Component 4 Part B Appendices

Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad

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Appendix 1: Map of Chad

UNHCR
The UN Refugee Agency

SUDANESE REFUGEES IN EASTERN CHAD

17.02.2004

GIMU / PGDS

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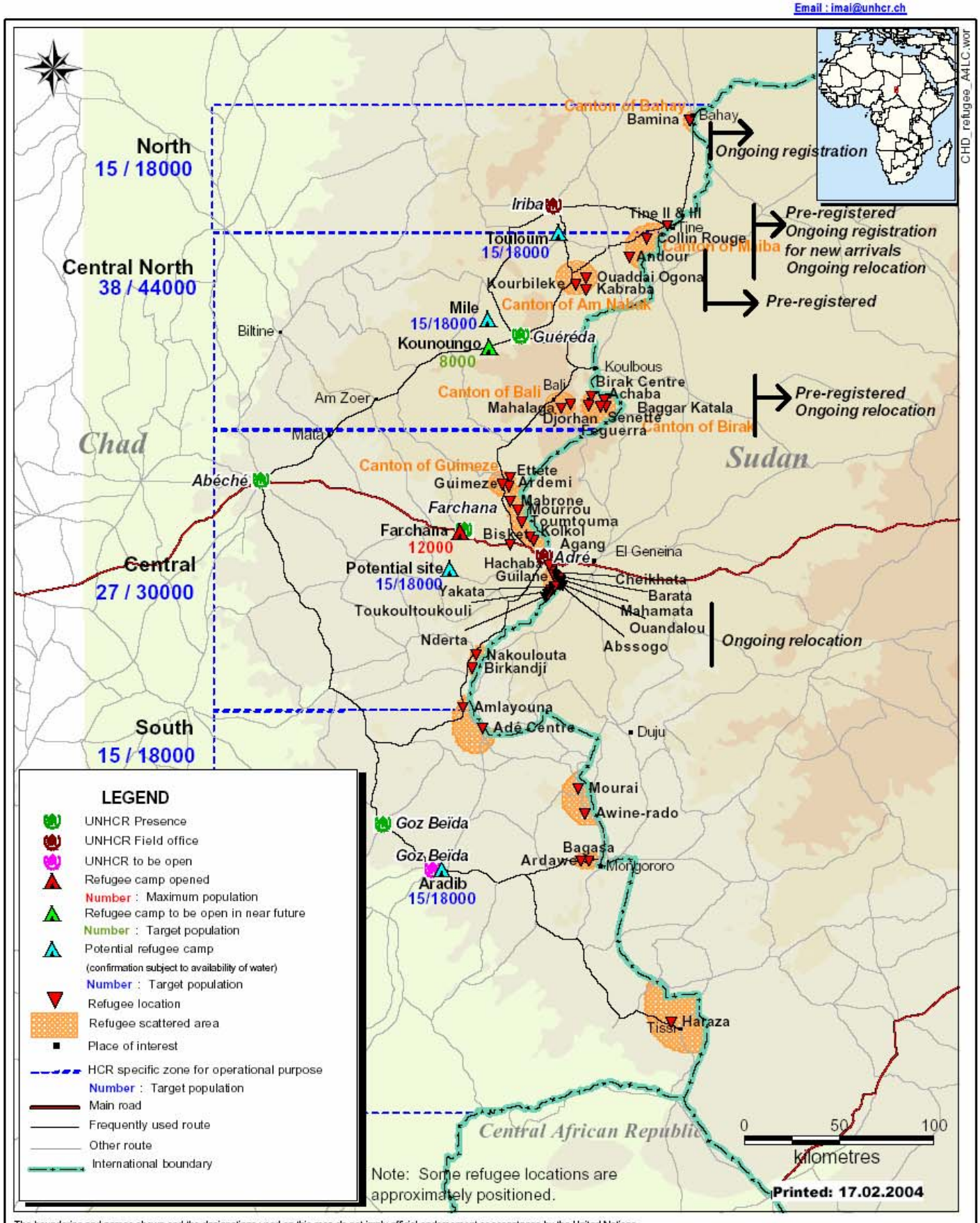

