# Inter-agency Field Manual on Reproductive Health in Humanitarian Settings











2010
Revision
for Field
Review





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# Foreword

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

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

The *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* is the result of a collaborative and consultative process engaging over 100 members from United Nations agencies and non-governmental organizations that make up the Inter-agency Working Group (IAWG) on Reproductive Health in Crises.

The updated information in this Field Manual is based on normative technical guidance of the World Health Organization. It also reflects the good practices documented in crisis settings around the world since the initial field-test version of the Field Manual was released in 1996, followed by the 1999 version, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*. This latest edition reflects the wide application of the Field Manual's principles and technical content beyond refugee situations, extending its use into diverse crises, including conflict zones and natural disasters.

Since 1999, the humanitarian community has further developed standards and guidelines for areas related to reproductive health, including gender, gender-based violence and HIV/AIDS in humanitarian settings. The 2004 revised *Sphere Humanitarian Charter and Minimum Standards in Disaster Response* incorporates the Minimum Initial Service Package for Reproductive Health—Chapter 2 of this Field Manual—as a minimum standard of care in disaster response. New tools and guidelines developed through the humanitarian reform process and the cluster system continue to recognize the authoritative guidance of the Field Manual for reproductive health interventions in humanitarian settings.

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. For the first time in history, reproductive health has been recognized at the Security Council level, with Resolution 1889 explicitly referencing the need to ensure women and girls' access to reproductive health 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 reproductive ill-health, posing serious challenges to efforts to achieve global benchmarks, including the Millennium Development Goals. This revised Field Manual 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.

More than 15 years have passed since the 1994 International Conference on Population and Development recognized reproductive health as a human right, and over 10 years have been spent in the practical application of the 1999 Field Manual. As members of the humanitarian community, we have a collective responsibility to uphold and realize the right to reproductive health for all women, men and adolescents in humanitarian settings.

Inter-agency Working Group on Reproductive Health in Crises

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## Organization of technical chapters (4 to 10):

- Introduction
- Objectives
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# Introduction

*Reproductive health is an essential component of humanitarian response*

All people, including those living in humanitarian settings, have the right to reproductive health (RH). To exercise this right, affected populations must have an enabling environment and access to comprehensive RH information and services so they can make free and informed choices.

Quality RH services must be based on the needs of the affected populations, particularly the needs of women and girls. They must respect the religious and ethical values and cultural backgrounds of the communities, while conforming to universally recognized international human rights standards.

Reproductive health care covers a wide range of services. These are defined as follows in the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in September 1994:

- family-planning counselling, information, education, communication and services;
- education and services for prenatal care, safe delivery and postnatal care, and infant and women's health care;
- prevention and appropriate treatment of infertility;
- prevention of abortion and the management of the consequences of abortion;
- treatment of reproductive tract infections, sexually transmitted diseases, including HIV/AIDS;
- prevention, early detection and treatment of breast cancer and cancers of the reproductive system, and other RH conditions;
- active discouragement of harmful traditional practices, such as female genital mutilation.

Providing comprehensive, high-quality RH services requires a multisectoral, integrated approach. Protection, health, nutrition, education and community service personnel all have a part to play in planning and delivering RH services.

The best way to guarantee that RH services meet the needs of the affected population is to involve the community in every phase of the development of those services, from designing programmes to launching and maintaining them to evaluating their impact. 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.

# Introduction

## The IAWG

At an Inter-agency Symposium on Reproductive Health in Refugee Situations held in Geneva, Switzerland, in June 1995, more than 50 governments, nongovernmental organizations (NGOs) and UN agencies committed themselves to strengthening reproductive health (RH) services to refugees. They formed the IAWG, the Inter-Agency Working Group on Reproductive Health in Refugee Situations, now called the Inter-Agency Working Group on Reproductive Health in Crises.

## The IAFM

Following the symposium, the IAWG, in consultation with affected communities, produced, extensively field tested and eventually printed and distributed in 1999 the first edition of the Inter-agency Field Manual on Reproductive Health in Refugee Situations (IAFM or "Field Manual"). To reflect the wide application of the Manual's principles and technical contents beyond refugee situations, it is now called the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings. The Field Manual supports the delivery of quality RH services. Its objectives in humanitarian settings are to:

- outline a standard set of minimum RH interventions to be put in place as a priority;
- serve as a tool to facilitate discussion and decision-making in the planning, implementation, monitoring and evaluations of RH interventions;
- guide RH officers, RH programme managers and service providers in introducing and/or strengthening evidence-based RH interventions based on the affected population's needs and demands and with full respect for their beliefs and values;
- advocate for a multisectoral approach to meeting the RH needs of affected populations and to foster coordination among all partners.

## What is new in the IAFM, 2nd edition?

The IAWG revised and updated each of the chapters. In addition to organizational, logistics and clinical updates relevant to RH coordination and implementation of services, this edition contains a new chapter on Safe Abortion Care. It also splits the chapter on HIV and Sexually Transmitted Infections from the previous edition into two separate chapters. The chapter called Reproductive Health for Young People in the earlier edition is renamed Adolescent Reproductive Health. (Note: adolescent Reproductive health remains a relevant theme cutting across the other chapters.) The Safe Motherhood chapter is now entitled Maternal and Newborn Health to emphasize the continuum from the antenatal to postnatal periods.

The guidance in this document is current at the time of publication. The IAWG will make updated information on new technical recommendations and technologies for RH interventions available on www.iawg.net.

## Who is the IAFM for?

RH officers and RH programme managers in humanitarian settings are the primary audience for the Field Manual. RH service providers (doctors, nurses, midwives, etc.) will also find useful information, although the manual does not contain detailed clinical guidance. Community-services officers, protection officers and others working to meet the needs of affected women, young people and men will also benefit from the guidance offered in this document.

## Outline of the IAFM, 2nd edition

### Where to Start

The Minimum Initial Service Package (MISP) for Reproductive Health in Crises is a set of priority activities to be implemented at the onset of an emergency. Comprehensive RH services must be implemented as soon as the situation permits.

Therefore, we recommend the reader to start with Chapter 1: Fundamental Principles and Chapter 2: Minimum Initial Service Package (MISP), before proceeding onto other technical chapters.

Chapter 1: Fundamental Principles lays the foundation for the subsequent technical chapters and provides the guiding principles for undertaking all RH care. The components of reproductive health described in the Field Manual are:

Chapter 2: MISP

Chapter 3: Assessment, Monitoring and Evaluation

Chapter 4: Adolescent Reproductive Health

Chapter 5: Family Planning

Chapter 6: Maternal and Newborn Health

Chapter 7: Comprehensive Abortion Care **NEW***

Chapter 8: Gender-based Violence

Chapter 9: Sexually Transmitted Infections **NEW**

Chapter 10: HIV **NEW**

** Although only the chapters marked "**NEW**" are completely new, **ALL** chapters have been updated significantly.*

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.

Technical standards included in the Field Manual are those set by the World Health Organization (WHO). The Field Manual provides programmatic direction with frequent reference to additional resource materials that can be found in the attached CD-ROM (**NEW**) and used to ensure comprehensive and reliable RH services.

## Taking it further: coordination and integration

The IAFM addresses the particular needs of adolescents. Also note that the Field Manual touches upon only cervical cancer (Chapter 9). Other cancers of public health importance, such as breast and prostate cancers, also require careful attention but are not within the scope of this manual.

In addition to adequate sanitation, food, water, housing, protection and primary health care, other

types of programmes and services directly and indirectly contribute to the reproductive well-being of affected populations. These encompass:

- Social and mental health services
- Education and empowerment of women and girls
- Livelihoods and income generation
- Save access to cooking fuel and alternative fuel sources, as well as other intersectoral activities that may reduce the risk of sexual violence.

Ensuring the reproductive health of affected populations in humanitarian settings requires that RH officers, programme managers and service providers coordinate with other services and adopt a multisectoral and integrated approach.



1

CHAPTER ONE

**Fundamental Principles**

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## 1 Introduction

**What is reproductive health?**

Reproductive Health (RH) 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. Reproductive health 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 the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law. They should also have the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

*See International Conference on Population and Development – Cairo 1994; Programme of Action, para 7.2.*

**Why is it essential to meet reproductive health needs 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 and external assistance is required. This can be the result of events such as armed conflicts, natural

# Fundamental Principles

disasters, epidemics or famine, and often involves population displacement.

In humanitarian settings, it is essential to provide RH services, because:

- Access to RH care is a right as described in the definition above and further explained in the Human Rights section below.
- Morbidity and mortality related to the reproductive system is a significant public health issue (see Box 1).
- Persons affected by conflict or disaster are entitled to protection and assistance. The timely provision of RH services can prevent death, disease and disability related to unwanted pregnancy, obstetric complications, sexual and other forms of gender-based violence, HIV infection and a range of reproductive disorders.

## 2 Objectives

The objectives of this chapter are to:

- set the framework that guides implementation of RH programming in humanitarian settings;
- explain the rationale for providing RH services and outline the principles that underlie the inclusion of essential RH care in relief efforts;
- guide RH officers, RH programme managers and service providers on how to assure that RH services are delivered in an effective, efficient and equitable manner.

### Box 1: RH Problems Are a Public Health Concern

✔ 529 000 women die each year — one every minute — from pregnancy-related causes. Ninety-nine per cent of these deaths occur in developing countries.[1]

✔ Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties. Girls under 15 are five times as likely to die from childbirth.[1]

✔ More than 340 million new cases of sexually transmitted diseases occur every year.[1]

✔ Nearly 34 million people in the world are HIV-infected.[1]

✔ 120 million women say they do not want to become pregnant, but are not using any method of family planning.[2]

✔ 20 million unsafe abortions occur every year — 55 000 each day — resulting in 80 000 maternal deaths and hundreds of thousands of disabilities.[2]

✔ It is estimated that each year tens of thousands of women and girls are subjected to sexual assault in conflict settings around the world.[1]

[1] "The World Health Report 2005: Make Every Mother and Child Count." World Health Organization, 2005. http://www.who.int/whr/2005/whr2005_en.pdf

[2] Reproductive Health: Ensuring That Every Pregnancy is Wanted. UNFPA. http://www.unfpa.org/rh/planning.htm

## 3 Fundamental principles of RH programming in humanitarian settings

The following principles underpin the implementation of RH programming in humanitarian settings.

1. Coordination
2. Quality of care
3. Communication
4. Community participation
5. Technical and managerial capacity-building
6. Accountability
7. Human rights
8. Advocacy

### 3.1 Coordination

**What is coordination?**

Coordination involves information sharing, compromise and collaborative action.

For RH services to be equitable, effective and efficient in a humanitarian setting, coordination must occur across agencies:

- among official bodies, agencies and other entities, for example, host country government, nongovernmental organizations (NGOs) and UN bodies;
- across sectors and clusters;
- within health programming, across levels of service providers: doctors, midwives, nurses, health assistants and other health-related providers, such as community health workers and traditional birth attendants;
- across levels of care: from communities to health centres and referral hospitals.

It is essential that coordination of RH programming be done in concert with overall health sector/cluster coordination and cover:

- Implementing the Minimum Initial Service Package (MISP)
- Delivering essential supplies
- Managing health information
- Conducting assessments
- Training service providers
- Integrating comprehensive RH services within health and social services

**Why is coordination important?**

Coordination of reproductive health within the health sector/cluster and with other relevant sectors/clusters can improve efficiency, effectiveness and speed of response, enable strategic decision-making and problem-solving and help avoid gaps and duplication in services. Coordination will help to deliver a standard package of RH services throughout an area, making good-quality RH care accessible to all. It can generate a multiplier effect that results in expanded coverage and efficient use of resources and can compensate for any single agency's limited expertise, staff, resources or range of activities.

**How should coordination be done?**

- At the onset of a humanitarian emergency where the Interagency Standing Committee (IASC) cluster system is activated, the health cluster lead agency must ensure that an agency is identified to lead reproductive health within the health cluster. The lead RH agency is selected on the basis of having a field presence and operational capacity to support the other health sector/cluster actors to implement RH services. Where the cluster system is not activated, a lead agency for reproductive health should be identified by the health sector lead agency.
- The agency identified to lead reproductive health must identify an RH officer. The RH officer works within the health coordination mechanism to ensure that technical and operation support is provided to the health cluster partners in scaling up coverage of RH services in the crisis areas.

Humanitarian workers with related responsibilities (health coordinator, RH officer, GBV/gender focal

point, and HIV focal point) should collaborate closely and share information on a regular basis.

In addition to facilitating communication across agencies and sectors, the RH officer must also ensure that RH programme managers engage with the host community, local authorities and other relevant actors to ensure that the concerns of these stakeholders are considered.

- To ensure access to appropriate RH care for affected populations served by a variety of agencies, the RH officer should provide technical guidance and advocate adherence to inter-agency standards (such as those outlined in this manual, IASC guidelines and in the Sphere Handbook) which stipulate compliance with appropriate national standards and guidelines).

## 3.2 Quality of care

**What is quality of care?**

Good-quality RH care is comprehensive, accessible and inclusive, addressing the RH needs of all persons without discrimination. This means that women, men, adolescents, elderly and the disabled — of all ethnicities, religions and sexual orientations — have access to services that meet recognized standards.

**Why is quality of care important?**

- Good-quality services help fulfill human rights.
- Good-quality services are effective:
  - Clients are more likely to use services and maintain good health practices when they receive good-quality care.
  - Providers are professionally satisfied and motivated when they deliver good-quality services.

**How can quality of care be enhanced?**

Quality of care is enhanced when *organizations*:

- comply with standard clinical protocols, for example, treatment guidelines and standard precautions;
- assure adequate coverage of facilities and personnel. Sphere and UN guidelines suggest the following minimum levels:
  - One community health worker per 500-1000 population
  - Community health workers should include women, men, youth, members of different ethnic groups, disabled and other groups in the population
  - One health centre with 2-5 service providers per 10 000 population:
    - One qualified health service provider per 50 outpatient consultations per day
    - One hospital per 50 000 population, with a minimum of 5 qualified service providers, including at least 1 doctor
    - One qualified service provider per 50 outpatient consultations per day
    - One qualified service provider on duty per 20-30 inpatient beds
- employ and support competent male and female service providers and provide regular updates and training on good practices
- maintain and coordinate logistics systems to ensure adequate supplies
- ensure the monitoring and evaluation methods measure the quality of services and guides quality improvement (see Chapter 3: Assessment, Monitoring and Evaluation).

Quality of care is enhanced when *service providers:*

- stay current on good practices and apply them to their work
- show respect to the people they serve

Quality of care is enhanced when *community members*:

- are empowered to hold implementing agencies accountable for the quality of services

## Box 2: Elements of Quality Reproductive Health Care

**Constellation of Services**

Onset of Emergency: MISP

As situation stabilizes: Comprehensive reproductive health, encompassing:

- Adolescent reproductive health care
- Family planning
- Maternal and newborn health care
- Safe abortion care
- Protection from and response to gender-based violence
- Prevention and treatment of STI/RTI/HIV/AIDS

Linkages to related services in other sectors and clusters

| Technical competence | Facilities and equipment | Supplies and logistics |
|---|---|---|
| • Job descriptions<br>• Treatment protocols<br>• Standard infection-prevention precautions<br>• Competency-based training<br>• Supportive supervision | • List of needed equipment<br>• Provision of missing items<br>• Preventive maintenance program<br>• Repair and replacement as needed<br>• Medical waste disposal | • Inventory and storage<br>• Inventory control system<br>• Logistics pipeline |
| **Information given to clients** | **Client satisfaction—What does the client care about? Is she/he getting it?** | **Information systems—Data for decision-making** |
| • Minimum preventive and care measures in the home<br>• Location and hours of services<br>• When to seek care<br>• Adequate knowledge to make informed choices<br>• Treatment counselling (how to take medicine, side effects, referral, return) | • Privacy from the view or hearing of others<br>• Confidentiality (not revealing patient information without patient's consent)<br>• Courtesy<br>• Efficiency<br>• Effectiveness<br>• Safety | • Purpose of information<br>• Identification of data needed<br>• Data collection<br>• Data storage and retrieval<br>• Data analysis<br>• Use of information (improving programmes, sharing with stakeholders) |

*Adapted from Bruce, J. (1990). "Fundamental Elements of the Quality of Care: A Simple Framework."* Studies in Family Planning *Vol. 21(No. 2): pp. 61-91.*

## 3.3 Communication

**What is communication?**

Communication involves agents (messengers) transmitting information through appropriate channels (e.g. poster, radio, person-to-person, etc.) in order that people get the information they need, when they need it, in the way that makes sense to them so that they can make practical decisions.

**Why is communication important?**

- Women, men and adolescents should understand how their bodies work and how to maintain and improve their reproductive health. Scientifically validated knowledge should be shared and discussed with communities to support people in making decisions on their reproductive health.
- Effective communication can address the concerns of social gatekeepers (e.g. officials, parents, mothers-in-law, intimate partners) thereby improving access to RH care.

**How can communication be done?**

Employ **basic good practices** in communication programming. For example:

- Understand what the intended audience knows and believes.
- Develop and pretest messages and materials with representatives of the intended audience.

Develop a **short list of key RH messages** that are disseminated consistently by all health and social welfare promoters throughout the community. Sample "key RH messages":

- At the onset of the humanitarian response (MISP implementation): "Women experiencing problems during childbirth should seek care at the hospital near the water point".
- As the situation stabilizes (comprehensive RH care): "Spacing pregnancies at least two years apart promotes the health of women, children and families".

Use **community-wide campaigns** to raise awareness broadly. For example:

- Inform people that HIV cannot be transmitted by sharing food, shaking hands or other casual contact.

Use **targeted campaigns**, based on discussions of common behaviours, to promote healthier practices among vulnerable groups. For example:

- Promote childbirth in a facility.
- Increase the adoption and continued use of safer sex practices.
- Increase the uptake of family planning among postpartum women.
- Promote visits to clinics by survivors of rape and other forms of gender-based violence.

Use **a model for client counselling** that assures a competent client-provider interaction such as GATHER:

**G – GREET** the client
**A – ASK** her what she is seeking
**T – TELL** her what you have available for her
**H – HELP** her decide what's best for her
**E – EDUCATE** her on her choice
**R – RETURN** Schedule a return visit and let her know she can come any time she has a question

## 3.4 Community participation

**What is community participation?**

Participation is the involvement of key stakeholders in all aspects of the programme cycle — assessment, design, implementation, monitoring and evaluation (see Chapter 3: Assessment, Monitoring and Evaluation). Opportunities for involvement should be transparent, free of coercion and open to all. It is essential to assure the participation of all groups, including women,

men and adolescents (both male and female). It may be necessary to seek out the active involvement of often-marginalized groups such as minorities, young people, widows and the disabled.

**Why is community participation important?**

Community participation is essential to assure the appropriateness, acceptability and sustainability of RH programmes. Returning a sense of control and independence to local actors can help communities recover from a crisis. Successful community participation involves both women and men in decision-making and implementation.

**How is community participation done?**

External actors (UN or NGO workers/implementing agency staff from outside the community) should initiate participation early in the response and move progressively to hand programme control over to local actors (see Figure 1). One early step is the identification of both male and female community leaders or health service providers, among the affected population.

The MISP is initiated as a priority in humanitarian settings based on the acknowledged need for immediate access to essential services. Information gathered through community participation in

**Figure 1: Community Participation**




- Local actors (women and men) manage the project; external actors* offer advice.
- Local and external actors manage the project together through counterpart relationships.
- Local and external actors implement activities together combining local and external contributions. External actors retain management and monitoring responsibilities.
- Local and external actors make project decisions together using joint analysis and planning processes. External actors implement, manage and monitor projects.
- Community members are consulted by external actors seeking local information and perceived needs. External actors plan based on information from the community and then implement, manage and monitor projects.
- Community members are informed by external actors regarding planned programmes. External actors plan, implement, manage and monitor projects.

*Humanitarian NGO workers/implementing agency staff from outside the community.

the initial response guides the ongoing delivery and future planning of services. Such information may include local birthing practices, training needs of health-care providers and barriers to access, such as the requirement that health providers speak the same language or cultural preference for providers of the same sex as clients.

## 3.5 Technical and managerial capacity-building

**What is capacity-building?**

Capacity-building covers the improvements needed within an organization to assure adequate technical and managerial competence to serve clients and to expand programmes. Local and international organizations should cooperate in two-way partnerships.

- Service providers must be competent to provide good-quality care.
- Organizations must have the management systems in place to:
  - hire, train, place, supervise and support service providers
  - maintain facilities and equipment
  - ensure supplies
  - design, monitor and evaluate services
  - engage with stakeholders
  - raise and manage funds.

**Why is capacity-building important?**

- Organizations need adequate technical and management capacity to deliver effective RH services to populations in need.
- Greater capacity within local, national, regional and international organizations can improve the coverage, quality and sustainability of RH services.
- Local service providers or agencies are frequently responsible to run programmes during heightened security threats.

**How is capacity-building done?**

- Assess current technical and management strengths and weaknesses of each partner organization and identify focus areas for improvement.
- Establish and agree on clear roles and responsibilities for each partner and document these roles.
- Jointly design, implement and evaluate technical trainings, updates and management improvement systems.

## 3.6 Accountability

**What is accountability?**

Accountability is the process of holding individuals and organizations responsible for performance according to set standards and principles. Relevant standards and principles include fiscal responsibility, humanitarian principles, professional standards, local and international laws and the principles described in this chapter. Accountability may include the imposition of sanctions for violations of the standards, for example, being fired for sexual exploitation or imprisoned for theft.

In the humanitarian community there is a movement towards ensuring accountability to recipients of assistance. For example, the Humanitarian Accountability Partnership (HAP) — International promotes accountability to beneficiaries through standards and a certification process. HAP identifies seven major principles of accountability:

1. Commitment to humanitarian standards and rights

2. Setting organizational standards of accountability and building staff capacity

3. Communicating and consulting with stakeholders, particularly beneficiaries and staff, about the organizational standards, the project to be implemented and the mechanism for addressing concerns

4. Participation — involving beneficiaries in planning, implementation, monitoring and evaluation of programmes

5. Monitoring and reporting on compliance with standards in consultation with beneficiaries

6. Addressing complaints — enable beneficiaries and staff to report complaints and seek redress safely

7. Implementing partners — maintaining a commitment to the principles when working through implementing partners.

**Why is accountability important?**

Effective accountability systems and processes help fulfil the entitlements and obligations inherent in universal human rights and acknowledge the equal humanity of all persons, including those affected by crisis, as well as humanitarian responders.

In the humanitarian community, efforts to promote accountability have been incorporated into the Sphere Humanitarian Charter and the *Code of Conduct for the International Red Cross and Red Crescent Movement and Nongovernmental Organization in Disaster Relief* (Code of Conduct). Adherents to the Humanitarian Charter recognize both the vulnerabilities and capacities of affected populations.

The UN humanitarian reform advocates for accountability, leadership, predictability and partnership to improve response.

**How can programmes be accountable to recipients?**

Abide by humanitarian standards, respect human rights and adhere to basic principles of RH care as outlined in this inter-agency manual and other documents, including:

- Sphere Humanitarian Charter and Minimum Standards in Disaster Response
- UN Secretary General's Bulletin "Special measures for protection from sexual exploitation and sexual abuse"
- IASC Gender Handbook in Humanitarian Action
- IASC Guidelines for Gender-based Violence Interventions in Humanitarian Assistance
- IASC Guidelines for HIV/AIDS Interventions in Emergency Settings
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
- IASC Matrix on Agency Roles and Responsibilities for Ensuring a Coordinated, Multisectoral Fuel Strategy in Humanitarian Settings and IASC Decision Tree Diagrams on Factors Affecting Choice of Fuel Strategy in Humanitarian Settings

In addition, ensure the following steps are taken:

- Establish ongoing communication with affected populations about your organization and its project plans and work.
- Engage beneficiary participation in all programming steps — assessing, planning, implementing and monitoring the project.
- Arrange mechanisms for beneficiaries to contact organizational representatives, lodge complaints and seek redress.
- Enforce systems within your organization to respond to improper conduct by staff (see Box 3: Sexual Exploitation and Abuse).

## 3.7 Human rights

**What are human rights?**

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.

The human rights principles contained in international and regional treaties form a part of international law. Several treaties establish legal contracts between nations in support of the

### Box 3: Sexual Exploitation and Abuse

Humanitarian agencies have a duty of care to beneficiaries and a responsibility to ensure that beneficiaries are treated with dignity and respect and that certain minimum standards of behavior are observed. In order to prevent sexual exploitation and abuse RH officers and programme managers must:

- create and maintain a working environment that prevents sexual exploitation and abuse (SEA);
- ensure that all staff (national and international) sign, and abide by, a code of conduct (CoC) against SEA. Retain originals of all acknowledgements in the appropriate employee files;
- ensure that reporting mechanisms on SEA by service providers are in place and known to the community;
- take appropriate action where there is reason to believe that any of the standards listed in the CoC have been violated, or that other sexually abusive or sexually exploitive behaviour has occurred. SEA by a service provider constitute acts of gross misconduct and are therefore grounds for termination of employment. The standards include:
  - Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defence.
  - Exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes exchange of assistance that is due to beneficiaries.
  - Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.

To ensure the maximum effectiveness of the Code of Conduct, RH officers and programme managers must post a copy, translated into the appropriate language, in clear view in public areas, such as waiting areas in clinics.

For a sample Code of Conduct see Appendix 3.

rights declared in the 1948 Universal Declaration of Human Rights. These include the International Covenant of Civil and Political Rights (1966), the International Covenant of Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All Forms of Discrimination against Women (1979), which specifically spells out forms of gender discrimination and the steps States must take to eliminate them, and the Convention on the Rights of the Child (1989).

In addition to the international human rights system, there are three major regional human rights systems; each one has its own human rights instruments and mechanisms:

- The African Union human rights system
- The Council of Europe human rights system
- The Inter-American human rights system

Other documents in which human rights principles are enshrined include international humanitarian law, international refugee law and national laws.

Political consensus documents, such as outcome documents of UN conferences, help interpret the application of human rights standards in legally binding international instruments. (Please refer to the CD ROM for the texts of key human rights documents.)

