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

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

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

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

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

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

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

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

Prevent excess maternal and newborn morbidity and mortality by:

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

Prevent unintended pregnancies by:

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

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

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

Other Priority

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

APPENDIX B: MISP FOR SRH MONITORING CHECKLIST

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

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

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

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

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

7.2	Health workforce	Yes	No
	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		

8. Other Priority Activity: SAC to the Full Extent of the Law

8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	

9. Special Notes

10. Further Comments

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

11. Actions (For the "No" Checks, Explain Barriers and Proposed Activities to Resolve Them.)

Number	Barrier	Proposed solution

APPENDIX C: MISP FOR SRH CALCULATOR

To access the MISP for SRH Calculator, visit:
http://iawg.net/resource/misp-rh-kit-calculators/.

MISP Calculator (2019) Guidance Note

What is the MISP calculator?

At the very onset of an acute humanitarian emergency, data on the affected population can range significantly depending on the quality of the information available before the emergency and based on the known demographic mix of the target population. The Minimum Initial Services Package for SRH in Humanitarian Settings (MISP) Calculator is a tool that can help coordinators and programme managers determine affected population demographics for advocacy, fundraising and programming at the very onset of an emergency.

The MISP calculator ONLY requires from the user affected population numbers. The MISP calculator works by automatically providing the user with a simple way to access the 'best available data' for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population.

How to use the MISP Calculator?

1. Click on the tab 'MISP calculator'
2. Select the country of origin of the target population (This may be different for IDPs, refugees, or host population)
3. Select the national or subnational level of the target population (in some settings you may be able to choose from provincial or municipal level)
4. Enter the number of persons affected
5. OPTIONAL: Enter any site specific information that you may have
6. Data will be calculated for MISP-related indicators including maternal and newborn health, contraceptives, sexual violence, HIV and other STIs
7. Click on the 'Visualizations' tab to see basic graphics on your data that can be used/ adapted for advocacy and fundraising

How is this version of the MISP Calculator (2019) different from previous versions?

This version of the MISP calculator has four major differences compared to previous versions.

1. The indicators provided are updated based on the revised MISP (2018).
2. There is a new functionality to allow for country specific data (if it exists) on the affected population to override the global constants if no site specific information is available.
3. There is now a basic visualization of the data that can be used for advocacy purposes.
4. The user should re-download the excel based tool every few months as UNFPA data branch will continuously update the national and sub-national data available for the tool to pull from.

What data will I recieve from the MISP Calculator?

The MISP calculator works by automatically providing the user with a simple way to access the “best available data” for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. If there is national- or subnational-specific data, the online tool will automatically replace the global constants with the ‘best available data’ (based on available census, survey and other relevant data sources) at the applicable level of administrative boundary (i.e. country, region, province, or municipality). The source of this information can be found in the “sources” box of the tool.

Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population in the green boxes. This data will overwrite global constants and national- or subnational-specific data and replace it as the ‘best available data’.

What will the MISP Calculator not provide me?

The MISP encompasses a minimum set of lifesaving SRH interventions that must be available from the very onset of every humanitarian emergency and expanded on as soon as the situation allows. The MISP calculator is designed for use at the onset of an emergency where funding, advocacy and programming is targeted at providing the MISP interventions. It is important to remember that the MISP includes the minimum essential services, not the only services that should be provided to affected populations. As soon as possible it is essential to expand on the MISP to a more context specific, comprehensive, SRH response. The MISP calculator will not provide all of the information on indicators beyond those included in the MISP for this component of the response.

The MISP calculator is designed to be a supportive tool to help SRH coordinators and programme managers in the earliest phases of an emergency. It will never be 100% accurate

or the only programmatic guideline to base all decisions off of. The calculator outputs should be analyzed by SRH coordinators and programme managers together to take decisions about their response. Coordinators and programme managers need to think about their target populations and how the characteristics of that population may limit the applicability of the data provided in the MISP calculator. It is particularly important to consider how the emergency may have impacted demographics or changed pre-crisis data.

If there are multiple target populations for the programme (e.g. refugee populations and host population) keep in mind you may need to work with the MISP calculator separately for each population as their indicators may differ significantly. Additionally, it is important to remember that some affected populations around the world are left out of national data collection for political or social reasons; if these groups are included in your programme consider the limitations of the data and make adjustments accordingly.

