Section 4
Part A

Evaluation of the use of the Minimum Initial Service Package (MISP) and RH kits in post-emergency situations

Part A of this component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was undertaken by Ms Nelly Common, Consultant and Dr Wilma Doedens, Technical Officer, UNFPA Humanitarian Response Unit, Geneva

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* The appendices are available on a CD-ROM containing the report and other documents related to the evaluation.

Executive summary

The purpose in component 4 of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs was twofold; first to conduct a retrospective evaluation of the use of the Minimum Initial Service Package (MISP) for reproductive health in emergencies and the distribution and use of RH kits in post-emergency situations and, second, to evaluate use of the MISP in the early phase of an emergency (Section 4 Part B). The retrospective evaluation involved the use of a two-part questionnaire to collect information on general issues including implementation of the MISP components, logistics for ordering, packaging, storage, and distribution of the kits, and usefulness of the IEC materials distributed with the kits (part one), and feedback on the contents of the RH kits (part two). Forty-eight questionnaires were distributed via e-mail in April 2003 to UNFPA, UNICEF and WHO field offices and to IRC and IFRC, in 39 countries.

Thirty-three (68%) of the 48 questionnaires were returned, 28 of which were completed fully.[1] Sixty-eight percent of respondents reported having implemented all of the MISP components at some point during an emergency, whereas 78% indicated that they had implemented at least one component. Of these, 81% had appointed an RH coordinator; 90% implemented prevention and medical management of the consequences of sexual violence; 90% addressed reduction of HIV transmission by distributing condoms (90%) and introducing universal precautions (65%); 100% implemented the prevention of neonatal and maternal mortality and morbidity through clean delivery kits and/or clean and safe deliveries; 72% planned for the provision of comprehensive RH services; and 72% established a data collection system for monitoring RH services. However, none of the 10 respondents indicating that they worked in the acute phase of an emergency reported putting in place all components of and supplies for the MISP within a month after the onset of the emergency.

Of the total number of RH kits ordered in 2000, 2001 and 2002, Kits 2 (clean delivery kit), 6 (professional midwifery delivery kit) and 5 (STI kit) were the most frequently ordered. Most of the organizations that completed a questionnaire indicated that they were satisfied with the usefulness of the RH kits and with the materials included in the kits. However, suggestions were made to add and/or change some items, and the need for more training on the correct use of the kits was highlighted. In addition, 40% of respondents indicated that they had encountered problems with in-country transportation and storage of the kits.

In conclusion, while the evaluation findings suggest that the MISP was better used than in the past, there is still room for improvement. In addition, while the RH kits were, in general, found to be useful, some helpful suggestions have been made for improvements. However, in some countries, problems with logistics may continue to pose a serious challenge to the distribution of the kits and, therefore, delay their use.

[1] The reader should bear in mind the small sample size in this retrospective evaluation of use of the MISP and use and distribution of RH kits: 33 respondents of 48 to whom the questionnaire was sent, with only 28 fully completed questionnaires. Thus, there is inevitable bias in the case of questions to which there were only a few responses, and since we cannot know the differences between the offices that responded and those that did not.

Introduction

1. In support of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs, UNFPA undertook a retrospective evaluation of the use of the MISP and the distribution and use of the RH Kit in post-emergency situations. This constitutes the first part of Component 4 of the Global Evaluation.

Background to the Reproductive Health Kits

2. A major objective of the Programme of Action adopted at the 1994 International Conference on Population and Development was to make reproductive health care accessible to all individuals by the year 2015. The Programme of Action specifically called attention to the needs of especially vulnerable populations, including displaced persons and refugees. Prior to this time, reproductive health was rarely considered in responses to humanitarian emergencies. Bearing this in mind, the concept of a "Minimum Initial Service Package" (MISP) was created during the Inter-agency Symposium on Reproductive Health in Emergency Situations held in June 1995.

3. The MISP (described in detail in *Reproductive Health in Refugee Situations: an Inter-agency Field Manual*) is a series of actions to respond to the reproductive health needs of populations in the early, acute phase of a refugee situation (which may or may not be an emergency). It is a set of activities that must be implemented in a coordinated manner by appropriately trained staff. One element of the MISP is the provision of essential reproductive health drugs, equipment and supplies, which may be the pre-packaged and warehoused RH kits reviewed in this section, or may be procured and assembled locally.