States that have signed or ratified human rights instruments are obligated to respect, protect and fulfil human rights. All national and local laws should respect human rights. States are obligated to protect people from violations of their rights by others. For example, when a State changes its laws on rape to ensure that any person who is assaulted, regardless of citizenship, marital status or gender, can receive an effective legal response and good-quality services, it has begun to meet its obligations to protect and fulfil rights. In other words, it is not enough for a person to have a right; she or he must be able to exercise that right.

**What are reproductive rights and how are they linked with human rights?**

Reproductive rights are a cluster of recognized human rights. The 1994 International Conference on Population and Development (ICPD) set out a framework for the realization of reproductive rights: "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."

Human rights critical to reproductive health include:

- Right to life
- Right to security of the person
- Right to decide the number, spacing and timing of children
- Right to nondiscrimination and equality
- Right to privacy
- Right to health
- Right to seek, receive and impart information
- Right to be free from cruel, degrading and inhuman treatment
- Right to remedy
- Right to the benefits of scientific progress

**Why are human rights important to RH programming?**

The legal and policy environments in which people (including service providers), in humanitarian settings live, think and act have an impact on the reproductive health of the population. These environments formally govern what can legally be done by local and external actors. They can also shape the attitudes and responses to RH initiatives.

While international human rights instruments primarily hold States responsible to fulfil human rights, nonstate actors such as international agencies play an important role in helping people realize their rights. Humanitarian workers have a dual responsibility to actively promote human rights and ensure that interventions do not violate them.

**How can RH programmes promote human rights?**

It is essential for RH service providers to be familiar with:

- international and regional human rights treaties and conventions to which the country in which they are working is a party;
- national rules and protocols governing: privacy and confidentiality, mandatory disclosure, registration and dispensing of drugs;
- national and/or customary laws regulating access to services, guardianship and informed consent;
- national criminal law and/or customary laws defining sexual violence crimes and legal response to sexual violence (including evi-

dence rules and legal age of consent).

Ensure that your RH programme is rights-based, that is, available, of good quality and accessible to all. Analyse and enhance your programme in the following areas:

- international human rights norms
- national legal standards
- local customs
- availability and accessibility of services.

Advocate and collaborate with advocacy groups at local and national levels to bring laws, policies and practices into compliance with international human rights. The rights enshrined in human rights treaties apply to all people, regardless of citizenship or legal residence; they are therefore applicable to refugees and internally displaced people. However, the services refugees receive are determined by the host country's national laws and its international obligations. In instances where a country's national laws are inconsistent with human rights principles, service providers can contribute to positive change through advocacy efforts.

## 3.8 Advocacy

**What is advocacy?**

Advocacy is strategic action to ensure that laws, policies, practices and social norms enable people to enjoy their right to reproductive health. RH advocacy can:

- target laws, policies, practices and social norms that affect whether individuals or groups have access to RH information and services;
- influence people with decision-making power to enact policies that support reproductive rights;
- influence the decisions and actions of community leaders whose opinions affect people's reproductive rights.

**Why is advocacy important?**

Advocacy is needed in humanitarian settings to ensure supportive policies and adequate funding for comprehensive RH services. RH programming requires advocacy because it is often misunderstood, it challenges some political and cultural attitudes and it is often not perceived as a standard or priority relief activity.

Advocacy is also needed to ensure that humanitarian workers adhere to the fundamental principles described in this chapter.

**How is advocacy done?**

- Advocacy requires careful strategic planning. It is not a one-time or a linear process. An advocacy strategy has to be assessed continually and adjusted to changing circumstances.
- An advocacy strategy includes: identification of a problem, short-term and long-term goals, activities and resources; anticipating potential challenges and preparing responses; and monitoring activities as they are implemented.
- Effective activities for advocacy include: developing policy proposals, sharing examples of good RH policies with decision-makers; presenting evidence of successful programmes from the field; engaging champions (informed, influential individuals who motivate change in others); working within existing coordination structures to ensure RH programmes are prioritized for funding and implementation; educating service providers; and maintaining communication with decision-makers to keep them informed.

## 4 Monitoring

The following measures can be used to monitor the implementation of the fundamental principles of RH programming.

### 4.1 Coordination

- Are MISP activities underway? Are MISP services available to all members of the affected population?
- In ongoing programming do all members of the affected population have equitable access to good-quality comprehensive RH care? Are RH indicators within acceptable norms?

### 4.2 Accountability

The measurement of accountability is described well in the Humanitarian Accountability Partnership. Some simple measures include:

- Documentation of beneficiary involvement in the planning, implementation, monitoring and evaluation of programmes
- Periodic project progress reports posted in public view
- Documentation of actions taken in response to beneficiary complaints concerning the programme.

### 4.3 Community participation

- Degree of transition from external to local control of programme elements.

### 4.4 Quality of care

- Reports showing collection of and response to the views of the beneficiary population
- Regularly completed supervision checklists with acceptable quality scores (see Figure 2).

### 4.5 Capacity-building

- The proportion of clinical and managerial staff performing according to required level of competency. (Example: a midwife's job description includes the ability to perform manual vacuum aspiration (MVA); the annual performance review records the number of MVAs performed during the year; a selection of the midwife's MVA charts are reviewed (e.g. five randomly selected charts) and scored relative to compliance with the standard protocol.)

### 4.6 Communication

- Health information materials visible in the community
- Client-provider interaction and client exit interview observed
- Over the longer term, evidence of behaviour change among community members.

### 4.7 Advocacy

- Presence of, or change to, policies that promote access to RH services
- Proportion of service providers and community members aware of RH policies
- RH services reflect implementation of positive RH policies

### 4.8 Human rights

- Utilization rate of RH services disaggregated by ethnicity, age, marital status, immigration/asylum status, religion, geography, etc.

| Figure 2: Sample Reproductive Health Supervision Checklist | | | | | | |
|---|---|---|---|---|---|---|
| **Date** | | | | | | |
| **Facility** | | | | | | |
| **Facility manager** | | | | | | |
| **Supervisor** | | | | | | |
| | | | | | | |
| **SCORE** | | | | | | |
| Indicator 1: Quality of Antenatal Care - 1st Trimester | | | | | | |
| **Steps** | Review five 1st-Trimester ANC consultations<br>Score 1 if the action was performed.<br>Score 0 if the action was not performed. | | | | | |
| | **Consultation Number** | **1** | **2** | **3** | **4** | **5** |
| **Essential actions** | Pt has at least 1 TT | | | | | |
| | BP checked | | | | | |
| | Urine checked for protein | | | | | |
| | Pt received at least 30 tablets of ferrous sulphate and folic acid | | | | | |
| | Pt was taught danger signs | | | | | |
| | Pt has received LLIN | | | | | |
| **Key:** Pt = patient; BP = blood pressure; LLIN = long-lasting insecticide-treated nets; TT = tetanus toxoid | | | | | | |

## 5 Further reading

**Essential reading**

The Sphere Project. *Humanitarian Charter and Minimum Standards in Humanitarian Response.* 2004. www.sphereproject.org/content/view/27/84 (Revision due 2010).

*Reproductive health during conflict and displacement - A guide for programme managers.* World Health Organization, 2000. http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_00_13/en/

**Additional reading**

UN Secretary General's Bulletin "Special measures for protection from sexual exploitation and sexual abuse", ST/SGB/2003/13, 9 October 2003. http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&DocId=1001083

*IASC Gender Handbook in Humanitarian Action. Women, Girls, Boys and Men - Different Needs, Equal Opportunities.* IASC, 2006. http://ochaonline.un.org/OCHAHome/AboutUs/GenderEquality/KeyDocuments/IASCGenderHandbook/tabid/5887/language/en-US/Default.aspx

*Guidelines for Gender-based Violence Interventions in Humanitarian Assistance.* IASC, 2005. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

*Guidelines for HIV/AIDS interventions in emergency settings*. IASC, 2004. http://www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf

Lisa VeneKlasen, with Valerie Miller. *A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation*. Practical Action Publishing, April 2007. http://developmentbookshop.com/product_info.php?products_id=741



2

CHAPTER TWO

# Minimum Initial Service Package

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## 1 Introduction

This chapter describes the Minimum Initial Service Package (MISP) to address reproductive health (RH) needs of populations at the onset of an emergency. The MISP defines which RH services are most important in preventing morbidity and mortality, particularly among women and girls, in humanitarian settings. Neglecting reproductive health in humanitarian settings has serious consequences: maternal and newborn deaths; sexual violence and subsequent complications such as trauma, sexually transmitted infections (STIs), unwanted pregnancies and unsafe abortions; and the possible spread of HIV. All activities of the MISP need to be implemented simultaneously. The MISP is a Sphere standard.

The MISP was developed based on well-documented evidence of RH needs in humanitarian settings and therefore can be implemented without an initial needs assessment. However, some basic demographic and health information of the affected population must be collected through the health coordination mechanism for optimum delivery of MISP activities.

It is important to note that the components of the MISP form a **minimum** requirement. *Plan for and implement comprehensive RH services, as outlined in Chapters 4 to 10 in this Field Manual, as soon as the situation allows. Even in circumstances where other components of reproductive health are provided, ensure that the MISP objectives are also implemented as they are priority.*

# Minimum Initial Service Package

### Objectives of the MISP

- **ENSURE** the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:
  - nominates an RH officer to provide technical and operational support to all agencies providing health services
  - hosts regular stakeholder meetings to facilitate implementation of the MISP
  - reports back to the health sector/cluster meetings on any issues related to MISP implementation
  - shares information about the availability of RH resources and supplies
- **PREVENT AND MANAGE** the consequences of sexual violence:
  - Put in place measures to protect affected populations, particularly women and girls, from sexual violence
  - Make clinical care available for survivors of rape
  - Ensure the community is aware of the available clinical services
- **REDUCE** HIV transmission:
  - Ensure safe blood transfusion practice
  - Facilitate and enforce respect for standard precautions
  - Make free condoms available
- **PREVENT** excess maternal and newborn morbidity and mortality:
  - Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:
    - ▷ At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications
    - ▷ At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies
  - Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and hospital
  - Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- **PLAN** for comprehensive RH services, integrated into primary health care (PHC) as the situation permits. Support the health sector/cluster partners to:
  - Coordinate ordering RH equipment and supplies based on estimated and observed consumption
  - Collect existing background data
  - Identify suitable sites for future service delivery of comprehensive RH services
  - Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff

*Note: It is also important to ensure contraceptives are available to meet the demand, syndromic treatment of STIs is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). In addition, ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in "hygiene kits") are distributed to women and girls.*

## 2 Objectives

The objective of this chapter is to provide information and guidance for RH officers, programme managers and service providers working in humanitarian settings on:

- the role and functions of the lead RH agency and RH officer;
- prevention of sexual violence and clinical management of the consequences of rape;
- priority interventions for reducing HIV transmission;
- priority interventions for reducing maternal and newborn morbidity and mortality;
- planning for comprehensive RH services integration into primary health care as the situation stabilizes;
- the supplies needed to implement the MISP.

## 3 Programming

### 3.1 RH lead agency and RH officer

From the beginning of the response in each humanitarian setting, the health sector or health cluster must identify a lead RH organization. This can be an international NGO, the Ministry of Health (MOH) or a UN agency. The nominated organization, which is the one identified as having the most capacity to fulfil this role, immediately dedicates a full-time RH officer for a minimum period of three months to provide operational and technical support to the health partners and to ensure the prioritization of reproductive health and achieve good coverage of MISP services.

**To ensure MISP implementation the following must be done:**

- The health sector/cluster identifies a lead RH organization.
- The lead RH organization puts in place an RH officer (see Box 4, p. 24, for RH officer terms of reference), who functions within the health sector/cluster. The RH officer, supported by the lead RH organization, ensures that:
  - all health agencies working in each of the crisis areas address reproductive health;
  - regular RH stakeholder meetings are held to correctly establish the MISP;
  - information from these meetings is shared and discussed in the general health sector/cluster coordination meetings.
  - Operational and technical support is provided for health partners to implement the MISP in all locations affected by the emergency. This includes:
  - giving guidance on and technical support for the coordinated procurement of RH supplies;
  - identifying skilled staff to implement MISP services.

### 3.2 Prevention of and response to sexual violence

In order to prevent sexual violence and respond to the needs of survivors from the onset of an emergency, put in place:

- mechanisms to protect the affected population from sexual violence;
- clinical services to care for survivors of rape
- community awareness of the available services for rape survivors.

#### 3.2.1 Prevent sexual violence

Sexual violence has been reported from most humanitarian settings, including those caused by natural disasters. All actors in humanitarian settings must be aware of the risk of sexual violence and coordinate multisectoral activities to prevent it and protect the affected population, in particular women and girls. The RH officer must discuss the issue of sexual violence in health coordination meetings. In collaboration with the overall health sector/cluster mechanism, the RH officer and RH programme staff must:

- ensure women, men, adolescents and chil-

### Box 4: RH Officer - Terms of Reference

The RH officer is responsible for supporting health sector/cluster partners to implement the MISP and plan for comprehensive RH service delivery. The RH officer's role is to:

- coordinate, communicate and collaborate with the health sector or health cluster coordinator and actively participate in health coordination meetings, providing information and raising strategic and technical issues and concerns;
- support the coordinated procurement of reference materials and supplies;
- host regular RH stakeholder meetings at relevant (national, sub-national/regional, local) levels to problem solve and strategize the implementation of the MISP and to provide MISP resource materials;
- ensure regular communication among all levels and report back on key conclusions, challenges requiring resolution (e.g. policy or other barriers that restrict the population's access to RH services) to the overall health coordination mechanism. Identify synergies and gaps and avoid duplication of efforts and parallel structures;
- provide technical and operational guidance on MISP implementation and audience-specific orientation sessions when and where feasible (e.g. for service providers, community health workers, programme staff and the affected population, including adolescents)
- liaise with other sectors (protection, water and sanitation, community services, camp coordination, etc.) addressing RH-related concerns;
- support health partners to seek RH funding through humanitarian planning processes and appeals in coordination with the health sector/cluster.

The RH officer must identify and understand and provide information about:

- the elements of national and host country policies, regulations and customary laws that:
  - support RH services for the affected population
  - create barriers and restrict access to RH services
- relevant MOH protocols for standardized care (e.g. protocols for clinical management of rape survivors; referral mechanisms for obstetric emergencies; and, when planning for comprehensive RH services, STI syndromic management and family planning protocols).

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

- Use the MISP checklist (see page 50) to monitor services. Collect service delivery information, analyse findings and act on identified gaps and overlaps.
- Collect or estimate basic demographic and RH information of the affected population to support MISP implementation and planning for comprehensive RH service delivery (see Chapter 2).

dren have access to basic health services, including sexual and RH services;
- design and locate health facilities to enhance physical security, in consultation with the population, in particular women and adolescents;
- consult with service providers and patients about security in the health facilities;
- locate separate male and female latrines and washing areas in the health facility in a secure location with adequate path lighting at night, and ensure doors lock from the inside;
- ensure all ethnic subgroup languages are represented among service providers or interpreters are available;
- hire female service providers, community health workers, programme staff and interpreters;
- inform service providers of the importance of maintaining confidentiality and have them sign and abide by a code of conduct against sexual exploitation and abuse (SEA);
- ensure that codes of conduct and reporting mechanisms on SEA by health staff are in place, as well as relevant punitive measures to enforce them.

### 3.2.2 Respond to the needs of rape survivors

In order to prevent and manage possible health consequences, rape survivors must have access to clinical care, including supportive counselling, as soon as possible after the incident. Ensure health-care services can provide such care at the onset of a humanitarian response.

Survivors may also need protection and psychosocial and legal support. As soon as possible, support a process to identify clear division of roles and responsibilities among health partners and between all sector/cluster programmes responding to needs of survivors (health, protection, security and community services) in order to ensure a coordinated, survivor-centered, confidential referral mechanism for survivors. The outcome document of this process is sometimes referred to as GBV Standard Operating Procedures (SOPs) (see Chapter 8: GBV).

**Box 5: Guiding Principles When Responding to the Needs of Survivors of Rape**

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**
**Nondiscrimination**

### 3.2.3 Clinical services for survivors of rape

When setting up clinical management services for rape survivors, RH officers and programme staff must:

- establish a private consultation area with a lockable filing cabinet;
- put in place clear protocols and sufficient supplies and equipment;
- hire male and female service providers fluent in local languages, or where this is not possible, trained male and female chaperones and translators;
- involve women and male and female adolescents in decisions on accessibility to services and on an appropriate name for the service;
- ensure services and a referral mechanism to a hospital in case of life-threatening complications are available 24 hours a day/7 days a week;
- once services are established, inform the community why, where and when (as soon as possible after a rape) these services should be accessed. Use communication

channels appropriate to the setting (e.g. through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets);
- ensure service providers are skilled. Where needed, organize information sessions or short refresher training on clinical care for survivors of rape. Clinical management of survivors of rape includes the following components:
  - supportive communication
  - history and examination
  - forensic evidence collection as relevant
  - compassionate and confidential treatment, including:
    - emergency contraception
    - treatment of STIs
    - postexposure prophylaxis (PEP) to prevent HIV transmission
    - care of wounds and prevention of tetanus
    - prevention of hepatitis B
    - referral for further services, e.g. health, psychological and social.

**Supportive communication**

Ensure service providers are able to extend compassionate and confidential support to the survivor through communication that is accurate, clear, nonjudgemental and involves active listening.

**History and examination**

A detailed history and a thorough medical examination are conducted after ensuring the survivor understands and consents to each step. Preprinted history and examination forms must guide the process and all findings must be thoroughly documented.

The primary purpose of the history and examination is to determine the clinical care that is needed. Taking the history and conducting the examination are done at the survivor's own pace. She or he is assured that they are in control, do not have to talk about anything they are uncomfortable with and can stop the process at any time. It is the survivor's right to decide whether or not to be examined.

**Forensic evidence collection**

- Local legal requirements, laboratory and storage facilities determine if and what forensic evidence should be collected.
- Evidence is collected during the medical examination if the survivor consents to it.
- At a minimum, a careful written record should be kept of all findings during the medical examination that can support the survivor's story, including the state of her clothes. The medical chart is part of the legal record and 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.
- If a microscope is available, a trained health-care provider or laboratory worker can examine wet-mount slides for the presence of sperm, which proves penetration took place. Further evidence (such as clothes, foreign materials, semen or blood for DNA or urine for toxicology testing) is only collected if local capacity for processing (storage, laboratory analysis) exists and if the evidence can be used in court.
- When requested by the survivor, the service provider can prepare a medical certificate or a police form. 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 centre or by the programme manager. The other copy is provided to the survivor if she wants it after careful counselling on the risk of further violence if the document is found in her possession.
- 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 Contraceptive Pill Regimens

**1. The levonorgestrel-only regimen:** 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen, it is more effective and has fewer side effects); or

**2. The combined estrogen-progestogen regimen (Yuzpe):** a dose of 100 microgram ethinyl estradiol plus 0.5 mg of levonorgestrel, taken as soon as possible, followed by the same dose 12 hours later.

*Emergency contraception*

**Emergency contraceptive pills (ECPs)** can prevent unwanted pregnancies if used *within 120 hours* (up to 5 days) of the rape. There are two ECP regimens that can be used (see box above).

- Treatment with either regimen should be started as soon as possible after the rape because efficacy declines with time. Both regimens are effective when used up to 72 hours after the rape, and continue to be moderately effective if started within 72 to 120 hours. The effectiveness after longer delays has not been investigated.
- There are products that are specially packaged for emergency contraception, but they are not available in all countries. If prepackaged ECPs are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills (see Table 1, p. 28).
- Counsel the survivor about how to take the pills, what side effects may occur and the effect the pills may have on her next period. ECPs do not prevent pregnancy from sexual acts that take place after their use. Provide her with condoms for use in the immediate future.
- Make it clear to the survivor that there is a small risk that the pills will not work. Menstruation should occur around the time when she would normally expect it. It may be up to a week early or a few days late. If she has not had a period within a week after it was expected, she should return to have a pregnancy test and/or to discuss the options in case of pregnancy. Explain to her that spotting or slight bleeding is common with the levonorgestrel regimen. This should not be confused with a normal menstruation.
- Side effects: Up to 50% of users report nausea with ECP. Taking the pills with food decreases nausea. The levonorgestrel-only regimen has been shown to cause significantly less nausea and vomiting than the combined estrogen-progestogen regimen (Yuzpe). If vomiting occurs within two hours of taking a dose, repeat the dose. In cases of severe vomiting, ECPs can be administered vaginally.
- Precautions: ECPs can safely be used by any woman or girl, even those who cannot use hormonal methods on a continuous basis, as the dose of hormones used is relatively small and the pills are used for a short time. ECPs will not be effective in the case of an established pregnancy. ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

**Table 1: Emergency Contraception Regimens**

| Regimen | Pill composition *(per dose)* | Common brand names | First dose *(number of tablets)* | Second dose 12 hours later *(number of tablets)* |
|---|---|---|---|---|
| Levonorgestrel only | 750 μg | Levonelle, NorLevo,Plan B, Postinor-2, Vikela | 2 | 0 |
| | 30 μg | Microlut, Microval, Norgeston | 50 | 0 |
| | 37.5 μg | Ovrette | 40 | 0 |
| Combined | EE 50 μg plus LNG 250 μg<br>or<br>EE 50 μg plus NG 500 μg | Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, Tetragynon/ PC-4, Preven, E-Gen-C, Neo-Primovlar 4 | 2 | 2 |
| | EE 30 μg plus LNG 150 μg<br>or<br>EE 30 μg plus NG 300 μg | Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon | 4 | 4 |

*a EE = ethinylestradiol; LNG = levonorgestrel; NG =norgestrel.*

*(Adapted from: Consortium for Emergency Contraception, Emergency contraceptive pills, medical and service delivery guidelines, Second Edition. Washington, DC, 2004).*

**Insertion of a copper-bearing IUD is an effective method of emergency contraception** if the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle). It will prevent more than 99% of expected subsequent pregnancies. When the time of ovulation can be estimated (the risk of ovulation is low up to day seven of the menstrual cycle), she can have a copper-bearing IUD inserted beyond five days after the rape, as long as insertion does not occur more than five days after ovulation.

Offer survivors counselling on this service so they can make an informed decision. A skilled provider should counsel the survivor and insert the IUD.

If an IUD is inserted, make sure to give full STI treatment, as recommended below. The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

*Presumptive treatment for sexually transmitted infections (STIs)*

- Offer survivors of rape antibiotics to presumptively treat gonorrhoea, chlamydial infection and syphilis (see Tables 2 and 3). 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 which are easy to take. For instance, if the survivor presents within 30 days of the incident, 400 mg of cefixime plus 1 g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and incubating syphilis.
- Be aware that women who are pregnant or who have known allergies should not take certain antibiotics, and modify the treatment accordingly (see Table 2).
- Presumptive STI regimens can start on the same day as emergency contraception and postexposure prophylaxis for HIV (PEP). To reduce side effects, such as nausea, the doses can be spread out (and taken with food).
- Provide hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. A total of three doses are needed, the second dose four weeks after the first and the third dose eight weeks after the second dose.



**Table 2: WHO-recommended STI Treatment Protocols for Adults**

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

| STI | Treatment |
|---|---|
| **Gonorrhoea** | **cefixime** 400 mg orally, single dose<br>or<br>**ceftriaxone** 125 mg intramuscularly, single dose |
| **Chlamydial infection** | **azithromycin** 1 g orally, in a single dose<br>*(This antibiotic is also active against incubating syphilis (within 30 days of exposure)*<br>or<br>**doxycycline** 100 mg orally, twice daily for 7 days<br>*(contraindicated in pregnancy)* |
| ***Chlamydial infection in pregnant women*** | **azithromycin** 1 g orally, in a single dose<br>*(This antibiotic also active against incubating syphilis (within 30 days of exposure)*<br>or<br>**erythromycin** 500 mg orally, 4 times daily for 7 days<br>or<br>**amoxicillin** 500 mg orally, 3 times daily for 7 days |
| **Syphilis** | **benzathine benzylpenicillin*** 2.4 million IU, intramuscularly, once only<br>*(give as two injections in separate sites)*<br>or<br>**azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)*<br>*(This antibiotic is also active against chlamydial infections)* |
| *Syphilis, patient allergic to penicillin* | **azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)*<br>or<br>**doxycycline** 100 mg orally twice daily for 14 days<br>*(contraindicated in pregnancy)*<br>*Both azithromycin and doxycycline are also active against chlamydial infections* |
| ***Syphilis in pregnant women allergic to penicillin*** | **azithromycin** 2 g orally as a single dose (for treatment of primary, secondary and early latent syphilis of < 2 years duration)<br>or<br>erythromycin 500 mg orally, 4 times daily for 14 days<br>Both azithromycin and erythromycin are also active against chlamydial infections |

| STI | Treatment |
|---|---|
| **Trichomonas** | **metronidazole** 2 g orally as a single dose<br>or<br>**tinidazole** 2 g orally as a single dose<br>or<br>**metronidazole** 400 or 500 mg orally, 2 times daily for 7 days<br>*Avoid metronidazole and tinidazole in the first trimester of pregnancy* |

** **Note:** 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.*

## Table 3: WHO-recommended STI Treatment Protocols for Children and Adolescents

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

| STI | Weight or age | Treatment |
|---|---|---|
| **Gonorrhoea** | < 45 kg | **ceftriaxone** 125 mg intramuscularly, single dose<br>or<br>**spectinomycin** 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose<br>or (if > 6 months)<br>**cefixime** 8mg/kg of body weight orally, single dose |
| | > 45 kg | Treat according to adult protocol |
| **Chlamydial infection** | < 45 kg | **azithromycin** 20 mg/kg orally, single dose<br>or<br>**erythromycin** 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 | **erythromycin** 500 mg orally, 4 times daily for 7 days<br>or<br>**azithromycin** 1 g orally, single dose |
| **Syphilis** | | **benzathine penicillin*** 50 000 IU/kg IM (up to a maximum of 2.4 million IU), single dose |

| STI | Weight or age | Treatment |
|---|---|---|
| *Syphilis, patient allergic to penicillin* | | **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 | **metronidazole** 5 mg/kg of body weight orally, 3 times daily for 7 days |
| | > 12 years | Treat according to adult protocol |
| **Note: If the survivor presents within 30 days of the incident, **benzathine penicillin** presumptive treatment for syphilis can be omitted if the treatment regimen includes **azithromycin,** which is effective against incubating syphilis as well as chlamydial infection.* | | |

*PEP to prevent HIV transmission*

The likelihood of HIV transmission after a rape can be reduced through the prompt administration of PEP. PEP must be initiated within 72 hours following exposure and continued for 28 days. PEP needs to be started as soon as possible after exposure as studies suggest that PEP is more effective the sooner it is initiated. WHO recommends a 28-day combination therapy with two nucleoside-analogue reverse-transcriptase inhibitors, preferably in a fixed-dose combination. (This guidance is current at the time of publication. As this is a rapidly evolving field, it may change. Please check www.iawg.net for updates.)