Where does the national or subnational data come from and who updates it?

The national or subnational data comes from different sources depending on the context. It can come from available census, survey or other data collected by various national or international statistical collection agencies. The source and year of the data is always indicated on the top of the calculator when you choose a country and/or region. The United Nations Population Fund (UNFPA) Population and Data Branch is continuously updating the information that the tool pulls data from; it is important for the user to re-download the tool every few months or for each new response to ensure that you are getting the most updated information available.

Where do the global constants come from and who updates it?

The global constants are determined based on an expert group assessment of low- and middle-income countries and/or humanitarian and fragile countries' averages. For more information, please contact the UNFPA Humanitarian Office.

Who can help me use the tool or answer any other questions that I have?

UNFPA Humanitarian Office and the UNFPA Population and Development Branch conducted a webinar on how to use the tool which can be found which can be found on UNFPA's website.

Depending on the country you are operating in, the UNFPA regional humanitarian adivsor can provide support on the use of the MISP calculator. Additionally please feel free to reach out to Humanitarian-SRHSupplies@unfpa.org for support from global UNFPA Humanitarian Office colleagues.

MISP calculator

Information can be overwritten manually in all green fields
No country specific data can be provided, if possible, provide site specific estimates, otherwise global constants are used
No data avialable -

For more information on the functionality of the MISP calculator, please refer to the Guidance note.

Country	Syria
Region	Aleppo Governorate
Province	
Municipality	
Affected population	500,000

Region/Province/Municipality incorrectly selected, please revise

Sources

United Nations Population Division - World Population Prospect: 2017 Revision

UN Population Division - World Contraceptive Use 2018
Global Burden of Disease Study 2017 (GBD 2017) Results
UN AIDS - AIDS Info - 2018 Estimates
United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 2018.
Trends in Maternal Mortality: 1990 to 2015, WHO, UNICEF, UNFPA, World Bank Group, UNFPA, 2015

Center for Reproductive Rights, The World's Abortion Laws, 2019

Basic statistics	Global constants	Country data	Site specific data	Best available data
Percentage of women of reproductive age (WRA)	26%	25%		25%
Percentage of adult population (18+)	63%	58%		58%
Percentage of young adolescent girls (10-14)	5%	6%		6%
Percentage of all adolescent girls (10-19)	9%	12%		12%
Percentage of adolescents (10-19)	19%	25%		25%
Percentage of adult men (18+)	31%	29%		29%
Crude birth rate (per 1,000 population)	23.9	20		20
STI prevalence	5%	3%		3%
Neonatal mortality rate (deaths per 1,000 live births)	-	8.7		8.7
Maternal mortality ratio (deaths per 100,000				

Basic statistics	Estimates based on global	Country estimates	Site specific estimates	Best available estimates	Units
Number of women of reproductive age (WRA)	127,500	125,000	-	125,000	Women of reproductive age
Number of adult population (18+)	313,150	287,885	-	287,885	Adults
Number of young adolescent girls (10-14)	24,350	30,000	-	30,000	Young adolescent girls (10-14)
Number of all adolescent girls (10-19)	47,150	60,000	-	60,000	Adolescent girls (10-19)
Number of adolescents (10-19)	97,250	125,000	-	125,000	Adolescents (10-19)
Number of adult men (18+)	157,350	145,000	-	145,000	Adult men
Number of live births in the next 12 months	11,950	10,100	-	10,100	Live births in the next 12 months
Number of live births in the next month	996	842	-	842	Live births in the next month
Number of currently pregnant women	8,963	7,575	-	7,575	Currently pregnant women
Number of adults living with an STI	13,905	8,949	-	8,949	Adults living with an STI

