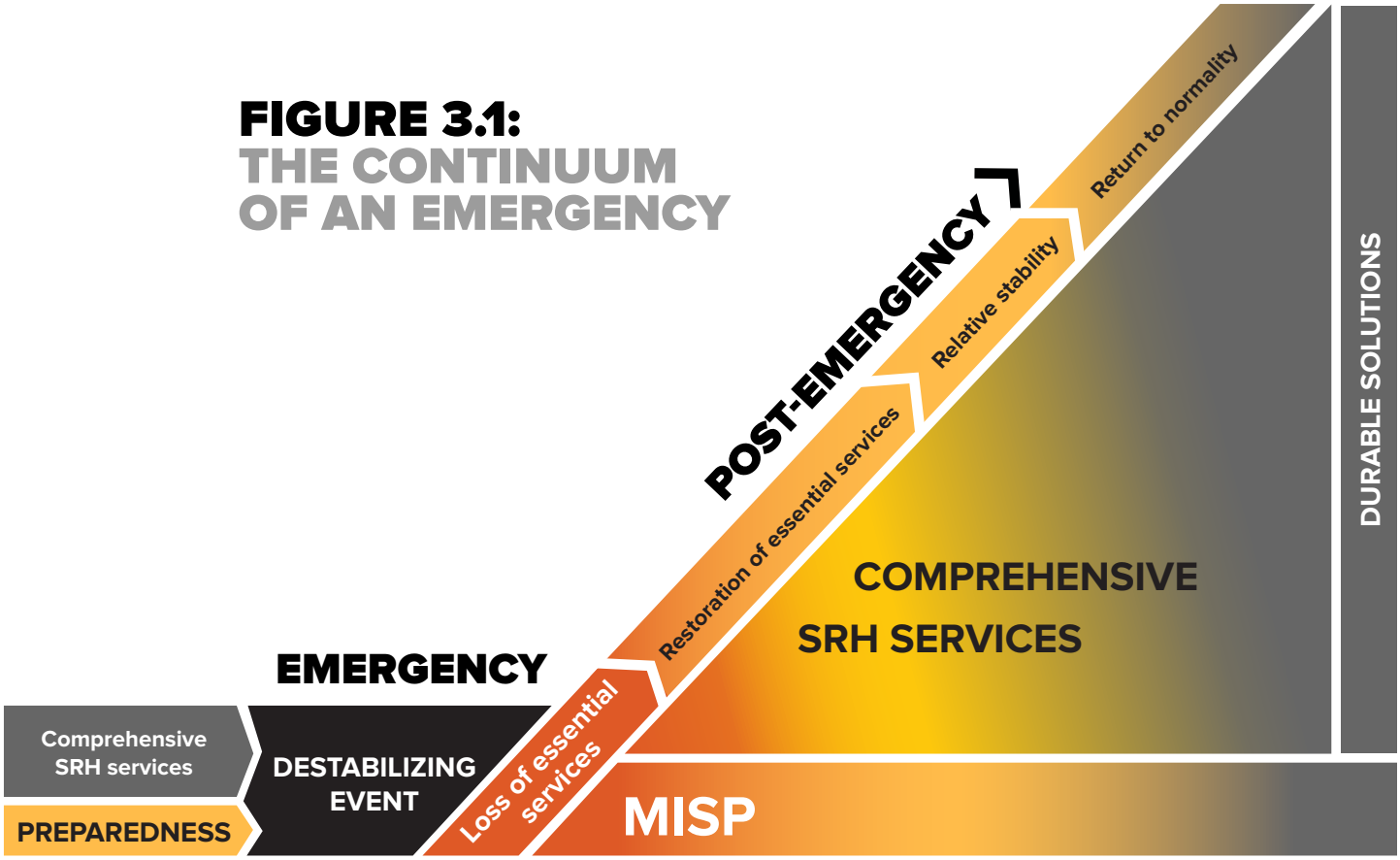
3.3.6 Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks.

