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/.*