

**INTER-AGENCY
FIELD MANUAL**

**ON REPRODUCTIVE
HEALTH IN
HUMANITARIAN
SETTINGS**

2018

IAWG

INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES

INTER-AGENCY FIELD MANUAL ON REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS

ACKNOWLEDGEMENTS

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) is grateful to all of the individuals who contributed to and provided feedback on this manual throughout the revision process. In addition to the individuals listed at the end of the manual, several staff members of the World Health Organization provided input on the development of this document and IAWG thanks them for their insights. The revised manual benefitted from extensive discussions and feedback from field staff at several regional and global meetings as well as all of those who participated in the 2012-2014 global evaluation. Thank you!

The views expressed in this manual are those of the authors and contributors and do not necessarily represent the views of, and should not be attributed to, their affiliated organizations.

PREFACE

Sexual and reproductive health (SRH) is a human right and, like all other human rights, applies to refugees, internally displaced persons, and others living in humanitarian settings. To realize this right, affected populations must have access to comprehensive SRH information and services so they are free to make informed choices about their health and well-being.

The provision of comprehensive and high-quality SRH services requires a multi-sectoral integrated approach. Personnel from sectors such as protection, health, nutrition, education, and community service all have an important role in planning and delivering SRH services. Needs are best met through involving affected communities in every phase of action: from assessing needs to designing programs, from launching and maintaining programs to evaluating their impact.

The *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM) is the result of a collaborative and consultative process engaging hundreds of representatives from United Nations agencies and non-governmental organizations that make up the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). Based on guidelines issued by normative bodies, particularly those of the World Health Organization, the 2018 IAFM incorporates specific evidence from, or examples about, the application and adaptation of global SRH or human rights standards in humanitarian settings. The 2018 IAFM reflects the wide application of the manual's principles and technical content beyond refugee situations, extending its use into diverse crises, including conflict zones and natural disasters. The IAFM continues to be the authoritative source for SRH in crises; the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response* incorporates the Minimum Initial Service Package for SRH - Chapter 3 in the 2018 IAFM - as a minimum standard of care in humanitarian response.

The global political community has also made progress, especially in addressing the gravity of sexual violence in armed conflict. The United Nations Security Council Resolutions 1325, 1820, 1888, and 1889 on Women, Peace, and Security affirm the unique needs, perspectives, and contributions of women and girls in conflict settings. The Security Council has recognized sexual and reproductive health, with Resolution 1889 explicitly referencing the need to ensure women and girls' access to SRH services and reproductive rights to achieve better socioeconomic conditions in post-conflict situations.

Unfortunately, large populations are still forced to spend decades away from their homes in refugee camps, internally displaced person settlements, or urban settings unfamiliar to them, due to ongoing conflict or as a result of a natural disaster. The average length of displacement for refugees is 17 years. Many persons affected by these chronic emergencies are highly vulnerable to life-threatening sexual and reproductive ill-health, posing serious challenges to efforts to achieve global benchmarks, including the Sustainable Development Goals. The 2018 IAFM aims to improve the health and well-being of affected populations from relief through the transition to development, while fostering preparedness and high-quality services that ensure the maximum participation of affected communities.

Nearly 25 years have passed since the 1994 International Conference on Population and Development recognized reproductive health as a human right. As members of the humanitarian community, we have a collective responsibility to uphold and realize the right to SRH for people in all humanitarian settings.



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CHAPTER 1

INTRODUCTION

- 1.1 Setting the context
 - 1.2 Sexual and reproductive health in humanitarian settings
 - 1.3 History of the Inter-Agency Field Manual (IAFM)
 - 1.4 Development of the 2018 IAFM
 - 1.5 Major changes in the 2018 IAFM
 - 1.6 Intended audience for the 2018 IAFM
 - 1.7 Where to find additional resources
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1.1 SETTING THE CONTEXT

In 2015, the United Nations High Commissioner for Refugees (UNHCR) estimated that the global forcibly displaced population exceeded 65 million for the first time in history. This included over 21 million refugees, 40 million internally displaced persons, and more than 3 million asylum seekers. Of those needing humanitarian assistance, approximately 1 in 4 are women and girls of reproductive age.

Sexual and reproductive health (SRH) is an essential component of the humanitarian response. Sexual and reproductive health is a state of complete physical, mental and social well-being (not merely the absence of disease and infirmity) in all matters relating to the reproductive system and its functions and processes. SRH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are people's rights to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice, as well as other interventions and strategies for fertility regulation that are not against the law. People should also have the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide individuals and couples with the best chance of having a healthy infant.

All people, including those living in humanitarian settings, have the right to sexual and reproductive health. To exercise this right, affected populations must have an enabling environment and access to comprehensive SRH information and services so they can make free and informed choices. Quality SRH services must be based on the needs of the affected populations, particularly the needs of women and girls. SRH services must respect the religious and ethical values and cultural backgrounds of the communities, while conforming to universally recognized international human rights standards.

1.2 SEXUAL AND REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS

A humanitarian setting is one in which an event or series of events has resulted in a critical threat to the health, safety, security, or well-being of a community or other large group of people. The coping capacity of the affected community is overwhelmed, in-country infrastructure is disrupted, and external assistance is required. This can be the result of events such as armed conflicts, natural disasters, epidemics, or famine and often involves population displacement.

In humanitarian settings, it is essential to provide SRH services. Morbidity and mortality related to SRH is a significant global public health issue and those in humanitarian settings often face heightened risks and additional barriers to SRH services. Access to SRH care is a right and persons affected by conflict or disaster are entitled to protection and assistance. The timely provision of SRH services can prevent death, disease, and disability related to unintended pregnancy, obstetric complications, sexual and other forms of gender-based violence, HIV infection, and a range of reproductive disorders.

Providing comprehensive, high-quality SRH services in humanitarian settings requires a multi-sectoral, integrated approach. Protection, health, nutrition, education as well as water, sanitation, and hygiene and community service personnel all have a part to play in planning and delivering SRH services. The best way to ensure that SRH services meet the needs of the affected population is to involve the community in every phase of the development of those services; only then will people benefit from services specifically tailored to their needs and demands and only then will they have a stake in the future of those services.

1.3 HISTORY OF THE INTER-AGENCY FIELD MANUAL (IAFM)

The global community began prioritizing the SRH needs of refugee and displaced populations in the mid-1990s. In 1995, more than 50 governments, United Nations (UN) agencies, and non-governmental organizations (NGOs) committed themselves to strengthening reproductive

health services for refugee populations and subsequently formed the Inter-Agency Working Group on Reproductive Health in Crises (IAWG).

BOX 1.1: WHAT IS IAWG?

The Inter-Agency Working Group on Reproductive Health in Crises is a broad-based, highly collaborative coalition that works to expand and strengthen access to quality sexual and reproductive health services for people affected by conflict and natural disaster. Formed in 1995 as the Inter-Agency Working Group on Reproductive Health in Refugee Situations, IAWG had over 2,100 individual members from 450 agencies in 2017. IAWG remains committed to advancing the sexual and reproductive health of people affected by conflict and natural disaster and works to:

- **Document gaps, accomplishments, and lessons learned**
- **Evaluate the state of sexual and reproductive health in the field**
- **Establish technical standards for the delivery of reproductive health services**
- **Build and disseminate evidence to policy makers, managers, and practitioners**
- **Advocate for the inclusion of crisis-affected persons in global development and humanitarian agendas**

IAWG is led by a 20-member Steering Committee comprising UN agencies and non-governmental humanitarian, development, research, and advocacy organizations.

One of the first activities of the new organization was to develop guidelines for providing reproductive health services in refugee settings. After extensive field-testing of a beta version, in 1999 IAWG-affiliated agencies released

Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. Importantly, the manual outlined a set of minimum reproductive health interventions to be put in place at the outset of a humanitarian crisis known as the Minimum Initial Service Package (MISP). The manual also served as a tool to: facilitate discussion and decision-making in the planning, implementation, monitoring, and evaluation of comprehensive reproductive health interventions; guide SRH Coordinators, health program managers, and service providers in introducing and/or strengthening evidence-based interventions; advocate for a multi-sectoral approach to meeting the comprehensive needs of affected populations; and foster coordination among partners. In 2010, IAWG released a new edition of the manual. Reflecting the relevance of the document for a broad array of refugee, crisis, conflict, and emergency settings, IAWG agencies retitled the manual the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM). In addition to technical updates, the 2010 IAFM reframed safe motherhood as maternal and newborn health, included stand-alone chapters on adolescent reproductive health, HIV, and sexually transmitted infections (STIs), and introduced a new chapter on comprehensive abortion care.

In 2016, IAWG embarked on a 24-month process to revise the IAFM. The result is the 2018 version of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (2018 IAFM).

1.4 DEVELOPMENT OF THE 2018 IAFM

Since the release of the 2010 IAFM, IAWG members have conducted both formal and informal evaluations of the use of the manual and the implementation of SRH interventions in humanitarian settings. Taken together these evaluations indicated that despite considerable progress in funding for, awareness of, and capacity to deliver SRH programming, significant gaps existed with respect to providing adolescent sexual and reproductive health services, offering a full range of contraceptive methods and comprehensive abortion care, providing emergency obstetric and newborn care, and preventing sexual violence. These findings informed the revision process. Feedback from practitioners in the field also

provided direction for the 2018 IAFM. In addition to technical updates, users of the manual working in a range of countries and settings expressed the need for simplified language, enhanced linkages between topics and chapters, and incorporation of case studies and programmatic examples to guide implementation.

Consistent with previous versions of the manual, human rights principles and evidence-based policies and practices ground the 2018 IAFM. The 2018 version explicitly recognizes that sexual and reproductive health and rights are central to the realization of fundamental human rights, including the right to life, the right to health, the right to be free from torture and ill-treatment, the right to privacy, the right to education, and the prohibition of discrimination, particularly on the basis of sex and gender. In alignment with international human rights obligations and guidance from numerous human rights and political bodies, the 2018 IAFM emphasizes that advancing sexual and reproductive health and rights requires that crisis-affected populations have access to comprehensive SRH information and services and the ability to make informed decisions free from violence, discrimination, and coercion.

Sexual and reproductive health guidelines issued by normative bodies, and particularly those of the World Health Organization (WHO), provide the technical foundation for the manual. Where possible, this manual incorporates specific evidence from or examples about the application and adaptation of global sexual and reproductive health or human rights standards in humanitarian settings. Although national laws, policies, and resources in specific contexts may complicate implementation of global standards, the 2018 IAFM presents evidence-based interventions that should be offered in all settings and to all affected populations, a position consistent with broader human rights principles.

The 2018 IAFM is a product of IAWG and thus the existing leadership structure governed the overall effort. IAWG formally began the revision process in March 2016. IAWG sub-working groups took the lead on individual chapter revisions, providing substantive input and technical updates through consultation and a review of published sources. These sub-working groups also reached out to field staff in multiple countries and in some cases engaged directly with refugee and displaced populations for feedback. The 2018 IAFM Taskforce, a body comprising more than 50

individuals from 21 UN agencies, international NGOs, and academic institutions and guided by a consultant with subject matter expertise, further developed and ultimately approved the substantive changes to individual chapters and made decisions regarding overarching structural revisions. Regular conference calls and 3 in-person meetings allowed for robust debate, compromise, and agreement. The final step in the process involved a technical review by members of the IAWG Steering Committee with relevant expertise to ensure all recommendations are based on the best evidence currently available. Thus, the 2018 IAFM represents the consensus of representatives from a wide cross-section of agencies working on SRH in the humanitarian sector.

1.5 MAJOR CHANGES IN THE 2018 IAFM

The revision process resulted in technical updates to all chapters of the 2010 IAFM. These changes reflect the best-available evidence on clinical practice and program implementation at the end of 2017. Importantly, the 2018 manual uses “sexual and reproductive health” in place of reproductive health, reflecting better the scope of the manual and expanded understanding of the field.

CHANGES TO THE MISP CHAPTER

Perhaps the most significant change reflected in the 2018 IAFM is to the MISP chapter. The MISP outlines a set of objectives and corresponding priority activities to be undertaken at the onset of a crisis (within 48 hours whenever possible). In the 2018 IAFM, prevention of unintended pregnancy is a standalone objective. The identified priority activities are to:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
- Provide information, including 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

A second major change to the MISP chapter involves explicit references to safe abortion care. In addition to incorporating pregnancy options counseling and provision of or referral for abortion services into clinical care for survivors of sexual violence, provision of safe abortion care, to the full extent of the law, is now included in the MISP chapter as a standalone “other priority activity.”

Finally, the MISP chapter strengthens guidance on HIV, maternal and newborn care, and transitioning from the MISP to comprehensive SRH. The new edition offers expanded content to facilitate planning for comprehensive services and focuses on health system building blocks. These revisions respond to a gap identified in the IAWG global evaluation.

ADDITION OF A LOGISTICS CHAPTER

The supply chain is a critical component of successful SRH service delivery; without medicines and other supplies health workers cannot provide effective services. Recognizing the importance of this issue the 2018 IAFM includes a chapter dedicated to logistics. The chapter maps the key stakeholders and processes that are essential to effective sexual and reproductive health supply chains; provides recommendations on transitioning from emergency to ongoing supply chains; outlines key steps including forecasting, procurement, transportation, and last-mile distribution; and identifies staff roles and responsibilities for effective supply chain management. The inclusion of this chapter responds directly to feedback from users in the field.

CHANGES IN EMPHASIS AND LANGUAGE

The 2018 IAFM places greater and more consistent emphasis on human rights obligations and principles, gender-based violence, the linkages between maternal and newborn health, and assessment, monitoring, and evaluation. The introduction and the revised chapter on “fundamental principles” engage more fully with the human rights underpinnings of the manual and situate the recommendations within broader international guidelines. The revised chapter on gender-based violence includes an expanded focus on a broader array of types of gender-based violence encountered in humanitarian settings and lays out

a survivor-centered, rights-based approach to these issues in humanitarian settings that pays specific attention to adolescents and lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual populations. The new version of the manual also places greater emphasis on quality care for mothers and newborns on the day of birth and contains more information about newborn health, including expanded content related to emergency obstetric and newborn care, essential newborn care, care for small and sick newborns, and respectful maternity care.

BOX 1.2: OUTLINE OF THE 2018 IAFM

- Chapter 1: Introduction
- Chapter 2: Fundamental principles
- Chapter 3: Minimum Initial Service Package
This chapter includes the new MISP objectives as well as details on the priority activities
- Chapter 4: Logistics *NEW*
- Chapter 5: Assessment, monitoring, and evaluation
- Chapter 6: Adolescent sexual and reproductive health
- Chapter 7: Contraception
- Chapter 8: Comprehensive abortion care
- Chapter 9: Maternal and newborn health
- Chapter 10: Gender-based violence
- Chapter 11: HIV
- Chapter 12: Sexually transmitted Infections (STIs)

As much as possible, each chapter contains stand-alone information. However, in order to avoid repetition, some of the chapters have references in the text that point to related issues in other chapters.

INCLUSION OF PROGRAMMATIC EXAMPLES

Finally, in response to expressed needs from the field, the 2018 IAFM includes a series of programmatic examples showcasing the implementation of SRH programming in different humanitarian settings. These examples involve numerous implementing agencies in different countries and regions operating during different phases of an emergency. Case studies also explore a range of challenges that those in the field routinely experience.

BOX 1.3: WHERE TO START?

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises is a set of priority activities to be implemented at the onset of an emergency. Comprehensive SRH services must be implemented as soon as the situation permits. Therefore, the 2018 IAFM is designed for readers to begin with Chapter 1 (Introduction), Chapter 2 (Fundamental principles), and Chapter 3 (MISP), before proceeding to the cross-cutting and technical chapters.

1.6 INTENDED AUDIENCE FOR THE 2018 IAFM

SRH Coordinators and health program managers in humanitarian settings are the primary audience for the 2018 IAFM. Service providers (doctors, nurses, midwives, etc.) will also find useful information about the MISP and a range of SRH issues. Community services officers, protection officers, and others working to meet the needs of affected women, men, and adolescents will also benefit from the guidance offered in this document. As the 2018 manual is intended for use in the field by a range of implementing agency staff, it thus does not provide detailed clinical guidelines; users are directed to and encouraged to consult additional resources as necessary.

BOX 1.4: USING THE IAFM: ADVICE FROM THE FIELD

I am going to make some assumptions that you are sitting somewhere in an emergency affected area right now. Maybe you are writing a proposal, creating the beginning of a program design, or trying to help technical staff adapt existing programs to the new reality of an emergency. For whatever reason you are reading this manual and for whomever you are working, we want you to know that the 2018 IAFM is for you. This is how I know that...many years after engaging in my first humanitarian response, I am now one of the many contributing authors to the 2018 version.

My name is Lara S. Martin and toward the beginning of my career I was reading a previous version of the IAFM, most likely for the same reasons you are. Every day my colleagues and I designed programs, wrote proposals, and worked with partners and donors in the middle of an emergency response. We implemented the MISP through all of our health programming. We mainstreamed gender-based violence through both our protection and health programming. We advocated for survivor-centered care in a context where access to basic services was limited by insecurity. Our programs were a success, but one of the main reasons for this (other than coffee and pure energy) was the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.

The IAFM was my guiding light every night. I would read the chapter I needed repeatedly then turn around every day to adapt implementation to our programming context and the realities of the work. I literally printed out the IAFM. I removed the MISP chapter to have it right by my desk every day at work. The classic graphic of the MISP was taped to the wall and was my personal litmus test for moving toward comprehensive programming. I used the suggested indicators along with the ones our donors required to monitor the quality of our data collection systems in the clinics. The MISP was essential to our log frames.

Yes, we were probably just like you. The 2018 IAFM will give you a clear protocol for your program design and implementation. It provides essential guidance on what to do and how to

do it for a SRH emergency response. If you find yourself in the first hours and days of an emergency, read this manual. If you find yourself in a protracted area with cyclical emergencies, read this manual. If you find yourself managing SRH technical staff, but are not yourself a SRH expert, read this manual.

Tear or print out what you need, use it the way that suits you best. In the 2018 version, you will find updates to the MISP, human rights considerations mainstreamed through every chapter, and even a chapter for logistics of SRH supplies. New graphics and a revised chapter on assessment, monitoring, and evaluation of SRH emergency programming are now also included. There are also additional tools and resources online. There is so much for you to use and adapt – there is no need to start from scratch every time you begin to design or implement programs. Be sure to visit the online tools section – there is good stuff there!

Just a concluding note: the contributing authors always had you and your program beneficiaries in mind while working on the 2018 IAFM. The realities of your work balanced how we approached writing evidence-based and evidence-informed best practice, truly influencing the content you will find herein. Future iterations of this manual will continue to improve upon this version. We hope that whoever you are, wherever you are, the 2018 IAFM helps guide your SRH programming, just as it did for me.

1.7 WHERE TO FIND ADDITIONAL RESOURCES

Development of the 2018 IAFM involved consultation of many hundreds of peer-reviewed journal articles, normative body guidelines, and case reports. The end of each chapter contains a sample of the most important resources, references, and tools. However, in order to make the 2018 IAFM user friendly, we have not included citations in the main text nor have we included an exhaustive list of resources. An online repository provides a library of available resources as well as the full reference list for the 2018 IAFM.

1.8 FURTHER READINGS AND ADDITIONAL RESOURCES

Foster, A.M., Evans, D., Garcia, M., Knaster, S., Krause, S., McGinn, T., Rich, S., Shah, M., Tappis, H., Wheeler, E. (2017). The 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: Revising the Global Standards. *Reproductive Health Matters*, 18–24.

IAWG. (2010). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York, NY: IAWG. Retrieved from: <http://iawg.net/resource/inter-agency-field-manual-on-reproductive-health-in-humanitarian-settings-2010/>

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CHAPTER 2

FUNDAMENTAL PRINCIPLES

2.1 Introduction

2.2 Objectives

2.3 Fundamental principles of sexual and reproductive health programming in humanitarian settings

2.3.1 Work in respectful partnership

2.3.2 Advance human rights and reproductive rights through sexual and reproductive health programming

2.3.3 Ensure technical, human rights, and financial accountability

2.3.4 Share information and results

2.4 Further reading and additional resources

2.1 INTRODUCTION

Fundamental principles are an expression of values and practices and are at once both operational and aspirational. Developed through extensive consultation with stakeholders in the humanitarian and sexual and reproductive health (SRH) sectors, the fundamental principles outlined in this chapter serve as both a guide for action and also establish the manual's identity and purpose.

2.2 OBJECTIVES

The objectives of this chapter are to:

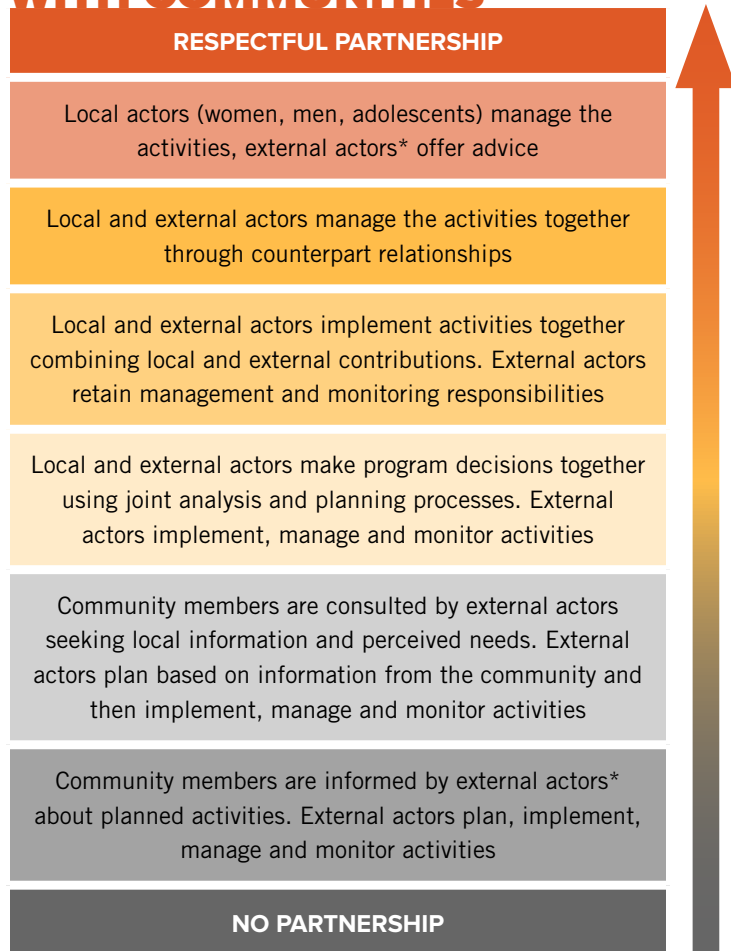
- Define the principles that must be the foundation of activities related to sexual and reproductive health in humanitarian settings
- Guide SRH Coordinators, health program managers, and service providers on how to put these principles into action in their work through examples

2.3 FUNDAMENTAL PRINCIPLES OF SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING IN HUMANITARIAN SETTINGS

The foundation of SRH programming in humanitarian settings should be guided by 4 fundamental principles:

- Work in respectful partnership
- Advance human rights and reproductive rights through SRH programming
- Ensure technical soundness, human rights, and financial accountability
- Share information and results

FIGURE 2.1: PROGRESSION OF RESPECTFUL PARTNERSHIP WITH COMMUNITIES



2.3.1 Work in respectful partnership

Partnership is a strategic way of organizing working relationships that values collaboration and joint decision-making over hierarchy in order to achieve a desired result, in this case, improvements in SRH coverage and quality.

Partnerships can be among organizations, including government authorities and local and international NGOs. Communities can also be a full partner in SRH programming, usually through village health committees and other service delivery organizations, civil society groups (women’s groups, disabled persons organizations, groups for lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people), supportive faith-based organizations, or other local groups. These groups should represent the full range of community members, including men and adolescents. Partnerships should also include culturally-sensitive approaches to identify strategic opportunities to advance SRH and challenge harmful practices.

Work in respectful partnership by:

- Engaging in respectful and meaningful partnership for a diversity of perspectives from a broad group of stakeholders (including government, international and local NGOs, community-based organizations (CBOs), and community beneficiaries)
- Acknowledging that partnerships vary greatly from one type of partner to another
- Openly discussing respective goals. Coordination will improve efficiency in communication, decision-making, response and use of resources, and viable outcomes
- Using culturally-sensitive approaches to identify both challenges and strategic opportunities for advancing SRH

Working in respectful partnership is an intentional process. As illustrated in Fig. 2.1, partnerships between humanitarian agencies and local communities evolve over time.

* Government or NGO humanitarian workers/implementing agency staff from outside the community

Different types of relationships have different advantages and disadvantages (see Fig. 2.2). When compared to “top down” relationships, that is, relationships that have an established hierarchy in power and decision-making, respectful partnerships incorporate the perspectives of a broader range of stakeholders, build capacity, and promote coordination. However, these relationships also require time and a commitment to compromise.

FIGURE 2.2: ADVANTAGES AND DISADVANTAGES OF RESPECTFUL PARTNERSHIPS AND TOP DOWN RELATIONSHIPS

RESPECTFUL PARTNERSHIPS	TOP-DOWN RELATIONSHIPS
ADVANTAGES	
<ul style="list-style-type: none"> • Strengthens the sense of shared objectives. Coordination improves efficiency of response and strategic decision-making, avoiding duplication of efforts • Diverse perspectives contribute to a fuller understanding of SRH needs, resources, successes, and failures and can challenge generalizations and assumptions. These lead to more effective programs • Shared learning builds each partner’s capacity and effectiveness • Fosters sensitivity to the local context, contributing to sustainability (if some partners are local) 	<ul style="list-style-type: none"> • Decisions can be made faster by one group
DISADVANTAGES	
<ul style="list-style-type: none"> • Can take longer to accomplish objectives • Requires compromise 	<ul style="list-style-type: none"> • Opportunities within local culture and society to advance SRH are missed (including local agents for change and response) • Programs are not well-adapted to local contexts, since all perspectives are not incorporated • Creates new or reinforces pre-existing power structures • Groups do not learn from each other, work in isolation or siloes, and duplicate efforts, leading to a waste of resources • Community needs are not met

We present some suggestions for how to develop successful partnerships on Fig. 2.3.

FIGURE 2.3: TO DEVELOP RESPECTFUL PARTNERSHIPS

DO	DON'T
<ul style="list-style-type: none"> • DO value the different perspectives and strengths that each partner brings to the work, as an opportunity to seek local, in-depth insight • DO recognize that each partner will further develop its own capacity through the partnership • DO jointly develop shared objectives, priorities and action plans • DO hold each other accountable for agreed-upon responsibilities • DO encourage participation from a broad range of stakeholders, as a principle of building respectful partnership • DO develop a common assessment about what challenges, and opportunities, the local context provides for sexual and reproductive health and rights (SRHR) 	<ul style="list-style-type: none"> • DON'T assume 'top' organizations know best and others bring little of value to the work • DON'T assume 'top' organizations are expert and others need capacity-building • DON'T permit the 'top' organizations to decide priorities and delegate tasks to other partners • DON'T permit 'top' organizations to hold others accountable, while they themselves are not accountable to the other partners • DON'T assume that people in the same culture or society have the same perspectives on and experiences of SRHR and other rights and needs • DON'T assume or generalize

2.3.2 Advance human rights and reproductive rights through SRH programming

International human rights are the set of global obligations that govern how States treat the people under their jurisdiction with a goal of ensuring the equal dignity, freedom, and well-being of all people. Human rights are universal; they apply to all individuals by virtue of their being human.

Reproductive rights are a set of recognized human rights. The 1994 International Conference on Population and Development (ICPD) set out a framework for the realization of reproductive rights, that has since been reaffirmed and strengthened by international human rights experts and political bodies.

BOX 2.1: ICPD REPRODUCTIVE RIGHTS FRAMEWORK

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence.

SRH Coordinators, health program managers, and providers can help people achieve their inherent human rights and reproductive rights by reducing inequalities and organizing programs so they benefit everyone. Actions include:

- Ensuring autonomous decision-making and choice by all clients with regard to services and commodities
- Promoting equity, with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g., rural/urban), religion, ethnic group, social group, and other characteristics
- Recognizing and addressing power dynamics and ensuring no force, coercion, discrimination, or violence/mistreatment/disrespect/abuse in health services
- Ensuring equality by meeting clients' varied SRH needs and ensuring that services are affordable or free, accessible to all, adequate given the cultural or crisis context, and of high quality
- Providing comprehensive, evidenced-based information about the commodities and services available

BOX 2.2: KEY TERMS

AUTONOMY: The ability of an individual to be her/his/their own person, to make her/his/their own choices on the basis of her/his/their own motivations, without manipulation by external forces

EQUALITY: The state of being equal, particularly with respect to rights, status, and opportunities

EQUITY: Fairness or justice in the way people are treated

ACCESSIBILITY: The extent to which a client or potential client can obtain services at the time they are needed

We present some suggestions for how to advance autonomy, access, and equity on Fig. 2.4.

FIGURE 2.4: TO ADVANCE AUTONOMY, ACCESS, AND EQUITY AND ADDRESS POWER DYNAMICS:

DO	DON'T
<ul style="list-style-type: none"> • DO examine program data to understand who is and who is not using services. • DO distribute service sites so they are convenient to underrepresented sub-groups and ensure they are physically and financially accessible for all • DO partner with local groups and carry out education activities that appeal to underrepresented sub-groups. For example, use appropriate language and messages for young people or minority groups • DO seek out voices of those not participating in education activities or services to better understand their needs • DO ensure that all those seeking services understand their options and are the decision-maker in their care • DO help women speak to their husbands and fathers and DO engage men directly in community education, if women say men must make SRHR decisions • DO train and supervise staff to ensure every client has received comprehensive and evidence-based information and gives informed consent for all services 	<ul style="list-style-type: none"> • DON'T assume those who do not use SRH services do not need or want them • DON'T assume any specific group, such as married women, young people, or unmarried women are prohibited from using services or that permission is required • DON'T discuss the reason for a patient's visit in public waiting rooms or disclose personal/medical information of patients to anyone except the patient or legal guardian • DON'T exclude certain clients from services based on personal views. For example, adolescents and unmarried people have a right to SRH services even if the provider believes they should not be sexually active • DON'T locate services only in sites convenient to your organization or to the majority group • DON'T require consent for services from another person/ male relative (unless explicitly required by law)

2.3.3 Ensure technical soundness, human rights, and financial accountability

Accountability is the process of holding individuals and organizations responsible for performance according to set standards and principles. In crisis settings, we must abide by humanitarian standards as well as professional medical, public health, legal, and financial accounting standards.

Ensure technical, human rights, and financial accountability by:

- Respecting all humanitarian and sexual and reproductive health and rights professional standards
- Using evidence-based and evidence-informed strategies in designing, implementing and evaluating programs
- Monitoring and improving the quality of care
- Evaluating programs and using findings to improve the program
- Ensuring clients’ voices are heard and rights are respected in service delivery

We present some suggestions for how to operationalize this principle on Fig. 2.5.

FIGURE 2.5: TO ENSURE TECHNICAL, HUMAN RIGHTS, AND FINANCIAL ACCOUNTABILITY

DO	DON'T
<ul style="list-style-type: none"> • DO use recommendations from articles and reports on “best practices” and “lessons learned” when designing comprehensive SRH programs, from the outset • DO examine your existing program to understand successes and failures when designing the next phase • DO ensure that you measure the results of your program, so you can improve activities • DO create a confidential process for complaints and input from those accessing services and a structure for addressing these complaints effectively at the health facility level, with monitoring of these processes by supervisory authorities • DO develop a Patient’s Bill of Rights and post it in locally relevant languages in all health facilities • DO encourage broad community engagement in participatory processes (committees, scorecards, surveys, questionnaires, etc.) 	<ul style="list-style-type: none"> • DON'T carry out the same activities the same way year after year unless you have evidence that they are still effective • DON'T wait until the end of a program to initiate review/ participatory processes

BOX 2.3: KEY STANDARDS IN THE HUMANITARIAN SECTOR

- Code of Conduct of the International Red Cross and Red Crescent Movement and Non-Governmental Organization in Disaster Relief
- Core Humanitarian Standard on Quality and Accountability
- Inter-Agency Standing Committee (IASC) Guidelines
- Sphere Humanitarian Charter and Minimum Standards in Disaster Response

2.3.4 Share information and results

Sharing information and results promotes ownership of programs by stakeholders and also helps other programs learn from our program’s successes and failures. The information we share varies by audience.

Share information and results with:

- Policy and financial decision-makers through advocacy
- Professionals through journal publications and conferences
- Communities through meetings, discussions, and newsletters

We present some suggestions for how to advance autonomy, access, and equity on Fig. 2.6.

FIGURE 2.6: TO SHARE INFORMATION AND RESULTS

DO	DON'T
<ul style="list-style-type: none"> • DO hold community meetings to discuss results from local sites and seek their feedback (open and anonymous fora) • DO involve local health and civil authorities early and regularly in the program to promote understanding and ownership • DO inform national and regional policymakers of summary results and implications for their strategic goals • DO inform donors of summary results, successes and challenges in the program • DO post summary results and lessons on your organization’s and other websites and social media to inform workers from other countries • DO publish results in professional journals to inform donor, advocacy, program and research colleagues • DO maintain regular discussion with these groups 	<ul style="list-style-type: none"> • DON'T hide disappointing results from any audience; DO discuss them to understand what caused them • DON'T assume specific audiences disapprove of your program; DO invite them to meetings to learn about your program

2.4 FURTHER READINGS AND ADDITIONAL RESOURCES

Bruce, J. (1990). Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning*, 21(2), 61-91.

Sphere Project. (2011). *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. Retrieved from: <http://www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22>

United Nations. (2013). *Convention on the Elimination of All Forms of Discrimination against Women. General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post Conflict Situations*. Retrieved from: <http://www.ohchr.org/documents/hrbodies/cedaw/gcomments/cedaw.c.cg.30.pdf>

CHAPTER 3

MINIMUM INITIAL SERVICE PACKAGE (MISP)

3.1 Introduction

3.2 Objectives

3.3 MISP programming

- 3.3.1 Ensure the health sector/cluster identifies an organization to lead implementation of the MISP
- 3.3.2 Prevent sexual violence and respond to the needs of survivors
- 3.3.3 Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
- 3.3.4 Prevent excess maternal and newborn morbidity and mortality
- 3.3.5 Prevent unintended pregnancies
- 3.3.6 Plan to integrate comprehensive SRH services into primary health care
- 3.3.7 Supplies to implement the MISP
- 3.3.8 Other sexual and reproductive health priorities

3.4 Human rights and legal considerations

3.5 Monitoring and evaluation

3.6 Further reading and additional resources

3.1 INTRODUCTION

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

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

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

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

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

BOX 3.1: OBJECTIVES OF THE MISP

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

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

PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

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

PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs:

- Establish safe and rational use of blood transfusion

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

PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
 - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
 - At health facility level: Skilled birth attendants and supplies for uncomplicated vaginal births and provision of basic obstetric and newborn care (BEmONC)
 - At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth

attendants to promote clean home deliveries when access to a health facility is not possible

- Establish a 24 hours per day 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of life saving post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

PREVENT UNINTENDED PREGNANCIES:

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

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

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

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

3.2 OBJECTIVES

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

- The role and functions of the lead SRH agency and SRH Coordinator
- Prevention of sexual violence and clinical management to prevent or mitigate the consequences of sexual violence
- Priority interventions to prevent HIV and other STIs and reduce related morbidity and mortality
- Priority interventions to reduce maternal and newborn morbidity and mortality

- Prevention of unintended pregnancies
- Planning for comprehensive SRH service integration into primary health care as the situation stabilizes, including procurement of commodities and supplies

3.3 MISP PROGRAMMING

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

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

BOX 3.2: SRH COORDINATOR TERMS OF REFERENCE

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

- Coordinate, communicate, and collaborate within the health, GBV, and HIV cluster/sectors/actors and actively participate in health and other inter-sectoral coordination meetings, providing information and raising strategic and technical issues and concerns
- Host regular SRH coordination meetings at national and relevant sub-national/regional and local levels with all key stakeholders, including MOH, local and international NGOs including development organizations working on SRH, relevant UN agencies, civil society groups, inter-sectoral (protection, GBV, HIV) representatives, and community representatives from often marginalized populations such as adolescents, organizations of PWDs and LGBTQIA organizations to facilitate implementation of the MISP

- Compile basic demographic and SRH information of the affected populations to support MISP advocacy, implementation and planning for comprehensive SRH service delivery
- Identify, understand, and provide information about the elements of national and host country policies, protocols, regulations, and customary laws that:
 - Support SRH services for the affected population
 - Create barriers and restrict access to SRH services
- With health, GBV, and HIV coordination mechanisms, support a mapping exercise/situation analysis of existing SRH services (including specialized local service providers that are already working with sub-populations such as LGBTQIA individuals and those engaged in sex work), and identify SRH program needs, capacities, and gaps and conduct a planning exercise in coordination with all relevant stakeholders for effective, efficient, and sustainable SRH services
- Support health partners to seek SRH funding through humanitarian planning processes and appeals including the flash appeals process (Central Emergency Response Fund (CERF) and Country-based Pooled Funds (CBPFs)) and the Humanitarian Response Plan, in coordination with the health sector/cluster
- Provide technical and operational guidance on MISP implementation, as well as orientation for health partners on the MISP, RH Kits, and other resources
- Support coordinated procurement and distribution of RH Kits and supplies and plan for long-term sustainable SRH procurement and distribution systems

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

- Ensure MISP services are monitored to ensure quality and sustainability. Utilize the MISP checklist to monitor services
- Ensure regular communication among all levels and report back on key conclusions and challenges requiring resolution to the overall health coordination mechanism
- Collect and apply service delivery data, analyze findings, identify solutions to service gaps, and plan for the provision of comprehensive SRH services
- Facilitate planning meetings with all stakeholders to identify synergies, needs, gaps, and opportunities, to support establishment of client-centered comprehensive SRH services as soon as possible and within 3-6 months of the onset of the emergency

TO ENSURE MISP IMPLEMENTATION THE FOLLOWING MUST BE DONE:

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

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

BOX 3.3: MISP COORDINATION AND ADOLESCENTS

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

3.3.2 Prevent sexual violence and respond to the needs of survivors

To prevent sexual violence and respond to the needs of survivors from the onset of an emergency, in the health sector/cluster:

- Work with other clusters, especially the protection or GBV sub-cluster, to put in place preventative measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence

- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Ensure confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

PREVENT SEXUAL VIOLENCE

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

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

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

PROGRAMMATIC EXAMPLE 3.1: MISP COORDINATION IN NEPAL

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

LOCATION: Nepal

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

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

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

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

- Design and locate health facilities to enhance physical security and safety and be accessible to persons with disabilities, in consultation with the population, in particular, women, adolescents, PWDs, and other marginalized populations
- Consult with service providers and clients about security and safety concerns regarding access to and within health facilities
- Ensure health facilities are in secure locations and have adequate path lighting at night
- Consider the need for security personnel at facility entrances
- Locate separate male and female latrines and washing areas in the health facility and ensure doors lock from the inside
- Hire and train female service providers, community health workers, program staff and interpreters
- Ensure all ethnic subgroup languages are represented among service providers, or interpreters are available
- Inform service providers and all other facility staff of the importance of maintaining confidentiality, including protecting survivor information and data
- Ensure health workers and all other facility staff have signed and abide by a code of conduct against sexual exploitation and abuse (SEA)
- Ensure that codes of conduct and reporting mechanisms on SEA (which ensure whistle blower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct

RESPOND TO THE NEEDS OF SURVIVORS OF SEXUAL VIOLENCE

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

As soon as possible, the SRH Coordinator, together with the GBV AoR lead or GBV sub-cluster, should obtain

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

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

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

BOX 3.4: GUIDING PRINCIPLES WHEN RESPONDING TO THE NEEDS OF SURVIVORS OF SEXUAL VIOLENCE

The following guiding principles should be respected at all times by all humanitarian actors who are responding to the needs of survivors:

- Safety
- Confidentiality
- Respect
- Non-discrimination

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

CLINICAL SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE

When setting up clinical services for survivors of sexual violence, SRH Coordinators and program staff must:

- Establish a private, non-stigmatizing consultation area with a lockable filing cabinet
- Put in place clear protocols and a list of patient rights in the languages of providers and patients
- Have sufficient supplies and equipment available
- Hire male and female service providers fluent in local languages and train male and female chaperones and interpreters
- Involve women, adolescent girls and boys, and other at-risk populations, such as people with disabilities and LGBTQIA groups, in decisions on accessibility and acceptability of services
- With the health cluster lead, ensure that services and a referral mechanism including transport to a hospital in case of life-threatening complications are available 24 hours a day 7 days a week

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

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

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

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

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

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

Supportive communication

Ensure service providers can extend compassionate and confidential support to the survivor through communication that is accurate, clear, non-judgmental, and involves empathetic active listening without pressuring the survivor to respond. Inform the survivor about available care options, encourage and address the survivor's questions and concerns, and obtain written or verbal consent for all aspects of care. Service providers must take care not to make promises or misrepresentations (particularly regarding security) that cannot be guaranteed.

History and examination

The health and well-being of the survivor is the main priority. Allow the survivor to choose a trusted person to be present at the examination if she or he so desires. For children, this may be their (non-offending) guardian, or where they are not available, a trained support person; the survivor should always be able to choose the sex of the support person and this is obligatory for children. Inform the survivor that the person is there to give the survivor support, but only at the survivor's request.

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

- Questions about the assault limited to what is needed for medical care (e.g., type of penetration, injuries) and, where appropriate, the collection of samples for forensic evidence. Do not ask the survivor to repeat information that is already noted on a referral form
- General medical information
- Medical and gynecological history for women and girls

- Assessment of mental state, by asking how the survivor is feeling and noting the survivor's emotions during the exam

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

The primary purpose of the history and examination is to determine the clinical care that is needed. History-taking and the examination are to be done at the survivor's own pace. The survivor should be assured that she or he is in control, does not have to talk about anything she or he is uncomfortable with, and can stop the process at any time. It is the survivor's right to decide whether to be examined and refuse any part of the exam. All aspects of the exam should be explained and consent obtained prior to touching the survivor. Allow the survivor to ask questions and agree to or refuse any aspect of the examination and treatment at any time.

The medico-legal system and forensic evidence collection, where feasible and when needed

Medico-legal system

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

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

Forensic evidence collection

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

documents should be provided free-of-charge

- The survivor is the only one who decides when and where to use the medical certificate

Compassionate and confidential treatment

Treatment can be started without examination if that is the survivor's choice. Treat life-threatening complications first and refer to higher-level health facilities, if appropriate.

Emergency contraception

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

Progestin-only ECPs

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

- Timeframe: Progestin-only ECPs should be provided as soon as possible to survivors of sexual violence because their efficacy declines with time. ECPs can be used up to 120 hours (5 days) after unprotected sex, but are more effective the sooner they are taken
- Safety: Progestin-only ECPs are safe for all women, girls, and adolescents of reproductive age, even for those who are advised not to use combined oral contraceptives for ongoing contraception, as the dose of hormones is relatively small and the pills are used for a short time
- Clinical screening: No clinical examinations or tests are needed before providing progestin-only ECPs. A pregnancy test is not required, as ECPs will neither cause any harm if the woman is already pregnant, nor affect a pre-existing pregnancy
- Mechanism of action: Progestin-only ECPs work by preventing pregnancy. They delay or prevent ovulation or stop the egg and sperm from meeting. ECPs do not have any effect after fertilization and cannot terminate or interfere with an established pregnancy. In other words, progestin-only EC does not induce an abortion

BOX 3.5: OVERVIEW OF EMERGENCY CONTRACEPTIVE PILL OPTIONS

PROGESTIN-ONLY ECPS

- One dose of levonorgestrel 1.5 mg
- Taken within 5 days (120 hours) of unprotected intercourse; efficacy is greatest when used closer to the time of sexual intercourse
- More effective and with fewer side effects than combined hormonal pills
- Most widely available type of dedicated emergency contraceptive pill

ULIPRISTAL ACETATE (UPA)

- 1 dose of ulipristal acetate 30 mg
- Taken within 5 days (120) of unprotected intercourse
- More effective than progestin-only pills in the 73-120 hours after unprotected intercourse
- More effective and with fewer side effects than combined hormonal pills

COMBINED HORMONAL ECPS

- Two doses of combined oral contraceptive pills. Each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel)
- The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) and the second dose should be taken 12 hours later
- If vomiting occurs within 2 hours of taking a dose, the dose should be repeated
- Less effective and with more side effects than progestin-only ECPs and UPA

- Side effects: Side effects are generally short-term, mild, and easily managed. These side effects may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. If vomiting occurs within two hours of taking a dose, the dose should be repeated and, if available, an antiemetic can be given. Notably, there are no long-term side effects of progestin-only ECPs; they are not associated with any serious medical complications and do not affect future fertility
- Regimens: Progestin-only ECPs are more effective and have fewer side effects than combined hormonal pills (the Yuzpe method). However, dedicated progestin-only ECPs are not available in all countries. If dedicated progestin-only ECPs are not available in your setting, first see if progestin-only oral contraceptive pills that can be used to create a 1.5 mg dose of levonorgestrel are available. If not, combined-hormonal oral contraceptive pills should be used to make EC
- Counseling: Counsel the survivor on how to take

progestin-only ECPs and what to expect after taking them. There is a small chance that the pills will not work. Inform the survivor that menstruation should occur around the time when it would normally be expected, but may be up to a week early or late. If the survivor has not had a period within a week after it was expected, she should return for a pregnancy test and/or to discuss options in case of pregnancy. Survivors should also be informed that progestin-only ECPs do not prevent pregnancy from sexual acts that take place after their use

- Repeated use: ECPs remain safe and effective in preventing pregnancy if taken more than once, even within the same menstrual cycle and there are no lifetime limits on the number of times a woman can take progestin-only ECPs. However, using an ongoing contraceptive method is recommended as the most effective way to prevent pregnancy. Progestin-only ECPs do not need to be taken more than once in a 24-hour period if unprotected sex occurs more than once during that timeframe

TABLE 3.1 EMERGENCY CONTRACEPTIVE PILL REGIMENS

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

Copper-bearing IUD

A copper-bearing IUD can also be inserted in medically eligible women through 5 days after unprotected sex, including in cases of sexual violence. This is a highly effective form of post-coital contraception and will prevent more than 99% of expected pregnancies. As the risk of ovulation is low through day 7 of the menstrual cycle, the woman can have a copper-bearing IUD inserted beyond 5 days after the sexual violence occurred, when ovulation can be estimated and as long as insertion does not occur more than 5 days after ovulation.

Providers should offer survivors full information and

counseling about this service (taking care to avoid further traumatization), so they can make a voluntary and informed decision about whether to use ECPs or have an IUD inserted. Counseling should include information about risks, benefits, side effects, and complications. Only a skilled provider should insert the IUD and only after performing a pelvic exam.

If an IUD is inserted, make sure to give full STI treatment, including antibiotics to empirically treat possible STIs and/or pelvic inflammatory disease (PID). The IUD may be removed at the time of the woman's next menstrual period or left in place as ongoing contraception (see Chapter 7).

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

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

Presumptive treatment for sexually transmitted infections

- Provide survivors antibiotics to presumptively treat gonorrhea, chlamydial infection, and syphilis, as warranted and if desired. If other STIs are prevalent in the area (such as trichomoniasis or chancroid), give presumptive treatment for these infections as well

- Give the shortest courses available in the local protocol. For instance, if the survivor presents within 30 days of the incident, 400 mg of cefixime plus 1g of azithromycin orally will be sufficient presumptive treatment for gonorrhea, chlamydial infection, and incubating syphilis

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

TABLE 3.2: WHO RECOMMENDED STI TREATMENT PROTOCOLS FOR ADULTS

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

* If the survivor presents within 30 days of the incident, benzathine benzylpenicillin can be omitted if the treatment regimen includes azithromycin 1 g as a single dose, which is effective against incubating syphilis as well as chlamydial infection. If the survivor presents more than 30 days after the incident, azithromycin 2 g as a single dose is sufficient presumptive treatment for primary, secondary, and early latent syphilis of < 2 years duration and also covers chlamydial infections.

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

Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care, to the full extent of the law

- Provide pregnancy testing at the time of the initial presentation, but do not withhold EC if this is not available
- Provide additional pregnancy testing at the 2 week

and 1 month follow-up visits

- Provide accurate information about pregnancy options, including continuing the pregnancy and parenting, continuing the pregnancy and placing the child for adoption, and having an abortion, as applicable, and non-biased counseling to facilitate informed decision-making
- If the survivor is pregnant as a result of sexual violence and an abortion is desired, provide safe abortion care or a referral for that care, to the full extent of the law

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

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

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

STI	WEIGHT OR AGE	TREATMENT
Chlamydial infection	< 45 kg	Option 1) azithromycin 20 mg/kg orally, single dose
		Option 2) doxycycline 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	> 12 years	Treat according to adult protocol
	> 45 kg but < 12 years	Option 1) erythromycin 500 mg orally, 4 times daily for 7 days
	Option 2) azithromycin 1 g orally, single dose	
Gonorrhea	< 45 kg	Option 1) ceftriaxone 125 mg intramuscularly, single dose
		Option 2) spectinomycin 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose
		Option 3) cefixime 8mg/kg of body weight orally, single dose
	> 45 kg	Treat according to adult protocol
Syphilis	All children	Option 1) benzathine benzylpenicillin* 50,000 IU/kg IM (up to a maximum of 2.4 million IU), single dose
Syphilis, patient allergic to penicillin	All children	Option 1) erythromycin 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days
Trichomoniasis	< 12 years	Option 1) metronidazole 5 mg/kg of body weight orally, 3 times daily for 7 days
	> 12 years	Treat according to adult protocol

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

Post-exposure prophylaxis (PEP) to prevent HIV transmission

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

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

FOR SURVIVORS OF SEXUAL VIOLENCE:

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

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

TABLE 3.4: RECOMMENDED COMBINATION THERAPIES FOR HIV-PEP

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

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

WEIGHT OR AGE	TREATMENT	PRESCRIBE	28-DAY SUPPLY
< 2 years or 5-9 kg	Zidovudine(AZT) syrup* 10 mg/ml	7.5 ml twice a day	420 ml (i.e. five 100 ml bottles or three 200 ml bottles)
	plus Lamivudine (3 TC) sup 10 mg/ml	plus 2.5 ml twice a day	plus 140 ml (i.e. two 100 ml bottles or one 200 ml bottle)
10-19 kg	Zidovudine (AZT) 100 mg capsule	1 capsule three times a day	90 capsules
	plus Lamivudine (3 TC) 150 mg tablet	plus ½ tablet twice a day	
20-39 kg	Zidovudine (AZT) 100 mg capsule	2 capsules three times a day	120 capsules
	plus Lamivudine (3 TC) 150 mg tablet	plus 1 tablet twice a day	plus 60 tablets

*Discard a bottle of syrup 15 days after opening

IMPORTANT TO KNOW:

- Pregnancy is not a contraindication for PEP. Inform women who are less than 12 weeks pregnant that the possible effects of the drug on the fetus are not known
- Provide enhanced adherence counseling. Counsel the survivor on common side effects of the drugs such as tiredness, nausea, and flu-like symptoms. These side effects are temporary and can be relieved with ordinary analgesics such as paracetamol
- Provide the full 28-day supply of PEP but schedule a return visit in 1 week to discuss adherence and offer return visits at any time in case survivor is concerned about side effects or other issues

Prevention of hepatitis B and human papillomavirus (HPV)

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

Consider providing the HPV vaccine to anyone age 26 or younger, unless the survivor has been fully vaccinated. In

most cases, a total of 3 doses need to be given over a 6-month period.

Care of wounds and prevention of tetanus

Clean any tears, cuts, and abrasions and suture clean wounds within 24 hours. Do not suture dirty wounds. Consider giving appropriate antibiotics and pain relief if there are large unclean wounds.

Give tetanus prophylaxis if there are any breaks in skin or mucosa and the survivor is not vaccinated against tetanus, or the vaccination status is uncertain. Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

Referral for further crisis intervention

With the survivor's consent or upon her or his request, offer referral to:

- A hospital in case of life-threatening complications or complications that cannot be dealt with at the health facility level
- Protection or social services if the survivor does not have a safe place to go when she or he leaves the health facility

- Psychosocial or mental health services where available. Liaise with GBV and protection focal points to identify psychosocial services in the setting. This may include services offered by the affected populations, women's centers, and other support groups

Follow-up care

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

Special considerations for children

The SRH Coordinator must understand and disseminate information about country-specific laws with regard to the age of consent for treatment, the professional who can give legal consent for clinical care if a parent or guardian is the suspected offender (for instance, a representative from the police, community services, or the court), and mandatory reporting requirements and procedures when service providers suspect, or are informed of, a case of child abuse.

Digital vaginal or anal or speculum examinations should not be conducted in children unless absolutely necessary. In those cases, children should be referred to a specialist.

Protocols showing appropriate drug dosages must be posted or easily available to service providers.

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

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

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

ESTABLISH SAFE AND RATIONAL USE OF BLOOD TRANSFUSION

The rational and safe use of blood for transfusions is essential to prevent the transmission of HIV and other transfusion-transmissible infections (TTIs) such as hepatitis B, hepatitis C, and syphilis. If HIV-contaminated blood is transfused, transmission of HIV to the recipient is almost 100%. Blood transfusions must not be undertaken if the facilities, supplies, and appropriately qualified staff do not exist.

RATIONAL blood transfusion includes:

- Transfusing blood only in life-threatening circumstances and when there is no other alternative

BOX 3.6: SPECIAL CONSIDERATIONS FOR SPECIFIC POPULATIONS

MALE SURVIVORS

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

PERSONS WITH DISABILITIES

Women, girls, men, and boys living with disabilities are at a higher risk of sexual violence. They also often face extreme discrimination by service providers; it is important to train and mentor health providers to reflect on their own attitudes related to disability, clinical care, and sexual violence. Host community organizations of persons with disabilities often have resources that health providers can use to ensure clinical care is provided to this often-hidden population.

LGBTQIA INDIVIDUALS

LGBTQIA individuals face a variety of different risk factors for sexual violence and it is important to acknowledge each population as having separate needs and facing different risks. More generally, LGBTQIA individuals, particularly transwomen, face discrimination by health providers and other duty bearers that prevents them from seeking SRH services, including clinical care for sexual violence. Engaging with LGBTQIA self-help or rights groups and making health facilities more respectful of diversity in gender identity and sexual orientation would allow critical health services to become more accessible to these populations.

PEOPLE WHO ENGAGE IN SEX WORK

People who engage in sex work often face stigmatization and discrimination by health providers, who may be less likely to take sexual violence against this population as a serious concern. Respectful care by these duty bearers is essential to ensuring critical health services to this population. Humanitarian actors should engage with sex worker populations to develop SRH care programming. Organizations led by refugees and people who engage in sex work often have the expertise and connections necessary to effectively provide clinical services to these groups.

ETHNIC AND RELIGIOUS MINORITIES

Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence, including oppression and harassment. These specific barriers must be considered when designing programs to reach survivors of sexual violence and provide clinical care. It is important to train caregivers, health providers, and other duty bearers on non-discriminatory practices related to SRH service provision.

- Using medicines to prevent or reduce active bleeding (e.g., oxytocin and misoprostol)
- Using blood substitutes to replace lost volume, such as crystalloid-based substitutes (Ringer's lactate, normal saline) wherever possible

SAFE blood transfusion includes:

- Collecting blood only from voluntary, unpaid blood donors at low risk of acquiring TTIs and developing stringent blood donor selection criteria
- Screening all blood for transfusion for at least HIV 1 and 2, hepatitis B, hepatitis C, and syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine HIV status (see Chapter 11). Although blood donation services should not be seen as a way for people to access HIV testing, if someone donating blood has a reactive test result this should be communicated to them. They should then be supported to link with clinical services for further testing to confirm their HIV status and, if confirmed, be linked to appropriate services
- Linking blood transfusion services with HIV counseling and testing services as soon as these are established as part of the comprehensive response and refer donors for HIV counseling and testing prior to screening their blood
- Conducting ABO grouping and Rhesus D typing and, if time permits, cross-matching
- Only transfusing blood to women of reproductive age with appropriate Rhesus type blood
- Ensuring safe transfusion practice at the bedside and safe disposal of blood bags, needles, and syringes

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

PROGRAMMATIC EXAMPLE 3.2: MISP IMPLEMENTATION IN JORDAN

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

LOCATION: Jordan

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

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

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

managers must work with the health cluster/sector partners to ensure that:

- Referral-level hospitals have sufficient supplies for safe and rational blood transfusion
- Staff have appropriate knowledge of safe blood transfusion practices and have access to supplies to reduce the need for blood transfusion
- Safe donors are recruited. Safe donors can be selected through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety. Recruit voluntary donors and do not request staff to donate blood

- Standard operating procedures for blood transfusion are in place. SOPs are essential components of a quality system in any organization and are used to ensure consistency in performing an activity. The use of SOPs is mandatory for all staff members performing blood transfusions. Keep copies of SOPs in a central location, and post them at a place where each procedure is performed so they are available for easy reference
- Responsibility for the decision to transfuse is assigned and medical staff are held accountable
- Staff are informed of protocols and follow procedures at all times to ensure safe blood transfusion practice at the bedside
- Waste products, such as blood bags, needles and syringes, are safely disposed
- Sites where blood is screened and where transfusion is performed have reliable light sources. To minimize the risk of errors, avoid blood transfusion at night as much as possible, unless sufficient lighting is available

ENSURE APPLICATION OF STANDARD PRECAUTIONS

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health workers. Under the “standard precautions” principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person. Standard precautions prevent the spread of infections such as HIV, hepatitis B, hepatitis C, and other pathogens within health care settings.

In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected. Regular supervision can help to reduce the risk of occupational exposure in the workplace. Emphasize the importance of standard precautions during the first health coordination meeting.

Standard precautions are:

- **Frequent hand washing:** Wash hands with soap and water before and after all patient contact. Make facilities and supplies for hand washing easily available for all service providers
- **Wearing gloves:** Wear non-sterile single use gloves for all procedures where contact with blood or other potentially infected body fluids is anticipated. Wash hands before putting on and after removing gloves. Discard gloves immediately after use. Require staff handling materials and sharp objects to wear heavy-duty gloves and to cover any cuts and abrasions with a waterproof dressing. Ensure sufficient supplies are available
 - o Note: Ensure the availability of an adequate and sustainable supply of gloves to carry out all activities. Never reuse or re-sterilize single use gloves; they become porous
- **Wearing protective clothing,** such as waterproof gowns or aprons, where blood or other body fluids might splash. Require staff to wear masks and eye shields where there is possible exposure to large amounts of blood
- **Safe handling of sharp objects:**
 - o Minimize the need to handle needles and syringes
 - o Use a sterile disposable syringe and needle for each injection
 - o Set up the work area where injections are given to reduce the risk of injury
 - o Use single-dose vials rather than multi-dose vials. If multi-dose vials are used, avoid leaving a needle in the stopper. Once opened, store multi-dose vials in a refrigerator
 - o Do not recap needles
 - o Position and inform patients correctly for injections
 - o Dispose needles and sharps in puncture- and liquid-proof safety boxes. Ensure puncture-resistant containers for sharps disposal are readily available, close at hand, and out of reach of

children. Sharp objects should never be thrown into ordinary waste bins or bags

- **Disposal of waste materials:** Burn all medical waste in a separate area, preferably within the health facility grounds. Bury items that still pose a threat, such as sharp objects, in a covered pit at least 10 meters from a water source
- **Instrument processing:** Process used instruments in the following order:
 - o Decontaminate instruments to kill viruses (HIV and hepatitis B) and make items safer to handle
 - o Clean instruments to remove debris before sterilization or high-level disinfection (HLD)
 - o Sterilize (eliminates all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. HLD (through boiling or soaking in a chlorine solution) may not eliminate spores
 - o Use or properly store items immediately after sterilization
- **Housekeeping:** Clean up spills of blood or other body fluids promptly and carefully with a 0.5% chlorine solution

Establish and implement workplace policies for occupational exposure

Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. Ensure PEP is available within the health sector as part of a comprehensive standard precautions package to reduce staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces and inform all staff how to access treatment for exposure.

When managing occupational exposure:

- Maintain **confidentiality** at all times
- Assess the risk of HIV transmission in case of occupational exposure: the type of exposure (percutaneous injury, mucous membrane splash, etc.), the type of exposed material (blood, other body fluids, etc.), and the likelihood of HIV infection of the source patient

- Counsel the source patient regarding HIV testing and conduct an HIV test if consent is obtained
- Provide counseling for the exposed worker on the implications of the exposure, the need for PEP, how to take it, and what to do in case of side effects
- Take a medical history and conduct an exam of the exposed worker only after informed consent, recommend HIV voluntary counseling and testing, and provide PEP when appropriate. PEP treatment protocols are the same as those for survivors of sexual violence. **An HIV test is not required (neither for the source patient nor the health care worker) before prescribing PEP**
- Educate on risk reduction through review of the sequence of events and advise the exposed worker to use condoms to prevent secondary transmission during the next three months
- Provide HIV voluntary counseling and testing at three and six months after the exposure, whether or not the exposed worker received PEP
- Complete an incident report

In order to ensure application of standard precautions, SRH Coordinator and health program managers must work with the health cluster/sector partners and:

- Ensure protocols for standard precautions are posted in each health facility, and supervisors enforce adherence to these
- Organize in-service orientation sessions on standard precautions for health workers and auxiliary staff where needed
- Establish supervisory systems, such as simple checklists, to ensure compliance with protocols
- Ensure first aid measures for occupational exposure are posted, and staff are informed and know where to report and obtain PEP if needed
- Review occupational exposure incidence reports regularly to determine when and how exposure occurred and to identify safety concerns and possible preventive measures

BOX 3.7: OCCUPATIONAL EXPOSURE FIRST AID

INJURY WITH A USED NEEDLE OR SHARP INSTRUMENT AND BROKEN SKIN	SPLASH OF BLOOD OR BODY FLUIDS ON UNBROKEN SKIN	SPLASH OF BLOOD OR BODY FLUIDS IN THE EYE	SPLASH OF BLOOD OR BODY FLUIDS IN THE MOUTH
<ul style="list-style-type: none"> • Do not squeeze or rub • Wash immediately using soap and water, or chlorhexidine gluconate solution • Do not use strong solutions. Bleach or iodine irritate the wound 	<ul style="list-style-type: none"> • Wash the area immediately. Do not use strong disinfectants 	<ul style="list-style-type: none"> • Irrigate the exposed eye immediately with water or normal saline • Tilt the head back and have a colleague pour water or normal saline • Do not use soap or disinfectant on the eye 	<ul style="list-style-type: none"> • Spit the fluid out immediately • Rinse mouth thoroughly with water or saline. Repeat several times • Do not use soap or disinfectant in the mouth

Report the incident to (insert name of relevant person-in-charge at health facility here) and take PEP if indicated

GUARANTEE THE AVAILABILITY OF FREE LUBRICATED MALE CONDOMS AND, WHERE APPLICABLE (E.G. ALREADY USED BY THE POPULATION), ENSURE PROVISION OF FEMALE CONDOMS

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

Provide lubricated condoms on request and ensure that condoms are available in all health facilities and in

accessible private areas in the community. These include latrines, bars, coffee shops, non-food distribution points, and youth and community centers. Consult with local staff about how condoms can be made available in a culturally sensitive way, particularly for adolescents and key populations, such as sex workers and their clients, men who have sex with men, persons using injectable drugs, and transgender persons. Where possible, community-led distribution of condoms within peer groups is useful. Key populations and adolescents will often know locations where their peers congregate and volunteers can be enlisted to distribute condoms to their peers. Ensure culturally appropriate messages are available to disseminate information on correct use and disposal of used condoms and educate key populations about correct use, as well as how to dispose of used condoms. Ensure condoms are also available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, and others.

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

BOX 3.8: ORDERING CONDOMS

Ensure that the procurement office responsible for bulk purchases for emergencies sources only WHO/UNFPA-approved condoms and adds a certificate in the relevant language to all shipments declaring that the condoms have been quality tested on a batch-by-batch basis by an independent laboratory.

Agencies with limited experience in condom procurement can procure them through UNFPA. UNFPA can rapidly ship bulk quantities of good-quality condoms to the field as part of the Interagency Reproductive Health Kits (RH Kits).

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

SUPPORT THE PROVISION OF ARVS TO CONTINUE TREATMENT

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

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

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

To determine who has been on treatment, examine health records or patient cards, ensuring that confidentiality is safe-guarded. Where possible, existing networks of people living with HIV can be useful to disseminate

information about the availability of ART for continuation of treatment. Use patients' treatment cards to determine the appropriate regimen. Many experienced patients can also identify which regimen they are using. In general terms, first line treatment will suffice. However, where the exact regimen (e.g., second-line regimen) is not available, the regimen should be matched with equivalent available first-line drugs, bearing in mind the national guidelines and WHO protocols for switching regimens. Per WHO recommendations, people who are already taking ARVs should not be re-tested for HIV. People on ART should also be offered condoms.

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

- Understand the HIV coordination system in the country. It is usually done through mechanisms led by the national HIV program, UNAIDS, the UN HIV coordination team, and civil society organizations. In high prevalence countries and in countries with an important proportion of people living with HIV (PLWHIV) taking ARV, the "Inter-Agency Task Team to Address HIV in Emergencies" convened by UNHCR and the World Food Program should also provide support to the health coordination mechanism and/or

CALCULATIONS FOR CONDOM SUPPLIES FOR 10 000 POPULATION OVER 3 MONTHS

MALE CONDOMS

ASSUME: 20% of population are sexually active males

THEREFORE: 20% x 10 000 persons = 2000 males

ASSUME: 20% of these will use condoms

THEREFORE: 20% x 2000 = 400 users

ASSUME: Each user needs 12 condoms per month

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

ASSUME: 20% wastage (2,880 condoms)

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

FEMALE CONDOMS

ASSUME: 25% of population are sexually active females

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

ASSUME: 1% of these will use female condoms

THEREFORE: 1% x 2,500 = 25 users

ASSUME: Each user needs 6 condoms per month

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

ASSUME: 20% wastage (90 female condoms)

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

the HIV country team

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

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

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

- Ensuring that HIV is included in needs assessments to inform scaling up HIV services once the situation stabilizes

The SRH Coordinator **should not** take the responsibility for:

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

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

Provide PEP to survivors of sexual violence

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

Provide PEP as appropriate for occupational exposure

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

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

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

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

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

Co-trimoxazole prophylaxis is recommended for adults (including pregnant women) with severe or advanced HIV clinical disease and/or with a CD4 count of ≤ 350 cells/mm³. In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or clinical disease severity. Co-trimoxazole prophylaxis is recommended for infants, children and adolescents with HIV, irrespective of clinical and immune conditions.

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

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

The syndromic management of STIs is an approach which is currently implemented in many countries and therefore

might exist before the crisis. It is a method built from algorithms (decision trees) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols. This approach is particularly relevant at the onset of a crisis, where people are less likely to come for follow-up visit and where access to laboratories might be difficult, impossible, or expensive. Antibiotics recommended by WHO for syndromic treatment of STIs are available in the Inter-Agency Reproductive Health Kits. Syndromic management is cost-effective, satisfactory for the patients, predictable (easing procurement and training), and has a strong public health base and impact.

3.3.4 Prevent excess maternal and newborn morbidity and mortality

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

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services
- Establish a 24 hour per day 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure availability of post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable

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

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

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

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

Management of intrapartum complications

WHO estimates that in any given population approximately 15% of women will develop a potentially life-threatening complication during pregnancy or at the time of delivery, and 5% to 15% of all deliveries may require a caesarean section. WHO estimates that 9% to 15% of newborns will require lifesaving emergency care. In order to prevent maternal and newborn morbidity and mortality, SRH Coordinators must ensure that basic and comprehensive EmONC services are available 24 hours per day, 7 days per week.

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

Where Type III female genital cutting (FGC) is common, SRH Coordinators and health program managers should ensure that SRH service providers are trained in deinfibulation as needed for childbirth or that a referral system is established for trained providers. Providers should ensure that women and girls have information on all aspects of the procedure and obtain consent.

Chlorhexidine cord care

Daily application of 7.1% chlorhexidine (CHX) digluconate to the umbilical cord stump during the first week of life is recommended for newborns who are born at home in settings with high neonatal mortality. Clean, dry cord care is recommended for newborns born in health facilities and

BOX 3.9: ESSENTIAL SERVICES FOR ALL NEWBORNS

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

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

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

Monitoring: Frequent assessment for danger signs of serious infections and other conditions that require extra care outside of the household or health post

Postnatal care checks: Women and babies should receive care at or as close to home as possible in the first week of life. The first 24 hours are the most critical time and should be prioritized for a postnatal visit. Every effort should be made to reach newborn babies at home as soon as possible after delivery

BOX 3.10: CHLORHEXIDINE FOR CLEAN CORD CARE AT HOME

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

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

Basic EmONC

While skilled attendance at all births in a health facility is ideal because it can help reduce morbidity and mortality associated with pregnancy and childbirth, it may not be feasible at the start of a humanitarian response. However, at a minimum, ensure that each health center has capacity to provide BEmONC and refer to a hospital for CEmONC, 24 hours per day, 7 days per week.

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

BOX 3.11: SIGNAL FUNCTIONS OF BASIC AND COMPREHENSIVE EMONC

Ensure basic EmONC at all health centers. This means that staff are skilled and have the resources to:

1. Administer parenteral antibiotics for treatment of sepsis
2. Administer uterotonic drugs (i.e., parental oxytocin or misoprostol tablets) for treatment of postpartum hemorrhage and administer intravenous tranexamic acid in addition to standard care for women with clinically diagnosed postpartum hemorrhage
3. Administer parenteral anticonvulsant drugs (i.e., magnesium sulfate) to manage severe preeclampsia and eclampsia

4. Perform assisted vaginal delivery (e.g., vacuum extraction)
5. Manually remove the placenta
6. Remove retained products of conception after delivery or an incomplete abortion
7. Perform basic neonatal resuscitation (e.g., with bag and mask)

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

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

Newborn care

Approximately two-thirds of infant deaths occur within the first 28 days of life. The majority of these deaths are preventable by initiating essential actions that can be taken by health workers, mothers, or other community members. Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation.

Comprehensive EmONC

Where feasible, support host-country hospitals with skilled staff, infrastructure, and medical commodities, including medicines and surgical equipment, as needed to provide CEmONC. If this is not feasible because of the host-country hospital's location or inability to meet the increased demand, the SRH Coordinator should work with the health sector/cluster and an agency such as the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross and Red Crescent Societies (IFRC), or Médecins Sans Frontières (MSF) and other NGOs to provide CEmONC, such as establishing a temporary field or referral hospital close to the affected population.

About half of those that have difficulty initiating breathing require resuscitation. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

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

BOX 3.12: NEWBORN CARE

Newborn care at health facility level:

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

Newborn care at hospital level:

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

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

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

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

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

BOX 3.13: SIGNS OF POSSIBLE SERIOUS BACTERIAL INFECTION IN NEWBORNS

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

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

To prevent and respond to complications including provision of EmONC:

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

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

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

Kangaroo Mother Care for preterm and low birth weight babies

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

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

Coordinate with the health sector/cluster and host-country authorities to ensure a referral system (including means of communication and transport) as soon as possible. Such a referral system must support the management of obstetric and newborn complications 24 hours a day, 7 days a week (24/7). It should ensure that women, girls, and newborns

who require emergency care are referred from the community to a health center where BEmONC is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health center must be stabilized and transported to a hospital with CEmONC services.

- Develop policies, procedures, and practices to be followed in health centers and hospitals to ensure efficient referral
- Determine distances from the affected community to functioning health centers and to the hospital, as well as transport options for referrals
- Post protocols in every health center, specifying when, where, and how to refer patients with obstetric and newborn emergencies to the next level of care
- Inform communities when and where to seek emergency care for complications of pregnancy and childbirth. Messages should be shared in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (with women's, LGBTQIA, and PWD groups) and other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines). Meet with and inform community leaders, traditional birth attendants, and others to distribute illustrative brochures or undertake other creative information, education, and communication (IEC) approaches

Without access to adequate EmONC, women and newborns will die unnecessarily. Therefore, it is vital to attempt to negotiate access to the referral hospital. Where 24/7 referral services are impossible to establish, it is essential that qualified staff are available at all times at health centers to provide basic EmONC. In this situation, it is helpful to establish a system of communication, such as the use of radios or cell phones, to get medical guidance and support from more qualified personnel.