The MISP is designed to form the starting point for SRH programming. It was developed based on well-documented evidence of SRH needs in humanitarian settings, and therefore, the four "clinical service delivery" components of the MISP (prevent and manage the consequences of sexual violence, prevent and respond to HIV, prevent excess maternal and newborn morbidity and mortality, and prevent unintended pregnancy) can be put in place without an in-depth SRH needs assessment among the affected population. Even in settings where other service components of SRH are provided, such as an antenatal care or safe abortion care, it is important to ensure that the MISP objectives are also implemented, as they are high priority actions.

When planning for the delivery of comprehensive SRH, the clinical services put in place as part of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction. After the situation stabilizes and while preparing for comprehensive SRH services, plan to obtain input from the community on the initial response in order to identify gaps, successes, and avenues for improvement.

The implementation of the MISP not only entails coordination to make life-saving clinical 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. To fully achieve Objective 6 of the MISP and support local and international stakeholders in planning for the delivery of comprehensive SRH services, several critical aspects need to be considered. These include:

FIGURE 3.1:
THE CONTINUUM OF AN EMERGENCY



NOTE: Crises seldom take a linear, clear-cut path from emergency, stability, recovery to development. Often, they are complex, with settings experiencing varying degrees of improvement or deterioration that can last decades. The provision of RH services must therefore take into account the non-linear trajectory of a crisis, and the gaps in services due to insecurity, competing priorities or swindling funds in protracted settings. The IAFM is applicable for all settings, wherever an agency finds itself on the emergency continuum.

- Communication among decision-makers (including national governments) and implementing partners
- Adequate financing
- Effective coordination
- Supply chain management
- Human resources management
- Monitoring and evaluation
- System of information sharing, feedback, and accountability to the affected community
- Planning an exit strategy for humanitarian partners

WHEN

Start planning for the integration of comprehensive SRH 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 unintended pregnancies, the transmission of STIs, complications arising from GBV, and maternal and newborn morbidity and mortality.

HOW

Catalyze participatory planning among national stakeholders and national and international partners as soon as the MISP indicators are reached and when humanitarian appeals processes and agencies begin longer-term planning processes. The objective of the participatory planning process is to integrate comprehensive SRH into national health system reconstruction efforts through a collective work plan for comprehensive SRH. Ensure that comprehensive service components are integrated into longer-term funding and planning processes.

WHAT

Table 3.6 shows examples of what should be assessed and planned for each of the WHO Health System Building Blocks.

TABLE 3.6: HEALTH SYSTEM BUILDING BLOCKS

HEALTH SYSTEMS BUILDING BLOCK	WHEN PLANNING FOR COMPREHENSIVE SRH SERVICES, COLLABORATE WITH ALL STAKEHOLDERS TO
Service delivery	• Identify SRH needs in the community • Identify suitable sites for SRH service delivery
Health workforce	• Assess staff capacity • Identify staffing needs and levels • Design and plan staff training
Health information system	• Include SRH information in the health information system
Medical commodities	• Identify SRH commodity needs • Strengthen SRH commodity supply lines
Financing	• Identify SRH financing possibilities
Governance and leadership	• Review SRH-related laws, policies, protocols • Coordinate with MOH • Engage communities in accountability

Service delivery

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

- Feasibility of communications and transport for referrals
- Distance to other health services
- Ease of accessibility for the affected population and the target group
- Possible integration with other services versus stand-alone services

Health work force

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 organizations and take into consideration existing curricula. Training health workers on patients' rights and the provision of unbiased, equitable care is critical. Where possible, use national trainers. Plan training sessions carefully, in order to prevent staffing gaps at health facilities, and provide adequate support so health workers can do their jobs effectively.

Health Information System

In order to move beyond the MISP 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.