LEGEND

- UNHCR Presence
- UNHCR Field office
- UNHCR to be open
- Refugee camp opened
  - Number : Maximum population
- Refugee camp to be open in near future
  - Number : Target population
- Potential refugee camp
  (confirmation subject to availability of water)
  - Number : Target population
- Refugee location
- Refugee scattered area
- Place of interest
- HCR specific zone for operational purpose
  - Number : Target population
- Main road
- Frequently used route
- Other route
- International boundary

Note: Some refugee locations are approximately positioned.

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Sources: UNHCR, Global Insight digital mapping - © 1998 Europa Technologies Ltd.

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Appendix 4: MISP Assessment Tools

Inter-Agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons

Component 4:
Determine Availability and Quality of the Emergency Response (MISP) to RH needs

FIELD STAFF INTERVIEWS

- Regional and Country Directors, Health and RH Program Coordinators and Managers -

[redacted]

Date: _____

Interviewer: _____

Interviewee Name:
_____

Position:
_____

Organization:
_____

Contact information:
_____

_____
_____

_____
_____

Date began working with this organization: _____

Major Responsibilities:
_____

_____
_____

_____
_____

Other Staff

Job title	**Female or Male**	**International or National**	**Training**

[redacted]

1) Have you ever heard of the Minimum Initial Service Package (MISP) for reproductive health (RH)?

   How did you learn about it?

2) What is your understanding of the objectives of the MISP?

3) What are the priority activities of the MISP?

4) Where would you obtain supplies to support implementation of the MISP?

5) Have you sought funding to implement the MISP? If so, from what source? Results?

If not, why not? e.g. sought funding for any components of RH?
Which donors/own organization? Results?

Identify organization/individual to facilitate coordination & implementation of MISP

6) Are there RH coordination activities in this setting? When did these activities begin i.e. how soon after the first influx of refugees to this setting?

7) Is there a focal point in your organization for RH? How soon after the first influx of refugees to this setting was an RH focal point in place?

   Title:

   Is there a lead agency addressing RH?
   Name of Organization:

   Is there an RH focal point in this lead agency organization?
   Name:

   Is there an RH focal point in each camp? How soon after the first influx of refugees/IDPs was the focal point in place?

8) Are there RH coordination meetings in this setting? When did they start? How often do they meet?

   Is there a TOR for the meetings and/or meeting minutes?

9) Are there health coordination meetings in this setting? How often?

   Other RH-related coordination meetings e.g. GBV? HIV/AIDS?

   Is there a TOR for the meetings or minutes from the meetings?

Prevent and manage the consequences of sexual violence

10) What sexual violence protection measures are in place? How soon after the first influx of refugees/IDPs were the measures put in place and were any problems encountered?

11) Is there a staff Code of Conduct in place? Reporting focal point and mechanisms?

12) Have refugee women and women's groups been consulted in site planning (water, latrines, access to health care) and other camp management e.g. registration food distribution?

13) Are women issued their own registration cards?

14) Are there special protection measures in place for female-headed household, widows, and unaccompanied children in the camp?

15) Are there female protection officers and guards?

16)

Sexual violence services, resources and protocols	**Yes**	**No**	**Notes (when were services started?)**
Are services in place to provide clinical care and psychosocial support for survivors of sexual violence? - detailed history - general physical exam - assessment of psychological trauma - gynae exam - tests/investigations (e.g. vaginal swab, pregnancy test) - treatment (e.g. STI treatment, emergency contraception)			
Is there a standard protocol for clinical care of survivors of sexual violence?			
Resources available?			
Staff aware of importance of early referral of survivors? Are TBAs aware?			
Female health workers to provide exam?			
Is PEP available?			
STI care – diagnosis? prophylaxis?			
Care for injuries?			
Psychosocial services?			
Are staff aware of relevant local laws regarding emergency contraception and abortion (what circumstances, i.e. only in cases of rape, etc.)?			