Maternal and newborn health	Global constants (default)	Country data	Site specific data	Best available data	Best available next 3 months	Best available next month	Units
Number of pregnancies that end in miscarriage or unsafe abortion (estimated as an additional percentage of live births)	15%			15%	379	126	Pregnancies that end in miscarriage or unsafe abortion
Number of still births	2%			2%	58	19	Stillbirths
Number of currently pregnant women who will experience complications	15%			15%	379	126	Currently pregnant women who will experience complications
Number of newborns who will experience complications	20%			20%	505	168	Newborns who will experience complications
Number of newborns weighing less than 2,500 g	5%	-		5%	126	42	Babies who will weigh less than 2,500 g at birth
Number of currently pregnant women who will have access and be able to give birth in a health center	15%			15%	379	126	Currently pregnant women who will have access and be able to give birth in a health center
Number of currently pregnant women delivering who will need suturing of vaginal tears	15%			15%	379	126	Currently pregnant women who will need suturing of vaginal tears
Number of deliveries requiring a C-section (Min/Max)	5% ##			5% 15%	126/379	260/779	Deliveries requiring a C-section
Number of maternal deaths averted if MISP is fully implemented and all pregnant women have access to EmOC services	100%			100%	2	1	Maternal deaths averted

Access to Sexual and Reproductive Health	Global	Country data	Site specific	Best available data	Best available	Units
Number of sexually active men in the population	20%			20%	100,000	Sexually active men
Number of sexually active men who use condoms	20%			20%	20,000	Sexually active men who use condoms
Number of WRA who use modern contraceptiv	15%	45%		45%	56,000	WRA who use modern contraceptives
Number of WRA who use female condoms	1%	-		9.0%	11,200	WRA who use female condoms
Number of WRA who use an implant	3%	-		9%	11,200	WRA who use an implant
Number of WRA who use combined oral contraceptive pills	5%	-		13%	16,800	WRA who use combined oral contraceptive pills
Number of WRA who use injectable contraception	8%	-		25%	30,800	WRA who use injectable contraception
Number of WRA who use an IUD	1%	-		2%	2,800	WRA who use an IUD
Number of people living with HIV	-	-		-	-	People living with HIV
Number of people living with HIV, receiving ART	-	-		-	-	People living with HIV, receiving ART
Number of people who will seek care for STI syndroms	3%			3%	7,917	People seeking care for STI syndroms
Number of cases of sexual violence who will seek care	2%			2%	2,500	Number of cases of sexual violence who will seek care
Status of abortion legislation	To save the woman's life				Status of abortion	To save the woman's life
Safe induced abortion rate	-		2%	2%	2,750	Abortions per 1,000 women of reproductive age

APPENDIX D: SAMPLE PROJECT PROPOSAL

This sample project proposal is for an NGO to submit to governments, United Nations agencies, such as UNFPA and UNHCR, or other donors.

PROJECT TITLE	Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)
ORGANIZATION	[Description of the organization and its work, including SRH activities, in the region]
BRIEF BACKGROUND, REASON FOR PROJECT AND PROBLEM TO BE ADDRESSED	The MISP for SRH will save lives if implemented at the onset of an emergency. Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy, such as unsafe abortion; and preventable cases of sexual violence and their consequences, such as unintended pregnancies, increased acquisition of sexually transmitted infections (STIs), increased transmission of human immunodeficiency virus (HIV), and ongoing mental health problems, including depression. The MISP for SRH is a set of priority activities designed to prevent sexual violence and respond to the needs of survivors; prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs; prevent excess maternal and newborn morbidity and mortality; prevent unintended pregnancies; and plan for comprehensive SRH services integrated into primary health care. Another priority activity of the MISP for SRH includes ensuring that safe abortion care to the full extent of the law is provided. The MISP for SRH can be implemented without an in-depth needs assessment because documented evidence already justifies its use and it represents the minimum SRH services to be provided during emergencies. The components of the MISP for SRH form a minimum requirement and it is expected that comprehensive SRH services will be provided as soon as the situation allows. The priority activities of the MISP for SRH are included in the 2018 revision of the Sphere Guidelines within the standards on SRH: “Standard 2.3.1 Reproductive maternal and newborn health care,” “Standard 2.3.2 Sexual violence and clinical management of rape,” and “Standard 2.3.3 HIV.”* An SRH lead agency with a designated SRH Coordinator is essential to ensuring coordination of MISP for SRH activities within the health sector/cluster. Under the auspices of the overall health coordination framework, the SRH Coordinator should be the focal point for SRH services and provide technical advice and assistance on SRH; liaise with national and regional authorities of the host country; liaise with other sectors to ensure a multisectoral approach to SRH; identify standard protocols for SRH that are fully integrated with primary health care, as well as simple forms for monitoring SRH activities; and report regularly to the health sector/cluster. [Insert brief background on emergency situation.]