- Address relevant MOH policies and protocols for standardized care, such as STI syndromic management, family planning protocols, and laws and regulations surrounding safe abortion care
- Build upon estimated demographic data to collect more specific SRH information of the affected population, such as:
  - Number of women of reproductive age (aged 15 to 49) estimated at 25% of the population, number of sexually active men estimated at 20% of the population, and the crude birth rate estimated at 4% of the total population
  - Age- and sex-specific mortality data. For example, the number of deaths in adolescent (15-19) year old girls, newborn mortality rate (number of deaths during the first 28 completed days of life per 1,000 live births in a given period), and existing background data on maternal mortality
  - STI and HIV prevalence, contraceptive prevalence and preferred methods, prevalence of unsafe abortion, and SRH knowledge, attitudes and behaviors of the affected population

Medical commodities

Once basic SRH services are established, work with health authorities and through the health sector/cluster to analyze the situation, estimate the use of medicines and disposable supplies, assess the SRH needs of the population, and reorder supplies as needed. Avoid continual ordering of the pre-packaged Inter-Agency Reproductive Health Kits to avoid incurring costs and wastage. Ordering SRH supplies based on demand will ensure the sustainability of the SRH program and avoid shortage of particular supplies and the wasting of others not typically used in the setting. Place follow-up orders for SRH supplies through regular medical supply lines in-country. Also consider procurement channels used by NGOs or through UNFPA's Procurement Services Branch.

When ordering supplies for the provision of comprehensive SRH services, coordinate SRH commodity management with health authorities and the health sector/cluster in order to ensure uninterrupted access to SRH services. Consider the following:

- Hire staff trained in supply chain management
- Estimate monthly consumption and utilization of SRH medicines and other consumables
- Identify medical supply channels. Investigate the quality of local supply channels. If this is inadequate, obtain SRH commodities through recognized global suppliers or with support from UNFPA, the United

Nations Children's Fund (UNICEF), or WHO. These agencies can facilitate the purchase of bulk quantities of high-quality SRH supplies at lower costs

- Place timely orders through identified supply lines based on estimates in order to avoid stock-outs
- Store the supplies as close to the target population as possible

BOX 3.16: DEFINITION OF HEALTH FINANCING SYSTEM

The WHO defines a good health financing system as one that "raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them," and that incentivizes both providers and users to be efficient.

Financing

Even as agencies implement an initial response to a crisis, they must consider longer-term financing mechanisms to ensure ongoing access to affordable, high-quality, comprehensive SRH care. A good health financing system is a critical building block in the effort to sustain comprehensive SRH care. Several financing options exist, including:

- 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 healthcare workers
- Social marketing and franchising

While a systematic review of financing mechanisms for contraception found that the evidence base was not yet robust enough to make strong recommendations, a variety of promising efforts are underway. For example, UNHCR has started 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 costs of maternal healthcare. UNHCR has had further success in integrating displaced populations into the national insurance structure of the country in which they are residing.

Governance and Leadership

Leadership and governance for SRH integrated into health systems strengthening can be driven from international, national, and community levels. International actors can assist by working with and leveraging development and humanitarian actors to identify where existing policies, guidelines, and protocols do not support SRH and rights or meet international standards and collectively work with governments to address them. All actors can advocate and support national leadership to implement a coherent, harmonized, and realistic health system strengthening (HSS) plan to address excess SRH-related morbidity and mortality. In addition, communities themselves should be engaged to develop demand and accountability mechanisms for quality SRH services.

- International, national, and local actors should advocate with governments to recognize the full range of SRH and rights gaps in policies and protocols and to mobilize resources to invest in SRH
- Communities understand their rights and participate in the design and implementation of SRH services, create demand and enforce accountability
- Resources should be provided to set up effective means for affected individuals and communities to register complaints and seek remedies

3.3.7 Supplies to implement the MISP

To implement the service delivery components of the MISP, the Inter-agency Working Group on Reproductive Health in Crises designed a set of kits containing medicines and other commodities aimed at facilitating the implementation of these priority SRH services: the Inter-Agency Reproductive Health Kits (RH Kits). The RH Kits complement the Inter-Agency Emergency Health Kit (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. Although it contains a midwifery kit, progestin-only ECPs, PEP, and supplies for the adherence to standard precautions, the IEHK does not have all supplies needed to implement MISP services.