For survivors of sexual violence:

- Assess the risk of exposure to HIV before prescribing PEP. Take the history of the event (including whether there were multiple attackers), vaginal or anal penetration and the type of injuries sustained.
- Offer voluntary counselling and testing for HIV (see Chapter 10: VCT) in the first two weeks after the incident. However, an HIV test is not mandatory before prescribing PEP.
- Offer PEP to all eligible survivors, including those who do not want to undergo HIV testing. Start the first dose of PEP as soon as possible. Do not delay starting PEP while waiting for a VCT result.

Do not offer PEP to survivors who are known or found to be HIV-positive. While it is not likely to harm, there is no expected benefit. Refer HIV-positive survivors to HIV treatment, support and care services where available.

**Table 4: Recommended Two-drug Combination Therapies for HIV-PEP in Adults**

| Weight or age | Treatment | Prescribe | 28 days supply |
|---|---|---|---|
| Adult | Combined tablet containing **Zidovudine** (300 mg) and **Lamuvidine** (150 mg) | 1 tablet twice/day | 60 tablets |
| | or | or | or |
| | **Zidovudine** (ZDV/AZT) 300 mg tablet | 1 tablet twice/day | 60 tablets |
| | plus | plus | plus |
| | **Lamuvidine** (3TC) 150 mg tablet | 1 tablet twice/day | 60 tablets |

**Table 5: Recommended Two-drug Combination Therapies for HIV-PEP in Children**

| Weight or age | Treatment | Prescribe | 28 days supply |
|---|---|---|---|
| < 2 years or 5-9 kg | **Zidovudine (ZDV/ AZT) syrup*** 10 mg/ml | 7.5 ml twice a day | = 420 ml (i.e. 5 bottles of 100 ml or 3 bottles of 200 ml) |
| | plus | plus | plus |
| | **Lamivudine (3 TC) syrup** 10 mg/ml | 2.5 ml twice a day | = 140 ml (i.e. 2 bottles of 100 ml or 1 bottle of 200 ml) |
| 10 – 19 kg | **Zidovudine (ZDV/ AZT)** 100 mg capsule | 1 capsule three times a day | 90 capsules |
| | plus | plus | plus |
| | **Lamivudine** (3 TC) 150 mg tablet | ½ tablet twice a day | 30 tablets |
| 20 – 39 kg | **Zidovudine (ZDV/ AZT**) 100 mg capsule | 2 capsule three times a day | 120 capsules |
| | plus | plus | plus |
| | **Lamivudine** (3 TC) 150 mg tablet | 1 tablet twice a day | 60 tablets |

** Discard a bottle of syrup 15 days after opening*

### Box 6: Three-drug ARV PEP

A regimen comprising a three-drug regimen is only recommended where:

- The source person is HIV-positive, taking antiretroviral therapy and is known to have signs of, or a personal history of a proven, antiretroviral therapy resistance

or

- The background prevalence of antiretroviral therapy resistance in the community exceeds 15% (where this is known).

| **Recommended three drug combination therapies** | | | |
|---|---|---|---|
| Zidovudine (AZT) | + Lamuvidine (3TC) | + Lopinavir | with a Ritonavir boost |

Adherence to the triple-drug regimen may be more difficult than to the two-drug regimen. Because of the potentially dangerous side-effects, refer the survivor to a clinician or medical doctor with experience in HIV treatment.

From: *Post-exposure Prophylaxis to Prevent HIV Infections, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.* WHO/ILO. 2007.

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.
- 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.
- Survivors may be given a one-week supply of PEP with the remaining three weeks' supply given upon follow-up visits.
- Provide the full 28-day dose to survivors who cannot return for any reason or in settings where there is likely to be ongoing displacement.

*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 dirty 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 four weeks, third dose at six months to one 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 centre level;
- **protection or social services** if the survivor does not have a safe place to go to when she or he leaves the health centre;
- **safe abortion care** where it is legal. Determine the legal indications for safe abortion care. In many countries the law allows termination of pregnancy resulting from rape. Termination of pregnancy may also be allowed in relation to the mental and physical health of the woman. Trained service providers can provide abortions in the first trimester:

- through manual vacuum aspiration (MVA) for up to 12 weeks since the last menstrual period (LMP), or
- with medical methods for up to nine weeks since LMP. WHO recommends a combination of **200 mg mifepristone orally followed by 800 µg misoprostol vaginally 36 to 48 hours later**. Where mifepristone is not available, evidence supports use of misoprostol alone 800 µg vaginally repeated every 12 hours up to three doses, although it is less effective than when used in combination with mifepristone.
  - Provide pain relief; e.g. ibuprofen 800 mg three times a day or as needed.
  - Advise women to return for one or more follow-up visits after 10-14 days. Cases of ongoing pregnancy should be referred for MVA; cases of incomplete abortion are managed either expectantly, with an additional dose of misoprostol or with an MVA procedure.
- Dilatation and curettage (D & C) with metal instruments should be used only where vacuum or medical methods of abortion are not available. MVA is quicker and associated with less blood loss than D&C. Therefore, every effort should be made to replace D&C with MVA.

- Psychosocial services where available. Liaise with GBV and protection focal points to identify psychosocial services available in the humanitarian setting. This may include initiatives offered by the affected population, women's centres and other support groups.

*Special considerations for children*

The RH officer must understand country-specific laws with regard to the age of consent; the professional (for instance a representative from the police, community services or the court) who can give legal consent for clinical care if a parent or guardian is the suspected offender; 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 examination should never be conducted in young children.**

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

*Special considerations for male survivors*

Male survivors are less likely to report an incident because of embarrassment, shame, criminalization of same sex relationships or the lack of recognition of the extent of the problem by service providers and programme 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 all relevant treatments.

### 3.2.4 Inform the community of the available services

Use appropriate communication channels (e.g. leaflets, radio messages, information sessions by TBAs and health workers) to inform the affected population of the availability of confidential services, and the importance of survivors attending these as soon as possible after an incident.

## 3.3 Reduce the transmission of HIV

To reduce the transmission of HIV from the onset of the humanitarian response, the RH officer must work with the health sector/cluster partners to:

- establish safe and rational blood transfusion practice;
- ensure application of standard precautions;
- guarantee the availability of free condoms.

Although not a component of the MISP, it is important to make antiretrovirals (ARV) available to continue treatment for people who were enrolled in an ART programme prior to the emergency,

including women who were enrolled in PMTCT programmes.

### 3.3.1 Safe 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;
- using medicines to prevent or reduce active bleeding (e.g. oxytocin);
- using blood substitutes to replace lost volume such as crystalloid-based substitutes (Ringer's lactate, normal saline) or colloid-based substitutes (haemaccel, gelofusin) 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 10: HIV). Do not reveal the results of a positive screening test to donors where they cannot be referred to voluntary counselling and testing (VCT) services. In this case screen blood for transfusion and discard it if it cannot be used. Link blood transfusion services with VCT services as soon as these are established as part of the comprehensive response and refer donors for VCT prior to screening their blood;
- conducting ABO grouping and Rhesus D (RhD) typing and, if time permits, cross-matching;
- ONLY transfusing blood to women of reproductive age with appropriate RhD 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, RH officers and programme 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 know how 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 (SOPs) 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 by all staff members dealing with blood transfusions every time they perform an activity. Keep copies of SOPs in a central location, and post them at the 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 of;
- 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.

### 3.3.2 Standard precautions

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure of blood or body fluids among patients and health-care 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 and hepatitis C and other pathogens within health-care settings.

In humanitarian settings there may be a lack of health sector 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.
  - Note: Ensure the availability of an adequate and sustainable supply of gloves to carry out all activities. NEVER reuse or resterilize 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:**
  - Minimize the need to handle needles and syringes.
  - Use a sterile disposable syringe and needle for each injection.
  - Set up the work area where injections are given to reduce the risk of injury.
  - 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 refrigerator.
  - Do not recap needles.
  - Position and inform patients correctly for injections.
  - 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 metres from a water source.
- **Instrument processing:** Process used instruments in the following order:
  1. *Decontaminate* instruments to kill viruses (HIV and hepatitis B) and make items safer to handle.
  2. *Clean* instruments before sterilization or high-level disinfection (HLD) to remove

debris.
3. *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.
4. *Use or properly store* items immediately after sterilization.

- **Housekeeping:** Clean up spills of blood or other body fluids promptly and carefully.

**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 reducing staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces (see Box 7) 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 material exposed to (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 counselling 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 counselling and testing and provide PEP when appropriate. PEP treatment protocols are the same as those for survivors of sexual violence (see Table 4). **An HIV test is not required before prescribing PEP.**
- Educate on risk reduction through review of sequence of events and advise the exposed worker to use condoms to prevent secondary transmission during the next three months.
- Provide HIV voluntary counselling 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, RH officers and RH programme 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-care workers and auxiliary staff where needed;
- establish supervisory systems such as simple checklists to ensure compliance with protocols;
- ensure first-aid measures in case of 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 occurs and to identify safety concerns and possible preventive measures.



**Box 7: First Aid**

**Occupational Exposure: First Aid**

**Injury with a used needle or sharp instrument and broken skin**

- 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.

**Splash of blood or body fluids on unbroken skin**

- Wash the area immediately. Do not use strong disinfectants.

**Splash of blood or body fluids in the eye**

- 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.

**Splash of blood or body fluids in the mouth**

- 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 here)* and take PEP if indicated.**

### 3.3.3 Make free condoms available

Condoms are key protection methods to prevent transmission of HIV and other STIs. Although not everyone will know about them, in most populations some people will use condoms. Ensure male and female condoms are available from the earliest days of a humanitarian response and order sufficient supplies of good-quality male and female condoms immediately (see Box 8).

## Box 8: Ordering Condoms

- Ensure that the procurement office responsible for bulk purchases for emergencies 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 RH Kits (see paragraph 3.5).
- Male condoms are available in the Interagency RH Kit 1, part A. Female condoms are in the Interagency RH Kit 1, part B. These kits contain sufficient supplies to cover the needs of a population of 10 000 people for three months (see calculations below). Leaflets explaining appropriate use of male and female condoms are also included.

**Calculations for condom supplies for 10 000 population over 3 months**

| **Male condoms** | **Female condoms** |
|---|---|
| *Assume*: | *Assume*: |
| 20% of population are sexually active males | 25% of population are sexually active females |
| *Therefore*: | *Therefore:* |
| 20% x 10 000 persons = 2000 males | 25% x 10 000 persons = 2,500 females |
| *Assume:* | *Assume:* |
| 20% of these will use condoms | 1% of these will use female condoms |
| *Therefore:* | *Therefore:* |
| 20% x 2000 = 400 users | 1% x 2,500 = 25 users |
| *Assume:* | *Assume:* |
| Each user needs 12 condoms per month | Each user needs 6 condoms per month |
| *Therefore:* | *Therefore:* |
| 400 x 12 x 3 months = 14,400 male condoms | 25 x 6 x 3 months = 450 female condoms |
| *Assume:* | *Assume:* |
| 20% wastage (2,880 condoms) | 20% wastage (90 female condoms) |
| *Therefore:* | *Therefore:* |
| TOTAL = 14,400 + 2,880 = 17,280 (or 120 gross) | TOTAL = 450 + 90 = 540 (or 3.8 gross) |

Provide condoms on request and ensure that condoms are available in all heath facilities and in accessible private areas in the community such as in latrines, in bars, at non-food distribution points and in youth and community centres. Consult with local staff about how condoms can be made available in a culturally sensitive way, particularly for most at-risk groups, such as sex workers and their clients, men who have sex with men, injecting drug users and young people. Adolescents may be helpful in identifying locations where their peers congregate. Ensure condoms are also available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, etc.

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

## 3.4 Prevent excess maternal and newborn morbidity and mortality

**Priority activities to prevent excess maternal and newborn morbidity and mortality are:**

- Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:
  - At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications
  - At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies.
- Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and the hospital.
- Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

**Box 9:**
**Basic and Comprehensive EmOC and Newborn Care**

- Ensure basic EmOC and newborn care at all health centres. This means that staff are skilled and have the resources to provide:
  - parental antibiotics
  - parental uterotonic drugs (oxytocin)
  - parental anticonvulsant drugs (magnesium sulfate)
  - manual removal of retained products of conception using appropriate technology
  - perform manual removal of placenta
  - assisted vaginal delivery (vacuum or forceps delivery)
  - maternal and newborn resuscitation

- Ensure comprehensive EmOC and newborn care at hospitals. This means that staff are skilled and have the resources to support all of the interventions above, as well as to:
  - perform surgery under general anaesthesia (caesarean delivery, laparotomy)
  - provide rational and safe blood transfusion

(See Chapter 6 for additional information.)

### 3.4.1 Ensure availability of EmOC and newborn care services

According to the UN Process Indicators of Emergency Obstetric Services, an estimated 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 will 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 resulting from complications, RH officers must ensure that basic

and comprehensive EmOC and newborn care services are available 24 hours per day, seven days per week (see Box 9).

**Basic EmOC and newborn care**

While skilled attendance at all births in a health facility is ideal because it can help reduce maternal 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 at each health facility basic EmOC and newborn care interventions (as outlined in Box 9), as well as capacity to refer to the hospital if needed, are available 24 hours per day, seven days per week.

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

Approximately two-thirds of infant deaths occur within the first 28 days. The majority of these deaths are preventable by initiating essential actions that can be taken by health-care workers, mothers or other community members. Approximately 5% to 10% of newborns do not breathe spontaneously at birth and require stimulation. About half of those who have difficulty initiating breathing, require resuscitation. The major reasons for failure to breathe include preterm birth and acute intrapartum events resulting in severe asphyxia.

To prevent and address these complications:

- Provide midwives and other skilled birth attendants in health centres with materials and drugs to conduct deliveries, to deal with complications and to stabilize women prior to transport to the hospital if needed.
- Ensure skilled birth attendants are competent to provide emergency and routine newborn care, including:
  - initiation of breathing;
  - resuscitation;
  - thermal protection (delayed bathing, drying, skin-to-skin contact);
  - prevention of infection (cleanliness, hygienic cord cutting and care, eye care);
  - immediate and exclusive breastfeeding;
  - management of newborn illness and care for preterm/low birth weight babies.

Supplies to support basic EmOC and newborn care are included in the Interagency RH Kits (see paragraph 3.5). Newborn resuscitation supplies are available in Interagency RH Kit 6. When ordering supplies from other sources, make sure the midwifery package includes newborn resuscitation supplies.

**Comprehensive EmOC and newborn care**

Where feasible, support host-country hospitals with skilled staff, infrastructure, medical commodities, including medicines and surgical equipment, as needed to provide comprehensive EmOC and newborn care (see Box 9). If this is not feasible because of the host-country hospital's location or inability to meet the increased demand, the RH officer should work with the health sector/cluster and an agency such as ICRC or IFRC to resolve the problem, such as establishing a referral hospital close to the affected population.

### 3.4.2 Establish a referral system to manage obstetric and newborn emergencies

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 in a humanitarian setting. Such a referral system must support the management of obstetric and newborn complications 24 hours a day, seven days a week. It should ensure that women, girls and newborns who require emergency care are referred from the community to a health centre where basic EmOC and newborn care is available. Patients with obstetric complications and newborn emergencies that cannot be managed at the health centre must be stabilized and transported to a

hospital with comprehensive EmOC and newborn care services.

- Determine policies, procedures and practices to be followed in health centres and hospitals to ensure efficient referral.
- Determine distances from the affected community to functioning health centres and to the hospital, as well as transport options for referral.
- Post protocols in every health centre, specifying when, where and how to refer patients with obstetric emergencies to the next level of care.
- Inform communities when and where to seek emergency care for complications of pregnancy and childbirth as soon as possible. Meet 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 EmOC and newborn care, women and newborns will die unnecessarily. Therefore it is extremely important to attempt to negotiate access to the referral hospital. Where 24/7 referral services are impossible to establish, it is particularly essential that qualified staff are available at all times at health centres to provide basic EmOC and newborn care (see paragraph 3.4.1). In this situation, it is helpful to establish a system of communication, such as the use of radios or cell phones, to communicate with more qualified personnel for medical guidance and support.

### 3.4.3 Clean delivery kits

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 centre without the assistance of skilled birth attendants. Make a clean delivery package available to all visibly pregnant women to promote clean home deliveries when access to a health facility is not possible. Distribution can be done at registration sites for instance.

In communities where traditional birth attendants (TBAs) are assisting home deliveries, they can be given clean delivery packages and additional basic supplies. Link these 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 in the comprehensive RH programme where they may be able to play a

**Box 10: Encourage Childbirth in Health Centres**

It is important to emphasize that where health centres with skilled birth attendants and sufficient equipment and supplies are available, all women should be told where these clinics are and should be encouraged to deliver there. This information can be provided when the clean delivery packages are distributed, as well as through communication with the community.

**Box 11: Clean Delivery Package**

The packages contain very basic materials:

- one sheet of plastic (for the woman to deliver on)
- a bar of soap
- a pair of gloves
- one clean razor blade (new and wrapped in its original paper) (to cut the umbilical cord)
- three pieces of string (to tie the umbilical cord)
- two pieces of cotton cloth (one to dry and the other to warm the baby)
- explanatory leaflets with pictures

role as a link between families, communities and local authorities and the RH services see Chapter 6: Maternal and Newborn Health.

Clean delivery packages and supplies for traditional birth attendants can be ordered through UNFPA (Interagency RH Kit 2A and B, see paragraph 3.5). Because these materials are often easily obtained locally and do not expire, it is possible to assemble these packages on-site and prestock 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.

## 3.5 Supplies to implement the MISP

To implement the service delivery components of the MISP (provide clinical care for survivors of rape; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality), the Inter-agency Working Group on Reproductive Health in Crises (IAWG) designed a set of kits containing drugs and supplies aimed at facilitating the implementation of these priority RH services: the Interagency Reproductive Health Kits (RH Kits). The RH Kits complement the Interagency Emergency Health Kit 2006 (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; however, although it contains a midwifery kit, emergency contraceptive pills (ECPs), PEP treatment to prevent transmission of HIV after rape and supplies for the adherence to standard precautions, the IEHK does not have all supplies needed to implement the MISP.

The RH Kits are designed for use at the onset of the humanitarian response and contain sufficient supplies for a three-month period for different population numbers, depending on the population coverage of the health-care setting for which the kits are designed.

The 13 RH Kits are divided into three blocks; each block targets a different health service delivery level:

- Block 1: Community and primary health-care level: 10 000 persons/3 months
- Block 2: Primary health care and referral hospital level: 30 000 persons/3 months
- Block 3: Referral hospital level: 150 000 persons/3 months

**Block 1**
Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at community and primary health care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.

**Block 2**
Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health-care providers with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

**Block 3**
In humanitarian settings, patients from the affected population 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. Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive EmOC and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150 000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.

### 3.5.1 RH Kit procurement and logistics

UNFPA is in charge of assembling and delivering the Interagency RH Kits. However, agencies should not be dependent on one source for

**Table 6: Inter-Agency Reproductive Health Kits**

| **Block 1** | | |
|---|---|---|
| **Kit No.** | **Kit Name** | **Colour Code** |
| Kit 0 | Administration | Orange |
| Kit 1 | Condom<br>(Part A: male condoms plus Part B: female condoms) | Red |
| Kit 2 | Clean Delivery (Individual)<br>(Part A: clean delivery packages plus part B: supplies for birth attendants) | Dark Blue |
| Kit 3 | Post-Rape<br>Part A: ECP and STI treatment plus Part B: PEP | Pink |
| Kit 4 | Oral and Injectable Contraception | White |
| Kit 5 | STI treatment | Turquoise |
| **Block 2** | | |
| **Kit No.** | **Kit name** | **Colour Code** |
| Kit 6 | Delivery kit (Health Facility) | Brown |
| Kit 7 | IUD | Black |
| Kit 8 | Management of Complications of Miscarriage and Abortion | Yellow |
| Kit 9 | Suture of Tears (cervical and vaginal) and Vaginal Examination | Purple |
| Kit 10 | Vacuum Extraction Delivery (Manual) | Gray |
| **Block 3** | | |
| **Kit No.** | **Kit name** | **Colour Code** |
| Kit 11 | Referral level (Part A plus B) | Fluorescent green |
| Kit 12 | Blood Transfusion | Dark green |

supplies and should include RH supplies in their overall medical supply procurement. Order the Interagency 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 RH services. Coordinate the ordering of health supplies within the health sector/cluster to avoid waste.

When planning to order RH Kits, prepare a plan for in-country distribution of the kits. This plan outlines how many of which kits go to which partners, 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).

| Table 7: Interagency RH Kit Points of Contact | | | |
|---|---|---|---|
| **Address** | **UNFPA**<br><br>Humanitarian Response Branch<br>220 East 42nd Street<br>New York, NY 10017<br>USA | **UNFPA**<br><br>Humanitarian Response Branch<br>11-13 chemin des Anémones<br>1219 Chatelaine,<br>Geneva, Switzerland | **UNFPA**<br>Procurement Services Branch<br>Midtermolen 3<br>2100 Copenhagen<br>Denmark |
| **Fax** | +1 212 297 4915 | +41 22 917 80 16 | +45 35 46 70 18 |
| **E-mail** | hrb@unfpa.org | hrb@unfpa.org | procurement@unfpa.dk |
| **Website** | www.unfpa.org | | http://web.unfpa.org/procurement/form_request.cfm |

Be prepared to receive goods as soon as they arrive at the port of entry to the country and ensure that all relevant forms for customs clearance have been prepared ahead of time so there are no unnecessary delays with importing the kits. The logistics cluster, where it exists, may be able to help facilitate this.

Information on the kits or assistance with ordering can be provided by UNFPA field offices, agency partners or UNFPA Procurement Services Branch (PSB) or UNFPA Humanitarian Response Branch (HRB).

## 3.6 Plan to integrate comprehensive RH services into primary health care

Start planning for the integration of comprehensive RH 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 unwanted pregnancies, the transmission of sexually transmitted infections, complications of gender-based violence and maternal and newborn morbidity and mortality.

Initiate comprehensive RH service delivery components as soon as the standards for the MISP indicators are reached (see Chapter 3: Assessment, Monitoring and Evaluation). When humanitarian appeals processes and agencies start longer-term planning (for 6-12 months), comprehensive services must be integrated into funding and planning processes, such as the Common Humanitarian Action Plan (CHAP), Consolidated Appeals Process (CAP) and applications to the Central Emergency Response Fund (CERF).

In order to design a comprehensive RH service delivery program, integrated into primary health care, RH officers and RH programme managers must work within the health sector/cluster to:

- order RH equipment and supplies
- collect existing background data
- identify suitable sites for future comprehensive RH service delivery
- assess staff capacity to provide comprehensive RH services and plan for training/retraining.

**Box 12: MISP and Comprehensive RH Services**

| RH Components (not in order of priority/ importance) | Priority RH Services (MISP) | Comprehensive RH Services |
|---|---|---|
| FAMILY PLANNING | ** Provide contraceptives such as condoms, pills, injectables and IUDS to meet demand* | Source and procure contraceptive supplies<br>Provide staff training<br>Establish comprehensive family planning programming<br>Provide community education |
| GENDER-BASED VIOLENCE | Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters<br>Provide clinical care for survivors of rape | Expand medical, psychological, social and legal care for survivors<br>Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital mutilation<br>Provide community education<br>Engage men and boys in GBV programming |
| MATERNAL AND NEWBORN CARE | Ensure availability of emergency obstetric and newborn care services<br>Establish 24/7 referral system for obstetric emergencies<br>Provide clean delivery packages to visibly pregnant women and birth attendants | Provide antenatal care<br>Provide postnatal care<br>Train skilled attendants (midwives, nurses, doctors) in performing EmOC and newborn care<br>Increase access to basic and comprehensive EmOC and newborn care |
| STIs, INCLUDING HIV PREVENTION AND TREATMENT | Ensure safe blood transfusion practice<br>Facilitate and enforce respect for standard precautions<br>Make free condoms available<br>**Make syndromic treatment available as part of routine clinical services for patients presenting for care*<br>** Make treatment available for patients already taking ARVs, including for PMTCT, as soon as possible* | Establish comprehensive STI prevention and treatment services, including STI surveillance systems<br>Collaborate in establishing comprehensive HIV services as appropriate<br>Provide care, support and treatment for people living with HIV/AIDS<br>Raise awareness of prevention, care and treatment services for STIs, including HIV<br>Provide community education |

### 3.6.1 Order RH equipment and supplies

Once minimal initial RH services are established, work with health authorities and through the health sector/cluster to analyse the situation, estimate the use of medicines and disposable supplies, assess the needs of the population and reorder supplies as needed. Avoid continued ordering of the prepackaged RH Kits. Ordering RH supplies based on demand will ensure the sustainability of the RH programme and avoid shortage of some supplies and wasting of others not used in the setting.

Place follow-up orders for RH supplies through regular medical supply lines in-country. Also consider procurement channels used by NGOs or through UNFPA Procurement Services Branch (see paragraph 3.5.1).

When ordering supplies for comprehensive RH services, RH officers and RH programme managers must coordinate RH commodity management with health authorities and the health sector/cluster in order to ensure uninterrupted access to RH commodities and avoid waste.

- Hire staff trained in supply chain management.
- Estimate monthly consumption of RH medicines and disposables.
- Identify medical supply channels. Investigate the quality of local supply channels. If this is inadequate, obtain RH commodities through recognized global suppliers or with support from UNFPA, UNICEF or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality RH supplies at low cost.
- Place timely orders through identified supply lines based on your estimates in order to avoid stock-outs.
- Locate the supplies as close to the beneficiary population as possible.