OBJECTIVES

1. Identify lead SRH organization and individuals to facilitate the coordination and implementation of the MISP for SRH.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive SRH services, integrated into primary health care as the situation permits.

Other priority: It is also important to ensure safe abortion care to the full extent of the law.

ACTIVITIES

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

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP for SRH
- Reports back to the health, gender-based violence (GBV) sub-cluster/sector, and/or HIV national coordination meetings on any issues related to MISP for SRH implementation
- In tandem with health/ GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of SRH services

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

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

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

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population prior to the crisis), ensure provision of female condoms
- Support the provision of antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission programs

- Provide post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

Prevent excess maternal and newborn morbidity and mortality:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services, including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC)
  - At health facility level: Skilled birth attendants and supplies for uncomplicated vaginal births and provision of basic emergency obstetric and newborn care (BEmONC)
  - care from health facilities; clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- Establish a 24/7 referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of lifesaving post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

Prevent unintended pregnancies:

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

Plan for comprehensive SRH services, integrated into primary health care as soon as possible. **Work** with the health sector/cluster partners to address the six health system building blocks: service delivery, health workforce, health information system, medical commodities, financing, and governance and leadership.

Other priority: Ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Monitor and evaluate project implementation:

- Regularly complete the MISP for SRH Checklist as found in the revised *Inter-Agency Field Manual*: Reproductive Health in Humanitarian Situations for all project implementation areas.

	Collect or estimate basic demographic information; total population; number of women of reproductive age (ages 15–49, estimated at 25% of population); number of sexually active men (estimated at 20% of population); crude birth rate (estimated at 4% of the population); age-specific mortality rate (including neonatal deaths 0–28 days); and sex-specific mortality rate.
INDICATORS	1. Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception) 2. Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100 3. Percent of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100 4. Coverage of supplies for standard precautions, which is defined as the percentage of health delivery sites with sufficient supplies to ensure standard precautions can be practiced: (number of health service delivery points with adequate supplies to carry out standard precautions/number of health service delivery points) x 100 5. Coverage of HIV rapid tests for safe blood transfusion, which is defined as the percentage of referral hospitals that have sufficient HIV rapid tests to ensure all blood destined for transfusion is screened: (number of hospitals with sufficient HIV rapid tests to screen blood for transfusion/total number of hospitals) x 100 6. Condom distribution rate, which is defined as the rate of condom distribution among the population: number of male condoms distributed/total population/month 7. EmONC needs met, which is defined as the proportion of women with major direct obstetric complications who are treated in EmONC facilities: (number of obstetric complications [antepartum hemorrhage, postpartum hemorrhage, obstructed labor, pre-eclampsia, eclampsia or puerperal sepsis] treated at an EmONC facility/ expected number of deliveries) x 100 8. Coverage of clean delivery kits, which is defined as the rate of distribution of clean delivery kits among pregnant women in their third trimester: (number of clean delivery kits distributed/estimated number of pregnant women) x 100 9. Percentage of health facilities providing long-acting reversible and short-acting contraceptive methods available to meet demand 10. Percentage of health facilities providing syndromic STI treatment available at health facilities
TARGETED BENEFICIARIES	(Total number of) crisis affected, of whom (xx) are women 15–49 years old.
PROJECT DURATION	Six months to one year.

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

APPENDIX E: MISP FOR SRH ADVOCACY SHEET

What is the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) and why is it important?

1. The MISP for SRH is a priority set of lifesaving activities to be implemented at the onset of every humanitarian crisis. It forms the starting point for SRH programming in humanitarian emergencies and should be sustained and built upon with comprehensive SRH services throughout protracted crises and recovery.

2. Two-thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflict, natural disaster, or both.[141]

3. The MISP for SRH saves lives and prevents illness, disability, and death. As such, the MISP for SRH meets the lifesaving criteria for the Central Emergency Relief Fund.

4. Neglecting SRH needs in humanitarian settings has serious consequences, including preventable maternal and newborn morbidity and mortality; preventable consequences of unintended pregnancy, such as unsafe abortion; and preventable cases of sexual violence and their consequences, such as unintended pregnancies, increased acquisition of sexually transmitted infections, increased transmission of human immunodeficiency virus (HIV), and ongoing mental health problems, including depression.