The RH Kits are designed for use at the onset of the humanitarian response, even in the most conflict-affected and resource-poor settings. Specifically, none of the equipment in the RH Kits depends on electricity. The supplies contained in the RH Kits are calculated to be sufficient for a three-month period for the population size covered by the health facility level targeted by each RH Kit.

Through 2018, the 13 RH Kits are divided into 3 sets; each set targets a different health service delivery level, with their respective population coverage:

- ***RH Kit 0:*** An administrative RH Kit containing office supplies to conduct meetings and training sessions. Meant for settings where such supplies cannot be obtained from the local market
- ***RH Kits 1 to 5:*** Community and primary health care level: Health facility coverage for 10,000 persons/supplies for 3 months
    - o This set contains 6 RH Kits intended for use by service providers delivering SRH care at the community and primary health care level
    - o The RH Kits contain mainly medicines and disposable items
    - o RH Kits 1 and 2 are subdivided into parts A and B, which can be ordered separately
- ***RH Kits 6 to 10:*** Primary health care and referral hospital level: Health facility coverage for 30,000 persons/supplies for three months
    - o The items in these 5 RH Kits are intended for use by trained health providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level
    - o These RH Kits contain disposable and reusable materials
    - o RH Kit 6 has subparts A and B, which can be ordered separately
- ***RH Kits 11 and 12:*** Referral hospital level: Health facility coverage for 150,000 persons/supplies for 3 months
    - o In humanitarian settings, hospitals may require additional equipment and supplies as a result of the increased caseload from the crisis-affected population
    - o Two RH Kits are available for this purpose that contain disposable and reusable supplies to provide comprehensive EmONC at the referral (surgical obstetrics) level
    - o RH Kit 11 has subparts A and B, which are usually used together but that can be ordered separately

RH KIT PROCUREMENT AND LOGISTICS

UNFPA is in charge of assembling and delivering the Inter-Agency RH Kits. Order 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 SRH services. Agencies should not be dependent on one source for supplies and should include SRH commodities in their overall medical supply procurement.

When planning to order RH Kits, it is essential to coordinate with other partners in the health coordination structure and develop a plan for in-country distribution of the RH Kits. This plan outlines how many of each RH Kit go to which partner, and 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).

If you are unable to procure in country or redistribute pre-positioned supplies, you may need to import supplies. Be prepared to receive goods as soon as they arrive at the port of entry to the country and ensure that all relevant documents and forms for customs clearance have been prepared in advance to prevent unnecessary delays while importing the RH Kits. The logistics cluster, where it exists, may be able to help facilitate this.

Information on the RH Kits or assistance with ordering can be provided by: UNFPA field offices, UNFPA Procurement Services Branch (PSB), or UNFPA Humanitarian and Fragile Context Branch (HFCB).

BOX 3.17: INTER-AGENCY RH KIT POINTS OF CONTACT

ADDRESS	UNFPA country offices	UNFPA Humanitarian and Fragile Contexts Branch 605 Third Avenue New York, NY 10158, USA	UNFPA Humanitarian and Fragile Contexts Branch 11-13 chemin des Anémones 1219 Chatelaine, Geneva, Switzerland	UNFPA Procurement Services Branch Marmorvej 51, 2100 Copenhagen, Denmark
EMAIL		procurement@unfpa.org	procurement@unfpa.org	procurement@unfpa.org
WEBSITE	www.unfpa.org	www.unfpa.org		www.unfpaprocurement.org/order