BOX 3.14: HELPING SMALL NEWBORNS SURVIVE AND THRIVE WITH KMC

GETTING STARTED WITH KMC

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

POSITIONING

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

FEEDING

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

DURATION

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

FOLLOW-UP

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

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

Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects women, girls, families, and entire communities. Globally, unsafe abortion, that is abortions performed either by persons lacking the necessary skills or in an environment lacking the minimum medical standards, or both, accounts for nearly 8% of maternal deaths, 97% of which occur in the developing world. Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion. Most countries now allow abortion to be performed on multiple grounds including when the pregnancy endangers the woman's life, threatens the woman's physical and/or mental health, is the result of rape or incest, or involves a fetus with a severe impairment.

Post-abortion care (PAC) is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and is a life-saving intervention. Typically, women presenting for post-abortion care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. Women who have suffered more severe complications may present with shock, hemorrhage, sepsis, and intra-abdominal injury. Severe complications are more likely in settings where access to safe and legal abortion care is limited.

A rapid, initial assessment should be performed on all women presenting for care. If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization. Once the initial assessment and stabilization are underway, a more complete clinical assessment should be done to determine the cause and begin treatment. Shock in PAC clients is usually either hemorrhagic or septic. Hemorrhagic shock is the result of severe blood loss, which may be caused by an incomplete abortion, uterine atony, or vaginal, cervical, uterine, or intra-abdominal injury. Septic shock is the end result of infection, which may come from incomplete abortion, endometritis, or intra-abdominal injury. A history and directed physical exam with concurrent treatment should be done urgently for definitive management of underlying causes. Treatment may require immediate uterine evacuation; in the first trimester this is typically done through vacuum aspiration or the use of misoprostol. If

the woman requires treatment beyond the capability of the facility where she is seen, stabilize her condition before transferring her to a higher-level service.

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

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

In all humanitarian settings, there are women and girls who are in the later stages of pregnancy and who will therefore deliver during the emergency. At the onset of a humanitarian response, births will often take place outside of a health center without the assistance of skilled birth attendants. Make a clean delivery package available to all visibly pregnant women to improve birth and essential newborn care practices when access to a health facility is not possible. For example, distribution can be done at registration sites or via community health workers where there is an established network.

In settings where access to facilities is not possible and traditional birth attendants (TBAs) are assisting home deliveries, they can be given clean delivery kits and additional basic supplies. The provision of supplies for the newborn will encourage essential newborn care practice. Where the community was trained in their use prior to the emergency, clean delivery kits can also include misoprostol tablets aimed at preventing PPH and a tube of chlorhexidine gel/solution 7.1% (delivering 4% chlorhexidine (CHX)) to prevent cord infection among newborns. The provision of these high impact interventions is part of community-based interventions that also include education to pregnant women in their use. Recent evidence from both stable and crisis settings suggests that self-administration of misoprostol can be done safely and effectively. Misoprostol has the potential to reach women who give birth, by choice or by necessity, at home or in health facilities that lack electricity, refrigeration, and/or skilled health providers. In settings with national protocols for advanced distribution of misoprostol tablets for PPH prevention and chlorhexidine for cord care, the SRH

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

Link TBAs to a health clinic with skilled birth attendants where they can register and replenish their supplies. This is a first step to integrating them within a comprehensive SRH program where they may be able to play a role as a link between families, communities, and local authorities, and the SRH services or in referring or accompanying laboring women to the health facility for delivery after appropriate services have been established.

BOX 3.15: CLEAN DELIVERY AND NEWBORN KITS

CLEAN DELIVERY KIT

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

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

NEWBORN KIT

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

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

Clean delivery kit packages and supplies for community-level distribution can be ordered through Inter-Agency Reproductive Health Kit procurement process. Because these materials are often easily obtained locally and do not expire, it is possible to assemble these packages onsite and pre-stock them as a preparedness measure in settings where they do not need to be immediately available. It may be possible to contract with a local NGO to produce the packages, which could provide an income generation project for local women.

PROGRAMMATIC EXAMPLE 3.3: MISP IMPLEMENTATION IN TANZANIA

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Tanzania

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

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

RESULTS: The IRC established two fully functioning emergency reproductive health clinics and a maternity unit and filled staffing gaps in the clinics to ensure 24/7 access to RH services with an efficient medical referral

system in place. RH Kits were then shipped from IRC's pre-positioned stock in Amsterdam to supply project sites with commodities and medicines. Urgent RH services to the displaced Burundian population were established with in-service clinical refresher training for staff. Community Health Workers were identified to raise community awareness of priority RH needs and available RH services. Results showed 64 new clients per week for family planning; 15 clients per month for management of abortion; an average of 3 survivors of sexual assault per week received clinical care; and an average of 215 deliveries were conducted per month in the maternity unit.

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

3.3.5 Prevent unintended pregnancies

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

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

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

- A range of oral contraceptive pills, hormonal injectables and implants, IUDs, male and female condoms, and emergency contraceptive pills should be made available immediately to meet demand in the affected population where providers are trained and skilled to provide, and in the case of long-acting reversible contraceptive, remove the method
- Providers with existing competency should begin providing all methods at the onset of the crisis
- All forms of contraception should be provided on a confidential basis, without requiring the consent of a partner or parent

- Condoms should be available at community and health facility levels and all contraceptive clients counseled on dual protection against STIs and HIV and pregnancy. Protection against pregnancy and STIs/HIV makes this “dual protection”
- Emergency contraception should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual

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

- Providers should ensure quality of care that emphasizes clients’ confidentiality and privacy,

clients’ voluntary and informed choice and consent, method eligibility, effectiveness, possible side effects management, follow-up, and guidance on method removal as appropriate for women of all ages, including adolescent girls

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

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

PROGRAMMATIC EXAMPLE 3.4: MISP IMPLEMENTATION IN NIGERIA

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Nigeria

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

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

RESULTS: The IRC conducted a situation analysis of existing structures and gaps, which informed the strategy and work plan. The IRC recruited midwives and skilled

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

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

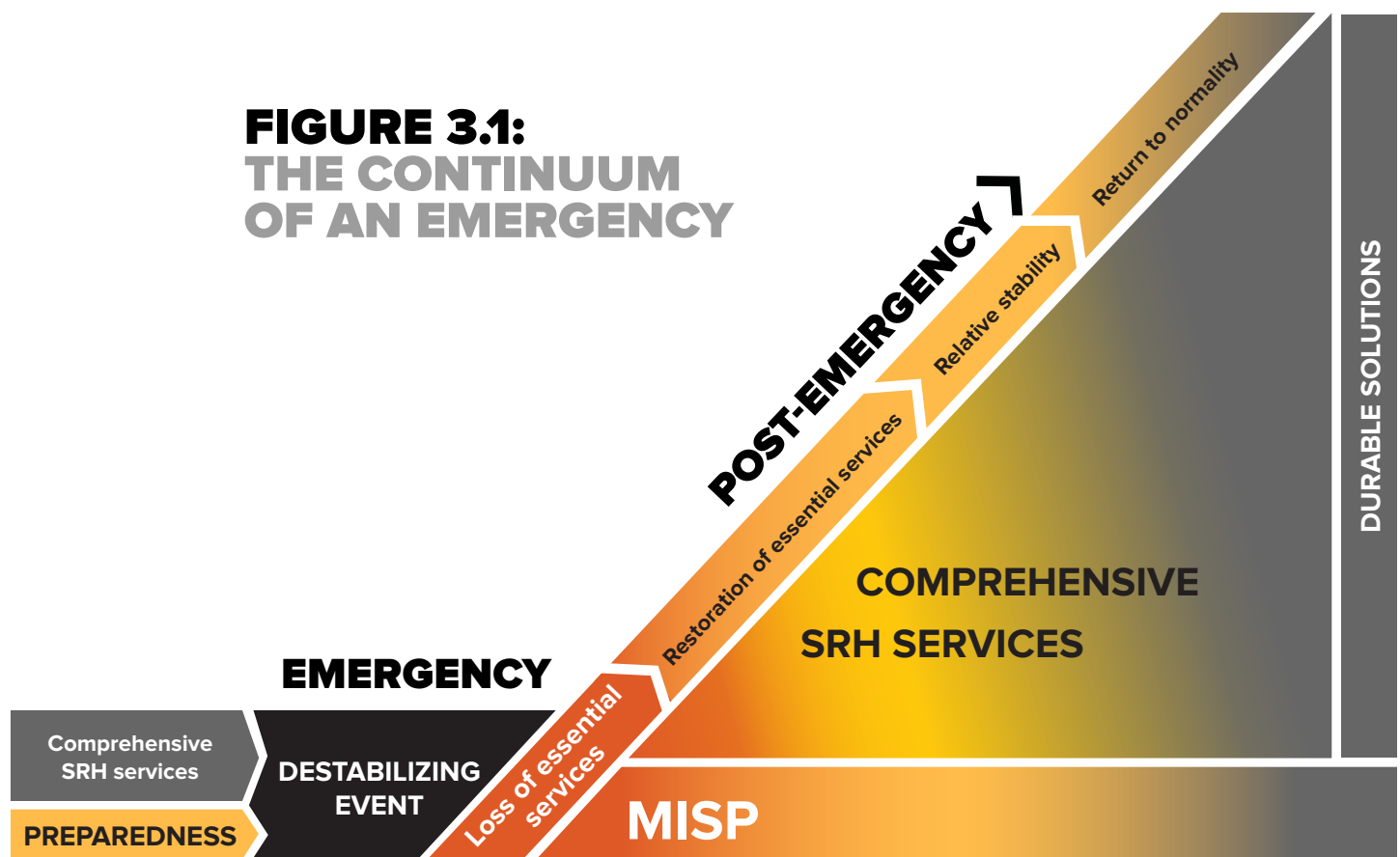
3.3.6 Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks.

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

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

The implementation of the MISP not only entails coordination to make life-saving clinical services available, it is also essential to start addressing comprehensive SRH as soon as possible. This requires vision, leadership, effective coordination skills, and a sound understanding of the local situation and opportunities related to health system reconstruction. To fully achieve Objective 6 of the MISP and support local and international stakeholders in planning for the delivery of comprehensive SRH services, several critical aspects need to be considered. These include:

**FIGURE 3.1:
THE CONTINUUM
OF AN EMERGENCY**



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

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

WHEN

Start planning for the integration of comprehensive SRH activities into primary health care at the onset of the humanitarian response. Failure to do so may unnecessarily delay the provision of these services, which increases

the risk of unintended pregnancies, the transmission of STIs, complications arising from GBV, and maternal and newborn morbidity and mortality.

HOW

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

WHAT

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

TABLE 3.6: HEALTH SYSTEM BUILDING BLOCKS

HEALTH SYSTEMS BUILDING BLOCK	WHEN PLANNING FOR COMPREHENSIVE SRH SERVICES, COLLABORATE WITH ALL STAKEHOLDERS TO
Service delivery	<ul style="list-style-type: none"> • Identify SRH needs in the community • Identify suitable sites for SRH service delivery
Health workforce	<ul style="list-style-type: none"> • Assess staff capacity • Identify staffing needs and levels • Design and plan staff training
Health information system	<ul style="list-style-type: none"> • Include SRH information in the health information system
Medical commodities	<ul style="list-style-type: none"> • Identify SRH commodity needs • Strengthen SRH commodity supply lines
Financing	<ul style="list-style-type: none"> • Identify SRH financing possibilities
Governance and leadership	<ul style="list-style-type: none"> • Review SRH-related laws, policies, protocols • Coordinate with MOH • Engage communities in accountability

Service delivery

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

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

Health work force

Staff capacity can be measured through supervisory activities (e.g., monitoring checklists, direct observation, client exit interviews) or through formal examinations of knowledge and skills. When planning for training or retraining of staff, work with national authorities, academic institutes, and training organizations and take into consideration existing curricula. Training health workers on patients' rights and the provision of unbiased, equitable care is critical. Where possible, use national trainers. Plan training sessions carefully, in order to prevent staffing gaps at health facilities, and provide adequate support so health workers can do their jobs effectively.

Health Information System

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

- Address relevant MOH policies and protocols for standardized care, such as STI syndromic management, family planning protocols, and laws and regulations surrounding safe abortion care
- Build upon estimated demographic data to collect more specific SRH information of the affected population, such as:

- o Number of women of reproductive age (aged 15 to 49) estimated at 25% of the population, number of sexually active men estimated at 20% of the population, and the crude birth rate estimated at 4% of the total population
- o Age- and sex-specific mortality data. For example, the number of deaths in adolescent (15-19) year old girls, newborn mortality rate (number of deaths during the first 28 completed days of life per 1,000 live births in a given period), and existing background data on maternal mortality
- o STI and HIV prevalence, contraceptive prevalence and preferred methods, prevalence of unsafe abortion, and SRH knowledge, attitudes and behaviors of the affected population

Medical commodities

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

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

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

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

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

BOX 3.16: DEFINITION OF HEALTH FINANCING SYSTEM

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

Financing

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

- Community financing and community-based health insurance
- Conditional and unconditional cash transfers
- Out-of-pocket payments or user fees
- Results-based financing
- Voucher subsidies to clients and reimbursements for healthcare workers
- Social marketing and franchising

While a systematic review of financing mechanisms for contraception found that the evidence base was not yet robust enough to make strong recommendations, a variety of promising efforts are underway. For example,

UNHCR has started to implement successful cash-based interventions for health programs in refugee settings, such as a program offering Syrian refugee women short-term cash payments to offset the costs of maternal healthcare. UNHCR has had further success in integrating displaced populations into the national insurance structure of the country in which they are residing.

Governance and Leadership

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

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

3.3.7 Supplies to implement the MISP

To implement the service delivery components of the MISP, the Inter-agency Working Group on Reproductive Health in Crises designed a set of kits containing medicines and other commodities aimed at facilitating the implementation of these priority SRH services: the Inter-Agency Reproductive Health Kits (RH Kits). The RH Kits complement the Inter-Agency Emergency Health Kit (IEHK), which is a standardized emergency health kit that contains essential drugs, supplies, and equipment for the

provision of primary health care services. In a humanitarian setting, the IEHK is often rapidly available. Although it contains a midwifery kit, progestin-only ECPs, PEP, and supplies for the adherence to standard precautions, the IEHK does not have all supplies needed to implement MISP services.

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

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

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

RH KIT PROCUREMENT AND LOGISTICS

UNFPA is in charge of assembling and delivering the Inter-Agency RH Kits. Order RH Kits through UNFPA or identify other quality supply sources to ensure all necessary equipment and materials are available to provide the full range of priority SRH services. Agencies should not be dependent on one source for supplies and should include SRH commodities in their overall medical supply procurement.

When planning to order RH Kits, it is essential to coordinate with other partners in the health coordination structure and develop a plan for in-country distribution of the RH Kits. This plan outlines how many of each RH Kit go to which partner, and in which geographical setting. It also includes detailed plans for in-country transport and storage, including provisions for items that need to be kept cool (cold-chain).

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

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

BOX 3.17: INTER-AGENCY RH KIT POINTS OF CONTACT

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

TABLE 3.7: INTER-AGENCY REPRODUCTIVE HEALTH KITS

BLOCK 1

RH Kit No.	RH Kit Name	Color Code
RH Kit 0	Administration	Orange
RH Kit 1A RH Kit 1B	Part A: Male condoms Part B: Female condoms	Red
RH Kit 2A RH Kit 2B	Part A: Clean delivery (Individual packages) Part B: Supplies for birth attendants	Dark Blue
RH Kit 3	Post-rape	Pink
RH Kit 4	Oral and injectable contraception	White
RH Kit 5	STI treatment	Turquoise

BLOCK 2

RH Kit No.	RH Kit name	Color Code
RH Kit 6A RH Kit 6B	Delivery kit (Health facility) Part A: Reusable equipment Part B: Drugs and disposable equipment	Brown
RH Kit 7	IUD	Black
RH Kit 8	Management of complications of miscarriage and abortion	Yellow
RH Kit 9	Suture of tears (cervical and vaginal) and vaginal examination	Purple
RH Kit 10	Vacuum extraction delivery (manual)	Gray

BLOCK 3

RH Kit No.	RH Kit name	Color Code
RH Kit 11A RH Kit 11B	Referral level (Part A plus B) RH Kit 11A RH Kit 11B	Fluorescent green
RH Kit 12	Blood transfusion	Dark green

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

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

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

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

KEY

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

Primary health care facility level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order these kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

Referral hospital level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

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

* At the time of printing this manual Newborn Care Supply Kits are not yet available

** Misoprostol can also be procured to complement Kit 6B and Kit 8 for the Primary Health Care Facility

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

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

- Where providers or the population are trained to use the commodity
- Where the supplies were accepted and used prior to the emergency
- Temporary, in protracted or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels)
- Where the use of the supplies is allowed to the fullest extent of the national law

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

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

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

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

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

3.3.8: Other sexual and reproductive health priorities

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

SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW

Access to safe abortion care (SAC) to the full extent of the law should be facilitated from the onset of an emergency by direct service provision or referral to trained providers. In most countries, induced abortion is legally permitted in at least some circumstances. In many countries abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest. Programs should identify the conditions under which national policies, signed international agreements and international humanitarian and human rights law permit the provision of SAC.

Evidence demonstrates that access to safe abortion for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality. Global data indicate that unsafe abortion is present in countries where safe abortion care is not accessible to all women and girls and that the need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of SAC for women who are raped in crises; international human rights law supports access to SAC across all settings.

In most settings safe abortion care is legally permissible for some or all reasons and capacity exists to provide and/

or refer women to SAC services. If the woman chooses an abortion, health care workers should:

- Provide medically accurate information about abortion services in a form women can understand and recall
- Explain any legal requirements for obtaining safe abortion care
- Explain where and how to obtain safe, legal abortion services and their cost
- Provide medication abortion, with mifepristone/misoprostol if available or misoprostol-alone if mifepristone is unavailable, vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by WHO
- Provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method
- Consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of STIs

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

3.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

The MISP as a standard for humanitarian actors is supported by the international legal obligations of States to respect and ensure basic human rights, including reproductive rights, in humanitarian settings. During conflict situations, States are obliged to ensure the provision of humanitarian assistance to the civilian population where food, medicine, and other resources are inadequate. States also have a duty not to interfere with the provision of life-saving,

health-related, and other humanitarian assistance. Humanitarian assistance and protection of individual rights must be provided and ensured by States and other parties without discrimination. Further, human rights law remains applicable during conflict and crisis situations and should be used to provide additional details on affirmative obligations of States and responders, including comprehensive sexual and reproductive health care for all.

Recognizing that certain categories of people have particular needs in times of conflict and/or displacement, international law grants special treatment and protection to children and women, especially expectant mothers and women with small children. States and relief workers are required to give special attention to the health needs of women, by ensuring access to SRH services, including preventing HIV transmission, and access to female service providers. In addition, international refugee law requires that States treat refugees lawfully residing in their territory equal to their nationals with respect to social security schemes, including maternity and sickness benefits.

In emergencies, States have collective and individual duties to ensure the right to health by cooperating to provide humanitarian assistance, including access to SRH care. The United Nations Committee on Economic, Social and Cultural Rights has instructed States, in response to an emergency, to give priority in “provision of international medical aid...safe and potable water, food and medical supplies...to the most vulnerable or marginalized groups of the population.” In addition, the UN Committee on the Elimination of Discrimination Against Women (CEDAW) has clarified that in conflict and post-conflict situations, States must ensure the provision of “sexual and reproductive health care includes access to sexual and reproductive health and rights information; psychosocial support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post-abortion care; prevention and treatment of HIV/AIDS and other sexually transmitted infections, including post-exposure prophylaxis; and care to treat injuries such as fistula arising from sexual violence, complications of delivery or other reproductive health complications, among others.”

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

BOX 3.18: ADVOCACY

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

The MISP is:

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

3.5 MONITORING AND EVALUATION

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

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

FIGURE 3.2: SAMPLE MISP CHECKLIST

GEOGRAPHIC AREA:		REPORTING TIME PERIOD: __/__/20__ TO __/__/20__	START DATE OF HEALTH RESPONSE: __/__/20__	REPORTED BY:	
1. SRH lead agency and SRH Coordinator					
				YES	NO
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster				
	Lead agency				
	SRH Coordinator				
1.2	SRH stakeholder meetings established and meeting regularly:				
	National (MONTHLY)				
	Sub-national/district (BIWEEKLY)				
1.3	Local(WEEKLY)				
	Relevant stakeholders lead/participate in SRH Working Group meetings				
	Ministry of Health				
	UNFPA and other relevant UN agencies				
	International NGOs				
	Local NGOs				
	Protection/GBV				
	HIV				
1.4	Civil Society including marginalized (adolescents, persons with disabilities, LGBTQIA people)				
	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensures mapping and vetting of existing SRH services				
2. Demographics					
2.1	Total population				
2.2	Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)				
2.3	Number of sexually active men (estimated at 20% of population)				
2.4	Crude birth rate (national host and/or affected population or estimated at 4% of the population)				
3. Prevent sexual violence and respond to the needs of survivors					
				YES	NO
3.1	Multi-sectoral coordinated mechanisms to prevent sexual violence are in place				
3.2	Safe access to health facilities				
	Percentage of health facilities with safety measures (Sex segregated latrines with locks inside, lighting around health facility, system to control who is entering or leaving facility, i.e., guards or reception)				
3.3	Confidential health services to manage survivors of sexual violence				
	Percentage of health facilities providing clinical management of survivors of sexual violence (Number of health facilities offering care/all health facilities) x 100%				
	Emergency contraception				
	Pregnancy test				
	Pregnancy				
	PEP				
	Antibiotics to prevent and treat STIs				
	Tetanus toxoid/Tetanus immunoglobulin				
	Hep B vaccine				
	Safe abortion care				
	Referral to health services				
	Referral to safe abortion services				
	Referral to psychological, social support services				

3.4	Number of incidents of sexual violence reported to health services		
	Percent of eligible survivors of sexual violence who receive PEP within 72 hours of an incident (Number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100%		%
		YES	NO
3.5	Information on the benefits and location of care for survivors of sexual violence		
4. Prevent and respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		
4.4	Lubricated condoms available free of charge:		
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	People with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period (specify locations)		
4.7	ARVs available to continue treatment for people who were enrolled in ART prior to the emergency including PMTCT		
4.8	PEP available for survivors of sexual violence? PEP available for occupational exposure?		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		
5. Prevent excess maternal and newborn morbidity and mortality			
5.1	Availability of emergency obstetric and newborn care (EmONC) basic and comprehensive per 500,000 population	YES	NO
	Health center with basic EmONC five per 500,000 population		
	Hospital with comprehensive EmONC one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	YES	NO
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
	Hospital (to ensure comprehensive EmONC 24/7)	YES	NO
	One qualified service provider on duty per 20-30 inpatient beds for the obstetric wards		
	One team of doctor/nurse/midwife/anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care		
	Coverage of post-abortion care (PAC) (number of health facilities where PAC is available/number of health facilities) x 100%		
	Number of women and girls receiving PAC		
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 means of communication (radios, mobile phones)	YES	NO
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		
5.4	Functioning cold chain (for oxytocin, blood screening tests) in place		

5.5	Proportion of all births in health facilities (Number of women giving birth in health facilities in specified period/expected number of births in the same period)			%
5.6	Need for EmONC met (Number of women with major direct obstetric complications treated in EmONC facilities in specified period/Expected number of women with severe direct obstetric complications in the same area in the same period)			%
5.7	Number of caesarean deliveries/number of 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	Emergency contraception (progestin-only pills)			
6.4	Oral contraceptive pills			
6.5	Injectables			
6.6	Implants			
6.7	Intrauterine device			
6.8	Number of health facilities which maintain a minimum of 3 month's supply of each			NUMBER
	Condoms			
	Emergency contraception (progestin-only pills)			
	Combined oral contraceptive pills			
	Progestin only contraceptive pills			
	Injectables			
	Implants			
	Intrauterine device			
7. Planning for transition to comprehensive SRH services				
7.1	Service delivery	YES	NO	
	SRH needs in the community identified			
	Suitable sites for SRH service delivery identified			
7.2	Health workforce	YES	NO	
	Staff capacity assessed			
	Staffing needs and levels identified			
	Training(s) designed and planned			
7.3	Health information system	YES	NO	
	SRH information included in health information system			
7.4	Medical commodities	YES	NO	
	SRH commodity needs identified			
	SRH commodity supply lines identified, consolidated and strengthened			
7.5	Financing	YES	NO	
	SRH funding possibilities identified			
7.6	Governance, leadership	YES	NO	
7.7	SRH-related laws, policies, and protocols reviewed			

8. Other priority activity: Safe abortion care		
8.1	Coverage of safe abortion care (SAC) (number of health facilities where SAC is available/number of health facilities) x 100%	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	
9. Special notes		
10. Further comments		
Explain how this information was obtained (direct observation, report back from partner (name), etc.) and provide any other comments.		
11. Actions (For the “No” checks, explain barriers and proposed activities to resolve them)		
Number	Barrier	Proposed solution

3.6 FURTHER READING AND ADDITIONAL RESOURCES

ESSENTIAL MISP READINGS

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CHAPTER 4

LOGISTICS

- 4.1 Introduction
 - 4.2 Objectives
 - 4.3 Logistics programming
 - 4.3.1 Principles in supply chain management in emergency settings
 - 4.3.2 Essential program information needed for logistics and supply chain management decisions
 - 4.3.3 Supply chain: From preparedness to MISP to comprehensive SRH services
 - 4.3.4 Coordinating and making linkages
 - 4.3.5 Advocacy
 - 4.4 Human rights and legal considerations
 - 4.5 Monitoring and evaluation
 - 4.6 Further reading and additional resources
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4.1 INTRODUCTION

A strong supply chain is a critical component of sexual and reproductive health (SRH) service delivery. When SRH supplies – from contraceptive methods, to antibiotics for sexually transmitted infections, to medicines that prevent maternal death and basic supplies for small and sick newborns – are not available, SRH services cannot be effective. In short, ***no product, no program***.

The success or failure of a humanitarian response can hinge on effective supply chain management. Supply chain management is the leveraging of relationships for proper forecasting of commodity demand and quantities needed, procuring, warehousing, transporting, and distributing goods. Supply chain management aims to better align supply and demand. In other words, supply chain management means getting the right goods, in the right quantity and quality, from the right place/person, through the right channels, to the right place, at the right time. The terms “logistics” and “supply chain management” are often used interchangeably.

BOX 4.1: THE SIX “RIGHTS” OF LOGISTICS

The **RIGHT** goods
In the **RIGHT** quantities
In the **RIGHT** condition

DELIVERED...

to the **RIGHT** place
at the **RIGHT** time
for the **RIGHT** cost

The processes required to ensure that high quality SRH supplies are available in good condition, when and where they are needed, include forecasting and quantification, procurement, importing, warehousing, transportation, distribution, and data collection and reporting. Coordinating and managing these processes requires clearly delineated roles and responsibilities and a high level of communication, collaboration, and coordination among government agencies and program and logistics staff across various international and national partners.

When humanitarian emergencies occur – from rapid onset flooding to protracted conflict to slow-onset drought – organizations involved in the response must quickly identify or establish functioning, agile supply chains to provide lifesaving commodities to the affected population as soon as possible. Humanitarian response agencies also have a responsibility to help make supply chains robust, flexible, and sustainable in all settings and situations, whether in cities or in remote rural areas and whether as part of preparedness activities or in acute/post-acute emergencies or protracted crisis settings. Strengthening locally sustainable supply chains is critical not only during the transition from the implementation of the minimum initial service package (MISP) to comprehensive SRH service provision, but even in the acute phase of an emergency when the MISP is implemented. In some cases, multiple supply chains may exist, but at minimum these channels must be coordinated within the overall supply

chain system and move toward a sustainable integrated system as soon as possible.

No matter how the supply chain is designed, successful humanitarian supply chain management operations must address the full emergency program cycle, including emergency preparedness, initial response, and transition to sustainable supply chains. All of these phases of the emergency program cycle must be taken into consideration during the preparedness activities or the initial planning process for the response. The preparedness phase is critical to rapidly establishing a humanitarian supply chain when a crisis hits.

Logisticians may be the point persons leading many of the processes discussed in this chapter, but roles and responsibilities may vary by organization. ***SRH point persons must always coordinate with procurement and logistics staff***, whatever the specific titles or multiple roles individuals might play.

4.2 OBJECTIVES

The objectives of this chapter are to:

- Introduce key processes and stakeholders that are essential to effective humanitarian SRH supply chains
- Provide basic information about each link in the humanitarian SRH supply chain, from quantification and procurement to transportation and last-mile distribution
- Provide recommendations to facilitate a continuous smooth expansion of MISP services to comprehensive SRH programming in order to enable a return to the pre-existing supply chain system and/or facilitate a strengthened system
- Identify essential staff roles and responsibilities, including management practices, for building and maintaining effective humanitarian SRH supply chains

4.3 LOGISTICS PROGRAMMING

4.3.1 Principles in supply chain management in emergency settings

The principles underlying successful SRH supply chain management in emergency settings include:

- Meet the immediate SRH needs of the affected population, including marginalized sub-groups, by distributing SRH supplies as soon as possible after the onset of the crisis
- As soon as the situation stabilizes, transition away from reliance on Inter-Agency Reproductive Health Kits (see Table 3.7) and support a more sustainable, consumption-driven supply chain system at all levels
- Strengthen local capacity to be able to maintain a robust, sustainable supply chain over time
- Support local economies throughout the supply chain system, by sourcing locally as much as possible, when possible
- Prepare in advance to be able to meet SRH supply needs as soon after the onset of an emergency as possible
- Prevent stock outs while minimizing wastage
- Ensure provision of *quality assured* products

4.3.2 Essential program information needed for logistics and supply chain management decisions

Supply chain infrastructure will often be severely damaged or completely incapacitated in the wake of an emergency. In the initial stages of an acute emergency response it may not be appropriate to utilize the time, resources, and staffing to conduct a full coordinated logistics needs assessment. Instead, information collected pre-crisis such as any relevant secondary data, analysis of existing supply chains, historical data, and supplies that currently exist in country, as well as continuous collaboration with technical staff, can provide critical information for initial supply chain planning and implementation. Pre-crisis data and rapid situation overviews can help in fine-tuning

supply orders. Use this information in combination with existing tools, such as the Inter-Agency Reproductive Health Kits (RH Kits) Calculator developed by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, to guide initial SRH logistics and supply activities. Remember, just as the MISP does not need an assessment to begin implementation the same is true for the supply chains that support initial MISP implementation.

Pre-existing relationships and agreements, transportation plans, and other pre-crisis systems are also essential to planning and implementing supply chains in crises. The plans you make in your preparedness and planning activities are crucial to the success of any emergency response programming.

BOX 4.2: NEEDS ASSESSMENTS, PREPAREDNESS, AND LOGISTICS

Just as with implementing the MISP, a needs assessment for logistics and supply chain management is not immediately necessary following a new emergency. Data collected during the preparedness phase and other types of secondary/pre-existing data, can provide the information needed in the initial response. Logistics and supply chain systems should always be included in preparedness and planning activities, along with any annual contingency or security planning process.

Once possible and appropriate, multi-sector rapid/initial needs assessments will typically be performed by technical staff. These often have a focus on basic needs of affected communities such as health, shelter, food, and water, sanitation, and hygiene (WASH). It is critical that logistics, supply chain, and procurement staff work closely with technical staff (and vice versa) to gather and interpret key population data. An initial needs assessment is important to identify existing capacities and gaps in supply chain channels and key health products. This will also inform the development of a transition plan toward sustainable supply chains. The health sector and other sectors will conduct initial needs assessments within the first hours and days of an acute emergency. Agencies working on SRH programming must share assessment data across and within agencies, as well as across clusters, to inform supply chain programming.

As the response progresses, other assessments will be conducted by health and other technical sectors. These

include cross-sectoral coordinated needs assessments (typically led by the UN), which are helpful to understand the emerging health needs of the affected population (which directly informs supply chain needs). Staff working on supply chain, procurement, and logistics systems should be familiar with the data from such tools. They should share them amongst partners and encourage collaboration across clusters (health, logistics, etc.) throughout the processes to ensure robust supply chain management systems supported by well-informed stakeholders.

BOX 4.3: PARTNERSHIP AND COORDINATION

Logistics coordination encompasses all working groups and cluster mechanisms, including sub-working groups, state-level clusters, health facilities, community groups, etc. Information, data, assessments, and supply chain planning should be shared within and across agencies, as well as across clusters. True coordination mechanisms engage all key stakeholders at relevant points in the collaborative logistics process of establishing supply chain systems.

CRITICAL INFORMATION TO COLLECT AND UNDERSTAND FOR MISP IMPLEMENTATION IN ACUTE EMERGENCIES

SRH agencies should determine whether it is possible to obtain SRH supplies in-country to meet the needs of the affected population. When supplies are not already in-country, agencies will often procure RH Kits from the Procurement Services Branch of the United Nations Population Fund (UNFPA). The RH Kits can also be procured from regional warehouses where they have been pre-positioned. However, it is important to keep in mind that not every context will require procurement of RH Kits and that not every context will need every RH Kit. UNFPA's Humanitarian and Fragile Contexts Branch can help facilitate the procurement of RH Kits. For more information on the content and procurement of the RH Kits see Chapter 3.

Agencies should immediately coordinate with the clusters (health, logistics, and potentially protection) and across partner agencies to ensure SRH supplies are part of the health cluster core commodity-pipeline. This is essential

to avoid unintended SRH supply gaps emerging in the confusion of the initial response— especially if the SRH sub-cluster has not been activated yet.

Several data points can be used to inform logistics planning. These include, but are not limited to, total emergency-affected population, catchment area geography and population numbers, past clinic supply levels, current stock and storage in health facilities, product specifications, partner agreements, transportation options and warehousing conditions, government import regulations, staff capacity, and waste management processes. Use these data points to inform supply chain and logistics decisions, explained below; these data should come from your preparedness planning but if they are not available they may be collected during the acute phase (this is less than ideal).

Population size of the catchment area

The population size is the most important variable that informs orders of the RH Kits and other SRH supplies in acute emergencies. Even if the only data available is population size, the RH Kits Calculator can help to determine how many of each kit to order. RH Kits are constituted based on population assumptions (e.g., the contraceptive prevalence rate is 5%). The calculator can help order RH Kits when the actual population differs from the assumptions.

Number and scope of functioning health facilities

The number, location, and scope of functioning health facilities will also inform RH Kit ordering and supply chain planning. This includes the level of facilities (primary, referral, tertiary, etc.), the accessibility of facilities, and the number of staff and their skills level at each facility; this information will help ensure that the right kinds of RH Kits are procured for the specific context (for example, where providers are trained in their use), as well as inform distribution planning. The health cluster, with the agencies engaged in the cluster and the Ministry of Health (MOH), will collect these data at the outset. Note that, moving forward, all agencies should continue to feed into surveillance and other early warning systems that monitor health systems capacity, including the supply chain systems that serve them. This can prove critical in recurrent emergency contexts and/or in times of new displacement.

BOX 4.4: FORECASTING FOR RH KITS ACUTE RESPONSE

Do not assume 1 RH Kit per facility. Instead, use the population size of the catchment area (and any other available data on available health facilities and their care level) to estimate need by inputting this data into the RH Kits Calculator (see Section 4.6). Catchment area includes not only the affected community, but all those in the surrounding area that may be drawn to the services offered at the facility; service availability can create wider demand which should inform supply planning.

RH Kit product specifications

The RH Kits Calculator will also help in calculating the weight and volume of the required kits, including those that require cold storage. These specifications should be shared with the logistics, procurement, and program support teams.

Government requirements

Government requirements impact the processes of ordering, importing, transporting, disposing, and reporting on SRH supplies, including the RH Kits. Important regulations include humanitarian import exemptions, expedited clearance, pharmaceutical importation procedures, custom clearances, local transport requirements and medical waste management guidelines (or lack thereof). These procedures and policies vary widely from country to country, as does who has the authority to develop and implement the policies. It is recommended that agencies contact the MOH, national drug regulatory authorities, customs authorities, and/or other appropriate governing bodies, including the logistics cluster, to obtain the necessary information and permissions. For pharmaceuticals, be sure to include a percentage in your order to accommodate lab testing, which is often conducted at the national point of importation.

Partner agreements

Agencies must put in place mechanisms, such as memoranda of understanding and other agreements between agencies, necessary to access RH Kits from partners, including United Nations (UN) agencies or the government, as soon as possible. Pre-existing agreements are the gold standard and are helpful for quickly reactivating relationships and procedures.

Transportation and warehousing

Agencies must identify options and partners for in-country transportation and warehousing, from the port of entry through to the final destination for supplies. Where possible, rely on any pre-existing agreements with storage or transport vendors. Some SRH supplies, such as oxytocin, require a cold chain. Evaluate cold chain needs and options; they are a central consideration for any supply chain management plans including procurement plans. The availability of key cold chain infrastructure, including temperature-controlled refrigeration in warehousing, transport, and distribution hubs, as well as generators, should be identified. It is also critical to understand the capacity of local warehousing staff to maintain cold chains. Capacity building on cold chain management should be considered. Another important consideration is the security of available transportation and warehousing options. Consider how conflict may affect issues like the safe transportation of staff or the potential loss of items on transportation routes, and find alternative solutions and creative warehousing methods.

Inventory monitoring and reporting

Agencies and the SRH sub-cluster must identify and put in place pre-existing inventory management tools and templates. Address any gaps in these tools and coordinate with the health cluster and partner agencies (including those not actively engaged in the cluster) to ensure consistency.

Staff capacity and organizational logistics infrastructure

Agencies should determine staff capacity at every point in the supply chain to carry out the needed functions. There is no standard level for a minimum number of logistics staff. The minimum number of staff will depend on an organization's size and need, as well as the presence of existing organizations with logistics capacity. When determining the number of logistics staff to hire, organizations should consider their needs in handling procurement, coordinating customs clearance and government approval, managing warehouses and inventories, managing a fleet or coordinating third-party transport, and coordinating distribution, data management, and follow-up monitoring. Agencies should also determine existing mechanisms to ensure communication and

coordination among logistics and program staff throughout the supply chain.

Waste management

Many countries and agencies have waste management procedures in place pre-emergency. Identify these regulations if you have not already done so. If national guidelines do not exist, the World Health Organization (WHO) and United Nations Office for the Coordination of Humanitarian Affairs (OCHA) have guidelines on basic waste management principles for emergencies. However, the most comprehensive guidelines for medical waste management in emergencies are by the International Committee of the Red Cross. Additional information on waste management is listed below in the last section of Pillar 2.

CRITICAL INFORMATION TO COLLECT AND UNDERSTAND FOR TRANSITIONING TO COMPREHENSIVE SRH SERVICES

After the acute phase of a crisis response, conduct a detailed assessment to identify mechanisms necessary for establishing sustainable supply chains that allow delivery of comprehensive SRH services. This can be done by each agency for their own supply chains but should ideally be conducted across agencies engaged in the health cluster. There is no common tool to use for this purpose, but IAWG has recognized the need to develop a tool that will aid in the transition to sustainable supply lines.

The RH Kits are designed to be globally applicable in the initial phase of any acute emergency response; they are not designed to meet the specific SRH needs of a particular population in any region or country. They are not meant to be used for long-term programming and over-relying on these kits often results in tremendous waste, as some products will pile up and expire while others will continue to stock out in response to local consumption patterns. Further, there may not be funding for destruction of expired items or sufficient medical waste management infrastructure in the country or region. Moreover, long-term use of the RH Kits will delay the advancement of a context-specific and needs-driven SRH program. In addition, over-relying on the kits places a severe burden on global SRH supply chains; over-use of RH Kits in one emergency can result in a shortage of kits for the next emergency.

To avoid waste and better serve populations, logisticians,

supply chain managers, and/or procurement officers must coordinate with the SRH Coordinator and health program managers to immediately begin planning to transition from reliance on the pre-packaged RH Kits to more sustainable procurement and ordering mechanisms that reflect the actual SRH needs and consumption patterns in the specific context. This entails, for example, estimating future consumption to order each product individually in bulk to minimize waste; identifying the availability and quality of local products; identifying existing, sustainable transportation and warehousing options; determining existing staff capacity to manage supply chains; and integrating supply chain functions – from procurement to distribution to waste management – into local government and/or local agency processes. Assessing the supply chain components listed below as early in the response process as possible, along with the factors described above, will ensure a more effective program design and implementation.

Current stock

The current existing availability of supplies will inform all other supply chain processes. Service delivery agencies should share basic reports on inventory levels and expiration dates of products currently in health facilities, which can be used to inform current stock levels. SRH Coordinators and health program managers, or the procurement officers they work with, can also obtain information on existing supplies through data systems like the Health Management Information System (HMIS) and Logistics Management Information System (LMIS). They can also conduct very brief market assessments of commodity availability (including partners' commodity inventory). It may also be helpful to reach out to the food security cluster to inquire about relevant market assessments in emergency-affected areas. Consult the cluster coordination mechanisms for additional resources.

Product demand and consumption

Multiple sources can inform estimates of product demand and future consumption. Agencies can estimate the pre-crisis demand for SRH services and products based on health records and stock/inventory data, including HMIS and LMIS data. Health facilities must be encouraged to provide data on current product consumption patterns. If data on consumption are not available, work with national counterparts to estimate it on the basis of service provision

statistics and demographic data. It is important to continue to monitor product consumption data in order to adapt procurement to consumption patterns and to determine if commodities are actually reaching the target populations.

Transport and storage location

It is essential to conduct continuous mapping of existing transport and storage facilities at all levels – from central storage to last mile distribution. Transportation of goods and people (i.e., surge staff) will continue to be a critical component of any logistics system, particularly as the supply chain begins to support comprehensive SRH service delivery. Agencies must identify the vulnerability of key infrastructures and develop contingency plans to address any gaps in distribution.

Government policies, drug quality, and regulatory processes

Knowledge of relevant government policies, plans, and data collection mechanisms is essential for the design and implementation of SRH programs. Obtain information about regulatory processes and the quality of local drugs. The local WHO office can generally provide information on local availability of high-quality products and the quality of local vendors, as well as vendors that have been pre-vetted.

Tracking, inventory, and reporting mechanisms

Agencies should understand and feed into existing tracking and reporting mechanisms, such as the HMIS and LMIS, used to monitor consumption, inventory, supply, and other factors critical to maintaining a well-functioning supply chain.

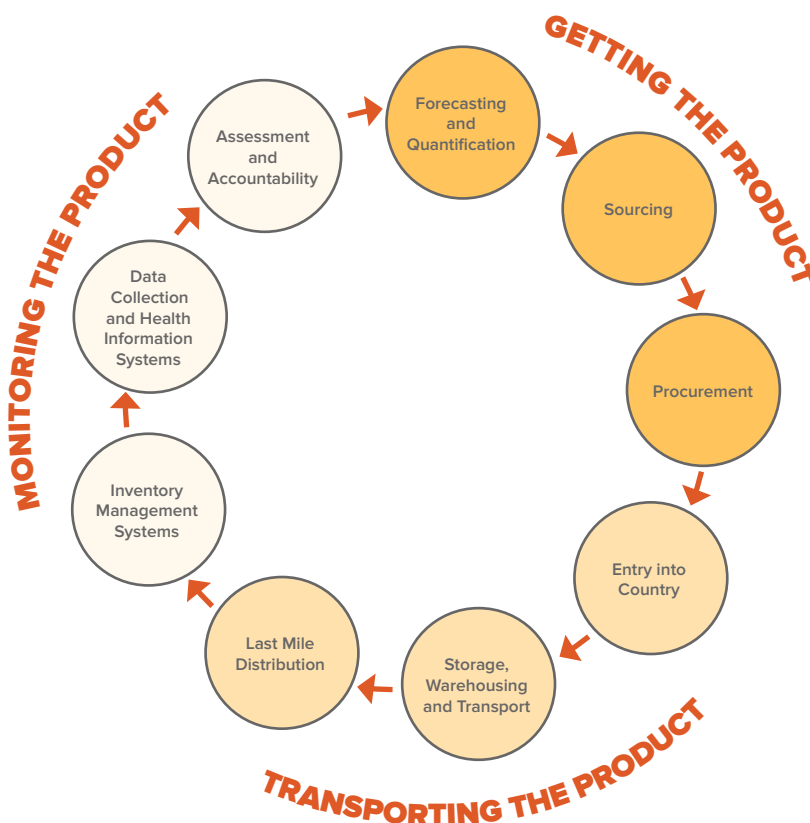
4.3.3 Supply chain steps: From quantification to distribution and from preparedness to MISP to comprehensive SRH services

This section briefly introduces each of the essential components of the supply chain. Agencies sometimes use different terminology to describe the supply chain links and some agencies combine multiple processes into fewer steps, although all frameworks capture the same basic processes. Figure 4.1 breaks the processes into many small steps so that non-logistics staff can follow and understand them.

Under each step in the supply chain outlined below, we provide key considerations that apply across the emergency program cycle, and then offer guidance specific to the preparedness, initial response, and recovery or protracted phases of an emergency. The notes on the recovery/protracted phase discuss the transition from initial response (MISP implementation) to provision of comprehensive SRH services, highlighting how emergency supply chains can be integrated into existing medical commodities supply chains, and how to establish sustainable and efficient comprehensive supply chain management systems. For more detail on supply chain management and its components (not specific to humanitarian settings), see JSI's Supply Chain Manager's Handbook (2017). Coordinating with the Health Cluster and SRH sub-cluster to analyze supply line needs and opportunities using the Health System Building Blocks (see Chapter 3) can guide planning for establishing or strengthening sustainable supply chain processes.

This section also discusses the human resource elements that need consideration throughout the supply chain

FIGURE 4.1: SUPPLY CHAIN CYCLE FOR SEXUAL AND REPRODUCTIVE HEALTH COMMODITIES IN HUMANITARIAN SETTINGS



management process. Investing in professional logisticians is critical to effective supply chain management. A logistician will most likely be moving forward many of the processes outlined below, with technical guidance from the SRH point person within each agency. It is critical to clearly delineate staff roles and responsibilities at every step, including leadership and oversight of the logistics processes (see the JSI Supply Chain Manager's Handbook for more information). Establishing effective supply chains requires people to engage with each other across the entire supply management system, including the logistician, the procurement officer, the customs agent, the provider in the clinic, the facility's pharmacy manager, and the end user. This system may look different during the acute phase versus the recovery phase, increasing in efficiency and robustness as the response expands to provide more comprehensive SRH services. The more comprehensive the SRH programming becomes, the more comprehensive the SRH supply chain management system must be. To facilitate strong and effective relationships and effective supply chain management, it is critical for technical specialists (e.g., doctors, nurses, midwives, pharmacists), program managers, and procurement and logistics specialists to understand their roles and reinforce the importance of logistics at every level of the supply management system.

PILLAR 1: GETTING THE REQUIRED COMMODITIES

Forecasting and quantification

Quantification is the process of estimating the quantities and costs of the products required to provide a population with a specific health service. It also encompasses determining when the products should be delivered to ensure an uninterrupted supply for the program. The term "quantification" is sometimes used interchangeably with "forecasting."

Accurate quantification depends on good information about products currently in stock, products on order, current consumption levels of each product, and expected changes in demand over time. Several data points can be used to inform quantification (as discussed above): total emergency-affected population, catchment area geography and population numbers, historical clinic supply levels, existing stock in health facilities, and any information on medical consumption trends. Other factors to consider

include product specifications and warehousing space (to ensure there is adequate space to store products), product shelf life, and government policies and customs clearance procedures (see more below) impacting importation of specific products. Always budget to account for some level of leakage/loss of product.

Incorrect quantification estimates can result in stock-outs or waste. Individuals responsible for procurement for an organization, at the national, sub-national, and facility levels must be able to know how much of each commodity the program needs, before it needs it, to prevent stock-outs. Note: the roles and responsibilities of these point persons will vary by organization (may be program managers, procurement officers, logisticians, pharmacists, etc.). Quantification should account for the processes of resupplying stocks (including lead time from the point of order to distribution) and how these processes will change over time, along with what buffer stock will be needed to avoid shortages. Quantification strategies should not only account for current procurement needs, processes, and distribution, but should be forward-looking to what the subsequent needs will be. Consider, for example, the likelihood of the population growing, in the case of continued displacement; difficulties in sending supplies during the rainy season; or increased demand because of health promotion activities.

Programming considerations for quantification across the emergency program cycle include:

- **Preparedness:** Deploy quantification experts to inform pre-positioning decisions and quantities of each kit or product. Several factors will influence quantification of pre-positioned supplies, including likelihood of a crisis occurring, the number of people that may be affected, warehousing or storage space, and shelf life of the products. Products with long shelf lives are particularly good candidates for pre-positioning. Products with short shelf-life can only be prepositioned if a rotation strategy is in place (first in and first out (FIFO))
- **Initial response:** In the acute phase of an emergency, the number of the affected population and catchment area will be the most critical information for quantification. Agencies planning to order the RH Kits can use the IAWG RH Kit Calculator to forecast need. Note that forecasting for the RH Kits should not

be done solely based on the number of functioning health facilities; forecasting must include population numbers. It is also important to agree very early on with health cluster and MOH on the reporting tools and schedules your system will use to track commodities and consumption, which will inform quantification moving forward

- **Transition to comprehensive SRH services:** As the situation stabilizes, quantification should be based on health facility inventory levels and anticipated consumption. You will begin to rely more on your logistics management information system (see Pillar 3). As you move from procuring RH Kits to procuring each product separately, it is particularly critical to build capacity on good stock keeping and management of health facility pharmacies, deploy trained forecasting and quantification experts, and use high-quality resources such as the Quantification chapter of JSI's Supply Chain Handbook and the Forecasting Guide for New and Underused Methods of Family Planning (see section 4.6)

Sourcing

Sourcing is the process of determining what brand/manufacturer to use for each product. Sourcing can vary significantly from the acute to recovery phases, but should always start with consideration to the potential for sourcing high-quality, local products. It is important to source products with a certification of quality (such as Good Manufacturing Practices (GMP) or Finished Pharmaceutical Products (FPP)) and to ensure that products are manufactured to conform to the WHO International Pharmacopeia, or equivalent. A simple first step in determining quality is to check if the product has approval from a Stringent Regulatory Authority (SRA), or has been Prequalified (PQ) by the WHO PQ Program, or has been recommended by the Expert Review Panel (ERP) in tier 1 or 2 of UNFPA. Consult the health cluster or UN partners for more information on how to ensure sourcing products that meet quality standards.

It is also important to note that some donors place limitations on sourcing processes, such as only allowing for UN sourcing, requiring a waiver to source elsewhere, or prohibiting local sourcing due to lack of high-quality products. SRH Coordinators, health program managers, and the procurement officers they work with must know

these restrictions before beginning the process, particularly on any pharmacological goods and large assets.

In some cases, drugs may be donated in a humanitarian emergency. This can be beneficial but also comes with risks. Sometimes local responders are not familiar with the donated products (or with the particular concentration or formulation of the drug) and have not been trained in their use. Further, the labels and instructions included in the packages may not be in a language that people can understand. Donated drugs can also have short expiry dates. For these reasons, it is critical to exercise caution with donated drugs.

Programming considerations for sourcing across the emergency program cycle include:

- **Preparedness:** Assess the range of SRH products available locally and their quality. Develop relationships with local vendors
- **Initial response:** Begin coordination across implementing partners, with the SRH sub-cluster, and/or UNFPA within the health cluster immediately, to discuss which services will be offered where. Ensure that agencies receiving supplies (often UN agencies) share requisition plans with implementing agencies (including NGOs) to inform their programming. The RH Kits can be a valuable resource during the initial response and should be used as needed. **However, as soon as possible, source and procure locally available good-quality products** – that is, products with a certification of quality that are already available within the country where you are working (i.e., on the local, regional, and/or national markets). In fact, some RH Kits take more time to arrive (if they are not already available in-country) and cost more than sourcing items locally. Even in the acute phase, obtaining product locally or regionally may be beneficial to complement the RH Kits
- **Transition to comprehensive SRH services:** Sourcing for each product should move toward a more robust process with multiple bids. As in the acute phase, decisions should be made based on product detail/specification needs and lowest price/best value (taking quality assurance into consideration). The supplier should be able to provide information like the following upon request: the manufacturer's name

and manufacturing site, GMP Certificate, Certificate of Pharmaceutical Product (CoPP), Certificate of Analysis (COA) of each batch, and batch test results of each batch

Procurement

Procurement is the process of purchasing the product, including submitting and financing orders. The most important step is obtaining all needed product detail and order specifications to procure exactly the right products. The relationships among the logisticians, procurement teams, and health teams are critical to the success of this process. The health team needs to provide precise information to the logistics team, specifically anyone managing procurement, to make the order accurately reflect factors such as the correct dosage and formulation of each medication, including different dosages and formulations needed for special populations like children and/or adolescents.

Before procuring products, make sure that all products requiring importation are registered for use in the country where you are programming (or that a waiver is in place), and that the agency is authorized to import them. It is also critical to determine, before procuring products, what funds will be used to cover which costs, taking into account handling and transport costs (see Pillar 2) and any donor restrictions on sourcing and distribution sites.

Programming considerations for procurement across the emergency program cycle include:

- **Preparedness:** Develop long-term agreements or other measures with UN agencies and/or master contracts or stand-by agreements with local and international vendors to facilitate the procurement process in case of an emergency. Build and support relationships among logisticians, procurement teams, and SRH teams. Pre-register commonly used pharmaceuticals, if possible
- **Initial response:** Consider any pre-existing contracts or other pre-emergency processes and relationships that can be leveraged (while adhering to local procurement laws and regulations)
- **Transition to comprehensive SRH services:** Continue to build and support relationships across logistics and programs teams, and across governments and other

partners, to improve the efficiency and sustainability of procurement processes

PILLAR 2: TRANSPORTING THE COMMODITIES

Entry into the country

The entry of commodities into a country, via customs and clearances, is critical to supply chain functioning. It is important to plan and prepare for this phase by knowing the mode of transportation by which the supplier will send the product through to its arrival (air, ship, etc.), exactly when and where the arrival is scheduled, and having staff on the ground ready (and waiting) to receive the shipment. It is also important to be flexible as challenges often emerge, given that there are numerous policies and processes (from customs to laboratory inspections) that must be cleared as part of the product's entry into the country. The following steps are relevant across all phases of the emergency cycle:

- Build and maintain relationships with the staff and management at the local airport, closest shipping port, local ground transportation depot, and a warehouse close to the port of entry to facilitate the product entry processes
- Advise the port of entry as soon as notification of a shipment arrival time is received, particularly for a shipment that requires cold chain storage of any kind
- Ensure all the paperwork needed for customs clearances, and any invoicing/payments, is with the staff picking up the delivery
- Clear all goods imported into a country through customs, even relief goods that are duty-free. Every country will have its own variations on the customs clearing process
- Engage a reputable Customs Clearing Agent to assist with the clearing process
- Support rapid entry of products into the country:
 - o Request for customs authorities to place a priority on relief goods. This is known as expedited clearance. There is often a fee for this service and your customs clearing agent can assist in the process

- o Note that The Guidelines for Drug Donations developed by the WHO and other agencies suggest that rapid customs clearance is required for all donated drugs (see Section 4.6). Customs and Ministry of Health officials managing drug donations are responsible for allowing entry of donations
- o As relief goods should be coming in duty-free, request that goods be allowed to be released from the customs zone immediately upon receipt, and made available for inland forwarding and distribution; this is known as “release of goods prior to clearance.” This does not do away with the requirement to process clearance documents, but only with the need for the goods to remain in bond until clearance is completed. This is not possible in many countries so be sure to know the local processes
- Be ready to address potential policy and/or operational challenges with products that can be controversial due to misperceptions about their function or use, such as emergency contraception, manual vacuum aspiration equipment, misoprostol, and narcotics. You can identify potential challenges by comparing the list of commodities included in the RH Kits with those that are registered nationally and those on the national Essential Medicines List (EML). Be prepared to advocate for their entry into the country to ensure rapid arrival of supplies. Use the World Health Organization’s Model List of Essential Medicines and list of quality-assured products as support. In some cases a UN agency may be able to bring in a product even when NGOs cannot (although this is not always the case)
- When importing pharmaceuticals and/or any kind of medical supply, keep in mind that the country will most likely conduct a laboratory inspection of a certain percentage of your supply/product and this may include the RH Kits. This is likely to take significant time and can result, at least for a period, in less product than anticipated
- **Preparedness:** Map existing points of entry, government policies, and regulations related to importing medicines and other health products, including in humanitarian emergencies. Advocate for policies that facilitate the rapid entry of products into the country in case of humanitarian emergencies, and for consistent implementation of such policies. These include: national registration and Essential Medicines List (EML) inclusion of all products in the RH Kits and other supplies needed to implement comprehensive SRH services; policies allowing humanitarian deliveries, including SRH supplies, to quickly enter the country and be deployed without delay; and policies establishing favorable trade/import regulations, such as tax exemptions, for humanitarian deliveries, including SRH supplies
- **Initial response:** Work through the UN (most frequently the United Nations High Commissioner for Refugees (UNHCR) when the organization is an implementing partner in a country, and UNFPA) to ensure duty-free imports of emergency program supplies and materials. UN agencies are covered by a blanket duty-free exemption due to their diplomatic status and a letter of donation can be included in a shipment. This may also already be in place through existing partner agreements between implementing agencies and the MOH
- **Transition to comprehensive SRH services:** Note that government policy or regulatory entry requirements may begin to change between the acute phase of an emergency (during which particular humanitarian exemptions may apply) and the post-acute phase where organizations will procure independently and from varied sources, including the private sector (when humanitarian exemptions may no longer apply)

Storage, warehousing, and transportation

Proper warehousing and transportation ensure that products reach their final destination and remain in good quality. Conduct a needs assessment (see Section 4.4.1) to learn what goods need to be stored in what conditions (including cold chain), what storage areas are used/available at ports of entry, warehousing options available at each leg of the journey including the last mile, and the

Programming considerations for product entry into country across the emergency program cycle include:

best transport options. The following steps are relevant across all phases of the emergency program cycle:

- Identify the dimensions of the products being procured and any unique storage requirements. Compare warehouse space with anticipated volume of goods
- Understand if a cold chain system can be established and/or maintained, know the gaps, and determine how to remedy them
- Review options for contracting with local vendors for storage and transportation. Identify any existing vendor contracts and develop new relationships as needed
- Understand if certain products may be difficult to transport through the country – for example, if they may be confiscated at checkpoints. Some medical products may be associated with other, non-medical uses, such as explosives. Be aware of these context-specific issues
- Identify warehouses that can be used and/or borrowed that have medical storage facilities (e.g., temperature control, fire prevention); it may be necessary to refit these warehouses to ensure medical storage requirements. Reach out to partners to share warehouses/space (e.g., World Food Program) or cold chain storage (e.g., the United Nations Children’s Fund (UNICEF)). Insecurity can impact warehousing choices. For example, in one context an organization may choose to store supplies within a UN facility to reduce the risk of looting, while in another location UN facilities may be at increased risk of looting
- Verify that the warehouses are temperate (in tropical countries you might need air conditioning or any other cooling system), dry, and protected against rain, pests, and robbery
- Explore transportation options and choose transport methods best suited to the products being shipped, including those that require cold chain. Consider the most secure/safe method and route. There may be regulations and/or in-country best practices to ensure security during transportation. Other factors to consider include the cost and speed of transport, and seasonal conditions that may impact transportation
- Ensure warehousing and transportation staff are trained on storage and transport requirements of the products, including cold chain

PROGRAMMATIC EXAMPLE 4.1: MANAGING PRODUCT ENTRY WHEN IT IS CONTROVERSIAL

ORGANIZATION: Anonymous

LOCATION: Redacted

INTRODUCTION: Misoprostol is a critical lifesaving postpartum hemorrhage medication. However, in many countries, misoprostol is controversial because of the perception that it is used as an abortifacient. This can cause problems when it enters the country, especially when the product is not included in the national Essential Medicines List or other national policies. Challenges can arise even when the product is included in national policies, norms, and guidance, as customs clearance procedures can depend on the directives of just a small number of powerful officials.

PROJECT DESCRIPTION: The humanitarian response agency procured misoprostol for use in their emergency response programming, but encountered challenges getting the products through customs due to the perceptions around misoprostol as an abortifacient. The SRH Coordinator met individually with the MOH official responsible for approving drug entry. She explained that it is on the WHO Essential Medicines List and that her agency procured a quality-assured product. She also discussed transparency of use in the program, explaining that its purpose is to save lives in cases of postpartum hemorrhage. The SRH Coordinator also offered to host a field site visit for the representative at any time in the future.

RESULTS: Following the one-on-one meeting, the MOH approved the misoprostol to enter the country and be deployed in the response. Although it is a highly regulated product, transparency, communication, and collaboration facilitated the delivery of misoprostol into this setting.

LESSONS LEARNED: Leveraging relationships and being transparent with national authorities about the use of controversial products can help to stem bottlenecks. Use global guidance, including the WHO EML, to support your case. Meeting individually with receptive MOH officials also helps.

- Develop and implement stocking/warehousing procedures around the FIFO rules (these are product rotation rules in warehousing to prevent waste due to expiration of product) and enforce stock keeping and reporting
- Remember to not only plan for inbound logistics to the clinic or program site, but also to plan for outbound logistics (from the clinic, program site, etc.). There will often be a need to transport items away from a clinic, such as empty boxes, large medical equipment no longer in use, supplies that are being redistributed to another clinic, or expired medical commodities

Programming considerations for storage and transportation across the emergency program cycle include:

- **Preparedness:** Map out storage and transportation options, including for cold chain, as part of preparedness activities for ongoing programs. Map out which parts of the country are prone to route disruptions, for example, due to flooding. Include back-up options and explore in advance potential partnerships with other agencies and/or local vendors. This will save time and money when an emergency strikes
- **Initial response:** Use the details on RH Kits (these can be obtained from UNFPA) as a guide to storage needs. However, note that kits may not always be standardized, as multiple suppliers become more common. Consider temporary warehouse solutions for each leg of the route, even to last mile delivery/distribution. Consider vulnerability of any warehouses along the supply chain, and back-up solutions
- **Transition to comprehensive SRH services:** Continue to analyze each point in the storage and transport system to make the supply chain as robust and efficient as possible. A network analysis identifies the most efficient set of storage nodes and transport routes for optimal service level and efficiency (see JSI Supply Chain Manager's Handbook listed in Section 4.6). Invest in strengthening national storage facilities. Continue to build staff capacity to maintain cold chains at all points. Transition, where possible, to contracting with local transportation and storage agencies, building capacity of local staff as needed

Last-mile delivery

Last-mile delivery is a crucial but often overlooked aspect of supply chain management. It involves moving goods from regional hubs to often remote program sites, such as health facilities, refugee or internally displaced person (IDP) camps, and even into homes. Engaging health staff, communities, and affected populations can increase the reliability of last-mile delivery, particularly utilizing participatory monitoring and accountability approaches. See more in the Interagency Supply Chain Group's Measuring Accountability for Last Mile Delivery (Section 4.6).

Agencies should develop storage and transportation plans all the way to the end-point, where the products will be distributed to clients. These plans should be shared with other agencies through the cluster mechanisms, including the Logistics Cluster. It is important to ensure that all goods can be stored properly once they reach their final destination (i.e., in health facilities). Consider both amount of space needed and cold chain requirements. It is also important to make sure health facility staff are aware of storage requirements, and impose stock keeping for all products. Investing in reliable store keepers will improve efficiency and reliability.

Programming considerations for last-mile delivery across the emergency program cycle include:

- **Preparedness:** Ensure health workers, including community health workers, in emergency/disaster prone contexts have knowledge of SRH commodities and RH Kits and understand the importance of stock-keeping. Ensure remote health centers have sufficient storage space and can meet cold chain requirements
- **Initial response:** Integrate all available resources and options in designing, planning, and executing the last mile delivery in your systems. Use the method(s) of delivery to the facility or distribution site that are accessible and appropriate to the context – from low-tech solutions to high-tech solutions. If a truck is needed but at a certain point the roads will be unpassable, consider human powered or animal powered methods. As technology expands, cargo drones may become more commonly used for last mile delivery in humanitarian relief. Drones have been piloted in last mile delivery in Rwanda, the Dominican

Republic, and Nepal, among other countries, with preliminary success in delivering medical supplies. It is important to ensure that supplies distribution directly to the end user (condoms, emergency contraception, other contraceptive methods, etc.) does not increase the protection risk of the end user (for example, the risk of sexual exploitation and abuse)

- **Transition to comprehensive SRH services:** New technologies are being piloted to improve last-mile delivery in protracted or recovery crisis situations. For example, pilot studies on the Information Mobilized for Performance Analysis and Continuous Transformation (IMPACT) Team Network, where IMPACT teams use mobile technology to provide real-time reports on stock out rates and other supply chain data, have shown improved accuracy in restocking remote clinics and health facilities (see Section 4.6)

Waste management

Waste management for medical supplies is often overlooked when planning for supply chains. Medical waste can include sharps waste (needles), pharmaceuticals (expired or damaged substances) and other hazardous medical waste (human tissue, blood). Disposing of these items in an appropriate manner will ensure that people, animals, and the environment are protected from expired medicines, used equipment or hazardous substances.

Countries have varied waste disposal policies and systems in place for normal non-medical waste, let alone for medical-waste. It is critical that humanitarian actors ensure proper medical waste disposal across all settings, meeting WHO standards and national requirements.

Programming considerations for waste management across the emergency program cycle include:

- **Preparedness:** Map existing government policies and regulations related to medical and non-medical waste and reconcile with what occurs in practice. If needed, support the government to create guidelines, policies and infrastructure for waste disposal in line with WHO guidance. The local WHO office may be able to support this process
- **Initial response:** Ensuring forecasting and procurement is done responsibly will help reduce the

amount of over-ordered, and as a consequence not used and expired, commodities. Create agreements with the MOH to integrate prepositioned commodities that are near expiry into other health facilities to prevent expiry. Ensure that staff at all levels of the supply chain are aware and trained on the guidelines on medical-waste management. If no medical-waste disposal exists, it is the responsibility of the organization to transport and manage this waste in a safe manner

- **Transition to comprehensive SRH services:** Build national capacity to ensure that waste is being disposed of in a safe manner and in line with WHO guidelines

PILLAR 3: MONITORING THE DISTRIBUTION AND CONSUMPTION OF THE COMMODITIES

Inventory tracking and tracing tools

Establishing data collection tools to track products and stock levels in health facilities and warehouses is critical to an effective supply chain system. This data informs quantification and procurement processes to meet commodity needs, avoid stock-outs, and minimize wasted products. A variety of tracking systems and reporting tools exist, from basic spreadsheets to powerful LMIS software that optimizes quantification and planning. The tools used often differ from the acute to recovery phases of a crisis, becoming more robust and more coordinated with national systems as the situation stabilizes.

Programming considerations for tracking and tracing tools across the emergency program cycle include:

- **Preparedness:** Map existing national logistics stock management tools. Develop tracking and tracing tools for use during an emergency, and train staff on how to use them and why they are important
- **Initial response:** In coordination with the health cluster, agencies should select and immediately deploy tracking and tracing tools for use in the acute phase, considering factors such as existing national tools, internet connectivity required, and staff training needed. Use the same management system for SRH commodities as is used for other commodities. At the beginning of an acute emergency response, it may be most feasible to use a basic spreadsheet file capturing

information such as product, product specifications, inventory levels, date of expiration, and date of storage. Ensure that health facility pharmacies have sufficient stock cards to cover the items in the RH Kits and other products used in the response

- **Transition to comprehensive SRH services:** More powerful tracking and tracing tools should be deployed as quickly as possible, in alignment with the health cluster and in coordination with MOH national/local systems. Many agencies and governments use LMIS to centralize inventory and stock calculations, which then inform purchasing, invoicing, and stock rotation based on expiration dates, consumption, and other data points. LMIS often utilize scanning/barcode systems, cloud, and mobile databases to track and trace goods across any location in the supply management system (traveling, in a warehouse, being distributed, etc.). As with all components of supply chain management, integrate LMIS for humanitarian commodities into national systems and regular/sustainable supply chain processes as soon as possible

Data collection and reporting process (staff capacity to use logistics information systems)

With any tracking and tracing tool, a variety of staff will need to collect a range of data (such as number of pill packs on a shelf, coming in, going out), input these into the system (many open source software options are available), and send it to the teams responsible for forecasting of and procuring products. Inventory management requires the full range of staff to engage in the logistics system. Pharmacists, nurses, midwives and doctors must take stock of goods/supplies at the clinic level and report this information as part of data collection efforts. Train your teams on the critical nature of each person's role, the data points and information needed, key indicators to monitor (listed in the below monitoring section), how often they should gather the necessary data, at what stock levels in their clinics/programs they need to reorder, and when will they be in danger of stock-outs, as well as monitor losses. Respecting and empowering their roles, the challenges they face, and communicating their importance will help to

ensure an effective supply management system supported by a truly engaged team.

Programming considerations for data collection processes and reporting across the emergency program include:

- **Preparedness:** Train humanitarian staff (pre-deployment) and the national health workforce on the importance of maintaining up-to-date information systems on supplies and inventory, what their role is in this process, and how to use the data systems that will be deployed during emergencies
- **Initial response:** Warehousing data and health facility data on SRH commodity movements and consumption must be collected at a central point (for example, the SRH sub cluster). Encourage all implementing partners to report on the same set of SRH commodities (at a minimum the consumables in the RH Kits) using the same tool
- **Transition to comprehensive SRH services:** As you expand on the MISP services toward comprehensive SRH, integrate your LMIS into existing national systems and build staff capacity on its use as soon as it is possible. Use or build on government training tools if available. Train staff on why data collection and reporting on commodities is important – for example, it is particularly critical to estimate demand for contraceptive commodities, which is important to ensuring the appropriate contraceptive method mix. Move toward building capacity in use software systems that make comprehensive programming and a robust supply chain management system easy to manage

Assessment and accountability

To continuously improve supply chains and ensure accountability to clients, conduct periodic analyses of the data collected through these processes. Conducting an audit of physical inventories to compare actual holdings to stock reports and records is essential for accountability. Ideally, community representatives and health center staff would conduct monthly (full or partial) physical inventories to verify/correct stock records accordingly.

In addition, a monthly review of data on loss and waste can suggest where bottlenecks, seasonality barriers, or other challenges are occurring. Use data collected through LMIS, HMIS, and/or other data collection tools to measure progress against annual performance goals. Develop strategies that will allow the system to constantly improve, becoming responsive and flexible but maintaining infrastructure over time. Monitor a few items and drugs through stock-out reports or surveys as proxy of your supply chain.

Establish feedback/complaint mechanisms to allow beneficiaries, staff, partner agencies, and companies

to provide regular feedback, such as rapid client exit interviews in which clients report on whether they received the desired/required medicine or contraceptive.

4.3.4 Coordinating and making linkages

Successful supply chain operations require extensive coordination, both internally among procurement and logistics teams within implementing agencies, and externally with a variety of stakeholders. Coordination is needed at every step, from ensuring that SRH supplies are part of the health cluster core-pipeline, to transporting

PROGRAMMATIC EXAMPLE 4.2: WORKING WITH COMMUNITY-BASED HEALTH COMMITTEES TO REDUCE STOCK OUTS OF SRH SUPPLIES IN A CRISIS-AFFECTED SETTING

ORGANIZATION: CARE

LOCATION: North Kivu, Democratic Republic of the Congo (DRC)

INTRODUCTION: North Kivu province in eastern DRC is a land of great natural beauty and resources. It is also home to a decades-long conflict that has brutalized the population, disrupted social networks, and ravaged the public healthcare system. CARE's Supporting Access to Family Planning and Post-Abortion Care (SAFPAC) Initiative has been working in eastern DRC since July 2011 to reduce unintended pregnancies and deaths from unsafe abortion in crisis-affected settings. The SAF PAC Initiative supports government health systems at primary and referral levels to provide a wide range of contraceptive services, including long-acting reversible contraception, to people affected by conflict and/or displacement. This initiative has the following components: 1) Clinical skills training, assessment, and coaching; 2) Supportive supervision; 3) Supply chain support; 4) Quality improvement; and 5) Community mobilization.