### 3.6.2 Collect existing background data

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

- Identify relevant MOH policies and protocols for standardized care, such as STI syndromic management and family planning protocols.
- Collect or estimate demographic and RH information of the affected population, such as:
  - the number of women of reproductive age (15 to 49 years old) — estimated at 25% of the population; the number of sexually active men — estimated at 20% of the population; the crude birth rate — estimated at 4% of the population;
  - age- and sex-specific mortality data, for example the number of deaths in adolescent girls, the newborn mortality rate (the number of deaths during the first 28 completed days of life per 1000 live births in a given period), existing background data on maternal mortality;
  - STI and HIV prevalence, contraceptive prevalence and preferred methods, and RH knowledge, attitudes and behaviour of the affected population.

For more information, see Chapter 3: Assessment, Monitoring and Evaluation.

### 3.6.3 Identify suitable sites

Collaborate with local authorities and the health sector/cluster partners to identify possible sites for comprehensive RH service, such as family planning (FP) clinics, STI outpatient rooms or adolescent RH services. It is important to consider the following factors (among others) when selecting suitable sites:

- feasibility of communications and transport for referrals
- distance to other health services
- proximity to affected population and the target group

### 3.6.4 Assess staff capacity and plan for training

Staff capacity can be measured through supervisory activities (e.g. monitoring checklists, direct observation, client exit interviews) (see Chapter 1: Fundamental Principles and Chapter 3: Assessment, Monitoring and Evaluation) or through formal examinations of knowledge and skills.

When planning for training or retraining of staff, work with national authorities and academic and training institutes and take into consideration existing curricula. Where possible, use national trainers. Plan training sessions carefully, in order not to leave health facilities without in-service staff.

## 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 times of conflict, 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.

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, including ensuring access to reproductive health-care services, including prevention of HIV infection, and to female service providers. In addition, international refugee law requires that States treat refugees lawfully residing in their territory the same as 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 RH care. In their response to emergencies, States are instructed 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." *

**Box 13: Advocacy**

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

The MISP:

- is a Sphere standard and is thus an internationally recognized, universal minimum standard of disaster response;
- is a life-saving intervention and a CERF minimum life-saving criterion eligible for CERF funding;
- is integrated in the global health cluster guidance.

* Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 40 (2000).

## 5 Monitoring

The RH officer implements the MISP checklist to monitor service provision in each humanitarian setting. In some cases, this may be done by verbal reporting from RH managers and/or through observation visits. At the onset of the humanitarian response weekly monitoring is done. Once services are fully established, monthly monitoring is sufficient. Discuss gaps and overlaps in service coverage within the RH stakeholder meetings and at health sector/cluster coordination mechanisms to find and implement solutions.

| Sample MISP Checklist | | | |
|---|---|---|---|
| Geographic area: | Reporting time period: _ _/ _ _/20 _ _ to _ _/ _ _/ 20 _ _ | Start date of health response: _ _/ _ _/20 _ _ | Reported by: |
| **1. RH lead agency and RH officer** | | | |
| | | YES | NO |
| 1.1 | Lead RH agency identified and RH officer functioning within the health sector/cluster:<br>Lead agency _____<br>RH officer _____ | ☐ | ☐ |
| 1.2 | RH stakeholder meetings established and meeting regularly: | | |
| | • National MONTHLY | ☐ | ☐ |
| | • Sub-national/District BIMONTHLY | ☐ | ☐ |
| | • Local WEEKLY | ☐ | ☐ |
| **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 (estimated at 4% of the population) | _____ | |

| **3. Prevent sexual violence and respond to the needs of survivors** | | | |
|---|---|---|---|
| | | YES | NO |
| 3.1 | Multisectoral coordinated mechanisms to prevent sexual violence are in place | ☐ | ☐ |
| | Confidential health services to manage survivors of rape | | |
| | • Emergency contraception | ☐ | ☐ |
| | • PEP | ☐ | ☐ |
| | • Antibiotics to prevent and treat STIs | ☐ | ☐ |
| | • Tetanus toxoid/Tetanus immunoglobulin | ☐ | ☐ |
| | • Hep B vaccine | ☐ | ☐ |
| | • Referral to health, psychological, social support services | ☐ | ☐ |
| 3.2 | Number of incidents of sexual violence reported to health services | _____ | |
| 3.3 | Information on post-rape care and access to services disseminated to community | ☐ | ☐ |
| **4. Reduce the transmission of 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 | Sufficient materials and checklists to ensure standard precautions in place | ☐ | ☐ |
| 4.4 | Condoms available free of charge: | | |
| | • Health facilities | ☐ | ☐ |
| | • Community level | ☐ | ☐ |
| 4.5 | Approximate number of condoms taken this period | _____ | |
| 4.6 | Number of condoms replenished in distribution sites this period (specify locations) | | |
| | _____ | _____ | |
| | _____ | _____ | |
| | _____ | _____ | |
| | _____ | _____ | |

| **5. Prevent excess maternal and newborn morbidity and mortality** | | | |
|---|---|---|---|
| | | YES | NO |
| 5.1 | **Health centre** (to ensure basic EmOC and newborn care 24/7)<br>• one qualified health worker on duty per 50 outpatient consultations per day<br>• midwife supplies, including newborn supplies available<br>**Hospital** (to ensure comprehensive EmOC and newborn care 24/7)<br>• 1 qualified service provider on duty per 20-30 inpatient beds for the obstetric wards<br>• 1 team of doctor/nurse/midwife/anaesthetist on duty<br>• adequate drugs and supplies to support comprehensive EmOC and newborn care 24/7 | ☐<br>☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐<br>☐ |
| 5.2 | Referral system for obstetric and newborn emergencies functioning 24 hours per day/7 days per week (24/7)<br>• means of communication (radios, mobile phones)<br>• transport from community to health centre available 24/7<br>• transport from health centre to hospital available 24/7 | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ |
| 5.3 | Functioning cold chain (for oxytocin, blood screening tests) in place | ☐ | ☐ |
| 5.4 | Number of caesarean deliveries/number of births x 100 | ☐ | ☐ |
| 5.5 | Number of clean delivery kits distributed/estimated number of pregnant women x 100 | _____ | |
| **6. Planning for transition to comprehensive RH services. Activities this period.** | | | |
| 6.1 | Sites for future delivery of comprehensive RH services (e.g. FP, STI management, adolescent reproductive health) | | |
| 6.2 | Staff training needs (for FP provision, STI management, etc.), training tools, facilitators: | | |
| 6.3 | RH commodities consumption (medicines and renewable supplies) monitored? | ☐ | ☐ |
| 6.4 | Procurement channels identified:<br>1 _____<br>2 _____<br>3. _____ | | |

| **7. Special notes** | | | |
|---|---|---|---|
| | | YES | NO |
| 7.1 | Basic contraceptive methods available to meet demand | ☐ | ☐ |
| 7.2 | ARV available for patients on ART, including PMTCT | ☐ | ☐ |
| 7.3 | STI treatment available at health facilities | ☐ | ☐ |
| 7.4 | Hygiene kits have been distributed | ☐ | ☐ |

| **8. Further comments** |
|---|
| Explain how this information was obtained (direct observation, report back from partner (name), etc.) and provide any other comments. |

| **9. Actions (For the "No" checks, explain barriers and proposed activities to resolve them.)** | | |
|---|---|---|
| **Number** | **Barrier** | **Proposed solution** |
| | | |
| | | |
| | | |
| | | |
| | | |

## 6 Further reading

**Essential reading**

**MISP**

*Minimum Initial Service Package (MISP) for Reproductive Health: A Distance Learning Module*. Women's Commission for Refugee Women and Children (Women's Refugee Commission), 2006. http://misp.rhrc.org/content/view/26/45/lang,english/

*MISP Cheat Sheet.* International Planned Parenthood Federation, August 2007. http://iawg.net/resources/MISP%20cheat%20sheet%2003%2001%2010.pdf

*Inter-Agency Reproductive Health Kits for Crisis Situations,* 4th Edition. UNFPA/IAWG, 2008. http://www.rhrc.org/resources/rhrkit.pdf

**Prevention of and response to sexual violence**

*Clinical Management of Rape Survivors: Developing Protocols for use with Refugees and Internally Displaced Persons,* revised edition. WHO/UNHCR, 2004. http://www.who.int/reproductive-health/publications/emergencies/924159263X/en/index.html

*Clinical Management of Rape Survivors e-learning tool*, WHO, UNHCR, UNFPA, 2009: http://www.who.int/hac/techguidance/pht/womenshealth/en/index.html

*Guidelines for Gender-based Violence Interventions in Humanitarian Settings, Focusing on*

*Prevention of and Response to Sexual Violence in Emergencies. I*nter-agency Standing Committee, 2006. http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv

**Emergency obstetric and newborn care**

*Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs.* Women's Commission for Refugee Women and Children (Women's Refugee Commission), 2005. http://www.rhrc.org/resources/emoc/EmOC_ffg.pdf

**Prevention of HIV transmission**

*Guidelines for addressing HIV in Humanitarian Settings, Interagency Standing Committee.* 2009. http://www.aidsandemergencies.org/cms/documents/IASC_HIV_Guidelines_2009_En.pdf

**Additional reading**

*Training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises: A Course for SRH Coordinators, Facilitator's Manual*. IPPF ESAOR, UNFPA, UNSW, 2008. http://www.ippfeseaor.org/NR/rdonlyres/76E30209-A4F4-4A00-BD90-D1B810056168/0/SPRINTFacilitatorsManual-part1.pdf

*Sexual and Gender-Based Violence Against Refugee, Returnee and Internally Displaced Persons, Guidelines for Prevention and Response*. United Nations High Commissioner for Refugees, 2003. http://www.unhcr.org/3f696bcc4.html

More on emergency obstetric care: http://www.who.int/making_pregnancy_safer/documents/managing_complications/en/index.html

More on blood transfusion safety: www.who.int/bloodsafety/en/

More on standard precautions: www.engender-health.org/ip/index.html

*Post-Exposure Prophylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.* WHO/ILO, 2007. www.who.int/hiv/pub/guidelines/PEP/en/



# 3

CHAPTER THREE

# Assessment, Monitoring and Evaluation

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## 1 Introduction

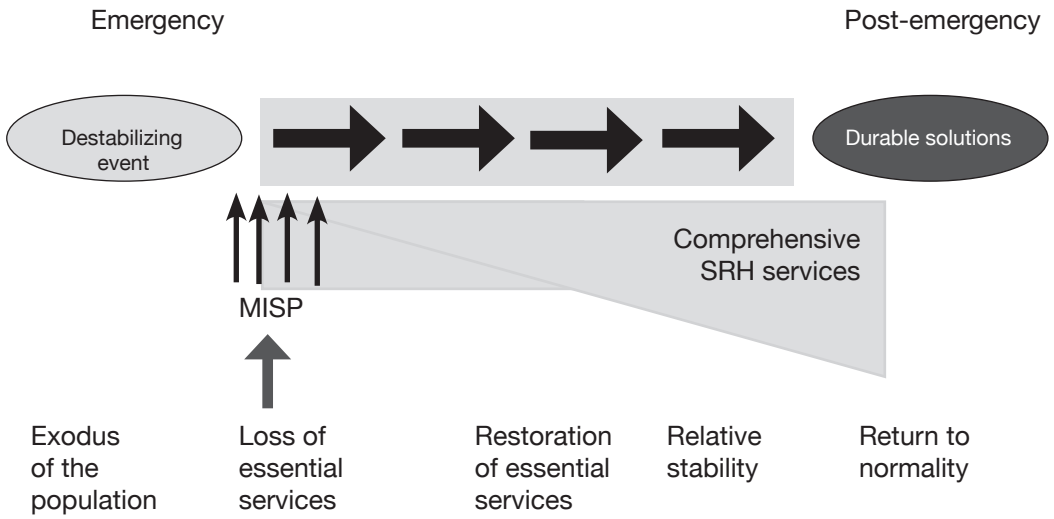
Assessment, monitoring and evaluation are used at different stages during a humanitarian response and are closely linked to public-health decision-making and the implementation of RH programme activities. The results of assessment, monitoring and evaluation inform planning for comprehensive RH programmes because they help to:

- understand the needs of populations of concern
- ensure effective and efficient use of resources
- determine the success or failure of a programme
- provide accountability and transparency to donors and beneficiaries.

RH officers and programme managers often find decisions regarding the transition from implementing MISP activities (see Chapter 2) to initiating comprehensive RH service components challenging. Timely dissemination of accurate assessment, monitoring and evaluation results will enable them to make evidence-based decisions about the steps in the transition to comprehensive RH programme implementation and service delivery. Appropriate use of the results will also ensure that activities are carried out in a sustainable manner, appropriate for the context and adapted to the needs of the population.

# Assessment, Monitoring and Evaluation

**Figure 3: 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 dwindling funds in protracted settings. The IAFM is applicable for all settings, wherever an agency finds itself on the emergency continuum.*

## 2 Objectives

The objectives of this chapter are to:

- describe how to assess, monitor and evaluate RH programmes;
- identify appropriate assessment, monitoring and evaluation methods, tools and indicators;
- provide guidance on planning the transition from the Minimum Initial Service Package (MISP) to comprehensive RH programmes.

## 3 Assessment, monitoring and evaluation

The fifth objective of the MISP requires that planning for comprehensive RH programmes is started from the onset of the humanitarian response. As soon as MISP service delivery targets have been reached and can be sustained (see Chapter 2: MISP), appropriate comprehensive RH service components can be implemented.

RH officers and programme managers must work within health sector/cluster mechanisms to ensure that this design process is in tune with other health planning and resource mobilization activities and that comprehensive RH services are integrated into

primary health care programme development.

When planning a comprehensive RH programme, is important both to understand the needs of the affected population and to take into consideration available resources and identified priorities within the existing health system. The health systems approach defines a number of "building blocks" that make up health systems and offers a useful programming framework within which RH components can be planned, assessed, monitored and evaluated (see Box 14).

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.

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

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

These three processes are linked along a con-

### Box 14: Health Systems Approach*

The six building blocks of a health system are as follows:

- Good **reproductive health services** are those which deliver effective, safe, quality reproductive health interventions to those that need them, when and where needed, with minimum waste of resources.
- A well-performing **reproductive health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient RH staff, fairly distributed; they are competent, responsive and productive).
- A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on reproductive health determinants, health system performance and RH health status.
- A well-functioning health system ensures equitable access to essential **reproductive health drugs, vaccines and technologies** of assured quality safety, efficacy, availability and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good **health financing system** raises adequate funds for reproductive 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. It provides incentives for providers and users to be efficient.
- **Leadership and governance** involves ensuring strategic reproductive health policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability.

The building blocks provide a useful planning model for the transition between MISP and more comprehensive RH programmes. However, RH officers and programme managers must recognize the interdependence of each block of the health system approach and ensure comprehensive RH services are implemented in an integrated manner.

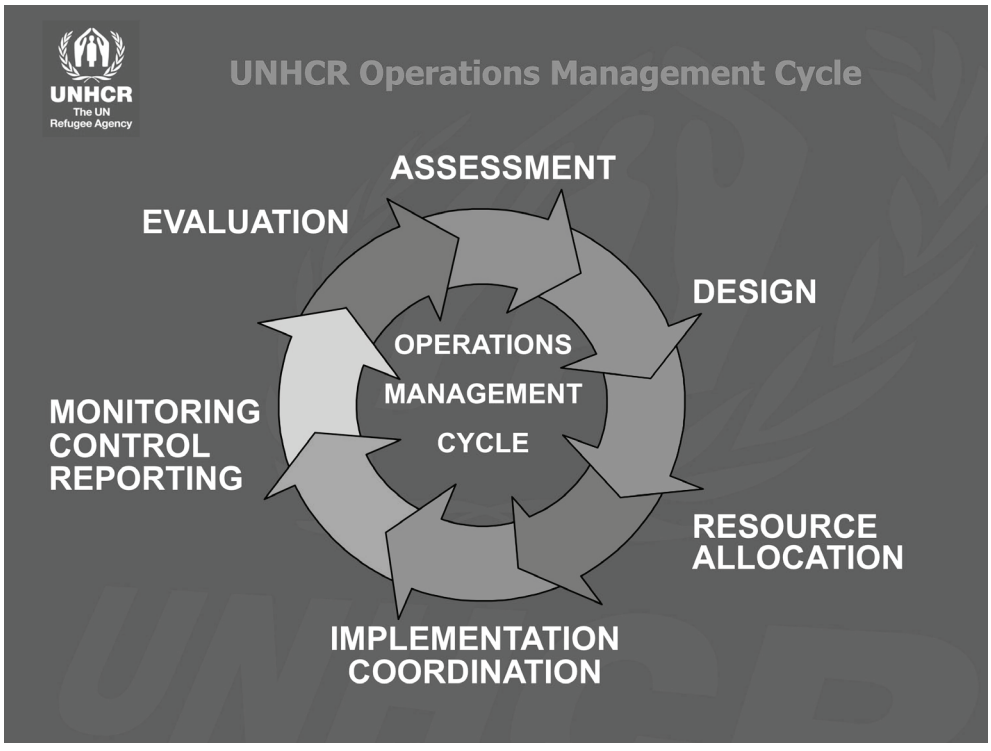
* *From:* Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. *WHO Geneva, 2007.*

tinuum of service provision called the project cycle. The project cycle is a tool which helps RH officers and programme managers understand how tasks and management functions should be performed during the course of RH programme implementation (see Box 15).

### Box 15: Project Cycle

The **project cycle** defines how assessment, monitoring and evaluation are linked along a continuum of service delivery and programme management. It helps RH officers and programme managers to understand how each can be used to inform decision-making throughout the cycle of programme design, planning and implementation (for an example, see the diagram below).

The ability to carry out successful and timely reproductive health projects in the challenging environment of a humanitarian response is crucial to ensure RH needs of the affected population are met. The most successful RH programmes are those which are designed based on an appropriate **assessment** of needs within the target population. Subsequent programme activities should then be **monitored** using carefully selected indicators to track progress towards clearly stated objectives (See section 3.2 Monitoring for more information on selecting and using indicators). Throughout implementation of the programme, 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 programme review and improvement.




There are a number of tools available to help guide this cycle of planning, assessment, monitoring and evaluation of programmes. One of most widely recognized is the **Logical Framework Approach (**LFA) or “logframe”. (For more information see Further Reading.)

## 3.1 Assessment

The purpose of an assessment is to rapidly gather information and identify the RH needs of the population and the capacity of the existing health system to respond to those needs.

### 3.1.1 When to do an assessment?

At the onset of the humanitarian response, an initial rapid assessment is carried out by the humanitarian partners. Within the health sector/cluster coordination system, RH officers must ensure that they obtain information on:

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

Strategies and plans are adapted accordingly, based on this information. The causes of the most important RH-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 Chapter 2). When MISP objectives 2, 3 and 4 are in place, a more in-depth assessment is conducted as part of objective 5, planning for the implementation of comprehensive RH services. Throughout the life of a program, periodic assessments can be used to evaluate its progress towards achieving objectives.

### 3.1.2 What tools are available for assessments?

Four important methods of collecting data in assessments include:

a. Reviews of existing information
b. Key informant interviews and focus group discussions
c. Health-facility assessments
d. Rapid surveys

**a. Reviews of existing information**
As part of the assessment to plan the introduction of comprehensive RH service components, a thorough review of secondary data sources should be conducted to compile existing RH information on the affected population. Such data will be available from Ministries of Health, UN agencies and NGOs. Examples include:

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

**b. Key informant interviews**
The purpose of key informant interviews is to collect information from a wide range of people — including community leaders, professionals or residents — who have firsthand knowledge about the affected population. The information collected during an assessment should include key informants' views of pre-existing conditions and practices, the current situation, changes in practices since the onset of the emergency, adequacy of current RH services and priority RH needs of the population. Key informant interviews can either be structured (consisting of a set of questions asked in a specific order) or unstructured (consisting mostly of open-ended questions which can be changed or adapted during the course of an interview).

**c. Focus group discussions**
The purpose of focus group discussions is to obtain information 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. If the discussion is among a sub-group in the population, such as women of reproductive age or

adolescent men, then the results can provide useful information which is representative of that specific group.

**d. Health facility assessments**
A health facility assessment is an inventory of the places where health care may be provided and the services provided at these sites. A structured checklist of topics can help to provide a description of the health facility, including inventory of RH services provided; staffing and coverage; and an inventory of RH equipment and supplies. This can also include reviews of routine statistics on RH services to determine if standard protocols are followed in order to assure quality of care.

**e. Rapid surveys**
Rapid surveys can be useful for gathering population-based information quickly during an assessment. Such surveys should be short and contain questions only pertaining to the information needed to identify basic RH needs (see Box 16). Surveys differ from focus group discussions as they do not permit participants to give detailed opinions on a topic.

For examples of the tools described, please see Further Reading.

### 3.1.3 Who is responsible for conducting assessments?

An assessment team may consist of one to three people with clinical, research, management and public health skills. The number of teams required will depend upon the size of the area to be covered, the prevailing access and security situation and the assessment methods that will be used. When selecting a 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. If appropriate, it is also good practice to include members of the affected population in the assessment teams.

The ideal team members:

- have technical skills, training and experience;
- have good communication skills in the local languages and are familiar with the population being assessed;
- are comfortable with discussing reproductive health topics, and are open to learning about reproductive health;
- have good analytical skills;
- are able to make sound decisions based on sparse data.

#### Box 16: Use of RH Surveys

Surveys can provide useful, population-based data that RH officers and service providers can use to improve and more effectively target RH care services. 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, based on the availability of resources (time, money, personnel). Surveys that are conducted during initial needs assessments, for example, often need to be carried out rapidly using small, convenient sampling methods. Once the situation stabilises, 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 comparable with other surveys that are conducted as part of the health response.

### 3.1.4 What data is needed in an assessment?

Chapters 4 to 10 provide recommendations on what data should be collected in assessments for each component of an RH programme (see table below). The health system building blocks provide a useful structure to classify RH assessment questions (see Box 14: Health Systems Approach, p. 57).

For more detailed information on assessment data, see:

| | |
|---|---|
| **Chapter 4: Adolescent Reproductive Health** | **p. 87** |
| **Chapter 5: Family Planning** | **p. 99** |
| **Chapter 6: Maternal and Newborn Health** | **p. 123** |
| **Chapter 7: Comprehensive Abortion Care** | **p. 145** |
| **Chapter 8: Gender-based Violence** | **p. 157** |
| **Chapter 9: Sexually Transmitted Infections** | **p. 169** |
| **Chapter 10: HIV** | **p. 185** |

### 3.1.5 How to analyse, use and disseminate assessment results?

The results of an assessment must be as specific as possible to allow for timely decisions on interventions to be made. They clearly prioritize needs and identify opportunities under each health system building block (see Box 14, p. 57). The results must offer suggestions on how to ensure MISP interventions are sustained and assist in planning the addition of comprehensive RH 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. Also communicate findings and decisions to the community.

## 3.2 Monitoring

Monitoring is the regular, ongoing collection, reporting and analysis of data throughout the duration of programme implementation and it is an essential part of any RH programme. Monitoring includes the timely dissemination of results so that action can be taken.

### 3.2.1 When to monitor?

A simple, routine information system that collects minimal reproductive health data is required from the onset of a humanitarian response and the implementation of the MISP (see Chapter 2). As the response evolves and more comprehensive RH service components are introduced, the monitoring requirements of RH programmes must adapt to reflect the changing needs upon which these components are planned, organized and delivered.

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 programme management and coordination. The periodicity of monitoring within such a system (e.g. daily, weekly or monthly) depends on the evolvement of the humanitarian response and the requirements of each organization. At least monthly data should be made available to inform regular programming decisions.

### 3.2.2 What are the tools for monitoring?

It is crucial to have tools and methods of collection that are common to all health partners to ensure that the data generated are standardised and of good quality. When utilized in a systematic and coordinated fashion by all partners, these resources help to ensure that data are collected to the same level of detail and are comparable across locations.

Routine RH data should be collected from a combination of health facility and community sources as part of the wider HIS. Sources of routine data include:

- Individual patient records and charts (e.g. partographs, antenatal cards, family planning cards);
- Daily registers and tally sheets (e.g. birth registers, antenatal tally sheets);
- Laboratory forms (e.g. HIV testing or syphilis screening results);
- Maternal death review forms (see Box 18);
- Community-based health workers/midwife reports;
- Weekly and/or monthly reporting forms.

The above list of tools is not exhaustive. Other data sources and methods of routine reporting (e.g. sentinel surveillance*) may need to be maintained alongside the HIS, according to the needs of each programme and/or agency. In some settings, population-based surveys can also be used as an effective tool to guide programme delivery. When repeated over time, these can provide a useful source of RH monitoring data.

### 3.2.3 What data is needed for monitoring?

The data required to monitor any RH programme are defined by the selection of indicators that are used to monitor progress of the programme towards a set of objectives. See Box 17 for definitions and issues to take into consideration when selecting and using RH indicators

Chapters 4 to 10 recommend key indicators that are used to monitor each component of a comprehensive RH programme (see table on page 61). A summary of each indicator including the formulae, units of expression and a corresponding standard is given in Annex 1B, p. 69.

A specific tool for monitoring RH programmes is a maternal death review (See Box 18) or a “near miss” review. Maternal death reviews and near miss reviews are critical in maternal and newborn health (MNH) programmes to promote and monitor changes in service delivery and to advocate for measures to prevent complications and deaths. (See Chapter 6: MNH.)

### 3.2.4 Who is responsible for monitoring?

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

The clinic supervisor is designated responsibility for compiling weekly or monthly reports. These are in turn sent to the RH or health programme manager for entry into and analysis with a computer.

* Sentinel surveillance is a monitoring method that uses a surrogate indicator for a public health problem, allowing estimation of the magnitude of the problem in the general population. For example the HIV prevalence in women attending antenatal care services is used as a proxy indicator for the HIV prevalence in the entire population.