TABLE 3.7: INTER-AGENCY REPRODUCTIVE HEALTH KITS

BLOCK 1		
RH Kit No.	***RH Kit Name***	***Color Code***
RH Kit 0	Administration	Orange
RH Kit 1A RH Kit 1B	Part A: Male condoms Part B: Female condoms	Red
RH Kit 2A RH Kit 2B	Part A: Clean delivery (Individual packages) Part B: Supplies for birth attendants	Dark Blue
RH Kit 3	Post-rape	Pink
RH Kit 4	Oral and injectable contraception	White
RH Kit 5	STI treatment	Turquoise
BLOCK 2		
RH Kit No.	***RH Kit name***	***Color Code***
RH Kit 6A RH Kit 6B	Delivery kit (Health facility) Part A: Reusable equipment Part B: Drugs and disposable equipment	Brown
RH Kit 7	IUD	Black
RH Kit 8	Management of complications of miscarriage and abortion	Yellow
RH Kit 9	Suture of tears (cervical and vaginal) and vaginal examination	Purple
RH Kit 10	Vacuum extraction delivery (manual)	Gray
BLOCK 3		
RH Kit No.	***RH Kit name***	***Color Code***
RH Kit 11A RH Kit 11B	Referral level (Part A plus B) RH Kit 11A RH Kit 11B	Fluorescent green
RH Kit 12	Blood transfusion	Dark green

In 2019, the structure and composition of the RH Kits will change (see Table 3.8).

TABLE 3.8: INTER-AGENCY REPRODUCTIVE HEALTH KITS (BEGINNING 2019)

OVERVIEW OF INTER-AGENCY REPRODUCTIVE HEALTH KITS TO SUPPORT IMPLEMENTATION OF THE MISP

Health Care Level	Kit Number	Kit Name
Community/Health Post	Kit 1 A	Male condoms
	Kit 2 A&B	Clean delivery (A – Mother, B – Birth Attendant)
	Kit 3	Post-rape treatment
	Kit 4	Oral and injectable contraceptives
	Kit 5	Treatment of sexually transmitted infections
Primary Health Care Facility (BEmONC)	Kit 6 A&B	Clinical delivery assistance – midwifery supplies (A – reusable, B - consumable)
	Kit 8	Management of complications of miscarriage or abortion
	Kit 9	Repair of cervical and vaginal tears
	Kit 10	Assisted delivery with vacuum extraction
Referral Hospital (CEmONC)	Kit 11 A&B	Obstetric surgery and severe obstetric complications kit (A – reusable and B - consumable)
	Kit 12	Blood transfusion

KEY

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.**

Primary health care facility level (BEmONC) **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 theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.**

Referral hospital level (CEmONC) **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.**

COMPLEMENTARY COMMODITIES:			
Level	**To complement**	**Item**	**Format**
Coordination	All Kits	Administration and training	Kit
Community/ Health Post	Kit 1A	Kit 1B - Female condoms	Kit
	Kit 2A	Chlorohexidine	Bulk
	Kit 2B	Misoprostol **	Bulk
	Kit 2A and 2B	UNICEF/Save the Children - Newborn care supply kit - community*	Kit
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)	Bulk
Primary Health Care Facility (BEmONC)	Kit 4	Kit 7A - Intrauterine device (IUD)	Kit
	Kit 4	Kit 7B - Contraceptive implant	Kit
	Kit 6A	Non-pneumatic anti-shock garment	Item
	Kit 6B	Oxytocin	Bulk
	Kit 6A & 6B	UNICEF/Save the Children - Newborn care supply kit - primary health facility*	Kit
	Kit 8	Mifepristone**	Bulk
	Kit 10	Hand-held vacuum assisted delivery system	Item
Referral Hospital (CEmONC)	11B	Interagency emergency health kit supplementary malaria module	Kit
	11A & 11B	UNICEF/Save the Children -Newborn care supply kit - *Hospita*)*	Kit

* At the time of printing this manual ***Newborn Care Supply Kits*** are not yet available
** Misoprostol can also be procured to complement Kit 6B and Kit 8 for the Primary Health Care Facility

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

Complimentary Commodities are disposable and consumable items that can be ordered under specific circumstances to complement the main kits:

- Where providers or the population are trained to use the commodity
- Where the supplies were accepted and used prior to the emergency
- Temporary, in protracted 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

Complimentary Commodities in KITS are procured based on the same catchment populations as the standard kits in that level.

Complimentary Commodities in BULK can be procured for a population of 10,000 or a multiple of 10,000 people.