PROJECT DESCRIPTION: In the absence of a functioning public-sector supply chain for SRH supplies in our operational areas, CARE supplied all the contraceptives, medicines, and supplies required to provide quality family planning and post-abortion care services. CARE procured SRH supplies from ASRAMES (the Regional Association for the Supply of Essential Medicines) and international vendors and gave them to district health authorities for distribution to health facilities on a quarterly basis ("push" system). The initiative tracked stock outs of 8 tracer products (oral contraceptive pills, injectables, implants, intrauterine devices, manual vacuum aspiration kits, pain medicine, high-level disinfectant, and gloves) through routine monthly reports submitted by the health center.

In the first phase, the initiative experienced recurring stock outs of implants, pain medicine, and high-level disinfectant. To some extent, this was due to factors beyond CARE's control such as a global shortage of implants and insecurity impeding resupply. It was also because health facilities did not restrict the use of pain medicine and high-level disinfectant purchased by CARE to family planning and post-abortion care services. Since CARE was the only supplier of these essential inputs to health facilities, CARE did not discourage this practice. However, CARE needed to find a way to strengthen forecasting and inventory management practices to prevent future stock outs.

To begin, CARE trained stock keepers, pharmacists, providers, and community representatives on stock inventory management practices and tools for health commodities in accordance with national guidelines. The community representatives were members of Health Area Development Committees known as CODESA. The CODESA is a community-based structure that represents all the villages/streets in the area served by a health center. It plays a vital role in holding health centers accountable to the communities they serve by reporting to them how health centers use their resources. CODESA members meet with the health center team once a month to analyze the results achieved, identify strengths and weaknesses to plan corrective actions. Initially, the initiative did not engage with CODESAs, but CARE realized this was a missed opportunity for improving the management of SRH supplies since

one of CODESAs' roles is to oversee the health center resources and, as the primary consumers of health services, they have a vested interest in good stewardship of health supplies.

In addition to training CODESA members on stock inventory management, CARE invited them to participate in monthly supportive supervision visits to health centers during which they conducted physical inventories to compare stock holdings to stock inventory records and to make sure that products in short supply got re-ordered right away. CARE also invited them to help receive deliveries from the district health pharmacy to verify the contents and documentation.

CARE helped to motivate CODESAs to take on these additional tasks by seeking their inputs during monthly supportive supervision visits to health facilities that CARE conducted jointly with district health officials and recognizing their efforts during quarterly project review meetings with all stakeholders. In addition, CODESAs got a percentage of the money that CARE paid to health centers that performed well on specified criteria, such as stock outs.

RESULTS: By involving CODESAs in routine stock inventory management, CARE reduced the number of stock outs in the health centers CARE supports to nearly zero, even during periods when insecurity prevented access to certain health centers. In the process, CARE succeeded in building mutual confidence between CODESAs and health staff in the health districts where CARE works, which, in turn, improved overall quality and uptake of SRH services.

There have been some challenges along the way. In the beginning, health staff did not trust or have confidence in the CODESA because they perceived it as a policing body that lacked health credentials. CARE addressed this by collaborating with the Ministry of Health to define the roles and responsibilities of CODESAs and health staff in the management of health supplies and equipment. Subsequently, CARE oriented CODESAs and health staff on their roles and responsibilities during the stock inventory management training and supported them to make quarterly stock management plans and review progress during quarterly stakeholder meetings.

LESSONS LEARNED: Community participation in the management and control of SRH supplies at the health-facility level is an effective mechanism for ensuring accountability of public health services, including commodities to users. In addition to improving the availability of essential SRH supplies, it is an effective way to build mutual trust between communities and government health authorities, and is a particularly useful tool for helping crisis-affected societies to lay the foundation for peace and a better future.

products around the country, to tracking stocks and addressing stock-outs.

In designing and implementing supply chain strategies, coordinate with the following stakeholders:

- **Health, protection, and logistics clusters:** Coordinate immediately with the health, protection, and logistics clusters to gather the data needed to estimate the SRH supply needs of the affected population and to ensure that SRH products are prioritized as part of the broader health response. At the same time, contact the UNFPA humanitarian focal point to begin the process of ordering the RH Kits
- **SRH working group/sub-cluster:** Ensure that SRH supply chain considerations inform broader SRH program design and implementation, and vice versa. For example, each component of SRH service delivery – from contraceptive provision to maternal and newborn health care to care for survivors of gender-based violence – should have a clearly defined essential package of commodities to inform

procurement and logistics staff of what is needed

- **Partner agencies:** Coordinate with partner agencies to ensure coverage of SRH supplies across geographical areas, populations, and facilities. During the preparedness phase and during the expansion of the MISP toward comprehensive SRH services, partner with governments and existing/local partners in the development sector – particularly those with long-standing programs in the area – to contribute to the process of returning to non-crisis supply chains
- **Government agencies:** A number of government agencies can act as both partners and gatekeepers at various points throughout the supply chain. For example, government officials can provide information about laws and policies governing the supply chain system, particularly entry of medicines into the country. They also can provide stock inventory management training materials, which should form the basis of any training during the transition to sustainable supply chains. Cultivate relationships

with relevant government agencies (from national to local level) as a critical step in the process of returning to or building longer-term, sustainable supply chains. Relevant government agencies include the Ministry of Health, the national drug regulatory agency, and others

- ***On-the-ground health care staff:*** Health workers, from doctors to nurses, midwives, and medical assistants, provide technical information needed to inform and maintain well-functioning supply chains. For example, they must provide consumption data and specifications on product details like the formulations and dosage(s) of commodities to inform ordering, including information about any special doses/formulations needed for specific populations using certain products. They are also important to maintaining up-to-date tracking and inventory systems, by reporting stock levels and flagging when items are needed (low stock levels or stock outs)
- ***Local transportation and warehousing vendors:*** Given the importance of transportation and storage for successful supply chains, build strong relationships with local stakeholders responsible for carrying out, contributing to, and overseeing these processes. This may include staff and management at the local airport or shipping port, local ground transportation depot, and warehouses from port of entry to the last mile
- ***Local medical suppliers:*** It is best to procure as much as possible from local sources (balancing this with other considerations like cost and quality). Coordinate with these suppliers and, where needed, with the WHO in this process

4.3.5 Advocacy

Many entry points exist to advocate for improved humanitarian SRH supply chains. Advocacy is needed to draw attention to the importance of SRH commodities in achieving humanitarian promises and meeting human rights obligations and to encourage decision-makers to address the need to allocate resources, including strategic planning and staff time, to improve humanitarian SRH supply chains. Decision-makers at all levels, from national to local leaders and from donors to humanitarian health

staff, have a role to play in designing, implementing, and monitoring policies, programs, and funding structures that improve access to SRH commodities. Advocacy messages to the following audiences may include:

Humanitarian response agencies should:

- Invest in strengthening their SRH supply chains, starting by analyzing bottlenecks, addressing gaps, building capacity, and measuring progress
- Ensure that staff trained in medical logistics/procurement are integrated into humanitarian SRH programs and at all levels of the supply chain
- Integrate senior humanitarian logistics and supply chain practitioners into the organization's strategic decision-making level and solicit their input on key fundraising and programming decisions. Often, the community of practitioners in humanitarian logistics and supply chain are still not represented at the strategic level within their organizations, and further have little direct dialogue with the institutional donor community
- Collaborate with the development sector on integrating SRH supplies into ongoing, sustainable medical commodity supply chains, including by building the presence of highly trained in-country logistics staff who are knowledgeable about SRH commodities.

National decision-makers should:

- Work with the health cluster on the procurement and distribution of SRH supplies across partners
- Register all products in the RH Kits (and other supplies needed to implement comprehensive SRH services) in the country, including emergency contraception, misoprostol, female condoms, and safe abortion supplies
- Establish policies to allow humanitarian deliveries, including RH Kits, to quickly enter the country and be deployed without delay
- Establish favorable trade/import regulations, such as tax exemptions, for humanitarian deliveries
- Establish national preparedness plans that will contribute to continuous access to SRH supplies in an

emergency (strategically pre-positioning commodities where appropriate)

- Build supply chain resilience, including contingency plans, to ensure SRH commodity security when emergencies arise. This includes identifying and addressing bottlenecks in the SRH supply chain to ensure equitable distribution to all persons in need of SRH services, taking into account how to reach traditionally vulnerable populations like adolescents, people with disabilities, and people based in very remote areas. Resilience efforts should also consider potential security concerns and power differentials among conflicting groups
- Establish sustainable waste management policies and practices for medical and non-medical waste

Local and community leaders should:

- Contribute to supply chain preparedness and planning, including contingency plans, for SRH commodities. Local and community leaders should always be included through participatory processes
- Contribute to the development of local preparedness plans in advance of emergencies that include SRH supplies within the broader health response, and implement these plans when emergencies arise

Donors should:

- Fund strategic investments to strengthen humanitarian SRH supply chains, including efforts to better understand and address bottlenecks. Donors should fund not only the full range of commodities themselves, but also the strengthening of the supply chains needed for the commodities to arrive at their final destination (the end user) when and where they are needed. These efforts should span the emergency program cycle, from preparedness to response to recovery
- Include all products in the RH Kits on their list of essential commodities for emergency response

SRH Coordinators, health program managers, and health and protection cluster officers should:

- Provide technical information and justification as needed when decision-makers claim that specific

SRH products, like emergency contraception or clinical management of rape commodities, are not needed

4.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

Sexual and reproductive health supplies are life-saving commodities. Achieving good sexual and reproductive health depends on the availability of high-quality, affordable SRH supplies. There is a critical link between access to the full range of SRH supplies and women's and girls' ability to exercise their right to decide freely and responsibly the number and spacing of children and to maintain their good health. This link is amplified for people affected by humanitarian emergencies, who often face greater risks to their SRH and challenges accessing SRH supplies that they depend on regularly (such as their preferred ongoing method of contraception), and whose needs may shift as their circumstances change in the wake of an emergency. SRH supplies are a direct contributor to self-determination, free choice, and autonomy.

Access to medicines, specifically, is critical to the realization of the rights to health and life. Human rights bodies have recognized that the provision of essential medicines is part of the minimum core obligations of the right to the highest attainable standard of health with which States must comply at all times (see ESCR Committee, General Comments 3 and 14).

Human rights bodies have provided detailed guidance (see ESCR Committee, General Comment 14) on the elements necessary to fulfill the right to health, noting that health services and goods, including SRH supplies and medicines, must be:

- Available in sufficient quantity
- Accessible to all without discrimination (this includes physical, economic, and information accessibility)
- Acceptable with respect to medical ethics as well as within a particular cultural context
- Of good quality and scientifically and medically appropriate

In the context of a humanitarian crisis, special care must be taken to ensure the safe accessibility of SRH supplies to all affected populations, including groups of people who are often marginalized – such as adolescents, people with a low-income, persons with disabilities, female and male survivors of gender-based violence, sex workers, and lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people. As the situation stabilizes, participation of the affected population in designing, implementing, and monitoring supply chains is key to ensuring that supplies and medicines are meeting demand and reaching marginalized groups (ESCR Committee General Comment 14). It is strongly recommended to engage these populations as soon as possible across supply chain management systems in emergency settings.

Although not codified in human rights law, the logistics sector has the opportunity to further the realization of health as a human right in tangible applications, including through ethical sourcing of products. In sourcing, the right to high-quality supplies must be paired and balanced with the right to development of local economies and communities (see United Nations General Assembly Resolution 41/128, Declaration on the Right to Development, A/RES/41/128). Sourcing products locally contributes to the local economy and to building sustainable supply chains in the affected area. Humanitarian agencies, in their efforts to “do no harm” and to leave the supply chain as strong and healthy as possible, should seek partnerships with local suppliers and vendors. At the same time, humanitarian actors must also consider product quality in their sourcing decisions. This is particularly critical for medicines because when low-quality, counterfeit, or expired products enter the supply chain, it is ultimately to the detriment of the end user. It is also an inefficient use of humanitarian sector resources. Agencies may implement their own processes for assessing product quality, drawing upon global and national standards and guidance to help them determine whether local products are high quality. As discussed above, goods should meet specific requirements for FPP. When high quality products are available locally, they should be used. When high quality products are not available locally, they must be procured elsewhere.

4.5 MONITORING AND EVALUATION

Metrics and data on logistics and the supply chain are crucial to the success of a humanitarian response. There are many indicators that logisticians use in non-emergency contexts to monitor the supply chain that are relevant in the acute and protracted phases of humanitarian programming. Coordinate with the logistics cluster to gather key cluster priorities and indicators in the country/context. Different donors and partners may also have other indicators to consider. Based on these resources and engagement with the cluster system in the emergency affected areas, develop the organizational logistics priorities and indicators. From this list, establish your key indicators – the necessary 4-5 indicators that capture information at particular points in the supply chain – ensuring consistency across agencies and with the clusters. These will be the basic data points the LMIS will collect, at all levels. In moving from acute response towards more comprehensive SRH programming, adjust the monitoring systems and data collection tools to collect more comprehensive information. Below are some key indicators that may be considered as priority data for collection. Some are appropriate for the acute phase and some are more appropriate for protracted settings, as well as recovery and transition to comprehensive logistics systems. Key indicators may include:

GENERAL

Acute

- Number of days delayed by customs clearance processes
- Number and percentage of items returned/rejected (# items returned/total products from clinic orders, define reason for return)
- Data management system established at every point in supply chain management system - at warehouse, at clinic, at country office, as part of HMIS, etc. This could be a robust LMIS software package or a Microsoft Excel spreadsheet

Recovery and protracted phases, and/or comprehensive systems

- Number and percentage of on-time commodity deliveries (# commodity deliveries on time/total # of commodity deliveries)

LMIS DATA POINTS FROM EACH WAREHOUSE/CLINIC/STOCKPILE, SUCH AS:

- Stock on hand
- Total amount and dollar value of damaged/lost/expired goods
- Total amount and dollar value of goods expired or damaged prior to field delivery/distribution/utilization
- Inventory levels vs. forecasted need (monthly inventory levels (by product type)/forecasted need from previous month forecasted need)
- Stock outs – the SPHERE indicator for stock outs, which can be used across all emergencies, is: “no health facility is out of stock of selected essential

medicines and tracer products for more than one week.” Additional stock out indicators that are very useful include:

- o Half-level of stock was flagged for ordering more product (y/n by type)
- o Data system captured this need (y/n)
- o Product was ordered (y/n)
- o Time to delivery to user (in days)
- o Percentage of stock cards properly maintained (with all IN and OUT entered and with physical inventory matching figure on the card)

For a much more comprehensive review of supply chain and logistics indicators, see JSI’s Measuring Supply Chain Performance: Guide to Key Performance Indicators for Public Health Managers. See also the list of indicators in the Interagency Supply Chain Group’s Measuring Accountability for Last Mile Delivery (Section 4.6).

4.6 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 5

ASSESSMENT, MONITORING, AND EVALUATION

5.1 Introduction

5.2 Objectives

5.3 Assessment, monitoring, and evaluation

5.3.1 Assessment

5.3.2 Monitoring

5.3.3 Evaluation

5.4 Human rights and legal considerations

5.4.1 Human rights standards

5.4.2 Ethical considerations of data collection

5.5 Further reading and additional resources

5.1 INTRODUCTION

In order to ensure sexual and reproductive health (SRH) programming is responsive to the needs of a population affected by humanitarian crisis, we use assessment, monitoring, and evaluation at different stages during a humanitarian response in order to:

- Understand and quantify the needs of populations of concern and contributing factors
- Ensure effective and efficient use of resources
- Identify programmatic barriers and enablers
- Determine the success or failure of a program
- Provide accountability and transparency to donors, beneficiaries, and other stakeholders

The type of humanitarian crisis and the form of displacement has implications for the way we design and execute assessments, monitoring, and evaluation. Methodological approaches and methods may vary depending on the context, such as in sudden onset natural disasters, protracted armed conflict, or epidemics or the location of

BOX 5.1: CHALLENGING CONTEXTS & SPECIAL POPULATIONS

URBAN SETTINGS

Over 60% of the world's refugees and 80% of internally displaced persons (IDPs) live in urban environments. Whereas refugee camps offer a controlled setting with easily defined boundaries and a population whose health status is relatively easy to track, refugees can live anonymously in cities. Though this can offer them better opportunities for livelihoods and self-sufficiency, it presents challenges in trying to collect data about their health status and needs.

Assessments in urban areas require mapping relevant stakeholders and service providers, conducting a situational analysis of the political, legal, and socio-economic context of the host city, and consideration of the differences between refugee subpopulations and their access to services and experiences within the host city.

When undertaking an assessment in an urban setting, it is encouraged to consider disaggregating the assessment components (i.e.,

mapping, situational analysis) by subpopulations within the refugee community. Among these subpopulations are women, children, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) individuals, persons with disabilities, people who engage in sex work, male survivors of sexual or gender-based violence (GBV), and the elderly.

MIGRANT POPULATIONS

Migrants are different from refugees. They are not forced from their homes, but rather choose to move for work, education, family reunion, or other reasons. Nevertheless, due to their mobility and often lack of legal status in the host country, this population presents special challenges in data collection.

Identifying migrants:

- Work with employers that hire large numbers of migrants
- Develop relationships with

community-based organizations or leaders in the communities from which migrants originate

Monitoring migrants' health status:

- Use mobile applications

Many migrants do not have legal status in the country they travel to, or are afraid of their own government. As such, it is important to explain to migrants how you will use the data you are collecting. In addition, ensure that you address concerns about confidentiality with the organizations you work through to identify migrants.

Remote or inaccessible locations

Some populations in humanitarian settings are unreachable due to natural barriers (mountains, flooding, earthquake upheaval, etc.) or insecurity. These situations require creative data collection techniques to assess the affected population's needs and monitor their SRH health status over time.

the displaced population, such as urban, semi-urban, rural, or camp-based. Robust and ethical data collection methods and appropriate use of the results will assist SRH Coordinators and health program managers make evidence-based decisions when transitioning from Minimum Initial Service Package (MISP) activities to comprehensive SRH services.

5.2 OBJECTIVES

The objectives of this chapter are to:

- Describe the what, when, and why of assessment, monitoring, and evaluation of SRH programs in humanitarian contexts

- Identify appropriate assessment, monitoring, and evaluation methods, tools, and indicators
- Provide guidance on ethical data collection and use and ways to use data for effective policies, programs, and advocacy

5.3 ASSESSMENT, MONITORING, AND EVALUATION

Knowing when to transition from the MISP to comprehensive SRH programming requires a robust and iterative monitoring and evaluation system. As soon as we reach and can sustain MISP service delivery targets, appropriate comprehensive SRH service components should be implemented.

Although assessments can be thought of as one type of evaluation, these terms are separated out in order to identify specific processes in humanitarian settings. The key terms used in this chapter are as follows:

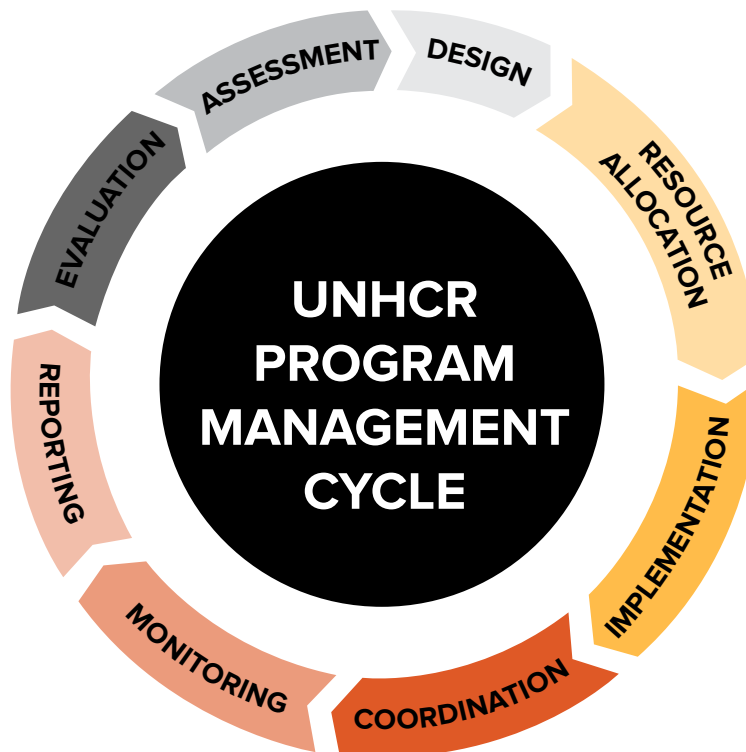
Assessment is a process for determining and addressing needs or “gaps” between current conditions and desired conditions and contributors to those gaps.

Monitoring is the ongoing, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of program milestones and objectives.

Evaluation is a process for determining whether a program has met expected objectives and/or the extent to which changes in outcomes can be attributed to the program.

A feedback loop called the operations management cycle links these 3 processes (see Fig. 5.1). This cycle shows the critical role data play throughout a humanitarian response in informing, monitoring, and evaluating SRH programming.

FIGURE 5.1: PROJECT CYCLE



The project cycle defines how assessment, monitoring, and evaluation are linked along a continuum of service delivery and program management. It helps SRH Coordinators and health program managers to understand how each can be used to inform decision-making throughout the cycle of program design, planning, and implementation.

The ability to carry out successful and timely reproductive health projects in the challenging environment of a humanitarian response is crucial to ensure SRH needs of the affected population are met. The most successful SRH programs are those which are designed based on an appropriate assessment of needs within the target population. Subsequent program activities should then be monitored using carefully selected indicators to track progress towards clearly stated objectives. Throughout implementation of the program, activities should be adequately evaluated to reflect on what is working well and what is not, and to feed back the results into a continual cycle of program review and improvement.

5.3.1 Assessment

PURPOSE

Identify the SRH needs of the population and contributing factors and determine the capacity of the existing health system to respond to those needs. Throughout the life of a program, we can use periodic assessments to evaluate its progress towards achieving objectives.

WHEN TO CONDUCT ASSESSMENTS

This depends on the type of information needed and the phase of the emergency. We often conduct some types of assessments, such as situational analyses and rapid assessments, in the acute phase of a humanitarian emergency when time and resources may be limited and a broad picture of the situation may be needed. Desk assessments are appropriate in the acute phase of an emergency to avoid a duplication of effort, but can also be useful throughout the emergency. Methods requiring greater resources, such as surveys and some participatory methods, may be more appropriate in later phases of an emergency in order to gather additional details on needs and gaps for more comprehensive SRH programming.

WHO CONDUCTS THE ASSESSMENT

An assessment team may consist of several people with clinical, research, management, and public health skills. The assessment team can be larger if the context allows for a more thorough assessment to be undertaken. The number of team members required will depend upon the size of the area to be covered, the size of the population being assessed, the prevailing access and security situation, and the assessment methods that will be used.

When selecting a data collection team, gender, age, ethnicity, and social status of its members should be considered. For example, in some cultures it may be inappropriate for a man to ask a married woman questions about her reproductive history. In general, it is good practice to include members of the affected population in the assessment teams, unless participants will be less comfortable disclosing sensitive information to data collectors of the same demographics.

The ideal team members:

- Have appropriate technical skills, training, and

experience

- Have good communication skills in the local languages and are familiar with the population being assessed
- Are comfortable discussing SRH topics
- Have good analytical skills to appropriately interpret the findings

METHODS

Examples of tools used for each of the methods described below can be found in Section 5.5. Note also that the methods described below are not mutually exclusive. For example, a desk review may be part of a rapid assessment. In addition, the list of methods is not meant to be exhaustive, but rather to give a broad range of examples appropriate to humanitarian settings.

Rapid assessments

At the onset of the humanitarian response, humanitarian partners carry out an initial rapid assessment. While the causes of the most important SRH-related morbidity and mortality are already addressed by the MISP and do not need to be assessed at the onset of the humanitarian response (see the MISP essential checklist in Chapter 3), there is nonetheless important information to be gathered with a rapid assessment to ensure appropriate strategic planning. Within the health sector/cluster coordination system, SRH Coordinators must ensure that they obtain information on:

- The number and location of people needing access to minimum SRH services
- The number and location of health-care staff providing, or capable of providing, the service components of the MISP
- SRH medical supply logistic opportunities
- MISP funding possibilities

Desk review

A thorough review of secondary data sources should be conducted to compile existing SRH information on the affected population (origin and/or host area data as appropriate). Such data will be available from Ministries of Health, United Nations (UN) agencies, and non-

governmental organizations (NGOs). Examples include:

- Demographic and Health Survey (DHS) or other available survey data
- Routine surveillance or health facility data, such as those reported to district or national health information systems
- Availability of SRH services, their geographic distribution, and functionality
- National strategic plans and/or UN Development Assistance Framework (UNDAF) assessments

Situational analysis

A situational analysis should be conducted to understand the legal, political, cultural, and socio-economic context of the locale and how this might impact the SRH needs and availability of services for affected populations. Notes should be made on how different subpopulations might be affected differently. We include guidance for how to review literature and indicators as part of the MISP assessment in Section 5.5.

Key informant interviews

Key informant interviews generate qualitative data from a wide range of people who have firsthand knowledge about the affected population. Key informant interviews ask open-ended questions and can be structured (a set of questions asked in a specific order), semi-structured (a set of questions and suggested probes that can be changed or adapted during the course of an interview), or unstructured (a list of guiding topics used for inductive, open-ended questioning). Key informant interviews should collect individuals' views of pre-existing conditions and SRH practices, the current situation, changes in practices since the onset of the emergency, adequacy of current SRH services, and priority SRH needs of the population.

Focus group discussions

Focus group discussions generate qualitative data about a group's beliefs and attitudes on a particular health issue or problem. Focus group discussions differ from key informant interviews as they allow for interaction among all the members of the group. They are particularly useful in generating information representative of a specific sub-group in the population, such as women of reproductive

age or adolescent males.

Participatory methods

The purpose of participatory methods is to make the assessment process as inclusive as possible of the target communities. Community organizations led by members of the affected population and informal groups of different subpopulations within the affected population should be engaged and involved throughout the process.

Participatory methods can include community members as researchers and/or conducting participatory activities for data collection. For example, involving community members in the development of assessment/evaluation questions, including community members as data collectors, and conducting participatory activities during data collection, including but not limited to the participatory ranking method, community mapping, timeline, photo elicitation, photo documentation, and others. These should be selected based on the study question and constraints. Community members should also be involved in the analysis and dissemination.

Health facility assessments

A health facility assessment is an inventory of the places where health care is provided and the types and quality of services provided at these sites. A structured checklist of topics can help to provide a description of the health facility, including an inventory of SRH services provided, staffing, and coverage and an inventory of SRH equipment and supplies. This can also include reviews of routine statistics on SRH services to determine gaps in service delivery and quality of care.

Mapping

This activity can often be done in conjunction with the health cluster/sector to include health facility assessments. Mapping of relevant stakeholders and service providers includes both those currently providing SRH services to affected populations and those who potentially could, such as government, private sector, international development actors, humanitarian actors, civil society, and community-based organizations (CBOs). Mapping should identify service providers that offer specialized services relevant to different sub-populations. The exercise should also engage local organizations to identify opportunities for referrals,

cost sharing, and other opportunities for linkages between different stakeholders and service providers.

BOX 5.2: USE OF SRH SURVEYS

Surveys can provide useful, population-based data that SRH service providers and program managers can use to improve and more effectively target SRH care services. However, they must be undertaken by those who have training in survey methodology. There are many factors to be taken into consideration when designing a survey. Decisions must be made with regard to sample size, acceptable error levels and sources of bias, availability of resources (time, money, personnel, etc.) and if the information could be collected as or more effectively using another data collection method.

Recognize the limitations of each decision. For example, surveys that are conducted during initial needs assessments often need to be carried out rapidly using small, convenient sampling methods and will not necessarily be representative of the target population. Once the situation stabilizes, more detailed survey questionnaires and more representative sampling methods can be used.

The decision on which survey methodology to use is coordinated with the health sector/cluster to ensure it is appropriate and will produce results that are compatible with other surveys that are conducted as part of the health response. When possible, existing survey instruments that have been tested in humanitarian or low resource settings should be used.

Surveys

Surveys can be useful for gathering population-based information from a sample that can be representative of the larger population of interest. Such surveys should be succinct and only contain questions necessary for the targeted program or intervention. Surveys differ from key informant interviews and focus group discussions as they do not permit participants to give detailed opinions on a topic, resulting in the “what” information rather than the “why” information.

BOX 5.3: NEED TO KNOW OR NICE TO KNOW

It is a common tendency to want to collect lots of information for assessments, monitoring, or evaluation, often with the thought that “it might be important.” However, collecting data requires valuable resources and it is crucial that careful thought go into determining what you need to know, why you need to know it, and how you can collect that information most effectively. If the information is not tied to the outcomes or impacts to be measured, you should not be collecting it.

Regardless of the type of assessment conducted, there are key steps in data collection that we should consider. Refer to ethical guidelines in the resources section for additional guidance:

1) Make sure the information-gathering activity is necessary and justified

- Before starting the activity, clearly define its intended purpose and audience, and make sure that there are sufficient resources to conduct it in an ethical manner
- Only use direct methods if the required information is not otherwise available
- If the information-gathering activity will not directly benefit the target beneficiaries involved or their community, do not proceed

2) Design the activity to get valid information

- Develop a protocol to clarify aims and procedures for collecting, analyzing, and using the information to which all partners agree. Information collected for generalizable knowledge is research and an ethics review board or institutional review board (IRB) should review the protocol, which can add considerable time to a project timeline
- Apply community definitions to set clear criteria for participant inclusion. Use existing records when possible, and recognize social and cultural barriers to participation. For surveys, or any other data collection activity meant to be representative, make sure appropriate sample size is calculated to measure target indicators

- All tools, such as questionnaires and discussion guides, should be developed through discussions with experts. These tools should then be translated locally, back-translated, and field-tested
- The use of a comparison group totally deprived of services is inappropriate with vulnerable groups. Alternative approaches should be explored to strengthen research findings. Comparison groups should be used only under careful ethical supervision and under specific conditions

3) Consult with stakeholder groups

- Consult locally to determine who must give permission for the activity to proceed
- Interviewers must be sensitive that they may be highly visible and a source of local interest. Clarify roles and expectations through stakeholder meetings and honor commitments
- An independent local stakeholder group should monitor activities

4) Anticipate adverse consequences

- In partnership with the stakeholders, anticipate all possible consequences for the target beneficiaries. Do not proceed unless appropriate responses to potentially harmful consequences can be provided
- Avoid stigma by holding community sensitization meetings and using community terminology when appropriate
- If the safety and security of participants cannot be assured, do not proceed
- Interviewers should have experience working with participants. They should be trained to respond to participant needs and require ongoing supervision and support. If appropriately skilled interviewers are unavailable, do not proceed
- In partnership with the community, determine what kind of follow-up is appropriate to respond to participants' needs, recognizing age, gender, ethnicity, and so on. If appropriate support cannot be assured to meet the participants' needs, do not proceed

- Prepare a reaction plan to anticipate serious needs. If support cannot be assured, do not proceed

There may be instances, such as child endangerment, where study teams should breach confidentiality to provide immediate protection to the participant. We must ensure that participants are aware of this before asking for any information.

BOX 5.4 KEY MESSAGE

The job of ethics review boards is to ensure that consent and data collection procedures protect the participants through established ethical guidelines. The requirements may exceed those listed in this chapter.

5) Conduct consent and interviewing procedures with sensitivity to participants' specific needs

- Participant must give her/his/their consent to participate through verbal or written consent
- Information given to participants must be written/read in clear local language and provide information about the purpose of the data collection, the nature of the questions to be asked, who is involved, what the risks and benefits are, how the participant was selected, and what steps will be taken to ensure privacy and confidentiality of the data collected
- Interviewers should make sure that participants know they can stop or withdraw at any time
- Investigators must provide participants with information about the activity in a manner appropriate to their culture and education. Consent forms and informational tools should be developed with stakeholders and field-tested
- Use an independent advocate to represent the views of children if there is any doubt about the protection provided by their guardian
- Avoid efforts to unduly influence participation by the use of incentives. If incentives are used, they should be in line with local living standards
- Interview procedures should reflect the need to protect the participants' best interests. Since SRH

is often sensitive, care should be taken to conduct interview/survey/focus group discussions in a private setting out of earshot of a participant's spouse, other family members, neighbors, etc.

6) Confirm that all stakeholders understand the limits to the activity and next steps

- Use appropriate procedures to maintain the safety and security of participants
- Share de-identified, aggregate research findings with stakeholders and beneficiaries in an accessible, appropriate format

BOX 5.5: WHAT DATA SHOULD BE COLLECTED IN AN ASSESSMENT?

Chapters 6 to 12 provide recommendations on what data should be collected in assessments for each component of an SRH program.

USE OF ASSESSMENT RESULTS

Team members should analyze data as soon after the data are collected as possible. The results of an assessment must be as specific as possible to allow for timely decisions on interventions to be made. The results must clearly prioritize needs and identify opportunities on how to ensure MISP interventions are sustained and to plan the addition of comprehensive SRH service components.

Share copies of the final report with all organizations involved in the humanitarian response, including the Ministry of Health (MOH), through the health sector/cluster coordination mechanism, as well as with logistics teams and procurement officers. Also communicate findings and decisions to the community in a way that will protect the confidentiality of the participants, such as through aggregated data. It may also be appropriate to share preliminary findings with the community to help validate the interpretation of the findings.

5.3.2 Monitoring

For monitoring and evaluation purposes, it is recommended to work with the existing health care system when possible and appropriate. Ideally, reporting systems and referral systems should align with existing structures; advocacy

may be required to make them more inclusive to displaced populations.

PURPOSE

Regularly collecting, reporting, and analyzing SRH data is essential for monitoring the performance and quality of health service delivery/SRH program and for identifying changes in the health status of the affected population. Monitoring includes the timely dissemination of results so action can be taken.

WHEN TO MONITOR

At the onset of a humanitarian response, a simple information system that collects minimal SRH data is required to monitor implementation of the MISP. As the response evolves and more comprehensive SRH service components are introduced, the monitoring requirements of SRH programs must adapt accordingly.

The periodicity of monitoring (e.g., daily, weekly, or monthly) depends on the stage of the humanitarian response and the requirements of each organization. At least monthly data should be made available to inform regular programming decisions, though more frequent data reports may be necessary depending on the stage (e.g., acute) and type of emergency (e.g., outbreak).

WHO CONDUCTS THE MONITORING

Nurses, midwives, and other SRH service providers working in health facilities are responsible for the routine collection and reporting of service data. In addition, community-based health staff should be involved in gathering community-level data. In order to ensure that data is comparable across different programs, all such staff must receive adequate training on the correct use and application of data collection tools in the field.

The clinic supervisor is responsible for aggregating reports. These are sent to the SRH or health program manager for computer entry and analysis. The clinic supervisor, or another designated supervisor, should conduct quality checks to ensure accurate and consistent data collection.

TOOLS

It is crucial that all health partners use the same tools and methods of data collection across all locations to

ensure that data are standardized, of good quality, and are comparable across locations.

Health data can be collected as part of an existing national health information system (HIS).

Where such a system does not exist or has been disrupted by the crisis, the health sector/cluster will implement an emergency monitoring system in order to support program management and coordination.

Routine SRH data should be collected from a combination of health facility and community sources as part of the wider HIS. Sex and age should always be collected from these sources to enable disaggregated analysis. Sources of routine data include:

- Individual patient records and charts (e.g., partographs, antenatal cards, contraception cards)
- Daily registers and tally sheets (e.g., birth registers, antenatal tally sheets)

- Laboratory forms (e.g., HIV testing or syphilis screening results)
- Maternal and perinatal death review forms
- Near-miss review
- Community-based health workers/midwife reports
- Weekly and/or monthly reporting forms
- Repeated surveys (a useful source of SRH monitoring data when repeated over time)
- Sentinel surveillance
- Commodities/supplies

The above list of tools is not exhaustive. Other methods of routine data collection may need to be maintained alongside the HIS, according to the needs of each program and/or agency.

BOX 5.6: SELECTING AND USING SRH INDICATORS

Indicators are defined as variables that can be monitored over time to track progress toward the achievement of objectives. For example: “coverage of antenatal care.”

An **objective** is the desired end-point to be reached at the end of program implementation. For example: Obstetric risk factors are detected and managed early in pregnancy.

Each indicator should be assigned a corresponding standard target to establish the minimum acceptable level of achievement that is required. For example: 90% of women attend the recommended number of antenatal visits during pregnancy.

If SRH programs implemented by different actors do not utilize the same indicators, they are not standardized, and neither is the health information that they generate. Consequently, the data produced by non-standardized health programs may be incomplete, cannot be aggregated, and are unsuitable for monitoring a situation.

This underscores the importance of participating in coordination mechanisms, such as the health cluster.

The process of indicator selection is not easy. Each indicator should be technically valid, simple, and measurable. Furthermore, the expansion from MISP to comprehensive SRH services within a country will open up new areas for monitoring and implementation that need to be continually taken into consideration. It is therefore recommended that any indicator should meet SMART criteria and should be:

Specific (what and who)

Measurable

Appropriate

Realistic (achievable)

Time bound

The mix of indicators selected for monitoring should also be appropriate

to measure program objectives across different stages of the project cycle. For example:

- Output (or process) indicators measure activities conducted to achieve specified outcomes. For example: the number of midwives trained in ANC protocols
- Outcome (or performance) indicators measure changes that result from program activities, such as changes in knowledge, attitudes and behaviors, or in availability of services. For example: the percentage of women who receive at least two doses of Tetanus Toxoid (TT) prior to delivery
- Goal (or impact) indicators measure changes in morbidity and mortality expected to result from program activities. For example: Incidence of neonatal tetanus

WHAT DATA SHOULD BE COLLECTED IN MONITORING?

Chapters 6 to 12 recommend key indicators used to monitor each component of a comprehensive SRH program. See Box 5.6 for definitions and issues to consider when selecting and using SRH indicators.

USE OF MONITORING RESULTS

Monitoring results enable program managers to analyze trends of specific indicators over time to determine whether the program is adequately serving the affected population. When indicators fall short of their targets, program managers need to use this information to make course corrections so as to achieve the intended objectives.

In order to use data effectively, it is critical to select indicators judiciously and to think of how the data will be used when selecting indicators. Too often, higher-level managers experience information overload and seldom use monitoring data effectively.

Effective use of data also requires regular feedback to lower-level managers and SRH staff. Often lower-level managers and front-line staff rarely receive any feedback from the vast quantities of data they are required to report. SRH program managers must give regular feedback to staff. This can be done by drawing graphs and discussing the trends and implications for programming, as well as by sharing key points from recent health sector/cluster coordination meetings. This engenders accountability and is a powerful motivating tool for lower-level managers, as it enables them to understand how they are contributing to SRH improvements in the general population.

5.3.3 Evaluation

PURPOSE

An evaluation enables SRH program managers to determine whether the SRH program met defined objectives. It compares program activities and services (outputs) with benefits (outcomes) and public health impact (goals).

PROGRAMMATIC EXAMPLE 5.1: MONITORING AND EVALUATION IN A REMOTE HUMANITARIAN SETTING

ORGANIZATION: CARE

LOCATION: Syria

INTRODUCTION: In northern Syria, CARE collaborates with local NGOs to provide both facility-based and community-based sexual and reproductive health services. Continuously rising levels of insecurity in Syria, unpredictable border restrictions, and CARE's determination to reach more remote and underserved areas, all result in a reliance on remote management, including third party monitoring of its activities.

PROJECT DESCRIPTION: CARE sub-contracts monitoring and real-time evaluation activities to independent firms with a proven track-record of methodological rigor who have access to project implementation areas and a strong team of staff on-the-ground in Syria. Using tools designed jointly between CARE and third-party firms, the third-party monitoring team verifies and triangulates data from clinical records with assessments it conducts on quality of care, supplies and equipment inventories, and patient exit interviews. The third-party monitoring firm then reports preliminary results at a joint meeting with both CARE and implementing partners before finalizing their findings.

In conducting third-party monitoring, the priority is selecting quality data sources and conducting effective triangulation that produces "good enough" information without putting partners under pressure and/or risk to provide evidence that is not available or unsafe to collect. The scope of monitoring is agreed with partners as part of planning, including discussion on the level of data that is appropriate, manageable and safe that will best demonstrate the effect of the project.

The feasibility of third-party monitoring is explored for each target area individually, taking into consideration security constraints. Where third-party monitoring is not feasible for security reasons, CARE and partners explores alternatives, such as peer monitoring. In some cases, CARE also contracts local groups based inside Syria to conduct independent monitoring of specific activities.

LESSONS LEARNED: One of the key lessons learned to date is that tri-partite planning between CARE, implementing partners, and the third-party monitoring firm is essential. Ensuring a common understanding of scope, purpose, and logistical and security implications of third-party monitoring activities is a key element of both successful implementation of third-party monitoring exercises and also maintaining effective, trusting working relationships among all partners.

WHEN TO CONDUCT AN EVALUATION

As defined above, evaluations require a sufficient amount of time in order to measure program outputs and impacts. Therefore, evaluations are not appropriate in acute situations where assessments and monitoring can provide feedback on emergency actions. However, 3 to 6 months post-acute phase, a comprehensive package of MISP process evaluation tools are available (see Section 5.5). As we plan and design more complex and comprehensive SRH programming, it is important to build in the framework for evaluations. Evaluations happen throughout the life of a project, not just at the end, and are timed according to the stages of project implementation and the needs of the affected population, implementing organization, and sometimes partners and coordinating bodies. We often use a mix of data sources and methods in order to measure process, outcomes, and impacts.

WHO SHOULD CONDUCT EVALUATIONS

External evaluators generate the most objective and unbiased evaluations. If the evaluator is involved in program coordination or management, it can sometimes be difficult for this person to remain a neutral participant and view the program in an impartial manner.

METHODS

Secondary data review

A review of available documents, such as monitoring reports and operational documents (such as site reports, mission reports, supervision reports, training records).

Primary data collection

Quantitative and qualitative methods, including those described in the assessment section. All stakeholders, including users of the services within the target population, should be included.

WHAT DATA SHOULD BE COLLECTED IN AN EVALUATION?

Typical questions that should be considered in evaluating an SRH program include:

- What were our goals?
- What was our logic frame?

- What did we do?
- What did we achieve?
- Did we achieve what we intended?
- What worked and why? What target group(s) did it work best for and why?
- What didn't work and why? What target group(s) did it work least for and why?
- What lessons have we learned?
- What else is needed to achieve our desired impact?

USE OF EVALUATION RESULTS

We use evaluation results to improve program planning and design. As such, they should reflect both on what is working well and what is not working well. Feedback should be provided to program managers and service providers as the program continues and not just at the end to ensure that issues identified in the evaluation are dealt with promptly before they become problems or risks. We should share the final evaluation report with all organizations involved in the emergency response, including the MOH, and disseminate the report at health sector/cluster coordination meetings. We should also share the findings and decisions directly with the community with consideration of confidentiality and privacy issues.

5.4 HUMAN RIGHTS AND ETHICAL CONSIDERATIONS

5.4.1 Human rights standards

Service providers and others who collect health-related data are obligated to keep health information confidential. The right to privacy under international human rights law protects the right to privacy and confidentiality of health information, including about a person's reproductive health, reproductive functions, sexual life, or sexuality. We include key ethical guidelines in Section 5.5. Key points to keep in mind to ensure respect for the right to privacy include:

- The confidentiality of an individual who provides information about his or her reproductive health status, including incidents of gender-based violence,

must be protected at all times. Anyone providing information about her/his/their reproductive health status, including incidents of gender based violence, must give informed consent before participating in data-gathering activity

- The right to privacy also applies to children, including within the health-care setting. Although information on the health status of children should not be disclosed to third parties, including parents, without the child's consent, this, of course, is subject to the age and maturity of the child, as well as to a determination of her/his/their best interests
- Information must be kept confidential at all times including when it is collected, stored, analyzed, shared, and otherwise used. In a healthcare setting, information about the health status of a patient may be shared with those directly involved in the treatment of a patient if this is needed for treatment
- A person's right to privacy is violated if a service provider discusses her/his/their reproductive health status with someone else without her/his/their authorization. Not only would this breach of confidentiality infringe on that person's right to privacy, but it could also cause significant protection problems for the person concerned. Disclosure of confidential health information has been known to lead to rejection by family members or the community, violence or threats of violence, or discriminatory treatment in accessing services

5.4.2 Ethical considerations of data collection

Privacy risks in data collection relate to the identifiability of participants and the potential harms they, or groups to which they belong, may experience from the collection, use, and disclosure of personal information - particularly sensitive SRH information. All health and humanitarian workers must be familiar with national laws and regulations on collection, storage, and use of health information.

Careful advance planning is crucial. Those responsible for data collection are responsible for thinking through all possible consequences, both intentional and unintentional, of the information-gathering activity and for anticipating the effect of the activity on participants and their families.

If there is any question about whether the data collection could be harmful to subjects, only begin the activity if services are in place to address possible consequences. If the information-gathering activity is not associated with a service, prepare referral information for subjects to reach the required support. If appropriate safeguards cannot be put into place, the activity should not proceed.

Discussions should be held with stakeholders and host community members, including children and adolescents, whenever possible. Community meetings at different stages of the information-gathering activity can serve a variety of purposes, including sensitization, review, and interpretation. These discussions can serve the dual purpose of improving adherence to ethical standards and improving the quality of the information gathered.

INFORMED CONSENT

Collection and use of data for purposes other than routine monitoring often requires informed consent of the person providing the information. This includes data collection where the information will be anonymized and delinked from the name and other identifiers of the respondent. In such cases, an ethics review board should be consulted for appropriate guidelines for informed consent. The aim of the informed consent process is to ensure that respondents are given information about and understand each of the following in a "statement of consent": 1) the purpose and content of the data collection; 2) the procedures that will be followed during the course of the data collection; 3) the risks and the benefits of their participation; and 4) their rights.

All potential participants should also be informed that they have the right to not participate in the data collection or to refuse to answer particular questions, and that doing so will not affect their ability to access services. If, for a specific purpose, information concerning an individual's health status needs to be disclosed to a third party, the person concerned needs to be contacted for their informed consent.

In the case of children, informed consent must be provided by a parent or guardian unless local laws state otherwise. In addition, children who are of an age to be able to understand the nature and implications of the information gathering and disclosure (i.e., are developmentally capable) must also give their consent.

BOX 5.7: KEY CONCEPTS

<i>Privacy</i>	<i>Confidentiality</i>	<i>Security</i>	<i>Identifiable information</i>	<i>Patient-identifiable data</i>
<p>Privacy refers to an individual's right to be free from intrusion or interference by others. Individuals have privacy interests in relation to their bodies, personal information, expressed thoughts and opinions, personal communications with others, and spaces they occupy. Research affects these various domains of privacy in different ways, depending on its objectives and methods. An important aspect of privacy is the right to control information about oneself.</p>	<p>The ethical duty of confidentiality refers to the obligation of an individual or organization to safeguard entrusted information. The ethical duty of confidentiality includes obligations to protect information from unauthorized access, use, disclosure, modification, loss or theft. Fulfilling the ethical duty of confidentiality is essential to the trust relationship between researcher and participant, and to the integrity of the research activity.</p>	<p>Security refers to measures used to protect information. It includes physical, administrative and technical safeguards. An individual or organization fulfils its confidentiality duties, in part, by adopting and enforcing appropriate security measures. Physical safeguards include the use of locked filing cabinets, and the location of computers containing research data away from public areas.</p>	<p>Where researchers seek to collect, use, share and access different types of information or data about participants, they are expected to determine whether the information or data proposed in research may reasonably be expected to identify an individual.</p>	<p>Patient-identifiable data refer to any personal data that can be used directly or indirectly to identify an individual (e.g., name or postcode). This also includes encrypted data if the solution for decryption is still in existence.</p>

LIMITS TO CONFIDENTIALITY

In some settings, national laws require service providers to report to authorities people testing positive for HIV, women who have undergone abortion, or certain cases of sexual violence. While official justifications for these policies and laws may include crime prevention or public health concerns, it is important to note that they may not be in accordance with international human rights standards and may violate the right to privacy.

Service providers need to be familiar with such laws and policies and their obligations. As part of the informed consent process, patients must be informed of any relevant limits to confidentiality. Where mandatory reporting rules are in place, service providers should explain the reporting mechanism to the patient and tell them what they can expect after a report is made.

5.5 FURTHER READING AND ADDITIONAL RESOURCES

GENERAL MONITORING AND EVALUATION RESOURCES

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CHAPTER 6

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

- 6.1 Introduction
 - 6.2 Objectives
 - 6.3 Adolescent sexual and reproductive health programming
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6.1 INTRODUCTION

Adolescence is a period of biological, physical, and cognitive changes and is accompanied by unique sexual and reproductive health (SRH) needs. Adolescents are resilient, resourceful, and energetic. They can play an integral role throughout the disaster risk management and humanitarian program cycles. Cognizant of the competing demands on adolescents, efforts should be made to offer opportunities to build on their capacities to promote their empowerment in this process. For example, they can serve as first responders in emergencies through activities such as assisting health providers as volunteers and community-based distributors. They can expand

access to quality SRH services for the wider community as well as for their peers at the community level. In addition, they can play a critical role in coordination mechanisms to ensure that adolescent needs are considered from the outset of emergencies.

Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse, and exploitation. These factors can disrupt protective family and social structures, peer networks, schools, and religious institutions and can greatly affect the ability of adolescents to protect themselves and practice safe SRH behaviors. Their new environment can be violent, stressful, and/or unhealthy. Adolescents (especially adolescent girls) who live in crisis settings are highly vulnerable to sexual coercion, exploitation, and violence, and may engage in high-risk or transactional sex for survival. Adolescents are a heterogeneous group; their risks and needs may vary depending on factors such as the environment and local context as well as their marital status, education level, disability status, gender and gender identity, bodily identity, sexual orientation, and social and economic status.

BOX 6.1: KEY FACTS AND FIGURES

- Among the countries with the 30 highest rates of child marriage, over 50% are in conflict
- Every hour, 26 adolescents (15-19) are newly infected with HIV. Adolescent girls and young women are disproportionately affected by HIV in sub-Saharan Africa where 7 in 10 new infections in adolescents are among girls
- From 2009-2012, proposals for adolescent sexual and reproductive health through humanitarian funding streams constituted less than 3.5% of all health proposals; the majority were unfunded

On the other hand, in some cases, crisis-affected communities may also be exposed to new opportunities, including access to better health care, schooling, and new languages and skills, which may place adolescents in privileged positions they would not have had in a non-crisis environment. Adolescents often adapt easily to new

situations and can learn quickly how to navigate through the new environment.

SRH Coordinators, health program managers, health care providers, social workers, and teachers working in humanitarian settings must consider and address the unique needs of adolescents. They must also consider especially vulnerable adolescents, including former child soldiers, adolescents heading households, adolescents with disabilities, adolescent mothers, and young girls who are at increased risk of sexual exploitation.

BOX 6.2: ADOLESCENTS PLACED AT INCREASED RISK

- Very young adolescents (under 14)
- Orphans and vulnerable children
- Adolescents engaged in transactional sex
- Adolescents living with HIV
- Adolescents engaging in same-sex intercourse
- Girl mothers
- Child heads of households
- Married adolescents
- Widowed girl adolescents
- Adolescents with disabilities
- Adolescents caring for persons with disabilities
- Child soldiers (including girls) and other children associated with fighting forces (in non-combatant roles)
- Adolescent survivors of sexual violence, trafficking, and other forms of gender-based violence
- Adolescents in urban settings

6.2 OBJECTIVES

The objectives of this chapter are to:

- Provide guidance to SRH Coordinators, health program managers, health service providers, social workers,

and teachers on effective, innovative, and culturally sensitive approaches in humanitarian settings that take into consideration the heterogeneity of adolescents, to increase availability of and accessibility to quality adolescent sexual and reproductive health (ASRH) services

- List the principles and resources that inform SRH Coordinators, health program managers, service providers, and community members on how to involve adolescents in ASRH programs
- Ensure the provision of adolescent-friendly SRH services and information and create a safe and supportive environment where adolescents can develop and thrive, despite the many challenges they face throughout a crisis

BOX 6.3: DEFINITION AND SCOPE

While this chapter refers to adolescents (typically defined as age 10-19), the services described here can be extended to a broader cadre of young women and men who may also benefit from youth-friendly services.

6.3 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

6.3.1 Minimum Initial Service Package implementation

The Minimum Initial Service Package (MISP) is a coordinated set of priority activities aimed to prevent and respond to sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancy, and transition to more comprehensive SRH services as the situation permits. The MISP may not address all of adolescents' needs and it may not be possible to incorporate all ASRH principles when implementing the MISP. Given this situation, it is essential to refer to the Adolescent SRH Toolkit in humanitarian settings developed by Save the Children and the United Nations Population Fund (UNFPA) for additional guidance on the establishment and provision of

adolescent-friendly MISP services along the disaster risk management cycle (see Section 6.6).

BOX 6.4: ADOLESCENTS CAN BE GOOD CANDIDATES FOR LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)

Methods of LARC, including contraceptive implants and intra-uterine devices (IUDs), are safe and effective for adolescents. They can be used in women and girls who have not yet begun childbearing. They offer several advantages over other contraceptive methods: they are extremely effective; they do not require the user to take any action once they are set in place; they are relatively discreet; and they prevent pregnancy for years—during a time when most girls want to avoid childbearing. Health providers should include LARC among the full range of contraceptive methods offered to adolescents.

6.3.2 Emergency and disaster risk management for health

Include the following as part of emergency and disaster risk management efforts:

- Support systematic engagement and partnerships with adolescents in all phases of humanitarian action, especially decision-making and budget allocations
- Strengthen adolescents' capacities to be effective humanitarian actors and support local adolescent-led initiatives and organizations in humanitarian response. This includes crisis-affected adolescents such as refugees and internally displaced persons living in informal urban settlements and slums

6.3.3 Needs assessment

As the situation stabilizes, conduct a needs assessment including a mapping of existing services in coordination with other ASRH and child health actors to inform the program design process and develop an action plan to improve the adolescent-friendliness of existing health services. Involve adolescents, who can be guided to identify their own vulnerabilities as well as capacities, in this process. Ensure inclusion of adolescents placed at increased risk (see Box 12.2). For example, make sure that 10-15% of adolescents consulted in needs assessments

are adolescents with disabilities. Use adolescent-friendly service assessment tools to determine whether health services meet the needs of adolescents. Also assess protective community resources. We should examine data gathered from multiple perspectives including those of adolescents on:

- **Health problems and behaviors:** Prevalence of SRH issues and practices among adolescents, including planned and unplanned pregnancy, contraceptive use, safe and unsafe abortion, maternal and neonatal mortality, safer sex practices, sexually transmitted infections (STIs), and HIV
- **Harmful practices and risk factors:** Adolescent vulnerabilities and harmful practices, including exposure to sexual violence and exploitation, child, early and forced marriage, trafficking, transactional sex, and traditional practices such as female genital cutting
- **Protective factors:** Protective community resources, such as supportive parents and teachers, peer support networks, and adolescent programs with connections to caring adults
- **Available resources:** Adolescent and community perceptions of existing ASRH needs and providing SRH services and information to adolescents, including professional and traditional services. Specific emphasis on how needs and services vary for different groups including girls, boys, lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) youth, and those with disabilities. Reasons for gaps in the provision of and access to services
- **Challenges:** Barriers to accessing existing services for different groups of adolescents, including lack of knowledge about ASRH issues, lack of information about ASRH services and where they are located, insecurity, limited freedom of movement, physical

barriers, cultural norms, lack of confidentiality/privacy, and lack of same-sex healthcare professionals

- **Opportunities:** In some situations, crises present adolescents with new opportunities for building upon their capacities and for improved access to health and education not only for themselves but also for their communities

In addition, SRH Coordinators, health program managers, and service providers must be familiar with national legislation and policies pertaining to adolescent SRH in the countries in which they work. While national governments have the authority and the responsibility to provide SRH education and services for adolescents and young people, restrictive policies may prevail.

Considerations should include:

- What are the laws or policies that restrict or prevent adolescent access to SRH information and services?
- What is the age of majority? What is the age of consent for sex? What is the age of consent for marriage? Is it different for boys/men and girls/women?
- Are there requirements for marital, parental, or guardian approval for providing health information and services to children? To non-child adolescents?
- Is the evolving capacity and best interest of children taken into consideration in laws/policies/protocols regulating adolescent access to SRH services, information, and education?
- What are the laws surrounding adolescent access to abortion-related services and to what degree are these laws implemented or enforced?
- Are there national or local laws or policies regarding sexual violence and other forms of abuse against children both within and outside of the family?

PROGRAMMATIC EXAMPLE 6.1: AN ADOLESCENT-INCLUSIVE SRH NEEDS ASSESSMENT

ORGANIZATION: CARE-International

LOCATION: Goma, Democratic Republic of Congo (DRC)

INTRODUCTION: DRC's reproductive health outcomes are among the poorest in the world. As of 2014, 27% of older adolescents (age 15-19) had begun childbearing; 21% were already mothers and 6% were pregnant. In the crisis-affected region of North Kivu, women and girls face even greater challenges. CARE's baseline survey of 709 adolescents and youth found that 32% of all surveyed girls aged 15-24 years were ever pregnant; of those who were pregnant, 29% got an abortion. As adolescents and young people in Goma City and its neighboring areas have grown up surrounded by crisis, this project aimed not only to address their SRH needs but also to provide them with the opportunity and agency to create change for themselves and their community.

PROJECT DESCRIPTION: The DFID-funded Aid Match project *Vijana Juu* (Swahili for "Up with Youth") was implemented by CARE from February 2016 to October 2017. This pilot project built upon CARE's existing Supporting Access to Family Planning and Post-Abortion Care (SAFPAC) intervention to assess feasibility of including a strong ASRH component within the SAFPAC model to meet the SRH needs of adolescents. The project was implemented in partnership with faith-based groups that manage health facilities and schools in close proximity to each other. CARE project staff, along with a representative from the Ministry of Health's National Program for Adolescent Health, facilitated workshops with youth from surrounding communities to review baseline assessment results and input into project design. CARE used its Community Score Card (CSC) approach to bring together youth, service providers, and government officials to agree upon 4 indicators that represent quality and accessibility of "youth-friendly services" and to put in place a process for monitoring progress on these indicators and trouble shoot problems related to access and service provision. The project also included adolescent-responsive services training and supervision for providers and a peer model approach. Moreover, the meaningful participation of program participants in designing, adapting, and providing ongoing feedback and an iterative program approach allowed for introducing additional program components such as an adolescent-specific referral card to reduce the waiting time young people face at health facilities. Given the positive feedback on this intervention, CARE introduced core Aid Match interventions (such as orientation of

providers to ASRH needs, implementation of fun referral cards, and procurement on supplies that meet adolescents' needs) in SAFPAC's other health facilities in Goma, further extending the availability of adolescent-responsive SRH services across 15 health facilities.

RESULTS: CARE provided contraceptive services to 22,633 new users of family planning across the 15 SAFPAC sites, including 4,681 new users in the initial 4 Aid Match sites. When excluding condoms as a method of choice, 44.7% of young people across the 15 health facilities and 48.9% of young people across the 4 initial Aid Match facilities chose a long-acting reversible contraceptive (implant or intrauterine device). One hundred percent of adolescents that accessed the CARE supported services through the project were satisfied with the services they received. Sixty young people were trained as peer-leaders/youth mentors and 10 peer-leaders/youth mentors were trained as community counselors, an intervention that was introduced to meet the needs of young people living in IDP camps and nearby host communities that did not have access to SRH services. Nine community-based organizations (CBOs) were supported to provide community engagement events focusing on ASRH, including community dialogues. Overall, 1,742 community dialogues were carried-out to raise awareness not only among young people on SRH but also to support an environment and community dynamics that facilitate their access to SRH services.

LESSONS LEARNED: Engaging young people through a participatory approach in project research, design, and implementation resulted in adolescent-relevant services and likely higher utilization of SRH services. Qualitative feedback indicates establishing an accountability mechanism through CSC provides adolescents the opportunity to share feedback on services that is relevant not only to them but for the community-at-large. Furthermore, the CSC approach improved relationships and encouraged dialogue among youth, community leaders and health providers. Based on supportive supervision activities undertaken by CARE staff, we noted that adolescents require additional compassion and support before, during, and after receiving contraceptive methods, especially during the process of identifying relevant long-acting reversible contraceptive methods. It is noteworthy that peer leaders across the 4 sites launched an adolescent network themselves, *Vijianna Vision*, so as to continue community-level activities beyond the life of the project.

BOX 6.5: PROVIDING POST-ABORTION CARE TO ADOLESCENTS

Adolescents and young people in crisis settings are at increased risk for unintended pregnancy and unsafe abortion, due to factors such as their psychosocial development, existing gender and social power dynamics, socio-economic status, sexual violence and coercion, and traditional/cultural values that prevent access to SRH information and services. Adolescents often lack awareness of and access to contraceptive methods to prevent pregnancy. Then, when faced with an unintended pregnancy, adolescents are more likely than adults to seek unsafe abortions and/or to wait longer to seek abortion care, for reasons ranging from fear of stigma to policy constraints and structural barriers such as transportation costs, to delays in realizing they are pregnant or a state of psychological denial of their pregnancy. This increases their risk of complications, including severe bleeding, infection, tearing of the uterus, infertility, and premature mortality.

It is critical that adolescents have access to high-quality post-abortion care. The barriers that adolescents face in accessing SRH services generally can be compounded when they need post-abortion care (PAC) due to misconceptions that PAC is an abortion service or that PAC encourages abortions, and pronounced provider biases toward adolescents in need of PAC. Adolescent participation along the program cycle for PAC services, provider training on adolescent-responsive PAC services, and integrated PAC-family planning programming complemented by community sensitization are critical to improving access to life-saving PAC services for adolescents in emergencies.

6.3.4 Principles for working with adolescents

Large-scale implementation of ASRH programs needs clear policies and guidelines, support from institutional leaders, continued training of health personnel and other staff, and inclusion of adolescent users in the design and monitoring of these services. When working with adolescents, it is important to consider:

- Management principles
- Service provision principles

MANAGEMENT PRINCIPLES

Recognize that adolescents are not a homogeneous group

Needs vary by age, sex, education, marital status, local and cultural context, gender, gender identity, bodily identity, sexual orientation, and disability status. Sub-groups have unique needs and risks. Design and implementation of all programming, including provision of health services and behavior change communication strategies, should be tailored to their specific needs and be age and sex appropriate. Given that some groups of adolescents are placed at higher risk, it is critical to ensure that protection mechanisms are in place to prevent and respond to violence and abuse of adolescents.

Engage in meaningful adolescent participation

The primary principle of working effectively with adolescents is to promote their participation, partnership, and leadership. Due to the barriers adolescents face when accessing SRH services, they should be involved in all aspects of programming, including design, implementation, and monitoring and evaluation. The emphasis should be on the need to engage adolescents in all stages of the program cycle, not just for tokenistic participation. Programs should develop creative strategies to foster inclusion and participation from the heterogeneous population of adolescents. Often it is the more privileged, “visible” adolescents that are consulted rather than those who are at particularly increased risk of being excluded. Given this situation, it is especially important to adopt strategies that build upon strengths and capacities and provide reasonable accommodations for those who would otherwise not be able to participate to their fullest ability, such as adolescents with disabilities, among others. It is helpful to identify adolescents who have served or can serve as leaders or peer educators in their communities. These adolescents can help address the needs of their peers during program design and can assist with implementing activities, such as condom distribution, peer education, monitoring of adolescent-responsive health services, and referrals to gender-based violence counselors. Services will be more accepted if they are tailored to needs identified by adolescents themselves. Adolescents may be helpful in ensuring that the MISP response also addresses their needs, for example, by identifying culturally sensitive locations to make condoms available.

Foster community involvement

Understanding the cultural context and creating a supportive environment is critical to advancing SRH services for adolescents, as they may be affected by community values regarding ASRH. Communities may frequently become especially protective of cultural norms and the process of socializing adolescents when an emergency occurs. As outlined in the MISP (see Chapter 3) it is important to make priority SRH information and services available, including for adolescents, at the onset of the humanitarian response. As soon as possible, focus on involving communities in issues that affect adolescent health, as this can lead to more sustained, positive health impacts. Community members, including parents, guardians, teachers, health care providers, and religious leaders, must be consulted and involved in developing programs with and for adolescents.

SERVICE PROVISION PRINCIPLES

Privacy, confidentiality, equity, and non-discrimination

Adolescents presenting to health providers often feel ashamed, embarrassed, or confused in seeking SRH services. It is important for providers to create the most private space possible in which to talk and provide services. Providers should be trained on adolescent-responsive service provision without bias, judgment, or discrimination. This should include strategies to establish trust, manage power dynamics, and safely engage adolescents with different types of disabilities in decision-making on their own health needs. Information is disseminated rapidly among adolescents and if their confidentiality is breached even once, adolescents will be extremely reluctant to access available services.

BOX 6.6: ADOLESCENTS IN EVERY REGION OF THE WORLD ENGAGE IN SEXUAL ACTIVITY – WHETHER BY CHOICE OR NOT

Across developing countries globally, 17% of girls have had sex by age 16 and 50% have had sex by age 19. Adolescent boys on average become sexually active at an earlier age than girls.

Girls aged 15-19	Africa	Asia	Latin America & Caribbean	All
% ever had sex, age 16	27	11	28	17
% ever had sex, age 19	66	41	67	50

Linking HIV prevention, treatment and care, and reproductive health

When adolescents access health services to seek HIV information, testing, and care, there is an opportunity to promote comprehensive SRH services such as:

- Safer sex education and information
- Contraception, including dual method use
- STI counseling and treatment

Conversely, offer all adolescents accessing contraception or other SRH services the opportunity to learn about their HIV status as well as available care and treatment options

(see Chapters 7, 11, and 12). It is also important to consider the specific needs and additional risks faced by adolescents who were born with and are living with HIV.

Sex of the service provider

Whenever possible, an adolescent should be referred to a provider of the sex of their choice. Ensure that survivors of gender-based violence who are seeking support and care at a health facility have the option of a female support person present in the examination room when a male provider is the only person available. This is essential when the survivor is an adolescent girl, but it is also important to give this option to adolescent boys who are survivors of gender-based violence.

6.3.5 Adolescent programming considerations and implications

It is important for SRH Coordinators and health program managers to remember the following factors that may increase the vulnerability of adolescents during an emergency:

ADOLESCENT GIRLS HAVE GREATER VULNERABILITIES COMPARED TO THEIR MALE COUNTERPARTS

Adolescent girls are an overlooked group within crisis-affected populations. One consequence is a dearth of distinct HIV protection and prevention responses. Where girls are married young, or forced to be married, they are often treated as adults in SRH programming, missing their unique needs around the importance of delaying first and subsequent births.

Existing power differences in relations between men and women can be heightened during an emergency. Adolescent girls are frequently expected to sustain social or cultural norms, such as being submissive to men, caring for their family, staying at home, or marrying young. Moreover, changing power dynamics created as a result of the co-mingling of displaced and host populations can place adolescent girls at increased risk. Economic hardships lead to increased exploitation, such as trafficking and the exchange of sex for money and other necessities, with their related SRH risks (including HIV, STIs, early pregnancy, unintended pregnancy, and unsafe abortion). Adolescent girls are vulnerable to gender-based violence, including sexual violence, domestic violence, female genital cutting, and early and forced marriage. The risks of a pregnancy for an adolescent girl can be exacerbated by pre-existing health conditions such as anemia. Young married girls often lack voice and decision-making power within the household due to the power imbalances with their husbands. The importance of addressing stigma against pregnant or young married adolescents and the need to build the self-efficacy and psychosocial well-being of adolescents cannot be underestimated.

SOCIAL NORMS AND SOCIAL SUPPORTS ARE DISRUPTED IN A CRISIS SITUATION

Poverty exacerbates threats to well-being while weakening family support systems for adolescents. Adolescents in crisis-affected settings must often find ways to survive and meet their basic needs for food, shelter, health, and education. The breakdown of social structures can be protective if harmful practices are discontinued, but it can also be a risk to adolescent health. Adolescents' use of free time in crisis settings may not be subjected to the same kind of scrutiny that would occur under other circumstances. When adolescents are separated from family, friends, teachers, community members,

BOX 6.7: HEALTH RISKS ASSOCIATED WITH EARLY MARRIAGE

Child marriage, defined as a formal marriage or informal union before age 18, affects one in three girls in developing countries. Rates of child marriage are particularly high in fragile states. During conflict, families may turn to child marriage to cope with economic hardship and to protect girls from increased violence. Health providers and community outreach workers should be aware that child marriage is likely to exist in crisis-affected communities. Married adolescents face significant health risks that require deliberate attention:

- Married adolescents are at high risk for maternal mortality and morbidity. Ninety percent of early first births occur within the context of marriage, and the risks for pregnancy complications are highest in adolescence. Complications during pregnancy and childbirth are a leading cause of death globally for girls aged 15-19. Married adolescents are also more vulnerable to pregnancy-related injuries such as obstetric fistula
- Married adolescents are at increased risk for intimate partner violence and sexually transmitted infections, including HIV, as well as for cervical cancer and malaria
- Child marriage is linked with early initiation of sexual activity. However, negotiation skills and knowledge of contraception and safe sex practices are limited among this population
- Not only is the health of the girl at risk, but that of her baby, too. Children born to married adolescents are at greater risk of infant mortality and morbidity

Adolescent-responsive SRH services (both static and mobile) are essential to ensuring that married adolescents have access to life-saving health services. Program design and implementation should include tailored outreach strategies to ensure that married adolescents can access SRH services.

and traditional culture, there may be less social control of risky behavior. Some adolescents, such as those with disabilities, may face increased isolation and be at increased risk of gender-based violence with this loss of familial and community support. Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices that could result in unintended pregnancy, unsafe abortion, STIs, and HIV. Gender inequality contributes to sexual, health, and social problems. Adolescent girls and boys, their families, and communities should be challenged and supported to change inequitable gender norms and capitalize on any opportunities afforded by new and/or changing circumstances.

HUMANITARIAN CRISES CAN DISRUPT ADOLESCENT-ADULT PARTNERSHIPS AT A TIME WHEN ROLE MODELS ARE ESSENTIAL

In stable settings, adolescents usually have role models in the family and community; such role models may not be

obvious in crisis settings. Service providers, community leaders, outreach volunteers, and adolescent club leaders may become important role models and must be aware of their potential influence. Service providers are also well positioned to address the psychosocial needs of adolescents, including mental health, traumatic war-related experiences, post-traumatic stress disorder, sexual abuse, exploitation, and victimization.

HUMANITARIAN CRISES USUALLY DISRUPT NOT ONLY DAILY LIFE, BUT ADOLESCENTS' FUTURE PERSPECTIVES

At a critical and vulnerable time of life, crisis may dramatically shift the individual's view on life. It may lead to increased risk-taking, such as violence, substance use, and/or unsafe sexual activity. Adolescents who attend activities or programs assisting them to plan for the future should be provided with immediate reasons to consider the consequences of unsafe sexual activity and the need to take responsibility for their actions. Training on improved

PROGRAMMATIC EXAMPLE 6.2: ADOLESCENTS AS FIRST RESPONDERS IN NEPAL AND SRI LANKA

ORGANIZATION: International Planned Parenthood Federation (IPPF)

LOCATION: Nepal and Sri Lanka

INTRODUCTION: South Asia is prone to natural disasters that have been growing in frequency and intensity in recent years. This includes the devastating earthquake in Nepal in 2015 and a huge landslide in Sri Lanka in 2016; these events affected a large number of people especially women and children.