4. The objectives of the MISP are to: identify organization(s) and individual(s) to facilitate and coordinate the implementation of the MISP; prevent and manage the consequences of sexual violence; reduce HIV transmission through the use of universal precautions and guaranteed availability of free condoms; prevent excess maternal and neonatal mortality and morbidity by providing clean delivery kits for mothers and/or birth attendants to use for home deliveries and midwife delivery kits for clean and safe deliveries at health facilities, and by initiating a referral system to manage obstetric emergencies; and, finally, plan for the provision of comprehensive reproductive health services, integrated into primary health care, when the situation permits.

5. In 1996, the members of the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations developed the concept and the original set of Emergency Reproductive Health Kits to facilitate the timely and appropriate delivery of reproductive health services in emergency and refugee situations. The RH Kits were conceived for ordering during the acute phase, and for use during a limited period of time for a fixed number of people.

6. *The Reproductive Health Kit for Emergency Situations* has been made available through UNFPA to support the implementation of reproductive health services in emergency situations. In 1999, UNFPA undertook the first evaluation of the Kit, following one year of use. This first evaluation aimed at reviewing the logistics process as well as the contents of the Kit, based on the comments received on the use

of the Kit at field level. Following the report on this evaluation, an IAWG technical meeting was organized and the contents of some of the sub-kits were revised, and the ordering and logistic processes were simplified. The kit was then renamed *Reproductive Health Kits for Crisis Situations.*

7. The current composition of the sub- kits that comprise The Reproductive Health Kits for Crisis Situations is:

- Administration (Kit 0)
- Male and Female Condoms (Kit 1A and 1B)
- Clean Delivery (Kit 2A: individual and 2B: for TBAs)
- Rape Treatment (Kit 3)
- Oral and Injectable Contraception (Kit 4)
- Treatment of Sexually Transmitted Infections (Kit 5)
- Clinical Delivery (Kit 6)
- Intrauterine Device (IUD) (Kit 7)
- Management of Miscarriage and Complications of Abortion (Kit 8)
- Suture of Tears (Vaginal and Cervical) and Vaginal Examination (Kit 9)
- Vacuum Extraction Delivery (Kit 10)
- Referral Level Kit for Reproductive Health (Kit 11A and 11B)
- Blood Transfusion (Kit 12)

8. The methodology used for the 1999 field review of the logistics process and the contents of the RH Kit was adapted and used for the present evaluation.

Identification of RH kit users

9. The UNFPA Procurement Unit, New York, is in charge of procurement and stockpiling of RH kits as well as dealing with orders from the field. Once a request is received, the Procurement Unit sends a pro-forma invoice to the requester with the budget code to be charged (for UNFPA field offices) or with the UNFPA bank account details (for non UNFPA field offices). In the meantime, the Procurement Unit proceeds to arrange for shipment with the main stock holding supplier (a medical trade company subcontracted by UNFPA for assembling kits). The supplier prepares the order including packing list, original invoice, and list of manufacturers. Once the money is received by UNFPA and the order is ready, it is shipped to the requester who is informed a few days before that the order has been sent.

10. For the purpose of the evaluation, UNFPA's Procurement Unit provided to UNFPA Humanitarian Response Unit (HRU), lists of RH Kit orders during 2000,

2001 and 2002. From the documents provided, a list of RH kits ordered by country and by kit number during these years was established (Appendix 2). From this, a list of Field Offices and contact persons was created to facilitate the distribution of the questionnaires. [1]

Development of questionnaire

11. The questionnaire used for the 1999 evaluation was adapted for the present evaluation by dividing it into two parts, as follows:

- Part I was designed to collect information on general issues including implementation of MISP components, logistics for ordering, packaging, storage and distribution of the kits, and usefulness of the IEC materials distributed with the kits.
- Part II was designed to collect feedback on the contents of the RH kits.