Complimentary Commodities with specific agency names can be ordered through the respective organizations including:

- Interagency Emergency Health Kit Supplementary Malaria Module – WHO
- UNICEF/Save the Children Newborn Care Supply Kits – UNICEF*

Additionally, it is important to keep in mind that other pre-packaged emergency medical kits for various interventions (Non-Communicable Diseases (NCD), Cholera, Severe Acute Malnutrition (SAM), etc.) can be procured from other partner organizations or may have been brought in by health partners already.

3.3.8: Other sexual and reproductive health priorities

The SRH lead agency, the SRH Coordinator, implementers, and service providers should ensure that these services are available at the onset of a crisis when capacity already exists to offer them. When existing capacity is not present, these services should be made available once implementation of the MISP priority activities is underway, ideally within three months after the onset of an emergency, if not sooner. These services should be prioritized and must be advocated for and included when transitioning to comprehensive SRH services, based on their critical contribution to protecting the lives and dignity of women and girls.

SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW

Access to safe abortion care (SAC) to the full extent of the law should be facilitated from the onset of an emergency by direct service provision or referral to trained providers. 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. Programs should identify the conditions under which national policies, signed international agreements and international humanitarian and human rights law permit the provision of SAC.

Evidence demonstrates that access to safe abortion for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality. Global data indicate that unsafe abortion is present in countries where safe abortion care is not accessible to all women and girls and that 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 SAC for women who are raped in crises; international human rights law supports access to SAC across all settings.

In most settings safe abortion care is legally permissible for some or all reasons and capacity exists to provide and/or refer women to SAC services. If the woman chooses an abortion, health care workers should:

- Provide medically accurate information about abortion services in a form women 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 cost
- 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 WHO
- Provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method
- Consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of STIs

Supplies to support MVA and misoprostol alone for post-abortion care are included in the Inter-Agency RH Kit for managing complications of miscarriage and abortion. These supplies can also be used for safe abortion care. The mifepristone/misoprostol regimen is the global gold standard for medication abortion and should be provided in settings where mifepristone is registered and available. In 2019, mifepristone will be available in the RH Kits as a complementary commodity (see Table 3.2).

3.4 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 conflict situations, 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. Further, human rights law remains applicable during conflict and crisis situations and should be used to provide additional details on affirmative obligations of States and responders, including comprehensive sexual and reproductive health care for all.

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, by ensuring access to SRH services, including preventing HIV transmission, and access to female service providers. In addition, international refugee law requires that States treat refugees lawfully residing in their territory equal to 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 SRH care. The United Nations Committee on Economic, Social and Cultural Rights has instructed States, in response to an emergency, 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." In addition, the UN Committee on the Elimination of Discrimination Against Women (CEDAW) has clarified that in conflict and post-conflict situations, States must ensure the provision of "sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as fistula arising from sexual violence, complications of delivery or other reproductive health complications, among others."

Human rights bodies, particularly the Committee Against Torture and the Human Rights Committee, have also found that certain SRH violations, ranging from forced sterilization to denial of access to abortion services, may amount to torture or cruel, inhuman, or degrading treatment.

BOX 3.18: ADVOCACY

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

The MISP is:

- **An internationally recognized, universal minimum standard of disaster response**
- **A life-saving intervention and a Central Emergency Response Fund (CERF) minimum life-saving criterion eligible for CERF funding**
- **Integrated in the global health cluster guidance**

3.5 MONITORING AND EVALUATION

The SRH Coordinator implements the MISP checklist to monitor service provision in each humanitarian setting. In some cases, this may be done by verbal reporting from SRH managers and/or through observation visits. At the onset of the humanitarian response, weekly monitoring should be implemented. Once services are fully established an agreed upon, routine monitoring and evaluation should be put in place to determine progress towards quality MISP and comprehensive SRH services.

Discuss gaps and overlaps in service coverage within the SRH coordination meetings and at health sector/cluster coordination mechanisms to find and implement solutions.