5. The priority lifesaving SRH services in the MISP for SRH are integrated into the Sphere Minimum Health Standards in Humanitarian Response.[142]

6. The Global Health Cluster endorses the MISP for SRH as a minimum standard in health service provision in emergencies, as outlined in the *Inter-Agency Standing Committee Health Cluster Guide.*[143]

7. International laws support the rapid and unobstructed implementation of the MISP for SRH by humanitarian actors.[144] SRH services are also vital to realizing United Nations Security Council Resolutions 1325, 1820, 1888, and 1889 on Women, Peace and Security.

8. In addition to health, activities of the MISP for SRH must be coordinated with other sectors/clusters, including protection; logistics; water, sanitation, and hygiene; and early recovery.

9. As humanitarian actors become familiar with the priority activities of the MISP for SRH, they recognize that it can and should be provided within the context of other critical priorities, such as water, food, cooking fuel, and shelter.

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141 Zeid, et al., "For Every Woman, Every Child, Everywhere."

142 *The Sphere Handbook.*

143 *Health Cluster Guide: A Practical Guide for Country-Level Implementation.*

144 Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War (Geneva, August 12, 1949); Geneva Convention (III), Relative to the Treatment of Prisoners of War, Art. 3 (Geneva, August 12, 1949).; International Covenant on Civil and Political Rights, Art. 6 (UN General Assembly, December 16, 1966); Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War, Arts. 23, 55, 59, and 60 (Geneva, August 12, 1949); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), Art. 70 (June 8, 1977); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), Arts. 9–11 (June 8, 1977); Convention on the Elimination of All Forms of Discrimination Against Women (UN General Assembly, 1979); and the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, December 16, 1966).

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of reproductive health services

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

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

IARH Kit 3 IARH Kit 5 IARH Kit 8 IARH Kit 9

OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE AS SOON AS POSSIBLE. WORK WITH THE HEALTH SECTOR/CLUSTER PARTNERS TO ADDRESS THE SIX HEALTH SYSTEM BUILDING BLOCKS:

- Service Delivery
- Health Workforce
- Health Information System
- Medical Commodities
- Financing
- Governance and Leadership

GOAL

PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

IARH Kit 1 IARH Kit 3 IARH Kit 5 IARH Kit 12 Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

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

IARH Kit 1 IARH Kit 3 IARH Kit 4

OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
  - At health facility level: Skilled birth attendants and supplies for 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

IARH Kit 2 IARH Kit 6 IARH Kit 8 IARH Kit 9 IARH Kit 10 IARH Kit 11 IARH Kit 12

IARH Kit 8 **Other Priority**: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

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

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEmONC): 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.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmONC): 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.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

**** The new kit structure will only be available late 2019***

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEmONC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level-CEmONC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

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

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpaprocurement.org

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

APPENDIX G: ADOLESCENT-FRIENDLY CHECKLIST

This adolescent-friendly SRH service checklist was adapted from the *Adolescent SRH Toolkit for Humanitarian Settings* developed by Save the Children and the UNFPA.

Characteristics	Yes	No	Feasible Suggestion for Improvement
Health Facility Characteristics			
1. Is the facility located near a place where adolescents—both female and male—congregate (e.g., youth center, school, market)?			
2. Is the facility open during hours that are convenient for adolescents—both female and male—particularly in the evenings or on the weekend?			
3. Are there specific clinic times for adolescents?			
4. Are drop-in clients (clients without appointments) welcomed?			
5. Are SRH services offered for free or at rate affordable to adolescents?			
6. Are waiting times short?			
7. If both adults and adolescents are treated in the facility, is there a separate, discreet entrance for adolescents to ensure privacy?			
8. Do counseling and treatment rooms allow for privacy (both visual and auditory)?			
9. Is there a code of conduct in place for staff at the health facility?			
10. Is there a transparent, confidential mechanism for adolescents to submit complaints, feedback, or other accountability mechanisms for SRH services at the facility?			
11. Is the clinic accessible for those with disabilities?			
12. Are SRH services for boys and young men offered in places that welcome them?			
Provider Characteristics			
1. Have providers been trained to provide adolescent-friendly health services, which include nonjudgmental attitudes, empathy, active listening, and age-appropriate counseling?			
2. Have all staff members been oriented to providing confidential, adolescent-friendly services (e.g., receptionist, security guards, community health workers, cleaners)?			