### Box 17: Selecting and Using RH 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 programme implementation. *For example: Obstetric risk factors are detected and managed early in pregnancy.*

Each indicator should be assigned a corresponding **standard** to establish the minimum acceptable level of achievement that is required. *For example: 90% of women attend four or more ANC visits during pregnancy.*

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

The process of indicator selection is not easy. Each indicator should be technically valid, simple and measurable. Furthermore, the expansion from MISP to comprehensive RH 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:

**S** pecific (what and who)

**M** easurable

**A** ppropriate

**R** ealistic (achievable)

**T** ime bound

The mix of indicators selected for monitoring should also be appropriate to measure programme objectives across different stages of the project cycle. For example:

**Output (or process) indicators** measure actions needed for programme implementation and correspond to various activities necessary to achieve specified outcomes. *For example: the number of midwives trained in ANC protocols.*

**Outcome (or performance) indicators** measure changes that result from programme activities, such as changes in knowledge, attitudes and behaviours, or in availability of services. *For example: the number 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 programme activities. *For example: Incidence of neonatal tetanus.*

**Table 8: Data Requirements for Monitoring:**


| | |
|---|---|
| **Chapter 4: Adolescent Reproductive Health** | **p. 97** |
| **Chapter 5: Family Planning** | **p. 121** |
| **Chapter 6: Maternal and Newborn Health** | **p. 137** |
| **Chapter 7: Comprehensive Abortion Care** | **p. 154** |
| **Chapter 8: Gender-based Violence** | **p. 167** |
| **Chapter 9: Sexually Transmitted Infections** | **p. 184** |
| **Chapter 10: HIV** | **p. 199** |


### Box 18: Maternal Death Review

A maternal death review provides a rare opportunity for health staff and community members to learn from a tragic — and often preventable — event. It can help identify gaps in services, gaps in knowledge (both on the health-care provider side and the community side) and the need to improve referral procedures for obstetric complications. It is important to include multiple people (family members, TBAs, midwives, doctors, coordinators, community leaders, etc.) in the process of reviewing a maternal death, regardless of whether the death occurred in the community or in a health facility.

Points to be investigated include:

- Time of onset of life-threatening illness
- Time of recognition of the problem and time of death
- Timeliness of actions
- Access to care, or logistics of referral
- Quality of medical care until death

Verbal autopsy, which has been used in certain refugee situations, has proved relatively successful when medical records are unavailable.

Annex 4 provides a sample maternal death investigation form and guidelines for use.

## 3.2.5 How to analyse, use and disseminate monitoring results

Analysis of routinely collected health service or population-based data is essential for monitoring the performance and quality of health service delivery and in identifying changes in the health status of the affected population.

At the facility-level, statistics can be analysed manually by posting results on charts showing usage statistics in the reception area of the clinic. At organizational and health sector/cluster level, more efficient means of data management are required to ensure that results are analysed, disseminated and used in a timely and effective manner. Simple computer spreadsheet or database software is useful in helping to manage large volumes of data over time and across different locations.

The use of data and feedback of results is integral to ensuring that the information is translated into public health practice and measurable improvements in the reproductive health status of the population. Often lower-level managers are

required to report vast quantities of data to higher levels but they rarely receive any feedback. At the same time, the information overload at higher levels is such that in practice the data are seldom used effectively. RH programme managers must give regular feedback to staff and also discuss the main findings and recommendations for RH programming, based on recent results at health sector/cluster coordination meetings. Where appropriate, make reproductive health available to the population served by the health facility.

## 3.3 Evaluation

The purpose of an evaluation is to analyse the efficiency and effectiveness of a programme. It compares programme activities and services (outputs) with benefits (outcomes) and public health impact (goals) and helps RH officers to determine whether these met defined objectives.

### 3.3.1 When to evaluate?

It is important to schedule and plan for evaluations from the start of programme implementation. 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 organization.

### 3.3.2 What are the tools for evaluation?

Evaluations use systematic appraisal methods, and measure both qualtitative and quantitative aspects of service delivery. They can utilize similar methods to those used in assessments (see 3.1.1). Key informant interviews with community leaders or members from the affected population gather data to evaluate programme quality and acceptability.

An evaluation of the quality or accessibility of services includes a review of operational documents (such as site reports, mission reports, supervision reports, training records) and a qualitative health services checklist. Also view the data collected from the monitoring system as part of the evaluation process.

Population-based data can be collected to supplement and/or validate routinely collected data.

### 3.3.3 What data is needed in evaluation?

It is important to clearly specify the objectives of any evaluation and to clearly define the questions which the evaluation should answer. Typical questions which should be considered in evaluating project outputs and the project itself are:

- What did we do?
- What did we achieve?
- Did we achieve what we intended?
- What lessons have we learned?
- What else is needed?

### 3.3.4 Who is responsible for evaluation?

Evaluations must be as objective and unbiased as possible. If the evaluator is also involved in programme coordination or management, it can sometimes be difficult for this person to remain a neutral participant and to view the programme in an impartial manner. For this reason, it is useful for evaluations to be carried out by external evaluators.

### 3.3.5 How to analyse, use and disseminate evaluation results?

Evaluations should reflect both on what is working well and what is not working well, in order for the results to improve programme planning and design. Early feedback should be provided to programme managers and service providers to ensure that issues that are identified are dealt with promptly before they become problems or risks. The final evaluation report should be shared with all organizations involved in the emergency response, including the MoH, and disseminated at health sector/cluster coordination meetings. If appropriate, findings and decisions should also be shared directly with the community.

## 4.0 Human rights and legal considerations

### 4.1 Human rights standards

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. The right to privacy, therefore, imposes an obligation on service providers and others who collect health-related data to keep this information confidential. In a health-care 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 the treatment.

A person's right to privacy may, for example, be violated when their reproductive health status is discussed with someone else by a service provider without her 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, as it could lead to rejection by family members or the community, violence or threats of violence, or discriminatory treatment in accessing services.

Key points to be kept 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 reproductive health status, including incidents of gender based violence, must give informed consent before participating in data-gathering activity.

Information must be kept confidential at all times including when it is collected, stored, analysed, shared and otherwise used. 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 his or her best interests.

### 4.2 National legal considerations

Those who have access to health information must ensure that they take appropriate measures to ensure the confidentiality of the health information. Guidance about national laws and regulations on collection, storage and use of this health information should be available to health and humanitarian workers, and all health workers must be familiar with these rules.

Collection and use of data for monitoring and evaluation purposes also requires informed consent of the person providing the information. This includes data collection where the information will be anonymised and delinked from the name and other identifiers of the respondent. The aim of the informed consent process is to ensure that respondents are aware of, and understand, the purpose and content of the data collection exercise, the procedures that will be followed during the course of the exercise, the risks and the benefits of their participating, and their rights. As part of the informed consent process, the potential participant must be given information about each of these elements, through what is often referred to as a "statement of consent".

Everyone should also be informed that they have the right to not participate in the data collection or to refuse to answer particular questions. If, for a specific purpose, information concerning an individual's health status needs to be disclosed to a third party, the prior informed consent of the person concerned needs to be obtained. In the case of information relating to children, the 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.

## 4.3 Challenges and opportunities

In some settings service providers are required by national laws 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 Further reading

**Health cluster tools and indicators**

http://www.who.int/hac/global_health_cluster/guide/tools/en/index.html

*Monitoring and Evaluation Toolkit.* Reproductive Health for Refugees Consortium (RHRC), October 2004. http://www.rhrc.org/resources/general%5Ffieldtools/toolkit/index.htm

*Reproductive Health Assessment Toolkit for Conflict-Affected Women.* Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention, Department of Health and Human Services, Atlanta, GA, 2007. www.cdc.gov/reproductivehealth/refugee/ToolkitDownload.htm, www.cdc.gov/reproductivehealth/refugee/

*Assessment of "Minimum Initial Services Package" Implementation,* Women's Commission for Refugee Women and Children. http://www.rhrc.org/pdf/MISP_ass.pdf

*Monitoring Implementation of the MISP: A Check List,* Women's Commission for Refugee Women and Children, January 2003. www.rhrc.org/pdf/fs_misp_insert.pdf

Health Information System. UNHCR, 2007. www.unhcr.org/his

*Demographic Methods in Emergency Assessment: A Guide for Practitioners.* Center for International Emergency, Disaster and Refugee Studies (CIEDRS) and the Hopkins Population Center; Johns Hopkins University Bloomberg School of Public Health, Baltimore, MD, 2003. http://www.humanitarianinfo.org/IMToolBox/05_Assessments/Reference_Resource_Documents/2003_Demographic_Methods_In_Emergency_Assessment_CIEDRS.pdf

## List of annexes

The following indicators are a selection of core indicators that can be used to monitor a comprehensive RH programme. They are not sufficient for in-depth monitoring and evaluation of a programme. For more detailed lists, see the further reading sections in the relevant chapters.

Annex 1A: RH indicators for the MISP

Annex 1B: RH Indicators for Comprehensive RH programmes

Annex 2: RH reference rates and ratios

Annex 3: Estimating number of pregnant women in the population

Annex 4: Maternal death review form and guidance sheet

Annex 5: Sample monthly worksheets (HIS)

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 1. | Number of Reported Rape Cases | Impact | Number of rape cases reported to health facilities within a time period | Number of rape cases reported to health facilities/ time period | Time period for reporting to be set locally | | Disaggregated by sex and age groups<br><br>It is not possible to identify trends (temporal, geographical or otherwise) in rape cases based on this data nor is it possible to measure incidence<br><br>Note the number of facilities contributing this information each time period |
| 2. | Coverage of Supplies for Standard Precautions | Output | The percentage of health delivery sites with sufficient supplies to ensure standard precautions can be practiced | Number of health service delivery points with adequate supplies to carry out standard precautions/number of health service delivery points × 100 | /100 health service delivery points | 100% of health facilities have adequate supplies to carry out standard precautions | Measures the effectiveness of distribution of supplies related to standard precautions. "Sufficient supplies" are reported by each service point supervisor based on the workload. Should be disaggregated by soap, clean injection materials, gloves, sharps disposal supplies, and sterilizing equipment and supplies |
| 3. | Coverage of HIV Rapid Tests for Safe Blood Transfusion | Output | The percentage of referral hospitals that have sufficient HIV rapid tests to ensure all blood destined for transfusion is screened | Number of hospitals with sufficient HIV rapid tests to screen blood for transfusion /number of health service delivery points × 100 | /100 health service delivery points | 100% of health facilities have adequate supplies to carry out standard precautions | Measures the effectiveness of distribution of HIV tests to screen blood for transfusion. "Sufficient HIV tests" are reported by the service supervisor based on the caseload |
| 4. | Condom Distribution Rate | Outcome | Rate of condom distribution among the population | Number of male condoms distributed /total population/ month | /person/ month | 0.5 condoms / person / month | The standard 0.5 condoms/person/ month is an approximation of the more complicated standard condom calculation as described in the MISP chapter on page 40. The approximation is used to monitor condom distribution as part of the MISP |
| 5. | Coverage of Clean Delivery Kits | Output | Rate of distribution of clean delivery kits among pregnant women in their third trimester | Number of clean delivery kits distributed / Estimated number of pregnant women x 100/month | % | 100% | Measures whether women in late pregnancy have access to clean delivery kits. May have to estimate number of pregnant women |
| 6. | Availability of clinical management of rape survivors | Output | Percentage of health facilities with clinical management of rape survivors, including EC, PEP and presumptive STI treatment | Number health facilities offering clinical management of rape survivors / all health facilities x 100 | % | | Provision of clinical management of rape survivors requires the availability of trained staff, emergency contraception, ARVs for PEP and antibiotics for presumptive STI treatment |

## Annex 1B: Indicators for Comprehensive RH Programmes

This is a selection of indicators that are used to monitor comprehensive RH programmes. There may be other indicators. RH officers must decide which indicators to use based on their situation. The references in the further reading sections in each chapter provide more suggestions.

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| **A. Adolescent Reproductive Health** | | | | | | | |
| 7. | Incidence of STDs in young people | Impact | | Number of reported cases of STDs among young people by the specified time period / Total number of young people (x1000) | /1000 young people | | Measures a programme's potential impact on the incidence of STDs among young people.<br><br>Need to define age group for young people relevant to local situation. |
| 8. | Proportion of STI among those under 18 years | Process | Proportion of syndromic STIs diagnosed among under 18s | Number of STIs diagnosed among under 18s / Total number of STIs diagnosed x 100 | % | | |
| 9. | Proportion of births among those under 18 years | Impact | Proportion of births recorded among under 18s | Number of deliveries among women under 18 / Number of live births x 100 | % | | Measures how common births are among young women. |
| 10. | Condom use among young people | Outcome | Proportion of sexually active young people reporting condom use at last intercourse | Number of sexually active young people reporting condom use at last intercourse / Number of sexually active young people surveyed x 100 | % | | Measures the impact of a community-education programme about condom use on young people's behaviour. Disaggregated by sex and age groups. Requires a population-based survey. |
| **B. Family Planning** | | | | | | | |
| 11. | Contraceptive prevalence (CP) | Outcome | Proportion of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method | Number of women of reproductive age using any method of contraception/ Number of women of reproductive age x100 | % | | Measures what per cent of women is using contraception. Knowledge of the CP in country of origin will assist in setting the target. |
| 12. | Community knowledge concerning family planning | Outcome | Proportion of sexually active persons able to cite major messages about family planning | Number of sexually active persons able to cite major messages about family planning / Number of sexually active persons targeted for family planning messages x 100 | % | | Measures knowledge of family planning in the population and is based on the major messages given during awareness activities. Requires a population-based survey. |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 13 | Contraceptive supply | Outcome | | Number of service delivery points which maintain a minimum of 3 months' supply of each of combined oral contraceptive pills, progestin-only pills, and injectables / Number of service delivery points x 100 | % | | Measures effectiveness of contraceptive supply distribution system. |
| 14. | Coverage of FP counseling | Outcome | Proportion of clients attending FP services, who are offered counselling | The number of clients attending FP services who are offered FP counselling in addition to receiving a method of contraception / number of clients attending FP services x 100 | % | | Measures whether clients are counselled by FP service providers.<br><br>The indicator is measured in FP clinics and is available from clinic records, observation, or client exit interviews |
| **C. Maternal and Newborn Health** | | | | | | | |
| 15. | Neonatal mortality rate | Impact | Rate of deaths among newborns within the first 28 days of life | Number of live born infants who die< 28 days of age / Number of live births in the specified time period × 1000 | / 1000 live births | < 40 deaths /1000 live births | Measures the overall health status of newborns. |
| 16. | Proportion of low birth weight | Impact | Proportion of live births that were less than 2500 g | Number of live born infants weighing<2,500 g / Total number of live births (with birth weight recorded) x 100 | % | < 15% | Measures the health status of pregnant women and the adequacy of antenatal care. Birth weights also identify infants at higher risk who may need special care. |
| 17. | Stillbirth rate | Impact | Rate of still births in proportion to number of births | Number of still birth period / Total number of live births and stillbirths x 1000 | / 1000 total births / month | | A general measure of pregnancy outcome. May be elevated during outbreaks of diseases such as malaria or syphilis. Verify definition of stillbirth based on national policies. Still birth is defined as a fetal death after 22 weeks in most settings. |
| 18. | Investigation of maternal deaths | Process | Proportion of reported maternal deaths which are investigated | Number of reported maternal deaths which are investigated / Total number of reported maternal deaths x 100 | % | 100% | Measures the programme's capacity to identify all maternal deaths and to determine the risk factors that contribute to those deaths. Assumes that: a) both indirect and direct maternal mortality events are investigated, to reduce under- reporting; b) a protocol for investigations is in place. Investigation should be done according to established guidelines, and the results disseminated to health staff. |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 19. | Complete ante¬natal care | Outcome | Percentage of pregnant women who made at least 4 antenatal visits during pregnancy | Number of pregnant women who had made at least 4 ANC visits at the time of delivery / total number of live birth x 100 | % | 100% | Measures whether pregnant women are receiving minimal antenatal visits. This indicator is measured at the time of birth. |
| 20. | Coverage of syphilis screening | Outcome | Proportion of pregnant women who were screened for syphilis during pregnancy | Number of pregnant women who had been screened for syphilis during the antenatal period at the time of delivery / Total number of live births x 100 | % | 100% | Measures whether pregnant women are being screened for syphilis. This indicator is measured at the time of birth. |
| 21. | Tetanus vaccination coverage | Outcome | Proportion of pregnant women who received at least 2 doses of tetanus toxoid (TT) vaccine during pregnancy | Number of pregnant women who had received 2 doses of TT (or were fully vaccinated) during the antenatal period at the time of delivery / Total number of live births x 100 | % | 100% | Measures whether women of reproductive age are being vaccinated with tetanus toxoid.* This indicator is measured at the time of birth .Neonatal tetanus cases should also be reported. |
| 22. | EmOC services availability | Outcome | Number of health facilities with basic and/or comprehensive essential obstetric care / 500,000 population, by admin unit | Number of EmOC facility per population | / 500,000 population | At least 5 EmOC facilities/ 500 000 population, including at least 1 CEmOC | UN process indicator 1 |
| 23. | EmOC services utilization | Outcome | Proportion of all births in emergency obstetric care facilities | Number of deliveries in an EmOC centre / Number of deliveries x 100 | % | Acceptable levels to be set locally | Deliveries are irrespective of outcome (live or still birth). All EmOC should be included; camp based, government hospital. |
| 24. | EmOC needs met | Outcome | Proportion of women with major direct obstetric complications who are treated in EmOC facilities | Number of obstetric complications treated at EmOC / number of deliveries x 100 | % | 100% | Measures the quality of management of obstetric emergencies. Emergencies should have clear case definition and include: hemorrhage, eclampsia, obstructed/prolonged labour, sepsis. |
| 25. | Percentage of births assisted by a skilled attendant | Outcome | Proportion of births attended by skilled health worker* | Number deliveries attended by a trained health worker / Number of deliveries x100 | % | 100% | Trained health workers defined as doctors and/or persons with midwifery skills who can diagnose and manage obstetrical emergencies as well as normal deliveries. Traditional birth attendants (trained or untrained) are not included. |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 26. | Coverage of post-partum care | Outcome | Proportion of women who received 3 postnatal visits within six weeks of delivery | Number of women attended for post-natal care 3 times within 6 weeks of delivery / Number of live births x 100 | % | 100% | Measures whether women receive postpartum visits. Postpartum period defined as 42 days (6 weeks) following delivery. Factors determining the timing of the visit include: incidence and type of obstetric complications, the percent of low birth weight births, the proportion of home deliveries, and the neonatal mortality rate, among others. Recommended schedule for attendance at 6 hours, 6 days and 6 weeks. |
| 27. | Percentage of deliveries by Caesarean section, by administrative unit | Outcome | Caesarean sections as a proportion of all births | Number of births by caesarean section /number of live births x 100 | % | 5%-15% | The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%. |
| 28. | Direct obstetric case fatality rate | Impact | The case fatality rate among women with direct obstetric complications in EmOC facilities | Number of women attending EmOC facilities who die of a direct obstetric complication/ women attending seen for a direct obstetric complication x 100 | % | <1%> | |
| **D. Comprehensive Abortion Care** | | | | | | | |
| 29. | Abortion services performed with appropriate technology | Process | Proportion of abortion services performed with appropriate technology (vacuum aspiration or medical methods) | Number of abortion services performed with appropriate technologies / Number of all abortion services performed in the same period x 100 | % | 100% | “Abortion services” include treatment of abortion complications (resulting from either spontaneous or induced/unsafe abortion) as well as provision of induced abortion procedures.<br><br>Appropriate technology for abortion services, see Chapter 7: Comprehensive Abortion Care. |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 30. | Coverage of post-abortion contraception | Outcome | Proportion of women accessing abortion services who receive contraception prior to discharge from the facility | Number of women receiving abortion services who obtain a modern contraceptive method before leaving the facility / Number of all women receiving abortion services in same facility in the same period | % | 60% | "Abortion services" include treatment of abortion complications (resulting from either spontaneous or induced/unsafe abortion) as well as provision of induced abortion procedures.<br><br>The minimum recommended level is that at least 60% of the women receiving abortion care also receive a modern method of contraceptive methods prior to discharge from the facility. This is consistent with evidence on reproductive intentions among women obtaining abortion services, as well as tested models of successful postabortion contraceptive uptake.<br><br>Data collection is through routine facility logbook. |
| 31. | Awareness of legal indications for termination of pregnancy | Outcome | Percentage of providers who are aware of the legal indications for a termination of pregnancy in the host country and country of origin | Number of providers involved in abortion services who are aware of the legal indications for termination of pregnancy / Number of providers involved in abortion services x 100 | % | 100% | Data collection is through periodic surveys. |
| 32. | Coverage of induced abortion | Outcome | Proportion of women who receive abortion services that receive induced procedures | Number of women receiving induced abortion procedures at a facility / Number of all women receiving abortion services in the facility in the same time period x100 | % | 100% | Over time, a shift toward a higher proportion of women receiving induced abortion as part of all abortion services in facility.<br><br>Data Source: Health service records—but potential problems with underreporting (i.e. omission of cases not admitted to facilities) and misclassification. |
| **E. Gender-based Violence (GBV)** | | | | | | | |
| 33. | Timing of PEP provision | Outcome | Proportion of eligible rape survivors who receive post-exposure prophylaxis (PEP) within 72 hours of an incident occurring | Number of eligible rape survivors who receive PEP within 72 hours of an incident / Total number of rape cases reported x 100 | % | 100% of eligible rape survivors | Measures whether rape survivors have timely access to critical services. Assumes protocols for clinical management of rape are disseminated and applied. |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 34. | Timing of emergency contraception (EC) provision | Outcome | Proportion of eligible rape survivors who receive emergency contraception (EC) within 120 hours of an incident occurring | Number of eligible rape survivors who receive EC within 120 hours of an incident / Total number of rape cases reported x 100 | % | 100% of eligible rape survivors | Measures whether rape survivors have timely access to critical services. Assumes protocols for clinical management of rape are disseminated and applied. |
| 35. | Timing of STI prophylaxis | Outcome | Proportion of rape survivors who receive presumptive STI treatment within 2 weeks of an incident occurring | Number of rape survivors who receive presumptive STI treatment within 2 weeks of an incident / Total number of rape cases reported | % | 100% of eligible rape survivors | |
| 36. | Number of cases of sexual violence reported to health services | Impact | Number of cases of sexual violence reported to health facilities within a time period | Number of cases of sexual violence reported to health services/month | /10 000 population | | Case definitions of “Sexual Violence“ to be determined in each setting<br><br>Disaggregate by sex and age<br><br>It is not possible to identify trends (temporal, geographical or otherwise) in sexual violence cases based on this data<br><br>Note the number of facilities contributing this information each month |
| **F. Sexually Transmitted Infection (STIs)** | | | | | | | |
| 37. | STI/RTI management skills of service providers | Process | % of service providers trained (or retrained) to manage STI/RTI cases according to protocol | Number of service providers trained to manage STI/RTI cases according to protocol / total number of service providers x 100 | % | | Available from STI/RTI programme records. |
| 38. | STI/RTI case management | Outcome | % of patients with STI/RTI assessed, treated and counselled according to protocol | Number of patients with STI/RTI assessed, treated and counselled according to protocol / total number of patients with STI/RTI accessing services x 100 | % | | Data to be disaggregated by age and sex.<br><br>The indicator is measured in STI clinics, as well as in other RH services integrating STI/RTI and is available from clinic records, observation, or client exit interviews. |
| 39. | Incidence of genital ulcer disease | Impact | Incidence of genital ulcer disease among total population | Number of cases of genital ulcer disease / Total population x 1000 | / 1000 population / month | | |

| # | Indicator Name | Type | Description | Formula | Units | Standard | Remarks |
|---|---|---|---|---|---|---|---|
| 40. | Incidence of male urethral discharge | Impact | Incidence of male urethral discharge among male population | Number of cases of male urethral discharge reported / Total male population x 1000 | / 1000 population / month | | |
| **G. HIV/AIDS** | | | | | | | |
| 41. | Quality of blood donation screening | Outcome | 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.<br><br>Assumes blood transfusion kits are available and used correctly.<br><br>UNGASS indicator. |
| 42. | VCT post-test counselling and result | Outcome | Proportion of VCT clients tested for HIV, who received post-test result and counselling | Number of VCT clients post-test counselled / Number of VCT clients tested x 100 | % | 100% | Indirect measure of the quality of counseling and testing within a VCT programme. |
| 43. | PMTCT coverage | Outcome | Proportion of first time ANC visits who were pre-test counselled | Number of first ANC visits pre-test counselled / Number of first ANC visits | % | 100% | |
| 44. | PMTCT post-test counselling and result | Outcome | Proportion of first ANC visit clients tested for HIV, who receive post-test result and counselling | 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 programme. |
| 45. | Coverage of ARV in PMTCT programmes | Outcome | Ratio of mother-newborn pairs that swallowed ARV on time | Number of mother-newborn pairs who swallowed ARV according to protocol / Total number HIV positive deliveries x 100 | % | 100% | |
| 46. | Condom use | Outcome | Proportion of sexually active people reporting condom use at last intercourse | Number of sexually active people reporting condom use at last intercourse / Number of sexually active people surveyed x 100 | | | Measures the impact of a community-education programme about condom use on people's behaviour. Disaggregate by sex and age groups. Requires a population-based survey. |

## Annex 2: RH Reference Rates and Ratios

The figures shown here have been collected from various sources and cover different periods. They are intended to give estimates of what may be expected in some populations. These figures are not to be used as definitive baseline rates or as rates to be achieved. They merely indicate the possible range and may assist with resource planning and with targeting specific programmes.

| | | |
|---|---|---|
| **Abortions** | 10-15% | of all pregnancies may spontaneously abort before 20 weeks gestation |
| | 90% | of these will occur during the first three months |
| | 15-20% | of all spontaneous abortions that occur require medical interventions |
| **Hypertensive Disorder of Pregnancy (HDP) or Pre-eclampsia** | 5-20% | of all pregnancies will develop HDP |
| | 5-25% | of all primigravida pregnancies will develop HDP |
| **Labour and Delivery Complications** | 15% | of all pregnancies will require some type of intervention at delivery |
| | 5-15% | of all pregnancies will require a Caesarean section |
| | 10-15% | of all women will have some degree of cephalopelvic disproportion (higher in poorer socioeconomic populations) |
| | 10% | of deliveries will involve a primary postpartum haemorrhage (within 24 hours of delivery) |
| | 0.1-1.0% | of deliveries will involve a secondary postpartum haemorrhage (occurring 24 hours or more after delivery) |
| | 0.1-0.4% | deliveries will result in uterine rupture |
| | 0.25-2.4% | of all deliveries will result in some type of birth trauma to the baby |
| | 1.5% | of all births will have a congenital malformation (does not include cardiac malformations diagnosed later in neonatal period). |
| | 31% | of these malformations will result in death. |

Data Sources: WHO Collaborating Centre in Perinatal Care and Health Services Research in Maternal and Child Health, Pregnancy and Infant Health Branches, Division of Reproductive Health, NCCDPHP, Centers for Diseases Control and Prevention, Atlanta, GA., 30333 USA Sing, S. and Wulf, P., Estimated Levels of Induced Abortion in Six Latin American Countries, International Family Planning Perspectives, 1994, 20 (1): 4-13.