FIGURE 3.2: SAMPLE MISP CHECKLIST

GEOGRAPHIC AREA:	REPORTING TIME PERIOD: _ _/ _ _/20 _ _ TO _ _/ _ _/ 20 _ _	START DATE OF HEALTH RESPONSE: _ _/ _ _/20 _ _	REPORTED BY:

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)		
	Local(WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH Working Group meetings	YES	NO
	Ministry of Health		
	UNFPA and other relevant UN agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
	Civil Society including marginalized (adolescents, persons with disabilities, LGBTQIA people)		
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensures mapping and vetting of existing SRH services		
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 (national host and/or affected population or estimated at 4% of the population)		
3. Prevent sexual violence and respond to the needs of survivors			
		YES	NO
3.1	Multi-sectoral 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, i.e., 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		
	Pregnancy test		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/Tetanus immunoglobulin		
	Hep B vaccine		
	Safe abortion care		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological, social support services		

3.4	Number of incidents of sexual violence reported to health services		
	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%		%
		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		
	People 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	ARVs available to continue treatment for people who were enrolled in ART 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 emergency obstetric and newborn care (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 service provider on duty per 20-30 inpatient beds for the obstetric wards		
	One team of doctor/nurse/midwife/anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care		
	Coverage of post-abortion care (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)		%
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		%
5.7	Number of caesarean deliveries/number of lives 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	Emergency contraception (progestin-only pills)		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine device		
6.8	Number of health facilities which maintain a minimum of 3 month's supply of each	NUMBER	
	Condoms		
	Emergency contraception (progestin-only pills)		
	Combined oral contraceptive pills		
	Progestin only contraceptive pills		
	Injectables		
	Implants		
	Intrauterine device		
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		
	Training(s) designed and planned		
7.3	Health information system	YES	NO
	SRH information included in health information system		
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, leadership	YES	NO
7.7	SRH-related laws, policies, and protocols reviewed		

8. Other priority activity: Safe abortion care		
8.1	Coverage of safe abortion care (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.

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

3.6 FURTHER READING AND ADDITIONAL RESOURCES

ESSENTIAL MISP READINGS

IAWG. (2010). MISP Advocacy 2-pager: *What is the MISP? Why is it Important?* Retrieved from: http://iawg.net/wp-content/uploads/2016/07/MISP-Advocacy-Sheet-IAWG-FINAL-Nov09.pdf

International Planned Parenthood Federation. (2007, August). *MISP Cheat Sheet*. Retrieved from: http://iawg.net/wp-content/uploads/2015/09/MISP-cheat-sheet-rev.04-2010.pdf

Save the Children, & UNICEF. (2018). *Newborn Health in Humanitarian Settings: Field Guide*. Retrieved from: http://iawg.net/resource/newborn-health-humanitarian-settings/

UNFPA, & IAWG. (2011). *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed.). Retrieved from: http://iawg.net/wp-content/uploads/2016/07/interagency-reproductive-health-kits-for-crisis-situations-english.pdf

UNFPA, & Save the Children. (2013). *Adolescent Sexual and Reproductive Health in Humanitarian Settings: One hour interactive e-learning course*. Retrieved from: http://iawg.net/resource/e-learning-course-adolescent-srh-humanitarian-settings/

Women's Refugee Commission. (2011). *Minimum Initial Service Package (MISP) for Reproductive Health: A Distance Learning Module*. Retrieved from: http://iawg.net/minimum-initial-service-package/

Women's Refugee Commission. (2012). *Universal & Adaptable Information, Education & Communication (IEC) Templates on the MISP*. Retrieved from: http://iawg.net/resource/universal-adaptable-information-education-communication-iec-templates-misp/

Women's Refugee Commission. (2016). *MISP Calculator: Calculates the Reproductive Health Statistics Necessary for the Implementation of the MISP*. Retrieved from: http://iawg.net/resource/misp-rh-kit-calculators/

PREVENTION OF AND RESPONSE TO SEXUAL VIOLENCE

ICEC. (2013). *Regimen Update: Timing and Dosage of Levonorgestrel-alone Emergency Contraceptive Pills*. Retrieved from: http://www.cecinfo.org/custom-content/uploads/2013/01/ICEC_LNG-ECP-Regimen-Update_Jan-2013.pdf