12. After pre-testing and finalizing the questionnaire, which included review by the evaluation Steering Committee, it was translated to French. It was then sent to the "requester" via email with a letter of explanation. In cases of non-response two reminders were sent; the first reminder was sent two weeks after the questionnaire and the second reminder two weeks after the first reminder. In total 48 questionnaires were sent to UNFPA, UNICEF and WHO field offices as well as to the International Rescue Committee (IRC) and the International Federation of the Red Cross and Red Crescent Societies (IFRC) contacts, in 39 countries. At the field level, the UNFPA field offices contacted their implementing partners to complete the questionnaire and send it back to UNFPA HRU in Geneva.

Data analysis

13. When the questionnaires were returned, they were classified by country. Data from the first part of the questionnaire were entered into an Excel spreadsheet. Comments and recommendations made by field offices on the contents of kits were reported in a word document per kit number and incorporated into this report. After compilation of data, the analysis was done both by hand calculation and using Excel.

Findings

14. Of the 48 questionnaires that were sent 33 (68%) were returned, of which 28 were completed in full. Three respondents explained they could not complete the questionnaires for the following reasons: one field office (WHO Pakistan) informed UNFPA HRU that they had not ordered RH kits although the procurement unit

[1] Since this survey was conducted, UNFPA has seen a dramatic increase in the number of kits ordered by its field offices and other organizations (see **Appendix 3** for a list of kits ordered in an 18-month period in 2003-2004). The relative distribution of numbers ordered has also changed somewhat. Kits 2, 5 and 6 were the most frequently ordered in both time periods. Notably, the proportion of Kit 3 (the rape treatment kit) has more than doubled (from 3% to 7% of total), and the numbers of this kit ordered have increased from 15 over (2000-2002) to 417 (in 2003-2004). This reflects improved awareness of GBV in emergencies and increasing levels of service.

documents shown that WHO Pakistan had ordered kits in 2001; two UNFPA field offices did not have the time or could not contact their implementing partners to fill out the questionnaire.

15. The questionnaire received from Uzbekistan included information concerning orders of the kits made by Tajikistan as those two offices worked together for the distribution of the kit.

16. The UNFPA Field Office in Turkmenistan informed UNFPA HRU that kits ordered through their office were sent to the WHO Mazar-e-Sharif Office (Afghanistan), which proceeded to distribute the kits. For this reason, UNFPA Turkmenistan completed the questionnaire in collaboration with the WHO Field Office in Mazar-e-Sharif.

Implementation of MISP components

17. Seventy-eight percent (22) of respondents said they had implemented at least one of the MISP components, whereas 68% (15) had implemented all of the MISP components sooner or later in the emergency.

Among the 78% that implemented one or more of the MISP components:

- 81% (18) appointed an RH coordinator, usually an individual person rather than an NGO.
- 90% (20) implemented the prevention and medical management of the consequences of sexual violence.
- 90% (20) addressed reduction of HIV transmission. All of them distributed condoms and 65% (13) introduced universal precautions to prevent HIV transmission.
- 100% (22) implemented the prevention of neonatal and maternal mortality and morbidity component through the provision of clean delivery kits (kit number 2) and /or the facilitation of clean and safe deliveries at health facility, including the provision of kit number 6.
- 72% (16) made a plan for the provision of comprehensive RH services integrated into primary health care.
- 72% (16) established a data collection system for monitoring RH services.

18. The implementation time of the MISP components varies from an immediate action to one year after the occurrence of the emergency situation; but the majority of the respondents indicated that MISP components were implemented before the end of the first month. However, none of the 10 respondents that had worked in the acute phase of an emergency reported putting in place all the components of, and supplies for, the MISP within a month after the onset of the emergency.