## Annex 3: Estimating the Number of Pregnant Women in the Population

| Estimating Number of Pregnant Women in the Population If Total Population Is 100 000 | | | | |
|---|---|---|---|---|
| If CBR is (per 1,000 population) | 55 | 45 | 35 | 25 |
| a) Estimated number of live births in the year | 5500 | 4500 | 3500 | 2500 |
| b) Estimated live births expected per months (a/12) | 458 | 375 | 292 | 208 |
| c) Estimated number of pregnancies that end in still-births or miscarriages (estimated at 15 per cent of live births = a ´ 0.15) | 825 | 675 | 525 | 375 |
| d) Estimated pregnancies expected in the year (a + c) | 6325 | 5175 | 4025 | 2875 |
| e) Estimated number of women pregnant in a given month (70 % of d)* | 4400 | 3600 | 2800 | 2000 |
| f) Estimated % of total population who are pregnant at a given period | 4.4 | 3.6 | 2.8 | 2 |
| * This is a weighted estimate of full-term pregnancies plus those pregnancies that terminate early | | | | |

## Annex 4: Maternal Death Review Form and Guidance Sheet

UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

*****Confidential*** Maternal Death Review Report**

Audit every maternal death and e-mail this report to relevant parties within your IP and UNHCR (see guideline)

*Maternal Death: The death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes*

**REVIEWERS:**
List individuals involved in reviewing the death (names & titles / relationship to deceased):

1.
2.
3.
4.
5.
6.
7.
8.

**SUMMARY INFORMATION:**

| Host country: | Camp, settlement or area: | |
|---|---|---|
| Woman's name: | Nationality: | Age: |

**INFORMATION ON PREGNANCY:**

| Gravida: | Parity: | No. ANC visits: | Performed by (qualification only): |
|---|---|---|---|
| | | | |

Risk factors identified during antenatal visits:

☐ Anaemia ☐ Severe malaria ☐ High parity (above 4 pregnancies)

☐ Ante-partum haemorrhage ☐ Hypertension ☐ Previous caesarean section

☐ HIV/AIDS ☐ Diabetes mellitus ☐ Multiple pregnancy

☐ None ☐ Others (specify):

| Number of postnatal visits: | When (e.g. first 24 hours, 1 day, 1 week…): |
|---|---|
| | |

**INFORMATION ON DEATH:**

☐ Did not deliver: Suspected gestational age at the time of maternal death: ☐ weeks ☐ months

☐ Delivered/Aborted: Time between delivery / abortion and maternal death: ☐ hours ☐ days

Location of death:

☐ Home; ☐ On route; Specify details:

☐ Camp Health Facility Date & time of admission:

☐ Referral Health Facility Date & time of death:

**SUMMARIZED HISTORY OF IMMEDIATE EVENTS:**

| |
|---|
| |

**IDENTIFIED RELEVANT DELAY FACTORS:**

☐ Factors related to the 1st delay (delay in deciding to seek care)?

1.
2.
3.

☐ Factors related to the 2nd delay (delay in reaching care)?

1.
2.
3.

☐ Factors related to the 3rd delay (delay in receiving appropriate care at facility)?

1.
2.
3.

**CAUSE OF DEATH**:

Direct (e.g.: haemorrhage, obstruction, eclampsia, sepsis, etc.):
Indirect (e.g.: anaemia, HIV/AIDS, malaria, etc.):

| LESSONS LEARNED | ACTION TO BE TAKEN / PROPOSED SOLUTIONS |
|---|---|
| | |

| Date(s) of maternal death review: | Date of report: |
|---|---|

| Report compiled by (name & title): |
| --- |

UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

# Guideline for Reviewing Maternal Deaths

The purpose of this guideline is to support country programs in:

A) The *process of reviewing* a maternal death, and
B) The *requirements for reporting* a maternal death

## A) THE PROCESS OF REVIEWING A MATERNAL DEATH

***What is a maternal death?***

A maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

***Should each maternal death be reviewed?***

Yes. Every maternal death that occurs within a refugee camp (of a refugee or a national) or at a referral health facility should be systematically reviewed.

***What is the purpose of reviewing a maternal death?***

A maternal death review provides a rare opportunity for a group of health staff and community members to learn from a tragic – and often preventable - event. Maternal death reviews should be conducted as learning exercises that do not include finger-pointing or punishment. The purpose of a maternal death review is to improve the quality of safe motherhood programming to prevent future maternal and neonatal morbidity and mortality.

***What process should be used to review a maternal death?***

There are 2 main methodologies for reviewing maternal deaths that are relevant to a refugee setting:

1) **Community-Based Maternal Death Review / Verbal Autopsy**
   *Definition:* A method of finding out the medical causes of death and ascertaining the personal, family or community factors that may have contributed to the death of a woman who died outside of a medical facility
   *Requirements:* Cooperation from the family of the woman who died and sensitivity is needed in discussing the circumstances of the death
   *Advantages:* Provides means to arrive at medical cause of death when a woman dies at home, allows both medical and non-medical factors to be explored, and provides the opportunity to include the family's perspective on health services
   *Disadvantages:* Different assessors may arrive at different causes of death, deaths from indirect causes may be overlooked / underreported

2) **Facility-Based Maternal Death Review**
   *Definition:* A qualitative, in-depth investigation of the causes of and circumstances surrounding a maternal death at a health facility; the death is initially identified at the facility level but such reviews are also concerned with identifying the combination of factors at the facility and in the community that contributed to the death, and which ones were avoidable
   *Requirements:* Cooperation from those who provided care to the woman who died, and their willingness to report accurately on the management of the case
   *Advantages:* Is a well-understood process in some settings, allows for complete review of medical aspects, provides a learning opportunity for all staff, and can stimulate improvements to medical care
   *Disadvantages:* Requires committed leadership at the facility level, does not provide information about deaths occurring in the community

A 3rd, additional methodology for improving safe motherhood programs is optional for country programs with the necessary capacity:

3) **"Near Miss" Review**
   *Definition:* The identification and assessment of cases in which a pregnant woman survives an obstetric complication; there is no universally acceptable definition for such cases and it is important that the definition used be appropriate to local circumstances to enable local improvements in maternal care
   *Requirements:* Good-quality medical record system, a management culture where life-threatening events can be discussed freely without fear of blame, and a commitment from management and clinical staff to act upon findings
   *Advantages:* A "near-miss" may occur more frequently than a maternal death, it is possible to interview the woman herself during the review process, and can reduce the likelihood of future maternal deaths through quality improvement
   *Disadvantages:* Requires clear definition of severe maternal morbidity, selection criteria are required for settings with a high volume of life-threatening events

## B) THE PROCESS OF REPORTING A MATERNAL DEATH

***Should each maternal death be reported?***

Yes. The accompanying report form (or a substitute format available in your location) should be completed electronically for each maternal death review and e-mailed (at minimum) to:

- The UNHCR Health Coordinator, and
- The UNHCR Regional Reproductive Health Officer, and
- Other relevant staff (e.g. IP Health Coordinator, other partner agencies, etc.)

***How do I complete the* REVIEWERS *section of the form?***

It is important to include multiple people in the process of reviewing a maternal death, regardless of whether the death occurred in the community or in a health facility. Some examples of people you might want to include are:

- Relevant family members (sister, husband, boyfriend, parent(s), friend(s), etc.)
- Relevant health staff (TBAs, midwives, doctors, managers, coordinators, etc.)
- Relevant community leaders (religious, elders, women's association, youth, etc.)

***How do I complete the* INFORMATION *sections of the form?***

These three sections (summary information, information on pregnancy, information on death) allow you to document basic information pertaining to the woman who died. There might be additional factors specific to your location that you discuss during the review (e.g. the woman's address, her religion, etc.) that you do not need to document in the summary report.

***How do I complete the* SUMMARIZED HISTORY *section of the form?***

This section allows you to summarize the story of what happened. It is intentionally open-ended so that you can include the immediate events surrounding different types of maternal deaths. Some elements you might want to include (in both the review process and the report) are:

- Timeline of relevant events that have not already been documented
- Summary of the interventions / treatment provided prior to the death
- Relevant patient history not already documented

***How do I complete the* RELEVANT DELAY FACTORS *section of the form?***

This section encourages you to review and document the relevant delay factors by using the *Three Delay Model* for maternal mortality. Remember that there may be important community-level factors related to a death in a health facility, just as there may be important facility-level factors related to a death in the community.

***How do I complete the* CAUSE OF DEATH *section of the form?***

Some examples of direct causes of maternal death are:

| | | |
|---|---|---|
| Ectopic pregnancy | Eclampsia | Sepsis |
| Obstructed labour | Antepartum hemorrhage | Post-partum hemorrhage |
| Abortion complications | Anaesthetic complications | Embolism |

Some examples of indirect causes of maternal death are:

| | | |
|---|---|---|
| Anaemia | Malaria | HIV/AIDS |
| Heart disease | Substance abuse | Diabetes |

***How do I complete the* LESSONS LEARNED & ACTION TO BE TAKEN *section of the form?***

This will likely be the most important component of your maternal death review. After analyzing all of the relevant information, individuals involved need to agree on key lessons learned from the process and commit to action that will improve these areas in the future. It is important to consider lessons and action related to both the community and to the health facility.

## Annex 5: Sample Monthly Worksheets (HIS)*

# Health Information System

Reporting Form

**Organisation:** _____

**Location:** _____

**Reporting period:** _____

## 9.0 Reproductive Health

### 9.1 Antenatal Care

9.1a

| | Refugee | | National | |
|---|---|---|---|---|
| | < 18 | ≥ 18 | < 18 | ≥ 18 |
| First antenatal visit < 1st trimester | | | | |
| First antenatal visit > 1st trimester | | | | |
| Repeat antenatal visit | | | | |
| Number of syphilis tests conducted | | | | |
| Number of syphilis tests positive | | | | |
| Number of contacts of syphilis positive cases treated | | | | |
| Number of high-risk pregnancies detected | | | | |
| Number of abortions | | | | |

9.1b *Enter number of pregnant women at time of delivery who:*

| | Refugee | | National | |
|---|---|---|---|---|
| | < 18 | ≥ 18 | < 18 | ≥ 18 |
| Received 4 or more antenatal visits | | | | |
| Received 2 doses of tetanus toxoid during antenatal period | | | | |
| Received at least 2 doses of fansidar during antenatal period | | | | |
| Were screened for syphilis during antenatal period | | | | |
| Received 1 dose of mebendazole during antenatal period | | | | |
| Received 1 ITN* during antenatal period | | | | |

### 9.2 Delivery Care

| | Refugee | | | | National | |
|---|---|---|---|---|---|---|
| | < 18 | | ≥ 18 | | < 18 | ≥ 18 |
| | Home | Health Facility | Home | Health Facility | | |
| Live births | | | | | | |
| Still births | | | | | | |
| Low Birth Weight (< 2500g) | | | | | | |
| Attended by a skilled health worker** | | | | | | |
| Number of obstetric complications treated | | | | | | |
| Number of caesarean sections performed | | | | | | |

* ITN = Insecticide Treated Net ** excluding TBA



** This form is designed specifically for refugee situations. It should be adapted to depending on the setting.*

### 9.3 Postnatal Care

| | Refugee | | National | |
|---|---|---|---|---|
| | < 18 | ≥ 18 | < 18 | ≥ 18 |
| Attended for 3 postnatal visits within 6 weeks of delivery | | | | |

### 9.4 Family Planning (see separate reporting pad) (page 86)

### 9.5 Sexual and Gender Based Violence (SGBV)

| | Refugee | | | | National |
|---|---|---|---|---|---|
| | < 18 | | ≥ 18 | | |
| | Male | Female | Male | Female | |
| Total no. of rape survivors seen within 72 hours* | | | | | |
| Total no. of rape survivors seen within 72 - 120 hours* | | | | | |
| Total no. of rape survivors seen within 120 hours - 2 weeks* | | | | | |
| Total no. of rape survivors seen after 2 weeks* | | | | | |
| No. rape survivors given PEP** within 72 hrs | | | | | |
| No. female rape survivors given ECP*** within 120 hrs | | | | | |
| No. rape survivors given STI presumptive treatment < 2 wks | | | | | |
| No. cases of trauma in health post due to domestic violence | | | | | |

* of an incident occuring; ** PEP = Post Exposure Prophylaxis; *** ECP = Emergency Contraceptive Pill

# Health Information System

Reporting Form

**Organisation:** _____

**Location:** _____

**Reporting period:** _____

## 9.4 Family Planning

| | Cumulative number at start of period (a) | Refugee New Users (b) < 18 | Refugee New Users (b) ≥ 18 | Refugee Repeat Users <18 | Refugee Repeat Users ≥ 18 | Refugee Discontinued (c) <18 | Refugee Discontinued (c) ≥ 18 | Cumulative number at end of period (a + b - c) | Quantity of each method distributed during period* | units |
|---|---|---|---|---|---|---|---|---|---|---|
| COCP* - low dose *(Micro-gynon; Nordette)* | | | | | | | | | | cycles |
| COCP* - high dose *(Lo-femenal)* | | | | | | | | | | cycles |
| POP** *(Micro-val; Micro-lut)* | | | | | | | | | | doses |
| ECP*** *(Postinor-2)* | | | | | | | | | | doses |
| Injectable *(Depo-Provera)* | | | | | | | | | | doses (ml) |
| Implantable *(Norplant)* | | | | | | | | | | implants |
| Intra-Uterine Device (IUD) | | | | | | | | | | IUDs |
| Condom (Male) | | | | | | | | | | pieces |
| Condom (Female) | | | | | | | | | | pieces |
| Sterilisation (Male) | | | | | | | | | | sterilisations |
| Sterilisation (Female) | | | | | | | | | | sterilisations |
| Other | | | | | | | | | | |

* include methods given to all types of users

4

CHAPTER FOUR

# Adolescent Reproductive Health

## Contents


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## 1 Introduction

Adolescence is one of life's most fascinating and complex life stages and is accompanied by special reproductive health (RH) needs. Adolescents are resilient, resourceful and energetic. They can support each other through peer-to-peer counselling, education and outreach and contribute to their communities through activities such as assisting health providers as volunteers, providing care to people living with HIV/AIDS (PLHIV), and expanding access to quality RH services for their peers at the community level.

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 practise safe RH behaviours. Their new environment can be violent, stressful and/or unhealthy. Adolescents (especially young women) who live under marginalized circumstances are highly vulnerable to sexual coercion, exploitation and violence, and may have no choice but to engage in high-risk or transactional sex for survival.

On the other hand, crisis-affected communities may also be exposed to new opportunities, including access to better health care, schooling and learning 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.

RH officers, RH programme managers and health-care providers working in humanitar-

# Adolescent Reproductive Health

ian settings must consider and address the special needs of adolescents who are transitioning to adulthood in very complex and difficult settings. They must also consider especially vulnerable adolescents, including former child soldiers, children heading households, adolescent mothers and young girls who are at an increased risk of sexual exploitation.

## 2 Objectives

The objectives of this chapter are to:

- provide guidance to RH officers, programme managers and service providers on effective adolescent reproductive health (ARH) approaches in humanitarian settings;
- list the principles and resources that inform RH officers, programme managers, service providers and community members on how to involve adolescents in RH programmes;
- ensure the provision of youth-friendly RH services and create an environment where adolescents can develop and thrive, despite the many challenges they face throughout a crisis.

While this chapter refers to adolescents (ages 10-19), the services described here can be extended to a broader cadre of young people (ages 10 to 24) that can also benefit from youth-friendly services.

## 3 Programming

At the onset of an emergency, implement the Minimum Initial Service Package (MISP) for reproductive health (See Chapter 2: MISP). The MISP does not address all of adolescents' needs and it may not be possible to incorporate all ARH principles when implementing the MISP. MISP implementation, however, must be done in a way that is sensitive to the needs and preferences of adolescents. Incorporate the following as part of the initial response:

- Make condoms, both male and female, available in places where adolescents meet, preferably in private, accessible locations where they can access them clandestinely.
- Ensure adolescent girls are safe when carrying out household tasks such as collecting firewood, water or food.
- Ensure pregnant adolescent girls have access to emergency obstetric care services and referral mechanisms when necessary.
- Establish clinical care and referral services for survivors of sexual violence that are sensitive to adolescent needs and respect confidentiality.

### 3.1 Needs assessment

As the situation stabilizes, conduct a needs assessment in coordination with other RH and child health actors to inform the programme design process and develop an action plan to improve the youth-friendliness of existing health services based on the assessment. Involve adolescents in

this process, who can identify their own vulnerabilities as well as capacities. Use youth-friendly service assessment tools to determine whether health services meet the needs of adolescents. Also assess protective community resources. Gather information on:

- **prevalence of RH issues among adolescents,** including pregnancy, maternal and neonatal mortality and STI/HIV;
- **adolescent vulnerabilities and harmful practices,** including exposure to sexual violence and exploitation, trafficking, transactional sex and traditional practices such as female genital mutilation/cutting;
- **protective community resources,** such as supportive parents and teachers, and youth programmes with connections to caring adults;
- **adolescent services,** including professional and traditional services. Any reasons for gaps in the provision of and access to services should also be identified;
- **perceptions of ARH:** the adolescent and community perceptions of ARH needs, and of providing RH services and information to adolescents;
- **barriers to accessing existing services,** including insecurity, cultural norms, lack of confidentiality/privacy and lack of same-sex health-care professionals.

In addition, RH officers, programme managers and service providers must be familiar with national legislation and policies pertaining to adolescent reproductive health in the countries in which they work. Considerations should include:

- What are the laws or policies that restrict or protect adolescents' access to RH 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? And to non-child adolescents?
- Is the evolving capacity and best interest of children taken into consideration in laws/policies/protocols regulating their access to RH services, information and education?
- 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?
- Are there mandatory requirements for health-care providers to report child abuse (including sexual abuse) and/or sexual assault? If yes, to whom and what happens once the case is reported?
- Who is allowed to gather forensic evidence in the health sector in cases relating to sexual violence against a child and who is allowed to testify about this evidence in court?
- What are the local children's rights and women's rights organizations that work to support the access of children and adolescents to RH information and services?

## 3.2 Principles for working with adolescents

When working with adolescents, it is important to consider:

1. management principles

2. service provision principles.

### 3.2.1 Management principles

**Adolescents are not a homogeneous group:** Their needs vary by age, sex, education and marital status. RH behaviour change messages need to be age (10 to 14 years old and 15 to 19 years old) and sex appropriate.

**Engage in meaningful adolescent participation:** The primary principle in working effectively with adolescents is to promote their participation, partnership and leadership. Because of the barriers adolescents face when accessing RH

services, they should be involved in all aspects of programming, including design, implementation and monitoring. For example, it is helpful to identify youth who served as youth leaders or peer educators in their communities. These youth can help address the needs of their peers during programme design and can assist with implementing activities, such as condom distribution, peer education, monitoring of youth-friendly health services and referrals to gender-based violence counsellors. Services will be more accepted if they are tailored to needs identified by adolescents themselves. Adolescents may be helpful in ensuring that the MISP also addresses their needs, for example, by identifying culturally sensitive locations to make condoms available.

**Community involvement:** Understanding the cultural context and creating a supportive environment is critical to advancing RH services for adolescents as these may be affected by community values regarding adolescent reproductive and sexual health. Adults frequently become especially protective of cultural norms and the process of socializing youth when an emergency occurs. At the onset of the humanitarian response, it is important to make priority RH information and services available, including for adolescents, as outlined in the MISP (see Chapter 2). 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 and religious leaders, must be consulted and involved in developing programmes with and for adolescents.

### 3.2.2 Service provision principles

**Privacy, confidentiality and honesty:** Adolescents presenting to health providers often feel ashamed, embarrassed or confused. It is important for providers to create the most private space possible in which to talk. Information is disseminated rapidly among adolescents and if their confidentiality is breached even once, youth will not access available services.

**Linking HIV prevention, treatment and care, and reproductive health:** When adolescents access health services seeking HIV information, testing and care, there is an opportunity to promote comprehensive RH services such as:

- safer sex, including the use of dual protection
- family planning methods
- STI counselling and treatment

Conversely, offer all adolescents accessing family planning or other RH services the opportunity to learn about their HIV status, provided that care and treatment are available (see Chapter 5: Family Planning, Box 24, p. 108: Contraceptive Considerations for Adolescents).

**Sex of the service provider:** Whenever possible, an adolescent should be referred to a provider of the same sex, unless they prefer otherwise. Ensure that adolescent survivors of gender-based violence who are seeking support and care at a health facility have 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 important also to give this option to adolescent boys who are survivors of gender-based violence.

## 3.3 Programming considerations for adolescents

It is important for programme 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:** 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 the family, staying at home

and marrying young. Moreover, changing power dimensions created as a result of mixing 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 RH risks (HIV, STIs, early pregnancy and unsafe abortion). Adolescent girls are vulnerable to gender-based violence, including sexual violence, domestic violence, female genital mutilation/cutting and forced early marriage. The risks of a pregnancy for an adolescent girl can be exacerbated by pre-existing health conditions such as anaemia. Young married girls often lack voice and decision-making power within the household due to the power inequalities with their husbands.

- **Social norms and social supports are disrupted in a crisis situation:** The breakdown of social structures can be protective if harmful practices are discontinued, but it can also be a risk to adolescent health. The use of free time of adolescents in crisis settings may not be subjected to the same kind of scrutiny that would be under normal circumstances. When adolescents are separated from family, friends, teachers, community members and traditional culture, there is less social control of risky behaviour. Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices, that could result in unwanted pregnancy, unsafe abortion, STIs and HIV.
- **Humanitarian crises can disrupt youth-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 and youth club leaders may become important role models and must be aware of their potential influence.
- **Humanitarian crises usually disrupt not only daily life, but adolescents' future perspectives:** For adolescents this may manifest in a fatalistic view on life and lead to increased risk taking, such as violence, substance use and/or unsafe sexual activity. Adolescents who attend activities or programmes 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 in improved decision-making, negotiation and other life skills can be effective in encouraging adolescents to think through how to improve their current situation.
- **Adolescents can take on adult roles, in**

**Box 19: Vulnerable Groups among Adolescents**

Vulnerable groups among adolescents include:

- Very young adolescents (10 to 14)
- Girl mothers
- Orphans and vulnerable children
- Child heads of households
- Young married girls
- HIV-positive adolescents
- Child soldiers (including girls) and other children associated with fighting forces (in noncombatant roles)
- Adolescents engaged in transactional sex
- Adolescent survivors of sexual violence, trafficking and other forms of gender-based violence
- Adolescents engaging in same-sex intercourse

**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 leads to further social confusion.

- **Vulnerable groups:** Attention should be paid to age-, gender-, marital status- and context-specific vulnerabilities (see Box 19).

## 3.4 Services for adolescents

### 3.4.1 Provision of RH services at health facilities

Health services 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 mistrust and avoid services or seek help only when they are in desperate need of care. One important strategy in facilitating adolescent access to and use of RH services is to ensure that they are of high quality and "youth-friendly". At the same time, adolescents need to be made aware of the availability of youth-friendly services. Youth-friendly RH care services have characteristics that make them more responsive to the particular RH needs of adolescents, including the provision of contraceptives, emergency contraception, safe abortion care, STI diagnosis and treatment, HIV counselling, testing and care, and antenatal and postnatal care.

### 3.4.2 Provider questionnaire for adolescents

It is good practice to screen all adolescents who enter the health system for sexual and RH issues, substance use and mental health concerns. In doing this, the health-care provider will send a message to the adolescent that he or she cares about their needs and that the health centre is a safe place to discuss RH-related is-

**Table 9: Youth-friendly Health Service Characteristics**

| Health Facility Characteristics | Provider Characteristics | Administrative Characteristics |
|---|---|---|
| Convenient hours for adolescents | Respect for adolescents | Adolescent involvement |
| Convenient location | Nonjudgmental attitude | Boys and young men welcomed |
| Adequate space and sufficient privacy | Privacy and confidentiality honoured | Necessary referrals available |
| Comfortable surroundings | Peer counselling available | Affordable fees |
| | Same-sex providers when possible | Drop-in clients welcomed |
| | Strict confidentiality maintained | Publicity and recruitment that informs and reassures adolescents |
| | Staff trained in youth-friendly health service characteristics | |

sues. In addition, the information can be used by health providers to provide appropriate counseling and referrals.

Before collecting information from adolescents, consider the services available for referrals. Only ask sensitive questions if appropriate responses to potentially harmful situations can be provided, otherwise more damage 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 pneumonic HEADSSS: Home, Education/Employment, Activities, Drugs, Sexuality, Suicide and Depression, Safety.

### 3.4.3 Provision of RH services in the community

Community-based provision of services and information offers opportunities for adolescents to demonstrate leadership and gain new skills through volunteerism while gaining youth-adult partnerships. The community is also an ideal setting to receive RH information where adolescents are comfortable and open to dialogue and personal risk assessments.

**Peer educators**

Peer education offers many benefits since peers are usually perceived as safe and trustworthy sources of information. Well-designed, curriculum-based peer education programmes and supervised peer educators can be successful in improving adolescents' knowledge, attitudes and skills about reproductive health and HIV prevention. To ensure quality in peer education programmes:

- Provide high-quality, intensive training to peer educators, including regular assessments and reinforcement of their capacities, so they can provide accurate information to their peers.
- Use standardized checklists in the development and implementation of peer education programmes to improve quality.