[redacted]

17) Are services in place to reduce the transmission of HIV/AIDS? If so, what are they?

Are condoms freely available and visible? Where are they (clinics, bars, latrines, NGO offices)?

Current supply?

Stock-outs or other supply issues?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

Are universal precautions practiced e.g. protocols and monitoring mechanism for disinfection and sterilization of equipment; convenient hand washing facilities and safe waste disposal systems/availability and use of gloves?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

Is blood screened for HIV? How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

What is your system for obtaining and testing blood? Do you have access to sufficient IV fluid for patients?

[redacted]

18) Are services in place to prevent excess neonatal and maternal morbidity and mortality?

19) Are clean delivery kits available? Stock – stock issues? What supplies are included in the kits?

Where did they come from e.g. locally procured/assembled or ordered from?

Are they provided to all pregnant women? TBAs? How are they provided? (Note: Condoms and clean delivery should be available at the intake point/transit center where people register for their ration cards.)

How many have been distributed?

20) Have midwives been identified representing all ethnic groups? How many?

Are midwife delivery kits available? Stock – stock issues?

Where did they come from?

Have the supply needs of the midwives been assessed and addressed?

Have midwives been provided with information about the urgency of referring women who have survived sexual violence or are in need of emergency obstetric care?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

21) Is basic emergency obstetric care (EmOC) available? Location and distance?

Basic EmOC

Services Available	**Yes**	**No**	**Notes (when were services started?)**
1. Administer parenteral antibiotics			
2. Administer parenteral oxytocic drugs			
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia			
4. Perform manual removal of placenta			
5. Perform removal of retained products			
6. Perform assisted vaginal delivery			
Comprehensive EmOC (Basic plus)			
7. Perform surgery (Caesarean section)			
8. Perform blood transfusion			

22) Is comprehensive emergency obstetric care (EmOC) available?

Location and distance? Transport vehicles 24/7? Communication? Drivers 24/7?

Problems with emergency transport?

23) Have the needs of the referral hospital to ensure the provision of EmOC services been assessed? (Staff including MD and Anesthesiologist 24 hour coverage, running water, electricity, equipment, supplies, data collection) Addressed?

What follow-up is conducted of women referred?

What data is collected on women referred for complications of pregnancy and delivery?

What is the site - specific emergency referral system? Is there 24/7 coverage?

24) Has an information campaign been undertaken to inform the community e.g. refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about early referral of women who have survived sexual violence or who suffer from complications of pregnancy or delivery about how to access the system?

[redacted]

25) What steps have been taken to plan for the provision of comprehensive RH services integrated with primary health care services?

- Data Collection
- Sustainable equipment and supplies
- Staffing
- Training
- Family Planning
- STI including or and HIV/AIDS prevention and care
- GBV prevention and care (Ask specifically about plans to address FGM)
- Safe Motherhood
- Reproductive health for young people

[redacted]

26) Are there any activities to involve refugee women, men and adolescents to implement the MISP?

27) What are your recommendations to improve timely implementation of the MISP in new emergency settings?

28) Are you aware that the MISP is now a SPHERE minimum standard in health care? Are you aware that some donors such as the Bureau for Population, Refugees and Migration have included language in their cooperative agreements that encourages

NGOs to use SPHERE Standards as a basis for design, implementation, and evaluation in proposals, including proposed objectives and indicators?