General information on RH Kits

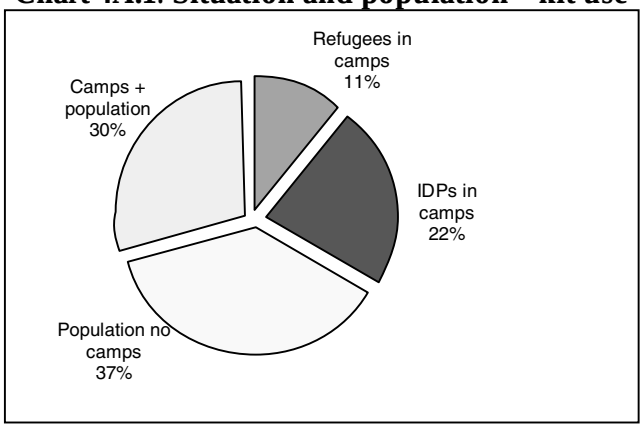
Situation and population

19. Most of the RH kits were ordered for use in a conflict situation (20). Eight field offices ordered kits for natural disaster situations and 4 ordered kits for emergency preparedness. The field office in the Democratic Republic of Congo ordered the RH kits for all three types of situations (conflict, natural disaster and emergency preparedness). Pakistan and Liberia ordered kits for conflict situations and for emergency preparedness.

20. Eight field offices used the kits exclusively during the acute phase of an emergency and 16 field offices used them exclusively during the post-acute phase. Four field offices (DRC, Liberia, El Salvador and Uzbekistan) used the RH kit during both phases. Most of the kits ordered for conflict situations were used during the post-acute phase. Kits ordered for natural disaster situations were utilized equally often during the acute and post-acute phase.

21. Sixty-seven percent of the kits were used for the benefit of populations not living in camps. Only three field offices (Pakistan, Guinea Conakry and Tanzania) utilized the kits exclusively for refugee camps. Swaziland reported the use of the kits for "local population affected by drought and food shortages".

Chart 4A.1: Situation and population – kit use



Ordering and funding

22. Most of the kits were ordered through the UNFPA Procurement Unit in New York (75%), although one field office ordered the kit through the Medical Trade Company. Fifty percent of the orders were funded through UNFPA's Special Emergency Funds, 32% through the regular programme of the field office and 21% through donations. Three field offices funded their orders through regular funds and special emergency funds, two field offices received special emergency funds and donations, and one field office did not answer this question.

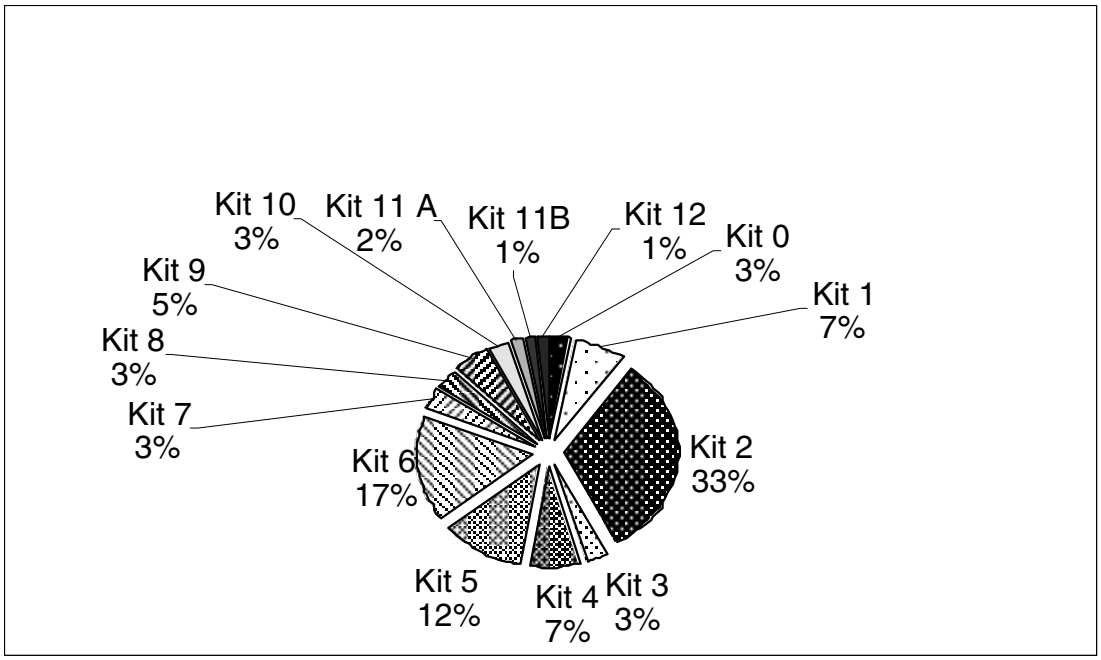
23. Of the total number of kits ordered in 2000, 2001 and 2002, the most frequently ordered kit was kit 2, followed by kit 6, and kit 5. The data provided by the 28 questionnaires seem to be representative of the overall ordering of RH kits during

this three year period, as witnessed by the overview of all orders received by the UNFPA Procurement Unit.