PROJECT DESCRIPTION: Among the various crises in the region to which IPPF has responded, its notable work in provision of timely life-saving SRH services outlined under the MISP in Nepal and Sri Lanka received special attention from various partners due to proactive involvement of trained adolescent youth volunteers. With support from the Department of Foreign Affairs and Trade under Australian Government, IPPF provided more than USD137,000 to its Member Associations for response work in Nepal and Sri Lanka. In both the responses, IPPF mobilized and engaged its trained adolescent and youth volunteers who actively participated in strategizing the response and providing services in the field to undertaking risk reduction activities

in the affected communities. Undergirding the effort is a belief that talking with young people about contraceptive use, safer sex behaviors, and gender-based violence helps in reducing their vulnerabilities and understanding better issues that are part of their day-to-day lives.

RESULTS: Trained youth volunteers in both responses supported provision of SRH services to over 22,849 people. More than 2,000 RH Kits were distributed in the two countries. Adolescent volunteers actively participated in camp management and the rapid assessment for the WHO health cluster and also attended the reproductive health cluster meetings. This helped in designing adolescent- and youth-friendly responses and in further liaising with other youth groups and partners.

LESSONS LEARNED: Adolescents and youth can act as catalysts for response work. Involvement of youth in planning and designing the intervention can improve the quality and effectiveness of the emergency response. Furthermore, capacitating youth in disaster risk reduction and SRH service provision including counseling, peer education, and referrals can play a pivotal role in saving lives.

decision-making, negotiation, and other life skills can be effective in encouraging adolescents to think through how to improve their current situation.

ADOLESCENTS MAY BE COMPELLED TO TAKE ON ADULT ROLES IN EMERGENCIES

Adolescents may be forced to take on adult roles and need coping skills that far exceed their years. Humanitarian crises may cause adolescents to wield more power than their adult counterparts, which exacerbates social confusion. Ensuring additional support for adolescents placed at increased risk who are made to take on adult roles, such as girl mothers, is particularly important.

ASRH PROGRAMMING SHOULD BE BASED ON THE CURRENT EVIDENCE-BASE AND EMERGING GOOD PRACTICES FOR INITIATING PROGRAMS AND SCALE-UP

Programming should be coordinated and complementary to meet the holistic needs of adolescents. Some popular interventions have been shown to be ineffective, especially when delivered piecemeal with inadequate or limited human and financial resources. Respecting the autonomy

and decision-making capacity of adolescents and supporting informed choice is critical.

CONSIDER THE UNIQUE NEEDS, VULNERABILITIES, AND OPPORTUNITIES FOR WORKING WITH HETEROGENEOUS GROUPS OF ADOLESCENTS

Evidence indicates that adolescent concerns include healthy growth and development, protection from risks, knowledge of emerging sexuality, and gender roles and norms. For these reasons, programming aimed to address the SRH needs of very young adolescents should consider the continued education of children and adults that inform and influence their decisions and behaviors, including service providers. It is important for providers to identify and adequately address the age-, gender-, marital status-, disability-, and context-specific vulnerabilities of adolescents (see Box 6.2).

6.3.6 Implementing sexual and reproductive health services for adolescents

As illustrated on Table 6.1, the World Health Organization

TABLE 6.1: GLOBAL STANDARDS TO IMPROVE QUALITY OF HEALTH CARE SERVICES FOR ADOLESCENTS

Standard 1	Adolescent health literacy	The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Standard 2	Community support	The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Standard 3	Appropriate package of services	The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfill the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Standard 4	Providers' competencies	Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect.
Standard 5	Facility characteristics	The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Standard 6	Equity and non-discrimination	The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Standard 7	Data and quality improvement	The health facility collects, analyses and uses data on service utilization and quality of care, desegregated by age and sex, to support quality improvement.
Standard 8	Adolescent participation	Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

(WHO) has developed global standards for providing quality health care services to adolescents. These overarching standards should guide the implementation of ASRH services.

PROVISION OF ASRH SERVICES AT HEALTH FACILITIES

Health service providers can play an important role in promoting and protecting the health of adolescents, yet there is abundant evidence that adolescents see available health services as not responding to their needs. Adolescents often mistrust and avoid SRH services or seek help only when they are in desperate need of care. Provider bias is a significant barrier that contributes to this situation and must be addressed, as it often prevents adolescents from seeking facility-based SRH care, as well as receiving adequate information and services around contraception in particular. Married adolescents, including very young adolescents, are also often treated as adults, without consideration for their unique physical, emotional, and psychosocial needs. Furthermore, adolescents with disabilities, particularly intellectual disabilities, may not be offered the same age-appropriate SRH information as others, because parents, community members, and service

providers alike make assumptions about their relationships and capacities.

Adolescents need to be made aware of the availability of “adolescent-responsive” services. Adolescent-responsive SRH services have characteristics that make them more responsive to the particular SRH needs of adolescents, including the provision of a full range of contraceptive methods, safe abortion care, STI diagnosis and treatment, HIV counseling, testing, and care, antenatal and postnatal care, and delivery services, including emergency obstetric and newborn care. It is particularly critical to ensure adolescents have on-site access to supplies for SRH services as they may not have the resources to obtain them elsewhere. Follow-up with adolescents on these services is critical (see Table 6.2).

It is essential to strengthen the linkages between the individual, family, health facility, and community to ensure holistic programming for adolescents. Thus, it is important to ensure that context-specific information, educational, and communications materials are developed and distributed to inform adolescents about the availability of and benefits to seeking SRH services.

TABLE 6.2: ADOLESCENT-RESPONSIVE HEALTH SERVICE CHARACTERISTICS

HEALTH FACILITY CHARACTERISTICS	PROVIDER CHARACTERISTICS	ADMINISTRATIVE CHARACTERISTICS
Convenient hours for adolescents	Respect for adolescents and their choices	Adolescent involvement and leadership
Convenient location	Non-judgmental attitude, empathy and active listening	Boys and young men welcomed
Adequate and space and sufficient privacy	Privacy and confidentiality honored	Necessary referrals available
Comfortable surroundings	Peer counseling available	Affordable fees
Accessible for those with disabilities	Same-sex providers when possible	Drop-in clients welcomed
	Strict confidentiality maintained	Publicity and recruitment that informs and reassures adolescents
	Staff trained in adolescent-responsive health service characteristics	Develop community-based partnerships to strengthen ASRH
	Approach every adolescent as an individual, with differing needs and concerns	

PROVIDER QUESTIONNAIRE FOR ADOLESCENTS

It is good practice to screen and conduct an individual assessment of all adolescents who enter the health system for SRH issues, substance use, and mental health

concerns. In doing this, the health care provider will send a message to adolescents that she/he/they cares about their needs and that the health center is a safe place to discuss SRH-related issues. In addition, the information can be used by health providers to provide appropriate

counseling and referrals. Trained, qualified, and dedicated ASRH staff, including clinical staff, are crucial to high-quality service provision.

Before collecting information from adolescents, consider the services available for referrals. Only ask sensitive questions if appropriate responses to potentially harmful situations and related referrals for additional services can be provided, otherwise more damage than good may be done. A possible adolescent psychosocial assessment that will help guide health providers to ask age-appropriate questions and adequately assess adolescent needs follow the mnemonic HEADSSS: Home, Education/Employment, Activities, Drugs, Sexuality, Suicide and Depression, Safety (see section 6.6).

PROVISION OF SRH SERVICES IN THE COMMUNITY

Community-based provision of services and information offers opportunities not only for adults but also for adolescents to demonstrate leadership and gain new skills through volunteerism while strengthening adolescent-adult partnerships. The community is also an ideal setting to receive SRH information and training and should be supported to establish an assets development approach for adolescents. This type of approach creates space for open dialogue, where adolescents are able to effectively navigate community sensitivities.

HARNESSING THE POWER OF ADOLESCENTS

Adolescents can be positioned to play leadership roles in the community by engaging them in emergency preparedness, capacity building, and other community-based initiatives. This includes participation in coordination meetings starting at the onset of the crisis as well as in camp management meetings. Including adolescents' voices in decision-making processes ensures that the issues of greatest concern to them, which may not be apparent to adults, can be addressed.

Adolescents can also serve as first responders for provision of community-based SRH services. Adolescents trained as community-based distributors (CBDs) are young people who have been trained to provide contraceptive counseling to their peers in the community. They typically focus on the provision of SRH information, oral contraceptives,

condoms and information on HIV, and refer clients to the health center for other contraceptive methods and services. Adolescent CBDs can effectively integrate SRH and HIV information.

Since many barriers preclude adolescents from accessing SRH services at clinics, training adolescent CBDs is a promising strategy to increase adolescent access to SRH services and information while giving the adolescent CBDs themselves leadership roles in the community. Adolescent CBDs often become allies of facility-based health services, through working with service providers on improving the quality of adolescent-friendly services. Set targets for the age, gender, and diversity when recruiting adolescent CBDs to ensure they are able to better reach less “visible” and more vulnerable adolescents.

BOX 6.8: ADOLESCENTS CAN PLAY A CRITICAL ROLE IN HUMANITARIAN RESPONSE

Adolescents can and should have a voice in programming that targets them. Effective ASRH programming builds on adolescents' capacities to promote their own empowerment. For example, adolescents can serve as first responders in emergencies by assisting health providers as volunteers and community-based distributors. They can also participate in coordination mechanisms to ensure that adolescent needs are considered from the outset of an emergency, through the recovery process. Engaging young people in project design, implementation, monitoring, and accountability mechanisms results in improved services.

Peer educators

There is little evidence to indicate that peer education programs are effective on their own. However, peer education may offer benefits since peers are usually perceived as safe and trustworthy sources of information. Well-designed, curriculum-based peer education programs and supervised peer educators can be successful in improving adolescents' knowledge, attitudes, and skills about SRH and HIV prevention. While peer models have traditionally been viewed as very effective for achieving behavior change at the community level, emerging evidence has shown varying degrees of effectiveness due to implementation challenges and lack of fidelity to program design. Adolescents are strongly influenced by

their peers and thus peer education should be employed in the context of a multifaceted approach. To ensure quality in peer education programs:

- Provide high-quality, intensive training to peer educators, including regular assessments and reinforcement of their capacities through refresher trainings, structured supervision, recognition, and ongoing mentorship to peer educators to address motivation and retention challenges, so they can provide accurate information to their peers
- Use standardized checklists in the development and implementation of peer education programs to improve quality

Youth centers

Emerging evidence indicates that “youth centers” are problematic for several reasons. They are usually accessed by more advantaged groups and are not cost-effective in increasing uptake of SRH services. However, adolescent-centered programming may offer other benefits for positive adolescent development and adolescents tend to engage in less risky behaviors when productively engaged. Therefore, while there is limited evidence of their effectiveness in increasing uptake of SRH services, youth centers could still be useful for meeting other objectives such as bringing marginalized adolescents together.

Adolescent outreach components

It is important to develop and implement specific outreach strategies to reach adolescents who may otherwise not have access to SRH information and services. Outreach strategies should be flexible and should include transportation budgets in insecure environments and otherwise hard-to-reach areas. Innovative strategies for effective outreach to adolescents placed at increased risk include use of new media such as blogs, social media and network sites, and photo share platforms, although the required technologies may not be available in all settings. Adolescent outreach activities can also be facilitated at a neighborhood level, strengthening the protective peer networks of those who may be isolated in their homes.

Community outreach

In addressing the principle of community involvement, use community outreach to gain support from and build the

skills of community members. Adults need information, skills, and encouragement, not only to support ASRH programming but also to feel more comfortable in providing information to adolescents. Community outreach may also help adolescents navigate gatekeepers and the social norms that pose barriers to accessing ASRH services.

Link ASRH services with educational settings

It is critical to strengthen linkages between SRH and educational settings in order to protect, build the resilience of, and aid recovery for adolescents. Adolescent use of SRH services during crises can be increased in an educational environment. Make ASRH services and information available in formal and non-formal schools as well as at vocational training centers. Link with educators to advocate for the creation of an enabling environment to ensure the provision of SRH services for adolescents.

Sex-specific hygiene facilities

Adolescents are likely to be uncomfortable and embarrassed about sharing hygiene facilities such as toilets with the opposite sex, and even with younger children. This is especially likely for girls during menstruation. Also, mixed-sex bathroom facilities are often cited as the location of school-related gender-based violence. A lack of sex-specific hygiene facilities, as well as a lack of feminine hygiene products, will discourage adolescent girls from attending school. In order to minimize school absenteeism and school-related sexual harassment and assault, and to promote a safer learning environment:

- Ensure safe, sex-specific hygiene facilities in schools
- Ensure appropriate washing facilities are available and accessible, including to adolescents with disabilities
- Provide girls with cloth or other culturally appropriate sanitary materials for use during menstruation

Curricula-based life skills education

Life-skills education should consider the importance of building adolescents’ developmental assets (human, social, financial, and physical) to leverage adolescents’ social roles, including their intellectual, emotional, and physical capital, as influential actors in their communities. Sexuality and HIV education programs based on a written curriculum and implemented among groups of adolescents

are a promising intervention to reduce adolescent sexual risk behaviors. Program managers should tailor curricula to ensure it is age, developmentally, and culturally appropriate. Characteristics of life skills curricula that have an impact on adolescent behaviors are outlined in Table 6.3 and include puberty and fertility education, menstruation, gender norms, healthy relationships, gender, gender identity, bodily identity, and sexual orientation.

As there are many challenges in providing sexuality education to adolescents, it becomes even more important for SRH Coordinators and health program managers to provide technical assistance to teachers and community educators to ensure they are comfortable in addressing the topics and choosing appropriate lessons for life skills curricula (see Box 6.6).

TABLE 6.3: CHARACTERISTICS OF EFFECTIVE LIFE SKILLS PROGRAMS

CURRICULUM DEVELOPMENT	CURRICULUM CONTENT	CURRICULUM IMPLEMENTATION
Involve people with different backgrounds	Focus on clear goals (e.g., prevention of STIs and/or pregnancy)	Train educators who can relate to adolescents
Assess needs and assets of the target group	Give clear messages on behaviors that lead to these goals (e.g., abstain from sex, use condoms, and/or other contraceptives)	Secure support from authorities, such as ministries of health, school districts or community organization
Design activities consistent with community values and available resources (e.g., staff time and skills, facility space, supplies)	Address risk and protective factors affecting sexual behaviors. This information should include puberty, menstruation, gender norms, gender identity, bodily identity, sexual orientation, HIV and other STIs, healthy relationships and pregnancy prevention.	Create a safe environment for adolescents to participate
Pilot-test the program	Use sound teaching methods and include multiple activities (appropriate to culture, age and sexual experience) that actively involve participants and help them personalize the information	Recruit adolescents and overcome barriers to their involvement (e.g., publicize the program, offer food, obtain parental consent)
	Cover topics in a logical sequence	Teach the full curriculum

BOX 6.9: LIFE PLANNING SKILLS

- Physical and emotional changes to expect during puberty
- Family planning
- Mental health
- Age-appropriate life skills for younger adolescents such as identifying values, understanding consequences of behaviors
- SRH life skills, such as condom self-efficacy, negotiating safe sex and contraceptive use, refusing unwanted sex
- Sexuality and gender, including discussion of socially constructed gender norms
- Health literacy and fertility awareness
- HIV/AIDS prevention
- Prevention of gender-based violence
- Linkages to health facilities, encouraging adolescents to seek out these services
- Other life skills, such as decision-making, critical thinking, self-efficacy, creativity, establishing values, communication, coping with emotions and stress

6.3.7 Coordinating and making linkages

Making links and coordinating between adolescent programs will enable the provision of more comprehensive ASRH services.

LINK SRH SERVICES WITH COMMUNITY SPACES AND SERVICES

Adolescents often seek out adults they trust in safe spaces where they feel information can be shared in confidence. Often, these people are working at the community level. Put in place referral systems to ensure that adolescents receive the appropriate treatment for problems that might be revealed outside the clinical setting, including sexual violence, unintended pregnancy, and unsafe abortion.

ENSURE MULTI-SECTORAL PROGRAMMING

SRH practitioners may be unable, or may lack the skills, to include livelihood components in their program. In coordination with the health cluster/sector, liaise with camp management (if applicable) and other cluster coordination groups to establish links between adolescent programs, health and protection, psychosocial services, education, and livelihood opportunities.

Supporting vocational training and skills development for adolescents will enhance their feeling of control and optimism for the future, and is essential to reconstruct and rehabilitate their social networks and communities, both during and after a humanitarian crisis. Collaborate with adolescent skills-building programs as a source for referral and to integrate SRH information into livelihood programs.

ENGAGE MEN AND BOYS AS AGENTS OF SOCIAL CHANGE

Rigid male social norms have been linked to increased sexual risk-taking, which can lead to higher risks of STI and HIV transmission, as well as increased substance use and gender-based violence. Conditions in humanitarian settings may challenge men who might feel under pressure to play out their traditional roles as providers and protectors, where they are dependent on external assistance. Resulting frustration and humiliation can lead to increased risk-taking behavior and intimate partner and intra-familial violence. Adolescent boys need safe environments where alternative male norms can be modelled while harmful

social norms can be deconstructed. This gives them the opportunity to address their own needs and actively engage them in discussions about reproductive health, thereby benefitting both adolescent girls and boys and promoting gender-equitable norms. However, it is important to ensure that such programming is gender transformative and does not inadvertently reinforce unequal gender norms.

GIRLS' EMPOWERMENT AND SOCIALIZATION

Working with girl-only groups is an ideal way to also challenge female social norms of passivity, subservience, and inferiority to men. Encourage girls to find their voice and solidify their beliefs and values, thereby enhancing their potential to be equal contributors to society. Humanitarian settings can often emphasize unequal gender and power relations. Given this situation, design programs to empower girls through emerging evidence-based models such as girl-centric approaches and asset-building programming for adolescent girls that contribute to their empowerment. Parallel efforts with boys and young men should also be undertaken.

6.3.8 Advocacy

Decision-makers at all levels, from national to local leaders and from donors to humanitarian health staff, often have the power to affect broad-based change because they design and implement policies and programs that affect adolescents' access to SRH information and services. Therefore, advocacy with these stakeholders can have a big pay-off.

Advocacy efforts can occur with and among different stakeholders; SRH Coordinators and health program managers, and service providers must be change agents. Engaging adolescents directly in advocacy efforts can be an effective strategy to identify opportunities for change at the policy or program level and communicate needs to key decision-makers.

Global efforts such as the Global Strategy on Women, Children, and Adolescents, the Compact for Young People in Humanitarian Action, and the Sustainable Development Goals support ASRH in humanitarian settings and can be used as advocacy tools. Sensitize and orient influential people who are part of the relief/development community as well as the community being served to the SRH

vulnerabilities, specific needs, and rights of adolescents.

DONORS AND POLICY MAKERS

- Donors should support multi-year (as appropriate, given the emergency context), multi-sectoral programming to facilitate iterative and reflective processes of program development that engage adolescents along the disaster risk management cycle
- Advocates should encourage donors and research organizations to agree upon and implement consistent age range and age cut offs, ensuring that data is collected on 10-19 year olds

HEALTH CLUSTERS

- The health sector/cluster should prioritize and approve ASRH-inclusive projects in humanitarian funding appeals from the very onset of crises and for effective transition to long-term programming that meets the unique needs of adolescents

EMERGENCY RESPONDERS, HUMANITARIAN ACTORS, AND SRH PROGRAM STAFF

- Both humanitarian and development organizations should address ASRH during emergency preparedness to build upon adolescents' capacities and address needs
- The program cycle should include participation, inclusion, and leadership of the heterogeneous adolescent population at all phases
- Advocates should work to ensure that available information and services are adolescent-responsive thereby ensuring an enabling environment and should highlight the needs of adolescents with officials, policy-makers, and donors
- SRH program staff should be involved in awareness-raising activities in the community, such as "open days" and community dialogues

COMMUNITY LEADERS AND OTHER INFLUENCERS ALONG THE ECOLOGICAL FRAMEWORK

- Influential individuals and groups should sensitize parents, teachers, community, and religious leaders

to the unique SRH needs of adolescents.

- Community leaders should ensure that there is a safe and supportive environment to facilitate adolescent health, protection, and development.

6.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

6.4.1 Human rights standards

The category of adolescent (10-19 years old) includes children, who are defined by the Convention on the Rights of the Child (CRC) as "every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier." The CRC lists the special protections to which children are entitled because of their status as children. It also recognizes the "evolving capacity of the child." This means that "as children acquire enhanced competencies, accordingly, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives." Children have a right to express their views in all matters affecting them and these views must be given due weight in accordance with the age and maturity of the child. Human rights expert bodies have recognized the right of adolescents to meaningfully participate in making decisions about their reproductive health care in line with their evolving capacities and adolescents' right to access reproductive health information and services.

In considering the issues of adolescent health and development, the Committee on the Rights of the Child has interpreted the CRC as obligating States to provide adolescents with access to SRH information and services. These services include, among others, birth preparedness, maternal care, safe abortion services and post-abortion care, and contraceptive services, including emergency contraception. This obligation is based on a range of rights included in the CRC, including the right to non-discrimination, the right to health, the right to information, the right to privacy, the right to expression of views and the right to protection from all forms of abuse, neglect, violence, and exploitation, including harmful traditional practices. These rights are also included in other international human rights instruments. They apply to non-child adolescents as well, and may be violated when:

- Adolescents do not have access to SRH services and information because of their age
- SRH information and services are denied to unmarried girls because of their unmarried status
- Adolescents living with HIV are disadvantaged in formal and non-formal educational and social settings
- Girls are subjected to harmful traditional practices, such as female genital cutting, child, early, or forced marriage, and virginity testing
- Third party authorization (from a parent, guardian, or spouse) is required either by law or in practice for adolescents to access SRH services
- Adolescents are denied the right to meaningfully participate in making decisions about their SRH care, in line with their evolving capacities, including girls' right to have their opinion heard and respected in making decisions about abortion
- Girls who bear children are denied their right to continue their education, such as when they are expelled from school or not provided the proper social or economic support to finish school
- Health workers disclose to a third party an adolescent's HIV status without obtaining legal consent to reveal such information
- Health workers disclose to a third party that an adolescent girl sought SRH services, including abortion or post-abortion care, without obtaining legal consent to reveal such information

6.4.2 Challenges and opportunities

In some cases, SRH program managers and service providers may face difficult decisions or dilemmas. They may find that their ability to ensure the human rights of adolescents is restricted by national legislation, harmful social or cultural norms, or medical misconceptions. Such practices and laws can be in conflict with internationally accepted human rights principles. For example:

- Service providers may be asked by an adolescent's family to conduct a virginity (hymen) examination to determine whether she has engaged in sexual activity or has been raped. Such examinations have

no medical validity and are a breach of the rights of the adolescent if done without her informed consent

- Some service providers may be asked by caregivers, or offer to conduct, procedures on adolescents with disabilities that may restrict their SRH rights. For example, forced or coerced sterilization is sometimes performed on women and girls with disabilities for menstrual management and personal care, and even for pregnancy prevention in situations where they are perceived at high risk of sexual abuse. Such practices are now recognized as a human rights violation
- Managers and service providers may be discouraged from initiating a program that provides SRH information or services to adolescents due to a common misperception that having access to sexuality education and SRH information may encourage adolescents to engage in sexual activity. In fact, accurate and accessible information supports adolescents' ability to make healthy decisions and to refuse to provide this information to adolescents is a denial of their rights
- Requiring that adolescents obtain parental consent for some services may hinder their ability to seek services confidentially and autonomously

SRH Coordinators, health program managers, or service providers may find themselves facing difficult issues around provision of SRH information and services to children and adolescents. Be aware of the agency's/organization's position on these issues and include it as part of the situation analysis and possible next steps. If facing a situation such as those described above, the first priority must be the best interest of the client, focusing on her/his/their safety and health. The safety of the SRH Coordinator, health program manager, or service provider as well as the safety of colleagues is also critical to consider.

Based on the assessment of the situation, it may make sense to:

- Talk to a supervisor
- Discuss possible options with the client including, as appropriate, information about local child rights and women's human rights organizations that might be able to help her/him/them

- Explore ways of mobilizing community support for adolescent-responsive SRH services
- Consider ways to support advocacy efforts, if the agency is engaged in advocacy on the issue, while respecting the confidentiality of the client. Identify with colleagues how to avoid/handle such situations in the future, including through strategies, such as values clarification exercises
- Raise these concerns in health coordination meetings
- Seek guidance on best culturally-sensitive approaches

6.5 MONITORING AND EVALUATION

To be sure that adolescents are making use of available SRH services and receiving SRH information, SRH indicators should be disaggregated by age and sex. Key adolescent sexual and reproductive health indicators include:

- Number of adolescent clients seeking services at health facility (disaggregated by very young adolescents, older adolescents, and other sub-groups)
- The degree to which adolescents report they felt they were meaningfully engaged in the program cycle (could be a qualitative indicator for program improvement purposes)
- Proportion of adolescents with an increase in knowledge on puberty and fertility awareness

6.6 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 7

CONTRACEPTION

- 7.1 Introduction
 - 7.2 Objectives
 - 7.3 Contraception programming
 - 7.3.1 Principles
 - 7.3.2 Minimum Initial Service Package implementation
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7.1 INTRODUCTION

Over 220 million women, most of whom are in the poorest countries in the world and most of whom wish to use contraception, still do not have access to modern contraceptive methods. Access to contraception decreases during natural or human-created crises, as health systems are compromised. New barriers to access come at a time when many people's desire and need for birth spacing and pregnancy prevention increase. Evidence shows that many recently displaced couples express having no desire to become pregnant for two or more years. Additionally, the loss of social structure and protective mechanisms during emergencies increase the risk of forced sex, risk-taking behaviors, and exposure to high-risk situations, highlighting the critical role of the availability of contraception, including emergency contraception and adolescent-responsive sexual and reproductive health (SRH) services. Each year,

these factors put thousands of women and girls at risk of unintended pregnancy, unsafe abortion, and related mortality and morbidity.

BOX 7.1: A NOTE ABOUT TERMINOLOGY

The terms birth spacing, family planning, and contraception are often used interchangeably. Providers should note the following distinctions. Birth spacing refers to the practice of maintaining an interval between births; the World Health Organization recommends a minimum interval of 24 months. Contraception prevents pregnancy by interfering with ovulation, fertilization, and/or implantation. Family planning refers to the comprehensive range of practices that allow individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.

Within this chapter, the term contraception is used with the understanding that contraception can also be used outside of family planning and can, in a number of ways, improve the health of women, girls, and their communities. Additionally, although not explicitly stated in every case, all references to contraception throughout this manual are on a strictly voluntary basis.

Improving access to contraception for women in crises has a significant impact on multiple fronts. It safely and cost-effectively prevents unintended pregnancies and reduces maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. Roughly 90% of unsafe abortion-related morbidity could be prevented by the use of effective contraception. Additionally, global data suggest that the provision of contraception could reduce maternal deaths by an additional 29%. An analysis of 22 US Agency for International Development priority countries found that increasing the availability of contraception from 2012 to 2020 could help avert approximately 7 million under-5 deaths and prevent 450,000 maternal deaths. The provision of comprehensive family planning information and services also leads to substantial improvements in women's earnings and children's schooling.

Access to contraception will also increase the engagement of women and girls in education, protection, life skills, and livelihoods programming by allowing them control over their fertility. The inability to control fertility and access

these critical programs during crises will impact their life trajectories long after the emergency has passed.

It is critical that the provision of contraception is understood by SRH Coordinators, health program managers, and service providers to be part of essential health programming from the earliest phase of an emergency through recovery.

7.2 OBJECTIVES

The objectives of this chapter are to provide guidance to SRH Coordinators, health program managers, and service providers that will:

- Outline critical aspects of delivering contraceptive services during humanitarian emergencies, in terms of contraceptive availability, quality, and demand
- Support the transition of contraceptive service delivery from an acute emergency through stabilization and recovery

7.3 CONTRACEPTION PROGRAMMING

7.3.1 Principles

INFORMED CONSENT

- Women, couples, and families have a right to determine the timing and size of their families, regardless of their displaced status or living in a fragile context
- Every contraceptive client has the right to information, confidentiality, and privacy and to be able to voluntarily choose a contraceptive method
- The affected population, both men and women, must be involved in all aspects of contraceptive programming
- High-quality contraceptive services meet individuals' and couples' needs at every stage of their reproductive lives through providing opportunities for making

informed decisions, a full range of methods, safe procedures, and continuity of services

- When available and of good quality, contraceptive services will be used, regardless of arguments against feasibility or acceptance
- Respect for client confidentiality and for the client's opinion and choices is paramount

HUMAN RIGHTS FRAMEWORK

- Coercing people to use a contraceptive method is unacceptable and in violation of international human rights law
- Under international law, universal access to family planning is a human right as all individuals and couples have the right to decide on the number, spacing, and timing of their children
- Everyone has a right to privacy and the right to equality and non-discrimination
- Everyone has a right to impart and receive information on contraception and birth spacing

PUBLIC HEALTH IMPERATIVE

- A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy

SUPPORT ACCESS FOR THE ENTIRE POPULATION

- Design contraceptive services so that they are accessible and convenient
- SRH Coordinators and health program managers should advocate for provision of comprehensive family planning services whenever possible
- The use of contraceptive methods contributes to women's empowerment, schooling, and economic stability

7.3.2 Minimum Initial Service Package implementation

At the onset of an emergency, it is important to ensure contraceptives are available as this constitutes a life-

saving intervention. Consequently, preventing unintended pregnancy is an objective of the Minimum Initial Service Package (MISP). Priority activities for SRH Coordinators, health program managers, and service providers should focus on:

- 1) Ensuring availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
- 2) 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
- 3) Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

A range of contraceptive methods, including condoms, emergency contraceptive pills, and intrauterine devices (IUDs) are available through the Inter-Agency Reproductive Health Kits (RH Kits). In many contexts contraceptive methods are also available through local sources.

7.3.3 Needs assessment

At the onset of a humanitarian crisis, the MISP should be implemented without undertaking a needs assessment. Priorities within the MISP are considered basic and essential to reduce SRH-related mortality and morbidity. However, Emergency Reproductive Health Coordinators can improve their initial response by obtaining situational information that will better inform the ordering of RH Kits and supplies:

- Population of the crisis-affected community
- Contraceptive Prevalence Rate (CPR) for host and displaced communities
- Method mix for host and displaced/affected communities
- The capacity of providers to provide specific methods of contraception

RH Kits provide a wide range of contraceptive methods that should be made available at the onset of new emergencies, based on available provider capacity. As the situation stabilizes, health service providers should coordinate a rapid initial assessment to inform further program development. Periodically, assessment findings and program recommendations must be reassessed to adapt to the changing needs of a population and their resulting family planning intentions.

ASSESS LOCAL CAPACITY

Trained health cadres (doctors, midwives, clinical officers, community health workers, etc.) exist within nearly every crisis-affected community. Efforts should be taken to identify them, verify their skills, and mobilize them for service delivery. Engaging local providers will support rapid scale-up of both clinical and community-based contraceptive services and establish more sustainable service delivery models that will more effectively transition to recovery. While taking stock of local capacity, humanitarian stakeholders can explore:

- What trained health cadres exist within this community?
- What methods have they been trained to provide?
- What capacity currently exists to deliver information about contraceptive methods, such as current and former community health workers, male and female family planning champions, or existing women's or religious groups in the crisis-affected population, job aides, point-of-service materials, posters promoting family planning, or local language training curricula for services, logistics, or health information systems?

Much of this information also can be gleaned from existing sources and materials reproduced. Few refugee programs have funding to develop quality behavior change communications (BCC) materials from scratch. And yet they are important to provision of quality services.

GATHER DATA

As programs move beyond emergency provision of MISP services (after the first 3 to 6 months), it is critical to tease out the special features that should characterize comprehensive contraceptive service delivery, including:

- Existence, location, and funding for programs that remain in place to deliver contraceptive services
- Community and cultural beliefs around fertility, family planning, and contraception
- Existence of religious prohibitions against and/or support for family planning, contraception, and birth spacing
- The role of men in contraceptive decision-making
- Cultural values and norms that affect access to services for women and youth
- Existence of stigmatized minorities in the refugee population and the barriers that may impact their access to contraception
- Laws and policies (prior to migration) that might impact access to a range of contraceptive services for all countries represented by host, IDP, and refugee populations
- Existence of national and sub-national family planning platforms, a National Population Policy, signatory to rights conventions, or Family Planning 2020 (FP2020) commitment
- Agencies or advocacy bodies that focus on laws, practices, or customs likely to restrain or restrict access to SRH services by refugees

This information can be gathered through:

- Donor and government reports
- Interviews or focus group discussions within host and displaced communities
- Formal knowledge, attitudes, and practices (KAP) studies
- Site visits
- Desk review and internet searches

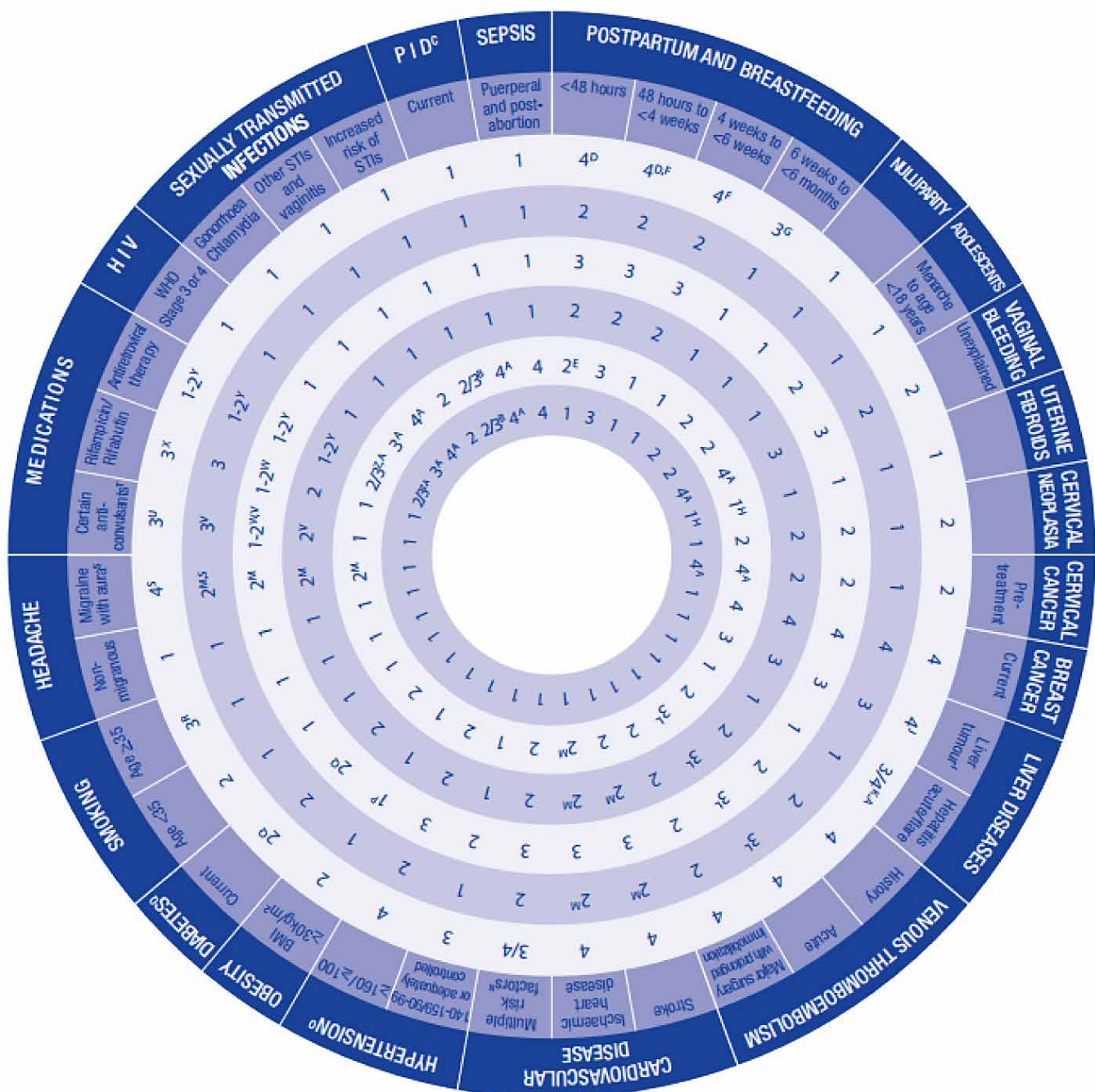
7.3.4 Service availability

METHODS AVAILABLE

There are many different types of contraceptive methods and products that can be offered by providers

in humanitarian settings. Depending on the emergency context, many of these methods may have been made available during the earliest phase of the emergency (if provider capacity existed and there was sufficient demand). However, as the situation stabilizes and program capacity improves, it becomes increasingly important to ensure that an appropriate method mix is available for the entire population and that family planning intentions are understood and met. Programs need to address the context of their operations, as the expectations of the affected population will be shaped by their previous exposure and use of a broader contraceptive method mix.

Not all methods and products are appropriate for all individuals and women's contraceptive needs may change throughout the reproductive life cycle and the emergency continuum. The World Health Organization's Medical Eligibility Criteria (MEC) for Contraceptive Use provides evidence-based guidance regarding who can use contraceptive methods safely, based on their medical conditions (see Fig. 7.1). At the facility, providers should also use the MEC wheel as a practical tool during counseling and method decision-making together with the woman. A woman who has actively chosen a method based on quality information is more likely to use it consistently and correctly.



Service providers must be able to help individuals make an informed and voluntary choice of contraceptive method. At a minimum, service providers should cover the issues listed in Box 7.2. They should also tailor the information to the reproductive health goals and profile of the individual and consider the needs of specific groups, including adolescents, women living with HIV/AIDS, breastfeeding women in the postpartum period, and women in the post-abortion period. Additionally, service providers should know where to refer women and couples if the method of choice is not available at the service point. Visual aids and posters with information related to each method should also be available at the service point. The 2018 version of *Family Planning: A Global Handbook for Providers* has all the essential information required and it should be the book of reference for every SRH service provider (see section 7.6).

BOX 7.2: ESSENTIAL INFORMATION WHEN PROVIDING CONTRACEPTIVE INFORMATION

- Relative effectiveness of the method
- Correct use of the method
- How the method works
- Common side effects
- Health risks and benefits of the method
- Signs and symptoms that would necessitate a return to the clinic
- Return to fertility after method discontinuation
- STI protection

Contraceptive research, innovation, and technologies are constantly developing and evolving. A range of new and not so new contraceptive methods is available. The following list includes the most common contraceptive and family planning methods that can be sourced and used globally in humanitarian settings.

- Condoms (male and female)
- Emergency contraception (EC)
- Lactational amenorrhea method (LAM)
- Oral contraceptive pills (OCPs)
- Injectables
- Implants
- IUDs
- Permanent methods (tubal ligation, vasectomy)

BOX 7.3: WHAT IS EMERGENCY CONTRACEPTION?

Emergency contraceptives are medications or devices that are used after sex to reduce the risk of pregnancy. A number of different modalities of emergency contraception are available globally. These include the post-coital insertion of the copper-bearing intrauterine device, non-hormonal pills that interact with progesterone receptors, progestin-only pills, and combined hormonal pills. Progestin-only emergency contraceptive pills, commonly referred to as ECPs, are the most widely used and best-known post-coital method of contraception (see Chapter 3 for more detail).

Although information should be provided about all of these methods, information about additional methods should be provided based on the context of the crisis or the geographical location.

LOGISTICS AND SUPPLY CHAIN

RH Kits provide basic contraceptive supplies for the delivery of the MISP during the first 3-6 months of an emergency. Dependence on RH Kits, as a situation stabilizes, should be avoided. Humanitarian actors should procure locally whenever possible and quality goods are available and work to establish or link with functioning logistics systems to ensure an ongoing supply of contraceptives and order supplies based on existing forecasting formulas.

PROGRAMMATIC EXAMPLE 7.1: COMPREHENSIVE CONTRACEPTIVE SERVICE DELIVERY IN A CRISIS SETTING

ORGANIZATION: CARE

LOCATION: Northern Syria

INTRODUCTION: The Syrian civil war has triggered the largest, most complex humanitarian response since the United Nations Office for the Coordination of Humanitarian Affairs declared it an emergency in September 2012. One of the biggest challenges for humanitarian agencies has been accessing affected populations in areas controlled by armed opposition groups. Much of the response for this crisis has focused on trauma care and primary health care, with little attention to sexual and reproductive health (SRH). In northern Syria, CARE has provided a wide range of sexual and reproductive health services like family planning and contraceptive services, referrals to emergency obstetric care, and management of sexual violence. Contraceptive services included short-acting methods as well as long-acting reversible contraception, specifically IUDs. This has been possible because of a collaboration to provide integrated SRH services between CARE, Syria Relief and Development, and UNFPA. Contraceptive services were integrated into primary health care services provided in static health facilities (supported by another donor) as well as mobile SRH clinics to take services to the communities.

PROJECT DESCRIPTION: At the primary health

care level, both at static and mobile SRH clinics, midwives and nurses provided contraceptive services, including counseling, pregnancy testing, and a range of contraceptive methods (IUDs, injectables, oral contraceptive pills, progestin-only emergency contraception, and condoms). Additionally, they provided clean delivery kits (for those who could not or would not deliver in a facility), antenatal care, safe delivery services, postnatal care, syndromic management of STIs, health education, and referrals for safe delivery and emergency obstetric care.

RESULTS: These interventions have proven to be successful, as this partnership has created 10 primary health clinics, 10 mobile clinics serving 60 communities and accounting for 61% of all family planning service delivery, and 1 “Women and Girls’ Safe Space.” Overall, the partnership has reached an estimated 388,660 people, including 97,165 women of reproductive age. Between April 2016 and July 2017, the partnership provided 60,876 family planning services including 9,726 IUD insertions, 7,156 injections with Depo-Provera, 22,611 cycles of oral contraceptives and 10,711 condoms.

LESSONS LEARNED: Pre-crisis, oral contraceptive pills dominated the method mix and now the preferred method is IUDs due to increased access to contraceptive services and supplies.

BOX 7.4: CONTRACEPTIVE FORECASTING FORMULAS

Contraceptive forecasting is the process of estimating the quantities of products that will be dispensed or used during a period of time and can be accomplished using a variety of methods. If reliable information on historical use is available, those data can be used to project future use as they will likely be the best predictors of short-term future use. If reliable historical data are not available, forecast demand using demographic data (number of estimated users by method for a year based on population data X the number of contraceptives a user of that method would use in a year, commonly known as a couple years of protection (CYP) factor) or service statistics (number of clients expected by method over a period of time X the number of contraceptives a user receives at a visit according to standard treatment guidelines.) After forecasting use, engage in supply

planning to determine the quantities of contraceptives required to fill the supply pipeline (including safety stock), schedule shipments, and estimate costs.

For further information on forecasting and supply planning, consult the following resources:

- The Quantification of Health Commodities (2017) produced by JSI
- The Quantification of Health Commodities: RMNCH Supplement produced by JSI Research & Training, Inc. with funding from the United Nations Children’s Fund (UNICEF) and Management Sciences for Health under the USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program

SPECIAL CONSIDERATIONS FOR CONTRACEPTIVE LOGISTICS INCLUDE:

- EC is hard to estimate early on. Use demand to forecast future needs. However, EC is not well known, so demand will likely increase as the population realizes it exists and understands when and how to use it
- Unlike other procured drugs (such as antimalarials and antibiotics) demand for contraceptive methods will likely grow over time. Supply projections and planning need to take this into consideration or there will be stock-outs. Plan to have a 3-month stock on hand and reorder accordingly
- There is no such thing as “condoms for HIV/AIDS and condoms for contraception.” People should be counseled about condom use for dual protection, and supplied liberally with condoms, through both clinics and community distribution channels
- If good user data to calculate contraceptive needs (after the MISP) is unavailable, country Demographic and Health Survey (DHS) or Health Management Information System (HMIS) data from before the crisis can help. Consult an expert as needed!

7.3.5 Implementing contraception and family planning programming

PROVIDERS

Family planning and contraceptive method providers at the health facility level should be qualified nurses, midwives, or doctors. Certain settings may have other nationally recognized qualified providers by different names (e.g., health assistants, clinical officers); qualified nurses, midwives, or doctors should supervise these cadres of providers. Identify and hire local staff from members of the host community as well as from the affected community who have skills and experience to provide quality contraceptive services. In rapid onset and complex emergencies, hiring providers with these skills is of high importance as the scope for conducting immediate trainings on any of the clinical skills is limited.

Community outreach with possible community distribution

becomes an important option for service delivery to increase accessibility. When community distribution of contraceptive commodities is part of the health response, ensure supervision and training of lay health workers. It is important for the community-based distributors to recognize medical issues that require referral to a health facility and follow-up. Create awareness among community members that the lay health worker is supervised by a nurse or a doctor who is available for clinical care or counseling, if necessary.

FACILITY

Facility-based contraceptive services should include a broad method mix with long-acting and short-acting methods, including barrier methods and emergency contraception. Facilities can be categorized using the primary health care model, where health posts are the most peripheral health facility functioning at the community level, followed by a mid-level health center, with both of these structures supported by a district-level hospital, functioning as the referral point for community-level health facilities. There may be other structures in between these main structures in different settings.

In the event of a disaster, many of these structures will have limited or no functionality and programs will have to make do with what little might be left behind in the aftermath. Provision of contraception is a relatively simple public health intervention with great potential for saving lives for women as well as for newborns and infants. However, it is important to ensure that basic amenities as well as good practices are put in place; this can be achieved with planning and modest resources. Some of the important aspects to consider are:

- Ensuring application of best practices in contraceptive services
- Establishing a good referral system for higher-level clinical care and client follow-up
- Designing contraceptive services in a manner that ensures clients' rights to privacy, confidentiality, and informed consent
- Implementing appropriate infection prevention and waste management procedures

QUALITY

High-quality contraceptive services meet individuals' and couples' needs at every stage of their reproductive lives through clinical competence of providers, counseling skills, including the information given to clients, method choice, interpersonal skills, support for continuation of method use, and integration with other health services. Service providers should provide clients with accurate and complete information, allowing women, men, and adolescents to voluntarily select a method that suits their needs.

Method choice and continuation

Due to personal preference and changing needs over the life course, a broad range of methods is an essential component of good contraceptive services. Method mix, including long-acting reversible contraception (LARC) and emergency contraception, is important to address informed and voluntary choice and changing client needs. These aspects of family planning programs have been associated with increased contraceptive prevalence. In the case of short-acting methods, it is important to facilitate the client's return visit so she can continue her method of choice. This should be addressed through providing longer term commodity allocation as well as introducing a reliable appointment or follow-up system encouraging clients to return for services for continued protection against unintended pregnancy. Maintaining a client follow up card at the health facility for each client can help health providers keep track of follow up services.

Provider competence

In order to provide a broad range of methods, providers must have the technical competence to provide related services, including skills in contraceptive insertion and removal. Providers need to be able to apply the following skills in their counseling and service provision:

- Describe methods, including effectiveness, correct use, advantages, and disadvantages
- Describe the mechanism(s) of action, common side effects, potential complications, and management of complications
- Use Medical Eligibility Criteria and identify associated drug interactions
- Provide instructions for accurate use of method and/or its proper administration
- Implement infection prevention principles and practices

Further, in order to provide good quality services, providers need to be aware of, and be prepared to adhere to, the following guidelines:

- Means for maintaining consistent and sufficient supply of contraceptive commodities and related supplies
- Mechanisms for documenting and keeping records of service provision, as well as for commodities and supplies required for service delivery
- Methods to initiate and maintain appropriate referrals to higher level facilities based on sound clinical decision-making practices

Counseling skills

For any contraceptive service delivery intervention, counseling is an essential component that forms the cornerstone for volunteerism and informed choice. High-quality counseling ensures clients are informed about their chosen method and fosters longer continuation. Being in a humanitarian setting is not a reason to cut corners on this quality aspect of service provision; on the contrary, investing in this integral part of quality contraceptive services helps to lay the foundation for high-quality services that are critical to establishing trust with clients and facilitating longer term service delivery interventions.

The following basic principles of contraceptive counseling should be demonstrated:

- Non-judgmental attitudes toward contraceptive users and nonusers, respecting their choices, dignity, privacy, and confidentiality
- Full explanation of advantages and disadvantages of different methods and information on management of side effects
- Evidence-based and tactful responses to rumors and misconceptions regarding contraceptive methods
- Sensitivity to the needs of specific groups (e.g., adolescents, persons with disabilities, people living

with HIV, persons engaged in sex work)

- Maintaining confidentiality for services and recognizing that partner permission or notification is not required
- Communication techniques, such as open interactive dialogue with clients: encouraging clients to express their questions and concerns, active listening, clarifying, asking clients to restate their understanding, acknowledging client feelings, and summarizing the discussion

- Documenting method choice and storing information in a confidential location

Providers should also be mindful of the possibility that a client is experiencing intimate partner violence or reproductive coercion in her/his/their relationship. If a provider suspects that a client is experiencing reproductive coercion, she/he/they should provide a safe and supportive environment and ensure the client's right to confidentiality is respected. It is also important for providers to know the referral system for gender-based violence (GBV) and provide information about services to the client.

BOX 7.5: ENSURING CONTRACEPTIVE USE IS VOLUNTARY

All persons have the human right to reproductive self-determination and thus to make decisions regarding their reproductive health without being subjected to violence, coercion, or discrimination. Consequently, a human rights-based approach to providing contraception and family planning requires that all services be offered on a voluntary basis. Providers must ensure that clients are provided with accurate information and are free to choose their preferred method without being subjected to undue influence or coercion. The key tenets of voluntarism in providing family planning includes:

- People have the opportunity to choose voluntarily whether to use family planning or a specific contraceptive method
- Individuals have access to information on a wide variety of contraceptive choices, including the benefits and health risks of particular methods
- Clients are offered, either directly or through referral, a broad range of contraceptive methods and services
- The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client

Service integration

Contraception services must be comprehensive as well as convenient. For example, a client should be able to complete all the services necessary for a visit and receive her/his/their contraception method of choice on the same day and at the same location as where the initial counseling took place.

SOCIAL BEHAVIOR CHANGE

Social behavior change communication (SBCC) is the use of communication to change behaviors, including service

utilization, by positively influencing knowledge, attitudes, and social norms. SBCC is systematic, evidence-based, and participatory and strengthens capacity. Because behaviors are deeply rooted in the social constructs of individuals and societies, the process of changing negative health behaviors involves developing a deep understanding of these constructs. During implementation of the MISP, humanitarian actors will focus on ensuring that clients know what services are available to them and where they can be found, that they feel safe and welcomed when they seek services, that services are open to all who need them, and that they are delivered with sensitivity to their specific

PROGRAMMATIC EXAMPLE 7.2: COMPREHENSIVE CONTRACEPTIVE SERVICE DELIVERY IN A CRISIS SETTING

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Nigeria

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

PROJECT DESCRIPTION: In August 2016, the IRC initiated MISP services and within 4 weeks had established the only reproductive health clinic in the Bakassi camp, which served 21,293 IDPs. The IRC also supported 4 government primary health care facilities within the Maiduguri Metropolitan Council-Jere area, with a particular focus on contraceptive services, post-abortion care, care for sexual assault survivors, and delivery care. Additionally, the IRC had established comprehensive reproductive health services in Konduga (population 9,371) and Monguno (population 40,147) through

SRH clinics. During this period, the IRC provided support to a total of 291,767 people in Borno State.

RESULTS: The IRC successfully scaled up contraception uptake through a combination of staffing support, commodity provision, community outreach by engaging volunteers and traditional birth attendants and training of government health providers. Following a contraception training for health care providers, new acceptors increased by 50% in just one week. Between January and March 2017 across all supported sites, the IRC served a total of 3,474 family planning clients. Of these clients, 69% (2,398) were new acceptors of contraception and 14.4% (346) opted for a long-acting reversible contraceptive method.

LESSONS LEARNED: These results demonstrate a capacity to rapidly scale contraceptive services in a fragile context with low contraceptive prevalence. Emergency responders must anticipate a low number of skilled health staff available, long lead times for procurement and recruitment, and low priority for SRH. To fill these gaps, responders must budget for more skilled staff including procurement staff and prepare data and evidence to share with local authorities and in the health cluster to prioritize SRH.

needs. As the transition to comprehensive SRH services occurs, more intensive SBCC should be a feature.

COMMUNITY OUTREACH AND INVOLVEMENT

Communities should be involved in the development and implementation of family planning programs, including specific sub-populations that may be more difficult to reach (adolescents, sex workers, persons with disabilities, lesbian, gay, bisexual, queer, questioning, intersex, and asexual (LGBTQIA) people, among others).

Male involvement

Male partners are often the decision-makers about whether their female partner can use contraception and, if permission is granted, which method she uses. Involve men as key stakeholders and partners to increase acceptance

BOX 7.6: DEFINING CULTURAL HUMILITY

In 1998, Melanie Tervalon and Jann Murray-Garcia developed the term “cultural humility” to describe an on-going process by which social work and medical professionals can learn about different cultures while engaging in meaningful reflection on their own cultural traditions, beliefs, and biases. In family planning, the most sensitive and complex areas of culture come into play. How we feel about pregnancy, contraception, abortion, female genital cutting, STIs, and the value of girl infants can divide even those within one culture. High-quality contraceptive service delivery recognizes the importance of practicing cultural humility while providing care, and places responsibility for establishing a respectful and non-judgmental space on the health service provider and agency.

of the program within the community and recognition of other SRH issues, such as the prevention and treatment of sexually transmitted infections (STIs), including HIV. Considering men's perspectives and motivations is integral to program activities.

Contraceptive use by men enables them to share the

responsibility of pregnancy prevention with their female partners. Some services may need to be specifically tailored to meet the needs of male users. Activities to encourage men's involvement include couples counseling, condom promotion, health facility times for men, peer-group sessions, and dissemination of SRH information at male social groups.

PROGRAMMATIC EXAMPLE 7.3: INVOLVING MEN IN CONTRACEPTION PROGRAMMING IN CONFLICT SETTINGS

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Chad

INTRODUCTION: In the Oure Cassoni camp of Amdjarass, the IRC-supported health center serves a total population of 46,000, including a host population of 20,000. Despite service availability and community mobilization activities in the camp, low acceptance of contraceptive methods posed a real challenge, particularly due to the influence of religious leaders on women's decision-making and health-seeking behaviors.

PROJECT DESCRIPTION: The IRC identified 40 influential religious leaders to attend awareness-raising and training sessions. The sessions presented the importance of contraception and, quite critically, addressed its advantages within the broader context of maternal and child health in Chad. The President's endorsement of reproductive health and contraception and references of supportive religious passages were reiterated throughout the trainings. A committee of religious leaders in support of contraception was formed to begin community sensitization efforts in mosques and to participate in data analysis meetings.

RESULTS: In Amdjarass, 316 clients accepted

contraception during the project's reporting period, exceeding the target and surpassing the achievement during the previous semester, when 180 clients accepted contraception. This performance is largely explained by religious leaders' involvement in contraception-sensitizations, especially at mosques, and the permanence of one trained IRC staff at the Ouré Cassoni health post to ensure service provision and capacity building of existing refugee staff. Before mobilization efforts took place, the IRC saw an average of 20 new acceptors per month, with an average of 8 acceptors of long-acting reversible contraception (LARC). After trainings of religious leaders and subsequent community sensitization efforts, the IRC saw an average of 33 new acceptors, with an average of 17 acceptors of methods of LARC.

LESSONS LEARNED: Religious leaders are often considered as a barrier to contraception in humanitarian contexts. Yet even in a context considered traditional and religious, contraception is accepted once people are well informed and quality services are in place. The perception of religious community beliefs as barriers is never an excuse to not offer contraceptive services during emergencies. However, more sensitization is needed to expand access for vulnerable groups as contraceptive use among adolescents girls and unwed women is still taboo.

Consulting with populations facing unique needs or specific risks

Contraceptive services should be made available to all segments of the population and thus key stakeholders should be involved in the consultation and development of programs. It is recommended that efforts be made to identify local groups who currently provide services to specific groups, such as the LGBTQIA community, and persons engaged in sex work, in order to establish referral pathways through existing networks. Providers can simultaneously receive training in service delivery and

sensitivity to groups that they may encounter through their work.

INFORMATION, EDUCATION, AND COMMUNICATION MATERIALS

Information, education, and communication (IEC) materials should be used in the acute phase to create basic awareness about availability of contraceptive services. These IEC materials can include posters, fliers in local languages with locally-appropriate images, and radio messages. In moving to the comprehensive service

delivery phase, IEC materials should shift to messages that motivate women, adolescents, men, couples, and other members of the community to use contraceptive services.

RESPONDING TO MISINFORMATION AND METHOD DISCONTINUATION

A comprehensive and client-centered contraception service delivery program facilitates method continuation and responds quickly and supportively to method switching. However, many women discontinue their contraceptive method for reasons other than desiring pregnancy, and very often these women do not switch to a new method. This leaves many of clients with an unmet need for contraception and at-risk of unintended pregnancy.

Providers offering contraception can minimize discontinuation by accurately describing side effects and ways to manage them if they arise. Providers should also be prepared and equipped to remove implants and IUDs if clients seek their removal.

As part of comprehensive SRH services, efforts can be made to ensure continuation including:

- Strengthen provider skills on counseling including side effects management
- Active follow-up for clients who miss an appointment to renew a contraceptive method
- Incorporation of community health workers (CHWs) into community-based contraceptive service delivery
- Active engagement of community members to dispel rumors
- Ensuring reliable stocking of contraceptives to prevent stock outs

7.3.6 Working with specific populations

ADOLESCENTS

Complications of pregnancy and childbirth are the second leading cause of death among girls 15-19 and 50% of sexual assaults are to girls 15 and younger. In humanitarian emergencies, risks for adolescents are exacerbated and therefore their reproductive health needs must be a priority. Adolescents in humanitarian emergencies face increased risks of sexual violence,

abuse and exploitation, unplanned pregnancy, and unsafe abortion. Health providers must ensure that adolescents - married, unmarried, with disabilities, in-school and out of school - are able to access SRH services in general and contraceptive services in particular. Circumstances that bring adolescents to care may not always be known and it is critical for providers to deliver non-judgmental, high-quality services and when the opportunity occurs to leverage this point of access to identify and deliver other needed services and resources as appropriate. For more information on adolescent sexual and reproductive health, see Chapter 6.

BOX 7.7: DEFINING “PERSONS ENGAGED IN SEX WORK”

Persons engaged in sex work is a term that encompasses female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work may vary in the degree to which it is “formal” or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. Additionally, in many contexts, including humanitarian settings, many individuals engaging in this practice do not self-identify as sex workers.

PERSONS ENGAGED IN SEX WORK

All persons engaged in sex work have a fundamental human right to the highest attainable standard of health. It is important that actions are taken programmatically, and at the point of service delivery, to ensure that these rights are realized. Service providers have an obligation to provide care to persons engaged in sex work, regardless of the legal status of sex work in the specific setting. Service providers should also keep in mind that persons engaged in sex work are capable of making informed decisions.

Service providers should offer persons engaged in sex work the same quality of care as all other clients. During their counseling, providers should:

- Discuss available methods of contraception, including dual method protection
- Provide counseling on safe sex and sexually

transmitted infection (STI)/HIV protection that addresses the specific needs of persons engaged in sex work, including instructions on the proper use of male and female condoms and lubricants

- Promote and provide condoms and lubricants in sufficient quantities
- Screen for HIV and other STIs and provide appropriate counseling, treatment, and follow-up
- Discuss the client's pregnancy intention
- Determine medical eligibility for the desired contraceptive method
- Provide or prescribe the client's preferred contraceptive method
- Make EC available

In addition, clients should be linked to safe abortion care and safe pregnancy care, as needed. Providers should be mindful that persons engaged in sex work confront many of the same SRH needs—including planned and unplanned pregnancies—as their peers who are not engaged in sex work, and should ensure to address these needs.

PERSONS WITH DISABILITIES

The Convention on the Rights of Persons with Disabilities (CRPD) declares that persons with disabilities should have the same range, quality, and standard of free or affordable health care and programs as provided to other persons, including in the area of SRH. However, the diverse reproductive health needs of persons with disabilities are rarely understood or addressed through SRH programming in emergency contexts. The SRH needs of persons with disabilities, their family planning intentions, and their access to contraceptive services should be understood and mainstreamed within comprehensive SRH programming.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, QUESTIONING, INTERSEX, AND ASEXUAL PEOPLE

Under international human rights law, States must secure equal rights—including rights to life, health, and security of person—for all individuals, regardless of their gender identity, sexual orientation, or other status. However, discriminatory laws, attitudes, and practices often produce health disparities and compromise the ability of LGBTQIA individuals to access quality reproductive health services. Providers are critical to ensuring that LGBTQIA individuals' equal rights to health are protected and fulfilled, and should be mindful of the particular barriers that LGBTQIA persons may face when seeking care. Providers should adopt a respectful and non-judgmental attitude when providing services and should strive to address any concerns that may be specific to this population.

BOX 7.8: PROVIDING EMERGENCY CONTRACEPTION TO RAPE SURVIVORS

Emergency contraception can reduce the risk of pregnancy after an instance of unprotected sex, including in cases of sexual violence. Global guidance from the WHO is clear that EC should be offered to women and girls to prevent the traumatic consequences of pregnancy resulting from rape, as part of comprehensive, woman-centered care. Failure to ensure that sexual violence survivors receive EC may harm their physical and psychological health (especially in areas where safe abortion is illegal or unavailable); such failure is a violation of their human rights.

For the millions of women and girls who have been affected by conflict, natural disasters and emergencies, both the need to access EC and barriers to it are increased. Forced displacement, exposure to violence, and separation from families and communities expose crisis-affected populations to increased risk of sexual violence and the accompanying risk of unintended pregnancies. At the same time, their access to regular contraception, which protect against such risk, is diminished.

And yet routine access to EC is lacking due to barriers at the levels of policy, laws, health systems, and awareness. Many of the countries with no registered EC product are currently, or have recently been, affected by conflict and may also host large displaced populations. Fragile settings may also be more likely to lack skilled staff and sufficient supplies.

BOX 7.9: POST-ABORTION CONTRACEPTION SERVICE DELIVERY

Providing timely and effective post-abortion counseling can help prevent future unintended pregnancies. Post-abortion contraceptive counseling is also associated with a reduction in maternal and child mortality and prevention of mother-to-child HIV transmission. Unfortunately, the proportion of women who receive a contraceptive method after abortion care remains low. Therefore, contraceptive counseling and provision of a method should be priorities in all abortion services. In addition, some women may have experienced an unintended pregnancy while already using a method; it is important to address the reasons for method failure, and counsel women accordingly. The World Health Organization recommends all women should receive contraceptive information and be offered counseling for and methods of post-abortion contraception, including emergency contraception, before leaving the health-care facility.

Providers must ensure that all women, including young women, receiving abortion-related care know:

- Ovulation and thus pregnancy can occur almost immediately after a uterine evacuation
- In general, all methods of contraception can be used immediately following a uterine evacuation
- Where she can obtain contraceptive services and methods including emergency contraception

Providing contraceptive services at the same time and in the same location as the abortion care can help ensure that a woman receives a contraceptive method before leaving the facility. If a woman is eligible and has been counseled and consented to the method, all methods of contraception—including IUDs and female sterilization—may be started at the same time as a vacuum aspiration. Most methods of contraception can be given at the same time as the first pill of a medication abortion. After medication abortion, an IUD may be inserted when it is reasonably certain that a woman is no longer pregnant and provided the client consents to the procedure.

7.3.7 Coordinating and making linkages

SRH Coordinators need to aim for the integration of contraceptive services and family planning programs in primary health care and other SRH programs, including:

- Provision of emergency contraception as part of the response to survivors of sexual violence and to meet demand
- Integration of contraceptive counseling and service delivery in STI and HIV programs, by ensuring that service providers
 - o Discuss pregnancy prevention and contraception with clients as needed
 - o Encourage dual protection (against pregnancy and STIs)
- Inclusion of contraceptive programming in adolescent healthcare services
- Incorporation of contraceptive counseling and management in the antenatal, delivery, and postpartum periods in maternal and newborn health programs
- Inclusion of contraceptive counseling and services,

and screening for contraceptive coercion, in gender-based violence programs

7.3.8 Advocacy

SRH Coordinators and health program managers should advocate for provision of comprehensive family planning information and services whenever possible. Efforts should be made to ensure service providers are aware of and implementing existing policies.

Engagement with local civil society organizations is essential to identifying and meeting the needs of affected populations. Local actors often best know the landscape and needs of the community and should be a resource in working with the government, donors, and other agencies to ensure that comprehensive, rights-based family planning programs are implemented. While national guidance and law take precedent, bringing these standards in line with international norms, standards, and protocols, is important to ensure that people have access to comprehensive, quality contraceptive information, services and supplies. Meeting with the local Ministry of Health officials, private donors, and other agencies to present data on unmet need, potential cost savings, and the health benefits of providing contraceptive services may result in stronger policies that save lives.

7.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

Under international law, universal access to family planning is a human right: all individuals and couples have the right to decide on the number, spacing and timing of children. At the 1994 International Conference on Population and Development (ICPD), governments agreed to make reproductive health care available to all, including a full range of contraceptive services. The right to the highest attainable standard of health includes the right to be informed and to have access to safe, effective, affordable, and acceptable methods of contraception. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee has explicitly called on states to ensure access to contraception, including emergency contraception, in conflict-affected settings.

Coercing people to use a contraceptive method is not family planning and is a violation of international human rights law. For example, forced sterilization without consent violates the right to informed consent, the right to health, the right to security and liberty of the person, and the right of individuals to decide freely on the number and spacing of their children.

7.5 MONITORING AND EVALUATION

7.5.1 Clinic/service register

Maintain a clinical register to record information and offer effective follow-up. In mobile populations, clients may wish to keep a copy of their records. The following information should be recorded in the client register (one client per row):

- Date
- Client name, or, if required for confidentiality, a unique identifier
- Client age and other demographic information
- Type of client
 - o New: Service providers must define the meaning

of “new” client. Is this client new to the facility (starting contraceptive use for the first time at this facility)? New to the specific method (starting this method for the first time)? New to using contraception (starting contraception for the first time in her life)? If using Ministry of Health forms, please note the correct definition.

- o Return: A client who is not new (according to the specific definition). This can include a client returning for a follow-up visit, for re-supply, or to change methods
- o Switcher: A client who switches immediately from using one method to using another. Both methods should be recorded
- Method selected (and brand name): Be sure to include all methods. It is best if there is a column to each method (e.g., OCPs, injectable, implant, IUD, etc.)
- Method removal (for IUDs and implants): Note reason for removal in a “comments” column
- Referred by: If the program integrates with other services and uses CHWs, this column can specify the source of the referral

The individual client form may also allow for tracking contraceptive use by a single client over time. This individual client record should contain additional information, including date, reason(s) for method discontinuation or switching, side effects, side effect management/treatment, etc.

7.5.2 Support client continuation

An integral part of any contraceptive program is to track continuation of use. To do this, SRH Coordinators, health program managers, and service providers need a system to identify clients who have not returned for re-supply appointments and remind them that they missed their appointment. The recommended system uses a box with dividers to file client cards as described below. If the standard practice is for the client to keep her/his/their card, then use a card with the following information to file in the appropriate month: name, age, date of visit, method taken, and date of return visit.

INFORMATION MANAGEMENT

Obtain a box sufficient to hold the filed cards. Divide the box into slots or shelves, one for each month of the year plus one for long-acting methods and one for “loss to follow-up less than 6 months.” After the appointment, place the client card in the appropriate slot for the month when the client is scheduled to return for her/his/their re-supply. At the end of the month, it is easy to see which clients missed their appointments and contact them with a reminder. It is important to maintain client confidentiality when reminding them of missed appointments.

Record-keeping forms should be simple and appropriate for the collected data and staff literacy levels. Use national or local formats that are known by the local staff and the affected population. Train all staff on maintaining appropriate records, including definitions and how to complete forms, and using the information collected in their program.

7.5.3 Indicators

Figure 7.2 provides information about the key indicators for provision of contraceptive services.

FIGURE 7.2: KEY INDICATORS

INDICATOR	DEFINITION	DATA SOURCE	COMMENTS
FACILITY INDICATORS			
Number of clients who start a modern contraceptive method at this facility, by method	Number of clients who begin using a contraceptive method, by method <ol style="list-style-type: none"> a. IUD b. Implants c. Tubal ligation d. Vasectomy e. Daily oral contraceptive pill f. Injectables g. Condoms (male or female) h. Emergency contraception <ol style="list-style-type: none"> 1. EC pills 2. IUD as EC 	Facility registers	Please include any client who starts a modern method, including those switching from another method You must define how long a client stops a method before re-starting; e.g., if a client has stopped using a method for 6 months (i.e., missed her last appointment for 6 months), she should be counted as re-starting
Integration	<ul style="list-style-type: none"> • Percentage of contraceptive clients also counseled about sexually transmitted infections • Percentage of contraceptive clients also referred to source of ongoing contraceptive method 		
Method mix	Numerator: Number of contraceptive clients who start each method Denominator: Number of clients who start a modern contraceptive method at this facility	Facility registers	
PROGRAMMATIC INDICATORS			
Number of contraceptive service delivery points that had no stock-outs of methods in previous month	Number of contraceptive service delivery points that had no stock-outs (for more than 1 day) of methods in previous month	Stock registers	It is important to check stocks of all methods that are provided by the facility (e.g., OCPs, injectables, IUDs, implants, EC)
Number of providers with technical competence to provide contraception	Number of providers with technical competence, as measured using a checklist, to provide contraceptive methods, by method	Program or supervision records	Supervisors should observe providers' competence using a checklist with each method periodically (for example, twice a year)

7.6 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 8

COMPREHENSIVE ABORTION CARE

8.1 Introduction

8.2 Objectives

8.3 Comprehensive abortion care programming

8.3.1 Minimum Initial Service Package implementation

8.3.2 Needs assessment

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8.3.4 Implementing comprehensive abortion care in the acute through recovery phases

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8.3.6 Coordinating and making linkages

8.3.7 Advocacy

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8.5 Monitoring and evaluation

8.6 Further reading and additional resources

8.1 INTRODUCTION

The World Health Organization (WHO) estimates that 56 million pregnancies end in induced abortion annually; 22 million of these are estimated to be unsafe, meaning that they are performed either by persons lacking the necessary skills or in an environment lacking the minimum medical standards, or both. Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects women, girls, families, and entire communities. Globally, unsafe abortion accounts for nearly 10% of maternal deaths, 99% of which occur in the developing world. Making pregnancy safer includes fulfilling women's and girls' right to access comprehensive sexual and reproductive health (SRH) services, including the provision of safe abortion care, and timely and appropriate management of unsafe and spontaneous abortion for all women.

Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion and require access to safe abortion care:

- Women and girls may not be able to continue with their contraceptive method because they lost it during displacement and/or lack access to contraceptive services

- Women and girls may want to delay childbearing until their security and livelihoods are assured, but may not have access to contraceptives due to disruptions in health services and supplies
- Many girls reach reproductive age while displaced
- Rape and other forms of sexual violence are often documented in conflict settings

To help governments, planners, and service providers implement their commitments to women's health and rights, the WHO updated their technical guidance in 2012 to strengthen the capacity of health systems to provide safe abortion care (SAC) and post-abortion care (PAC).

PAC is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and comprises 5 elements:

- Treatment of incomplete and unsafe abortion and complications that are potentially life-threatening
- Counseling to identify and respond to women's and girls' emotional and physical health needs and other concerns
- Contraceptive services to help women and girls prevent unintended pregnancy
- Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks
- Community and service provider partnerships for preventing unintended pregnancy, mobilizing resources (to help women and girls receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs

Comprehensive abortion care (CAC) includes all of the elements of PAC as well as safe induced abortion. These elements all contribute to reductions in maternal morbidity and mortality.

A range of technological options exist to help women prevent or cope with an unintended pregnancy, including a range of ongoing and peri-coital contraceptive methods, emergency contraception, medication abortion, and vacuum aspiration. Also, an increasing number of countries

have reformed their abortion laws to expand the legal indications for abortion, making abortion legal in nearly all countries in at least some circumstances. Furthermore, multiple international agreements and expert bodies have recognized a women's right to access safe abortion and its links to reducing maternal mortality.