3. Do staff members demonstrate respect for adolescents and their choices?			
4. Do the providers ensure the clients' privacy and confidentiality?			
5. Do the providers set aside sufficient time for client–provider interaction?			
6. Are peer educators or peer counselors available?			
7. Do providers approach every adolescent as an individual with different needs and concerns?			
8. Are there both male and female providers available (if possible)?			
Program Characteristics			
1. Do adolescents (female and male) play a role in the operation of the health facility?			
2. Are adolescents involved in monitoring the quality of SRH service provision?			
3. Can adolescents be seen in the facility without the consent of their parents or spouses?			
4. Are a wide range of SRH services available (contraception, STI treatment and prevention, HIV counseling and testing, ante- and postnatal care, delivery care)?			
5. Are there written guidelines for providing adolescent services?			
6. Are condoms available to both young men and young women in discrete locations?			
7. Are the SRH educational materials, posters, or other job aids/ information, education, and communications materials on site designed to reach adolescents?			
8. Are referral mechanisms in place for medical emergencies, mental health and psychosocial support, child protection, education, nutrition, social welfare programs, and so on?			
9. Are there mechanisms in place for adolescents to access SRH information and commodities at delivery points other than the health facility?			
10 Are adolescent-specific indicators monitored on a regular basis (e.g., number of adolescent clients, disaggregated by age and sex)?			

APPENDIX H: QUIZ ANSWERS

Unit 2 Quiz Answers: Coordination of the MISP for SRH

1. **False**

The lead SRH agency should dedicate an SRH Coordinator for a minimum of three to six months.

2. **b**

Mapping existing SRH services should be done in partnership with health, GBV, and HIV coordination mechanisms.

3. **e**

It is important that all stakeholders, including representatives from the affected community, NGOs, civil society organizations, and the GBV coordinator participate in the SRH working group meetings.

4. **d**

In order to ensure successful SRH coordination, meetings should occur in locations that are convenient for all stakeholders and should be held on a weekly or biweekly basis at the beginning of an emergency.

5. **True**

The MISP for SRH Checklist can be used to monitor the components of the MISP.

Unit 3 Quiz Answers: Prevent Sexual Violence and Respondto the Needs of Survivors

1. **False**

A survivor's rights, needs, and wishes should be prioritized and respected. Treatment and medication can be provided without an exam.

2. **d**

Clinical care for survivors of sexual violence includes history and examination, supportive communication, presumptive treatment of STIs, EC as soon as possible and within 120 hours after the rape, and pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law. It also includes PEP within 72 hours of exposure. Pregnancy testing is not required to provide EC or PEP.

3. **False**

Male survivors are less likely to report an incident because of shame, criminalization of same-sex relations, negative or dismissive provider attitudes, and the lack of recognition regarding the extent of the problem. Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and nondiscriminatory services that provide comprehensive care.

4. **True**

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

5. **c**

If you suspect that a staff member is violating the protection against sexual exploitation and abuse core principles, you should report the staff member to your supervisor or focal point for protection against sexual exploitation and abuse.

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

1. **False**

Syndromic management of STIs is standardized treatment protocols based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions on a single visit.

2. **a, b, c, d**

Ensuring confidentiality and the provision of condoms, co-trimoxazole (as recommended), and antiretrovirals is the role of the health provider when a crisis-affected person presents for continued antiretroviral treatment.

3. **e**

Safe handling of sharp objects, wearing of protective clothing, disposal of waste material, and frequent hand washing are all minimum requirements for infection control.

4. **e**

Condoms can be made available at health facilities, food and non-food distribution points, latrines, and popular bars or coffee shops in urban areas.

5. **True**

The SRH Coordinator should not take responsibility for procurement of antiretrovirals. It is the role of the HIV Coordinator (if one exists) or national HIV representative to support the health sector/cluster to ensure adequate supplies of antiretrovirals.

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

1. **c**

Feeding support includes promoting skin-to-skin contact, support for immediate and exclusive breastfeeding, and not discarding colostrum (or first milk).