**Community-based distribution**

Youth trained as community-based distributors (CBD) are young people who have been trained to provide contraceptive counselling to their peers in the community. They typically focus on the provision of RH information, oral contraceptives, condoms and information on HIV, and refer clients to the health centre for other contraceptive methods and services. Youth CBDs can effectively integrate RH and HIV information. Since many barriers preclude adolescents from accessing RH services at clinics, training youth CBDs is a successful strategy to increase adolescents' access to RH services and information while giving the youth CBDs themselves leadership roles in the community. Youth CBDs often become allies of facility-based health services, through working with service providers on improving the quality of youth-friendly services.

**Community dialogue**

In addressing the principle of community involvement, use community dialogue to gain support from and build the skills of community members. Adults need information, skills and encouragement not only to support ARH programming but also to feel more comfortable in providing information to adolescents.

### 3.4.4 Provide RH services in schools

Make ARH services and information available in formal and non-formal schools as well as at vocational training centres. Link with educators to advocate for the creation of an enabling environment to ensure the provision of RH services for adolescents.

**Sex-specific hygiene facilities**

Adolescents are likely to be uncomfortable and embarrassed about sharing hygiene facilities 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.
- Provide girls with cloth or other culturally appropriate sanitary materials for use during menstruation.

**Curricula-based life skills education**

Sexuality and HIV education programmes based on a written curriculum and implemented among groups of adolescents are a promising intervention to reduce adolescent sexual risk behaviours. Programme managers often tailor curricula to fit the local context. Characteristics of life skills curricula that have an impact on adolescent behaviours are outlined in Table 10.

RH officers and programme managers can 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 20).

**Table 10: Characteristics of Effective Life Skills Programmes***

| Curriculum development | Curriculum content | Curriculum implementation |
|---|---|---|
| • Involve people with different backgrounds<br>• Assess needs and assets of the target group<br>• Design activities consistent with community values and available resources (e.g. staff time and skills, facility space, supplies)<br>• Pilot-test the program | • Focus on clear goals (e.g. prevention of STIs and/or pregnancy)<br>• Give clear messages on behaviours that lead to these goals (e.g. abstain from sex, use condoms and/or other contraceptives)<br>• Address risk and protective factors affecting sexual behaviours<br>• 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<br>• Cover topics in a logical sequence | • Train educators who can relate to youth<br>• Secure support from authorities, such as ministries of health, school districts or community organization<br>• Create a safe environment for youth to participate<br>• Recruit youth and overcome barriers to their involvement (e.g. publicize the program, offer food, obtain parental consent)<br>• Teach the full curriculum |

**Adapted from Kirby, D et al.* Impact of Sex and HIV Education Programmes on Sexual Behaviors of Youth in Developing and Developed Countries*. Youth Net, Youth Research Working Paper No. 2, 2005.*

**Box 20: Life Planning Skills**

Life planning skills education includes:

- 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 behaviours
- RH life skills, such as condom self-efficacy, negotiating safe sex, refusing unwanted sex
- Sexuality and gender (including 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, creativity, establishing values, communication, coping with emotions and stress

## 3.5 Coordinating and making linkages with youth programmes

Making links and coordinating between youth programmes will enable the provision of more comprehensive services.

- **Link RH services with community services for adolescents:** 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 (e.g. sexual violence, unwanted pregnancy or unsafe abortion).
- **Ensure multisectoral programming:** RH practitioners may not be able, or have the skills, to include livelihood components in their programme. In coordination with the health cluster/sector, liaise with camp management and other cluster coordination groups to establish links between youth programmes, health and protection, psychosocial services, education and livelihood opportunities. Support the implementation of vocational training and skills development for adolescents; this 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 programmes as a source for referral and to integrate RH information into livelihood programmes.
- **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 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 behaviour and domestic violence. Adolescent boys need safe environments where alternative male norms can be modelled while deconstructing traditional social norms. Gain the support of men and boys: give them the opportunity to address their own needs and actively engage them in reproductive health, thereby benefitting both adolescent girls and boys.

- **Girls' empowerment and socialization:** Working with girl-only groups is an ideal way to also challenge female social norms of passivity, sub-service 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 often make communities protective of the traditional roles of women. Design programmes to empower girls with this in mind.

### 3.6 Advocacy

Sensitize and orient influential people who are part of the relief/development community as well as the community being served to the RH vulnerabilities, specific needs and rights of adolescents. RH officers, RH managers and service providers must be change agents and:

- advocate for information and services for adolescents that ensure available services are youth-friendly;
- be involved in awareness-raising activities in the community, such as "open days" and community dialogues;
- highlight the needs of adolescents with officials and policy-makers.

## 4 Human rights and legal considerations

### 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 eighteen 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.

In considering the issues of adolescents' health and development, the Committee on the Rights of the Child issued a general comment that interprets the CRC as obligating States parties to provide adolescents with access to sexual and reproductive information and services. This is based on a range of rights included in the CRC, including the right to nondiscrimination, 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 RH services and information because of their age;
- RH 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 mutilation/cutting, forced and early marriage and virginity testing;
- parental (or guardian) consent is required for provision of RH services to adolescents;
- 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 had an abortion or sought postabortion care without obtaining legal consent to reveal such information.

## 4.2 Challenges and opportunities

In some cases, RH programme 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, 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.
- Managers and service providers may be discouraged from initiating a programme that provides RH information or services to adolescents due to a common but wrong belief that having access to information on reproductive health and sexuality 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.

As an RH manager or service provider it is likely that you will find yourself facing difficult issues around provision of RH information and services to children and adolescents. You must be aware of your agency/organization position on these RH issues and include it as part of your analysis of the situation and possible next steps. If you find yourself facing a situation such as these described above, your first priority must be the best interest of your client- focusing on her/his safety and health. Your own safety and the safety of your colleagues are also critical to consider. Based on your assessment of the situation, you may then wish to:

- talk to your supervisor;
- discuss possible options with your client including, as appropriate, information about local child rights and women's human rights organizations that might be able to help her/him;
- explore ways of mobilizing community support for youth-friendly RH services;
- consider how you can support advocacy efforts if your agency is engaged in advocacy on the issue;
- while respecting the confidentiality of your client, identify with colleagues how to avoid/handle such situations in the future;
- raise these concerns in health coordination meetings.

## 5 Monitoring

To be sure that adolescents are making use of available RH services and receiving RH information, RH indicators should be disaggregated by age and sex. See Chapter 4 for selected indicators specific to adolescents. See below for key ARH indicators.

**Key Adolescent Reproductive Health Indicators:**

- Proportion of STIs among under 18 years old.
- Proportion of births under 18s.
- Condom use disaggregated by sex and age

## 6 Further Reading

*Community Pathways to Improved Adolescent Sexual and Reproductive Health: A conceptual framework and suggested outcome indicators.* Inter-Agency Working Group (IAWG) on the Role of Community Involvement in Adolescent Sexual and Reproductive Health, December 2007. http://www.unfpa.org/upload/lib_pub_file/781_filename_iawg_ci.pdf

*Adolescent Friendly Health Services: Agenda for Change.* WHO, WHO/FCH/CAH/02.14. http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf

Senderowitz J, Solter C and Hainsworth G. *Clinic Assessment of Youth Friendly Services: A tool for Assessing and Improving Reproductive Health Services for Youth.* Pathfinder International, 2002. http://www.pathfind.org/site/DocServer/mergedYFStool.pdf?docID=521

*Adolescent Reproductive and Sexual Health Toolkit for Humanitarian Settings.* UNFPA and Save the Children, 2009. http://www.savethechildren.org/programs/health/publications.html



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CHAPTER FIVE

# Family Planning

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*All people have the right to family planning services and information*

## 1 Introduction

Family planning (FP) allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. 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.

The use of FP methods has the potential to avert 32% of all maternal deaths and nearly 10% of childhood deaths, while at the same time decreasing rates of poverty and hunger.[*]

[*] Cleland, John, et al. "Family planning: the unfinished agenda." *The Lancet.* The Lancet Sexual and Reproductive Health Series, October 2006. http://www.who.int/reproductivehealth/publications/general/lancet_3.pdf.

# Family Planning

Additionally, the use of FP methods contributes to women's empowerment, schooling and economic stability. Due to the health risks of pregnancy, sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), and unsafe abortion, unprotected and unsafe sex is the second most important risk factor for disability and death in the world's poorest communities. FP methods are safe, effective and inexpensive to provide.

## 2 Objectives

The objectives of this chapter are to:

- provide guidance for RH programme managers and service providers on FP needs, methods, effectiveness and their appropriateness in humanitarian settings;
- describe factors necessary to establish FP services, including needs assessments, coordination, planning, implementation, monitoring and review.

## 3 Programming

The affected population, both males and females, must be involved in all aspects of FP programming, including volunteerism and choice. Religious and community leaders should also be involved to ensure that services are culturally appropriate.

The situation in the affected population's region or country of origin is an important factor influencing expectations, perceived needs and demand for family planning. Laws, infrastructure, religious and ethical values, cultural backgrounds and the competencies and skills of health-care providers from the host country have an important effect on the services that can be offered.

At the onset of the humanitarian response, some women may seek to continue using a contraceptive method that they used before the crisis. Although comprehensive FP programming is not part of the Minimum Initial Service Package (MISP), it is important to make basic contraceptive methods available to meet women's demands for continued family planning. Condoms should be made available from the start of the response to prevent transmission of STIs, including HIV, and unwanted pregnancy (see Chapter 2: Minimum Initial Service Package).

Once the situation stabilizes, women (and their partners) may want to start, change or discontinue a contraceptive method. FP counselling must precede FP method provision and must realistically reflect the methods available since a full range of FP services may not be available until later in the programme.

Every FP client has the right to confidentiality and privacy and to voluntarily choose a method. Contraceptive methods are commonly used by women; however, men are frequently the decision-makers within the family. Hence, men should be given appropriate information and encouraged to take an active role in the FP decision-making process. This will help ensure that joint responsibility is taken for FP decisions and maximize acceptance of the programme within the community. An exception would be where involving the man would compromise the safety of the woman.

Protocols used to manage FP services in the region or country of origin may be dif-

ferent from those used in the host country. Host country protocols need to be followed, although some negotiation, taking into account international standards, may be necessary where differences exist.

## 3.1 Needs assessment

In coordination with other health actors through the health cluster coordination mechanism collect background information on reproductive health (RH) from the affected community. Sources for this information include the Ministry of Health (MOH), UNAIDS, UNFPA, WHO, religious and community leaders and other governmental and nongovernmental agencies that work in reproductive health and/or family planning. Agency headquarters or regional offices can assist you in obtaining this information.

Conduct a review of national, multilateral or bilateral FP agencies and/or programmes in place prior to the crisis or in the country of origin in case of displacement, in order to find opportunities for collaboration and to identify any differences in protocols that need to be resolved. Any services that are made available must be available to both the affected population and the host community.

To understand the need and demand for family planning among the affected population:

- Investigate community and cultural beliefs and attitudes towards contraception.
- Assess potential providers' competencies of contraception provision, including traditional methods.
- Gather information on contraceptive prevalence by method.
- Verify availability of supplies and continuity of supplies.
- Determine availability and functionality of existing facilities.

Prohibitions, religious beliefs or the refusal to recognize women's reproductive rights may provoke opposition to family planning. Seek the support of the community and community and religious leaders for an Information, Education and Communication (IEC) campaign emphasizing birth spacing, safe motherhood and the health of women. Also involve members of the community (men, women and adolescents) and community leaders in setting up FP services. Without their support, the FP services programme might risk community censure.

Hold discussions with men, women (including leaders, traditional healers, traditional birth attendants (TBAs)), adolescents and local organizations to obtain suggestions on the locations of service delivery points; timing of services at the health facilities; and level of privacy and confidentiality needed to ensure maximum use and acceptability. Hold discussions with men and women separately depending on cultural and local norms (e.g. focus group of a local women's group).

RH programme managers and service providers must also be familiar with national legislation and policies in the countries in which they are working on the following issues related to family planning:

- What are the laws and policies on access to family planning information and services?
  - Are there laws or policies relating to universal access to FP information and services?
  - Are there laws or policies restricting access of some people (adolescents,

Emergency Contraceptive Pills (ECPs) are a back-up method for contraceptive emergencies, which women can use within the first five days after unprotected intercourse to prevent an unwanted pregnancy. Service providers must be aware that ECPs do not cause abortion. ECPs prevent ovulation and are not effective once the process of implantation has begun. ECPs do not affect an already existing pregnancy.* (See also paragraph 3.9.5 below and Chapter 2, paragraph 3.2.3.)

* *Emergency Contraception, Fact sheet N°244*, WHO, revised October 2005.

unmarried women, etc.) to FP information or services?
  - Are there laws or policies on the provision of emergency contraceptive pills (ECPs)? How are ECPs made available to women?
- Are there requirements for marital, parental or guardian approval for delivery of FP information and services to adolescents? Is the evolving capacity and best interest of adolescents taken into consideration in laws or policies regulating adolescents' access to FP information and services?
- Are there spousal approval or other status requirements (age, number of children) for women to undergo sterilization or access other kinds of FP services?

## 3.2 High-quality family planning services

High-quality FP services meet individuals' and couples' needs at every stage of their reproductive lives through providing opportunities for making informed decisions, a range of methods

### Box 21: High-quality Family Planning

**High-quality FP means that:**

- Services are convenient, accessible and acceptable to clients.
- Confidentiality of information and physical privacy is ensured.
- Providers are trained and competent to provide appropriate counselling to clients and take sufficient time to do so.
- Providers have the necessary technical skills and have access to service delivery guidelines, protocols and a sustainable supply of FP commodities.
- A range of FP methods is available.
- Clients' needs are assessed.
- Informed choice is ensured: complete and accurate information about available methods is offered.
- Method-specific counselling is conducted.
- Standards recommended by national or international protocols are maintained.
- All procedures are performed by trained personnel according to service delivery guidelines.
- Clients are resupplied with their method of choice in a timely manner, management of complications is ensured and when a client wants to switch methods, alternative options are offered.
- A logistics system is in place to ensure a sustainable supply of FP commodities.

to chose from, safe procedures and continuity of services. Service providers should provide clients with accurate and complete information, allowing women and men to voluntarily select a method that suits their needs.

## 3.3 Contraceptive logistics

At the onset of the humanitarian response, ensure service providers can respond to the demand for contraceptive continuation. Basic contraceptive methods are included in the Inter-Agency RH Kits (see Chapter 2: MISP, paragraph 3.5, p. 44). Once the MISP is implemented, clients must have access to FP counselling and services and be provided with the contraceptive method of their choice. Additional contraceptive stocks and a wider range of methods for comprehensive FP programming must be ordered. As soon as possible, move from ordering kits to an integrated logistics system based on demand to ensure sustained availability of a range of methods and to avoid wastage.

Train or hire staff with supply chain management skills to ensure timely ordering and avoid stock-outs. Investigate local supply channels and if these are inadequate, supplies should be obtained through official suppliers or with support from UNFPA, UNHCR or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality contraceptives at low cost to avoid stock-outs. Locate supplies as close to the affected population as possible.

### Box 22: Basic Steps to Manage Stocks of Contraceptives

- **Select contraceptive methods.** Base the selection of the range of methods on: past use within the target community and continuing users; providers' skills; local practice, law and culture; and the opportunity to offer clients a choice.
- **Calculate procurement quantities.** Base initial estimates based on local Ministry of Health (MoH) data and later from data generated within the displaced population. Review programming and procurement plans regularly so that quantities can be adjusted to reflect the needs of the population, which may change rapidly in size and composition.
- **Set up a record-keeping system.** Set up a system that collects logistics data from service delivery points and reports monthly or quarterly to the agency responsible for resupply. The data to be collected and reported should include:
  - stock on hand at the facility
  - lost, damaged or expired products, and
  - consumption (rate of consumption of each product).
- **Develop logistics management procedures.** Develop procedures to efficiently manage contraceptive procurement and inventory control (storage, transportation and distribution). Regular reporting and distribution schedules are a critical component of these procedures. Without timely information on supply levels and consumption, distributing adequate quantities of contraceptives to service providers becomes less likely. Avoid under- or over-supply by careful organization of the logistics. Appoint a supervisor (with secondary person in place) who assumes these specific responsibilities.

Sample records and report forms can be found in the resources in the Further Reading Section.

## 3.4 Opportunities for FP services

Design FP services so that they are accessible and convenient. Implement FP services at health centres, outreach health posts and through community-based distribution (CBD) channels. Some groups, such as adolescents (refer to Chapter 4: Adolescent Reproductive Health, para 3.3) and unmarried women, may need special consideration to feel comfortable using the services and to avoid the risk of stigmatization by the community. Availability of contraceptives at the consultation point is vital: Do not set up services requiring the client to obtain the selected method at a pharmacy or another site. An exception would be surgical procedures that are not available at the consultation point (e.g. voluntary sterilization). Put in place a referral system for clients who make these choices.

> Integrate FP counselling and methods into safe abortion care (SAC), post-abortion care (PAC), STI, HIV, antenatal care (ANC) and postpartum services to create opportunities for clients that may not be reached otherwise.

To ensure integration of FP for more comprehensive services, RH officers, programme managers and FP service providers must implement the following guidance:

- Ensure that FP information is provided during SAC or PAC counselling prior to any procedures and that if the woman is interested, her choice of FP method is made available to her in postprocedure counselling.
- When a woman, man or adolescent comes for care and treatment for STIs, including HIV, ask whether she or he is using a FP method and provide her/him with method-specific counselling and provision for the method of her/his choice. Men are still limited to male condoms and voluntary sterilzation; however, they can be involved in other FP choices with their partner.
- When a woman or girl comes for ANC, ask whether she was using a FP method before she got pregnant and if she would like to restart or start an FP method after delivery.
- When a woman comes for postpartum care services, ask whether she is using an FP method and counsel her based on her needs.

## 3.5 Human resources

- Organize supervision of FP services with a nurse, midwife or doctor with management experience.
- Identify and hire members of the affected community or local staff from the host community who have skills and experience to provide quality FP services.
- Ensure supervision and training of lay workers who provide CBD. Include the following in their training: how to recognize medical issues that should lead to referral; skills for client follow-up; and how to address contraceptive attitudes and beliefs. Create awareness among community members that the lay worker is supervised by a nurse or doctor, whom a client may see if clinical or counselling care is necessary.

As with all RH services, those involved in providing FP services must respect client confidentiality and show respect for the client's opinion and choices. To ensure continuing contraceptive use and increase FP uptake, providers should be of the same sex and cultural background as clients, and should have strong communication skills.

To ensure administrative, technical and referral support, there must be coordination and cooperation within the health sector/cluster coordination mechanism, the national FP programme and with NGOs and UN agencies involved in family planning. Such cooperation will also increase the sustainability of FP programmes.

## 3.6 Information, education and communication

Client counselling is an integral part of FP services. Appropriate, culturally acceptable information, education and communication (IEC) materials help individuals and couples make contraceptive choices. Information must include benefits and constraints of different methods, explanation on correct use and emergency methods in case of failure. In addition, materials with graphics and samples of contraceptives to show the client are helpful, particularly in areas with low literacy. As the FP programme expands, ensure that IEC materials are adapted to increase the quality of the services provided. Examples of IEC materials are provided on this manual's accompanying CD-ROM. Prepare versions in local languages or develop homemade materials and models.

## 3.7 Training of FP service providers

All staff providing FP services must have adequate training on contraceptive methods and counselling, as indicated in the list below. This training should be supplemented by periodic updates. As the FP programme expands, on-the-job training and supervised practice are essential to ensure high-quality performance. Tools and resources for training service providers are provided on the accompanying CD-ROM.

The elements of an adequate training programme for FP service providers include:

1. technical competence (3.7.1);
2. communication and counselling skills (3.7.2);
3. administrative skills (3.7.3).

### 3.7.1 Technical competence

Providers need to be aware of the following:

- Description of methods, including correct use, advantages, disadvantages and effectiveness (see Table 11: Comparing Oral and Local Application Hormonal Methods, p. 118).
- Mode of action, side-effects and management of side-effects, complications, danger signs
- Instructions for use or administration
- Medical eligibility and drug interactions
- Technical skills relating to the provision of each method, for example, infection prevention, insertion and removal of intrauterine contraceptive device (IUD) or hormonal implant
- Follow-up and resupply requirements, including ordering supplies
- Documentation and record keeping
- Referrals based on clinical decision-making

For methods that require specific technical skills, such as injectable contraceptives, implants, IUDs, male and female voluntary sterilization and the diaphragm, providers need hands-on training in method provision followed by close supervision and experience in counselling for and providing such methods.

### 3.7.2 Communication and counselling skills

In this component of training, FP service providers acquire the following skills:

- nonjudgmental attitude towards contraceptive users and nonusers, respecting their choices, dignity, privacy and confidentiality;
- evidence-based and tactful responses to rumours and misconceptions;
- sensitivity to the needs of specific groups (e.g. adolescents, disabled, people living with HIV);
- culturally sensitive, unbiased techniques;
- communication techniques, such as; open interactive dialogue with clients; encouraging clients to speak; active listening; clarifying; asking clients to restate their understanding; acknowledging client feelings; summarizing the discussion;
- documenting method choice.

Train providers in effective communication skills

**Box 23: Checklist for Establishing FP Services***

- ☐ Assessment of attitudes of different groups undertaken
- ☐ Contraceptive prevalence of country of origin (or in-country)
- ☐ Contraceptives procured and logistics system in place
- ☐ FP record-keeping system in place
- ☐ Active involvement of users of FP services
- ☐ Involvement of local men, women and community leaders
- ☐ FP service sites established with participation of affected populations
- ☐ Service providers trained in FP service delivery as defined by national authority

*Some of these tasks will have to be done simultaneously.

to provide method counselling within a limited time frame. Providers must be trained or updated on the use of educational materials and learn how to identify clients with special needs, such as adolescents, those at high risk of STIs, including HIV, women who are breastfeeding, etc. Role playing will increase providers' competency in approaching different cases.

### 3.7.3 Administrative skills

Administrative skills include record keeping, inventory control and supervising community-based distributors. Emphasize the specific skills necessary to carry out these tasks, why they are important and how and when to carry them out.

## 3.8 Family planning service provision

**Family planning consultation**

The first contact between a provider and client involves:

- registration and taking a reproductive health and medical history;
- physical examination (if indicated by the history), which may include a pelvic examination (e.g. to investigate unexplained vaginal bleeding);
- counselling on available contraceptive methods and the client's preferred choice while considering her/his STI/HIV risk and medical history;
- providing the selected contraceptive method and explanation on its use:
  - Counsel the client on correct use of the contraceptive, including the route of ad-

**Dual Protection**

Many sexually active people need dual protection: protection against unintended pregnancy and against STIs, including HIV. Those contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently, but are associated with higher pregnancy rates than condoms used together with another contraceptive method.

ministration, what to do in case of missed doses and where to access emergency contraception if needed. In addition, explain possible side-effects and reassure the client that she/he can return to the health facility at any time for management of side-effects or to change methods.

- scheduling a follow-up visit or visit by a lay worker:
  - Give new users a date for the follow-up visit. Such follow-up visits will give the client opportunities to ask questions about contraceptive use and any side-effects that she/he may have experienced. With some methods, such as contraceptive pills, condoms and injectable contraceptives, clients must have regular contact with the CBD service provider or the nurse to obtain the contraceptives. As the user becomes familiar with a method, follow-up visits can be initiated by the user her- or himself. Whatever the frequency of follow-up visits, the client should be assured of immediate access if she/he experiences any difficulties. When arranging follow-up visits, service providers must be sensitive to the literacy level of the client and use appropriate job aids to ensure that information is understood by the client.
- documenting visit in standardized data collection materials and patient records.

National protocols, job aids or checklists may exist. Ensure technical correctness and congruence with international standards.

**Pregnancy diagnosis**

The diagnosis of pregnancy is important because a provider should not prescribe a FP method for clients who are pregnant. The ability to diagnose early pregnancy will vary depending on resources and settings. Reliable pregnancy tests are very useful, but may not be available. Pelvic examination, if conducted by a skilled provider, is reliable at approximately 8–10 weeks since the first day of the last menstrual period. If neither of these are feasible, the checklist on the following page can be used by service providers to be reasonably sure that the client is not pregnant.

**Figure 4: Checklist to Exclude Early Pregnancy**

Ask the client questions 1 – 6. As soon as the client answers yes to any question, stop and follow the instructions.

| | | |
|---|---|---|
| NO | 1. Did you have a baby less than 6 months ago, are you fully of nearly exclusively breastfeeding and have you had no menstrual period since the birth? | YES |
| NO | 2. Have you abstained from sexual intercourse since your last menstrual period or delivery? | YES |
| NO | 3. Have you had a baby in the last 4 weeks? | YES |
| NO | 4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)? | YES |
| NO | 5. Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if you are planning to use an IUD)? | YES |
| NO | 6. Have you been using a reliable contraceptive method consistently and correctly? | YES |

↓ ↓

If the client answered no to all of the questions, pregnancy cannot be ruled out. Use a pregnancy test to exclude pregnancy, or client should await menstruation before starting her method of choice.

If the client answered yes to at least one of the questions and she is free of signs and symptoms of pregnancy, provide client with desired method.

**Box 24: Contraceptive Considerations for Adolescents**

- Although young women are often less tolerant of side-effects, counselling will help adolescents know what to expect and may make them less likely to stop using their methods.
- Unmarried adolescents may be at increased risk of STIs and HIV transmission. Counsel on dual protection strategies to reduce the risk of STI infection.
- Female adolescents may have less control than older women over having sex and using contraception. This may increase their need for emergency contraception. Counsel all adolescents who seek emergency contraception on FP methods and give them the option to take extra emergency contraception with them.
- Young women often prefer methods which they can use without others knowing (such as injectable contraceptives).
- Because of the many barriers for adolescents to access health care at facilities, CBD should also target adolescents.

For more information refer to Chapter 4: Adolescent Reproductive Health.

## 3.9 Family planning methods

Service providers must be able to explain the characteristics of each method, how to use it, its effectiveness, safety and side-effects. They must know how the method affects STI and HIV transmission, its appropriateness for clients who have special needs (such as adolescents, clients with acquired immunodeficiency syndrome (AIDS) and breastfeeding women) and the length of time between discontinuation of the method and return to normal fertility. Ensure providers have access to this information for all FP methods available in the setting and are able to use it in accordance with the reproductive goals of each client.