8.2 OBJECTIVES

The objectives of this chapter are to provide SRH Coordinators, health program managers, and service providers with:

- Programming information on comprehensive abortion care and provision of or referral to such services
- Basic clinical information to guide service delivery
- A framework to obtain accurate information and understand the administrative and regulatory context related to abortion in the setting where they are working
- An understanding of the social, cultural, and religious norms surrounding safe abortion care
- Tools to educate communities on their rights and policymakers on their duties

8.3 COMPREHENSIVE ABORTION CARE PROGRAMMING

The addition of safe induced abortion care to the elements of the PAC model results in a comprehensive approach that reduces maternal mortality and morbidity while supporting women in exercising their sexual and reproductive rights. Ideally, these services are provided as an integrated, comprehensive package.

Comprehensive abortion care need not be dependent on the availability of obstetricians/gynecologists or surgeons. With appropriate training and support, nurses, midwives, and other trained health care providers can safely provide first-line safe abortion and PAC services, even in outpatient settings, as is illustrated in Table 8.1.

TABLE 8.1: MANAGEMENT OF ABORTION AND POST ABORTION CARE IN THE FIRST TRIMESTER

	Lay health workers	Pharmacy workers	Pharmacists	Doctors of complementary systems of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Vacuum aspiration for induced abortion	**	**	**						*	*
Vacuum aspiration for management of uncomplicated incomplete abortion/ miscarriage	**	**	**						*	*
Medical abortion in the first trimester	Recommendation for subtasks (see below)	**	Recommendation for subtasks (see below)						*	*
Management of uncomplicated incomplete abortion/ miscarriage with misoprostol	**	**	**						*	*

* considered within typical scope of practice; evidence not assessed.
 ** considered outside of typical scope of practice, evidence not assessed.

8.3.1 Minimum Initial Service Package implementation

Comprehensive abortion care constitutes a life-saving intervention and is therefore incorporated into the Minimum Initial Service Package (MISP), a set of priorities activities to be undertaken at the onset of a crisis. Provision of pregnancy options counseling and safe abortion care and/ or referral to safe abortion care, to the full extent of the law, is included as part of the response to sexual assault survivors. Further, as a signal function in emergency obstetric and newborn care, ensuring the availability of life-saving post-abortion care in health centers and hospitals is a priority activity. In addition, provision of safe abortion care to all women to the full extent of the law is recognized as an “other priority activity.” Thus the SRH Coordinator, health program managers, and service providers should ensure that safe abortion care is available at the onset of a crisis when capacity already exists. When existing capacity is not present, SAC should be made available once implementation of the MISP priority activities is underway, ideally within 3 months after the onset of an emergency, if not sooner.

8.3.2 Needs assessment

When planning for abortion services, solicit information and consider community needs and perceptions, including women’s preferences for type and sex of the provider and location of services.

High incidence of unsafe abortion is often the result of laws restricting access to abortion as well as stigma. However, even where abortion is less restricted, women often lack access to safe and legal abortion services. The conditions under which abortion is legally permitted vary from country to country. In some countries, access is highly restricted; in other countries, pregnancy termination is available on request and on broad medical and social grounds. Virtually every country allows safe and legal abortion in some circumstances.

Understanding the context of abortion in each humanitarian setting is important for identifying entry points for the provision of services. This includes analyzing local laws and policies, understanding where women and girls currently seek induced abortion services, recognizing barriers and facilitators to the provision of CAC, and identifying local

champions of the provision of safe abortion care services. Indeed, working closely with local champions of CAC is critical to identifying the most effective entry points for service provision. These may include representatives of government ministries, civil society actors, health care providers, legal advocates, and others.

Assess clinical capacity to provide comprehensive abortion care, including:

- Skills of a full range of health service providers
- Availability of post-abortion care and basic emergency obstetric care, as CAC can be provided in any setting that also provides these services
- Availability of supplies and equipment for CAC, including manual vacuum aspiration kits, drugs used in medication abortion regimens, and contraceptive methods
- Indicator data centering on contraceptive use and availability and the number of PAC clients
- Availability of referral to higher level care if warranted, including capacity of referral facility and emergency transport system

SRH Coordinators, health program managers, and service providers must be familiar with national legislation and policies related to safe abortion in the countries in which they work:

- Is there a law, regulation, policy, and/or national guideline on termination of pregnancy/availability and accessibility of safe abortion services? Pay particular attention to:
 - o Grounds on which abortion is legally permissible (e.g., threats to the woman's life, physical, or mental health, fetal impairment or disability, rape, incest, socioeconomic or personal circumstances)
 - o Actual enforcement of laws, regulations, policies, and/or national guidelines
 - o Knowledge of laws, regulations, policies, and/or national guidelines among service providers and other local stakeholders
 - o Gestational age limits within which an abortion can be performed and whether there are situations

in which these limits can be waived

- o Availability of different abortion methods (e.g., electric or manual vacuum aspiration, medication abortion regimens with mifepristone/misoprostol, methotrexate/misoprostol, and/or misoprostol alone) and distribution and provision of medications for abortion and post-abortion care
- o Settings where abortion can be performed and/or the level of provider who can perform an abortion or provide abortion methods
- o Costs of an abortion
- o Regulations or expectations that require others (husbands, parents, guardians) to give permission for the procedure (third-party authorization)
- o Mandatory reporting requirements
- o Requirements for health providers who object to performing abortions (conscientious objection) to refer to a colleague who will provide abortion care
- The perspectives of women and girls as well as their families, partners, and other community stakeholders are critical to planning CAC including:
 - o Existing women's or other community groups in the local population that could help advocate for and inform the population of available services
 - o Social and cultural norms around unintended pregnancy and abortion, including how decisions are made around access to services and who is involved in decision-making
 - o Women's and girls' current abortion practices and preferences

8.3.3 Programming considerations

There is no one-size-fits-all approach to the provision of CAC in humanitarian settings and it is essential for humanitarian responders to collaborate toward increasing access to services. Promising entry points include, but are not limited to:

- Providing SAC through health facilities run by organizations and/or staffed by willing providers

- Offering technical support to qualified medical personnel already providing abortion services
- Reducing harm from unsafe abortion through the distribution of information and commodities for safe medication abortion

While not all organizations will be able to provide safe abortion care in every setting, there will already be CAC providers to whom organizations can actively refer in some contexts.

PROGRAMMATIC EXAMPLE 8.1: ESTABLISHING AN ABORTION REFERRAL SYSTEM

ORGANIZATION: Adolescent Reproductive Health Zone, Cambridge Reproductive Health Consultants, University of Ottawa

LOCATION: Northern Thailand

INTRODUCTION: For displaced and migrant women in northern Thailand, access to healthcare is often limited, unintended pregnancy is common, and unsafe abortion is a major contributor to maternal death and disability. Although abortion is legally permissible in Thailand for a number of indications, women from Burma have difficulty accessing services even when they meet the eligibility requirements. Based on a pilot project and situational analysis research, in 2015 a multi-national team introduced the Safe Abortion Referral Program (SARP) in Chiang Mai, Thailand to reduce the socio-linguistic, economic, documentation, and transportation barriers women from Burma face in accessing safe and legal abortion care in Thailand.

PROJECT DESCRIPTION: The Adolescent Reproductive Health Zone (ARHZ), a network of five community-based organizations serving refugee and migrant women from Burma, launched the SARP in April 2015. Prior to the launch, ARHZ counselors participated in a three-day training focused on the legal and medical frameworks around abortion in Thailand and Burma, pregnancy options counseling skill-building exercises, and the logistics of the SARP. The training also provided an opportunity for the ARHZ counselors to meet colleagues who were involved in the pilot project in Mae Sot, Thailand, Thai abortion providers, and North American researchers who provided technical assistance and monitoring and evaluation support. In addition to providing women with referrals for care, the SARP offers women financial support, including coverage of both the procedure and travel costs, interpreting services, and accompaniment, as needed and desired.

RESULTS: Over the first 2 years of the program, 81 women from Burmese communities in northern Thailand accessed the SARP; 52 women (64%) were successfully referred for care and received safe and legal abortions in either a Thai public hospital or a Thai private clinic. Both providers and women were overwhelmingly positive about their experiences with the SARP. Women reported lack of costs, friendly program staff, accompaniment to and interpretation at the providing facility, and safety of services as key features. After accessing the SARP and receiving support, women became community advocates for reproductive health.

LESSONS LEARNED: This experience suggests that referral programs for safe and legal abortion can be successful in settings with large displaced, migrant, and refugee populations. Identifying ways to work within legal constraints to expand access to safe services has the potential to reduce harm from unsafe abortion in humanitarian settings and facilitate women's access to high quality abortion care.

When services are provided it is important that they are offered in an equitable manner. This means that providers should not withhold services based on a client's age, marital status, disability, or religious affiliation and that all clients are treated in a respectful, non-judgmental manner. Organizations should have and disseminate a policy clearly stating these expectations and addressing attitudes of staff at all levels that may not be favorable to equitable provision of safe abortion services. One effective approach to improving staff attitudes is conducting values clarification and attitudes transformation (VCAT). Evidence demonstrates that VCAT participants hold more favorable attitudes toward access to safe abortion care upon completion of the curriculum.

CAC with manual vacuum aspiration is a safe and relatively simple procedure. As described in the task-sharing recommendations by the WHO, CAC can be safely and effectively provided by a range of health service professionals, including nurses and midwives, at any facility that provides basic emergency obstetric care. As with any clinical service, it is important to ensure the availability of sufficient, qualified health care personnel. The clinical competency of providers should be assessed before beginning the provision of services in order to develop a plan for competency-based training and supportive supervision.

COUNSELING AND INFORMED CONSENT

Service providers must be aware that women seeking abortion care may be under severe emotional stress or physical discomfort. They must ensure privacy, confidentiality, access to adequate information, and informed consent for treatment. High-quality counseling provides the woman with emotional support and contributes to the effectiveness of the procedure. Effective and unbiased counseling is structured completely around the woman's needs and concerns and occurs before, during, and after the procedure.

BOX 8.1: VALUES CLARIFICATION AND ATTITUDES TRANSFORMATION

Evidence suggests that stigmatizing attitudes held from the individual to the national leadership level—including by key players in the humanitarian community such as health care providers, program and technical staff, and senior leadership within humanitarian assistance agencies—play a powerful role in restricting women's access to safe abortion care in crisis and fragile settings. A global evaluation led by the Inter-agency Working Group on Reproductive Health in Crises (IAWG), and an internal survey among IAWG members, discovered that:

- Discomfort or personal objection to providing SAC based on religious and moral grounds influenced some humanitarian staff's professional conduct
- Negative attitudes towards abortion and fear of reprisal from their community due to real or perceived involvement in SAC influenced health care providers' willingness to provide services

This underscores that even with clinical skills and proper knowledge of the legal framework, providers' negative attitudes and fears related to the provision of contraception and safe abortion care continue to act as underlying barriers that restrict women's access to care in fragile and crisis-affected settings.

This is a very real challenge in abortion care, but one that can be addressed through adaptation and use of existing resources, such as values clarification and attitude transformation or "VCAT" materials and approaches, which have proven successful with abortion care in other settings. VCAT work is almost always necessary and is best done as pre-work to technical training and/or service implementation. Recent VCAT trainings within several humanitarian agencies have created momentum towards incorporating and/or strengthening SAC in some of their country programs and existing VCAT materials are currently being adapted for humanitarian contexts (see www.ipas.org).

Informed consent ensures that the woman understands, and is in agreement with, her proposed treatment plan, including its benefits, risks, and alternatives. Informed consent means that the woman makes her decisions freely, based on scientifically accurate, non-biased information, without pressure or coercion of any kind.

CLINICAL ASSESSMENT

Before performing a uterine evacuation, it is essential to assess a woman's clinical status and eligibility for medication methods or vacuum aspiration. This allows

the provider to assist the woman in making an informed choice about her preferred method of uterine evacuation. The assessment should be conducted in private.

The components of a complete clinical assessment are:

- A pertinent health history (including history of sexual violence)
- A careful physical and pelvic examination including a bimanual exam
- Collection of specimens and ordering of any lab tests, as warranted by the circumstances

An important part of the clinical assessment is an evaluation of the woman's emotional state, relevant relationship and family circumstances, and support systems, as they have a direct bearing on her clinical experience. Open, supportive communication and a gentle, reassuring manner help ensure that the provider obtains the relevant information needed to offer the best possible care for the woman.

Women presenting for treatment of incomplete abortion or abortion complications (post-abortion care) should be assessed with particular care because they may have life-threatening complications. Uterine evacuation is often an important component of case management and once the patient is stabilized, this procedure should not be delayed. Prompt transfer to a referral hospital may be needed if the woman requires treatment beyond the capability of the health center where she is seen. Her condition should be stabilized before she is transferred.

INFECTION PREVENTION

As with any medical procedure, there is a risk of infection to patients, service providers, and support staff through contact with contaminants. To minimize the risk, standard precautions must be observed at all times. These include using appropriate barriers (such as gloves and masks), handling waste carefully, and taking precautions to prevent injuries. Iatrogenic infection is prevented by following standard precautions, using aseptic techniques and ruling out or treating cervical infection before performing transcervical procedures.

Administer prophylactic antibiotics, 200 mg of oral doxycycline or 500 mg of oral metronidazole, for all women prior to vacuum aspiration. Where antibiotics

are unavailable, uterine aspiration may still be offered. Therapeutic antibiotics should be administered to all women who are suspected of or who have been diagnosed with an infection. Women who show no signs of infection do not need to continue antibiotics after the procedure.

Routine use of antibiotics is not recommended for women undergoing medication abortion. Women who have signs or symptoms of a sexually transmitted infection (STI) at the time of medication abortion should be treated appropriately and medication abortion can be provided without delay.

Immediately after use, all reusable surgical instruments used in abortion care should be sent for cleaning and sterilization. Medical equipment and supplies intended for single use should not be reused. Follow standard instrument processing guidance and manufacturers' instructions. Some manufacturers produce aspirators and cannulae made of high-grade plastics that are engineered to be sterilized in an autoclave, while other plastic instruments will crack and melt when exposed to high heat. Health care workers should always refer to the instructions for use of all items being disinfected, to ensure they are using the appropriate form of disinfection.

PAIN MANAGEMENT

Women undergoing first trimester vacuum aspiration should receive a combination of pain medications (such as oral ibuprofen or diclofenac), local anesthesia in the form of a paracervical block, and non-pharmacologic approaches to treat pain. Medications should be supplemented with supportive techniques to decrease pain and anxiety. Some techniques that may be helpful include respectful staff, a clean, secure, and private setting, counseling, verbal support, gentle surgical technique, and a heating pad or hot water bottle in the recovery room. General anesthesia is rarely necessary and puts the woman at greater risk. Paracetamol is not effective for pain relief during vacuum aspiration.

All women undergoing medication abortion in the first trimester should also be offered pain management with non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or diclofenac. In addition to medications, other methods that may help women manage pain during a medication abortion are thorough counseling, a supportive environment, and applying a heating pad or hot water bottle

to the lower abdomen. These methods are complementary but not adequate substitutes for pain management with medications.

Studies have shown that NSAIDs do not reduce the effectiveness of misoprostol. Additionally, studies have shown paracetamol and acetaminophen to be ineffective for pain relief for uterine evacuation.

UTERINE EVACUATION INDICATIONS AND METHODS

Induced abortion: First trimester

The recommended abortion methods in the first trimester are manual or electric vacuum aspiration or medication methods using a combination of mifepristone followed by misoprostol. Where mifepristone is not available, evidence supports use of misoprostol alone, although it is less effective than when used in combination with mifepristone, and less effective than vacuum aspiration. The use of mifepristone and/or misoprostol for safe abortion and post-abortion care requires the back-up of vacuum aspiration services, either on site or through referral,

in case of failed or incomplete evacuation of uterine products. Sharp curettage/dilation and curettage is an outdated surgical abortion technique and should be replaced by medication or aspiration methods.

Vacuum aspiration

- Manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA) are recommended for pregnancies up to 12-14 weeks (12-14 weeks since the first day of the woman's last menstrual period (LMP))
- Vacuum aspiration is extremely effective and safe and is successful in 98%-100% of cases
- The procedure should not be completed by sharp curettage
- Examine the products of conception after the procedure to exclude the possibility of ectopic or molar pregnancy or incomplete abortion

BOX 8.2: DISPOSAL OF PRODUCTS OF CONCEPTION

Any disposable material that has come in contact with body fluids should be considered infectious waste and disposed of properly; this includes human tissue such as products of conception (POC).

Some local protocols dictate that a health facility's infectious waste be removed by a second party, such as a private company or government organization, and disposed of off-site. Wherever infectious waste is deposited, it must always be contained and, ideally, incinerated. To dispose of infectious waste, including POC:

- Burning solid infectious waste in an incinerator or oil drum is the best option
- Open burning in a secured area is an acceptable alternative
- Bury solid infectious waste on-site, as long as it is secured behind a fence or wall away from any water source. Initial depth should be 2 to 5 meters deep. As waste is added, cover it with 10 to 30cm (4 to 10 inches) of soil. When the level of waste reaches to within 30 to 50 cm of the ground surface, fill the pit with dirt, seal it with concrete, and dig another pit. Burying waste is the next best option after burning
- Pour liquid infectious waste down a sink or drain connected to an adequately treated sewer or pit latrine. Burial of infectious liquid with other infectious waste is an acceptable alternative

Products of conception resulting from medication abortion should be disposed of in the same way as other infectious waste. If a woman passes the POC at home, she should be advised to dispose of them by whatever appropriate means are available to her, such as pouring them down a toilet that is used for feces or by burying them away from a water source.

Medication methods

- Medication abortion methods can be used up to 12 weeks of pregnancy
- A combination of mifepristone followed by a prostaglandin such as misoprostol is the gold standard
- Research protocols for pregnancies up to 12 weeks report success rates of over 95%
- Misoprostol only for induced abortion, using the recommended regimen, is successful in approximately 85% of cases

TABLE 8.2: MIFEPRISTONE AND MISOPROSTOL REGIMENS FOR ABORTION UP TO 12 WEEKS

GESTATIONAL AGE	MIFEPRISTONE DOSE	MISOPROSTOL DOSE, ROUTE AND TIMING
Up to 10 weeks	200 mg orally	After 24-48 hours, 800 µg buccally, sublingually, or vaginally for one dose
10-12 weeks	200 mg orally	After 36-48 hours, 800 µg vaginally followed by 400 µg vaginally or sublingually every 3 hours for a maximum of 5 doses of misoprostol

TABLE 8.3: MISOPROSTOL-ONLY REGIMENS FOR ABORTION UP TO 12 WEEKS

DOSE	ROUTE	TIMING
Misoprostol 800 µg (four 200 µg pills) OR	Vaginal	Every 3 -12 hours for a maximum of 3 doses
Misoprostol 800 µg (four 200 µg pills)	Sublingual	Every 3 hours for a maximum of 3 doses

Misoprostol may reduce the cost of CAC services. The cost of a uterine evacuation depends on the clinical regimen, the technology, and the cost of providing backup in case re-evacuation is needed. Uterine evacuation with misoprostol is considered a low-cost treatment and, as with MVA, can be provided by a range of health service providers.

Induced abortion: Second trimester

Women in the second trimester and beyond should be referred to a hospital with facilities, supplies, and trained providers for management. Two types of abortion procedures are recommended in the second trimester: dilatation and evacuation (D&E) and misoprostol-based methods (mifepristone plus misoprostol or misoprostol alone). D&E involves preparing the cervix and then evacuating the uterus with a combination of vacuum aspiration and forceps. This procedure

PROGRAMMATIC EXAMPLE 8.2: COMMUNITY-BASED DISTRIBUTION OF MISOPROSTOL FOR EARLY ABORTION

ORGANIZATION: Community-based organizations, Cambridge Reproductive Health Consultants, Ibis Reproductive Health, University of Ottawa

LOCATION: Northern Thailand

INTRODUCTION: Although abortion is legal in Thailand for a number of indications, women from Burma residing in Thailand are rarely able to access safe services. However, misoprostol is widely available in clinics, pharmacies, and drug shops throughout northern Thailand.

PROJECT DESCRIPTION: In 2011, a multi-disciplinary team at Ibis Reproductive Health partnered with individuals associated with several local community-based organizations in Tak Province, Thailand to establish a misoprostol distribution network. Using a train-the-trainer model, Network leaders received a five-day training in the medical and legal aspects of misoprostol use for early pregnancy termination (defined as ≤ 9 weeks’ gestation), contact information for an on-call expert who could discuss complicated cases or review protocols, the indications for referral to post-abortion care services, and the logistical issues surrounding medication distribution and case documentation. After determination of eligibility based on self-report and counseling, trained Network members instructed women who desired an abortion to vaginally administer 800 mcg of misoprostol, a second 800 mcg dose 24 hours later, and a third 800 mcg dose one week later, if needed. Network providers gave women quality-verified misoprostol.

RESULTS: Over the first 3 years, 918 women received early abortion care using misoprostol through the community-based distribution program. Of these, 885 women (96.4%) were not pregnant at follow-up, 29 were pregnant at follow-up (3.2%), and four women were lost to follow-up (0.4%). Interviews revealed that providers are motivated

to participate due to concerns surrounding unsafe abortion in the community and frame their work as a public health intervention and women felt positively about their abortion experiences and the initiative. All providers and women that we interviewed, including those women who remained pregnant after taking the misoprostol, would recommend the initiative to others and felt expanding the reach of the Network was warranted.

LESSONS LEARNED: Global efforts to provide women with medically accurate information about medication abortion, including misoprostol-alone regimens for early abortion, have inspired harm reduction programming, dissemination of medically accurate information through telemedicine services and websites, and the establishment of call centers in contexts where access to safe services is limited, or unavailable. Findings from this initiative demonstrate that community-based distribution of misoprostol can be a safe, effective, and culturally resonant strategy for increasing access to safe abortion, even in a legally restricted, low-resource, conflict-affected setting. The findings and project model may be relevant for replication in similar settings where continued maternal morbidity and mortality resulting from unsafe abortion and restrictive abortion laws exist.

requires skilled clinicians, specialized instruments, and more intensive clinical care than aspiration in early pregnancy. D&E provision is appropriate for higher-volume sites, as the experience level of providers is directly related to complication rates. Medication-based regimens with mifepristone plus misoprostol or misoprostol alone are used to both prepare the cervix and induce uterine contractions and eventual pregnancy expulsion. When both instrumentation and medication methods are available, women should have the option to choose their preferred method. Second trimester abortion with medications requires fewer technical skills and resources and can be offered in facilities where D&E cannot be provided. Generally, second trimester medication abortion can be offered wherever obstetrical services are available.

Post-abortion care

Both vacuum aspiration and misoprostol alone are safe, effective, and acceptable methods for evacuation of the

uterus for post-abortion care in the first trimester. Misoprostol for the treatment of incomplete abortion is an important option in humanitarian settings where it may be difficult to maintain MVA equipment and appropriately trained providers and where referral for surgical uterine evacuation may be delayed. The use of misoprostol for obstetric indications is rapidly evolving. SRH Coordinators, health program managers, and service providers should stay abreast of the evolving clinical and technical literature.

Both D&E and medication abortion methods are used for post-abortion care in the second trimester and beyond (see previous sub-subsection). Determination of method is based on the specific clinical indications as well as provider and patient preference.

TABLE 8.4: MISOPROSTOL FOR INCOMPLETE ABORTION UP TO 13 WEEKS UTERINE SIZE

DOSE	ROUTE	TIMING
Misoprostol 600 µg (three 200 µg pills)	Oral	Single dose
OR		
Misoprostol 400 µg (two 200 µg pills)	Sublingual	Single dose

Prevention of tetanus

Women who have had unsafe abortions with non-sterile instruments are at risk of tetanus. Provide or refer the patient for tetanus prophylaxis if this is known or suspected, particularly in communities where tetanus after abortion has been reported.

BOX 8.3: SAFETY OF INDUCED ABORTION

“When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.” World Health Organization, 2012.

Managing complications

While rare, complications are possible with uterine evacuation procedures and they must be dealt with by qualified providers immediately. Serious complications are very rare. Ensure that women have ongoing access to emergency care during their treatment. If the woman requires treatment beyond the capability of the facility where she is seen, stabilize her condition before she is transferred to a higher-level service.

Typically, women presenting for post-abortion care are ambulatory and complaining of vaginal bleeding and pain and fever or chills and need treatment for incomplete abortion. Women who have suffered more severe complications may present with shock, hemorrhage, sepsis, and intra-abdominal injury. Severe complications are more likely in settings where unsafe abortion is common.

A rapid, initial assessment should be performed on all women presenting for care. If a woman shows signs and symptoms of shock or has heavy vaginal bleeding, she needs immediate stabilization.

Once the initial assessment and stabilization are underway, a more complete clinical assessment may be done to determine the cause and begin treatment. Shock in PAC clients is usually either hemorrhagic or septic. Hemorrhagic shock is the result of severe blood loss, which may be caused by an incomplete abortion, uterine atony, or vaginal, cervical, uterine, or intraabdominal injury. Septic shock is the end result of infection, which may

come from incomplete abortion, endometritis, or intra-abdominal injury. A history and directed physical exam with concurrent treatment should be done urgently for definitive management of underlying causes. Treatment may require immediate uterine evacuation. If the woman requires treatment beyond the capability of the facility where she is seen, stabilize her condition before she is transferred to a higher-level service.

Post-procedure counseling and follow-up

Women should be given instructions on how to take care of themselves after the procedure. Service providers should explain signs of a normal recovery and signs and symptoms of possible complications that require immediate attention. They should also provide detailed information about post-abortion contraception and protection from sexually transmitted infections (STIs). Routine follow-up after uterine evacuation using MVA, medication abortion with mifepristone followed by misoprostol, or treatment of incomplete abortion (PAC) with misoprostol is not necessary. However, because of lower efficacy, routine follow-up after induced abortion with misoprostol-only is recommended. In all cases, if there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, she may be scheduled approximately two weeks after the procedure to confirm the process was successful, or to receive additional desired services.

Post-abortion contraception

Lack of access to adequate contraceptive services is an important contributor to the need for safe abortion. Conversely, unintended pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective contraceptive services. Ensure that all staff providing comprehensive abortion services know how to counsel on and provide contraceptive methods following SAC or PAC. Contraceptive acceptance and continuation rates are higher when offered at the site of initial treatment and when a wide range of short-acting, long-acting and permanent methods are available.

At a minimum, all women receiving abortion care must be counseled on post-abortion contraception and understand that:

- Ovulation can occur as early as 10 days after an

abortion, resulting in pregnancy even before menses returns

- All methods, including an intrauterine device (IUD) or hormonal methods, may be started immediately after uncomplicated uterine evacuation with vacuum aspiration
- Hormonal methods, including implants, oral contraceptive pills, and injectables, may be started on the same day as the first dose of the medication abortion drug
- IUDs can be used as soon as the provider is reasonably sure the woman is no longer pregnant

BOX 8.4: WORKING WITH EXISTING PROVIDERS TO IMPROVE THE QUALITY OF ABORTION CARE

A humanitarian organization responding to a crisis in Asia identified unsafe abortion as an important cause of maternal morbidity and mortality. Although abortion is permitted in this country under some circumstances, it remains legally restricted and culturally taboo. Discussions with key informants revealed that women and girls prefer to seek abortion services from private providers because of their perceived discretion and confidentiality. However, further interviews demonstrated that the quality of abortion services was variable and international standards of safe abortion care were not followed.

Despite issues with service quality, the humanitarian organization identified these private providers as an important entry point for increasing access to safe abortion care in a legally restricted crisis setting. The humanitarian organization believed it could reach more women and girls through improving the quality of services already offered by these providers than by introducing services through new providers with whom women and girls were unfamiliar. This humanitarian organization mapped all the private providers of abortion services in the area and selected willing providers with necessary medical qualifications to receive technical support. The humanitarian organization provides clinical training and mentorship, supportive supervision, and essential supplies and equipment to ensure the private providers meet international standards in voluntary informed choice, counseling, uterine evacuation, and provision of contraception.

One challenge faced by the humanitarian organization was ensuring equitable access to safe abortion services, since these private providers charge safe abortion clients user fees. While unable to eliminate user fees, the humanitarian organization also supports willing midwives on its own staff to provide safe abortion care free of charge in the government facilities they support. Women and girls who cannot afford the private providers can seek safe abortion care from these midwives. (See Programmatic Example 8.3).

8.3.4 Implementing comprehensive abortion care in the acute through recovery phases

As is outlined in Chapter 3, provision of safe abortion care contributes to reducing excess maternal morbidity and mortality. Comprehensive abortion care, including post-abortion contraception, should be provided during the acute through recovery phases of a crisis using the clinical guidance described in this chapter.

However, competency-based clinical training and values

clarification activities may not be possible during an acute emergency. Where possible, services should be provided by those already skilled in the provision of comprehensive abortion care. In many cases, rapid, on-the-job training can be provided to qualified health care workers to build their skills when previously trained providers are not available. When transitioning to comprehensive services, organizations should plan for competency-based training, ongoing clinical mentorship, and continued improvement of staff attitudes to support high-quality service provision.

8.3.5 Working with specific populations

ADOLESCENTS

The extremely high number of young women who continue to resort to unsafe abortion makes it critical to ensure that young women, regardless of marital status, have access to safe abortion as part of comprehensive health care services.

There are many social, economic, logistical, policy, and health system barriers to safe abortion care for young women, including stigma and negative attitudes towards adolescent sexuality, fear of negative repercussions, lack of access to comprehensive sexuality education, limited financial resources, cost of care, transportation, third-party involvement laws, and concerns over privacy and confidentiality. These dynamics explain why young women often find no alternative than to resort to unsafe abortion, even in settings where safe abortion is legal. These dynamics also shed light on why young women who obtain abortion care tend to access it later in the pregnancy and are more likely to delay seeking help for abortion-related complications than adults.

PROGRAMMATIC EXAMPLE 8.3: PROVIDING COMPREHENSIVE ABORTION CARE

ORGANIZATION: Confidential

LOCATION: Crisis-affected Asian country where abortion is restricted to only a few circumstances

INTRODUCTION: According to the World Health Organization, 25 million unsafe abortions (45% of all abortions) occurred every year between 2010 and 2014. The overwhelming majority of unsafe abortions occurred in developing countries in Africa, Asia, and Latin America. In one crisis-affected country in Asia, this humanitarian organization has made great strides in increasing access to contraceptive and post-abortion care services. Despite this progress, the number of unsafe abortions remained high, putting women's health and lives at risk.

PROJECT DESCRIPTION: The organization recognized the need for greater access to safe abortion care (SAC) and decided to introduce comprehensive abortion services (CAC) into its programming. In doing so, CAC was integrated into the services already offered by nurses and midwives in government health facilities and support was provided to improve the quality of abortion services offered by private providers. Values clarification and attitude transformation (VCAT) activities were important first steps to fostering an environment conducive to high quality, unbiased care. The organization conducted on-the-job training on misoprostol and manual vacuum aspiration for CAC and provided all necessary supplies and equipment. In order to maintain client privacy and confidentiality, a system was devised to record SAC clients in the post-abortion care (PAC) register with a confidential mark. Women were informed of CAC services during one-on-one community outreach sessions to maintain a low profile within the community. When working with private providers, the organization developed a Memorandum of Understanding, facilitated competency-based trainings on contraception, MVA, and infection prevention, and provided all necessary supplies and equipment in exchange for the price reduction of contraceptive and CAC services.

RESULTS: In the first year of the initiative, 3,411 women and girls received CAC services. Of these, 3,086 were PAC clients and 325 were SAC clients. From July to December of 2017, the 59 public facilities supported by the organization received 206 SAC and 1,064 PAC clients. At the 11 supported private providers, 25 SAC and 715 PAC clients accessed services. As a result of facilitated trainings, these private providers are now using MVA and misoprostol in lieu of dilation and curettage (D&C) for CAC clients.

LESSONS LEARNED: VCAT workshops are key to improving attitudes among health providers as well as organizational staff. Maintaining a low profile, ensuring client confidentiality, working with nurses and midwives, and conducting one-on-one CAC information sessions were particularly helpful strategies for integrating SAC at the government facilities. Implementing CAC through a network of private providers has proved challenging due to their reluctance in recording and sharing data and higher costs for services remains a barrier for women and girls. Measuring the quality of care of private providers is also challenging without direct observation.

BOX 8.5: GUIDING PRINCIPLES OF ABORTION CARE FOR YOUNG WOMEN

- Young women have the right to decide whether, when, and with whom to have sex
- Young women have the right to decide whether, when, and with whom to have a child
- Young women have a right to high-quality health care which includes comprehensive abortion care and contraceptive services
- Young women have a right to confidential care that protects their privacy and safety
- Young women are the most important stakeholders in their SRH care
- Young women have perspectives and experiences that older people do not, which can help improve service provision
- By voluntarily seeking safe abortion care, young women can be presumed capable of informed consent to such care

Clinical provision of abortion care for young women is generally the same as for adult women. However, a few clinical differences should be considered.

- **Counseling:** Young women may have had little opportunity to learn about SRH and may consequently need more information than many adult women
- **First pelvic exam:** It is possible that this will be a young woman's first pelvic exam and she may be nervous or afraid. Ensure auditory and visual privacy, offer a female health worker, or a relative, friend or partner, stand near her and talk to and support her during the pelvic examination if the young woman wants, explain what will be done, do not begin to examine her until receiving her consent even if an adult has legally consented on her behalf, and perform the examination as gently and smoothly as possible to minimize discomfort and anxiety
- **Vacuum aspiration:** Although no studies have been done on the subject, providers may find that a young, nulliparous woman's cervix may be more difficult to dilate than that of an older, parous woman and thus

may require a slower dilation process. This can be accomplished either by starting with a smaller dilator than is required by women with one or more children, or by priming the cervix with misoprostol. The latter may constitute clinical protocol for all uterine evacuations in some facilities. Anesthesia dosages remain the same as for older women

- **Medication abortion:** Early medication abortion has been proven to be safe, effective, and acceptable for young women, as for adult women. Dosage regimens are the same for both populations

BOX 8.6: ABORTION CARE FOR HIV POSITIVE WOMEN

Women living with HIV have the same rights as other women to decide whether to carry a pregnancy to term or have an abortion.

Women receiving abortion care who are HIV-positive need specific information, support, counseling, and medical care. If counselors have not undergone extensive HIV training, they should refer HIV-positive women to appropriate services, where available. HIV-positive women should be offered information that can help them better understand their condition and improve their own health, as well as the health of their sexual partners and children.

Women living with HIV and AIDS may use all currently available abortion procedures, including medication abortion regimens. Women living with HIV or AIDS may be at risk for anemia, especially if they have malaria or are taking certain antiretroviral therapies. As with any woman, if heavy bleeding occurs after the initiation of medication abortion care, treat promptly with vacuum aspiration.

Health-care workers should treat the blood and body fluids of all persons as potential sources of infection, independent of diagnosis or perceived risk. Standard precautions should be followed with all clients and all workers, regardless of their presumed infection status or diagnosis, and there is no reason to treat individuals with known blood borne diseases differently.

WOMEN WHO HAVE EXPERIENCED VIOLENCE

It is likely that providers will encounter women who have experienced sexual violence. Women who have experienced such violence, which includes rape, sexual

assault, coercive sex, incest and involuntary sex work, will often experience related health conditions, such as physical injury, STIs, psychological distress, or unplanned pregnancy. Physical or psychological violence during pregnancy may also contribute to miscarriage or the desire for an abortion.

Abortion care visits may be the only contact that women who have experienced violence have with the healthcare system. Counselors should develop a standard method for asking all clients about violence in their lives and incorporate those questions into routine counseling. Health workers must be cognizant of their own limitations in assisting women experiencing violence, be aware of any existing gender-based violence (GBV) referral pathways and, whenever possible, refer women to others specialized in addressing these women’s needs.

Special violence-related counseling considerations include:

- An unintended pregnancy may be the result of rape or incest
- A spontaneous abortion could have been caused by physical abuse
- A woman may face further violence if her abortion or use of contraception is not kept confidential

- A woman may have been forced or coerced into having an abortion
- The pregnancy could have been wanted

8.3.6 Coordinating and making linkages

It is critical that all women and girls who have received comprehensive abortion care be counseled on contraception and provided with their method of choice on the same day as the procedure. Service providers should also identify other SRH needs each woman or girl may have and refer her or offer information on relevant services, such as management of reproductive tract infections or post-rape care. Women and girls presenting for post-rape care with a pregnancy should be offered a safe abortion or a referral, if they wish.

All health care workers should have basic skills on and favorable attitudes toward safe abortion care so they can identify those women who may want the service, refer them to the appropriate provider, and treat them with respect. Health care providers who claim conscientious objection to providing abortion must refer the woman or girl to another willing and trained provider in the same or another easily accessible health facility. In places where referral is not possible, the objecting provider must provide the abortion to save the woman’s life or to prevent damage to her health.

PROGRAMMATIC EXAMPLE 8.4: PROVIDING MENSTRUAL REGULATION AND POST-ABORTION CARE IN AN ACUTE CRISIS

ORGANIZATION: Confidential

LOCATION: Crisis-affected Asian country where abortion is restricted to only a few circumstances

INTRODUCTION: According to the World Health Organization, 25 million unsafe abortions (45% of all abortions) occurred every year between 2010 and 2014. The overwhelming majority of unsafe abortions occurred in developing countries in Africa, Asia, and Latin America. In one crisis-affected country in Asia, this humanitarian organization has made great strides in increasing access to contraceptive and post-abortion care services. Despite this progress, the number of unsafe abortions remained high, putting women’s health and lives at risk.

PROJECT DESCRIPTION: The organization recognized the need for greater access to safe abortion care (SAC) and decided to introduce comprehensive abortion services (CAC) into its programming. In doing so, CAC was integrated into the services already offered by nurses and midwives in government health facilities and support was provided to improve the quality of abortion services offered by private providers. Values clarification and attitude transformation (VCAT) activities were important first steps to fostering an environment conducive to high quality, unbiased care. The organization conducted on-the-job training on misoprostol and manual vacuum aspiration for CAC and provided all necessary supplies and equipment. In order to maintain client privacy and confidentiality, a system was devised to record SAC clients in the post-abortion

care (PAC) register with a confidential mark. Women were informed of CAC services during one-on-one community outreach sessions to maintain a low profile within the community. When working with private providers, the organization developed a Memorandum of Understanding, facilitated competency-based trainings on contraception, MVA, and infection prevention, and provided all necessary supplies and equipment in exchange for the price reduction of contraceptive and CAC services.

RESULTS: In the first year of the initiative, 3,411 women and girls received CAC services. Of these, 3,086 were PAC clients and 325 were SAC clients. From July to December of 2017, the 59 public facilities supported by the organization received 206 SAC and 1,064 PAC clients. At the 11 supported private providers, 25 SAC and 715 PAC clients accessed

services. As a result of facilitated trainings, these private providers are now using MVA and misoprostol in lieu of dilation and curettage (D&C) for CAC clients.

LESSONS LEARNED: VCAT workshops are key to improving attitudes among health providers as well as organizational staff. Maintaining a low profile, ensuring client confidentiality, working with nurses and midwives, and conducting one-on-one CAC information sessions were particularly helpful strategies for integrating SAC at the government facilities. Implementing CAC through a network of private providers has proved challenging due to their reluctance in recording and sharing data and higher costs for services remains a barrier for women and girls. Measuring the quality of care of private providers is also challenging without direct observation.

8.3.7 Advocacy

Comprehensive abortion care is a proven and necessary health intervention to prevent maternal mortality and morbidity. Too often political, religious, or cultural factors rather than medical evidence influence decisions around abortion care. Even when abortion is legal without restriction as to reason, there are often additional regulatory barriers and stigma that hinder access for women and girls.

There is important advocacy that can be done to alleviate these challenges to health providers and obstructions to care for women. Staff should be well informed on national and international laws and policies – as well as their organizational position – on abortion, including referrals, duties around conscientious objection, and reporting requirements. SRH Coordinators, health program managers, and other key staff should engage with local actors, Ministry of Health officials, donors, and other agencies to call for greater access to CAC by:

- Expanding circumstances under which abortion is provided/permitted
- Aligning national policies with international standards
- Presenting data on unmet need and consequences of limiting/not providing CAC services
- Adhering to international medical protocols, such as the WHO guidelines on safe abortion care
- Ensuring the provision of comprehensive abortion care by skilled health providers, including MVA

- Raising awareness around and ensuring the provision of safe abortion care at the onset of an emergency, as outlined in the Minimum Initial Service Package
- Prioritizing CAC for all women and girls by including it in humanitarian funding appeals
- Advocating for the inclusion of mifepristone and misoprostol in national medicine lists for medication abortion
- Engaging staff, beneficiaries, and community leaders in awareness raising campaigns

8.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

The right to safe and legal abortion is supported by numerous international treaties and agreements. The International Conference on Population and Development (ICPD) commitments to ensure access to post-abortion care and safe abortion and to reduce maternal mortality due to unsafe abortion underpin the guidance given in this chapter.

Since the adoption of the ICPD Program of Action, multiple human rights bodies have reinforced the link between unsafe abortion and maternal mortality and have found that the denial of access to safe and legal abortion violates the rights to life, health, privacy, equality, freedom from discrimination, and freedom from torture or ill-treatment. International human rights law requires States to take

positive steps to ensure access to abortion services and information where legal, and to ensure that it is legal, at minimum, when a woman's life or health is at risk, in cases of severe or fatal fetal anomalies, and in cases of rape and incest. Failure to permit abortion in these situations has been found to constitute a violation of the state's human rights obligations. Human rights bodies have called on States to eliminate punitive measures for women and girls who undergo abortions and for health providers who deliver abortion services, recognizing the connection between criminalization of these services, high rates of unsafe abortion, and maternal mortality. Increasingly, these bodies have urged States to ensure access to safe abortion care without restriction and irrespective of its legality. Many countries have liberalized laws with respect to abortion, and abortion is legal in nearly all countries in at least some circumstances. The Center for Reproductive Rights maintains a database of abortion laws worldwide and updates this resource regularly; the WHO also launched an open access database dedicated to abortion laws, policies, and health standards in 2017 (see Section 8.6).

In crisis settings, states must ensure the provision of comprehensive SRH services, including access to safe abortion services, among other key reproductive health services. Specifically, with regard to survivors of sexual violence, international agreements and expert bodies support the right of women raped in war to access safe abortion care. They have found that the denial of safe abortion to rape survivors violates the rights to health and privacy and could amount to a violation of the prohibitions on ill-treatment and discriminatory medical care.

The following have been found to constitute violations of human rights:

- Denial of abortion services to a woman whose pregnancy poses a risk to her life or health, results from rape or incest, or has severe or fatal fetal anomalies
- Denial of post-abortion care, including in settings with restrictive abortion laws, or conditioning post-abortion care on the woman admitting inducing abortion or disclosing information about an abortion provider
- Violating patient confidentiality by reporting an illegal or unsafe abortion to authorities

BOX 8.7: A RIGHTS BASED APPROACH TO COMPREHENSIVE ABORTION CARE

The comprehensive definition of reproductive health and rights agreed upon at the 1994 UN International Conference on Population and Development provides a framework for legitimizing and protecting women's reproductive rights. Specific rights that support abortion-related care include:

- The right to decide whether and when to have children. Women should have access to the contraceptive methods they want and to decide when to terminate a pregnancy
- The right to life. Women should not die due to unsafe abortion
- The right to health. This right includes access to comprehensive SRH services, including SAC. Women should not suffer short- and long-term injuries due to unsafe abortion
- The right to dignity and bodily integrity. Young women should be able to consent to their own uterine evacuation procedure
- The right to freedom from discrimination. For example, uterine evacuation is a procedure only women and not men need, so it should not be unduly restricted
- The right to freedom from inhumane and degrading treatment. For example, this may be violated when abortion or post-abortion care is denied
- The right to the benefits of scientific progress. For example, this right is upheld when providers are able to use WHO recommended uterine evacuation methods
- The right to freedom of opinion and expression. For example, this right is upheld when people are able to voice their support for safe abortion care

- Requiring third-party authorization, either by law or in practice, to access abortion services or post-abortion care
- Forcing women to undergo abortion or sterilization against their will or without full and informed consent
- Forced pregnancy (can also constitute a war crime)

8.5 MONITORING AND EVALUATION

Engage beneficiary participation to continuously monitor and evaluate safe abortion and PAC services and the legal and policy framework governing the provision of comprehensive abortion care. Assess the level of use of these services and review clients' records, the availability and proper use of equipment and supplies, and specific indicators of the quality of care. Identify changes or problems that occur, including by creating accessible mechanisms for beneficiaries to seek redress, provide feedback to staff, and intervene to correct any problems identified. Maintain a clinical register to record information about CAC clients; this information can be coded or masked to protect confidentiality.

The following information should be recorded in a gynecology or CAC register and kept in a confidential and locked location:

- Date
- Client name or, if required for confidentiality, unique identifier
- Client age and other demographic information
- Age of pregnancy (in weeks)
- Diagnosis (e.g., induced abortion, incomplete abortion, complete abortion)
- Complications (e.g., moderate/light vaginal bleeding, severe vaginal bleeding, sepsis, shock, injury to organs). This is more relevant for PAC clients coming in with an incomplete abortion
- Treatment/procedure (e.g., MVA, mifepristone and misoprostol, misoprostol alone, dilation and curettage, parenteral antibiotics, blood transfusion, pain management)
- Post-abortion contraception: Yes/No and method selected (e.g., oral contraceptive pills, injectable, implant, IUD, Sterilization)
- Referral to a higher level facility

Program may also choose to have an individual client record that contains more detailed clinical data.

8.6 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 9

MATERNAL AND NEWBORN HEALTH

- 9.1 Introduction
 - 9.2 Objectives
 - 9.3 Maternal and newborn health services
 - 9.3.1 Minimum services for preventing maternal and newborn morbidity and mortality
 - 9.3.2 Transitioning to comprehensive maternal and newborn health services
 - 9.3.3 Comprehensive maternal and newborn health services
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9.1 INTRODUCTION

Globally, 1 in 7 women will face a complication during pregnancy or childbirth. There are over 303,000 maternal deaths each year, 99% of which occur in the developing world. Every year, an estimated 2.9 million newborns die in the first 4 weeks of life (the

neonatal period) and 2.6 million more are stillborn, dying in utero during the last 3 months of pregnancy (including during childbirth).

Two-thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflict, natural disaster, or both. Emergent humanitarian settings and situations of conflict, post-conflict, and disaster significantly hinder the progress of maternal and newborn mortality reduction. In such situations, the breakdown of health systems can cause a dramatic rise in deaths due to complications that would be easily treatable under stable conditions. For example, Sierra Leone has the world's highest maternal mortality ratio (MMR) at 1,360 maternal deaths per 100,000 live births. South Sudan and Somalia have MMRs of 789 and 732, respectively. In countries designated as fragile states, the estimated lifetime risk of maternal mortality is 1 in 54, compared with 1 in 5,800 in the UK or 1 in 8,800 in Canada.

BOX 9.1: CAUSES OF MATERNAL DEATH

The World Health Organization (WHO) reports the most common causes of maternal mortality include:

ABORTION (8%)

EMBOLISM (3%)

HEMORRHAGE (27%)

HYPERTENSION (14%)

SEPSIS (11%)

OTHER DIRECT CAUSES (10%)

INDIRECT CAUSES (27%)

Many of these causes are preventable or could be managed by skilled providers with adequate resources at the facility level. The Global Strategy for Women's, Children's and Adolescent's Health builds on strategies for Ending Preventable Maternal Mortality (EPMM) and the Every Newborn Action Plan (ENAP) and lays out a roadmap for ending all preventable deaths of women, children, and adolescents within a generation. Achieving the 2030 targets for reducing maternal and newborn mortality requires intentional efforts to minimize inequities in access to and quality of care around the time of birth, including increased focus on care for mothers and babies

Most maternal and neonatal deaths occur around the time of labor, delivery, and the immediate postpartum period. The “day of birth” is the most dangerous with more than 40% of maternal and newborn deaths and stillbirths occurring in the first 24 hours after birth. The leading causes of maternal death are hemorrhage, hypertension, sepsis, and complications of unsafe abortion. Other direct causes of maternal mortality include embolism, complications of delivery, and obstructed labor/ruptured uterus. Indirect causes of maternal death include malaria and existing disorders, such as HIV, when exacerbated by pregnancy. Neonatal deaths are up to 7 times more frequent than maternal deaths. The 3 main causes of neonatal mortality are intrapartum-related complications, infections, and complications of prematurity and low birth weight (LBW). The leading causes of both maternal and newborn death are presented in Box 9.1 and Box 9.2.

BOX 9.2: CAUSES OF NEONATAL DEATH

The WHO reports the most common causes of neonatal death include:

CONGENITAL (10%)

COMPLICATIONS FROM PRETERM BIRTH (35%)

DIARRHEA (1%)

INTRAPARTUM RELATED (24%)

PNEUMONIA (5%)

SEPSIS/MENINGITIS (15%)

TETANUS (2%)

OTHER (8%)

in humanitarian settings where an increasing proportion of preventable deaths occur.

Ensuring respectful maternity care is especially critical in a humanitarian setting, where everyday violence and lack of accountability mechanisms are already affecting both women seeking care and their providers. The care provided has to be acceptable to the population served so that women are not deterred from delivering in a facility with a skilled birth attendant. Psychosocial support in pregnancy and childbirth is also needed to account for the life-changing circumstances in which women find themselves.

9.2. OBJECTIVES

The objective of this chapter is to assist sexual and reproductive health (SRH) Coordinators, health program managers, and service providers working with crisis-affected populations to:

- Understand evidence-informed interventions and barriers to implementation that impact maternal and newborn health (MNH)
- Plan for and implement comprehensive and respectful MNH services in humanitarian settings
- Improve quality of care for mothers and newborns that supports the universal rights of childbearing women throughout pregnancy, childbirth, and postpartum periods

9.3. MATERNAL AND NEWBORN HEALTH PROGRAMMING

One of the objectives of the Minimum Initial Service Package (MISP) is to prevent excess maternal and newborn morbidity and mortality (see Chapter 3). MISP interventions focus on the day of birth because most maternal and neonatal deaths occur around the time of labor, delivery, and the immediate postpartum period. This chapter also describes approaches for SRH Coordinators, health program managers, and service providers to program for comprehensive MNH services as soon as the situation allows, building upon the MISP interventions. While this manual provides guidance on programmatic approaches and service components of MNH, it is not meant to provide detailed comprehensive clinical management guidelines. Section 9.7 of this manual and the supplementary resources online provide more information.

BOX 9.3: PRIORITY ACTIVITIES OF THE MISP RELATED TO PREVENTING EXCESS MATERNAL AND NEWBORN MORTALITY AND MORBIDITY

- 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
 - At health center level: Skilled birth attendants and supplies for uncomplicated vaginal births and management of basic obstetric and newborn complications (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 hour 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

9.3.1 Minimum services for preventing maternal and newborn morbidity and mortality

EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC)

Basic emergency obstetric and newborn care (BEmONC) must be provided at the health center level to address

the main complications of childbirth, including newborn complications. If these are not available, stabilize the mother and/or newborn before referral to a hospital.

“Signal functions” are key medical interventions that are used to treat the direct obstetric complications that cause the vast majority of maternal deaths around the globe, as outlined on Table 9.1. This includes treatment

of complications from unsafe and/or incomplete abortion. Some critical services are not mentioned but are included within these functions. For example, conducting caesarean surgeries implies that anesthesia is provided.

The insufficient supply of high quality lifesaving commodities is a persistent bottleneck in efforts to end preventable maternal deaths and the provision of signal functions 1-3 (Table 9.1) are dependent on the continuous availability of essential drugs. With specific reference to

managing post-partum hemorrhage (PPH), misoprostol should also be available as an essential lifesaving commodity at facilities as it can be used to prevent and manage PPH, with minimal training of providers needed. Magnesium sulfate (MgSO₄) is the drug of choice for the prevention and treatment of eclampsia.

Caesarean surgery may be necessary when vaginal birth could pose a risk to the woman or baby – for example due to prolonged labor, fetal distress, or because the fetus has

TABLE 9.1: SIGNAL FUNCTIONS FOR EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC)

BASIC EMONC (BEMONC)	COMPREHENSIVE EMONC (CEMONC)
<ol style="list-style-type: none"> 1. Administer parenteral antibiotics for treatment of sepsis 2. Administer uterotonic drugs (i.e., parenteral oxytocin or misoprostol tablets) for treatment of postpartum hemorrhage 3. Administer parenteral anticonvulsants to manage preeclampsia and eclampsia (i.e., magnesium sulfate) 4. Perform assisted vaginal delivery (e.g., vacuum extraction, forceps delivery) 5. Manually remove the placenta 6. Remove retained products of conception (e.g., manual vacuum aspiration, misoprostol for treatment of incomplete abortion) 7. Perform basic neonatal resuscitation (e.g., with bag and mask) 	<p>Perform signal functions 1-7, plus:</p> <ol style="list-style-type: none"> 8. Perform surgery (e.g., caesarean section) 9. Perform safe blood transfusion observing universal infection prevention precautions

an abnormal presentation or position. However, caesarean surgeries without a medical indication can cause significant complications, disability, or death, particularly in settings that lack the facilities to conduct safe surgeries or treat potential complications.

As with obstetric emergencies, newborn emergencies cannot always be predicted. For example, when complications arise during labor and are not recognized or properly dealt with on a timely basis, the baby may emerge stillborn or be born alive but severely stressed and may not spontaneously begin to breathe. Therefore, staff must be prepared for neonatal resuscitation at every birth and equipment for newborn bag and mask ventilation must be available.

BOX 9.4: NEWBORN RESUSCITATION

5%-10% of all newborns need some type of resuscitation at birth. Newborn resuscitation consists of a range of interventions, from the simple, such as keeping the baby dry and warm, stimulation, positioning and clearing airway (suction), to the more complex, such as ventilation (bag- and mask-resuscitation). All newborns must be closely monitored following resuscitation.

Similarly, staff must be prepared to identify and treat possible severe newborn infections. Clean birth practices, hand washing before contact with a baby, clean cord care, and immediate and exclusive breastfeeding significantly contribute to prevention of infection in newborns. There are also simplified algorithms for the diagnosis and treatment of potentially severe newborn infections, including guidelines for initial treatment prior to referral, and treatment when referral is not possible.

Finally, staff should be prepared to diagnose, prevent, and manage complications associated with prematurity and low birth weight, provided there is the capacity and infrastructure needed to comprehensively support preterm infants. Small and sick newborns require timely, high-quality inpatient care to survive. This includes provision of warmth and feeding support, as well as more intensive and advanced care in some cases.

Ensure health providers are competent in providing emergency obstetric and newborn care procedures, and can refer to higher levels of care when needed. Publicly display protocols and make relevant medicines, equipment

and supplies available in all health centers.

REFERRAL SYSTEMS

Because most maternal and perinatal deaths are due to a failure to get skilled help in time for complications of childbirth, it is critical to have a well-coordinated system to identify obstetric complications and ensure their immediate management and/or referral to a hospital with comprehensive EmONC (CEmONC) capacity. This includes protocols specifying when and where to refer and an adequate record of referred cases (including individual names, reasons for referral, outcomes at the referral facility, return to the initial health facility, and follow-up with providers there). Quality referral systems and counter-referral systems require clinical, communication, and transport protocols, as well as trust and understanding between the community, service providers, health center, and the hospital. As a rule, health staff must understand that the further away the referral facility is, the earlier they must make a decision to refer women with obstetric complications.

PROGRAMMATIC EXAMPLE 9.1: MANAGING OBSTETRIC REFERRALS IN A REFUGEE CAMP SETTING

ORGANIZATION: American Refugee Committee (ARC)

LOCATION: Rwanda

INTRODUCTION: ARC is managing health centers in 3 refugee camps in Rwanda. All the facilities are integrated into the Ministry of Health (MOH) structure to ensure provision of high quality curative and preventative primary health care, including reproductive health and nutrition for refugees.

PROJECT DESCRIPTION: ARC provides primary health care according to MOH standards, including antenatal care (ANC), safe delivery, post-natal care, and family planning services. Patients presenting with complications at ANC visits, outpatient consultations, or inpatient consultations are immediately referred to a district hospital. If necessary, a plan to deliver at a district hospital is established. Women who come to the maternity service to deliver but are determined to be complicated and beyond the capacity of health center to handle safely are also immediately referred to the district hospital using ambulances available at each camp health center. If the case is not able to be managed at the district hospital level, the woman is referred to the next level (tertiary hospital). The referral to secondary or tertiary levels is based on standard operating procedures developed by UNHCR using referral forms; these document the outcome of the referral and help the referring institution learn from the process. Referral costs to secondary level institutions (district hospital) are paid by ARC, with reimbursement from UNHCR, while tertiary level referrals are covered by another partner.

RESULTS AND LESSONS LEARNED: Full integration of refugee health services into the host country MOH structure has enabled refugee women to access comprehensive EmONC and other secondary and tertiary health care services. This process has helped to ensure that cases are referred on time and has had a positive impact on maternal mortality, with 2 or fewer deaths per year in the camps where ARC provides services.

CLEAN, SAFE DELIVERY AND NEWBORN CARE KITS

In all humanitarian settings, there are women and girls in the later stages of pregnancy who will give birth during the emergency. At the onset of a humanitarian emergency and in settings with high levels of home deliveries before the emergency, births may take place outside of health facilities without the assistance of skilled birth attendants.

Clean, safe delivery and newborn care kits should be made available to all visibly pregnant women to improve birth practices when access to a health facility is not possible. Distributions can be done at registration sites or via community health workers where there is a network established. At a minimum, kits should include 1 sheet of clean plastic for the women to deliver on (noting she should assume birth position of choice), a bar of soap, a pair of gloves, 1 new razor blade to cut the umbilical cord, 3 pieces of string to tie the cord, 2 pieces of cotton cloth (1 to dry and the other to cover the baby), and 1 tube of 7.1% chlorhexidine digluconate antiseptic gel for clean cord care.

In settings with national protocols for advanced distribution of misoprostol tablets for PPH prevention, this essential life-saving commodity should be included in all kits. Decades of research have proven the safety and efficacy of using misoprostol as a prophylactic uterotonic to reduce post-partum hemorrhage when taken immediately after birth of a newborn. The World Health Organization recommends the administration of misoprostol by community health workers and lay health workers where skilled birth attendants are not present and oxytocin is not available. Recent evidence from both stable and crisis-affected settings suggests that self-administration of misoprostol can be done safely and effectively. In particular, misoprostol has the potential to reach women who give birth, by choice or by necessity, at home or in health facilities that lack electricity, refrigeration, and/or skilled health providers.

In all settings, context-appropriate instructional materials should be provided in all kits. At the time of distribution, women should be provided with essential information on kit contents, use, and danger signs.

9.3.2 Transitioning to comprehensive MNH Services

Comprehensive MNH programming has **3 strategic priorities**:

- Understand and remove barriers to MNH services
- Increase availability of evidence-informed MNH services
- Improve utilization and demand for MNH services

QUALITY OF CARE

Quality of care underpins all components of comprehensive MNH services and is considered a key component of the right to health and the route to equity and dignity for women and children. Characteristics of quality MNH services include:

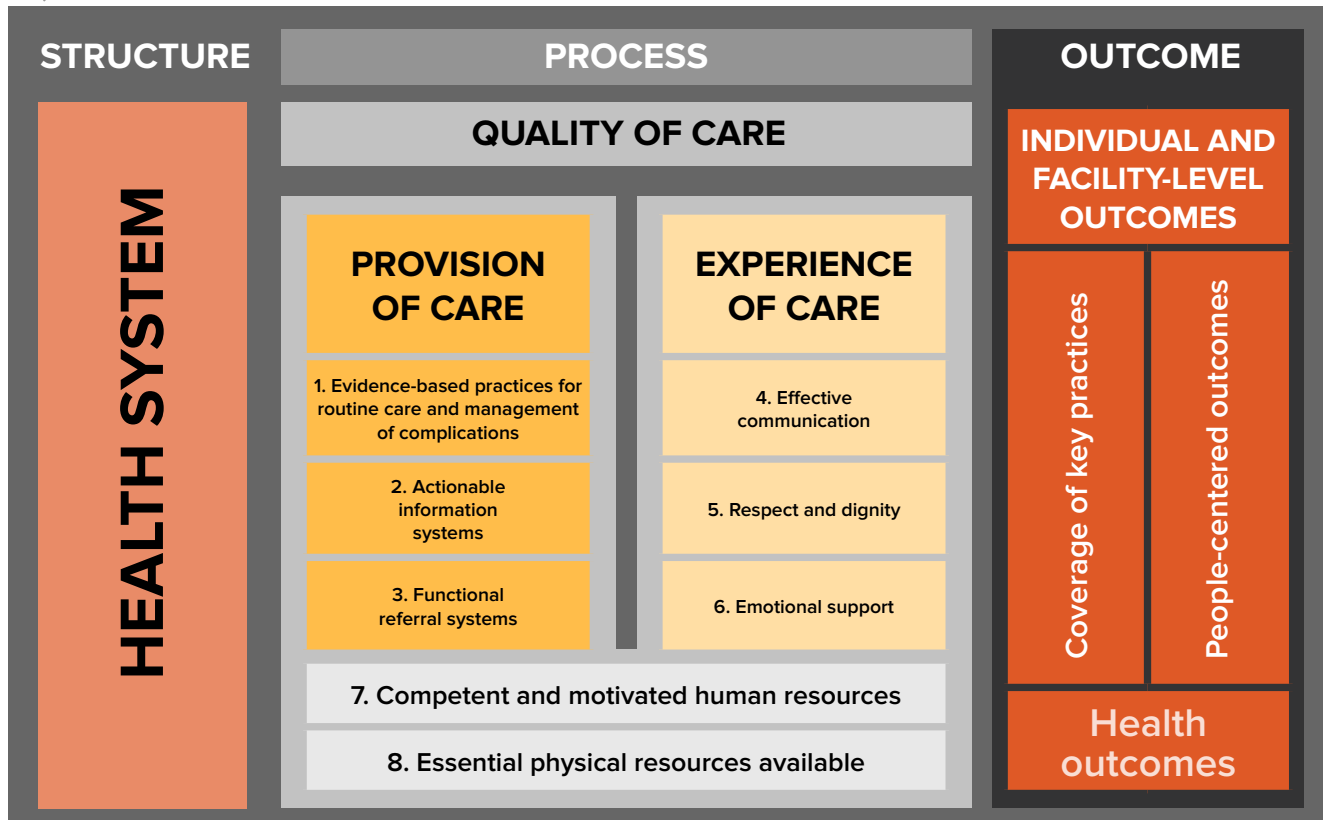
- **Availability:** There must be at least 5 EmONC facilities (including at least 1 CEmONC facility) for every 500,000 people. They must be open and adequately staffed 24 hours per day and 7 days per week (24/7), as childbirth and complications can occur any time
- **Accessibility:** Services must be reachable by roads or waterways and affordable means of transport can be found
- **Acceptability:** Providers must be committed and enabled to treat everyone with dignity and respect, create trust, and promote demand for services
- **Effectiveness:** Services include evidence-informed interventions to improve maternal and newborn health and survival in pregnancy, childbirth, and the postnatal period
- **Affordability:** Efforts must be made to offer services at reduced cost or free of charge
- **Culturally appropriate:** Consider language and culture of the target populations, such as preference for a female health provider; however, lack of a female provider should not be a barrier to services
- **Safety:** Care and services should not harm patients
- **Timely:** Care and services should be provided when and where needed

- **Respectful:** Services must respect every woman's humanity, feelings, choices, and preferences. They should uphold the **Respectful Maternity Care Charter: The Universal Rights of Childbearing Women**

As the WHO's vision for quality of care for maternal and newborn health illustrates (Fig. 9.1), quality MNH

services in any setting requires competent and motivated human resources, health infrastructure, appropriate use of effective clinical and nonclinical interventions in a humane, supportive environment where a woman (or her family if required) can feel that she understands what is happening and what to expect before, during, and after childbirth.

FIGURE 9.1: THE WORLD HEALTH ORGANIZATION'S QUALITY OF CARE FRAMEWORK



9.3.3 Comprehensive MNH services

ANTENATAL CARE

Recommended antenatal care schedules may vary by country. An ideal antenatal care (ANC) package consists of eight antenatal contacts with the first contact early in pregnancy, 2 contacts during the second trimester (at 20 and 26 weeks gestation), and 5 contacts in the third trimester (at 30, 34, 36, 38 and 40 weeks). This guidance replaces WHO's 4-visit focused antenatal care model; the word "contact" is used instead of "visit" to emphasize the connection between a pregnant woman and her health provider(s) and include provision for contacts with health workers via community outreach activities as

well as traditional clinic visits. In any setting, the primary objectives of antenatal care are to:

- Provide disease prevention and health promotion
- Identify and manage pre-existing health problems and complications arising during pregnancy
- Provide counseling on birth preparedness and complications readiness
- Establish a relationship of trust between woman and provider

For an overview of antenatal care interventions, see section 9.7.

BOX 9.5: PROMISING PRACTICE: GROUP ANTENATAL CARE

Group Antenatal Care (G-ANC) is an alternative to traditional ANC (i.e., provided by a skilled provider to 1 individual woman at a time). G-ANC is provided for a group of up to 15 pregnant women of approximately the same gestational age. Trained facilitators lead a series of structured, highly participatory 2-hour meetings that integrate the usual health assessment with information, education, and peer support. Research has demonstrated increased attendance, knowledge, and patient and provider satisfaction as well improved health practices and outcomes with G-ANC. The WHO ANC Recommendations on Antenatal Care for a Positive Pregnancy Experience recommends G-ANC in the context of research.

Immunization

All women giving birth, and their newborn babies, should be protected against tetanus. Immunizing women during pregnancy is recommended to provide protection against both maternal and neonatal tetanus. Antenatal services provide a convenient opportunity for vaccinating pregnant women. However, where ANC coverage is inadequate and there is a high risk for maternal and neonatal tetanus, mass immunization of women of childbearing age could be an alternative, albeit more costly, option.

Screening for syphilis

All pregnant women should be screened for syphilis at the first antenatal visit. Syphilis contributes to maternal morbidity and negative pregnancy outcomes. Every year, maternal syphilis causes half a million stillbirths and miscarriages and is responsible for at least half a million infants born with congenital syphilis. Previously, the standard tests for syphilis were difficult to perform and not appropriate for primary care settings. Simple and effective rapid diagnostic tests (RDTs) for syphilis are now available with results immediately available so that women (and their partners) testing positive can be treated without delay at the point of care.

Diagnosis and treatment of asymptomatic and symptomatic urinary tract infections

During pregnancy, urinary tract infection is associated with increased risks of maternal and newborn morbidity and mortality, even when the infection is asymptomatic. Screening and treatment of urinary tract infections can reduce the risk of maternal sepsis and anemia, preterm birth, low birth weight, and perinatal death. This includes antenatal urine screening combined with appropriate antibiotic treatment for women diagnosed with bacteriuria.

Nutrition needs of pregnant and lactating women

During pregnancy and lactation, women's nutritional needs for energy, protein, and micronutrients increase significantly. Pregnant women require an additional 285 kcal/day and lactating women require an additional 500 kcal/day. Adequate intake of iron, folate, and iodine are particularly important for the health of women and their infants. The increased micronutrient needs of pregnant and lactating women are usually not met through the provision of a basic food ration. Pregnant and lactating women should therefore receive an appropriate fortified food supplement providing 500 to 700 kcal for on-site feeding and 1,000 to 1,200 kcal if provided as a take-home ration. Pregnant women must receive daily supplements of iron (60 mg/day) to prevent anemia and folic acid (400 µg/day) to prevent neural tube defects.

Birth preparedness and complication readiness

Many maternal and newborn deaths could be prevented if women received care when needed. Three phases when delays often contribute to maternal and neonatal death are: 1) deciding to seek care; 2) reaching care; and 3) receiving care. Preparing for birth and complications reduces delays. Antenatal care is an opportunity for health care providers to support a woman and her family to establish a birth and emergency plan based on her unique needs, resources, and circumstances. The birth and emergency plan identifies her intentions about where and with whom she intends to give birth and actions to be taken in the event of complications (e.g., transport, place of referral, emergency funds). The plan also includes identifying a support person, planning childcare, saving money, planning transport, and educating family members about the signs of a complication (See Box 9.6) and what action to take. As most complications during labor and

childbirth are unpredictable, delivery under the care of a skilled birth attendant in a well-equipped health facility that can address potential complications is recommended and must be encouraged.

BOX 9.6: KEY MESSAGES FOR BIRTH PREPAREDNESS

- Prepare a birth kit
- Choose a facility
- Choose a birth companion
- Save money for birth expenses
- Have a transportation plan for day and night
- Teach family members danger signs and discuss decision making
- Have a plan for healthy timing and spacing of pregnancy

BOX 9.7: KEY DANGER SIGNS IN PREGNANCY

- Vaginal bleeding
- Severe abdominal pain
- Convulsions
- Severe headache
- Fever
- Fast or difficult breathing

Counseling on post-partum family planning (PPFP) and health needs is also an important part of birth preparedness. PPFP, which aims to prevent the high risk of unintended and closely spaced pregnancies during the first year following childbirth, is one of the highest impact interventions to avoid increased risk of premature birth, low birth weight, fetal and neonatal death, and adverse maternal health outcomes. Unmet demand for PPFP services remains high in many countries therefore PPFP should be introduced in ANC and again following birth and in the postpartum period. All women should be given information about the physiological process of recovery after birth and told that some health problems are common, with advice to report concerns to a health care professional. Women should also be counseled on post-partum care and hygiene, nutrition, birth spacing and family planning, including post-partum pregnancy risks and contraceptive options, and when to return for post-natal examinations and immunization.

Counseling on newborn care includes guidance on breastfeeding, cord care, and prompt recognition of newborn danger signs. Post-natal contacts should occur within 24 hours of birth as well as at 48-72 hours, 7-14 days, and 6 weeks after birth. For births that occur outside of the facility an extra contact at 24-48 hours is recommended.

Recording of clinical data

All clinical findings and treatments provided during antenatal care must be recorded, preferably on a health card or record that stays with the woman. Good record-keeping is essential to facilitate appropriate decision-making and interventions.

CHILDBIRTH CARE

Childbirth includes labor, delivery, and the immediate post-partum period. Childbirth should take place in a health facility that ensures privacy, confidentiality, and dignified and respectful care free from discrimination; is secure, safe, and equipped with the necessary essential supplies, drugs, and personnel; and has access to transport to and communication with referral hospitals for obstetric and newborn emergencies. SRH Coordinators and SRH health program managers must ensure that all healthcare facilities have clinical protocols in place as well as protocols for standard precaution measures, including medical waste management for amniotic fluid, blood, and placentas. Hand washing and other infection prevention measures must be maintained.

Partograph

The partograph is an often underutilized decision-making tool for supporting intrapartum care, specifically monitoring the progress of labor and detecting maternal or fetal complications. The simplified WHO partograph (see section 9.7) is an important tool used in many settings to:

- Identify complications during labor (e.g., fetal complications) in a timely manner
- Inform decision-making regarding prolonged labor and use of augmentation
- Improve clinical practice and quality of care provided to women (e.g., decrease newborn mortality due to intrapartum complications)

Numerous factors contribute to underutilization of the partograph and challenges may be exacerbated in humanitarian settings. Strategies for facilitating correct use of the partograph include:

- Establishing a champion for partograph use within the facility
- Ensuring that management protocols for labor and delivery are linked to the partograph so that providers know what actions to take as labor progresses
- Monitoring the partograph's use and updating providers on how to use it correctly

Prevention of post-partum hemorrhage

One of the leading causes of maternal mortality is post-partum hemorrhage. Administration of a uterotonic drug within one minute of the birth of the baby reduces the risk of retained placenta and PPH.

Oxytocin is the recommended uterotonic for the prevention of atonic PPH. However, in some settings it may not be possible to provide oxytocin to all women in the third stage of labor because of the absence of skilled staff, difficulties in ensuring safe injection practices, and/or lack of refrigeration, all of which are necessary for oxytocin use. In these settings, the use of misoprostol, a heat-stable uterotonic tablet, is recommended. Health workers who administer misoprostol must be trained in avoiding administration before birth, correct use (misoprostol 600 µg orally immediately after the birth of the baby), and counseling the woman on side effects and managing side-effects. In such cases no active intervention to deliver the placenta should be carried out.