Appendix 5: List of Field Staff Interviews, Health Facilities Observed, and Focus Groups Conducted

List of Field Staff Interviews

1. Abeche Referral Hospital, Director
2. Abeche Referral Hospital, Gynecologist
3. Abeche Referral Hospital, Manager
4. Abeche Referral Hospital, Senior Midwife
5. Abeche Referral Hospital, Statatician
6. CNAR, Registration, Farchana Camp
7. COOPI, Resident Representative, N'Djamena
8. CRS/SECADEV, Technical Advisor, Farchana Camp
9. CRS/SECADEV, Technical Advisor, Kounoungo Camp
10. CRS/SECADEV, Technical Advisor, Abéché
11. CRT, Assistant Coordinator, Farchana Camp
12. CRT, Coordinator, Farchana Camp
13. GTZ, Construction Assistant, Farchana
14. GTZ, Construction Supervisor, Abeche
15. GTZ, Head of Office, Abeche
16. International Medical Corps, Acting Country Director, N'Djamena
17. International Medical Corps, Nurse/Midwife, Abéché
18. International Medical Corps, Nurse/Midwife/Roving Operations Team, Abéché
19. International Medical Corps, Logistician, Abéché
20. International Medical Corps, Nurse/Nutritionist, Guereda
21. International Medical Corps, Medical Coordinator, Guereda
22. International Medical Corps, Doctor, Abéché
23. International Rescue Committee, Emergency Response Team Health Coordinator, Bahai
24. International Rescue Committee, Emergency Response Team Leader/Coordinator, Chad
25. Intersos, Logistician
26. Ministry of Health Staff Nurse, Mahameta village (Adré)
27. MSF- Belgium, Medical Doctor, Birak
28. MSF-Belgium, Field Coordinator, Birak
29. MSF-Belgium, Medical Coordinator, Abeche
30. MSF-Belgium, Medical Coordinator, N'Djamena
31. MSF-Belgium, Water/Sanitation Engineer, Birak
32. MSF-France, Anesthetist, Adré
33. MSF-France, Logistician, Adré
34. MSF-France, Medical Doctor, Adré
35. MSF-France, Nurse, Adré
36. MSF-France, Surgeon, Adré
37. MSF-Holland, Financial Controller, N'Djamena
38. MSF-Holland, Medical Doctor, Adré
39. MSF-Holland, Team Leader, Adré

40. MSF-Holland, Team Leader, Adré
41. MSF-Holland, Water/Sanitation Engineer, Adré
42. Norwegian Church Aid, Field Manager, Iridimi Camp
43. SECADEV, Camp Manager, Kounoungo Camp
44. SECADEV, Community Services Manager, Kounoungo Camp
45. SECADEV, Sanitation Supervisor, Touloum Camp
46. SECADEV, Water Supervisor, Touloum Camp
47. UNFPA, National Program Officer, Chad
48. UNHCR, Protection Assistant, Touloum Camp
49. UNHCR, Senior Program Officer, N'Djamena
50. UNHCR, Site Planner, Abéché
51. UNHCR, Head of Field Office, Adré
52. UNHCR, Head of Field Office, Iriba
53. UNHCR, Protection Assistant, Farchana Camp

List of Health Facilities Observed

1. Abeche Referral Hospital
2. MSF-Belgium Birak Referral Hospital
3. Mahameta Health Post (Adre)
4. MSF-Holland Health Clinic, Farchana Camp
5. MSF-Belgium Mobile Clinic, Kounoungo Camp
6. MSF-Belgium Mobile Clinic, Touloum Camp
7. MSF-Belgium Mobile Clinic, Iridimi Camp
8. MSF-Belgium, Referral Hospital, Tine
9. Ministry of Health Clinic, Bahai

List of Focus Groups Conducted

1. Adré border, 17 men, Masalit ethnic group
2. Bahai, 9 midwives, Zaghawa
3. Farachana camp, 11 girls, ages 12-19
4. Iridimi camp, 12 boys, ages 13-17
5. Kounoungo Camp, 14 women, ages 16-42
6. Kounoungo Camp, 9 adolescent girls, ages 10-18
7. Senette, 12 women, Tama ethnic group, ages 14-32
8. Tine, 11 women
9. Tine, 7 men
10. Touloum camp, 6 community workers with SECADEV (4 Chadian, 2 refugees)