Table 4A.1: Frequency of RH kit orders (n=28)

Kit Number	Number of times ordered
Kit 2 and Kit 6	24
Kit 5	23
Kit 8 and Kit 9	20
Kit 1, Kit 11 A and 11 B	19
Kit 4	16
Kit 3	15
Kit 0, Kit 10 and Kit 12	14
Kit 7	13

Chart 4A. 2: Percentage of RH kits ordered during 2000, 2001, 2002



24. The reasons provided from the field for not ordering a specific kit were, in the first place, because there were sufficient supplies already (especially for contraception methods: Kit 1, 4 and 7), because supplies were available in the local market, or because there was no need for the kit, as the RH component that the kit covers was not relevant in the situation.

Shipping and packaging

25. Between 2000 and 2003 it took between 2 weeks and 5 months to receive the complete order in country. Orders shipped by sea, rather than by air, understandably took far longer to arrive. Fifty percent of the orders arrived within 1 month: six countries received the kits within 2 weeks, three countries within 3 weeks, and 4

within a month. One country received the complete order within five and a half months.[2]

26. Most of the recipients were satisfied with the shipping and import of the RH kits (80%), however, 20% (5) were not satisfied:

- five received the notice of arrival (1) and the appropriate documentation and invoice too late (4);
- one received a notice of dispatch different from the contents of the kit received;
- one declared that the customs procedure was not completed in time;
- one was dissatisfied because invoices and packing lists did not specify the unit price of the individual items in the kits.

27. The majority of recipients were satisfied with the packing. For those who were not satisfied, the reasons given were:

- The size of the boxes is too big and too large for transportation and storage (four respondents).
- The boxes are not strong enough (1 respondent).
- Two field offices received the boxes with the labelling inside the box. One field office found it difficult to reconstitute kits 2 and 6 from all the different boxes received. Francophone countries were requesting the labelling in French. One recipient found mistakes on the list of contents; one packing list had a wrong address.

In-country logistics

28. In 76% of cases, a logistician assisted with in-country transport and storage. Sixty percent of the field offices did not encounter problems with transportation and storage of the RH kit. However, 21% found that the volume of the shipment received was too large for the transportation and storage capacities available in the country. The other 19% encountered difficulties mainly due to the adverse conditions in country. For example, IRC Sudan, which received kits in Khartoum for a project based in Wau (south Sudan), had problems not only with the volume of the shipment but also with the in-country transportation due to lack of roads, irregular flights, and lack of electricity. In Cote d'Ivoire difficulties were encountered with storage due to heat and humidity, which spoiled the quality of condoms and drugs.

29. In relation to transportation and storage, the cold chain could not be respected in 41% of cases, mostly during in-country transportation. It should be noted that two of the 24 field offices that responded to this question did not respect the cold chain because they did not know some of the items had to be kept cool.

[2] In this case, kits had been ordered to replace pre-deployed stocks for contingency planning.

30. For 74% of cases, distribution of the RH kits was completed more than one month after their arrival in country. Only 7% completed the distribution of the kits within 2 weeks.

Table 4A.2 Distribution of kits by health care level (N=27)

Health Care Levels	No. Responses
Primary Health Care Centres / clinics / posts	20
Referral level hospital	16
Ministry of Health	9
Individual Health Workers	8
Other Organizations (IFRC, MDM, UNHCR, MSF-F, World Vision, Merlin, MSF-H)	6
Individual women / men	5

Training on MISP and RH Kits

31. Seventy-four percent of the people dealing with the MISP and the RH kits had not received any training in this subject. However, when asked if they organized trainings on the MISP and RH kits, 45% of them said they did. Among those who answered that they had received MISP and RH kit training, 99% organized training on the use of the MISP and the RH kits later on.