In settings where there were programs for advance distribution of misoprostol for self-administration to prevent post-partum hemorrhage at home delivery in place before the emergency, every effort should be made to ensure continued availability as soon as possible after the emergency. In other settings, this may be introduced as part of a comprehensive strategy for addressing post-partum hemorrhage at both community and facility levels.

Immediate newborn care

Essential newborn care is the basic care required for every baby. Irrespective of where the birth takes place, cord clamping should be delayed 1-3 minutes to increase the

newborn's iron reserves for the first 6-8 months of life. Essential care for all newborns also includes **thermal care** (drying and keeping the baby warm through skin-to-skin contact for the first hour after birth, delaying bathing), **infection prevention** (promoting and supporting handwashing for all caregivers, providing hygienic umbilical cord and skin care), **feeding support** (early and exclusive breastfeeding), and **monitoring of newborns for danger signs** indicating the need for additional care.

BOX 9.8: KEY DANGER SIGNS IN NEWBORNS

- Not feeding
- Fast breathing
- Severe chest in-drawing
- No spontaneous movement
- Fever
- Low body temperature
- Jaundice in the first 24 hours of life or yellow palms and soles at any age

Prevention and management of preterm birth

Preterm birth is the single largest cause of perinatal and neonatal mortality and morbidity and the leading cause of death in children under the age of 5. Infant deaths and long-term disabilities following preterm birth can be reduced when interventions are appropriately provided to the mother at imminent risk of preterm birth and to the preterm infant after birth. Recommended interventions for women with imminent preterm birth include provision of antenatal corticosteroids to women 24 to 34 weeks gestation, provision of antibiotics for preterm pre-labor rupture of membranes, and provision of magnesium sulfate to women less than 32 weeks gestation for fetal neuroprotection if preterm birth is likely within 24 hours. Accurate gestational age dating is essential to guide appropriate care and interventions should only be considered when adequate hospital-level care is available for the woman and newborn.

Complications associated with LBW/preterm birth are hypoglycemia, hypothermia, feeding difficulty, jaundice, and increased risk of infection. Care of the LBW/preterm baby include kangaroo mother care (KMC) or prolonged skin-to-skin care, keeping babies warm, immediate and exclusive breastfeeding, feeding assistance, prevention

PROGRAMMATIC EXAMPLE 9.2: PROMOTING NEWBORN CORD CARE

ORGANIZATION: JSI Research & Training Institute, Inc., in partnership with the Government of Nepal

LOCATION: Nepal

INTRODUCTION: Chlorhexidine (CHX) is a broad spectrum antiseptic that reduces bacterial colonization on the umbilical stump of newborns. JSI is assisting the Government of Nepal and other partners to reduce neonatal mortality by scaling up the use of chlorhexidine for umbilical cord care. Since its inception, 1.5 million babies received CHX, 5,800 newborn deaths were prevented, and 67% of newborns now have access to CHX. The April/May 2015 earthquake resulted in 9,000 people dying, 800,000 houses damaged, and 500 health facilities destroyed.

PROJECT DESCRIPTION: Following the earthquakes in 2015, the JSI-led program Chlorhexidine Navi Care Program (CNCP) quickly mobilized female community health volunteers (FCHVs) and staff to respond in the 15 districts most affected and rapidly distributed CHX and trained health workers in its use thereby quickly scaling-up services to help those most affected.

RESULTS: Within months post-earthquake, JSI specifically assisted with continued scale-up of the program, distribution of the emergency relief packages for health volunteers, and capacity-building of service providers (1,308 health workers and 703 FCHVs). Consequently, the program supplied around 65,490 of CHX gel tubes in these districts.

LESSONS LEARNED: Existing programs, staff, community members, and structures can be rapidly mobilized post disaster, thus expanding and/or returning to comprehensive MNH services quickly.

BOX 9.9: KEY NEWBORN CARE PRACTICES

- Delayed bathing
- Skin-to-skin contact
- Clean cord care
- Exclusive breastfeeding
- Immunization

of infection and early identification and appropriate treatment of infections and complications.

POSTNATAL MATERNAL AND NEWBORN CARE

The postnatal period is a time of rapidly occurring physiological changes for the mother and baby, with the first 24-48 hours being the most critical. Sixty percent of maternal deaths and 40% of neonatal deaths occur in the first 24 hours following childbirth. Following the non-complicated delivery of a healthy term baby, it is recommended to keep mother and baby in the health facility for observation for at least 24 hours. If discharged prior to 48 hours following delivery, a qualified provider must assess mother and baby within 24-48 hours after discharge. Ensure health workers are trained in recognizing postpartum complications and referring mothers and newborns who may need additional observation or treatment. Inform families to know the danger signs for postpartum mothers and newborns in order to seek care early if needed. Where possible all postpartum women should also have a home visit within the first week regardless of where she gave birth.

At least three additional postnatal contacts are recommended for all mothers and newborns, on day 3 (48-72 hours), between days 7-14 after birth, and 6 weeks after birth. These visits provide an occasion to assess and discuss hygiene, breastfeeding, and appropriate methods and timing of family planning. Ensure health providers support early and exclusive breastfeeding and discuss appropriate nutrition with the mother. These visits also provide an opportunity to weigh the newborn, discuss his or her care, and provide referrals; newborns must be referred to the under-5 clinic for immunizations, growth monitoring, and other well-child services.

Breastfeeding

Breastfeeding is particularly important in humanitarian settings. The risks associated with bottle feeding and breast-milk substitutes are dramatically increased when there is poor hygiene, crowding, and limited access to clean water and fuel. In these situations, breast milk may be the only safe and sustainable source of food for infants. Therefore,

it is important to promote an environment that supports exclusive breastfeeding by promoting uninterrupted skin-to-skin contact, helping mothers initiate breastfeeding within an hour of birth, showing mothers how to express breast milk, giving no food or drink other than breast milk unless medically indicated, encouraging mothers and babies to remain together, and encouraging breastfeeding on demand without restriction on length or frequency of feeding. On-demand breastfeeding during the first 6 months also provides contraceptive protection, provided menses has not returned and no other food is given to the baby (lactational amenorrhea method).

Post-partum family planning

The purpose of postpartum family planning is to help women decide on the contraceptive method they want to use, initiate use of the method, and support her to continue contraceptive use for 2 years or longer, depending on the reproductive intentions of the woman or couple. Counseling on PFP can be provided at many points of contact in the health system from the antenatal period to 12 months after birth. An important consideration when planning a PFP program or intervention is clinical safety, that is, which methods can be used at what point in time following birth and given the mother's breastfeeding status (see Chapter 7).

RAISING AWARENESS AND INCREASING UTILIZATION OF MNH SERVICES

To make sure that the services provided are appropriate, of the highest quality, and fully utilized, SRH Coordinators and health program managers must ensure that:

- All women and their families know where to obtain assistance for ANC, childbirth, and postnatal care and how to recognize signs of complications
- MNH services are provided by competent, motivated, and skilled staff working within an enabling environment, including having appropriate and sufficient supplies, receiving refresher trainings and close supervision
- Services are free from harm and ill treatment which might otherwise discourage women from seeking services, including delivery at a facility with a skilled birth attendant
- Service providers understand and respectfully discuss

community beliefs and practices and health-seeking behaviors related to pregnancy and childbirth, such as nutrition, birthing positions, presence of relatives for support, and traditional practices both positive (breastfeeding) and harmful (female genital cutting)

SRH Coordinators and health program managers can use the model of the **Three Delays** to identify barriers to service utilization in their setting.

BOX 9.10: DEFINING THE THREE DELAYS

- **Delay 1:** Delay in the decision to seek care
- **Delay 2:** Delay in reaching care
- **Delay 3:** Delay in receiving quality care

9.4 PROGRAMMING FOR COMPREHENSIVE MATERNAL AND NEWBORN HEALTH

9.4.1 Needs assessments

After the MISP is in place, integrate MNH considerations into needs assessments for comprehensive SRH planning in order to design an appropriate and comprehensive MNH program. Using a combination of tools, SRH Coordinators need to collect or estimate the following information, in coordination with other health sector/cluster actors:

POPULATION CHARACTERISTICS

- The size of affected population and its geographical distribution
- Demographic indicators about the MNH status of the affected population prior to the crisis, for example, the maternal mortality ratio (MMR), neonatal mortality rate (NMR), crude birth rate (CBR), general or total fertility rate (GFR, TFR), contraceptive prevalence rate (CPR), percentage of births with a skilled birth attendant (% SBA), etc.
- The number of women of childbearing age, pregnant women, and newborns
- The number of deliveries per month
- Beliefs, knowledge, attitudes, and practices of the

population related to pregnancy and childbirth

- Community awareness of and satisfaction with the MNH service availability and quality

NATIONAL LEGISLATION AND POLICIES

SRH Coordinators, health program managers, and service providers must also be familiar with national legislation and policies related to MNH. For example, determine where there are laws, regulations or policies regarding:

- Reducing maternal mortality
- Access to and provision of MNH services. Pay particular attention to provisions on:
 - o Routine performance of maternal, perinatal, and neonatal death audits and reviews
 - o Licensing for skilled birth attendants
 - o Traditional birth attendants (TBAs)
 - o Use, distribution, and provision of medicines essential for maternal and neonatal health (including at the community level)
- Mandatory birth registration
- Testing pregnant women for HIV and prevention of mother-to-child transmission of HIV
- Treatment, care, and support for HIV positive pregnant women
- Third-party (i.e., a husband's) authorization to seek maternal health services
- Female genital cutting (FGC) and/or other harmful practices that have damaging consequences to maternal health
- The elimination of early and forced marriage, the minimum age of marriage, and/or free and full consent to marriage

MNH SERVICE AVAILABILITY AND READINESS

Map existing health service delivery points by geographic location and type and the agency supporting/managing them. Each facility needs to be evaluated for its capacity

to provide quality MNH services, including EmONC, the availability of skilled health providers and medical supplies, and/or the possibility to refer to higher level services. Examples of information to collect include:

- Number, location, and type of health centers and hospitals
- Which among these facilities provide MNH services, including BEmONC and CEmONC
- Availability of functioning equipment, supplies, and medicines for MNH service delivery
- Provisions for standard precautions, including medical waste and placenta disposal facilities
- Number, availability, type and skill levels of health staff (training needs assessment)
- Availability of MNH protocols and guidelines
- On referral mechanisms:
 - o Distances from community to BEmONC facilities
 - o Distances from BEmONC to CEmONC facilities
 - o Feasible transport options
 - o Means of communication
 - o Protocols for managing and referring complications
- Availability of clean water, electricity, refrigeration, and sanitation (bathing and toilet facilities) at the service delivery points
- Availability of adequate nutrition for pregnant and lactating women
- Information, education, and communication (IEC) on the availability of services

9.4.2 Principles for working in maternal and newborn health

- Maintain focus on both the woman and the newborn (mother-baby dyad)
- Consider service capacity pre-crisis and resources available at different levels (start with where the capacity is)

- Maintain compliance with global clinical and program standards
- Ensure a continuum of woman/family-centered quality, respectful, and dignified care, free from harm and ill treatment, from pregnancy through the post-partum period

9.4.3 Programming considerations

LOGISTICS AND SUPPLY CHAIN

Logistics are critical for successful MNH service provision. In the initial phases of the emergency response, focus should be on ensuring that MNH service providers have life-saving commodities available and that transportation is available to facilitate timely referral of obstetric and newborn complications when needed. As the situation stabilizes and programs transition to provision of comprehensive MNH services, a broader range of logistics issues must be considered in program planning and implementation.

Procurement

In many settings, Inter-Agency Reproductive Health Kits (RH Kits) are the primary source of supplies for MISIP implementation. However, RH Kits are not intended to replace national supply chains, and efforts should be made to assess what is available and establish or repair public and private sector supply chains and pipelines as quickly as possible. When relying on RH Kits, it is important to note that RH Kits do not contain sufficient supplies for provision of comprehensive intrapartum care. For example, through 2018, the block of RH Kits (6-10) for health centers only includes enough supplies to stabilize and refer clients with obstetric or newborn complications. It does not include enough oxytocin for every woman to receive a uterotonic after delivery for PPH prevention, nor enough magnesium sulfate to administer both loading and maintenance doses to women with severe pre-eclampsia or eclampsia.

RH Kit contents can be used as a guide for procurement in the early phases of emergency response. However, every effort should be made to procure the full range of items on the WHO and/or national essential medicine lists for comprehensive MNH services as soon as possible. MNH

program managers should work with service providers and logistics teams to procure the correct items, in the correct dose and form, for the target population.

In times of crisis, large donations of infant formula, feeding bottles, and teats are often received from various sources. Although intentions are generally good, there is lack of awareness that such donations can do more harm than good as there are neither basic infrastructure nor adequate conditions to reduce the risks linked to the preparation of infant formula and other breast milk substitutes. Therefore, these donations should be avoided. Instead, suitable substitutes forming part of the regular inventory of foods and medicines must be procured, distributed, and fed only to the small number of infants who have to be fed on breast milk substitutes after a proper needs assessment.

Supply management

An important part of logistics for MNH is establishing the cold chain and there are some items within the RH Kits that need cold chain support. The quicker SRH Coordinators and health program managers establish this in an emergency response, the more flexibility and capacity there will be for programming. Solar powered refrigerators and mobile technologies for supply management are being used more often in emergencies.

Transportation for referrals

For every logistician working in emergency response and every MNH program manager, there are few things worse than needing transportation for a person in need of urgent health care but being unable to find it. Be it due to a lack of planning, a lack of resources, or the context, transportation seems to always top the list of programming needs just after staffing. However, there is one area that is often overlooked until there are tragic consequences: transportation for referral systems. These referral systems do not need to rely on the purchase of a brand new hard top vehicle, but should be as locally contextualized and reliable as possible. In some areas due to security, rented vehicles may be the most appropriate approach, while in others a system of donkey carts or even stretchers to hand carry women to the main road may be suitable. What matters is that that SRH Coordinators and health program managers begin planning at the beginning of any

MNH programmatic response whichever transportation referral system works the quickest and ensures access to emergency care within the resources of the program. Several forms of transportation may need to be connected in order to get a woman to the hospital. For example, the woman may be carried by stretcher to the main road where the ambulance meets her and takes her the remaining distance to the hospital.

HUMAN RESOURCES AND TASK-SHARING

Levels of health facilities, their sizes and services, and the cadre of health providers vary among contexts, making it difficult to reach global consensus on an optimal number and composition of health workers. Programmers should therefore adhere to national level standards for numbers and profiles of health staff to ensure an adequate skill mix and capacity to provide maternal and newborn services. Human resources providing MNH services should be composed of a range of providers (e.g., doctors, midwives, nurses, pharmacists, community health workers

(CHWs)) who are trained, competent, compassionate, and respectful and work within an enabling environment and in adequate number to meet client volume with high quality of care. Ethnicity and gender of health providers may also be important aspects to consider in maternity care in certain contexts. Benefit and incentive schemes, including ensuring safe, gender-sensitive environments for staff should be considered in order to facilitate mental health, wellbeing, motivation and retention of health workers in remote and hardship settings.

While it is promising that training community health workers and/or TBAs could improve perinatal and neonatal outcomes, evidence is currently mixed and insufficient. As such, where skilled birth attendants are not available, or access to facilities is limited, training community health workers and/or TBAs in selected interventions may reduce poor health outcomes for neonates. However skilled birth attendants will continue to be essential to reduce maternal and newborn mortality.

BOX 9.11: SKILLED BIRTH ATTENDANT VERSUS TRADITIONAL BIRTH ATTENDANT

A skilled birth attendant is defined as an accredited health professional – such as a midwife, doctor, or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirths, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns.

Although traditional birth attendants, either trained or untrained, cannot be considered skilled providers, they often hold a special place in the community. Training

of TBAs to be skilled birth attendants is no longer recommended, but it is important to integrate them into other service delivery aspects of MNH. For example, TBAs can play a role in promoting sexual and reproductive health, addressing barriers to care, facilitating referrals to health facilities, and providing labor support to women. This can optimize community acceptance of MNH services and help build links between families, communities, local authorities, and reproductive health services.

Task-sharing MNH services is a critical strategy to expand access in settings with a shortage of health workers. Much evidence has been generated to support task-sharing key interventions from more senior staff to mid-level health workers and community health workers.

A quality assurance approach that ensures services are of high quality, respectful, regularly monitored, supported, and well-managed should be established. An effective quality assurance framework would ensure that staff achieve and maintain competencies on essential clinical

and interpersonal skills required to provide high quality MNH services. Provider performance should be assessed at baseline, gaps identified, and capacity building interventions identified including effective training models. It is important that training models be adapted to meet population needs and scope of work of cadres per national legislation and policies. Furthermore, participation of community and clients in project design and monitoring will help to ensure principles of quality services, including respectful care, are upheld.

9.4.4 Special issues and populations

OBSTETRIC FISTULA

It is estimated that more than 2 million women suffer from untreated obstetric fistula and at least 50,000 to 100,000 new women are affected each year. The vast majority of fistula cases are caused by prolonged or obstructed labor, one of the leading direct causes of maternal mortality and morbidity.

SRH Coordinators and health program managers must ensure that national fistula programs, if they exist, reach refugee and internally displaced communities. Fistula eradication strategies include primary prevention, secondary prevention, treatment, and reintegration. Primary and secondary prevention include delaying early marriage and childbirth, improving nutrition for girls and adolescents, educating against harmful traditional practices, increasing education for women and girls, using the partograph correctly and consistently, and improving access to emergency obstetric care, especially caesarean surgeries.

FEMALE GENITAL CUTTING

FGC-associated complications during pregnancy can be identified through history taking and pelvic examination during antenatal care. Where excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (Type III FGC) is common, the vulva area should be routinely inspected at the first ANC visit. Opening up of the infibulation is performed during the second trimester, after careful counseling of the woman and her partner. Once the infibulation has been opened up, episiotomy should only be performed if necessary during labor and if the woman gives informed consent.

When a woman with an unopened Type III FGC gives birth, the formation of rigid scar tissue around the vaginal opening is likely to lead to

PROGRAMMATIC EXAMPLE 9.3 : DEVELOPING A NEWBORN CARE FIELD GUIDE

ORGANIZATION: Save the Children and other partners

LOCATION: South Sudan

INTRODUCTION: Relatively poor newborn outcomes persist in areas affected by conflict or political instability. Recognizing this need, Save the Children and the United Nations Children's Fund (UNICEF) led an interagency effort to develop the Newborn Health in Humanitarian Settings Field Guide (Field Guide). Save the Children, in collaboration with Johns Hopkins Bloomberg School of Public Health, UNICEF, International Medical Corps (IMC) and the US Centers for Disease Control and Prevention piloted implementation of the Field Guide in South Sudan. South Sudan is the world's newest country following decades of civil war with a high number of internally displaced people and refugees due to renewed conflict internally and within surrounding countries. The long history of conflict has resulted in a limited health workforce and poor medical supply chains and infrastructure.

The baseline study objectives:

- 1) What factors influence the implementation of the Field Guide among International Medical Corps health workers and program staff at the community and health facility level?
- 2) What are health worker attitudes toward the adoption of newborn practices?
- 3) What is the association between the intervention and changes in newborn care practices at baseline and 5 months post intervention?

PROJECT DESCRIPTION: The project was implemented through international non-governmental organization-run sites at the community, health center, and hospital levels in refugee and internally displaced camp settings. Key intervention areas were provision of newborn care supplies, training of community and facility health workers, and supervision and training of program managers. Cross-cutting areas included ensuring data quality and behavior change and communication.

RESULTS: Baseline and endline assessments were conducted using a mixed-methods approach. Results indicate improvements in knowledge and practices for community and facility health workers as well as knowledge and care-seeking behavior by mothers.

LESSONS LEARNED: This project revealed that 1) Provision of quality newborn care services is feasible; 2) Positive attitudes among the health workers towards the importance of newborn care practices exist; 3) Newborn-specific medicines and supplies are often lacking; and 4) Low knowledge among mothers and community and facility health workers on newborn danger signs and key practices exists.

delay in the second stage of labor, which may endanger both the woman and the baby. An anterior episiotomy, cutting the scarred infibulations, possibly extended into lateral episiotomies, may be needed for safe delivery. Alternatively, the baby may need to be delivered by caesarean. Providers need to be trained to not resuture the labia together after delivery, but to suture the edges separately on each side to avoid recreating an infibulation. Both partners need sensitive counseling to understand and accept the changes after deinfibulation.

PREVENTION AND TREATMENT OF MALARIA

Malaria is the cause of 2%-15% of anemia in pregnant women in Africa, resulting in an increased risk of maternal mortality and morbidity. Malaria also increases the risk of spontaneous abortion, stillbirth, preterm birth, and low birth weight. An estimated 3%-8% of all infant deaths can be traced back to malaria infection in the mother. To prevent malaria in pregnancy:

- Advise women to cover doors and windows to prevent mosquitoes from entering the living space, avoid going out after dark or before dawn and use mosquito coils to either kill or drive mosquitoes away
- Encourage all pregnant women to sleep under insecticide-treated bed nets (ITN) from as early in pregnancy as possible and continue using an ITN during the postpartum period, together with their babies. Nets must be used all night, every night and cover the entire bed
- Provide intermittent preventive therapy of pregnant women with sulfadoxine-pyrimethamine (IPTp-SP) in areas of moderate to high malaria transmission. IPTp-SP should be initiated as early as possible in the second trimester. IPTp-SP is ideally administered as directly observed therapy and is recommended at each scheduled ANC visit until the time of delivery as long as doses are given at least one month apart
- Assess any pregnant woman with anemia and/or fever who has been exposed to malaria and treat her for malaria according to country guidelines
- An integrated package of interventions is needed to prevent malaria, iron deficiency, and anemia in

pregnancy. To ensure effectiveness of IPTp-SP, the dose of folic acid should be limited to less than 5 mg. Ideally, use a combined daily supplement of iron 60 mg and folic acid 0.4 mg starting as early as possible in pregnancy

SCREENING FOR HIV/AIDS AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

Screening for HIV and prevention of mother-to-child transmission is an essential component of comprehensive MNH services in many countries. An estimated 150,000 children were newly infected with HIV in 2015, over 90% of them through mother-to-child transmission. Without treatment, about half of these HIV positive children will die before their second birthday. Without intervention, the risk of mother-to-child transmission ranges from 15% to 45%. With specific interventions, the risk of transmission can be reduced to less than 2% in non-breastfeeding populations and to 5% or less in breastfeeding populations.

Key recommendations and principles of prevention of mother-to-child transmission (PMTCT):

- Offer all pregnant women voluntary HIV counseling and testing in the first ANC visit. Antiretroviral therapy (ART) should be initiated immediately in women who test positive for the first time once already pregnant, as per the recommendation to initiate ART in all adults living with HIV regardless of WHO clinical stage and CD4 cell count. Ideally pregnant HIV positive women should be initiated on lifelong treatment, but in the absence of this option the national protocol should be observed
- Pregnant women and mothers known to be HIV-positive should be provided with lifelong antiretroviral treatment or antiretroviral (ARV) prophylaxis throughout pregnancy and breastfeeding
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence
- The key to ensuring support within families is involving partners in programs for PMTCT and providing couples counseling and ongoing follow up

See Chapter 11 for the recommended ART regimen to use for pregnant and breastfeeding women.

9.4.5 Coordinating and making linkages

Strong inter-sectoral linkages are needed to provide comprehensive maternal and newborn health services.

Achieving and maintaining adequate water, sanitation and hygiene (WASH) services in health care facilities is critical for infection prevention and control. Clean and safe health care facilities also improve the experience of care, trust in the health system, and demand for services.

Links to mental health and psychosocial support programs are also essential. Depression, anxiety, and other maternal mental health problems are a common cause of disability during and after pregnancy, affecting the quality of life of both mothers and children.

Linkages to gender-based violence (GBV) prevention and response efforts are also essential. Women who experience violence during their pregnancies potentially face a number of complications to maternal and newborn health. Survivors of GBV need integrated and comprehensive care that addresses their legal, psychological and health needs, and the barriers they face in accessing services. Health care providers have an important role to play in both providing care and, in some cases, identifying those who have experienced violence and facilitating linkages to legal and social protection services.

9.4.6 Advocacy

At times, service providers may face difficult decisions or dilemmas when providing MNH information and services. Providing appropriate care may be restricted by national legislation, social or cultural norms, or medical misconceptions. For example, laws on age of marriage may be different for boys and girls and girls may therefore be subject to early and/or forced marriage. Social norms may prevent women from leaving their homes to go to a health facility for MNH services or certain groups of people in a humanitarian setting (e.g., refugees and internally displaced persons (IDPs)) may not be able to access EmONC services through government-sponsored program. Such norms, laws, and practices can be in conflict with internationally accepted human rights principles. SRH

managers or service providers may face such dilemmas and must be aware of agency/organization positions on these SRH issues. This information also needs to be included in the analysis of the situation and possible next steps.

When faced with a difficult situation, SRH Coordinators, health program managers, or service providers should first and foremost give priority to the client's safety and health as well as their own safety and that of colleagues. Next steps may include:

- Talking with a supervisor
- Discussing options with the client
- Finding out if the agency is engaged in advocacy on the issue and ways one can contribute
- Exploring linkages with and referrals to local organizations that might be able to help the client further
- While respecting the confidentiality of the client, working with colleagues and other SRH providers to identify how to avoid/handle such situations in the future
- Raising these concerns in health coordination meetings

9.5 HUMAN RIGHTS

Respectful maternity care (RMC) in humanitarian settings is a woman's right, not a luxury. Ensuring that women are not only satisfied with their experiences of care but have a good birth experience can be the catalyst to ensuring they survive and thrive. Women's experiences with maternal and newborn health services can empower and comfort them, or can inflict lasting damage and emotional trauma. Mistreatment of women in maternity care is a global issue and undermines ongoing efforts to increase skilled birth attendance. Mistreatment is complex with many drivers, including the health system itself and gender inequities. Efforts to reduce mistreatment and advance RMC are integral to improving quality of care.

Respectful maternity care is a universal human right that is due to every childbearing woman in every health system and setting. The Universal Rights of Childbearing Women recognized in the Respectful Maternity Care Charter include:

- The right to be free from harm and ill treatment before, during, and after childbirth
- The right to information, informed consent and refusal, and respect for her choices and preferences (including the right to her choice of companionship during labor and delivery, where possible)
- The right to privacy and confidentiality before, during, and after childbirth
- The right to be treated with dignity and respect before, during, and after childbirth
- The right to equality, freedom from discrimination, and equitable care before, during, and after childbirth
- The right to healthcare and the highest attainable level of health including access to antenatal, delivery, and postpartum care for all mother-baby pairs and all necessary measures to reduce preventable maternal and perinatal mortality and morbidity
- The right to liberty, autonomy, self-determination, and freedom from coercion

The fulfilment of other human rights, such as the right to adequate food, shelter, clean water, information and education, are also key to ensuring the survival and health of mother and child.

9.6 MONITORING AND EVALUATION

9.6.1 MNH service availability and utilization

Ongoing monitoring of MNH services is essential to understand the needs of women and newborns in the acute emergency phase, and whether their needs are being met as response activities progress to providing comprehensive MNH services. Data that are required for monitoring can

be obtained through a variety of mechanisms, which are explained in greater detail in Chapter 5.

In the acute emergency phase, emergency obstetric and newborn care, essential newborn care, and referral pathways are areas of key concern to be assessed and monitored. As programs shift to comprehensive MNH service provision, monitoring efforts should move past tracking the availability of services and begin to assess utilization and quality of provided services. Data related to routine ANC, care during childbirth, post-natal care, and the workforce will, in most cases, be collected through facility-based systems. The registers and aggregated report templates should be standardized and simplified as much as possible. It is important to minimize the burden of monitoring efforts by only requiring the collection of data that will be used to make clinical and programmatic decisions.

Monitoring the existence and functionality of referral pathways is also key to providing quality MNH services in the aftermath of an emergency. Information about referrals received and made should be collected by facilities when possible (through registers or referral forms). Assessments of referral systems will require collaboration with all functioning health facilities and investigation into all requirements for a functional referral system. This will include facility mapping, knowledge of the capacities of each facility, transportation options, and communication channels.

9.6.2 MNH service quality

Quality of MNH services is an area that NGOs and funders are increasingly interested in assessing and monitoring. Quality refers to both the care that is provided as well as the experience of care, which can include the perspective of the provider and the client. There are many aspects of quality of care that can be monitored, from appropriate use of clinical interventions to client satisfaction, and the aspects that can be monitored will be determined by program objectives. To obtain data related to service quality, program managers can utilize facility records but will also need to utilize other data collection means which can include client and provider interviews, facility assessments, direct service observations, and focus groups with clients and/or providers.

MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

Mortality audits and near-miss reviews are tools that can be used to assess quality of care. Reviews of maternal deaths, stillbirths, and neonatal deaths, as well as cases where the woman or baby almost died, are used to identify the factors leading to the complications or death. They also help identify health system breakdowns and can inspire local solutions to prevent such complications or deaths in the future. There are several different techniques that can be used to conduct maternal and perinatal mortality audits and near-miss reviews as part of a comprehensive MNH program. It is extremely important to start the assessments with an understanding that no names will be recorded and no blame will be assigned. This process of mortality audit and feedback, if combined with an action plan and clear targets, shows greater impact on health care practices and outcomes than other quality improvement strategies.

9.6.3 Priority indicators for monitoring MNH services in humanitarian settings

There are many indicators related to MNH that can be utilized to monitor program implementation and progress. In emergency contexts, data collection and monitoring efforts should be limited to necessary information and specific to program activities and goals. The top 11 indicators for monitoring efforts recommended are listed below.

PERCENT OF PREGNANT WOMEN WHO HAD AT LEAST 4 ANTENATAL VISITS DURING PREGNANCY

- Definition: Number of women giving birth who received antenatal care from a skilled provider 4 or more times during pregnancy divided by the total number of live births in a given period
- Purpose/rationale: Antenatal care coverage is the recommended indicator for access to care during pregnancy
- Data collection methods and considerations: Data can be collected from representative household surveys. In some settings, facility data and vital registration systems may also be used

SKILLED BIRTH ATTENDANCE RATE

- Definition: Percent of live births attended by skilled personnel in a given period (number of births attended by doctors/nurses/midwives trained in providing obstetric and newborn care divided by the total number of live births in the same period)
- Purpose/rationale: Most non-abortion-related maternal deaths happen during labor and delivery or within the first few days following birth. Skilled birth attendance rate is the recommended indicator for access to lifesaving care during childbirth
- Data collection methods and considerations: Data can be collected from representative household surveys or demographic/health surveillance systems. In some settings, facility data and vital registration systems may also be used

PERCENT OF WOMEN AND GIRLS GIVING BIRTH AT A FACILITY WHO RECEIVE A UTEROTONIC IMMEDIATELY AFTER BIRTH FOR PREVENTION OF POST-PARTUM HEMORRHAGE

- Definition: Number of women who received a uterotonic (oxytocin or misoprostol) in the third stage of labor divided by the total number of women giving birth in the same period
- Purpose/rationale: Post-partum hemorrhage is the leading cause of maternal mortality in low-income countries and the primary cause of nearly one-quarter of maternal deaths globally. Uterotonic administration immediately after birth is the recommended indicator for quality of care during childbirth
- Data collection methods and considerations: Data should be collected from facility records

PERCENT OF MOTHER-BABY DYADS WHO RECEIVE POSTNATAL CARE WITHIN TWO DAYS OF CHILDBIRTH

- Definition: Number of women/girls and their babies who receive postnatal care within two days of childbirth divided by the total number of women/girls with a live birth in a given period

- Purpose/rationale: Early postnatal care is critical for detection of complications in postpartum women and their newborns. Postnatal care coverage is the recommended indicator for access to postnatal care
- Data collection methods and considerations: Data can be collected from representative household surveys. In some settings, facility records may also be used

AVAILABILITY OF EMONC FACILITIES

- Definition: The number of facilities providing basic and comprehensive obstetric services (known as signal functions) at least once in the previous 3 months per 500,000 population
- Purpose/rationale: This indicator demonstrates the availability of life-saving obstetric care services. It is intended to reflect how facilities are actually functioning and not how they are supposed to function
- Data collection methods and considerations: Data can be collected from facility surveys that examine medical records or service statistics. Interviews with knowledgeable staff who attend obstetric patients are a second, albeit, potentially more biased source of information than written records

CESAREAN SECTIONS AS A PROPORTION OF ALL BIRTHS

- Definition: Number of live births at a facility delivered by caesarean section divided by the number of live births at a facility in a given time
- Rationale: This indicator is a marker of comprehensive emergency obstetric care and provides insight for both maternal and newborn care. If the percentage is high (expected range 5-15%), it may mean that there is use of non-indicated caesarean sections. When aggregated by facility, it may also highlight inequities of human resources, training, and equipment/supplies
- Data collection: Data should be collected from facility records. Women who are transferred to referral health facilities because of obstetric complications should be included, although the ability to obtain that data will depend on the strength of the referral system

DIRECT OBSTETRIC CASE FATALITY RATE (OR INSTITUTIONAL MATERNAL MORTALITY RATE IF CAUSE OF DEATH CANNOT BE CONFIRMED)

- Definition: Number of women giving birth at a facility who die before discharge due to direct obstetric causes divided by the total number of women giving birth at the facility in a given time
- Purpose/rationale: Maternal deaths are rare events, and it may not be practical to conduct large-scale surveys required to estimate maternal mortality at a population level. Direct obstetric case fatality rate is a recommended indicator for the availability and quality of emergency care
- Data collection methods and considerations: The data should be collected from facility records

STILLBIRTH RATE

- Definition: Number of babies born after 28 weeks gestation born with no signs of life divided by the total number of births in a given period
- Purpose/rationale: Stillbirth rate is an important indicator of the quality of care during childbirth
- Data collection methods and considerations: The data should be collected from facility records

EARLY NEONATAL MORTALITY RATE (PRE-DISCHARGE)

- Definition: Number of babies born at a facility that die during the first 24 hours of life (or before discharge if staying less than 24 hours) divided by the total number of live births at that facility in a given period
- Purpose/rationale: Worldwide, nearly 2 million infants die each year around the time of delivery. Early neonatal deaths include neonates born at term who could not be resuscitated, for whom resuscitation was not available, or who had a specific birth trauma, where death occurred within 24 hours of delivery
- Data collection methods and considerations: The data should be collected from facility records

NEONATAL RESUSCITATION RATE

- Definition: Number of babies successfully resuscitated divided by the number of babies born at a facility in a given time period that are not breathing/crying at birth
- Data collection methods and considerations: The data should be collected from facility records

PROPORTION OF BABIES WITH LBW

- Definition: Number of babies born weighing less than 2500 grams divided by the total number of live births in a given period
- Purpose/rationale: Low birth weight is either the result of preterm birth or restricted fetal growth. Risks of neonatal mortality are significantly higher among babies with low birthweight
- Data collection methods and considerations: The data should be collected from facility records

9.7 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 10

GENDER-BASED VIOLENCE

- 10.1 Introduction
 - 10.2 Objectives
 - 10.3 Gender-based violence programming
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 - 10.3.3 Programming considerations for gender-based violence survivors
 - 10.3.4 Psychosocial support considerations for gender-based violence survivors
 - 10.3.5 Coordinating and making linkages
 - 10.3.6 Advocacy
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10.1 INTRODUCTION

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

The term “gender-based violence” (sometimes referred to as “sexual and gender-based violence”) highlights the gendered dimension of these types of acts. In other words, this term highlights the relationship between females' subordinate status in society and their increased vulnerability to violence. Women and girls are the most affected by GBV and thus the term “gender-based violence” is often used interchangeably with the term “violence against women.” However, violence against men and boys may also be gendered and/or sexual in nature, particularly when they are subjected to torture,

detainment, or forced participation as child soldiers. Additionally, the term GBV may also be used to refer to violence targeting lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) persons who face risks as a result of being seen as defying a society's established sexual and gender norms, otherwise referred to as gender non-conforming.

GBV includes:

- Sexual violence, including rape, sexual abuse, sexual exploitation and forced prostitution
- Domestic and intimate partner violence

- Child, early, and forced marriage
- Harmful traditional practices such as female genital cutting, so-called “honor” crimes, and widow inheritance
- Human trafficking, including sex trafficking, child trafficking, and labor trafficking
- Denial of resources and lack of opportunities based on gender, sexual orientation, and/or gender identity
- Harmful acts based on sexual orientation and/or gender identity

BOX 10.1: GENDER-BASED VIOLENCE: SOME DEFINITIONS

SEXUAL VIOLENCE (SV)

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes:

- **Rape/attempted rape**
Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape
- **Sexual abuse**
Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions
- **Sexual exploitation**
Any actual or attempted abuse of a position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)

Domestic violence takes place between current or former intimate partners (spouses, boyfriend/girlfriend) as well as between family members (e.g., mothers-in-law and daughters-in-law). Domestic violence may include sexual, physical, and psychological abuse. Other terms used to refer to domestic violence perpetrated by an intimate partner include “spousal abuse” and “wife battering.”

FEMALE GENITAL CUTTING

FGC constitutes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. These practices are sometimes referred to as “female circumcision” or “female genital mutilation.”

FORCED EARLY MARRIAGE

This occurs when parents or others arrange for and force a minor to marry someone. Force may occur by exerting pressure or by ordering a minor to get married and may be for dowry-related or other reasons. Forced marriage is a form of GBV because the minor is not allowed to, or is not old enough to, make an informed choice.

Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many forms of GBV are illegal and criminal acts in national laws and policies, although these may differ in both content and implementation from country to country. Although responsibility for GBV falls to the protection cluster, prevention of sexual violence, particularly in facilitating safe access to health care and care for survivors of sexual violence, and other medical and mental health care, are under the remit of the health sector/cluster.

The consequences of GBV can be immediate or long-term, resulting directly from violent acts or secondary long-term effects:

- The physical consequences range from relatively

minor injuries to severe injuries leading to death or permanent disabilities and impairments, unintended pregnancies, unsafe abortion, adverse pregnancy outcomes, including miscarriage, low birth weight, and increased rates of fetal death and neonatal and infant mortality, sexually transmitted infections (STIs), including HIV, pelvic inflammatory disease, infertility, and chronic pain syndromes, and urinary tract infections

- Psychological consequences include anxiety, including post-traumatic stress disorder (PTSD), depression, feelings of inferiority, inability to trust, fear, increased substance use and abuse, sleep disturbances, eating disorders, sexual dysfunction, and suicide or self-harm

BOX 10.2: GENDER-BASED VIOLENCE IN HUMANITARIAN SETTINGS

- In the Democratic Republic of the Congo during 2013, the United Nations' Children's Fund (UNICEF) coordinated with partners to provide services to 12,247 GBV survivors; 3,827, approximately 30%, were children, of whom 3,748 were girls and 79 were boys
- In Pakistan following the 2011 floods, 52% of surveyed communities reported that privacy and safety of women and girls was a key concern. In a 2012 protection rapid assessment with conflict-affected internally displaced persons (IDPs), interviewed communities reported that a number of women and girls were facing aggravated domestic violence, forced marriage, early marriages, and exchange marriages, in addition to other cases of gender-based violence
- In Afghanistan, a household survey in 2008 showed that 87.2% of women reported one form of violence in their lifetime and 62% had experienced multiple forms of violence
- In Liberia, a survey of 1,666 adults found that 32.6% of male combatants experienced sexual violence while 16.5% were forced to be sexual servants. Of a sample of 388 Liberian refugee women living in camps in Sierra Leone, 74% reported being sexually abused prior to being displaced; 55% experienced sexual violence during displacement
- Of 64 women with disabilities interviewed in post-conflict Northern Uganda, one third reported experiencing some form of GBV and several had children as a result of rape
- In a 2011 assessment, Somali adolescent girls in the Dadaab refugee complex in Kenya explained that they are in many ways 'under attack' from violence that includes verbal and

physical harassment, sexual exploitation and abuse in relation to meeting their basic needs and rape, including in public and by multiple perpetrators. Girls reported feeling particularly vulnerable to violence while accessing scarce services and resources, such as at water points or while collecting firewood outside the camps

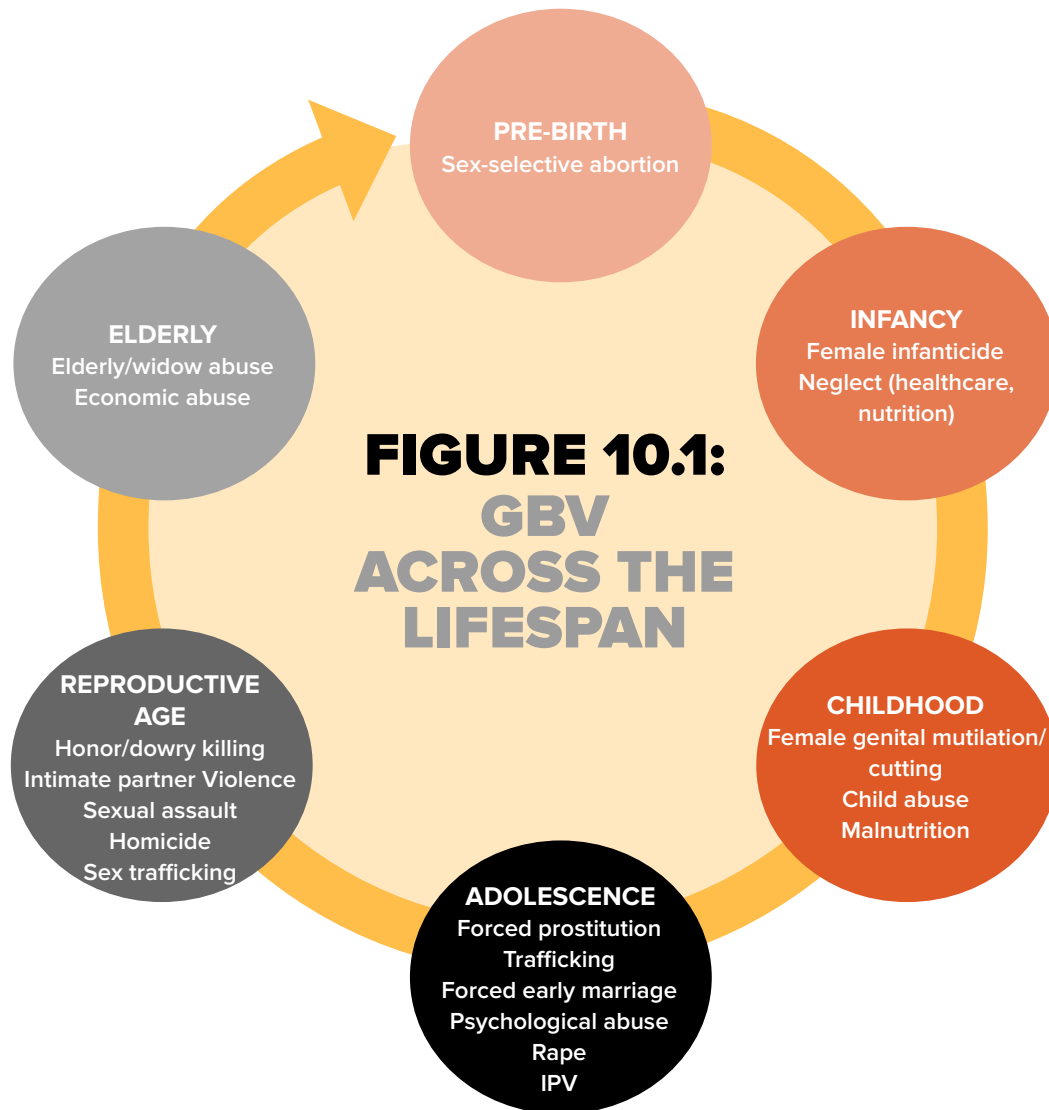
- In Mali, daughters of displaced families from the North (where female genital cutting is not traditionally practiced) were living among host communities in the South (where FGC is common). Many of these girls were ostracized for not having undergone FGC; this led families from the North to feel pressured to perform FGC on their daughters
- Domestic violence was widely reported to have increased in the aftermath of the 2004 Indian Ocean tsunami. One NGO reported a three-fold increase in cases brought to them. Studies from the United States, Canada, New Zealand and Australia also suggest a significant increase in intimate partner violence related to natural disasters
- Research undertaken by the Human Rights Documentation Unit and the Burmese Women's Union in 2000 concluded that an estimated 40,000 Burmese women are trafficked each year into Thailand's factories and brothels and as domestic workers
- The Gender-Based Violence Information Management System (GBVIMS), initiated in Colombia in 2011 to improve survivor access to care, has collected GBV incident data from 7 municipalities. As of mid-2014, 3,499 females (92.6% of whom were 18 years or older) and 437 males (91.8% of whom were 18 years or older) were recorded in the GBVIMS, of whom over 3,000 received assistance

- GBV also has a large impact on the social health of the individual and the community in terms of stigma, isolation, and rejection of survivors and children born as a result of rape (including by husbands and families), losses in women’s income potential, interrupted education of adolescents, and homicide (e.g., so called “honor” killings and female infanticide)

Although GBV is a global issue the nature and extent of

specific types of GBV vary across countries and regions. GBV is often underreported, but various forms of GBV have been documented during humanitarian crises and it should be assumed that GBV is occurring from the start of a crisis regardless of whether prevalence data are available.

Gender-based violence may occur throughout and across the life cycle (see Fig. 10.1). Some people are more vulnerable than others based on their membership in different identity groups.



10.2 OBJECTIVES

This chapter focuses on the responsibility of sexual and reproductive health (SRH) Coordinators, health program managers, and service providers in preventing and

responding to GBV-related health consequences. The objectives of this chapter are to assist them to understand:

- How GBV can take a range of forms and affect different subpopulations
- The roles and responsibilities of the health sector in responding to GBV in humanitarian settings

- The multi-sectoral approach to prevent and respond to GBV
- How to support the integration of GBV prevention and response elements into the health sector/cluster

10.3 GENDER-BASED VIOLENCE PROGRAMMING

10.3.1 Minimum Initial Service Package implementation

Health services are often the first - and sometimes the only - point of contact for survivors seeking assistance for GBV. From the earliest stages of an emergency, health actors must work to prevent and provide clinical care for survivors of sexual violence per the Minimum Initial Service Package (MISP). Preventing sexual violence and responding to the needs of survivors is a core objective of the MISP. Priority activities center on: 1) Working with other clusters, especially the protection or gender-based violence sub-cluster, to put in place preventive measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence; 2) Making clinical care and referral to other supportive services available for survivors of sexual violence; and 3) Putting in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

As soon as possible, health sector actors should be equipped to provide clinical care to survivors of all types of GBV and make referrals as necessary to other relevant services. Crucial to providing accessible and quality healthcare services for GBV survivors, is ensuring their delivery in a safe, confidential, dignified and non-discriminatory manner that considers the survivor's gender, age, and any specific needs.

10.3.2 Needs assessment

While assessments are an important foundation for program design and implementation, they are not a prerequisite for putting in place some essential GBV prevention, mitigation, and response measures prior to or from the

onset of an emergency. Many risk-reduction interventions can be introduced without conducting an assessment. For example, health sector actors can implement the MISP at the onset of every emergency.

Integrate GBV considerations into needs assessments for comprehensive SRH service planning. Within the multi-sectoral framework, SRH Coordinators and health program managers are part of the Health sector/cluster and must collaborate with other sector/cluster actors involved in GBV programming to collect the following information:

AT THE COMMUNITY LEVEL

- Level of awareness about the health consequences of GBV and when and where to access relevant health services
- Level of awareness of GBV-related services and resources among populations at-risk

AT THE PROGRAM LEVEL

- International and local actors working on GBV
- The existence of national, multi-sectoral and interagency operating procedures, protocols, practices, and reporting forms
- Location and type of services providing care for survivors of GBV (health, community support, social, psychological, legal)
- The extent of adherence to ethical and safety standards in health services (safety, privacy, confidentiality, respect)
- SRH program staff and healthcare provider training needs
- Availability of supplies to care for survivors of sexual violence, including emergency contraception (EC), post-exposure prophylaxis (PEP), and medicines and manual vacuum aspiration (MVA) equipment for safe abortion care to the full extent of the law
- GBV data collected at the facility-level

AT THE NATIONAL LEVEL

- National protocols related to GBV medical care and referral

- National laws related to GBV and types of GBV mentioned
- National plans/policies to eliminate GBV. What types of GBV does the plan target?
- The legal definition of rape. The legal age of consent for sexual activity. Does it differ for boys and girls?
- Mandatory reporting laws for cases of sexual abuse and sexual assault
- National laws on abortion in the context of rape and incest
- Cadres of health service providers authorized to collect forensic evidence and the range of forensic evidence admissible in courts of law

It is generally accepted that GBV, and in particular sexual violence, is underreported almost everywhere in the world. Survivors fear potentially harmful social, physical,

psychological, or legal consequences if they disclose the event. In settings characterized by instability, insecurity, loss of autonomy, breakdown of law and order, and widespread disruption of community and family support systems, disclosure is even less likely. Any available data, in any setting, about GBV reports from police, legal, health or other sources will represent only the small proportion of survivors who choose to self-report and should not be used to establish prevalence or incidence or to make conclusions about common types of GBV.

Any inquiry into sexual violence and other forms of GBV must be designed and carried out with an understanding of the situation and take into consideration how the information will be used, who will see it, how the information will be reported, to whom and for what purpose and who will benefit from it. Consider ethical and safety issues at all times when involved in collecting, analyzing and reporting on GBV information.

BOX 10.3: SAFETY, ETHICAL, AND METHODOLOGICAL RECOMMENDATIONS FOR DOCUMENTING AND SHARING INFORMATION ON GBV CASES REPORTED TO SRH SERVICES

WHEN DOCUMENTING INFORMATION

- Basic care and support for survivors must be available before commencing any activity that may involve individuals disclosing information about their experiences of GBV
- The safety and security of service providers involved in gathering information about GBV is of paramount concern and in humanitarian settings in particular should be continuously monitored
- The confidentiality of individuals who provide information about GBV must be protected at all times and they must give informed consent before their information is documented
- SRH service providers caring for GBV survivors must be carefully selected and receive relevant and sufficient specialized training and ongoing support
- Staff must be trained on and held accountable for adhering to data protection protocols
- Additional safeguards must be put into place if children (i.e., those under 18 years) are involved

WHEN SHARING DATA

- Keep in mind the audience and possible use of the data and offer guidance on interpretation of the data
- Provide the context for all reported data. If known, and safe to do so, provide information on the camps/clinics/districts from where cases are reported. Be specific, e.g., “reported cases from X number of health facilities”
- Only share a comprehensive description of the incident if this cannot be linked back to individual survivors (precise date and location, information on the victim, ethnicity, age, sex, medical findings, should only be included when safe to do so)
- Provide additional information that may have contributed to changes in the number of reported cases from the previous reporting period. For example, more services available, public information campaigns, upsurge in violent attacks. Whenever possible, information on when incidents took place should be collected and the information reported along with aggregated numbers
- Label all tables and reports appropriately to avoid the information being taken out of context

10.3.3 Programming considerations for GBV survivors

Health programming approaches to prevent, mitigate, and respond to GBV must be adapted to the changing nature of emergencies, including the increasing urbanization of internally displaced, migrant, and refugee populations, protracted emergencies especially in fragile states, as well

adaptions to both slow and sudden onset emergencies. Furthermore, strategies for coverage and access for non-camp settings, rural areas, and more inaccessible settings (e.g., areas under siege, high security contexts) must be considered and addressed. Table 10.1 presents key actions for preventing and responding to GBV at different stages of emergency.

TABLE 10.1: KEY ACTIONS FOR HEALTH ACTORS TO PREVENT AND RESPOND TO GBV

KEY ACTIONS	PREPAREDNESS	RESPONSE	RECOVERY
Ensure women and adolescent girls have immediate access to priority reproductive health services as outlined in the MISP at the onset of an emergency		X	
Ensure GBV survivors have access to high-quality, life-saving health care, including post-rape treatment and clinical care for other forms of GBV		X	X
After the immediate onset and during transition phases, re-establish comprehensive reproductive health services, including GBV treatment and referral systems			X
Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming (with due caution where this poses a potential security risk or increases the risk of GBV)	X	X	X
Pre-position trained staff and appropriate supplies to implement clinical care for GBV survivors in a variety of health delivery systems (e.g., medical drugs, equipment, administrative supplies, mental health and psychosocial support, referrals, etc.)	X	X	
Develop and/or standardize protocols and policies for GBV-related health programming, in partnership with Ministry of Health, as feasible, and civil society actors including women's rights groups, to ensure integrated, quality care for survivors	X	X	X
Enhance the capacity of health providers to deliver quality care which is age, gender and culturally appropriate to survivors through training, support and supervision on GBV prevention and clinical care for sexual assault and other forms of GBV. Ensure a clear focus on clinical and attitudinal competencies for child-friendly care and to promote access and recovery for both male and female survivors	X	X	X
Promote integration of available health services in GBV standard operating procedures and/or referral pathways; promote quality of care assessments as context allows	X	X	X
Assess and address the accessibility of health and reproductive health facilities that integrate GBV-related services (e.g., provide safe and confidential escorts to facilities, make opening times convenient, ensure universal access for persons with disabilities, eliminate service fees, etc.)	X	X	X
Implement strategies that maximize the quality of survivor care at health facilities (e.g., implement standardized guidelines for the clinical care of sexual assault; establish private consultation rooms; maintain adequate supplies and medical drugs; provide follow-up services, etc.)		X	X
Ensure information sharing and coordination between health and GBV working groups, including identifying joint actions to address GBV risks and ensure protection for women, girls and other at-risk groups and provide quality health services to GBV survivors		X	X
Seek out the GBV coordination mechanism for support and guidance and, whenever possible, assign a focal point to regularly participate in GBV working group meetings		X	X
Identify, collect and analyze a core set of indicators - disaggregated by sex, age, disability and other relevant vulnerability factors - to monitor GBV risk-reduction activities throughout the program cycle	X	X	X

SRH Coordinators and health program managers must ensure that service providers are trained to provide competent, confidential, and compassionate clinical care for survivors of sexual violence and that they have the supplies to do so. This section outlines different types of GBV and their SRH consequences as well as specific prevention and response strategies.

SEXUAL VIOLENCE

Sexual violence takes many forms and includes rape, sexual harassment, forced pregnancies/abortions, sexual exploitation, and sex-trafficking. Sexual violence is often referred to as any non-consensual sexual act, attempt to obtain a sexual act, unwanted sexual comments, or advances directed against a person's sexuality.

Individuals displaced, living in conflict and other emergency settings face increased vulnerability to sexual violence. For these populations, violence may occur within the context of war or conflict, during transit and displacement, and in the camp/settlement setting. Due to the breakdown of family and social structures and changes to law enforcement and protective structures, loss of secure housing, limited economic opportunities and instability, conflict- or crisis-affected populations face an increased risk of opportunistic sexual violence by both known or unknown perpetrators. Moreover, in some conflict or post-conflict settings, sexual violence is used as a tactic of war. It is estimated that more than 1 in 5 women/girls experience sexual violence during displacement in their lifetime. This is likely an underestimate due in part to lack of awareness of available services and stigma associated with reporting these violations.

At a minimum, health facilities in humanitarian settings are expected to establish basic clinical care according to the MISP guidelines and referral for psychosocial and protection services for survivors of sexual violence. Typically access to these services for survivors requires that survivors or family members and communities seek out services and disclose the sexual abuse. Some of the barriers survivors face are lack of knowledge around available services and the importance of timely care. Furthermore, the survivors need to trust in the confidentiality, privacy, and compassion of the health provider at facility level. These are some of the reasons why sexual violence continues to be under-reported, services under-utilized, and victimization of

sexual violence survivors continues in humanitarian settings.

Impact on health

Sexual violence is among the most pervasive forms of violence and is a major public health concern. It is a traumatic experience that may have a variety of negative consequences on women's psychological, physical, sexual, and reproductive health.

The negative health impacts of sexual violence may be both short- and long-term and may include:

- Physical injury
- Psychological disorders
- STIs including HIV
- Unintended pregnancy and unsafe abortion
- Fistula and chronic pain
- Death

Death may result directly as a result of violence or as the result of suicide after the event. Further, sexual violence survivors may also be at risk of being killed by family members or members of the community, a practice that is sometimes referred to as an "honor killing."

Sexual violence diminishes the ability of women and girls, along with other at-risk populations, to meaningfully participate in development, peacekeeping, educational opportunities, and economic activities. Entire communities suffer deeply due to the multi-layered impacts of sexual violence.

SRH response

The health sector's responsibilities when responding to sexual violence are to:

- Ensure that health facilities are equipped and staffed and that high quality, life-saving health services including post-rape care are available
- Enhance the capacity of health providers at all levels to respond to survivors through training, support, and supervision in a non-discriminatory, confidential, and safe manner

- Through training, support, and supervision, providers should be sensitized to address issues such as counseling for and providing emergency contraception and comprehensive safe abortion care, virginity testing as medical malpractice, and caring for girls, boys, men, LGBTQIA individuals, and other marginalized groups
- Ensure the health sector actively participates in the development and continual update of a functional and comprehensive referral pathway that takes all needs of survivors into account
- Ensure that standards and protocols for prevention and treatment of consequences of sexual violence including documentation and information sharing in a confidential manner are in line with international guidelines and that these are properly and consistently implemented

Healthcare providers frequently come into contact with survivors of sexual violence and are in a unique position to create a safe and confidential environment for survivors to disclose their experiences of violence. Sometimes the survivors will need clinical care to prevent or treat consequences of sexual violence and in some cases the appropriate support will be referral to other resources and services depending on the survivor's needs and wishes. Irrespective of the circumstances, healthcare providers who come into contact with survivors need to be sensitive to signs and symptoms of sexual violence and act appropriately.

DOMESTIC AND INTIMATE PARTNER VIOLENCE

The World Health Organization (WHO) defines IPV as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Intimate partner violence is considered one form of domestic violence, which also includes other forms of violence that takes place in the home or family, such as child or elder abuse and abuse from other relatives. Globally, 1 in 3 women is beaten, coerced into sex, or otherwise abused by a past or current intimate partner in the course of her lifetime.

Economic coercion is a form of IPV where one partner, typically the male partner in a heterosexual relationship,

controls vital resources and assets of the other partner compelling that individual into some course of action. Frequently, economic coercion limits a woman's ability to leave an abusive relationship and fosters dependence. This is particularly true in emergencies where social and economic systems are destabilized, as well as in camp settings where access to and control of resources is important.

Impact on health

Domestic and intimate partner violence impacts the survivor in a myriad of ways. These can include, but are not limited to:

- Physical injury, including breaks, bruises, sexual assault, and other forms of trauma
- Psychological disorders, including depression, PTSD, and suicide
- STIs including HIV
- Miscarriage and pregnancy loss
- Forced pregnancy, unintended pregnancy, and unsafe abortion
- Death

SRH response

Service providers and healthcare personnel can play a strategic role in detecting, referring, and caring for women living with violence. The response steps below are a minimum response, to be expanded quickly to comprehensive care as soon as possible. It is also important that care be provided in a sensitive way, meeting the needs of increasingly vulnerable populations (women, adolescents, young boys, elderly persons, persons with disabilities, LGBTQIA people, etc.).

Detection

Abused women often seek health care, even when they do not disclose the violent event. Thus, interventions by SRH providers can potentially mitigate both the short- and long-term health effects of GBV on women and their families.

Train all SRH providers to recognize signs of domestic and intimate partner violence and how to respond to suspected or reported abuse. If abuse is suspected (for example if

the provider sees unexplained bruises or other injuries), SRH professionals may probe for more information in a private, caring, and nonjudgmental manner. For example: “Has your partner or another person important to you ever hurt or physically harmed you in any way (such as hitting, kicking or burning you)?” or “Are you afraid of your partner?” Maintain confidentiality because the survivor and/or other relatives could be subjected to further harm. Make sure the survivor has a safe place to go to. If she has to return to the abuser, retaliation may follow. If a safe place is not immediately available, work with the survivor to develop an alternative safety plan.

In collaboration with Health Coordinators, ensure that:

- All clinic and reception staff are aware of domestic and intimate partner violence
- All staff understand and apply the four guiding principles of safety, respect, confidentiality, and non-discrimination
- Posters and leaflets that condemn violence and information on support groups are displayed

Referrals

Train all SRH providers to refer cases of domestic and intimate partner violence by doing the following:

- If the abuser learns that the matter has been reported, help the survivor to assess her present risk for harm: “Are you or your children in immediate danger?” “Do you feel safe to go home?” “Would you like some help with the situation at home?”
- Offer information and referral for legal advice, social support, or other services. Help her to identify sources of support such as family and friends, local women’s groups, shelters, and legal services. Make it clear to the survivor that she is not alone
- Refer her for post-rape services or other medical treatment as needed
- Refer her to psychosocial services and mental health support if available

Care

Domestic or intimate partner violence often includes sexual violence and survivors should receive care accordingly.

In addition, care for domestic and IPV survivors should include:

- Providing first line support using a survivor-centered approach
- Being equipped to provide 24/7 emergency care and treating acute injuries
- Referring to appropriate and available mental health services

HARMFUL PRACTICES

The term “harmful practices” may refer to various abuses of the rights of women and girls including, but not limited to, female infanticide, child, early, and forced marriage, female genital cutting (FGC), and so-called “honor” crimes. Harmful practices can be understood as social conventions upheld by deeply-rooted discriminatory gender, social, and cultural norms and inequalities, beliefs relating to women’s position within the home and society, women’s sexual morality, and, in some cases, marriageability. Conflict or crisis settings exacerbate the risk of some of these harmful practices. Due to their high prevalence globally and specific impact on the SRH of women and girls, this section focuses on the issues of FGC and child, early, and forced marriage.

FEMALE GENITAL CUTTING

It is estimated that over 200 million girls and women have undergone some form of FGC and 3 million girls are at risk of being subjected to the practice each year. The majority of these girls and women live in Africa, although the practice is also prevalent in certain countries in the Middle East and North Africa, Asia, and other regions. SRH Coordinators and health program managers must be aware that FGC and health consequences related to FGC may be common among the population in the setting in which they work. FGC, regardless of the type (see Box 10.4), constitutes an extreme form of discrimination against women and is a violation of human rights. Approximately 10% of women and girls who are subjected to FGC undergo Type III, the most severe form.

BOX 10.4: FGC CLASSIFICATIONS ACCORDING TO THE WHO

TYPE I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
TYPE II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
TYPE III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
TYPE IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization

FGC is often performed by traditional practitioners with limited knowledge of anatomy and medicine, who may be unable to effectively respond when complications arise. Professional medical practitioners may also be asked to perform FGC, out of a belief that it will make the procedure safer. The WHO urges health professionals not to legitimize the practice by performing any form of FGC, including re-infibulation, which is the sewing of the external labia back together after a deinfibulation, or opening of the labia, has been performed to allow for sexual intercourse or child birth.

BOX 10.5: KEY MESSAGE

The medicalization of FGC - willful damage by health professionals to healthy organs for nontherapeutic reasons - is a misguided and unethical step that fails to address the fundamental injustice of FGM.

Impacts of FGC on SRH

There are no health benefits to girls and women from FGC and those who experience it are at risk for a number of immediate and long-term health consequences that may impact them throughout the course of their lives.

Immediate complications include:

- Hemorrhage (one of the most common complications), pain, shock
- Infections, including local infections, abscess

formation, septicemia, genital and reproductive tract infections, urinary tract infections, and transmission HIV or other infections from the use of unsanitary tools

- Urine retention
- Issues with the wound healing
- Injury to neighboring organs, such as the urethra, vagina, or rectum
- Death

Long-term complications include:

- Menstrual difficulties, including dysmenorrhea, irregular menses, and difficulty passing menstrual blood
- Pain and/or difficulty in passing urine
- Recurrent urinary tract infections
- Chronic pelvic infections which may increase the risk of ectopic pregnancy or infertility
- Abscesses and cysts
- Possible increased risk of transmission of HIV
- Reduced sexual sensitivity and painful intercourse

Problems during pregnancy and childbirth are common in women who have undergone Type III FGC. Obstetric complications include prolonged or obstructed labor,

caesarean section, obstetric lacerations, hemorrhage, and infection. The causal relationship between prolonged and/or obstructed labor and obstetric fistula suggests that some forms of FGC may also lead to an increased risk of fistula. These various complications are also associated with higher incidence of stillbirth and neonatal death, as well as fetal asphyxiation.

The trauma of FGC may have long-term psychological impacts. The procedure, and the physical health consequences resulting from it, are associated with issues such as anxiety, depression and post-traumatic stress disorder. The physical and psychological impact of FGC may for some also contribute to the development of problems in sexual relationships.

It is important to remember that not all women who have undergone FGC will experience any particular related health problem. On the other hand, women may be unaware that the health problems they suffer are the result of FGC.

SRH response

SRH service providers must be able to interview and conduct a physical examination of women who have undergone FGC, recognize and provide appropriate information, counseling, support, treatment and/or referral for further management of the complications of FGC in a confidential, private, and non-judgmental manner (see Chapter 9).

Maternal and newborn health

Ensure SRH service providers who have midwifery duties are trained to assess and manage women with complications due to FGC during pregnancy, labor and delivery, and the post-partum period. This includes deinfibulation and infant resuscitation at delivery.

Deinfibulation

In settings where Type III FGC is common, SRH Coordinators and health program managers must ensure that service providers are trained in deinfibulation (opening up an infibulation) when indicated, or know when and where to refer for this procedure. In addition to being performed to allow for intercourse, this procedure is recommended for preventing and treating obstetric complications, facilitating childbirth, and preventing and treating urologic complications, including urinary tract

infections and urine retention. Providers should ensure clients undergoing deinfibulation for childbirth or other reasons have information on the health consequences of re-infibulation (procedure to narrow the vaginal opening in a woman after she has been deinfibulated) and the benefits of not re-infibulating. Deinfibulation, performed with informed consent, may also be viewed as an attempt to restore a woman's right to the highest attainable standard of health.

Contraception

Contraception is as appropriate for girls and women with FGC as it is for any other client. Women who have undergone Type III FGC may have difficulties in using a method that has to be inserted vaginally, such as an intrauterine device (IUD), female condoms, or vaginal rings. This highlights the importance for contraceptive counseling and method mix.

CHILD, EARLY, AND FORCED MARRIAGE

Each year approximately 15 million girls globally are married before their 18th birthday. Although child marriage occurs in communities around the world, the majority of these marriages are concentrated in developing countries, where 1 in 3 girls is married before 18 and 1 in 9 is married before age 15. There is increasing evidence to suggest that child marriage often increases during times of crisis.

In addition to gender or cultural norms, socioeconomic factors, including dowries, bride price, or a lack of resources to care for daughters, often also play a role in families' decisions to marry off girls. During humanitarian emergencies families often experience loss of livelihoods and may struggle to provide the food and other resources needed to take care of children, amplifying the economic factors that lead to child marriage. Furthermore, some families may seek to marry off girls to those they feel are better able to provide for them during the crisis, or perceive marriage as a means of protection from other forms of violence, including sexual violence, which increases during emergencies. Preventing and responding to child, early, and forced marriage requires an inter-sectoral response.

Impact of child, early, and forced marriage on SRH

Child, early, and forced marriage violate a number of

human rights, including the right to the highest attainable standard of health.

Early pregnancy

Young brides often face pressure to prove their fertility by becoming pregnant soon after marriage. This pressure, exacerbated by the unequal power dynamics within early marriages, limits girls' decision-making, and a lack of information about the contraception options that are available to them often leads to early pregnancy. The stress of pregnancy, labor, and delivery on the bodies of adolescent girls who have not yet reached physical maturity heightens their risk of complications, including miscarriage, pre-term birth, post-partum hemorrhage, prolonged and/or obstructed labor, obstetric fistula, and death. Maternal mortality is the second leading cause of death among adolescent girls between the ages of 15-19 worldwide.

HIV/STIs

Married girls are often significantly younger (often more than 10 years younger) than their husbands, who may have had more sexual partners and therefore have a greater risk of carrying and passing on sexually transmitted infections, including HIV, to their brides. Power differentials that may exist between husbands and wives, due to gender norms, and inequality are also often compounded by age differences and as a result girls may be unable to refuse sex or negotiate safer sex.

Increased risk of other forms of violence

In addition to child marriage being a form of gender-based violence, evidence has shown that girls who marry at a young age are more likely to experience sexual or physical violence within the home.

SRH response

As married adolescent girls are frequently isolated at home, they are often hard to reach with information and/or services (which are typically tailored to older women or unmarried adolescents) despite their need (see Chapter 6).

Antenatal and obstetric care

Adolescent girls, regardless of marital status or other factors, are often less likely to seek antenatal care (ANC)

than those in their twenties or thirties. However, ANC can help to identify pregnancy complications early, including anemia and hypertension, and provide young girls (and family members) experiencing their first pregnancy the opportunity to learn to recognize the signs of complications.

Due to the high risk of delivery complications, including prolonged and/or obstructed labor, adolescent girls should be urged to, if at all possible, deliver with the assistance of a skilled birth attendant.

Contraception

Married adolescents have the same right as other women and girls to access family planning information services, including a full range of contraceptive methods. Providers should ensure that adolescent girls are made aware of these services and how to access them. Post-partum contraceptive planning counseling can provide an opportunity to inform girls of the benefits of family planning and birth spacing. As with other services respectful and confidential care is vital.

HUMAN TRAFFICKING

BOX 10.6: HUMAN TRAFFICKING IN HUMANITARIAN CONTEXTS

Among the factors that increase trafficking risks for refugees are their physical insecurity; social, economic and political marginalization; victimization by smugglers facilitating refugee movement; experience with sexual violence; social isolation or other negative consequences resulting from sexual violence; pressure to engage in survival sex; severe disruptions to family structure; and lack of legal protection.

Human trafficking is an additional risk facing women and girl refugees in urban and camp settings. Unaccompanied children who are refugees are at a greater risk of abuse and human trafficking. According to the United Nations (UN), human trafficking is the “recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving

of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.” Sex trafficking has the most direct relation to sexual and reproductive health, although other forms of trafficking (i.e., forced labor) may also negatively impact overall health status.

Reliable data on human trafficking is difficult to obtain and verify, due to variations in definitions, invisibility and illegality of the activity itself, and conflation with other activities, such as sex work.

Based on current, reliable evidence, those who are trafficked into the sex industry and as domestic servants are more likely to be women and children. Reports on trafficking of males indicate that men and boys are more commonly trafficked for various other forms of labor, and that these trafficking sectors generally differ by country or region.

Impacts on health

Many of the SRH implications of human trafficking are due to sexual violence. However, other impacts that have consequences for SRH include forced or coerced use of drugs or alcohol, social restrictions, and/or emotional manipulation.

SRH response

If a person has been trafficked, chances are SRH care will be responsive rather than preventive. People who have been trafficked should be provided with a full range of SRH services, as needed and as warranted by the circumstances, as well as psychosocial supports. It is essential that service providers offer non-stigmatized physical care and examinations.

10.3.4 Psychosocial support considerations for GBV survivors

Many survivors experience long-lasting psychological and social effects, although the impact of GBV can vary from person to person. The psychological consequences of GBV can inhibit a survivor’s functioning and well-being, not only personally, but in relationships with family members, and can even extend to the wider community.

Social stigma, isolation, and rejection, including by

intimate partners, spouses, and families, are serious consequences, often making emotional recovery difficult due to withdrawal from day-to-day activities and from social support. Most societies blame victims of sexual violence for the incident which can socially isolate them and prolong or prevent recovery, the effects of which can be compounded across generations, especially with children born as a result of rape. Furthermore, IPV, early marriage, FGC and other harmful practices are socially normalized in many communities and societies. Therefore, survivors of GBV or those not complying with these harmful social practices may face exclusion and risk different forms of emotional and physical violence.

The range of psychological consequences for individual survivors vary across anxiety and fear, depression, anger, self-blame, flashbacks and nightmares, feelings of powerlessness, sexual problems, and mood swings. For most survivors, these experiences are normal emotional responses to trauma. These psychosocial effects can last for years, causing prolonged suffering, and may sometimes lead to self-harm or even attempted suicide. With social and emotional support, many survivors learn to cope and the distress decreases over time. However, ongoing professional psychosocial and mental health care can be very important for survivors and if possible, all survivors should be offered to be referred to trained counselors who can provide professional psychological evaluation and care.