Appendix 6: UNHCR Camps Sites and Activities by Implementing Partners

Appendix 7: Population of Camps

Appendix 8: Generic MISP Proposal for Inclusion in the CAP

10. Project Summaries

Appealing Agency	**UNFPA**
Project Title:	Implementing the Minimum Initial Service Package of Reproductive Health interventions (MISP) in the refugee crisis.
Project Code:	(number assigned by OCHA's Financial Tracking Unit)
Sector:	Health
Themes:	Safe Motherhood, Sexual Violence – prevention and management. HIV/AIDS, Refugees
Objective:	To reduce reproductive health-related morbidity and mortality, through making a minimum set of reproductive health interventions available as early as possible and through planning for the provision of more comprehensive RH services as the situation permits.
Targeted Beneficiaries:	110 000 refugees, of whom 22 000 are women 15 – 49 yrs old:
Implementing Partners:	**XXXXX**
Project Duration:	6 months
Total Project Budget:	
Funds Requested:	250 000 US$

2. The Project Description

In the early phase of a refugee crisis morbidity and mortality related to reproductive health (RH) continue and, in fact, are often increased: The risk for complications of pregnancy and deliver and maternal and neonatal mortality is increased through the lack of access to emergency obstetric care, the increased risk of malnutrition and epidemics, and the increased incidence of childbirth under unhygienic circumstances. Furthermore, the risk of sexual violence may increase during social instability and population movement; and STI and HIV transmission are more likely in areas of high population density. The lack of FP methods increases risks associated with unwanted pregnancy. Some aspects of reproductive health must therefore be addressed in the early phase of an emergency to reduce reproductive morbidity and mortality, particularly among women. This is best done through the widely accepted Inter-Agency standard of the Minimum Initial Service Package of Reproductive Heath Interventions in Crisis Situations (MISP). This strategy assures that basic, limited reproductive health services are delivered to the population as soon as possible, without spending time on a site-specific needs assessment. The strategy includes reproductive health supplies and medication and coordination and future planning activities.

UNFPA will work together with implementing partner XXXX . The project will provide for a Reproductive Health Coordinator to work in collaboration with the

Health Coordination team. RH supplies and medicines will be delivered in the form of RH kits. The RH coordinator will be responsible for identifying health centers and health staff that can implement the objectives of the MISP; distribution of the RH materials; and monitoring and evaluating the activities. The activities will focus on: 1) Preventing and managing the consequences of Sexual Violence through including the community in secure planning of the camp design, assuring a medical response for survivors of rape, and protection of at risk groups. 2) Reducing HIV transmission through collaborating with the other Health Sector partners to enforce respect for universal precautions, make safe blood transfusions available, and assuring the availability of free condoms. 3) Preventing excess neonatal and maternal morbidity and mortality through providing all pregnant women in the last trimester with clean birthing materials, assuring clean and safe deliveries at health facility, and initiating the establishment of a referral system for obstetric emergencies. Furthermore, the RH coordinator, in collaboration with al partners and beneficiaries will plan for provision of comprehensive RH services, integrated into Primary Health Care, as soon as the situation permits.

3. Financial Summary:

Budget items	Amount
Salary RH Coordinator	50 000 US$
RH Supplies and infrastructure support	120 000 US$
Hardware (vehicle, computer, etc	50 000 US$
Software (admin, office hiring, etc)	30 000 US$
Total	**250 000 US$**