2. **d**

BEmONC services should be accessible at the health facility level, and CEmONC services should be accessible at the referral hospital level.

3. **True**

Newborns should be referred to a health facility if they have reduced activity or lack of movement.

4. **False**

If a woman presents for post-abortion care, the first thing a skilled health provider should do is conduct a rapid, initial assessment. If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization.

5. **a, b, c**

The SRH Coordinator should work with health sector/cluster, communities and host-country authorities to establish an effective referral system at the onset of a humanitarian crises.

Unit 6 Quiz Answers: Prevent Unintended Pregnancies

1. **a, b, c**

Methods used by the target population prior to the crisis; methods registered in country; and potential for migration where removal of long-acted methods cannot be removed.

2. **False**

Contraceptive services must be accessible for all crisis-affected populations, including adolescents, unmarried and married women and men, sex workers and clients, LGBTQIA persons, ex-combatants, uniformed staff, and injecting drug users.

3. **c**

It is true that EC will not harm an existing pregnancy, EC needs to be taken within 120 hours and that it is more effective when taken earlier, and that the correct dosage of oral contraceptive pills can be used where dedicated EC pills are not available. It is not true that adolescent girls cannot take EC.

4. **a, b, c**

Confidentiality, privacy, and informed choice should be emphasized to ensure quality of care when providing contraception.

5. **a, b, d, e**

Effectiveness of the method, common side effects of the contraceptive method, how the method works, and STI protection should be provided to all clients during contraceptive counseling.

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

1. **e**

Health information system, health workforce, service delivery, medical commodities, finance, and governance and leadership are the six WHO health system building blocks.

2. **True**

In order to ensure ongoing access to affordable comprehensive SRH care, long-term financing mechanisms must be considered at the initial response to a crisis.

3. **c**

When selecting a site to deliver comprehensive SRH services, it is preferable to integrate with other services versus standalone services.

4. **False**

When transitioning to comprehensive SRH services, avoid continual ordering of the prepackaged IARH Kits to avoid incurring costs and wastage. Ordering SRH supplies based on demand will help ensure the sustainability of the SRH program and avoid shortages of particular supplies, as well as the wasting of others not typically used in the setting.

5. **b**

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

Unit 8 Quiz Answers: Other SRH Priorities to the MISP

1. **d**

Physicians and nurse can provide first-line safe abortion care with manual vacuum aspiration and medication when properly trained and supported.

2. **e**

Providing safe abortion care through health facilities staffed by willing providers, offering technical support and resources to qualified medical personnel already providing abortion services, distributing information and commodities for safe medication abortion, and identifying and referring women to providers and organizations that have capacity are ways to facilitate safe abortion care to the full extent of the law.

3. **True**

Cost of care, fear of negative repercussions, and stigma are barriers to safe abortion care for young women.

4. **True**

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

5. **e**

Safe abortion care should be prioritized in the MISP for SRH as a clinical component of care for survivors of sexual violence and as another priority of the MISP.

Unit 9 Quiz: Ordering IARH Kits

1. **a, b, c**

An organization should order complementary commodities when providers or the population are trained to use the commodity, when the supplies were accepted and used prior to the emergency and if the supply is allowed to the fullest extent of the national law and is included in the national drug list.

2. **a**

IARH Kits contain sufficient supplies for a three-month period.

3. **b, c, d**

Primary health care, referral hospital, and community/health post are the different levels of health care for which the IARH Kits are designed.

4. **c**

UNFPA manages the IARH Kits.

5. **a, b, c, e**

The information needed to order the IARH Kits includes detailed contact, delivery and financing information, information about the type of setting and the target population size, where the kits will be used and which organization will organize the distribution of the kits, and the number of health centers and referral hospitals.

How to Order Copies

The MISP for SRH module is available online on the IAWG on RH in Crises' website (www.iawg.net) and the Women's Refugee Commission's website (www.womensrefugeecommission.org). Print copies can be ordered by emailing info@wrcommission.org or info.iawg@wrcommission.org.

Contact Us

Women's Refugee Commission
15 West 37 Street
New York, NY 10018, USA
info@wrcommission.org

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INTER-AGENCY WORKING GROUP ON REPRODUCTIVE HEALTH IN CRISES