THE SURVIVOR’S HEALING PROCESS BEGINS FROM THE FIRST VISIT TO THE CLINIC

SRH service providers must ensure close coordination between clinical and psychosocial support services to enable staff to provide the survivor with referral to psychosocial or mental health services. Psychosocial support should begin from the very first encounter with the survivor. Providers at all health and community services must be trained to listen and provide emotional support whenever a survivor discloses or implies that she has experienced GBV, give information, provide options for psychosocial referral and help the survivor to start to regain a sense of dignity and control.

BOX 10.7: KEY MESSAGES WHEN PROVIDING CARE TO SEXUAL VIOLENCE SURVIVORS

- The survivor is not to blame for the assault
- The survivor may experience a series of confusing emotions that may take some time to go away
- The survivor's response is normal and understandable given what has happened to her/him/them
- Early medical care will help prevent serious physical problems
- The survivor is not alone. Talking about the experience often helps people
- Let the survivor know what sources of support are available to her/him/them and that it is her/his/their choice to access these support services
- Ensure that the survivor knows the information about the assault will be kept confidential and that she/he/they do not need to share the story to access services

The behaviors and attitudes of health staff that the survivor comes into contact with can play a significant role in the survivor's recovery. It is essential that health staff are trained to provide rights-based and compassionate care for survivors which includes dispelling myths and misconceptions surrounding sexual violence and other forms of GBV. This includes practically addressing victim-blaming, and other practices (i.e., invasive techniques not medically indicated such as speculum examination or virginity testing) that can re-traumatize survivors. Multiple and intrusive interviews about the incident can also re-traumatize the survivor and should not be required to access services. Survivors should be protected from having to repeat their story to multiple staff members from within the same service or different organizations. They should also be protected from participating in coerced interviews with media or different government authorities. Health staff must be trained in child-friendly techniques for providing quality care to child and adolescent survivors. Furthermore, non-discrimination and stigma reduction training must be integrated into clinical capacity building for all staff working with female and male survivors, persons engaged in sex work, LGBTQIA populations,

persons with disabilities, and other marginalized groups.

In most cultural settings, the support of family and friends is likely to be a key factor in overcoming the trauma of violence. Providers must facilitate participation and integration of survivors in the community. Community-based activities that can be appropriate are:

- Identify and train appropriate existing resources in the community, such as traditional birth attendants, midwives, women's groups, religious leaders, and community services programs to know how to support survivors
- Develop women's support groups, including providing training to or specific support for integrated or marginalized community self-help groups such as persons with disabilities or LGBTQIA persons. In some contexts it may be appropriate to have support groups specifically designed for survivors of sexual violence and their families; however, great care must be taken not to increase social stigma by singling out one group of people
- Create special drop-in centers and spaces for survivors where they can receive confidential and compassionate care
- Provide material support as needed via health or other community services
- Encourage use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors. Many such practices can be extremely beneficial; however, ensure that they do not perpetuate blaming-the-victim or otherwise contribute to further physical or psychological harm to the survivor

These activities must be culturally appropriate and must be developed after consultation (and if possible in cooperation) with community members. They will need ongoing financial and logistical support and, where appropriate, training and supervision.

Psychosocial supports are also needed for survivors of FGC and women who were forced into early marriage. The organization and labelling of such support must be adapted because FGC and early marriage are often

socially sanctioned and people may not see themselves as survivors.

10.3.5 Coordinating and making linkages

True comprehensive care to survivors comes from 4 separate sectors including health, police and justice, social services, and coordination and governance. Protection, health, GBV, and wider service institutions must work in a coordinated way to provide survivor-centered care for those impacted by GBV.

To date, the multi-sectoral programming model forms the “best practice” for prevention of and response to GBV in humanitarian settings. Key characteristics of the multi-sectoral model include full engagement of the affected community, interdisciplinary and inter-organizational cooperation and collaboration and coordination among health, psychological, legal, and security services when responding to the needs of survivors of GBV.

The underlying principle of this model recognizes the rights and needs of survivors of GBV as paramount in terms of access to respectful and supportive services, guaranteed confidentiality and safety, and the ability to determine a course of action for addressing the GBV incident, based on the individual survivor’s needs and wishes.

Because of the importance of multi-sectoral collaboration in GBV programming, SRH Coordinators and health program managers must actively participate in a process to clarify roles and responsibilities and collaboration within and among sectors to prevent and respond to GBV. The outcome of this process is sometimes referred to as standard operating procedures (SOPs) for GBV. Developing agreed-upon SOPs must be a collaborative process that occurs through a series of consultations with key stakeholders and actors in the setting.

While all sectors/clusters have a role to play in prevention of and response to GBV, at a minimum, this process should include representatives from health, psychosocial, safety/security and legal/justice/protection sectors (UN agencies, national and international NGOs, community-based organizations, and relevant government authorities when appropriate).

Representatives from other sectors/clusters (including education, food and nutrition, camp management/shelter/

site planning and water/sanitation) should also participate in the development of SOPs.

Within the multi-sectoral model, the responsibilities of the health sector/cluster include:

- Provide clinical care to men, women, and child survivors of sexual violence and other types of GBV
- Ensure drugs (emergency contraception) and supplies (post-rape kits and medicines and MVA equipment to support safe abortion care to the full extent of the law) are available and staff has been properly trained in the health facility
- Document findings in an objective and non-judgmental manner in standard intake forms according to WHO recommendations
- Collect forensic evidence where appropriate (see Chapter 3) and if informed consent is given
- Provide testimony in cases where a survivor chooses to pursue legal action
- Identify survivors of various types of GBV and offer referral to appropriate services
- Conduct GBV awareness sessions at community and facility levels

10.3.6 Advocacy

In order to prevent GBV from occurring, SRH Coordinators and health program managers must work in close collaboration with local stakeholders, particularly women’s non-governmental organizations, as well as professional organizations, aiming at a joint decision by the community to abandon these practices. Organize discussion and information sharing in the community aimed at empowerment, realization of girls’ and women’s human rights, and providing information on impacts on women and girl’s health and rights and the harmful consequences of the practices and the benefits of abandoning them.

All agencies should advocate for the enactment and/or enforcement of national laws against GBV in accordance with international legal obligations, including prosecution of offenders and the implementation of legal measures to protect and support the survivor.

10.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

GBV is a violation of fundamental human rights and can be a serious impediment to the realization of human rights and fundamental freedoms. These include the rights to:

- Life, liberty, and security of the person. This right is at risk when a person is subjected to GBV forms including SV, IPV, and FGC
- The highest attainable standard of physical and mental health. For example, this right may be restricted if a person is denied access to appropriate medical care following rape or if a girl child is forced into early marriage
- Freedom from torture or cruel, inhuman, or degrading treatment or punishment
- Freedom from all forms of discrimination, including on the basis of sex, gender, gender identity and expression, and sexual orientation. This right may be threatened when laws fail to protect women and girls from GBV and/or where they must be accompanied by a husband or father to obtain medical treatment after rape. All forms of violence against women are a manifestation of gender-based discrimination against them
- Enter into marriage with free and full consent and the entitlement to equal rights to marry, during marriage and at its dissolution. Forced marriage is a denial of this right as is marital rape

PROGRAMMATIC EXAMPLE 10.1: BARRIERS TO SRH CARE AND EXPERIENCES OF UNINTENDED PREGNANCY AMONG YOUNG WOMEN IN NICARAGUA

ORGANIZATION: Center for Humanitarian Emergencies, Emory University

LOCATION: Nicaragua

INTRODUCTION: Over 89% of Nicaraguan women experience physical, sexual, or psychological abuse in their lifetimes. In addition, there is a high unmet need for SRH services, with over half (65%) of pregnancies among women 15-29 unintended. The 2006 Nicaraguan “total ban” on abortion creates penalties for women who obtain abortion under any circumstances, as well as for providers, resulting in a chilling effect. Complications from unsafe abortion contribute to the country’s high maternal mortality ratio.

PROJECT DESCRIPTION: We conducted 10 in-depth interviews with women aged 16-23 who had experienced an unintended pregnancy. Topics included pregnancy and family planning history, circumstances surrounding unintended pregnancy, and experiences with abortion.

RESULTS: All of the women had only been pregnant 1 time and 5 had gotten pregnant between the ages of 14-17. Four considered an unsafe abortion and 2 became pregnant as a result of nonconsensual sex. One woman, Ana Maria* received an unsafe abortion.

Ana Maria was 19 when an older man in her village, her brother’s best friend, raped her. She didn’t tell anyone what had happened, not even her family. She was a virgin and knew little about pregnancy or how to prevent it. But sometime after her assault she began to suspect she was pregnant. Her fears were confirmed by a home pregnancy test and later by blood test at a community clinic. Desperate, Ana Maria told her rapist that she was pregnant. He coerced her to see a “natural medicine” practitioner and gave her the money to have an abortion. Ana Maria travelled to see the woman who terminated the pregnancy by inserting a long rod into her vagina. The woman told her she would experience some cramping and be fine in a few days. Hours later Ana Maria felt feverish and began passing dark fetid clots of blood. Her brother, seeing that she was ill demanded, that she tell him what had happened. When she did, he helped her to get to a nurse. Although many health providers are reticent to provide post abortion care because of the legal limits on abortion, one nurse helped Ana Maria. She received treatment for a perforated uterus – a common complication from unsafe abortion. As a result of her experience, Ana Maria reported feelings of depression and isolation.

QUESTIONS TO CONSIDER: What were the missed opportunities related to SRH prior to and following Ana Maria’s assault? Aside from the rape itself, what other forms of GBV did Ana Maria experience? What are the human rights issues that arise from the case of Ana Maria?

**A pseudonym has been used*

- Right to decide freely the number and spacing of children. Reproductive coercion is a violation of this right
- Freedom of movement, opinion, expression and association. These are restricted when someone is trafficked, subjected to forced confinement or is prohibited by a husband or parent from accessing health or other services. The latter constitutes a form of psychological intimate partner violence
- Right to information. Preventing young girls and women from accessing information about ways to prevent unintended pregnancies and manage their reproductive choices is a violation of this right

Girls are particularly at risk of GBV due to their sex, as well as their young age. The Convention on the Rights of the Child states that children have the right to protection from all forms of physical or mental violence, including from sexual abuse, whether the abuse takes place in the family or in institutions, as well as from organized sexual abuse. Children also have the right to be protected from harmful practices, such as FGC, and to safely prevent unintended pregnancy, including by using emergency contraception.

Gender-based violence survivors have the right to seek medical treatment without cumbersome procedural requirements. Therefore, preventing the survivor from accessing and obtaining medical treatment by requiring her to present a marriage certificate, have the authorization of the husband or file a police report is a denial of this right. Where adolescents are involved, States should ensure legal provisions that provide for the possibility of medical treatment without parental consent for adolescents.

10.4.1 Guiding principles

Reproductive health managers or service providers in different contexts are likely to face similar dilemmas. The key to providing safe and ethical care for GBV survivors is ensuring practical adherence to the guiding principles and by implementing four inter-related approaches:

- **A survivor-centered approach** means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV-related programming
- **A rights-based approach** utilizes international human rights norms and principles to analyze and address

the root causes of discriminatory practices and violations

- **A community-based approach** is essential to empower individuals, families and communities with the knowledge, skills and resources to change harmful social norms perpetuating GBV.
- **A systems approach** analyzes GBV-related issues across an entire organization, sector, and/or humanitarian system to design systematic and context-specific solutions to improve GBV prevention and mitigation efforts in the short-term and in the long-term

The survivor-centered approach can guide professionals - regardless of their role - in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions.

Guiding principles for SRH service providers:

- **Safety:** The safety and security of the survivor and others, such as her/his/their children and people who have assisted her/him, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them
- **Confidentiality:** Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment
- **Respect:** The survivor is the primary actor, and the role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor
- **Non-discrimination:** Survivors of violence should

receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic

A key component of the survivor-centered approach is “informed consent”. For SRH staff this involves providing accurate information in a neutral manner to GBV survivors about all services available, the benefits and possible consequences of accessing these services and sharing information to enable the survivor to make an informed decision that is best for him/her. Survivors should never be coerced into accessing a service against her/his/their wishes. Furthermore, SRH service providers must let the survivor know that they can retract their consent for the service or information sharing at any time (even during service provision or after sharing information about the incident).

BOX 10.8: INFORMED CONSENT

This refers to approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced. Children are generally considered unable to provide informed consent because they do not have the ability and/or experience to anticipate the implications of an action, and they may not understand or be empowered to exercise their right to refuse. Service providers working with children must facilitate assent (for older children) or get consent from the designated adult guardian or caregiver. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory, or intellectual disabilities.

10.4.1 Challenges and opportunities

At times, SRH Coordinators, health program managers, and service providers may face difficult decisions when providing care for survivors of GBV. They may find that national legislation or social or cultural norms place

restrictions on the provision of certain services or in certain circumstances. For example:

- In some societies, it is common in cases of sexual violence for the family and/or the authorities to force unmarried female survivors to marry the perpetrator (double-victimization).
- In communities where a woman’s virginity at the time of marriage is considered very important, the family of a survivor may ask service providers to conduct a “virginity test”
- If patient confidentiality is compromised, services provided to the survivor can put the survivor at risk of reprisals and continued violence
- Health service providers’ attitudes and behaviors often reflect the discriminatory attitudes of affected communities, including victim-blaming, which may create a barrier for survivors to access services and effect their recovery
- A service provider may suspect or know that the perpetrator of violence is someone related to or close to the survivor and may feel that the survivor’s safety is not guaranteed, particularly in the case of children

In these cases, the SRH Coordinator, health program manager, or service provider may:

- Talk to their supervisor
- Discuss options with their client
- Discuss advocacy options and strategies within their organization or clinic structure
- Explore linkages with and referrals to local organizations that might be able to help the client
- While respecting the confidentiality of their client, discuss with colleagues how to avoid such situations/handle them in the future
- Raise these concerns/challenges in health coordination meetings

10.5 MONITORING AND EVALUATION

Monitoring and reporting on cases of GBV, information sharing, incident documentation, and data analysis must be agreed upon as part of the SOP. Collecting and analyzing information on GBV can provide valuable information if it is conducted and shared appropriately.

Indicators to be collected at the health-facility level:

- Number of reported cases of sexual violence reported to health services (per month).
- Timing of EC provision (percentage of eligible rape survivors presenting to the health services within 120 hours who receive EC)
- Timing of PEP provision (percentage of eligible rape survivors who present to the health services within 72 hours and receive PEP)
- Number of women and girls who receive safe abortion care (SAC) to the full extent of the law

Indicators to measure annually:

- Number of health workers trained in providing clinical care to survivors of sexual violence (see Chapter 3 for details)

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CHAPTER 11

HIV

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11.1 INTRODUCTION

Significant progress has been made over the last 3 decades in response to the human immunodeficiency virus (HIV) epidemic globally. However, addressing HIV remains an ongoing challenge, particularly in humanitarian contexts. Although a significant proportion of people affected by humanitarian emergencies are people at risk of or living with HIV, access to HIV prevention, treatment, and care is often not prioritized during emergencies. HIV transmission in humanitarian settings is complex and is dependent on the dynamic interaction of a variety of factors. This includes HIV prevalence and vulnerability of some groups within the population in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement, and the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees).

However, the characteristics that define a complex emergency, such as conflict, mass displacement, loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV. This increased vulnerability occurs by:

- Reducing access to HIV prevention, treatment, and care services due to the breakdown in health infrastructure
- Disrupting social support networks, increasing exposure to rape and sexual exploitation, increasing sex work, and increasing use of psychoactive substances, including injection drugs
- Exacerbating existing inequalities, stigmatization, and marginalization of key populations at risk of HIV and those living with HIV
- Increasing population movement to an area of higher HIV prevalence

In 2017, approximately 36.9 million people globally were living with HIV; nearly 59% were accessing antiretroviral therapy. About 1.7 million people living with HIV were affected by humanitarian emergencies in 2013, the most recent year for which we have data, including 174,000 children (age 0-14), 81,000 pregnant women, and 193,000 adolescents. Treatment coverage was low in emergency affected populations, but was generally similar to global treatment coverage at the time. In 2013, 63% of all people living with HIV had no access to antiretroviral therapy while 68% of people living with HIV affected by emergencies had no access to treatment. However, the coverage varied by sub-population; the largest treatment gap was in children affected by emergencies (83%), followed by adolescents (76%), adults (67%), and pregnant women (55%). Despite recent advancements in user-initiated interventions and mobile health tools, HIV services for key populations (see section 11.3.4) remain inadequate in most settings.

When planning HIV programming in humanitarian settings, sexual and reproductive health (SRH) Coordinators and health program managers together with HIV service providers and program managers must consider:

- The combined impact of humanitarian emergencies

and HIV, including factors which may increase vulnerability to HIV

- Existing policy and practice in humanitarian response which aim to prevent the spread of HIV and mitigate its impact
- The availability and accessibility of prevention, care, and treatment services for people living with HIV, including interruption, restarting, or continuation of antiretroviral treatment, and opioid substitution therapy (OST) for people who inject drugs (PWID)
- The need to initiate antiretroviral therapy (ART) at least in people who have tested HIV positive for the first time presenting with advanced HIV disease progression according to national policies and guidelines
- Stigma and discrimination against people living with, at risk of, and affected by HIV
- The need to prevent and manage other sexually transmitted infections (STIs)

11.2 OBJECTIVES

The objective of this chapter is to assist SRH Coordinators, health program managers, and service providers to:

- Plan for and implement comprehensive HIV prevention, care, and treatment services as part of the humanitarian response
- Understand evidence-informed interventions and barriers to implementation
- Improve utilization and demand for HIV services

11.3 HIV PROGRAMMING

11.3.1. Preparedness

Disruption of HIV prevention and treatment services can have a significant impact on transmission risks, including

mother-to-child transmission, and on the health of people living with HIV. To mitigate these risks, the inclusion of HIV and AIDS within preparedness efforts is key.

1. Include HIV in humanitarian action plans. The ability to address the needs of people living with HIV or affected by HIV in a timely manner is directly linked to the inclusion of these needs in the preparedness and contingency plans of both the HIV program and the general national disaster preparedness plans. In doing so, involve all relevant stakeholders, including organizations of people living with HIV, health workers from implementing agencies involved in HIV and SRH service delivery, and representatives from communities, women's groups, and key populations, as relevant. Protocols to conduct situation analysis and needs assessments adapted to the national context developed within the preparedness phase should include HIV.
2. Pre-position buffer stocks, redistribute supplies in areas with greater need, and provide support for transport and emergency procurement to ensure drug and commodities supply in humanitarian settings. In acute emergencies when no buffer stocks are in place, consider including HIV, prevention of mother-to-child transmission (PMTCT), and ART starter kits in global/regional emergency supplies for uninterrupted antiretrovirals (ARVs), HIV counseling and testing (HCT), and key prevention services/commodities access.
3. Provide leadership and support to ensure ARVs are included in the emergency response from the outset. Put HIV on health cluster/coordination meeting agendas and integrate HIV systematically into humanitarian assessments.

11.3.2 Minimum Initial Service Package implementation

The Minimum Initial Service Package (MISP) components related to HIV interventions at the onset of a humanitarian response focus on prevention of HIV transmission and reduction in morbidity and mortality due to HIV and other STIs. To reduce the transmission of HIV from the onset of the humanitarian response, the SRH Coordinator must work with health sector/cluster partners to:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of ARVs to continue treatment for people who were enrolled in an ART program prior to the emergency, including women who were enrolled in PMTCT 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 of syndromic diagnosis and treatment of STIs in health facilities

These priority interventions should be provided in all humanitarian emergencies regardless of the local HIV epidemiology. In contexts of high prevalence of injection drug use, access to sterile needles or syringes (and continuity of OST) should be provided, in line with the national policies.

This chapter describes approaches for SRH Coordinators, health program managers, and service providers to program for comprehensive HIV prevention, care, and treatment services as soon as the situation allows, building upon the MISP interventions. When planning for comprehensive HIV prevention, care, and treatment services, a needs assessment should be undertaken as a first step.

11.3.3 Needs assessment

SRH Coordinators, health program managers, and service providers must collect or estimate the relevant information for the setting they work in, in coordination with representatives of the Ministry of Health (MOH) and other sector/cluster actors. Various methods of data collection and study designs are available to assess HIV-related needs of displaced populations, from quantitative survey approaches to data monitoring and in-depth ethnographic studies to rapid cross-sectional qualitative

studies. Joint assessment missions on HIV-related needs require consensus on objectives and priorities but also common standardized approaches and tools. It must be recognized that tools need to be adapted in each specific context. Experience has shown that a joint assessment between government and non-governmental stakeholders has many advantages.

The assessment team should work with local non-governmental organizations (NGOs), community-based organizations (CBOs), and other key informants (such as displaced people, key populations) to gather information from local perspectives.

POPULATION CHARACTERISTICS

- Population information (demographic information of host and displaced populations), patterns of displacement, and numbers of people in different settings (rural, urban, migration)
- HIV and other STI prevalence (for both displaced and host populations). This can be found on the UNAIDS website, as well as with the National AIDS Control Program or from MOH surveillance sources
- Number of people living with HIV from the affected population whose HIV treatment services were disrupted (e.g., PMTCT and ART programs) and who are in need of continuation of ARV regimens
- The profile and number of populations whose essential HIV prevention services (such as condoms and lubricant, needles and syringes, OST) have been disrupted or are at risk of disruption
- Behavioral, structural, and environmental factors that might place vulnerable subgroups at increased risk of HIV transmission

HEALTH SERVICES CHARACTERISTICS

- Health facilities and health staff already available in the area (international, from the MOH, and from communities)
- Health facility and community-based staff, including pharmacists, with experience in HIV prevention, treatment, and care and training needs of staff
- Availability of condoms and condom-compatible lubricant

- Availability of sterile injection equipment for PWID and OST
- National ARV protocols for prevention (PEP), pre-exposure prophylaxis (PrEP), PMTCT, and treatment (ART) and available antiretrovirals
- Availability of laboratory services, including point of care rapid tests
- Availability of different types of HIV testing
- Existence of a reliable supply chain that can support sustainable access to HIV prevention, care, and treatment commodities (such as ARVs and condoms)
- Availability of food and nutrition support
- Availability of local organizations or peer networks and peer groups of people living with HIV or key populations or those that provide services to these populations in the local context

NATIONAL LEGISLATION AND POLICIES

SRH program managers and service providers must also be familiar with national legislation and policies related to HIV, assess how refugees and internally displaced persons (IDPs) are included, and if there are any gender, age, or other status-based restrictions. Examples include:

- Laws and/or policies on HIV testing, including pre- and post-test counseling. Are there mandatory testing laws? Specifications as to where testing can take place?
- Laws and/or policies related to condom distribution, PWID, and harm reduction services (especially OST and needle and syringe programs)
- Laws and/or policies regarding HIV transmission, sex work, or same-sex sexual relations
- Laws and/or policies regarding health care provider disclosure of HIV status
- Laws and/or policies governing provision of and access to ART and whether displaced (refugees/IDPs) are included in national HIV plans and policies

HIV EPIDEMIC CHARACTERISTICS

To have an impact on HIV prevalence, program efforts must be targeted appropriately. As a useful programming guide, the World Health Organization (WHO) and UNAIDS have categorized HIV epidemics in different countries broadly as low level, concentrated level, and generalized epidemics (see Table 11.1).

TABLE 11.1: HIV EPIDEMIC SCENARIOS

	EPIDEMIC SCENARIO	KNOW YOUR EPIDEMIC
Low level	HIV prevalence <1%: HIV prevalence has not reached significant levels in any sub-population. This suggests either that networks of risk are diffuse or that the virus has been introduced recently	Knowledge of risk behaviors, sexual networks, and other factors indicating the potential for HIV spread - such as rates of other STIs - is essential for prevention planning
Concentrated	HIV prevalence is high enough (5% or more) in one or more key populations, such as men having sex with men, people who inject drugs, transgender people, or sex workers and their clients, to maintain the epidemic in that sub-population. However the virus is not circulating in the general population, where the prevalence remains < 1%	The future course of this type of epidemic will be determined by <ul style="list-style-type: none"> • The size of the vulnerable sub-population(s) and the frequency and nature of interactions between them and the general population • The extent of tailored HIV programs provided by and for affected key populations • The degree to which key populations are able to self-mobilize (affected by stigmatization, and conversely by community empowerment)
Generalized	HIV prevalence is 1%-15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic. In a population with more than 5% prevalence every sexually active person has potentially a high risk of infection and no sub-populations are considered “low-risk”	Social norms that lead to multiple sexual partner relations and/or norms and policies that prevent people from protecting themselves (for example, norms that decrease girls’ access to education and information) are directly implicated in the epidemic dynamics and need to be addressed

11.3.4 Principles of working with key populations and vulnerable groups

There are certain key populations who in almost all settings are disproportionately affected by HIV. These include gay men and other men who have sex with men (MSM), PWID, persons who engage in sex work, transgender people, and people in prisons and other closed settings. The disproportionate risks reflect both legal and social barriers that increase vulnerability and risk-associated behaviors among members of these populations.

In certain contexts, other groups also are particularly vulnerable to HIV infection, for example, adolescents, migrant workers, refugees, long-distance truck drivers,

military personnel, and, in southern Africa, young women. These populations are not uniformly vulnerable or equally affected across different countries and epidemic settings. Countries should identify these additional populations specific to their settings and develop and tailor services accordingly. In many countries, inadequate coverage and poor quality of services for key populations and vulnerable groups undermine responses to HIV. All countries should consider the importance of reaching these groups, understanding their needs, empowering them and providing them with equitable, accessible, and acceptable services.

BOX 11.1: KEY POPULATION: MEN WHO HAVE SEX WITH MEN

Men who have sex with men (MSM) include all men who have same-sex relations, regardless of their self-identified sexual orientation (gay, bisexual, or heterosexual). Worldwide, MSM are estimated to be 24 times more likely to be infected with HIV than the general population, with HIV prevalence ranging from 14% to 18% across the Americas, Asia, and sub-Saharan Africa. HIV responses for MSM continue to be hampered by homophobia, discrimination, violence, and criminalization, all of which affect the physical and mental health of MSM and limit their access to services. Addressing homophobia, stigma, and discrimination is central to implementing evidence-informed and rights-based HIV prevention, care and treatment services.

Delivering a continuum of services in close partnership with communities of MSM increases access and reduces morbidity, mortality and onward transmission of HIV. Effective HIV programming for MSM includes:

- Community empowerment is central to all prevention efforts. Empowerment supports MSM to address structural constraints to their health, human rights and well-being, and improves access to services. Building capacity of MSM networks supports planning, implementation, scale-up, management, and monitoring of HIV programs with MSM
- Addressing violence is a most urgent and prioritized need of MSM. Protection from violence, discrimination, and other forms of human rights violation is necessary to ensure that HIV interventions can be implemented effectively
- Condom and lubricant provision is a core prevention intervention, which includes managing supplies, multi-level promotion, and creating an enabling environment to increase condom use
- Comprehensive healthcare services include HCT, PrEP and PEP, ART, treatment of STIs and other co-infections, addressing mental health and substance use issues including needle and syringe programs and OST for MSM who inject drugs
- Community-led services are an important method of service delivery. Men's health groups and organizations of MSM are essential partners in

providing outreach, managing drop-in centers, and helping peers navigate health, justice, and social services. MSM participation and leadership builds trust, makes programs more comprehensive and responsive, and creates enabling environments for HIV prevention

- Integrated services enable treatment, care, and support for multiple co-morbidities (e.g., HIV, viral hepatitis, TB, STIs, and mental health conditions) and poor social situations (e.g., detention, lack of housing, and unemployment). Integrated services facilitate better communication and care and enable better outcomes for MSM clients

HIV programs for MSM can face resistance and criticism from the broader community, especially where social, cultural, and religious attitudes stigmatize MSM. However, with funding and support, program implementers can increase acceptance of the MSM community and interventions. For example:

- Determine the size and characteristics of MSM communities among the affected population and involve them in designing and implementing targeted HIV prevention activities
- Promote understanding and acceptance of diverse sexual orientation and gender identities in public awareness campaigns to decrease homophobia
- Sensitize and build capacity for professionals, particularly health workers, law enforcement officials, social workers and community workers, to interact or work with MSM and apply rights-based approaches and evidence-informed practice
- Implement and enforce anti-discrimination and protective laws, to eliminate stigma, discrimination, and violence
- Monitor and report violence, in consultation with clients and with an understanding of legal risks, and establish redress mechanisms to provide justice
- Ensure health services are accessible, acceptable, patient-focused, and based on principles of medical ethics, avoidance of stigma, non-discrimination and the right to health

BOX 11.2: KEY POPULATION: PEOPLE WHO INJECT DRUGS

The United Nations Office on Drugs and Crime (UNODC) estimated that in 2014 worldwide around 11.7 million people had recently injected drugs; of these, 1.6 million were living with HIV (13.5%). Injecting drugs is highly prevalent in Eastern and South-Eastern Europe and 27% of PWID reside in East and South-East Asia. Rates of new HIV infection have been found to be 24 times higher amongst people who inject drugs than the general population. HIV is highly prevalent among PWID in South-West Asia, and Eastern and South-Eastern Europe, where respectively 27.9% and 22.9% of PWID are living with HIV. Sharing contaminated needles and syringes contributes to a third of new HIV infections outside sub-Saharan Africa. Women who inject drugs are particularly stigmatized and are vulnerable to violence and HIV. Insufficient coverage of harm-reduction programs in settings where unsafe injecting drug use is high, is of concern because of high risk for transmission of HIV and other infections such as viral hepatitis.

While sharing syringes and other equipment for drug injection is a well-known route of HIV transmission, injection drug use also contributes to the epidemic's spread beyond the circle of those who inject. Sexual partners of PWID are at risk through sexual transmission. Children born to mothers who contracted HIV through sharing needles or having sexual intercourse with a PWID may become infected as well. People who engage in sex work and MSM using stimulant drugs (cocaine, amphetamines) have also higher prevalence of sexual risk behaviors.

PWID may also have additional HIV transmission risks such as sex work and imprisonment. The criminalization of injection drug use can lead to social marginalization and limit access to health and HIV services, including HCT and ARV. All these can further fuel the epidemic.

HIV services for people who inject drugs should therefore focus on a harm reduction approach. The comprehensive package for the prevention, treatment, and care of HIV among people who inject drugs includes nine interventions ranked by order of priority as follows:

- 1) Needle and syringe programs
- 2) Opioid substitution therapy
- 3) HIV testing and counseling
- 4) Antiretroviral therapy
- 5) Prevention and treatment of sexually transmitted infections
- 6) Condom programs for people who inject drugs and their sexual partners
- 7) Targeted information, education, and communication for people who inject drugs and their sexual partners
- 8) Prevention, vaccination, diagnosis and treatment for viral hepatitis
- 9) Prevention, diagnosis, and treatment of tuberculosis

Provision of sterile needles and syringes reduces the risk of HIV transmission. Where possible, and depending on context, provision of other elements of harm reduction services, such as non-coercive opioid substitution therapy (methadone or buprenorphine) for people dependent on opioids, naloxone for overdose prevention, and psychosocial support could be considered. In addition, PMTCT services for women who inject drugs and for sexual partners of PWID as part of SRH programming should be considered. Quality condoms should always be provided.

In most cases, service providers lack experience, skills, and competency to provide good quality services to people who inject drugs. In such cases, training for service providers on HIV-related services for PWID should be considered. Peer-led community outreach is an effective way for reaching PWID who are not in contact with health and HIV prevention services. More specifically:

- Determine the size and characteristics of PWID among the affected population and involve them in designing and implementing targeted HIV prevention and treatment activities.
- Create demand and offer access to sterile injection equipment through needle and syringe programs
- Create demand and offer access to OST and other evidence-based drug dependence services
- Create demand and offer access to HCT and ART
- Create demand and offer access to condoms, STIs prevention and treatment, and SRH services
- Address and mitigate stigma and discrimination

In addition, Naloxone should be provided in the community to prevent death due to the overdose of opiates.

BOX 11.3: KEY POPULATION: PEOPLE WHO ENGAGE IN SEX WORK

The exchange of sexual services for money or goods is present in all communities and is often prevalent in emergency-affected populations. This includes persons who do not consider themselves sex workers but who lack other forms of income and offer sexual services to support themselves and their dependents during humanitarian situations. Thus, as well as ensuring security and access to food and support for vulnerable people, it is of utmost importance to provide non-stigmatizing HIV and SRH services for all persons providing sexual services within humanitarian settings. People who engage in sex work and their families benefit from support mechanisms, including the provision of assistance and incentives as well as legal, economic, and social services to reduce dependency on sex work for survival.

Globally, people who engage in sex work experience 10 times higher prevalence of HIV than the general population, with an average 12% rate of HIV infection. There are numerous reasons for this risk, including multiple sexual partners, vulnerability to sexual violence, unsafe working conditions, barriers to the negotiation of consistent condom use, and lack of access to health services. Stigma, discrimination, violence, and criminalization of sex work limit access to services and ability to reduce risk. For example, police may harass people who engage in sex work and use possession of condoms as evidence of sex work. Violence, alcohol and drug use in some settings also increase the vulnerability and risk face by this key population.

A number of interventions have been identified for reducing HIV within the context of sex work:

- Community empowerment is central to reducing risk for people who engage in sex work and other key populations. It enables effective planning, implementation and monitoring of all aspects of HIV and STI prevention, treatment and care. Building capacity of sex worker networks supports implementation and scale up of interventions that are tailored for local sex worker communities
- Addressing violence against people who engage in sex work is a priority, often of greater immediate concern than preventing HIV. HIV programs need to include protection from violence, discrimination, abuse, and other human rights violations, including by some State actors
- Condom and lubricant programming is a key intervention for ensuring adequate provision of male and female condoms and lubricants, including in community settings
- Clinical and support services need to be rights-based and people-focused, ensuring voluntary and informed consent and avoidance of any coercion and/or judgmental attitudes of providers. Voluntary services include HCT, PrEP and PEP, ART, treatment of STIs and

co-infections, such as TB and viral hepatitis, including hepatitis B virus vaccination, and additional services for SRH, harm reduction for people who engage in sex work who inject drugs, post-rape care, and mental health services. In locations with high STI prevalence and limited health services, periodic presumptive treatment for STIs may be offered to people who engage in sex work for limited time periods. Uptake of all services is dependent upon people who engage in sex work being adequately informed and empowered to make their own choices about accepting treatment and support

- Provision of community-led services increases reach and delivery of services acceptable to people who engage in sex work by peers within community settings. A community-led approach to planning, delivering and monitoring services makes programs more effective and sustainable, with delivery via outreach, mobile clinics and safe spaces (drop-in centers), and peer navigation through health, social, and justice systems to maximize uptake and ensure sex workers' rights are upheld. Interventions can also address the "demand" side of sex work - working to change the behavior of clients - to reduce violence against people who engage in sex work and reduce demand for unprotected paid sex. Humanitarian staff, peacekeepers, civil police, and members of the general population can be clients of sex workers in humanitarian settings
- Interventions to protect against discrimination and violence, and other rights violations faced by people who engage in sex work, and to enhance sex workers' right to social, health, and financial services are critical. These may need to be linked to protection or gender-based violence sectors
- Health services should be made available, accessible and acceptable to people who engage in sex work based on the principles of avoidance of stigma, non-discrimination and the right to health
- Advocacy with community leaders is useful for increasing awareness and acceptance of the importance of providing services for people who engage in sex work

Finally, any efforts to stop human trafficking and sexual exploitation of children need to work in harmony with sex worker communities and HIV, protection, or gender-based violence programs. Blind sweep "raid and rescue" operations disregard sex workers' rights and make both sex work and trafficking more hidden, increasing the risk of HIV and violence. Sex worker communities are excellent allies for anti-trafficking efforts and need to be consulted and involved. Often people who engage in sex work themselves will know if individuals are being forced or coerced into providing sexual services or are under age 18 years (sexually exploited children).

11.3.5 Programming considerations

HUMAN RESOURCES, TASK-SHARING, AND TASK-SHIFTING

Strong and effective health systems depend on having enough clinical staff, with the right skills, in the right place. But the number of available health workers remains inadequate in many settings with a high burden of HIV and this is accentuated in emergency settings. Universal access to HIV services will not be possible without strengthened health systems, including a significant expansion of the health workforce. Against this background, the need for a plan to strengthen and expand the health workforce in the context of HIV becomes clear. Given increasing numbers of patients, shortages of trained medical personnel, and financial constraints, treatment must be provided more efficiently.

Scaling-up HIV prevention, treatment, and care programs cannot only rely on formally trained health care professionals, as these are insufficient to respond to the needs. Rather, programs must also involve management and support staff from outside the clinical health sector who can free up time for health care providers to perform clinical work. Task-sharing and task-shifting (in which physicians, nurses, dentists, and other health professionals delegate health care responsibilities and relevant knowledge to others, including trained community health workers (CHWs) and community-led care and support, can make more efficient use of existing human resources and ease bottlenecks in service delivery without compromising patient outcomes. Sharing of responsibility may also involve the delegation of some clearly delineated tasks to newly created cadres of health workers who receive specific competency-based training.

Task-sharing is the process of enabling a range of lay and trained healthcare professionals - such as nurses, midwives, clinical officers, and community health workers - to provide clinical tasks and procedures safely that would otherwise be restricted to higher level cadres. Task-sharing emphasizes a knowledge base requirement for delegated roles and responsibilities and underscores the involvement of health professionals' collaboration when providing care.

The World Health Organization defines task-shifting as the process whereby specific tasks are transferred, when appropriate, to health workers with less training and fewer

qualifications. Community health workers, including people living with HIV, can safely and effectively provide specific HIV services, both in a health facility and in the community. Unlike informal and opportunistic task shifting/sharing, deliberate strategies are accompanied by training, certification, support, and supervision.

TRAINING

It is essential that capacity to implement good quality HIV programs exists to ensure good quality HIV services are provided. However, capacity can differ from context to context. In addition, the nature of an emergency may require expansion of specific skills and competencies among health providers (e.g., how to respond to sexual violence, or how to effectively manage HIV commodities). For this reason, it is important to include a basic assessment of capacity gaps as part of the needs assessment and program planning. Based on identified capacity and skill gaps, training can be conducted, focusing on different target audiences, such as:

- Health care providers in clinics or health posts
- Health sector managers in implementing agencies
- Community health workers and peer-outreach workers
- Others depending on identified needs and gaps

Wherever possible, use existing training manuals or materials and utilize local expertise.

PROVISION OF SERVICES IN DIFFERENT CONTEXTS AND SETTINGS

Over 60% of the world's refugees and IDPs live in urban environments. Unlike a refugee/displaced persons camp, cities allow refugees to live anonymously, make money, and build a better future. But they also present dangers. Refugees may be vulnerable to exploitation, arrest or detention, and can be forced to compete with the poorest local workers for the worst jobs. Large numbers of refugee women, children, and older people in urban areas, are confronted with a range of protection risks, including the threat of arrest and detention, refoulement, harassment, exploitation, discrimination, inadequate and overcrowded shelter, as well as vulnerability to sexual and gender-based violence (GBV), HIV, substance use disorders and human trafficking.

In urban contexts, particular efforts must be made to reach refugees and IDPs, as there are often no records and such persons often do not receive direct material support or services from host governments or humanitarian agencies. Service providers experience challenges reaching refugees and IDPs within urban settings and such persons often have little opportunity to voice their concerns. Furthermore, refugees in urban areas often face numerous disadvantages compared with low income city dwellers, such as lack of community support systems, language barriers, exclusion from social security systems or health insurance schemes, and insufficient disposable income. Stigma and discrimination may also reduce access to already overstretched government health services.

In countries where nationals have subsidized or free health services, the first priority would be the integration of refugee health services with the national health system, with the aim of assuring the same access for urban refugees as those available to nationals. This would particularly apply to primary health services and SRH-specific services such as contraception services, antenatal and postnatal care, emergency obstetric care, and HIV/STI and GBV management. If this privilege is not granted by the host government, there is the need to set up alternative services and develop an advocacy strategy.

Informal protective community-led services and peer networks must also become a cornerstone of urban protection. These peer networks can be among refugees, for instance in the form of support groups, including for GBV survivors, elders, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) people, people who engage in sex work, people with disabilities (PWD), people who inject drugs, people in prisons, and people living with HIV. Key populations can be encouraged to mobilize and form local networks to work collectively. Where possible, provide community drop-in centers where services can be provided, and people can meet and initiate community action. Engage local organizations that have expertise working in a particular neighborhood or geographic area that is seeing an influx of refugees; others may have expertise working with urban subpopulations, including vulnerable groups like LGBTQIA people, people who engage with sex work, homeless persons, and people living with HIV.

BOX 11.4: KEY POPULATION: TRANSGENDER PEOPLE

Transgender people are rarely identifiable in national surveillance systems, and there is limited understanding of the global burden of HIV and other STIs among transgender populations. Data are only available from middle and high-income countries and indicate that transgender women, in particular, are at disproportionate risk for HIV infection, 49 times higher than the general population. A meta-analysis published in 2013 found an HIV prevalence rate of 17.7% among 7,197 transgender women from low- and middle-income countries.

Transgender populations are distinct from MSM and often have different vulnerabilities and health needs (such as hormone therapy) and require gender sensitive services. Transphobia and a lack of gender-congruent identity documents may limit their ability to access health care. Healthcare workers providing HIV services may require sensitization to ensure they provide gender-affirming services for adult and adolescent transgender people, free from transphobia.

A “syndemic” (synergistic epidemic) of multiple, co-occurring health problems markedly affects transgender people, especially transgender women, including high rates of violence, victimization, substance use, sexual abuse and assault, and depression with suicidal ideation and attempts. This syndemic is associated with structural and social inequalities, including stigma and discrimination, lack of identity documents that match gender expression, unemployment, low-paid sex work, homelessness, and lack of access to health services, including gender-affirming care. Transgender women who seek psychological affirmation of their gender from partners may be more willing to have sex without condoms and many partners of transgender women are at high risk of HIV.

Many transgender people use feminizing or masculinizing hormones to physically align with their gender identity. Many prioritize hormone therapy; this may be an entry point into HIV testing and care. Uncertainty remains over how hormonal contraceptives, particularly in large doses, affect HIV acquisition and transmission. Ethinyl estradiol - the estrogen commonly used in oral contraceptives - has well-characterized drug interactions with some ARV drugs; these contraceptives are widely used by transgender women. Data are lacking on drug interactions between ARVs and 17- β estradiol – a drug commonly used for hormone replacement therapy. Testosterone and ARVs may be co-administered. However testosterone suppresses estrogen, resulting in vaginal atrophy (thinning and drying of the vaginal lining). Although data are unavailable, this raises concerns about the impact on HIV acquisition among transgender men.

Some considerations for programming include:

- Acknowledge and build upon the strengths, competencies, and capacities of transgender people, especially their ability to express their views and articulate what services they need. Partner with community-led organizations of transgender people, building upon their experience and credibility with transgender people
- Involve transgender people meaningfully in the planning, design, monitoring, implementation, and evaluation of services suited to their needs in local contexts
- Fully utilize existing infrastructure and services, such as services for adolescents that have been demonstrated to be appropriate and effective, and add components for reaching and providing services to young transgender people
- Ensure that there is sufficient capacity amongst professionals, particularly health workers, law enforcement officials, social workers and community workers, to interact or work with transgender people and apply rights-based and gender-sensitive approaches and evidence informed practice
- Adequate supplies of condoms and lubricant should be made available, emphasizing the need to ensure use of lubricant. Behavior change interventions can be delivered via internet, social marketing, drop-in centers, and outreach to venues (e.g., nightclubs, sex venues)
- HIV clinical services for transgender people include HCT, PrEP and PEP, ART, treatment for STIs and other co-morbidities including tuberculosis and viral hepatitis, including the hepatitis B virus vaccination where immunization coverage is incomplete. Further services include for mental health issues, harm reduction for transgender people who inject drugs, and further drug and alcohol programs. Transgender people should receive adequate SRH services including contraception. Transgender women should be counseled about the risks of using oral hormonal contraceptives for feminization treatment
- Violence against transgender people should be prevented and addressed in partnership with trans-led organizations. All violence should be monitored and reported, and redress mechanisms established to provide justice

BOX 11.5: KEY POPULATION: PRISONERS

People in prisons are 5 to 10 times at higher risk for HIV. In addition to HIV risk behaviors, such as unsafe sexual activities and sharing injection equipment or body piercing equipment, factors related to the prison infrastructure and prison management, including health also contribute to vulnerability to HIV, tuberculosis, and other health related risks in prisons. These factors include overcrowding, violence, poor prison conditions, corruption, denial, stigma, lack of protection for vulnerable prisoners, lack of training for prison staff, isolation, and poor medical and social services.

In such contexts, effective HIV response requires addressing HIV prevention and treatment needs of those in need to ensure widest possible access to high quality services. A comprehensive package of 15 interventions for HIV in prisons includes:

- 1) Information, education, and communication (IEC)
- 2) Condom programs
- 3) Prevention of sexual violence
- 4) Drug dependence treatment, including OST
- 5) Needle and syringe programs
- 6) Prevention of transmission through medical or dental services
- 7) Prevention of transmission through tattooing, piercing, and other forms of skin penetration
- 8) Post-exposure prophylaxis
- 9) HIV testing and counseling
- 10) HIV treatment, care, and support
- 11) Prevention, diagnosis, and treatment of tuberculosis
- 12) PMTCT
- 13) Prevention and treatment of STIs
- 14) Vaccination, diagnosis, and treatment of viral hepatitis
- 15) Protection of staff from occupational hazards

BOX 11.6: ESSENTIAL MESSAGES

- HIV, the virus that causes AIDS, can spread through unprotected sexual contact (vaginal, anal, and oral sex without a condom) with someone who is infected with HIV, transfusions of HIV infected blood, reusing needles, syringes and other skin penetration equipment contaminated with HIV, and from a woman living with HIV to her child during pregnancy, childbirth, or breastfeeding
- Everyone must know about HIV and AIDS and how to prevent HIV transmission, because HIV is not curable, only preventable and treatable
- There is effective antiretroviral treatment for HIV and also for certain opportunistic infections (AIDS-defining conditions). Although ART is not a cure, it can control HIV and prolong life if taken lifelong
- Having an STI (e.g., chlamydia, gonorrhea, syphilis) increases one's risk of transmitting or acquiring HIV
- The risk of infection through sexual intercourse can be reduced by using barrier protection, such as condoms, correctly every time, maintaining a mutually monogamous relationship with an uninfected partner, abstaining from sexual intercourse, or using oral pre-exposure prophylaxis
- Everyone who may have been exposed to HIV should consult a qualified health worker for voluntary, informed HIV testing and counseling to protect their health
- Pregnant women should access HIV testing and counseling. If infected, they will be offered appropriate medication to reduce the risk of transmitting the infection to their infant during pregnancy delivery or breastfeeding
- Stigma, discrimination, wrong information, and negative attitudes towards people living with HIV and key populations increase the potential for suffering and for HIV to spread. Discrimination against people living with HIV is a human rights violation

11.3.6 Implementing comprehensive services for HIV prevention and care

Once the conditions allow, scaling up should occur from the initial minimum HIV package to comprehensive HIV prevention, care, and treatment services. SRH Coordinators, health program managers, and service providers, should review the findings of the situational needs assessment and implement comprehensive HIV services, according to available services and the security condition. Continuum of HIV care refers to a comprehensive package of HIV prevention, testing, treatment, and care services provided for people at risk of acquiring HIV and people living with HIV and their families.

HIV AWARENESS

Public information campaigns should be conducted to raise community awareness about how HIV is and is not transmitted and promote the rights of people living with HIV, the benefits of knowing one's HIV status, and the availability of services for HIV prevention, testing, care, and support. Information about safe disclosure is also critical. People, and in particular women and girls who may be at risk of violence, must have informed choice about to whom they disclose, for whom they disclose, and when, where, and how they disclose. People living with HIV and affected communities should be involved in the formulation, implementation and monitoring of such campaigns.

Communication efforts in the early humanitarian response focus on informing people where they can access basic HIV services. As soon as possible, review the findings of the initial assessment, to tailor communications toward local populations affected by HIV, for example:

- What level of knowledge and common misconceptions about HIV do people have?
- What common practices put people at risk of HIV transmission?

- What elements of the new situation increase the risk of HIV transmission?
- What are the common attitudes and beliefs regarding people living with HIV and key populations?

Public information and health service-based campaigns can increase awareness about HIV, STIs, and other SRH issues within newly formed communities of refugees and IDPs. In addition, design and tailor specific communications campaigns to:

- Target key populations and other people vulnerable to HIV transmission. Displaced people face increased risks because protective community systems and health services are interrupted, sexual networks change, youth may initiate sexual activity earlier, drug use may change and people may initiate sex work as means of livelihood
- Reduce stigmatizing attitudes and discriminatory behavior against people living with HIV and key populations and assure care and support for them

Community-led programs, such as community drop-in centers and peer outreach, are effective ways to motivate people to practice safer behaviors and access services. A variety of community groups can be involved and mobilized including networks of people living with HIV, LGBTQIA people, sex workers, people who inject drugs, and people with disabilities. Support can also be sought from community and religious leaders, health clubs at schools, post-HIV test clubs, and Stop-AIDS associations in the police and military. Associations of people living with HIV and other community groups can be powerful catalysts for change of individual and community-wide attitudes.

BOX 11.7: POPULATIONS AT-RISK: YOUNG PEOPLE AND ADOLESCENTS

Young people (10–24 years), including adolescents (10–19 years), continue to be vulnerable, both socially and economically, to HIV infection. This is particularly true for adolescents, especially girls, who live in generalized HIV epidemic settings or who are members of key young population groups.

Adolescents often have poor access to and uptake of services, which increases adolescents' vulnerability to and risk of contracting HIV. For those under 18 years of age, policy and legal barriers related to age of consent often prevent access to a range of health services, including for HIV and SRH services. Such barriers also limit adolescents' ability to exercise their right to informed and independent decision-making.

Adolescents and youth, including those from key populations, should have access to tailored and age-appropriate and rights-based information and services. There should be meaningful participation of young people in the design, implementation, monitoring and

evaluation of policies and programs. This includes:

- Provision of rights-based and gender-transformative comprehensive sexuality education
- Access to comprehensive adolescent SRH services, including for HIV, other STIs, and contraception
- Ensuring that sufficient and accurate information about reproductive health and rights is provided
- Creating peer education and support programs
- Providing adolescents with treatment, care, and support
- Supporting adolescents living with HIV to make informed decisions about if, when and to whom to disclose their HIV status
- Supporting adolescents with treatment adherence and the transition from pediatric to adult services

BOX 11.8: POPULATIONS AT-RISK: PEOPLE WITH DISABILITIES AND THE ELDERLY

Access to HIV prevention, treatment, and care should be recognized as an essential component of realizing the universal right to health. However, people with different types of disabilities (such as hearing, visual, physical, and intellectual disabilities) and the elderly may face difficulties accessing health services. HIV service planning should promote accessibility of services for these groups.

Key factors associated with HIV, such as lack of education and social marginalization, are more common for both men and women with disabilities which may increase their vulnerability to HIV. This is due to the lack of appropriate access to HIV prevention, information, and services, and the high rate of sexual and gender-based violence against persons with disabilities of all ages.

Key considerations include:

- People with disabilities have equal or greater exposure to all known risk factors for HIV
- Include people with disabilities and the elderly in HIV training groups so they can get involved in prevention and outreach initiatives themselves
- Sensitize educators, outreach workers, clinical, and social services staff on disability
- Ensure prevention programs reach people with disabilities, for example, HIV and life skills programming targeting young people should incorporate the specific concerns of young people with disabilities in school and those that are not
- Identify local disability organizations and involve them in all phases of prevention efforts
- Ensure measures to improve accessibility of health services is inclusive of those with disabilities. Such measures should also safeguard the privacy of the clients during communication of sensitive information
- Ensure all public education materials and initiatives are accessible to and inclusive of children and adults with different abilities and disabilities, by involving them directly in the selection of content and format (e.g., sign language, braille, digital or audio versions, simple language, simplified graphic information, etc.), testing, and adaptation of materials
- In awareness-raising campaigns involving the media, it is important that images reflect the target population for the messages and should therefore not exclude people with disabilities

BOX 11.9: POPULATIONS AT RISK: UNIFORMED PERSONNEL

Military and other uniformed personnel are often at high risk of HIV and STIs mainly due to their work environment, mobility, age, and other factors influencing exposure. One important factor leading to increased vulnerability to HIV in uniformed services is the practice of posting personnel far from their accustomed communities and families for varying periods of time. As well as freeing them from traditional social controls, it removes them from contact with spouses or regular sexual partners and can lead to increased risk-taking behaviors.

Key considerations for programming include:

- Peer education can be an effective tool in educating uniformed and prison services about HIV prevention, care, and treatment
- Involve police, military, and other uniformed personnel in the planning, design, monitoring, implementation, and evaluation of HIV prevention services suited to their needs in local contexts
- Facilitate access to voluntary confidential counseling

and testing for police, military, and other uniformed personnel

- Condoms should be made widely available at all military, prison, and police sites, for example through condom dispensers placed in washrooms, clinics, HCT centers and/or offices and transport and dispatch offices
- HIV awareness training should be provided for all prison, military, and police personnel prior to deployment
- Ensure that HIV prevention services to police, military, and other uniformed personnel is linked with prevention services for clients of people who engage in sex work
- Crisis management plans and disaster management plans should include guidance on universal precautions to reduce the transmission of HIV in medical emergencies and in responses to accidents

HIV PREVENTION

HIV prevention programs are interventions that aim to halt the transmission of HIV and thus protect individuals and communities. HIV prevention programs may focus on preventing sexual, blood-borne, or maternal-to-child transmission of HIV. A combination of interventions works best, including biomedical approaches, behavior change communication, and removing structural barriers to prevention.

Health staff, program managers, and service providers need to understand the HIV epidemic characteristics in the settings in which they work and the knowledge and behaviors of the local population in order to tailor HIV programming. In humanitarian settings, people may engage in behaviors that place them at higher risk of HIV, even if they do not self-identify as being at risk. Adolescent girls and young women may have multiple SRH and HIV vulnerabilities and thus HIV prevention needs to be placed in the context of comprehensive SRH education and services.

Although key populations and populations at risk have unique characteristics and require tailored approaches, the following elements should be considered across all HIV programs and their applicability determined depending on context and resources.

- Involve community groups from the start in program design, implementation and monitoring. Community-led programs are most effective if community networks can be mobilized
- Provide HIV prevention information to enhance community awareness of HIV
- Tailor combination HIV prevention programs by including different interventions depending on local HIV geographic population vulnerabilities
- Decentralize HIV services and incorporate community-led approaches to service delivery to increase accessibility and acceptability. Peer-based outreach, mobile services, and drop-in centers are useful for reaching those with limited access to public health facilities
- Promote consistent and correct use of male and female condoms as well as condom compatible lubricants and ensure their availability, affordability, and reliable supply
- As part of a combination prevention approach, offer voluntary oral PrEP, such as that containing tenofovir disoproxil fumarate (TDF) for populations at substantial risk of HIV infection

- Make PEP available to all eligible people on a voluntary basis as soon as possible after exposure to HIV
- Promote voluntary medical male circumcision (VMMC) as an additional strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic or generalized HIV epidemics and low prevalence of male circumcision
- Train health and social workers to provide high quality, client-friendly, HIV-related services to people living with HIV and their partners and families, including syndromic management of STIs, family planning counseling and contraceptive services, HIV counseling and testing, PMTCT, pediatric testing and treatment, and treatment for tuberculosis (TB) and AIDS
- Address structural barriers including policies, legislation, and customary practices that discriminate against and prevent access to and utilization of appropriate HIV prevention, treatment, and care services by different groups. This should include the creation of safe spaces tailored to each group where people can comfortably meet and seek information and referrals for care and support

BOX 11.10: DEFINITIONS OF PMTCT AND EMTCT OF HIV AND SYPHILIS

Preventing mother-to-child transmission (PMTCT) of HIV and syphilis is a multi-pronged strategy.

- 1) Help women of reproductive age avoid HIV and other STIs
- 2) Prevent unintended pregnancies
- 3) Provide ARV prophylaxis during pregnancy, delivery, and breastfeeding
- 4) Provide care, treatment and support to mothers and their families
- 5) Provide penicillin as needed

eMTCT stands for elimination of mother-to-child transmission.

BOX 11.11: KEY MESSAGE

MANDATORY HIV TESTING SHOULD NEVER BE SUPPORTED.

THIS COMPRISES A VIOLATION OF A PERSON'S RIGHTS.

HIV counseling and testing

Voluntary HIV counseling and testing describes a process initiated by an individual who wants to learn her or his HIV status. HCT is not a priority intervention at the onset of a humanitarian response because it is not an immediately lifesaving intervention. However, as soon as the situation allows it is important to offer HCT for people who want to know their serostatus. HCT services are standard practice to improve the health and well-being of individuals and as an entry point to appropriate care and treatment services. Provide counseling to prepare clients for their test result and to encourage behavior change, whatever the test outcome.

BOX 11.12: THE 5 Cs

HCT should be voluntary and adhere to the 5 Cs:

- Consent
- Confidentiality
- Counseling
- Correct test results
- Connection to care, treatment, and prevention services

Quality assurance of both testing and counseling is essential.

Provider-initiated HIV testing and counseling

Evidence suggests that many opportunities to diagnose HIV in clinical settings are being missed, even in places with serious HIV epidemics. While expanded access to client-initiated HIV testing and counseling is still necessary to increase coverage of HIV testing and counseling, provider-initiated counseling and testing (PICT) can increase uptake of HIV testing, improve access to health services for people living with HIV, and may create new opportunities

for HIV prevention. PICT involves the healthcare provider specifically recommending an HIV test to patients attending health facilities; individuals must specifically decline the HIV test after receiving pre-test information if they do not want the test to be performed.

In **generalized epidemics** where an enabling environment is in place and adequate resources are available (including recommended standards for HIV prevention, care, and treatment), HIV testing and counseling should be offered by healthcare providers as part of standard clinical care. If there are resource and capacity constraints, a phased implementation of this PICT will be needed. The following is a priority list for phased implementation:

- TB clinics
- STI services
- Antenatal, childbirth, and post-partum health services
- Medical inpatient and outpatient facilities

In **low level and concentrated epidemics**, healthcare providers should not initiate HCT to every patient attending a health facility, since most people will be at low risk. In such settings, the priority should be to ensure that HCT is recommended to all adults, adolescents, and children who present to health facilities with signs and symptoms suggestive of underlying HIV infection, including TB, and to children known to have been perinatally exposed to HIV. HCT facilities should be made available in stabilized humanitarian settings, either through established services, or mobile clinics.

Some behaviors that put people at a higher risk of exposure to HIV, such as sex work or injection drug use, also make people more susceptible to coercion, discrimination, violence, abandonment, incarceration, or other negative consequences upon disclosure of an HIV positive test. Healthcare providers require special training and supervision to uphold standards of informed consent and confidentiality for these populations. HIV counseling and testing for these groups should be accompanied by the implementation of a supportive social, policy, and legal framework.

BOX 11.13: QUALITY HCT SERVICES

Whether client- or provider-initiated, the following program components ensure quality HCT services:

- Consent, privacy, and confidentiality are essential. HIV testing must only be done on a voluntary basis. Always obtain informed consent before someone undergoes testing. HCT must never be imposed on anyone under any circumstance
- Make services available free of charge
- Ensure pre- and post-test counseling is part of all HCT services
- Post-test support services must be available, including referral networks and access to additional testing (such as a CD4 count) to assess suitability for entry into care and treatment programs
- HCT should only be carried out when adequate testing standards are available. Follow the nationally validated testing algorithm for HIV testing, while paying due consideration to specific human rights issues that may arise for the affected population
- Use testing technologies that are appropriate for the setting, such as rapid tests utilizing finger stick whole blood specimens. Obtaining a test result with rapid HIV tests takes less than 30 minutes and is associated with higher rates of successful post-test counseling and follow-up. This supports the decentralization of HCT. Consider local storage conditions and order rapid tests that do not require refrigeration where appropriate

BOX 11.14: RETESTING PRIOR TO ENROLLMENT IN CARE

It is a priority to retest all people who are diagnosed to be HIV positive prior to enrollment in HIV care and/or treatment in order to verify their serostatus. Failure to do this may lead, in rare cases, to people being diagnosed incorrectly, with potentially serious adverse long-term consequences.

Retesting a person diagnosed to be HIV positive to verify the diagnosis should include:

- Retesting of a new specimen for each newly diagnosed individual, preferably conducted by a different provider using the same testing algorithm, prior to initiation of ART
- Retesting that is preferably conducted at a different site, ideally the site where the decision about ART initiation will be made

Antiretroviral drugs for HIV prevention

ARV drugs play a key role in HIV prevention, including prevention of mother-to-child transmission, reducing the transmission of HIV to serodiscordant sexual partners (PrEP), and preventing the acquisition of HIV when a person is exposed (PEP). People living with HIV taking ART who achieve optimal viral suppression are extremely unlikely to pass HIV to sexual partners. It is important to plan the provision of essential ARV and ART programs. Providing HIV-related services to populations in humanitarian settings is a difficult yet critical undertaking, which is firmly rooted in international human rights laws. As with all HIV and AIDS policies and programs, ART must be linked to a prevention, care, and support program and not be implemented as a parallel intervention but rather as an integrated program linked to other services (e.g., health, nutrition, education, social services and water and sanitation). Where ART is available it is important that counseling covers the risks and benefits of ART and the importance of adherence to the treatment schedule.

Post-exposure prophylaxis

SRH Coordinators, health program managers, and service providers must ensure that the prompt (within 72 hours) administration of PEP to reduce the likelihood of HIV transmission is included in protocols for the following two situations:

- **Services for sexual violence survivors:** In order to prevent and manage possible health consequences of sexual violence, and rape in particular, survivors must have access to clinical care, including supportive counseling and emergency contraception (within 120 hours). This care also includes the provision of PEP (within 72 hours)
- **Occupational exposure:** Despite universal precautions put in place and adhered to in healthcare settings, occupational exposure to blood and body fluids potentially infected with HIV may occur, for example through a needle stick injury. Ensure PEP is available in these settings as part of a comprehensive universal precautions package that reduces the likelihood of HIV transmission after such an exposure

The recommended PEP regimen is a 28-day combination therapy. While a two-drug PEP regimen is effective, three drugs are preferred.

BOX 11.15: KEY RECOMMENDATION

ART SHOULD BE INITIATED IN ALL PREGNANT AND BREASTFEEDING WOMEN LIVING WITH HIV REGARDLESS OF CLINICAL STAGE AND AT ANY CD4 CELL COUNT AND CONTINUED LIFELONG.

Prevention of mother-to-child transmission

In the absence of ART, the probability of HIV transmission from an HIV-positive woman to her infant during pregnancy, labor, delivery, or breastfeeding range from 15% to 45%. This can be reduced to below 5% with effective interventions during the periods of pregnancy, labor, delivery, and breastfeeding. These interventions primarily involve ART for the woman and a short course of ARV drugs for the infant. Access to ART should be provided as part of the MISP in all settings during the acute emergency. Extended PMTCT services should be incorporated into comprehensive maternal and newborn health (MNH) services when the acute phase is over.

Although most attention is paid to the medical intervention, the WHO PMTCT framework outlines a comprehensive PMTCT program following four prongs:

- Help women of reproductive age avoid HIV and other STIs
- Prevent unintended pregnancies
- Provide ARV prophylaxis during pregnancy, delivery, and breastfeeding
- Provide care, treatment and support to mothers and their families.

HIV testing and counseling

In many countries, offering HIV testing in antenatal care (ANC) as part of PMTCT has led to substantial decreases in new pediatric HIV infections and increased ART coverage for women. Testing of partners and retesting of pregnant women in late pregnancy or during breastfeeding has been less widely implemented and should be prioritized in high prevalence settings. PICT should be provided for all women on their first ANC visit. Testing can be provided by lay providers who are trained and supervised. Male partners

should be strongly encouraged to get tested and couples counseling should be made available. In high prevalence settings, retesting is recommended in the third trimester or during labor or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy.

Antiretroviral prophylaxis

Mothers known to be HIV-positive should be provided with lifelong ART or ARV prophylaxis throughout pregnancy

and breastfeeding. ART should be initiated immediately in women who test positive for the first time in pregnancy. Ideally, pregnant HIV positive women should be initiated on lifelong treatment, but in the absence of this option the national protocol should be observed. Key to ensuring support within families is involving partners in programs for PMTCT and providing couples counseling and ongoing follow up. Table 11.2 outlines preferred and alternative first-line ART regimens for HIV-positive pregnant and breastfeeding women.

TABLE 11.2 PREFERRED AND ALTERNATIVE FIRST-LINE ART REGIMENS

FIRST-LINE ART	PREFERRED FIRST-LINE REGIMEN	ALTERNATIVE FIRST-LINE REGIMENS ^{x,y}
Adults	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + DTG* TDF + 3TC (or FTC) + EFV400*,**,*** TDF + 3TC (or FTC) + NVP
Pregnant/breastfeeding women	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + NVP
Adolescents	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF (or ABC) + 3TC (or FTC) + DTG*,** TDF (or ABC) + 3TC (or FTC) + EFV400*,**,*** TDF (or ABC) + 3TC (or FTC) + NVP
Children 3 years to less than 10 years	ABC + 3TC + EFV	ABC + 3TC + NVP AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + EFV (or NVP)
Children less than 3 years	ABC (or AZT) + 3TC + LPV/r	ABC (or AZT) + 3TC + NVP

* Safety and efficacy data on use of DTG and EFV400 in pregnant women, people with HIV/TB coinfection and children and adolescents younger than 12 years of age are not yet available

** Conditional recommendation, moderate quality evidence. Refer to full guideline for more detail

*** EFV at lower dose (400 mg/day)

3TC lamivudine, **ABC** abacavir, **ATV** atazanavir, **AZT** zidovudine, **DRV** darunavir, **DTG** dolutegravir, **EFV** efavirenz

FTC emtricitabine, **LPV** lopinavir, **NVP** nevirapine, **r** ritonavir, **TDF** tenofovir

^x For adults and adolescents d4T should be discontinued as an option in first-line treatment

^y ABC or boosted protease inhibitors (PIs) (ATV/r, DRV/r, LPV/r) can be used in special circumstances

Where a woman who is known to be living with HIV presents for antenatal, delivery, or post-partum care, actively pursue the opportunity to prevent transmission of HIV to her infant. For the implementation of a prevention of mother-to-child transmission program the following must be established:

- ANC services
- Provider-initiated HIV testing and counseling
- Continuous availability of ARVs according to PMTCT protocols
- MNH care including safe delivery care
- Counseling on infant feeding
- Early infant diagnosis

Adapt monitoring systems by introducing patient passports as portable patient records. In acute emergencies when routine monitoring systems cannot be used, temporarily use a simplified paper-based facility record and develop a group of key indicators for humanitarian settings. This should be implemented as part of an approach that addresses other medical issues beyond HIV to help eliminate identification of HIV status and related stigma.

BOX 11.16: KEY RECOMMENDATION

MOTHERS LIVING WITH HIV SHOULD BREASTFEED FOR AT LEAST 12 MONTHS AND MAY CONTINUE BREASTFEEDING FOR UP TO 24 MONTHS OR LONGER (SIMILAR TO THE GENERAL POPULATION) WHILE BEING FULLY SUPPORTED FOR ART ADHERENCE.

Infant feeding

The risk of infants acquiring HIV through breastfeeding from mothers living with HIV must be balanced against the higher risk of death among non-breastfed infants from causes such as malnutrition, diarrhea, and pneumonia. Evidence on HIV transmission has shown that exclusive breastfeeding for up to 6 months is associated with a 3- to 4-fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding. The WHO recommends that mothers living with HIV should breastfeed for at least

12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence.

Staff working in this area should coordinate within the health sector/cluster and with national health authorities to promote a single infant feeding practice across communities as the standard of care.

The provision of ARVs to pregnant and breastfeeding women living with HIV and their infant is strongly recommended and the health sector/cluster should strive to introduce or continue them (see antiretroviral prophylaxis above). However, the absence of ARVs does not change the recommendations regarding breastfeeding.

ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practicing mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs. Shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all. In settings where health services provide and support lifelong ART, including adherence counseling, and promote and support breastfeeding among women living with HIV, the duration of breastfeeding should not be restricted.

BOX 11.17: PREVENTING HIV INFECTION IN INFANTS AND YOUNG CHILDREN

The WHO promotes a comprehensive strategic approach to the prevention of HIV infection in infants and young children, which consists of:

- Primary prevention of HIV infection
- Prevention of unintended pregnancies among women living with HIV
- Prevention of HIV transmission from mothers living with HIV to their infants
- Care, treatment, and support for mothers living with HIV, their children and families

In comprehensive SRH programs, all 4 components must be implemented in order to reach the overall goal of improving maternal and child health in the context of HIV.

PROGRAMMATIC EXAMPLE 11.1: INTEGRATING SRH AND HIV PROGRAMMING IN A HUMANITARIAN CONTEXT

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Uganda

INTRODUCTION: In Uganda, the International Rescue Committee is responding to the South Sudanese refugee crisis while also continuing to serve the host population and vulnerable communities. IRC provides primary health care support, including comprehensive sexual reproductive health (SRH) services, in the newly established settlement in Yumbe district through 2 health facilities that serve over 100,000 refugees. Additionally, the IRC supports 8 health facilities in Adjumani district (with a refugee population of over 86,000) and 3 health facilities in Kiryandongo district (with a refugee population of over 60,000 refugees) with delivery of SRH services.

PROJECT DESCRIPTION: According to UNAIDS, 360 new HIV infections occur per week in Uganda among adolescent girls and young women aged 15–24 years. In all efforts, HIV programming is integrated within comprehensive sexual and reproductive health work, ensuring care, treatment, and support for HIV positive patients. The IRC offers HIV counseling and testing (HCT) in all IRC-supported health facilities in an integrated manner. This includes both client- and provider-initiated HCT and routine HCT for pregnant women. Patients who have tested positive are provided with antiretroviral medications either at the same

location or through referral to a nearby accredited facility. HIV positive patients are also linked to available support services, including peer-support mechanisms such as family support groups for mother-baby pairs.

Through its SRH initiatives across Uganda, the IRC conducts routine HIV tests for all pregnant women, providing counseling and antiretroviral drugs to lower the risk of transmission from mother-to-child. The IRC also started family planning counseling for women who are HIV positive and for those who are not planning on having a child at the moment. This is in line with the integrated approach to HCT, linking this with other SRH services such as family planning, chronic illness care, post-abortion care, adolescent SRH, and gender-based violence.

LESSONS LEARNED: The IRC follows standard protocols set forth by the WHO and the Ministry of Health to ensure quality of SRH and HIV services. To support awareness-raising and promote care-seeking behavior, the IRC works with partners on the ground, such as Village Health Team members, to effectively inform communities about HIV prevention and treatment. Community engagement approaches include working through community and religious leaders, use of peer-support groups, and other community fora. The combination of quality health service provision with community level activities to increase awareness and demand for services serves to improve health outcomes for the affected population.

Oral pre-exposure prophylaxis

Oral PrEP is the use of antiretroviral drugs before HIV exposure by people who are not infected with HIV in order to block the acquisition of HIV. It is recommended that PrEP containing TDF should be offered as one prevention choice for people at substantial risk of HIV infection in combination with other HIV prevention approaches. “Substantial risk” of HIV infection is provisionally defined as HIV incidence around 3 per 100 person-years or higher in the absence of PrEP. HIV incidence higher than 3 per 100 person-years has been identified among some groups of MSM, transgender women, and heterosexual men and women who have sexual partners with undiagnosed or untreated HIV infection.

The WHO recommends PrEP be used as part of a package of combination prevention interventions that includes HIV testing, condom use, as well as screening and treatment of STIs. For this reason, appropriate messaging and counseling to potential users will be essential for successful and optimal use of PrEP. In addition, provision of PrEP needs to be consistent with the prevailing national guidelines.