Appendix 9: Generic MISP Proposal for Submission to Donors

10. INGO Sample Project Proposal

Project Title:	Implementing the Minimum Initial Service Package (MISP) of Reproductive Health
Organization:	Description of the organization and its work, including reproductive health activities, in the region.
Brief background and reason for project or problem to be addressed:	The MISP for reproductive health activities will save lives if implemented at the onset of an emergency. Neglecting reproductive health in emergencies has serious consequences: preventable maternal and infant deaths; unwanted pregnancies and subsequent unsafe abortions; and the spread of sexually transmitted infections, including HIV/AIDS. The (MISP) is a set of priority activities designed to: prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services. The MISP includes a kit of equipment and supplies to complement a set of priority activities that must be implemented in the early days and weeks of an emergency in a coordinated manner by trained staff. The MISP can be implemented without a new needs assessment because documented evidence already justifies its use. The components of the MISP form a minimum requirement and it is expected that comprehensive reproductive health services will be provided as soon as the situation allows. The MISP is a minimum standard in the SPHERE 2004 guidelines. A RH Coordinator is essential to ensuring coordination of MISP activities among all health implementing agencies. Under the auspices of the overall health coordination framework, the RH Coordinator should: be the focal point for RH services and provide technical advice and assistance on RH; liaise with national and regional authorities of the host country; liaise with other sectors to ensure a multi-sectoral approach to RH; introduce standardized strategies for RH which are fully integrated with PHC, standardized protocols, and simple forms for monitoring RH activities; and report regularly to the health coordination team. Brief background on emergency situation.
Objectives:	▪ Identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP. ▪ Prevent and manage the consequences of sexual violence. ▪ Reduce HIV transmission by: enforcing respect for universal precautions against HIV/AIDS, guaranteeing the availability of free condoms. ▪ Prevent excess neonatal and maternal morbidity and mortality by: providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries, providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility and initiating the establishment of a referral system to manage obstetric emergencies. ▪ Plan for the provision of comprehensive reproductive health (RH) services, integrated into Primary Health Care (PHC), as the situation permits.
Activities:	Collect or estimate basic demographic information: ▪ Total population ▪ Number of women of reproductive age ▪ Number of men of reproductive age ▪ Crude birth rate ▪ Age-specific mortality rate ▪ Sex-specific mortality rate ▪ Number of pregnant women ▪ Number of lactating women Prevent and manage the consequences of sexual violence ▪ Systems to prevent sexual violence are in place

	▪ Health service able to manage cases of sexual violence ▪ Staff trained (retrained) in prevention (protection measures) and response systems for cases of sexual violence Prevent HIV transmission ▪ Materials in place for adequate practice of universal precautions ▪ Condoms procured and visibly available to displaced population ▪ Health workers trained/retrained in practice of universal precautions Prevent excess neonatal and maternal morbidity and mortality ▪ Clean delivery kits available and distributed ▪ UNICEF midwife kits (or equivalent) available at the health center ▪ Staff competency assessed and retraining undertaken ▪ Referral system for obstetric emergencies functioning Plan for provision of comprehensive RH services ▪ Basic information collected (mortality, HIV prevalence, CPR) ▪ Sites identified for future delivery of comprehensive RH services Identify as organization(s) and individual(s) to facilitate the MISP ▪ Overall RH Coordinator in place and functioning under the health coordination team- RH focal points in camps and implementing agencies in place ▪ Staff trained and sensitized on technical, cultural, ethical, religious and legal aspects of RH and gender awareness ▪ Material for the implementing of the MISP available and used
Indicators:	▪ Incidence of sexual violence: Monitor the number of cases of sexual violence reported to health services, protection and security officers. ▪ Estimate condom coverage: Calculate the number of condoms available to make visibly available in various settings (clinical exam rooms, latrines etc.) to the population. ▪ Estimate of coverage of clean delivery kits: Calculate the number of clean delivery kits available to cover the estimated births in a given period of time.
Targeted Beneficiaries:	(total number of) refugees/IDPs, of whom (xx) are women 15 – 49 yrs old
Project Duration:	6 months to one year
Project Budget:	▪ salary for RH Coordinator ▪ RH supplies and infrastructure support (coordinate with UNFPA to obtain supplies) ▪ Travel ▪ Indirect Costs (xx %)