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

IAWG Training Partnership Initiative, & Women's Refugee Commission. (2017). *Clinical Management of Sexual Violence Survivors, Facilitator's Guide*. Retrieved from: https://iawg.net/wp-content/uploads/2017/08/CMoRS-2017-FINAL.pdf

WHO, UNFPA, & UNHCR. (2004). *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons*. Retrieved from: http://apps.who.int/iris/bitstream/10665/43117/1/924159263X.pdf

WHO, UNHCR, & UNFPA. (2009). *Clinical Management of Rape Survivors e-learning Tool*. Retrieved from: http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/

PREVENTION AND RESPONSE TO HIV

EngenderHealth. (2011). *Infection Prevention: A Reference Booklet for Health Care Providers* (2nd ed.). New York, NY. Retrieved from: https://www.engenderhealth.org/pubs/quality/infection-prevention.php

IASC. (2010). *Guidelines for Addressing HIV in Humanitarian Settings*. Retrieved from: http://www.unaids.org/sites/default/files/media_asset/jc1767_iasc_doc_en_0.pdf

Interagency Task Team HIV in Humanitarian Emergencies. (2015). *Prevention of Mother-to-Child Transmission (PMTCT) in Humanitarian Settings: Part II Implementation Guide*. Retrieved from: https://www.childrenandaids.org/sites/default/files/2017-04/IATT_Part-2-PMTCT-in-Humanitarian-Settings_2015_0.pdf

WHO. (n.d.). *Blood Transfusion Safety*. Retrieved from: http://www.who.int/bloodsafety/en/

EMERGENCY OBSTETRIC AND NEWBORN CARE

IAWG Training Partnership Initiative. (2017). *Clinical Refresher Trainings: Assisted Vaginal Delivery via Vacuum Extraction; Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration*; and, *Basic Emergency Obstetric and Newborn Care in Humanitarian Settings: Select Signal Functions*. Retrieved from: http://iawg.net/tpi-home/resources/

Save the Children, & UNICEF. (2018). *Newborn Health in Humanitarian Settings: Field Guide*. Retrieved from: http://iawg.net/resource/newborn-health-humanitarian-settings/

WHO. (2011). *Guidelines on Optimal Feeding of Low Birth-Weight Infants in Low- and Middle-Income Countries*. Retrieved from: http://www.who.int/maternal_child_adolescent/documents/9789241548366.pdf?ua=1

WHO. (2012). *Guidelines on Basic Newborn Resuscitation*. Retrieved from: http://apps.who.int/iris/bitstream/10665/75157/1/9789241503693_eng.pdf?ua=1

CONTRACEPTION

WHO. (2015). *Medical Eligibility Criteria Wheel for Contraceptive Use*. Retrieved from: http://www.who.int/reproductivehealth/publications/family_planning/mec-wheel-5th/en/

WHO. (2016). *Selected Practice Recommendations for Contraceptive Use* (3rd ed.). Retrieved from: http://apps.who.int/iris/bitstream/10665/252267/1/9789241565400-eng.pdf?ua=1

WHO. (2018). *Family Planning: A Global Handbook for Providers*. Retrieved from: http://www.fphandbook.org/

TRANSITIONING FROM THE MISP TO COMPREHENSIVE SRH

WHO, UNPFA, Escuela Andaluza de Salud Pública (2011). *Sexual and Reproductive Health during Protracted Crises and Recovery: Granada Report*. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/70762/WHO_HAC_BRO_2011.2_eng.pdf;jsessionid=D814E1C0963906CA5EC212E3BE48535F?sequence=1

SAFE ABORTION CARE

WHO. (2015). *Safe Abortion: Technical & Policy Guidance for Health Systems*. Retrieved from: http://apps.who.int/iris/bitstream/10665/173586/1/WHO_RHR_15.04_eng.pdf?ua=1

OTHER

WHO. (2011). *WHO Compendium of Innovative Health Technologies for Low-Resource Settings*. Retrieved from: http://www.who.int/medical_devices/innovation/compendium/en/