Table 4A.3 Categories of health care workers trained (n=14)

1.	TBAs and Community Health Workers
2.	Nurses and Midwives
3.	Doctors and Medical Assistants
4.	Other (UN staff, community women and men, people working in laboratories)

(1 = most often, 4 = least often)

Monitoring use of RH Kits

32. Seventy-six percent of respondents monitored the use of the kits using forms created by their organization (57%), or the UNHCR form (14%) or some other form not indicated in the questionnaire (28%). Sixty percent conducted supervision of the health care workers who used the RH kits.

IEC materials

33. It appears that some of the respondents did not understand the question concerning the usefulness of IEC materials included in the kits; 8 respondents did not complete this question (30%). Some of the respondents answered this question indicating they used documents that were not part of any of the kits they ordered. Other respondents answered “no” to use of the documents, but without explanation, making it difficult to know whether this was because they did not use the documents or because they had not received them.

34. Five respondents among the 28 stated that they had not received the IEC materials or that they did not receive all documentation that should be included in the kits, especially concerning the "sterilization by pressure cooker" brochure in kit 6. Otherwise, most answered that they were using the documentation provided with the kits they ordered.

Contents of RH Kits

35. Most of the organizations and UNFPA field offices that completed the questionnaire on the contents of the RH kits were satisfied with the usefulness of the RH kits and with the materials included in the kits. Some suggestions from respondents about the contents of the kits are summarized below:

- Prices of some kits are too high, some NGOs would like to purchase kits but do not because of the prices. All of the equipment, disposables and drugs are available on the local market at a cheaper price.
- Kits have lower quality materials than the ones that can be found in the country
- Addition of a penis model in Kit 1 A
- Addition of gumboots and aprons for Kit 2 B (TBAs)
- Addition of PEP in Kit 3
- Addition of pain killers in Kit 8
- Condoms are too big for local conditions; prepare special packages for some regions that require smaller size.

36. Most of the suggestions from respondents are related to the technical contents of the kits. Some other important points for the improvement of the use of the MISP and RH kits are highlighted, as follows.

37. Training: Four respondents requested training on reproductive health in emergency situations so as to be able to coordinate services in a timely and appropriate manner. It is clear from the comments received on the contents of the kits that reproductive health field workers need to become more familiar with the correct use of items included in the kits. Training should include courses for the field staff of UNFPA and other UN agencies and also for their national counterparts at ministry and NGO partner level.

38. It would be very useful to organize at least two trainings per year on reproductive health in emergencies for those reproductive health field workers who are dedicated to the job but who lack knowledge on how to implement a prompt response. At least one of the two trainings should be in English and the other one in French or in another UN language such as Arabic. The trainings should be organized on different continents each year.

39. Shelf life of drugs: There were some reports of drugs already expired or drugs with too short a shelf life. None of the field offices reported how they are dealing with the expired drugs or with those that have a short shelf life. Distribution of drugs with a very short shelf life may be unsafe as they might be used when expired. UNFPA, together with the Medical Trade Company, should ensure that drugs included in the RH kits are not past their expiry date and have at least one year of shelf life after being sent to the field.

40. IEC materials: Requests for translation of IEC materials have come mainly from French and Arabic speaking countries. In addition, there were reports of missing or never received IEC materials. A review of the distribution system of the IEC materials is needed to assure that the field offices receive the appropriate materials to help them in the use of the RH equipment and drugs. This applies, in particular, to the demonstration leaflets and technical guidelines.

41. In conclusion, while the evaluation findings suggest that the MISP was better used than in the past, there is still room for improvement. In addition, while the RH kits were, in general, found to be useful, some helpful suggestions have been made for improvements.[3] However, in some countries, problems with logistics may continue to pose a serious challenge to the distribution of the kits and, therefore, delay their use.

[3] Since this section of the evaluation was undertaken, a further round of revisions to the RH Kits contents has been made. The expiration dates of drugs was an issue addressed in the latest round of Kits revisions and policy changes.