BOX 11.18: WHEN TO START ART

Adults (>19 years old) and adolescents (10–19 years of age)	<ul style="list-style-type: none"> • ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count • As a priority, ART should be initiated in all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adults with a CD4 count ≤ 350 cells/mm³
Pregnant and breastfeeding women	<ul style="list-style-type: none"> • ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and at any CD4 cell count and continued lifelong.
Children younger than 10 years of age	<ul style="list-style-type: none"> • As a priority, ART should be initiated in all children <2 years of age or children younger than 5 years of age with WHO clinical stage 3 or 4 or CD4 count ≤ 750 cells/mm³ or CD4 percentage <25% and children 5 years of age and older with WHO clinical stage 3 or 4 or CD4 count ≤ 350 cells/mm³ • ART should be started in all TB patients living with HIV regardless of CD4 count • TB treatment should be initiated first, followed by ART as soon as possible within the first 8 weeks of treatment
Timing of ART for adults and children with TB	<ul style="list-style-type: none"> • HIV-positive TB patients with profound immunosuppression (e.g., CD4 counts less than 50 cells/mm³) should receive ART within the first two weeks of initiating TB treatment • ART should be started in any child with active TB disease as soon as possible and within 8 weeks following the initiation of antituberculosis treatment regardless of the CD4 cell count and clinical stage

11.3.7 Implementing comprehensive care for people living with HIV

ANTIRETROVIRAL THERAPY FOR PEOPLE LIVING WITH HIV

From the beginning of the humanitarian response, ensure continuation of ARV drugs for people who were already enrolled in an ART program before the onset of a crisis. For patients who are on ART, or who were on ART but who no longer have access to the medication, ARV continuity is a priority in order to ensure treatment effectiveness and to avoid developing viral resistance.

When refugees and returnees who are on ARV treatment are repatriated to their region or country of origin, ensure that they can continue their treatment without interruption. Link with health authorities in the country or region of origin to coordinate this.

Plan for comprehensive HIV testing and counseling and ART programs as soon as possible. Before initiating ART services, it is important, together with the representatives of the MOH and/or the health sector/cluster, to consider the following questions:

BOX 11.19: KEY RECOMMENDATIONS

For antiretroviral therapy for people living with HIV, the following are recommended:

- Perform an HIV test – or obtain a document - to confirm HIV status and a patient card showing the ART regimen that is/was followed
- If the individual is currently on ART, continue the treatment without interruption. If there has been treatment interruption, assess the reasons for the interruption and restart the regimen as soon as possible
- If the same ARV drugs as in the previously followed first-line regimen are not available, and if there is no history of treatment failure or serious adverse reaction to proposed alternative ARVs, substitute another first line regimen immediately, based on national protocols
- Patients who were previously taking protease inhibitors that are not available in the new setting can be prescribed a first-line regimen until second-line regimens become available. However, people who were on protease inhibitors due to an adverse reaction to a first-line regimen must be closely monitored if they are restarted on a first-line regimen. If toxicity recurs and second-line regimens are not available, ART should be discontinued. Continue prevention of opportunistic infections
- Provide adherence counseling and support in light of the emergency context and new adherence barriers

- What is the minimum provision of ARVs that can be made available?
- For how long is funding available? A minimum funding of one year should be guaranteed
- Can the affected population be enrolled in national ART programs?
- What are potential procurement and drug management constraints?
- What is the mobility of the population? What is the security situation and future likelihood of displacement that could lead to treatment interruption?
- What is the laboratory capacity (at the health center and/or the referral level)?
- Support to people living with HIV, including social protection and psychosocial support
- Treatment adherence support
- Patient information and education
- TB treatment and prophylaxis for opportunistic infections
- Family planning
- Food and nutrition support
- Community/home based care
- Palliative care

BOX 11.20: INITIATING A MINIMUM PACKAGE OF ART SERVICES

- National policies are available and known, standard operating procedures and standard treatment protocols are in place. When available, national protocols should be followed. In the absence of a national protocol, WHO guidelines should be followed
- Trained clinic and community workers with competence in treatment protocols, patient counseling, and community mobilization are available
- A 6 month start-up supply of medicines, including ARV, co-trimoxazole, TB treatment and treatment for other opportunistic and co-infections, and a procurement system to assure an uninterrupted supply of required medicines is in place
- Diagnostic supplies and laboratory capacity, including at least HIV diagnostics, hemoglobin or hematocrit determination, CD4 cell counts, TB diagnostics, malaria and syphilis testing are available
- A patient monitoring system (including patient treatment cards to provide to patients on ART to allow for follow up and continued care in another health facility) and referral and communication networks is established
- Information packages for patient counseling, education and community mobilization exist

Comprehensive care for people living with HIV is a component of primary health care that must be available in any humanitarian setting. This is especially important in settings with a generalized epidemic. The elements of comprehensive care include:

SUPPORT TO PEOPLE LIVING WITH HIV

Develop confidential programs to provide psychosocial support for people living with HIV. This may include individual counseling and support, support groups, or friends of people living with HIV and families to whom the patient has disclosed her/his/their HIV status.

Ensure that people living with HIV have non-discriminatory access to necessary food supplements and nutrition counseling through food assistance programs. Listing all eligible people without divulging reasons for their inclusion on the supplementary feeding lists helps avoid discrimination.

In humanitarian settings, people living with HIV need to be assured of an adequate supply of safe drinking water as they are more susceptible to infection and less able to recover from bouts of water-borne diseases. For similar reasons, provide people living with HIV with a long-lasting insecticidal net to reduce the risk of contracting malaria in endemic areas.

TREATMENT ADHERENCE SUPPORT

There are many reasons for which ART treatment adherence may be compromised in humanitarian emergencies, including low accessibility of services, lack of availability and accessibility of drugs, and poor quality of services provided. In addition, lack of acceptance or ability of the individual to adhere to the regimen may be influenced by factors including nutrition, stigma, and understanding about HIV and the benefits of ART by the patient. People living with HIV sometimes access ART from more than one

health facility which makes follow-up difficult.

In order to support people to adhere to their drug regimen, a number of measures can be taken including:

- Advocating for food support
- Implementing strategies to fight stigma
- Fostering social support through treatment adherence support groups
- Promoting expert patients who can provide support on a one-to-one basis
- Undertaking efforts to increase the level of understanding about HIV and the positive effects of ART
- Providing travel health cards to ensure access to medications

PATIENT INFORMATION AND EDUCATION

Standard patient information leaflets can be developed but it is important to consider the following:

- Specific circumstances including age appropriate information, language, literacy, and level of education
- Information on living with HIV as well as prevention measures

TB TREATMENT AND PROPHYLAXIS FOR OPPORTUNISTIC INFECTIONS

In many parts of the world, TB is the leading cause of HIV-related morbidity and mortality. Collaborate with TB control programs to ensure access for people living with HIV to TB treatment. Isoniazid is an effective, well-tolerated, and inexpensive antibiotic for TB preventive therapy, and should be provided to all people with HIV once active TB disease has been excluded.

To prevent other opportunistic infections in people living with HIV, cotrimoxazole is an effective, well tolerated and inexpensive antibiotic used to prevent pneumocystis pneumonia (PCP) and toxoplasmosis in adults and children with HIV. It is also effective against other infectious and parasitic diseases and demonstrates significant benefits in regions affected by malaria. Furthermore, all HIV-exposed children born to mothers living with HIV must receive

cotrimoxazole prophylaxis, commencing at 4-6 weeks of age and continued until HIV infection can be excluded. In all cases follow national guidelines.

From the start of the humanitarian response, ensure continuation of prophylaxis and refer patients quickly to services providing this.

FAMILY PLANNING

People living with HIV must have access to family planning resources. Offer quality counseling on issues such as contraceptive methods when living with HIV, dual protection with both condoms and a pregnancy prevention method, emergency contraception, abortion, and availability of pregnancy support.

FOOD AND NUTRITION SUPPORT

People living with HIV are particularly vulnerable to food insecurity. There is a correlation between food insecurity and treatment adherence, retention, and success. Food insecurity and limited food consumption can reduce adherence to ART, which exacerbates illness and may lead to drug resistance, and increase transmission. Uninterrupted access to treatment, care, and food and nutrition support is crucial to ensuring adherence and preventing drug resistance and the need for expensive second and third line ART regimens.

Food and nutrition for people living with HIV plays a key role in improving retention and treatment outcomes. Most importantly, it reduces mortality risk among people living with HIV who are malnourished (body mass index (BMI) <18.5). Currently, malnourished people living with HIV are 2 to 6 times more likely to die when starting ART compared to people with optimal nutritional status. Given that the HIV epidemic is often most severe in food-insecure settings, food and nutritional assistance provides critical support to people and helps promote access and adherence to treatment and care in these resource-constrained settings. As part of the continuum of care, nutrition assessment and counseling should be included in the comprehensive package of treatment and care to support nutritional status and health. In specific situations, support, in the form of nutritious food, and household and/or livelihood support, may also be required.

Symptomatic people living with HIV require more calories than people who are HIV-negative. At the same time,

HIV and associated opportunistic infections undermine the immune system, limiting nutrient intake, absorption, and use. In the absence of treatment, undernutrition weakens the immune system even further, which increases susceptibility to infections, lowers quality of life and increases mortality risk. Because of the significant association between low BMI and mortality among both people living with HIV and TB patients, patients should be treated for all three conditions (HIV, TB, and malnutrition) concurrently.

COMMUNITY/HOME-BASED CARE

It is important to establish a community/home-based care

system to which people with advanced HIV infection can be referred when discharged from the hospital. This is best initiated as soon as the humanitarian situation stabilizes. Clinical and social support for people living with HIV must go hand in hand.

PALLIATIVE CARE

Palliative care should cover the management of both acute and chronic symptoms and terminal care. Important elements include pain control, other symptom management, terminal care, back-up-to any community/home-based care provided, information, and education.

BOX 11.21: IMPLEMENTING COMPREHENSIVE CARE FOR CHILDREN LIVING WITH HIV

Children present different challenges in the management of HIV especially in the diagnosis and treatment. The following actions are recommended for the care of children with HIV:

- Early diagnostic approaches vs. Nucleic Acid Testing (NAT), including point of care diagnosis
- Base initiation of treatment for children on national guidelines
- Use WHO guidelines for clinical HIV diagnosis where diagnostic and monitoring facilities are not available
- When ordering syrup formulations, be prepared to have sufficient refrigerated storage space and a functioning cold chain as they come in large volumes
- In settings where the diagnosis of HIV in children born to HIV-positive mothers may be delayed due to lack of laboratory testing capacity, start these children on cotrimoxazole at 4-6 weeks of age, or on first contact with health services
- Where polymerase chain reaction (PCR) monitoring is not available, and in children < 18 months who are diagnosed clinically, counsel parents to seek confirmatory testing after 18 months of age with conventional antibody tests
- Unaccompanied minors and orphaned children need specific attention and may need to enter a special legal process or agreed upon guardian/caregiver arrangements
- The best interests of the child should drive all decisions

11.3.8 Coordinating and making linkages

HIV prevention and treatment and people living with HIV service provision should be integrated with other elements of SRH including contraception, comprehensive abortion care, and GBV and STI prevention and response. Further, HIV programming is critical for adolescent sexual and reproductive health, maternal and newborn health, LGBTQIA health, and mental health programming.

Coordinating with agencies and stakeholders working with key at-risk populations and incorporating people living with HIV into the design and implementation of initiatives is crucial. Engagement with other sectors is also critical and should include:

- Working with the local/host community health system
- Coordinating with the local/host country justice/security system
- Coordinating with respect to the supply chain for medical supplies, including ARVs, HIV testing kits, etc.
- Coordinating among sectors and stakeholders (government, international NGOs and UN agencies working on the displaced/refugee program), to integrate HIV and HIV prevention messages in:
 - o Protection: Protect against HIV-related human rights violations, orphans and unaccompanied.

- o Education: Promote access to relevant and proactive sexual education for all children and young people (see Chapter 6)
- o Shelter: Integrate HIV in shelter activities
- o Food security, nutrition and livelihood support: Ensure food security, nutrition and livelihood support and provide nutritional support to people living with HIV
- o Camp coordination: Integrate HIV in camp coordination and camp management.
- o Water, sanitation and hygiene: Integrate HIV in water, sanitation and hygiene programs
- Coordinating with human rights organizations and other local organizations

11.3.9 Advocacy

In humanitarian settings, advocacy for HIV is fundamental to securing equitable access to HIV and health services. Hostile policies, marginalization of vulnerable groups, criminalization of key populations, and inadequate funding are barriers requiring strong advocacy efforts. Significant advocacy is often required to secure buy-in and support from national governments, local authorities, and international partners and donors. SRH Coordinators and health program managers should advocate to relevant stakeholders to ensure that populations affected by emergencies have access to quality HIV prevention, care, and treatment services including treatment for opportunistic infections. It is particularly necessary to advocate for MISP interventions in the acute phase of the emergency and then to progressively and consistently advocate for comprehensive services as the emergency stabilizes.

All SRH actors should:

- Advocate for and create awareness of the importance of integrating HIV within emergency preparedness during the pre-crisis period through inclusion in the humanitarian response plan to ensure that HIV interventions are promptly implemented once a crisis occurs
- Advocate for national HIV policies to be aligned with the latest WHO guidelines and that displaced people are integrated into the national HIV policy, programming, and resource allocation. These populations are often overlooked
- Advocate for the provision of basic assistance to people living with HIV who are chronically ill, including adequate shelter, nutritional support, and palliative care. Because people living with HIV often have higher nutritional needs, include advocacy for additional nutritional provisions
- Advocate for cross-cutting health system strengthening to ensure durability of services and infrastructure. This is often challenging, but it is important to have a long-term view of disaster response and mitigation.
- Advocate for the inclusion of people representing affected communities in local, regional, and national coordination forums. It is especially important to ensure the involvement of communities in creating local solutions in order to strengthen ownership and effectiveness of services
- Advocate for adoption and introduction of effective interventions at all levels. For instance, advocacy for inclusion of PrEP in national guidelines could be essential in countries that have yet to adopt it
- Advocate for children's and women's rights and gender-sensitive policies and interventions. Women, young girls, and children are at risk of sexual violence, abuse, and exploitation especially in emergency settings. Protecting children and women is a priority. To mitigate gender inequalities, gender-based violence and exploitation, advocacy for girls' education, economic empowerment and rights is often necessary. In addition, advocacy for gender-sensitive interventions and response programs to gender-based violence that are linked to HIV prevention is often essential
- Advocate for SRH information and services for adolescents, especially girls and key young populations. This includes advocacy on meeting contraceptive needs for women
- Advocate against social and structural drivers of stigma and discrimination of people living with HIV and key populations. This may include attitudes, employment

practices, or legislation and laws that stigmatize or discriminate against these populations. Where there are legal obstacles to accessing evidence-based HIV prevention (for example needles and syringe or OST for people who inject drugs), care, and treatment, advocate for these to be repealed

- Advocate and support governments to meet their accountability obligations under international human rights commitments and national policies. This may include advocacy related to government and donors fulfilling their commitments to providing the best possible care to people regardless of their displacement status, migration, race, and other characteristics and that these services meet accepted minimum standards

11.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

Ensuring that human rights are respected and protected is critical both for reducing exposure to HIV and mitigating its adverse effects on individuals and communities. International human rights law contains a number of points that are of direct relevance to people living with or otherwise affected by HIV. The provision of rights promoting HIV interventions is essential in emergency programs, where sexual violence and reduced access to HIV prevention, care, and treatment services increase the risk of HIV transmission. Key human rights issues include:

- The right to access HIV and AIDS healthcare. The right to the highest attainable standard of mental and physical health includes the right to available, accessible, acceptable, and quality health facilities, goods and services. Access to HIV programs must be at least equivalent to those available to others in the surrounding host community. Furthermore, the right to health can only be realized in conjunction with rights to food, water, housing, and freedom from discrimination and violence, among other rights
- The right to access HIV information and education. The right to health includes the right to essential health information and education on HIV, as well as SRH

- The right to be free from discrimination. All persons should enjoy the right to be free from discrimination on the basis of gender, sexuality, and HIV status and ensure access to HIV prevention, treatment, and care services
- The right to voluntary health interventions. The right to provide informed consent and to be free from mandatory HIV testing. The right to physical integrity ensures that all persons have the means to make voluntary, informed decisions about their health care, including whether to learn their HIV status
- The right to privacy and confidentiality in HIV-related care. Guarantees of privacy and confidentiality of health information are essential to ensuring that all persons, including women regardless of marital status, can seek health services without fear that their HIV status will be disclosed or revealed
- The right to access asylum procedures and protection from expulsion and refoulement. For those who are asylum seekers, their HIV status does not constitute a bar to accessing asylum procedures. The right to be protected against refoulement is the cornerstone of international refugee law and HIV status is not a ground for any exception to this principle. HIV status would also not fall within the permitted grounds for expulsion to a third country
- The right to HIV-related protection measures for women, girls and boys. Women and girls are disproportionately affected by HIV and AIDS and gender inequality can play a significant role in the protection problems they face, including increased exposure to violence. Appropriate measures need to be taken to ensure their protection against sexual or physical violence and exploitation. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV
- The right for people in prisons to access health services equivalent to the community. Health care in prisons should have the same standards, same ethics, adapted to the needs and linked to health services in the community

States have recognized the importance of gender equality, empowerment, and participation of women and girls in all aspects of HIV prevention and response. In particular, gender-specific protection must be adequately addressed and special attention must be paid to the health needs of women and girls, including ensuring access to reproductive health care and services, and appropriate counseling and treatment in all cases of sexual and gender-based violence.

Children are entitled to special protection under international law, as highlighted in the UN Committee on the Rights of the Child. In particular, the Convention on the Rights of the Child specifies that non-discrimination, best interests of the child, the right to life, survival and development, and participation of the child should guide the responses in all cases involving children.

SRH Coordinators, health program managers, and service providers must be familiar with national legislation and policies and guidelines pertaining to HIV prevention, treatment, and care in the country. In some instances, human rights may be compromised by national laws, policies, or social and cultural misconceptions. It is important to discuss potential dilemmas with teams and supervisors and decide on the agency/organization's type of engagement. Important immediate steps service providers can undertake are to ensure they inform clients directly on possible negative consequences of the law. Furthermore, it is important to explore referral possibilities for clients to another agency or organization that could provide legal support and assistance. Organizations may decide to advocate on the issue and contribute to joint agency advocacy efforts.

11.5 MONITORING AND EVALUATION

If collected systematically across sectors and agencies, the set of indicators listed on Table 11.3 can help gauge the degree to which the set objectives of the multi-sectoral response are achieved. The information collected will help HIV program planners and managers, as well as humanitarian actors, to monitor whether:

- HIV preparedness is in place for an emergency situation
- The required HIV interventions, for both the MISP and comprehensive services, are in place during a humanitarian crisis
- The needs of key populations at higher risk of exposure to HIV and other groups at-risk are adequately addressed
- The desired coverage and impact of the intervention is achieved

TABLE 11.3 PRIORITY INDICATORS

NAME	DESCRIPTION	FORMULA	STANDARD	REMARKS
Quality of blood donation screening	Percentage of donated blood units screened for HIV in a quality assured manner	Number of donated blood units screened for HIV in a quality assured manner/Total number of donated blood units screened x 100	100%	Measure blood safety for transfusion. Assumes blood transfusion kits are available and used correctly
PMTCT coverage	Proportion of first time ANC visits who were pre-test counseled	Number of first ANC visits pre-test counseled/Number of first ANC visits	100%	
PMTCT post-test counseling and result	Proportion of first ANC visit clients tested for HIV, who receive post-test result and counseling	Number of first ANC visit clients who receive post-test result and counseling/Number of first ANC visit clients tested for HIV x 100	100%	Indirect measure of the quality of counseling and testing within a PMTCT program
Coverage of ARV in PMTCT programs	Percentage of HIV-positive pregnant women receiving ART to reduce the risk of mother-to-child transmission	Number of pregnant women who swallowed ARV according to protocol/Total number HIV positive deliveries x 100	100%	
Coverage of ART among infants	Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for PMTCT			
ART Coverage	Percentage of people living with HIV receiving ARVs (according to national protocol)			

11.6 FURTHER READING AND ADDITIONAL RESOURCES

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CHAPTER 12

SEXUALLY TRANSMITTED INFECTIONS (STIs)

- 12.1 Introduction
 - 12.2 Objectives
 - 12.3 STI programming
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12.1 INTRODUCTION

Sexually transmitted infections (STIs) cause a large proportion of the global burden of ill health. The World Health Organization (WHO) estimates that more than 357 million new cases of 4 curable STIs (gonorrhea, chlamydia, syphilis, and trichomoniasis) occurred in 2012. If viral (non-curable) STIs, such as human papillomavirus (HPV), herpes simplex virus (HSV), hepatitis B, and human immunodeficiency virus (HIV) infections are included, the number of new cases may be 3 times higher. Among women, non-sexually transmitted reproductive tract infections (RTIs), such as yeast infection or bacterial vaginosis, are even more common.

BOX 12.1: STI VERSUS RTI

Not all sexually transmitted infections are reproductive tract infections; not all reproductive tract infections are sexually transmitted:

- STI refers to the way of transmission
- RTI refers to the site where the infections develop

Reproductive tract infection is a broad term that includes sexually transmitted infections as well as other infections of the reproductive tract that are not transmitted through sexual intercourse. In most cases, STIs have much more severe health consequences than other RTIs, thus the term STI/RTI is used in this manual to highlight the importance of STIs within RTIs. When information provided in the document is relevant to sexually transmitted infections only, the term STI is used alone.

STIs/RTIs are found worldwide, but transmission and prevalence (how common they are) are influenced by social and economic factors as well as by biology and behavior. Therefore, the burden of STIs/RTIs varies greatly from region to region and from community to community. For example:

- STIs such as syphilis, gonorrhea, and chancroid may spread more rapidly in places where communities are disrupted, migrant labor is common, and commercial sex networks are active
- Iatrogenic infections, that is infection caused by medical procedures or examinations, are more common where there are many STIs and where service providers do not have the training or supplies to perform procedures safely. Postpartum and post-abortion infections are more common where safe services and follow-up care are not available
- Endogenous infections, such as yeast infection and bacterial vaginosis, are common worldwide and are influenced by environmental, hygienic, hormonal, and other factors

The emergence of HIV has focused greater attention on the control of STIs. There is a strong correlation between STIs and HIV transmission. The presence of other STIs has been found to increase the risk of sexual transmission of HIV.

In humanitarian settings, the risk of STI (including HIV) transmission may be high due to increased sexual violence, the presence of workers in high mobility jobs (e.g., truck drivers, peacekeepers), transactional sex, alcohol and drug use, lack of information and access to condoms, and high population density in camps.

12.2 OBJECTIVES

The objectives of this chapter are to assist sexual and reproductive health (SRH) Coordinators, health program managers, and service providers in humanitarian settings to:

- Meet the needs of individuals infected with STIs/RTIs or who may be at risk of STIs/RTIs
- Support the implementation of effective public health approaches to reduce the transmission of STIs

12.3 STI PROGRAMMING

12.3.1 Minimum Initial Service Package implementation

Ensuring the availability of syndromic diagnosis and treatment of STIs is incorporated into the Minimum Initial Service Package (MISP) under the objective, “prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.” Guaranteeing the availability of free lubricated male condoms and ensuring provision of female condoms when the population was exposed to them before the crisis are also important components of prevention. It is also necessary to make treatment available for patients presenting with STI symptoms as part of routine clinical services at the onset of the humanitarian response.

12.3.2 STI public health package

Sexually transmitted infections are a public health problem of major significance in most parts of the world. Failure to diagnose and treat STIs at an early stage may result in severe and life-threatening consequences, including

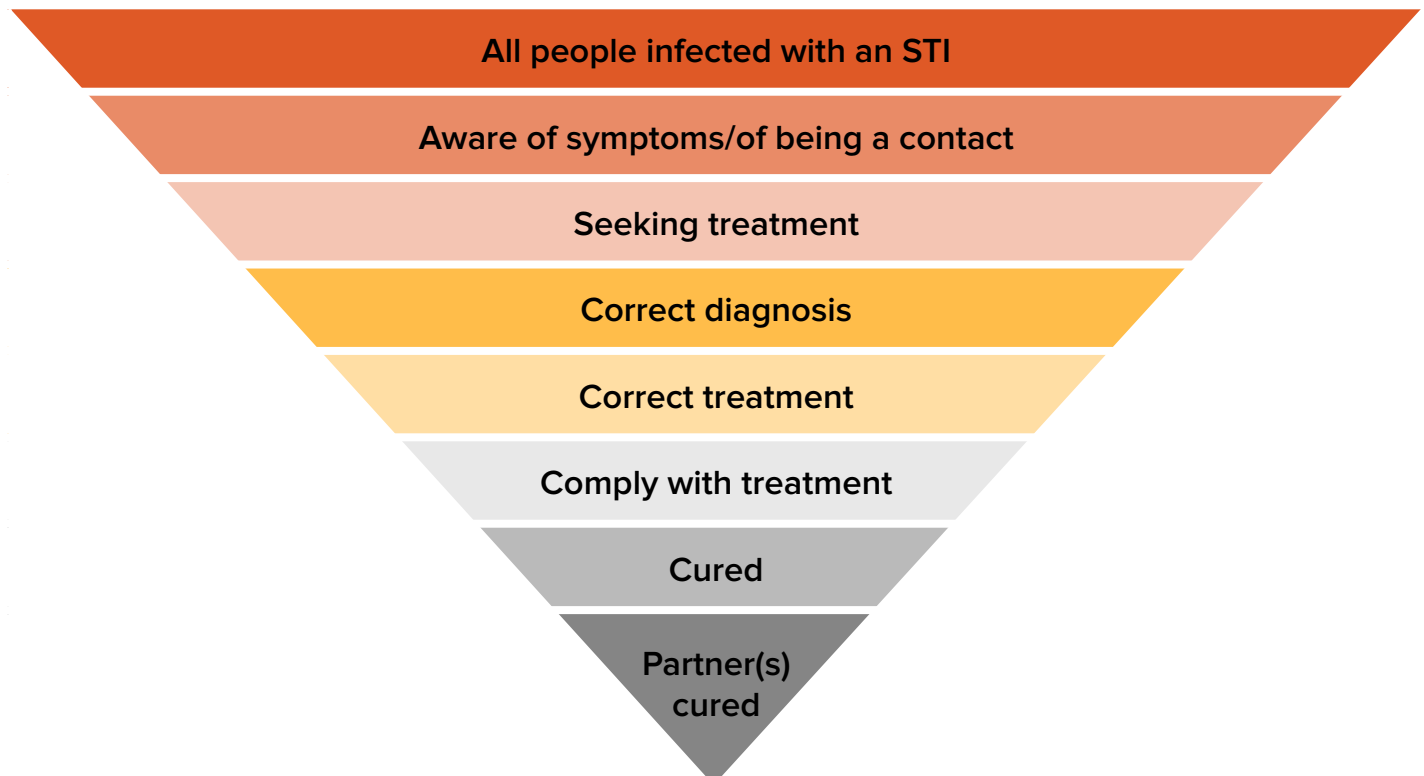
infertility, miscarriage, preterm delivery, stillbirth, ectopic pregnancy, ano-genital cancer, and premature death, as well as neonatal and infant infections. There are a number of challenges to providing effective STI/RTI services to the people who need them, as shown on Fig. 12.1. Many people are asymptomatic or not aware that they have an STI (and STIs are more often asymptomatic in women) and

therefore do not seek care (see Fig. 12.2). Others who have symptoms choose to treat themselves or seek treatment at pharmacies or from traditional healers. Those who come to the clinic may not get the appropriate diagnosis and treatment. In the end, only a small proportion of people with an STI are cured and avoid reinfection.

FIGURE 12.1:
ASYMPTOMATIC
VERSUS
SYMPTOMATIC
INFECTIONS



FIGURE 12.2: STIs: A PUBLIC HEALTH PROBLEM



The objective of STI programming is to reduce the prevalence of STIs by interrupting their transmission, reducing the duration of infection, and preventing the development of complications in those infected.

Controlling the spread of STIs is challenging. Public health programs must not only ensure accessible, good-quality health services that provide comprehensive STI case management, but also address biological, behavioral, and social factors that influence the spread of STIs.

The complete public health package includes:

AT COMMUNITY LEVEL

- Safer-sex promotion campaigns
- Condom programming
- Public awareness of STIs and promotion of early use of clinic services

AT HEALTH SERVICE LEVEL

- Comprehensive STI case management at first contact
- Specific services for populations at risk, including sex workers, adolescents, military personnel, and prisoners

INTEGRATION OF STI MANAGEMENT

- Integrate STI prevention, screening, and care into other services

12.3.3 Needs assessment

After the MISP is in place, SRH Coordinators should integrate STI considerations into needs assessments for comprehensive SRH service planning in order to design appropriate and comprehensive STI prevention, treatment, and control programs. They need to collect the following information, in coordination with other health sector/cluster actors:

- Prevalence and types of STIs in the host and home country, region or area. This information may be available from the national STI programs and the WHO
- The presence of at-risk groups and the location within the affected community where interventions should

be targeted as a priority (e.g., where sex work takes place, bars). This information can be obtained through interviews with key informants from the community

- Cultural and religious beliefs, attitudes, and practices concerning sexuality, reproductive health, and STIs/RTIs. This information can be obtained through qualitative research using focus group discussion, interviews and, if possible, knowledge, attitudes, and practices (KAP) surveys
- Existence of a reliable and sustainable medical commodity supply chain that can support the implementation of STI/RTI services

SRH Coordinators must be familiar with national legislation and policies related to STIs:

- Are there national guidelines or protocols on the management of STIs? If yes, are there discrepancies between national policies and WHO guidelines? Do the guidelines account for the latest patterns of antibiotic resistance in STI infection within the country?
- Are STI guidelines accessible to the healthcare providers that need them? For example, in printed formats, charts, and quick reference job aids?
- Are all appropriate STI treatment drugs included in national drug treatment guidelines? Do national guidelines include drugs that are no longer effective against certain infections?
- Are the STI drugs part of the country's Essential Medicines List? Which health care providers can prescribe them?
- Are there any restrictive policies limiting STI service provision?
- Are there laws or national policies regarding partner notification?
- Are there national policies relating to STI control programs?

It is also necessary to:

- Liaise with national health authorities to identify or develop a syndromic management protocol for STIs

- Identify a reliable medical commodity supply chain to ensure sustainable supply of effective STI drugs
- Identify people in the affected community who have been trained in STI prevention and control and staff training needs
- Identify appropriate sites to set up STI management services as well as other SRH services that should integrate it

12.3.4 Community interventions

The community-level approach to prevention and control of STIs/RTIs includes:

- Safer sex promotion campaigns, including consistent condom use, fewer partners, and delaying onset of sexual activity
- Condom programming
- Public awareness of STIs and promotion of early use of clinic services
- Integration with HIV prevention campaigns and community outreach efforts

SAFER SEX PROMOTION

The best approach to prevent STIs is to avoid exposure. This can be achieved by:

- Using condoms correctly and consistently
- Decreasing the number of sex partners
- Giving support to young people for decisions to delay sexual activity

Condoms are the most reliable method available for people to protect themselves or their partner from any risk of STI acquisition. When used correctly and consistently during every act of intercourse, condoms can greatly reduce the risks of pregnancy and STIs (including HIV infection). STIs can still occur despite condom use; genital ulcers or warts can be transmitted through contact with parts of the body not covered by the condom.

People commonly get an STI because they misuse condoms or use them inconsistently. When handled or stored incorrectly, for example in wallets or in a hot place,

or if used with oil-based lubricants, male condoms may fail. Condom breakage is usually due to incorrect use, not to defects in the device.

Male condoms are mostly made of latex and are widely available, inexpensive, and highly effective. Because they are easy to carry, protection can be available at any time.

Female condoms are made of polyurethane or nitrile plastic, which is sturdier than latex, and are becoming more widely available and at a lower cost than when first introduced. They have the advantage of giving the woman control over their use, although she may still have to negotiate use with her sexual partner.

Limiting the number of sex partners can help reduce exposure to STIs. People in mutually monogamous relationships (where both partners have no other sex partners) have no risk of STIs if both are free of infection. Sexual abstinence is another way to avoid risk of STIs (although other RTIs are still possible).

Many people need prevention strategies other than monogamy or abstinence. Monogamous relationships do not provide protection from STIs when they follow one another in rapid succession (serial monogamy). Couples who are separated from each other for periods of time may also require other strategies. Men and women whose jobs involve travel (e.g., migrant workers, vendors, truck drivers, soldiers) are more likely to have multiple partners and return home with an STI. Whatever the circumstances, both women and men with multiple partners (or whose partners have multiple partners) need reliable protection from STIs.

Delaying sexual activity and reducing exposure to STIs. Young people, in particular adolescents, can avoid STIs and pregnancy at a time when they are particularly vulnerable by delaying sexual activity until they are older. Young people should know that they can get support and confidential information on methods, including condom use, for preventing pregnancy and STIs when they decide to become sexually active.

Support for delaying sex is most important for young girls as they may face severe social and health consequences if they become pregnant or develop an STI. Adolescent girls are particularly vulnerable to cervical infections that can lead to pelvic inflammatory disease (PID), infertility,

ectopic pregnancy and, in the long term, cervical cancer.

Of paramount importance to STI risk reduction is ensuring women and adolescent girls have agency over sex and can decide when, how, and with whom to have sex. This will require societies to condemn all forms of violence against women and girls that put women and adolescent girls at high-risk for STIs and other negative outcomes. Women and girls must be safe to make decisions about whether to have sex and to engage in safe practices without the threat of violence or forced or coerced sex. This will not only require support from their partner(s) but also information and self-efficacy and skills to negotiate sexual decision-making and changes in social norms that promote and condone girls' and women's physical autonomy. Activities to support the achievement of this outcome might include community-level activities that condemn violence against women and girls, discussion groups and participatory workshops that engage men and women to explore gendered roles, examine sexual decision-making, and challenge and transform traditional masculinities, as well as comprehensive sexual education in schools.

CONDOM PROGRAMMING

Good quality condoms are essential for the protection of the consumer and the credibility of the SRH program. There are many brands of condom on the market. Several agencies can facilitate the purchase of bulk quantities of good quality condoms at low cost.

To ensure access to condoms, a system of procurement and distribution must be in place. Condoms and instructions for their use should be available in health facilities, distribution centers (such as food and non-food item distribution areas), community centers, shops, bars, and youth and women's groups, etc. Discuss with authorities and partners whether or not to continue making condoms available free of charge after the initial humanitarian response. The introduction of some form of partial cost-recovery (social marketing) may be considered in situations where this is feasible and appropriate. Social marketing strategies may be explored with appropriate partners.

Community health workers and peer educators need to be trained in the promotion, distribution and use of condoms. Promotional campaigns can be launched at public events such as football matches, mass rallies, dance parties, theatres, and group discussions. Liaise with groups

involved in HIV prevention and family planning activities in the area. Condom programming and counseling messages should incorporate the concept of dual protection from STIs and pregnancy from the inception.

PUBLIC AWARENESS OF STIs

Community education and outreach are needed to promote early use of healthcare services to cure STIs/RTIs and prevent complications. Develop messages to teach people how to recognize symptoms and when and where to seek care. Community messages should also address the risk of acquiring or transmitting an STI while asymptomatic. Disseminate the messages through public advertisements, radio, papers, and teaching sessions at clinics, etc.

Individuals with STIs also need support from family members and their community to ensure they can seek care. This will require work at the community level to reduce stigma against STI clients. Conducting participatory training and awareness raising activities with community members to increase their awareness of STIs and how common they are, challenge and reduce existing stigma, and foster supportive behavior among community members towards individuals living with STIs is critical.

12.3.5 STI and reproductive tract infection case management

Effective and prompt management of STIs is one of the cornerstones of STI control, as it prevents the development of complications for the individual, decreases the spread of STIs in the community, and offers a unique opportunity for targeted education about STI prevention. The sooner an STI is cured, the less chance there is that it will be transmitted to other people. Appropriate treatment of STIs at the first contact between patients and healthcare providers is therefore an important public health measure. In the case of young people, there is a potential to influence future sexual behavior and treatment-seeking practices.

STI management involves more than diagnosis and treatment. Even when STIs are correctly treated, treatment failure or reinfection may occur. Some patients may stop taking their medicines as soon as they start to feel better, fail to arrange for their sex partners to be treated, not use condoms, or not abstain from sex during treatment. Drug resistance may also be a reason for treatment failure. Therefore, comprehensive case management must be

undertaken during the first encounter and include:

- Diagnosis
- Prompt and effective treatment according to protocols
- Education and counseling of the patient, including condom provision
- Partner notification and treatment
- Follow-up as appropriate
- Quality of care

DIAGNOSIS

Diagnosing STIs is challenging, as there is no simple tool that provides the correct diagnosis within a short time and without using expensive laboratory tests. Diagnosing STIs can be done in 3 ways:

Clinical diagnosis

The service provider determines the underlying cause of the infection based on clinical examination and personal experience. This approach is not reliable, as even the most experienced providers cannot make specific diagnosis based on clinical assessment alone. Furthermore, mixed infections cannot be detected.

Laboratory diagnosis

This approach uses laboratory tests to determine the cause of the STI/RTI. However, this approach is problematic in many settings, because inexpensive, simple, reliable tests may not exist. Most available tests do not give immediate results, which will lead to delays in treatment or no treatment if patients do not return for care. In addition, the sensitivity and specificity of commercially available tests vary and false negatives are common. Where laboratory facilities are available, they must be staffed by suitably qualified personnel. This puts a constraint on the time and resources of the health services, increases costs and reduces access to treatment.

Exceptions to this are laboratory tests for HIV and syphilis (either the Rapid Plasma Reagin (RPR) test or the Rapid Diagnostic Test (RDT)). These tests can be conducted by healthcare staff with minimal training and give results in a short time. They can be used for screening.

Syndromic approach

Many STIs/RTIs can be identified and treated on the basis of characteristic signs and symptoms that can be grouped together into syndromes, as illustrated in Table 12.1.

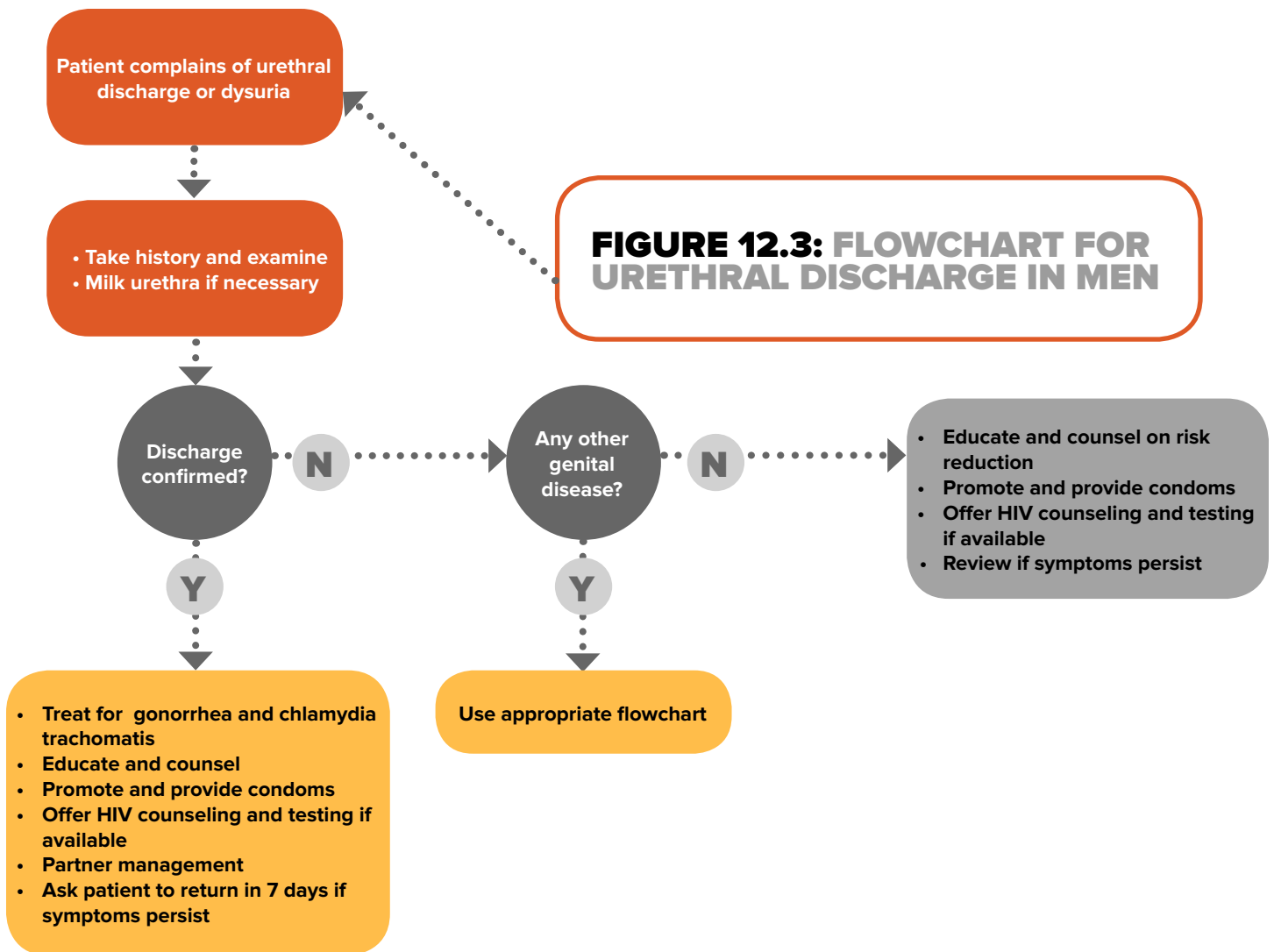
TABLE 12.1: STI SYNDROMES

SYNDROME	STI/RTI
Genital ulcer (for both men and women)	Syphilis Herpes Chancroid Granuloma inguinale Lymphogranuloma venereum
Urethral discharge (in men)	Gonorrhoea Chlamydia
Vaginal discharge	Bacterial vaginosis Yeast infection Trichomoniasis Gonorrhoea Chlamydia
Lower abdominal pain (in women)	Gonorrhoea Chlamydia Anaerobic infections
Inguinal bubo (in men and women)	Chancroid Lymphogranuloma venereum (Granuloma inguinale or Donovanosis where prevalent)

It is often difficult to know exactly what organism is causing the syndrome and treatment needs to cover several possible causative infectious agents. Therefore, the syndromic approach is based on:

- The identification of consistent groups of symptoms and easily recognized signs
- The provision of treatment that will deal with the majority of or the most serious organisms responsible for producing a particular syndrome

A simplified tool (flow chart) guides health workers in the implementation of syndromic management of STIs (See Fig 12.3).



Advantages of the syndromic approach

- Patients are treated at the first contact with the healthcare system, which leads to a decrease in complications for the individual and eventually a reduction in transmission of STIs in the population
- The approach is cost-saving (no expensive lab tests)
- Prompt treatment improves client satisfaction
- It is easier to monitor a service that uses the syndromic approach, because of the standardization of staff training, diagnosis, treatment and supplies management

Disadvantages of the syndromic approach

- Over-diagnosis and over-treatment increase treatment cost (but this is outweighed by the overall cost-effectiveness of the syndromic approach)
- Giving multiple antimicrobials possibly increases the risk of side effects
- The syndromic approach cannot be used for screening because asymptomatic infections cannot be detected. As a result, detection and management of cervical infections in women and girls may be limited
- If the patient is not counseled properly, there may be an increased risk of domestic violence

BOX 12.2: THE CASE OF VAGINAL DISCHARGE

Syndromic approach works well for urethral discharge and ulcerative STIs, but is not as effective for vaginal discharge. Most vaginal discharge is the result of an RTI, such as yeast infection and bacterial vaginosis. These organisms cause vaginal infections and are not sexually transmitted. Much less often, vaginal discharge may be the result of an inflammation of the cervix (cervicitis) caused by gonorrhea or chlamydia. These organisms are sexually transmitted.

Vaginal discharge algorithms are not designed to detect the more serious and often asymptomatic cervical infections. At present, accurate detection of gonococcal and chlamydial cervicitis requires expensive laboratory tests (polymerase chain reaction (PCR)), which are not available in most settings. Other screening tools include

speculum examination (which may detect many, but not all, cervical infections) and culture for gonorrhea (which is accurate and not expensive or technically difficult, but needs to be set up in established laboratories).

In humanitarian settings, service providers must take a no-missed-opportunities approach. This means that they look for risk factors in a patient's history (e.g., does the partner have symptoms? Is the client a sex worker?) and for signs on examination (e.g., is there mucopurulent discharge? Does the cervix bleed easily when touched?). Screening may be done during pregnancy or any time a speculum examination is performed for other reasons. Service providers must offer regular screening to people with frequent exposure to STIs, such as sex workers.

PROGRAMMATIC EXAMPLE 12.1: IMPLEMENTING THE SYNDROMIC APPROACH IN A HUMANITARIAN CONTEXT

ORGANIZATION: Save the Children

LOCATION: Yemen

INTRODUCTION: Ongoing conflict in Yemen has resulted in one of the world's largest humanitarian crises, with more than 20 million people in need of assistance and less than half the country's health facilities functioning.

PROGRAM DESCRIPTION: In 2010, Save the Children launched a program in Amran governorate in western central Yemen to address the sexual and reproductive health needs of displaced women and girls. Save the Children, in collaboration with the Ministry of Health, trained mobile health teams of doctors, midwives, and nurses to deliver a range of services including contraception, antenatal care, and postnatal care. The program later expanded to other governorates and districts. As of 2017, Save the Children in Yemen's health program is functional in 8 governorates supporting almost 75 fixed health facilities and mobile teams serving 110 sites.

RESULTS: Soon after mobile health teams were deployed, health providers began to report a large number of clients in need of STI case management and it became critical to address this service gap. In order to do so, Save the Children staff first reviewed Yemen's national guidelines on the syndromic management of STIs to ensure they were up to date and there were no major discrepancies with WHO guidelines. Then, Save the Children partnered with the WHO, the Ministry of Health, and governorate officials to conduct a training on syndromic management of STIs for 25 midwives.

At static health facilities, the team printed and displayed STI syndrome management flow charts to aid health providers in case management. Mobile health teams used smaller flip charts during their outreach activities. The health team also worked closely with community volunteers and trained them to share messages on STI signs and symptoms and encourage women to come to the facility or mobile clinic for care. STI services were integrated into the full package of SRH services provided in the program and were delivered in a confidential space, which helped to reduce stigma. In addition, rapid syphilis tests were integrated into routine antenatal care that was provided by mobile health teams. From January to December 2017, more than 6,000 women and men received treatment for an STI in Save the Children supported facilities in Yemen.

LESSONS LEARNED: Securing support and buy-in from the Ministry of Health and governorate officials to implement the syndromic approach was important to the success of the program. In order to do so, it was important to position STI services as an integral component of a comprehensive package of SRH services. Partner notification and treatment remains challenging due to the polygamous context, although it is encouraged during counseling. The program also works hard to ensure a steady supply of STI commodities and drugs but this is often affected by the procurement delays and barriers resulting from ongoing insecurity. Despite these challenges, the program has successfully been able to improve provider competency on syndromic management of STIs and expand women's access to these important services.

Treatment

STI/RTI symptoms and signs are treated based on the organisms most commonly responsible for each syndrome. Antibiotic resistance to several sexually transmitted pathogens is increasing, which may render some widely available and low-cost antibiotic regimens ineffective. Therefore, treatment algorithms need to be adapted based on:

- Local epidemiology (the prevalence of STIs/RTIs and the pathogen underlying the syndromes in the population)
- Antimicrobial sensitivity patterns (e.g., which antibiotics are effective against *Neisseria gonorrhoeae* and *Haemophilus ducreyi*)
- Cultural and behavioral practices

At the onset of a humanitarian response, it may be necessary to use the WHO standard treatment guidelines with antimicrobials that are known to be effective globally. Some recommended antimicrobials from these guidelines are included in the Inter-Agency Reproductive Health Kits (RH Kits). In many countries the Ministry of Health (MOH) has developed national STI protocols. It is important to encourage the use of the appropriate protocol in the setting as soon as possible. Such standardized treatment guidelines will facilitate staff training and procurement of supplies for STI programs and this will help ensure that all patients receive adequate treatment. Consequently, SRH Coordinators must implement national STI protocols where these exist. Where they do not exist, encourage discussions between the MOH and the WHO to develop an adapted national or regional protocol.

TABLE 12.2: EXAMPLES OF STI/RTI DETECTION AND TREATMENT STRATEGIES

METHOD	EXAMPLE — NO MISSED OPPORTUNITIES
History-taking	Ask about STI/RTI symptoms or concerns at each SRH visit
Clinical screening	Speculum and bimanual examination to look for signs of STI/RTI not noticed by the patient
Laboratory screening	Serological screening for syphilis Pap smear for early detection of cervical cancer; voluntary counseling and testing for HIV
Presumptive treatment on basis of risk criteria	Treatment of partners of STI patients, sex workers who have had unprotected exposure, etc. Survivors of sexual violence Treatment of women having a transcervical procedure
Combination strategies	Presumptive treatment of sex workers at first visit followed by regular visits for speculum/bimanual examination and Gram stain of cervical smear

Patient education and counseling

Patient education and compassionate and confidential counseling are essential components of STI/RTI management and include:

- Explaining the nature of the infection, possible complications (such as infertility), the medication to be taken, and the importance of compliance with the treatment
- Promoting safer sexual behavior. People may adopt safer sexual behaviors following treatment of an

STI. Therefore, each clinic visit is an opportunity to promote future prevention and adherence to current treatment

- Promoting, demonstrating, and providing condoms, as well as negotiating condom use with partners
- Discussing the risk of HIV infection and offering voluntary HIV testing
- Informing and communicating with sexual partner(s), options for partner tracing and the risk of violence or stigma (see Box 12.3)

- Screening for sexual violence, as appropriate and feasible, and referring survivors to available supports and services

BOX 12.3: STIs/RTIs AND STIGMA

Note that not all RTIs are sexually transmitted. Therefore, service providers must be careful not to mislabel or stigmatize someone as having an STI when the diagnosis is an RTI or is not clear. For instance, vaginal discharge is usually associated with an endogenous vaginal infection and not with an STI. Attempting to notify and treat sexual partners in this situation would be unnecessary as partners do not need treatment and notifying them may be damaging to the relationship. Violence, distrust, and divorce are possible consequences of partner notification if not managed correctly.

Partner management

Principles

When managing sexual partners, service providers must be sensitive and respectful, ensure confidentiality, and offer a voluntary and non-coercive approach. A patient who is successfully treated for an STI will experience relief of symptoms, but may return later with a reinfection if sexual partners are not also treated. The sexual partner may or may not have symptoms and, if left untreated, could spread infection to others in the community as well. It is essential for STI control to help patients notify their sexual partners and arrange for treatment. Note that partners include not only current partner(s) but all partners within the last 2 to 3 months. Partner management includes notification, referral and treatment. It is important to use a culturally accepted and safe way of informing the partner or partners.

Notification and referral

Many sexual partners are reluctant to wait or pay for services, particularly when they are asymptomatic and feel healthy. Organize services so that sexual partners have easy access to treatment (e.g., avoid long waiting times, waive normal clinic fees).

Partner notification can be offered in several ways:

1. Patient referral: Patients are encouraged to contact their sexual partners themselves. They can be given referral slips for their partners. These referral slips

explain how to arrange a clinic visit and must include a code to indicate the syndrome that was diagnosed in the index patient (the original patient who had symptoms). If confidentiality can be guaranteed, it is useful to include the record number of the index patient on the referral slip to help monitor partner referral rates (see Fig. 12.4)

2. Provider referral: Service providers with training in contact-tracing techniques notify partners and arrange for necessary treatment
3. A combination of Option 1 and Option 2 can be used where patients are first asked to contact partners themselves (patient referral). If unsuccessful after one to 2 weeks, trained service providers attempt to trace the contact for treatment (provider referral)

Because of the expense of provider referral and the perceived threat to patient confidentiality, the more practical and workable option is patient referral (Option 1).

FIGURE 12.4: EXAMPLE OF PARTNER REFERRAL

KINDLY PRESENT YOURSELF TO:
 Townville Clinic, New Town
 Tel: 456 834

OPENING HOURS

Monday 9:00 am – 3:00 pm
 Tuesday 9:00 am – 3:00 pm
 Wednesday 9:00 am – 3:00 pm
 Friday 9:00 am – 1:30 pm

Date: _____ Code: ABCD

Treatment of sexual partners

The primary objective is for the partners to be seen by a service provider for screening, treatment, and education. However, this may not be possible in humanitarian settings and different strategies to ensure the treatment of partners can be applied:

- Immediate treatment when partner presents to the service provider (based on the diagnosis in the index patient, whether or not partners have symptoms or

signs of infection). The WHO recommends use of the same antibiotic regimen as for the index patient

- Immediate treatment and taking specimens for laboratory testing
- Provide the index patient with appropriate treatment to give to her or his partner(s) (known as expedited partner treatment)

Treatment follow-up

In humanitarian settings, routine follow-up visits can be inconvenient for patients and burdensome for clinic staff. Syndromic management usually provides effective treatment for the most common STIs/RTIs and most patients will get better quickly. It is good practice to advise patients to come back if symptoms get worse or no improvement is seen after a week of treatment (2 to 3 days for pelvic inflammatory disease). Patients with genital ulcers have to return after 7 days if not getting better. Treatment should be prolonged beyond 7 days if a new layer of skin has not formed over the ulcer.

When patients do not get better, the following questions will help service providers determine whether this is due to treatment failure or reinfection:

- Treatment failure: Did the patient take all the medicines as directed? Did the patient stop taking medicines after feeling some improvements? Was the treatment based on national treatment guidelines? Consider the possibility of drug resistance if this was not the case
- Reinfection: Did the partner(s) receive treatment? Did the patient use condoms or abstain from sex after starting treatment?

Recurrence is also common with endogenous vaginal infections, especially when underlying reasons are not addressed in patient education (e.g., vaginal douching or drying agents). Refer patients to a higher level when the complexity of their case exceeds the capacity of your health center.

Quality of care

In order to ensure the quality of STI programs, services must be available, accessible, affordable, and appropriate. SRH Coordinators and health program managers can achieve this by reducing barriers to services (e.g., appropriate opening

times, private, confidential, respectful, and good quality clinical care) and reaching out to people who may not typically use STI services, including sex workers and their clients, military personnel, prisoners, and adolescents who are at higher risk of STIs. Encourage men to participate in STI/RTI prevention.

Quality of services and staff technical skills and motivation will improve if SRH Coordinators and health program managers:

- Post standard national STI management protocols in examination rooms. This can include syndromic approach charts posted in work stations
- Put in place a confidential and voluntary partner tracing system
- Arrange for training of service providers to become proficient in both technical and counseling skills. Trainings should address provider attitudes and stress the importance of supportive and non-judgmental attitudes in providing quality care throughout the entire STI prevention and care management cycle
- Collaborate with Health Coordinators to integrate a sustainable supply of effective STI drugs into the medical commodity supply line
- Conduct regular supervisory visits and in-service trainings

12.3.6 Coordinating and making linkages

SRH Coordinators need to aim for the integration of STI/RTI services into primary health care and other SRH programs, including:

- STI assessment in contraceptive and family planning services, by ensuring that service providers
 - Discuss STIs/RTIs with all clients at each visit (including inquiring about symptoms in partners)
 - Screen for STIs if necessary
 - Encourage dual protection (against pregnancy and STIs)
- STI presumptive treatment in post-rape care services
- STI/RTI programming in adolescent healthcare services

BOX 12.4: RAPID DIAGNOSTIC TESTS FOR SYPHILIS SCREENING

In most countries, the rapid plasma reagin (RPR) test is used to screen for syphilis. RPR is a non-treponemal antibody test, which means that a positive result is suggestive of active infection. The test will become negative when the disease has been treated early and cured. RPR is difficult to use in many humanitarian settings because it requires refrigeration and skilled laboratory staff.

Many rapid diagnostic tests (RDT) for syphilis have become commercially available in the last few years. RDTs provide accurate, qualitative detection of antibodies to *Treponema pallidum* and an infection can readily be detected very soon after exposure, as well as in its later stages.

The advantages of RDTs are that they do not require refrigeration and have long shelf lives, making them a good option for humanitarian settings. It takes 10 to 30 minutes for the result and there is no need for a laboratory or other instrumentation. Service providers can easily interpret the results visually. The small blood volume needed allows for a

finger-stick sample in place of a venous blood draw.

In view of the importance of early treatment in the prevention of neonatal syphilis, RDTs present an excellent opportunity for the implementation of routine screening for syphilis in antenatal care services in humanitarian settings, where the RPR test is not available or cannot be done. The disadvantage of RDTs is that, because they are treponemal antibody tests, they cannot distinguish between active and cured disease. However, in antenatal care, all patients who have a positive RDT, even if they had a positive test in a previous pregnancy, should be treated (again). Even if they were treated in a previous pregnancy, there is the possibility of reinfection with severe consequences for mother and baby if left untreated. The benefits of such presumptive treatment outweigh the risks associated with not getting treated. RDTs are not recommended for screening of blood for transfusion, as they would lead to too many false positives. Rapid non-treponemal antibody (RPR-like) tests for syphilis will become available in the near future.

BOX 12.5: HPV AND CERVICAL CANCER

Human papillomavirus is a very common infection and more than three-quarters of sexually active women are estimated to be infected at least once in their lifetimes. The risk of acquiring HPV infection is highest soon after sexual activity begins. Most of these infections are self-limiting and harmless, but persistent infection can cause cervical cancer in women. HPV also causes other ano-genital cancers (e.g., of the vagina, vulva, and penis), head and neck cancers and genital warts in both men and women.

CERVICAL CANCER SCREENING

Screening and treatment of early stages of cervical cancer (cervical dysplasia or pre-cancer) is effective in reducing morbidity and mortality from cervical cancer. Indications for screening depend on local resources. Where cytology is available and well established, all women over 35 years old should be screened every 5-10 years. Where cytology services are limited, such as in humanitarian settings, service providers must ensure that all women are screened once around the age of 40. Cytology by Papanicolaou (Pap) smear is currently recommended. However, it is resource intensive, as it requires staff who can perform a speculum examination and who are trained in smear collection techniques, as well as the availability of cytology services for reading smears.

Techniques such as Visual Inspection using Acetic Acid (vinegar) (VIA) or Visual Inspection using Lugol's Iodine (VILI) have proven to be cost effective in resource-constrained settings. When followed by cryotherapy for treatment of dysplasia, either through referral or immediate treatment ("single visit approach"), visual inspection is shown to be safe, acceptable, feasible and effective in reducing cervical cancer incidence and mortality.

HPV VACCINATION

The greatest impact of current HPV vaccines will be on girls who are immunized before they are exposed to HPV, that is, before they are sexually active. The full vaccination consists of 3 doses and produces a very high immune response that lasts for at least 5 years. The overall impact of the HPV vaccines will depend upon their delivery to those populations most in need of them. It is in resource-limited countries, where cervical cancer screening programs are poor or absent and cervical cancer incidence and mortality highest, that women are in greatest need of primary prevention through HPV vaccines. Yet the high cost of HPV vaccines is a significant barrier to widespread access and the expected costs and benefits need to be considered in the overall health budget.

- STI/RTI assessment and management in the antenatal, delivery, and postpartum period. For example:
 - o STI/RTI risk assessment for all clients in antenatal care, including syphilis screening and HIV voluntary counseling and testing (see Box 12.4).
 - o Vesicles or ulcers suggestive of genital herpes and occurring near delivery may be an indication for referral for caesarean section, since vaginal delivery carries a risk of disseminated herpes in the newborn and a high risk of newborn death
 - o Prophylaxis for ophthalmia neonatorum is given routinely to all newborns
- Prevention of cervical cancer activities in comprehensive SRH services (See Box 12.5)

12.3.7 Advocacy

SRH Coordinators and health program managers should advocate for the provision and integration of STI services whenever possible. Efforts should be made to ensure STI protocols are up-to-date, appropriate, accessible, and used by health providers. Effective STI control will require Ministry of Health officials, private donors, and other agencies to prioritize and invest in primary and secondary prevention strategies, strong partner notification and treatment programs, active targeted health promotion and sex education, STI stigma reduction efforts, and new technologies and vaccines.

12.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

The right to safe, confidential, and appropriate prevention, care, and treatment of STIs is protected as a human right under the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This right includes the right to prevention, treatment, and control of diseases.

Respect for human rights must inform all aspects of planning for STI programming during a humanitarian response where sexual violence, disruption in sexual norms and practices, and access to treatment and medications exacerbate existing barriers.

The right to STI-related services is inherent to many human rights:

- Access to STI diagnosis, treatment, and care is a component of respecting a person's right to health and right to life
- The right to health includes the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases and requires the establishment of prevention and education programs for behavior-related health concerns such as STIs
- STI management in antenatal care is essential in protecting both the rights of the pregnant woman and the rights of the child
- These rights equally apply to children and adolescents. Service providers who deny access to STI services based on age, marital status, or parental or guardian consent without considering the developmental stage of the child are not respecting that child's human rights
- The right to privacy requires that health workers act in such a way as to make patients feel safe and protected when receiving diagnosis, treatment, or counseling for STIs
- Providing access to STI services for the entire population, including adolescents, sex workers, and men who have sex with men, regardless of the legal status of prostitution and homosexuality/same sex sexual encounters in a country, protects the right to equality and nondiscrimination
- Everyone has a right to impart and receive information on STIs. This right also pertains to the inclusion of adolescents in all STI education, awareness-building, and outreach activities. Use language and outreach activities that ensure all target population are reached
- The right to enjoy the benefits of scientific progress and its applications can be limited when clients are denied access to new STI prevention and treatment technologies, such as visual inspection using acetic acid (VIA), cryotherapy, and the HPV vaccine

12.4.1 Challenges and opportunities

At times, providing appropriate and safe access to care and treatment for STIs can place a service provider in an uncomfortable situation. Stigma, restrictive national policies, and social and cultural norms may interfere with service delivery and patients' right to access care. For example:

- Health centers that do not offer services to sex workers in countries with laws against prostitution or discriminatory practices against people engaged in sex work
- Service providers not willing to assess adolescent clients due to beliefs that unmarried individuals should not engage in sex
- Clients reluctant to seek services due to policies on mandatory reporting of certain STIs and non-confidential partner tracing

It is important to remember that many barriers to STI care and treatment access are against internationally accepted human rights principles. SRH program managers and service providers should be aware of their agency's position on these issues and include it as part of the analysis of the situation and possible next steps.

Health program managers or service providers facing such a dilemma must give priority to their client's safety and health, and their own and colleagues' safety. Then, they may:

- Talk to their supervisor
- Discuss options with the client
- Discuss programming options and strategies within their organization or clinic structure. For example, if clients become nervous and uncomfortable when approached about STIs or refuse to talk about the issue, evaluate the amount of privacy available in the clinic and suggest physical changes that would make patients feel protected and encourage discussion
- Explore linkages with and referrals to local organizations that might be able to help the client, keeping in mind that different age groups or other sub-populations may need to be targeted at different times and places

- Find out whether their agency is engaged in advocacy on the issue and how to contribute
- While respecting the confidentiality of the client, identify with colleagues how to avoid or handle situations for clients in the future
- Raise these concerns in health coordination meetings

12.5 MONITORING AND EVALUATION

Indicators to monitor STI programs include:

- The proportion of service providers who received training in STI/RTI case management according to current protocol
- The proportion of STI/RTI clients who were assessed, treated, and counseled according to protocol (disaggregated by age and sex)
- Percentage of new antenatal care clients who are screened for syphilis and the percentage that test positive for syphilis

12.6 FURTHER READING AND ADDITIONAL RESOURCES

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CONCLUSION

A mere 20 years ago, sexual and reproductive health (SRH) services were virtually non-existent for refugees, displaced persons, and others living in humanitarian settings. In many ways this updated manual — founded on the tenet that sexual and reproductive health is a human right, and as such, applies to everyone, everywhere — and the wealth of guidance and experience contained therein, serves as a reminder of how far our field has come since the Inter-Agency Working Group (IAWG) produced the first version of this manual in 1999. The 2018 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM) is a culmination of years of hard-won, and not always linear, progress to ensure that people affected by humanitarian crises, in particular women and girls, have access to the comprehensive SRH information and services necessary to realize their basic rights.

The contributors to the 2018 version of the IAFM, including United Nations and implementing agencies, technical and human rights experts, advocates, local program managers and practitioners, and researchers, represent a wealth of expertise and experiences across the SRH and humanitarian fields. Although they came to the table with a diversity of perspectives, they were all united by a common passion for ensuring that people whose lives have been uprooted by war, violence, famine and/or natural disasters have access to the sexual and reproductive health care that is foundational to upholding their rights and dignity. Notably, nearly all of the contributors to the 2018 IAFM lacked dedicated time or funding to participate in this process, let alone to do so as extensively and as meaningfully as they did — a true testament to their dedication to reaching people affected by crises with higher-quality, more efficient, more compassionate, and more inclusive care. Through a thorough process of building consensus among a diverse group of experts, IAWG has emerged with a manual that is stronger for the diversity of input that went into it.

The end-users of this manual, SRH Coordinators and health program managers, were consulted as a first step in the process and were kept in mind throughout the development of this resource. It was intended to provide technical updates, clarity, and support, highlight challenges and key considerations, and most importantly offer potential solutions from people who have been in your shoes. Nuances of language, attention to inclusivity, feasibility in a variety of resource-constrained settings, and even the graphic design, have been considered at length, always with an eye toward clarity, conciseness, and usability at the field-level. While there are many issues that are decidedly not black and white – as is the nature of the complex settings where we work – IAWG has endeavored to produce a manual that will be a useful resource to you and your colleagues in your efforts to provide SRH services to crisis-affected populations and that shares best practices that can be adapted to the complicated settings where you work.

We turn it over to you now to continue your critical, yet so often under-resourced and under-valued work. We hope this manual will serve as a valuable tool in your toolbox: as a guide, a reference, but also a symbol and a reminder of the supportive community of practitioners, technical experts, donors, researchers, and advocates who are here to support you. Thank you for the work you do in service of and in partnership with the women, girls, boys, and men affected by crises.

We invite you to join the conversation at <https://knowledge-gateway.org/iawg> or by visiting www.iawg.net. You can also email us at info.iawg@wrcommission.org.

LIST OF ABBREVIATIONS AND ACRONYMS

AoR	Area of responsibility	CYP	Couple years protection
ANC	Antenatal care	DHS	Demographic and Health Survey
ARC	American Refugee Committee	EC	Emergency contraception
ARHZ	Adolescent Reproductive Health Zone	ECPs	Emergency contraceptive pills
ART	Antiretroviral therapy	EML	Essential Medicines List
ARV	Antiretroviral	EmONC	Emergency obstetric and newborn care
ASRH	Adolescent sexual and reproductive health	ENAP	Every Newborn Action Plan
BCC	Behavior change communications	ENC	Essential newborn care
BEmONC	Basic emergency obstetric and newborn care	EPMM	Ending Preventable Maternal Mortality
BMI	Body mass index	ERP	Expert Review Panel
CAC	Comprehensive abortion care	EVA	Electric vacuum aspiration
CBD	Community-based distributor	FCHV	Female community health volunteer
CBO	Community-based organization	FGC	Female genital cutting
CBR	Crude birth rate	FIFO	First in, first out
CCM	Cold chain management	FP2020	Family Planning 2020
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women	FPP	Finished Pharmaceutical Products
CEmONC	Comprehensive emergency obstetric and newborn care	GBV	Gender-based violence
CHW	Community health worker	GBVIMS	Gender-Based Violence Information Management System
CHX	Chlorhexidine	GFR	General fertility rate
CNPD	Chlorhexidine Navi Care Program	GMP	Good Manufacturing Practices
COA	Certificate of Analysis	HBB	Helping Babies Breathe
CODESA	Health Area Development Committees	HCT	HIV counseling and testing
CoPP	Certificate of Pharmaceutical Product	HEADSSS	Home, education/employment, activities, drugs, sexuality, suicide and depression, safety
CPR	Contraceptive prevalence rate	HIS	Health information system
CRC	Convention on the Rights of the Child	HIV	Human immunodeficiency virus
CRPD	Convention on the Rights of Persons with Disabilities	HLD	High-level disinfection

HMIS	Health Management Information System	MEC	Medical eligibility criteria
HPV	Human papillomavirus	MgSO ₄	Magnesium sulfate
HSV	Herpes simplex virus	MIRA	Multi Sector Initial Rapid Assessments
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	MISP	Minimum Initial Service Package
IASC	Inter-Agency Standing Committee	MMR	Maternal mortality ratio
IAWG	Inter-agency Working Group on Reproductive Health in Crises	MNH	Maternal and newborn health
ICPD	International Conference on Population and Development	MOH	Ministry of Health
ICRC	International Committee of the Red Cross	MR	Menstrual regulation
IDP	Internally displaced person	MSF	Médecins Sans Frontières
IEC	Information, education, and communication	MSM	Men who have sex with men
IEHK	Inter-Agency Emergency Health Kit	MVA	Manual vacuum aspiration
IFRC	International Federation of the Red Cross and Red Crescent Societies	NMR	Neonatal mortality rate
IMPACT	Information Mobilized for Performance Analysis and Continuous Transformation	NSAID	Non-steroidal anti-inflammatory drug
IPTp-SP	intermittent preventive therapy of pregnant women with sulfadoxine-pyrimethamine	NSP	Needle and syringe program
IRB	Institutional review board	OCP	Oral contraceptive pill
ITN	Insecticide-treated bed nets	OST	Opioid substitution therapy
IUD	Intrauterine device	PAC	Post-abortion care
KAP	Knowledge, attitudes, and practices	PCP	Pneumocystis pneumonia
KMC	Kangaroo Mother Care	PCR	Polymerase chain reaction
LAM	Lactational amenorrhea method	PEP	Post-exposure prophylaxis
LARC	Long-acting reversible contraception	PICT	Provider-initiated counseling and testing
LBW	Low birth weight	PID	Pelvic inflammatory disease
LGBTQIA	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual	PMTCT	Prevention of mother-to-child transmission
LMIS	Logistics Management Information System	POC	Products of conception
LMP	Last menstrual period	PPFP	Post-partum Family Planning
		PPH	Post-partum hemorrhage
		PPROM	Premature pre-labor rupture of membrane
		PQ	Prequalified
		PrEP	Pre-exposure prophylaxis

PTSD	Post-traumatic stress disorder	UNICEF	United Nations Children's Fund
PWD	People with disabilities	UNODC	United Nations Office on Drugs and Crime
PWID	People who inject drugs	VCAT	Values clarification and attitudes transformation
RDT	Rapid Diagnostic Test	VCT	Voluntary counseling and testing
RH Kits	Inter-Agency Reproductive Health Kits	VIA	Visual inspection using acetic acid
RMC	Respectful maternity care	VILI	Visual inspection using Lugol's iodine
RPR	Rapid Plasma Reagin	VMMC	Voluntary medical male circumcision
RTI	Reproductive tract infection	WASH	Water, sanitation, and hygiene
SAC	Safe abortion care	WHO	World Health Organization
SAFPAC	Supporting Access to Family Planning and Post-Abortion Care		
SAM	Severe acute malnutrition		
SARP	Safe Abortion Referral Program		
SBA	Skilled birth attendant		
SEA	Sexual exploitation and abuse		
SOP	Standard operating procedure		
SRH	Sexual and reproductive health		
SRHR	Sexual and reproductive health and rights		
STI	Sexually transmitted infection		
SV	Sexual violence		
TB	Tuberculosis		
TBA	Traditional birth attendant		
TDF	Tenofovir disoproxil fumarate		
TFR	Total fertility rate		
TPTL	Threatened pre-term labor		
TT	Tetanus Toxoid		
TTI	Transfusion-transmissible infection		
UN	United Nations		
UNFPA	United Nations Population Fund		
UNHCR	United Nations High Commissioner for Refugees		

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