### 3.9.1 Fertility awareness methods

Effective use of fertility awareness methods requires that a woman knows how to tell when the fertile time in her menstrual cycle begins and ends. These methods include those that rely on symptoms of fertility, such as tracking the basal body temperature or daily cervical secretions (Two-day Method) or calendar-based methods, which rely on keeping track of days of the menstrual cycle (Standard Days Method). Using these methods requires cooperation of both partners.

Fertility awareness methods are particularly appropriate for people who do not wish to use other methods for medical reasons or because of religious or personal beliefs. Service providers should advise couples that these methods do not protect them from STIs, including HIV infections, and, due to their low effectiveness, may not be appropriate when pregnancy would be an unacceptable risk to a woman's health.

### 3.9.2 Hormonal contraceptives

Hormonal contraceptives contain progestogen alone or in combination with estrogen to prevent a woman from ovulating. They are common, highly effective and easy to use. There are several administrative routes (by mouth, injection, implants, skin patch, etc.), which are discussed in Tables 11 to 13. When a woman chooses a hormonal method, she must be counselled on correct use, what to do in case of a missed dose and possible side-effects, such as changes in menstrual bleeding patterns. Supportive counselling and continued reassurance during follow-up visits will help clients correctly use the method and tolerate common side-effects.

**Table 11: Comparing Oral and Local Application Hormonal Methods**

| Characteristics | Combined oral contraceptives (COC, "the pill") | Progestogen-only contraceptives (POP, "mini-pill") | Combined patch | Combined vaginal ring |
|---|---|---|---|---|
| **Method of use** | Pills taken orally | Pills taken orally. Safe for breastfeeding women and their babies | Patch worn on upper outer arm, back, abdomen or buttocks—not on breasts | Ring inserted in the vagina |
| **Contains** | Low doses of 2 hormones—a progestogen and an estrogen | Very low doses of a progestogen | Continuously releases 2 hormones—a progestogen and an estrogen | Continuously releases 2 hormones—a progestogen and an estrogen |
| **Frequency of use** | Daily for 21 days, followed by a break or pills without hormones for 7 days | Daily. No break between packs | Weekly: Patch is changed every week for 3 weeks. No patch worn 4th week | Monthly: Ring kept in place for 3 weeks and taken out during 4th week |
| **Effectiveness** (Pregnancy rate as commonly used) | Depends on user's ability to take a pill every day<br><br>As commonly used, about 8 pregnancies per 100 women over the first year | Depends on user's ability to take a pill every day at the same time<br><br>Breastfeeding: About 1 pregnancy per 100 women over the first year<br><br>Not breastfeeding: About 3 to 10 pregnancies per 100 women over the first year | Requires user's attention once a week. Effectiveness rates under research. May be more effective than COCs | Depends on user keeping the ring in place all day, not leaving it out for more than 3 hours at a time. Effectiveness rates under research. May be more effective than COCs |
| **Bleeding patterns** | Typically, irregular bleeding for the first few months and then lighter and more regular bleeding | Typically, in breastfeeding women the pills lengthen the period of no monthly bleeding<br><br>For nonbreastfeeding women frequent or irregular bleeding is common | Similar to COCs, but irregular bleeding is more common in the first few cycles than with COCs | Similar to COCs, but irregular bleeding is less common than with COCs |

| Characteristics | Combined oral contraceptives (COC, "the pill") | Progestogen-only contraceptives (POP, "mini-pill") | Combined patch | Combined vaginal ring |
|---|---|---|---|---|
| **Average delay in time to pregnancy after stopping method** | No delay | No delay | No delay | No delay |
| **Privacy** | No physical signs of use but others may find the pills | No physical signs of use but others may find the pills | Patch may be seen by partner or others | Some partners may be able to feel the ring |
| **Other considerations** | Verbal consent plus FP counselling with explanation on how to take pills | Verbal consent plus FP counselling with explanation on how to take pills | Verbal consent plus FP counselling with explanation on how patch is used and rotated | Verbal consent plus FP counselling with demonstration on how and when to insert and remove |
| **Provider skills** | Trained in FP counselling | | | |

*Adapted from:* Family Planning A Global Handbook for Providers. *USAID, John's Hopkins Bloomberg School of Public Health, WHO, 2007.*

**Table 12: Comparing Injectable Methods**

| Characteristics | DMPA | NET-EN | Monthly Injectable (CIC) |
|---|---|---|---|
| **Method of use** | Intramuscular (IM) or sub-cutaneous (SC) injection every 3 months | IM injection every 2 months | IM injection every 1 month |
| **Contains** | A progestogen—depot medroxyprogesterone acetate | A progestogen—norethisterone enanthate | Two hormones: a proges-togen and an estrogen |
| **Time-limit for repeat injection to be ef-fective if the client comes too early or too late for her ap-pointment** | Up to 2 weeks early or 4 weeks late | Up to 2 weeks early or 2 weeks late | Up to 7 days early or 7 days late |

| Characteristics | DMPA | NET-EN | Monthly Injectable (CIC) |
|---|---|---|---|
| **Injection technique** | Deep intramuscular (IM) injection into the hip, upper arm or buttock<br><br>A DMPA subcutaneous (SC) injection exists in uniject syringes<br><br>**IM and SC injections should be given as intended;** otherwise they may not be completely effective | Deep IM injection into the hip, upper arm or buttock<br><br>May be slightly more painful than DMPA | Deep IM injection into the hip, upper arm, buttock or outer thigh |
| **Bleeding patterns** | Irregular and prolonged bleeding at first, then no bleeding or infrequent bleeding. About 40% of users have no monthly bleeding after 1 year | Irregular or prolonged bleeding in first 6 months but shorter bleeding episodes than with DMPA<br><br>After 6 months bleeding patterns are similar to those with DMPA. 30% of users have no monthly bleeding after 1 year | Irregular, frequent or prolonged bleeding in first 3 months. Mostly regular bleeding patterns by 1 year. About 2% of users have no monthly bleeding after 1 year |
| **Average weight gain** | 1–2 kg per year | 1–2 kg per year | 1 kg per year |
| **Effectiveness** (Pregnancy rate as commonly used) | About 3 pregnancies per 100 women in the first year | Similar to DMPA | |
| **Average delay in time to pregnancy after stopping injections** | On average 10 months after last injection | On average 6 months after last injection | On average 5 months after last injection |
| **Other considerations** | FP counselling plus verbal consent plus reminder card for reinjection visit in 12 weeks | FP counselling plus verbal consent plus reminder card for reinjection in 8 weeks | Verbal consent plus FP counselling plus reminder card for reinjection in 4 weeks |
| **Provider skills** | Trained in FP counselling and administration of injections | | |

*Adapted from:* Family Planning A Global Handbook for Providers. *USAID, John's Hopkins Bloomberg School of Public Health, WHO, 2007.*

| Table 13: Comparing Implants | | | |
|---|---|---|---|
| **Characteristics** | **Norplant** | **Norplant Jadelle/Sino-Implant (II)** | **Implanon** |
| **Delivery method** | 6 capsules inserted under the skin | 2 rods inserted under the skin | 1 rod inserted under the skin |
| **Contains progestogen** | Levonorgestrel | Levonorgestrel | Etonogestrel |
| **Lifespan** | Up to 7 years | Up to 4 or 5 years | 3 years |
| **Effectiveness (Pregnancy rate in the first year of use)** | Pregnancy will occur in only 5 per 10 000 women using implants<br><br>In women 70–79 kg the method becomes less effective after 5 years of use<br><br>In women >80 kg the method becomes less effective after 4 years of use | Pregnancy will occur in only 5 per 10 000 women using implants<br><br>In women >80 kg this method becomes less effective after 4 years of use | Pregnancy will occur in only 5 per 10 000 women using implants<br><br>Weight has no known impact on effectiveness |
| **Bleeding patterns** | In the first few months lighter and fewer days of bleeding or irregular bleeding that lasts more than 8 days or infrequent or no bleeding<br><br>After about one year lighter and fewer days of bleeding, irregular and infrequent bleeding | | Implanon users are more likely to have infrequent or no monthly bleeding |
| **Average delay in time to pregnancy after implants are removed** | No delay | No delay | No delay |
| **Availability** | Being phased out; Norplant are no longer being inserted | Expected to replace Norplant by 2011 | Primarily available in Europe and Asia<br><br>Also approved for use in United States |
| **Other considerations** | Removals only and counselling on other methods<br><br>Verbal consent if providing another method and written consent if providing another implant | FP counselling, verbal and written consent and reminder card for return visit in one week to check site and remove bandage<br><br>Provide effectiveness card for Jadelle expiration in 5 years or Sino-Implant in 4 years | FP counselling, verbal and written consent and reminder card for return visit in one week to check site and remove bandage<br><br>Provide effectiveness card for Implanon expiration in 3 years |
| **Provider skills** | Trained in FP counselling and insertion and removal of implants | | |

### 3.9.3 Barrier methods

Barrier contraceptive methods prevent pregnancy by physically preventing sperm from entering the uterus. The most frequently used barrier methods are male and female condoms (see Table 14). Condoms are the only FP methods that protect against both pregnancy and STIs. (For more information on condoms, see Chapter 9: Sexually Transmitted Infections p. 169.) Other barrier methods, such as spermicides and diaphragms, may be requested by persons who are familiar with them. If requested, every effort should be made to supply these methods. Spermicides are one of the least effective of all contraceptive methods when used alone. Frequent use of spermicides can increase the risk of HIV acquisition in high-risk clients, such as commercial sex workers.

**Table 14: Comparing Male and Female Condoms**

| Characteristics | Male Condoms | Female Condoms |
|---|---|---|
| **How to wear** | Rolled over the man's erect penis<br><br>Fits the penis tightly | Inserted into the woman's vagina<br><br>Lines the vagina loosely and therefore does not constrict the penis |
| **When to use** | Immediately before sex | Up to 8 hours before sex |
| **Material** | Most commonly made of latex (sometimes of synthetic materials or animal membranes*)<br><br>* Condoms made with animal membranes do not protect against HIV. | Most are made of a thin, synthetic film (polyurethane or nitrile)<br><br>Some models are made of latex |
| **Sensation during sex** | Sexual intercourse may feel less sensitive | The condoms which are made of synthetic film, conduct heat, so sexual intercourse can feel very sensitive and natural |
| **Noise during sex** | May make a rubbing noise during sex | May rustle during sex |
| **Lubrication** | Users can add lubricants:<br>• water- or silicone-based only<br>• applied to outside of condom | Users can add lubricants:<br>• water-, silicone- or oil-based<br>• before insertion, applied to outside of condom<br>• after insertion, applied to inside of condom or to the penis |
| **Breakage or slippage** | Tend to break more often than female condoms | Tend to slip more often than male condoms |

| Characteristics | Male Condoms | Female Condoms |
|---|---|---|
| **When to remove** | The penis must be withdrawn from the vagina before erection subsides | The penis can remain in vagina after erection subsides<br><br>Remove the female condom before the woman stands |
| **Area covered** | Protects most of the penis and the woman's internal genitalia | Protects both the woman's internal and external genitalia and the base of the penis |
| **Effectiveness (Pregnancy rate as commonly used)** | About 15 pregnancies per 100 women whose partners use male condoms over the first year (If used correctly with every act of sex, about 2 pregnancies per 100 women) | About 21 pregnancies per 100 women using female condoms over the first year (If used correctly with every act of sex, about 5 pregnancies per 100 women) |
| **Protection against HIV** | When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms | When used consistently and correctly, female condom use prevents HIV transmission |
| **How to store** | Store away from heat, light and dampness | Plastic condoms are not harmed by heat, light or dampness |
| **Re-use** | Cannot be re-used | Reuse not recommended |
| **Cost and availability** | Generally low cost and wide availability | Usually more expensive and less widely available than male condoms |
| **Other considerations** | Counsel and demonstrate on how and when to apply and remove (ideally with penis model) | Counsel and demonstrate on how and when to apply and remove (ideally with vagina model) |
| **Provider skills** | Trained in FP counselling, demonstration and redemonstration | |

### 3.9.4 Intrauterine devices (IUDs)

Intrauterine devices (IUDs) are small, flexible plastic devices that contain either copper or a progestogen. A specifically trained health-care provider inserts it into a woman's uterus through her vagina and cervix, using proper infection-prevention procedures (including a "no-touch" insertion technique). IUDs are among the most effective methods in preventing pregnancy.

**IUDs and STIs.** By itself, the IUD does not cause pelvic inflammatory disease (PID). IUD insertion when a woman has gonorrhoea or chlamydia may occasionally lead to PID, therefore this should be avoided. If a client's situation places her at very high individual risk of infection, she generally should not have an IUD inserted. When laboratory screening for gonorrhoea and chlamydia is unavailable (see Chapter 9: STIs), service providers should ask the client to consider her own risk and to think about whether she might have an STI. If she considers herself at high risk of acquiring an STI, she should be counselled on alternative FP methods. In special circumstances, if other, more appropriate methods are not available or not acceptable, service providers should consider presumptively treating her with a full curative dose of antibiotics effective against both gonorrhoea and chlamydia and inserting the IUD after she finishes treatment.

If a woman develops a new STI after her IUD has been inserted, she is not especially at risk of developing PID because of the IUD. She can continue to use the IUD while she is being treated for the STI. Removing the IUD has no benefit and may leave her at risk of unwanted pregnancy. She should be counselled on condom use and other strategies to avoid STIs in the future.

**Table 15: Comparing IUDs**

| Characteristics | Copper-bearing IUD | Levonorgestrel IUD |
|---|---|---|
| **Effectiveness (Pregnancy rate in the first year of use)** | Pregnancy will occur in 6 to 8 per 1000 women over the first year | Pregnancy will occur in 2 per 1000 women over the first year |
| **Length of use** | Approved for 10 years | Approved for 5 years |
| **Bleeding patterns** | Longer and heavier monthly bleeding, irregular bleeding and more cramping or pain during monthly bleeding | More irregular bleeding and spotting in the first few months<br><br>After one year it is common to have no monthly bleeding<br><br>Causes less bleeding than copper-bearing IUDs over time |
| **Anaemia** | May contribute to iron-deficiency anaemia if a woman already has low iron blood stores before insertion | May help prevent iron-deficiency anaemia |
| **Main reasons for discontinuation** | Increased bleeding and pain | No monthly bleeding and hormonal side-effects |

| Characteristics | Copper-bearing IUD | Levonorgestrel |
|---|---|---|
| **Average delay in time to pregnancy after IUD is removed** | No delay | No delay |
| **Noncontraceptive benefits** | May help protect against endometrial cancer | Effective treatment for long and heavy monthly bleeding (alternative to hysterectomy)<br><br>May also help treat painful monthly bleeding<br><br>Can be used as the progestogen in hormone replacement therapy |
| **Postpartum use** | Can be inserted up to 48 hours postpartum | Can be inserted 4 weeks postpartum |
| **Use as emergency contraception** | Can be used within 5 days after unprotected sex | Not recommended |
| **Insertion** | Requires specific training but easier to insert than levonorgestrel IUD | Requires specific training and a unique, more difficult insertion technique Women may experience more faintness, pain and nausea or vomiting at insertion than with the copper-bearing IUD |
| **Cost** | Less expensive | More expensive |
| **Other considerations** | FP counselling, verbal and written consent. Provide explanation how to check strings for clients who wish to do so | |
| **Provider skills** | Trained in FP counselling and Cu IUD insertion and removal | Trained in FP counselling and LNG-IUD insertion and removal |

### 3.9.5 Emergency contraception (EC)

(For more information on EC see Chapter 2: MISP, p. 27.)

The two methods of emergency contraception are:

- emergency contraceptive pills (ECP)
- copper IUD.

Emergency contraceptive pills can prevent unwanted pregnancy if used within five days (120 hours) after unprotected sex. ECP should be taken as soon as possible after unprotected intercourse. **They are most effective the sooner they are taken, but can still be effective when taken up to five days after unprotected sex.**

Two formulations are available (see Box 25).

ECPs can safely be used by any woman, even those who cannot use hormonal methods on a continuous basis, as the dose of hormones used is relatively small and the pills are used for

### Box 25: Emergency Contraceptive Pill Regimens

The **levonorgestrel-only regimen:** 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen; it is more effective and has fewer side-effects). These pills are specially packed for emergency contraception.

The **combined estrogen-progestogen regimen (Yuzpe):** a dose of 100 microgram ethinyl estradiol plus 0.5 mg of levonorgestrel, taken as soon as possible, followed by the same dose 12 hours later. These pills are either specially packed for emergency contraception or can be taken from regular combined oral contraceptive pill packs.

*Levonorgestrel-only (LNG) pills have been shown to be more effective than combined pills for emergency contraception and have significantly fewer side-effects. The levonorgestrel-only regimen is included in WHO's Model List of Essential Medicines.*

a short time. ECPs should not be given if there is a confirmed pregnancy. ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence of harm to the woman or to an existing pregnancy. Use the pregnancy checklist to reasonably rule out pregnancy prior to providing ECP (see Figure 4: Checklist to Exclude Early Pregnancy).

Periodic ECP use is possible, but is not recommended as a method of family planning. However, a request for EC provides an entry point to discuss family planning and counsel the client on continuous contraceptive methods. Utilize that opportunity!

A **copper-bearing IUD** can be inserted up to five days after unprotected intercourse as an emergency contraceptive. When the time of ovulation can be estimated, a copper-bearing IUD can be inserted beyond five days after unprotected intercourse, as long as insertion does not occur more than five days after ovulation.

This may be a good option for a woman who wants to use an IUD for continuing contraception. It is more effective in preventing pregnancy than ECPs.

Ensure that the client is eligible for IUD insertion. If an IUD is inserted as EC after a rape, ensure that full presumptive STI treatment is provided (see Chapter 2: MISP).

### 3.9.6 Voluntary surgical sterilization

Male (vasectomy) and female (tubal ligation) sterilization are desirable methods of contraception for some clients who have decided to have no more children.

Surgical contraception should only be performed in safe conditions with informed consent of the user, by trained personnel and with the necessary equipment. Sterilization should be available to clients, especially if they are familiar with the method from their region or country of origin and if it is allowed within the host country. This method does not protect against STIs, including HIV.

## 3.10 Postpartum family planning

A woman is protected from pregnancy in the postpartum period if:

1) she is fully breastfeeding (baby receives only breast milk or, once in a while, some added vitamins, water, juice or other nutrients) or nearly fully breastfeeding (more than three-fourths of all feeds are breast milk); **and**
2) she has not resumed menstruating; **and**
3) she is less than six months postpartum.

This is called the lactational amenorrhoea method (LAM). Its effectiveness, as commonly used, is about two pregnancies per 100 women in the

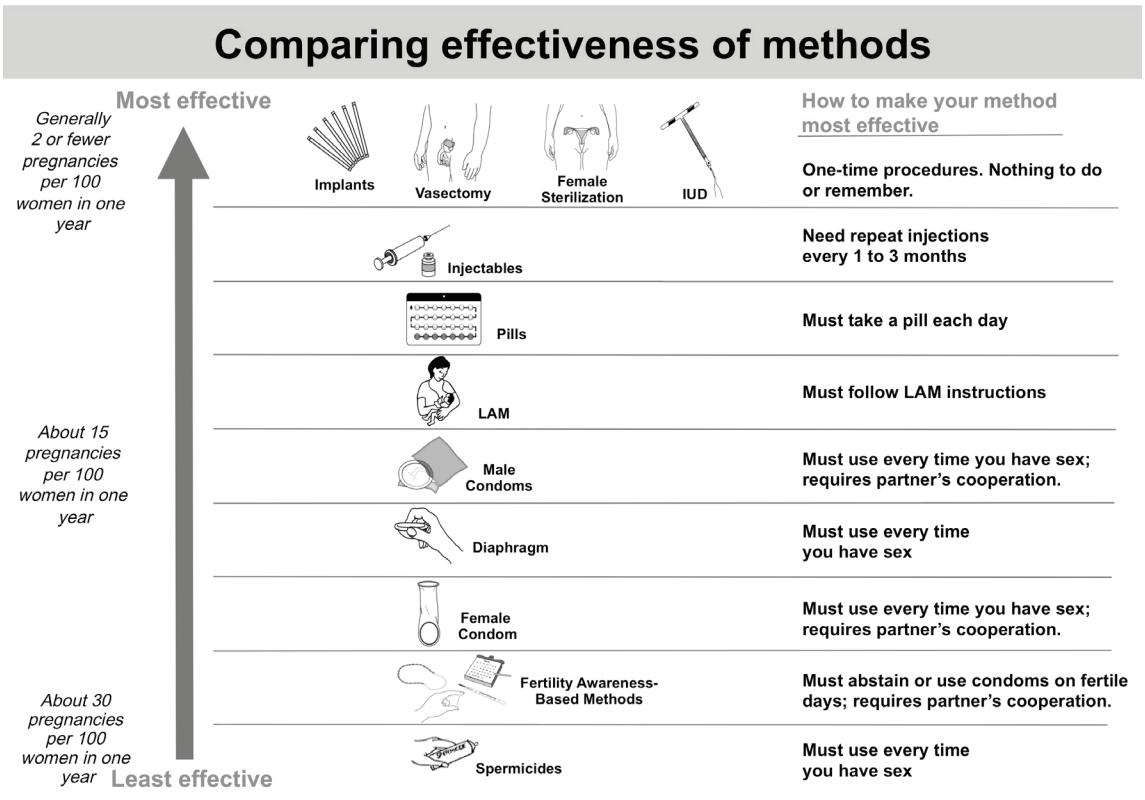
first six months after childbirth. Counsel women using this method to choose another FP method when they approach month-six postpartum or when any of the above criteria change.

Women may initiate the following FP methods safely:

- **Barrier methods:** condoms can be used immediately postpartum.
- **IUD insertion**: IUDs can be inserted either during the first 48 hours after a vaginal or caesarean delivery by a specially trained provider or four weeks postpartum. Insertion of an IUD between 48 hours and four weeks postpartum is not recommended. Expulsion rates are lowest when inserted four weeks or more after delivery or at a time unrelated to pregnancy.
- **Sterilization:** may be performed during the first seven days or six weeks postpartum.
- **Progestogen-only methods (pills, injectables, implants):** may be initiated six weeks postpartum for breastfeeding women, and immediately postpartum for nonbreastfeeding women.
- **Combined methods (pills and injectables):** may be initiated six months postpartum for breastfeeding women and at six weeks postpartum for nonbreastfeeding women.
- **Natural methods (Standard Days Method):** may be initiated when a woman has re-established a regular menstrual cycle.

**Table 16: Contraceptive Effectiveness**

This chart shows how effective methods are as usually used. The top four methods are most effective; the user has nothing to do once the procedure is complete. The effectiveness of the other methods depends on the user's behaviour; they are only effective when used correctly.




Adapted from: *Decision-making tool for family planning clients and providers*. WHO. 2005. www.who.int/reproductivehealth/publications/family_planning/9241593229/en/index.html

## 3.11 Family planning for people living with HIV

Encourage condom use for all HIV-positive people to protect them from STIs and to prevent HIV transmission to sexual partners. If an HIV-positive woman desires more effective pregnancy protection, she may wish to use another contraceptive method in addition to condoms.

Women with HIV can use most methods of contraception, with the following considerations:

- An IUD should not be inserted in any woman with a gonorrhoea or chlamydia infection or if a woman is at very high individual risk for these infections. HIV-positive women who are clinically well (whether or not on antiretroviral therapy (ART)) can use an IUD.
- If a woman is taking rifampicin for tuberculosis, she should not use contraceptive pills, the combined patch, the combined ring or implants, as contraceptive effectiveness may be decreased.
- Spermicides, either alone or in combination with barrier methods, should not be used by women with HIV infection or AIDS.
- Women on ART who are using hormonal methods are advised to also use condoms because some antiretroviral drugs (ARVs) reduce the effectiveness of hormonal methods.

Refer to Chapter 10: HIV for more information.

## 3.12 Infertility

Infertility is the failure to achieve a pregnancy or to give birth to a child after 12 months or more of regular unprotected sexual intercourse. If a woman has never been pregnant before, the disease is primary infertility. If a couple has previously given birth to a child, but currently meets the definition of infertility, this is described as secondary infertility. Infertility has many causes, which can be medical, such as postpartum infection, post-abortion infection, iatrogenic infertility, endometriosis, STIs and other infectious diseases that have caused fallopian tube, vas deferens or epididymal damage, or non-medical. Within a humanitarian setting, secondary and even primary infertility can be the result of stress and major changes in lifestyle.

Worldwide, couples view infertility as a tragedy that carries social, economic and psychological consequences. Infertility is an unmet need in family planning and up to one in four ever-married women of reproductive age in most developing countries suffer from primary and, more significantly, from secondary infertility.

Counselling of couples is critical. Make it clear that infertility is not a woman's problem alone, because between 25% and 50% of infertility may be due to the male partner. Examine the reproductive organs or genitalia of both male and female partners for any structural abnormalities. Where possible, semen analysis is crucial as a basic laboratory test for all infertile couples. Basal body temperature can be a helpful tool as an initial evaluation for ovulation. At a minimum, investigate and, when necessary, treat both partners for medical causes (most specifically STIs) or psychological and emotional problems. Consider and manage issues associated with abnormal body mass index (BMI), diet, cessation of smoking, use of certain medications and pre-existing medical conditions, such as diabetes, heart disease or psychiatric disease. Counsel couples on fertility awareness, menstrual regularity, sexual timing and techniques, as well as STI prevention.

Where these services are available, refer the couple for advanced medical evaluation (such as transvaginal ultrasound, cervical mucus evaluation, postcoital testing, hysterosalpingography, hormone assays) and relevant procedures, such as intrauterine insemination (IUI), surgical interventions and assisted reproduction.

## 3.13 Male involvement in family planning programmes

Involve men in FP programmes to increase acceptance of the programme within the community and to increase recognition of other RH issues, such as the prevention and treatment of STIs and HIV. Considering men's perspectives and motivation is integral to programme activities. Contraceptive use by men enables them to share the responsibility of family planning with their female partners. FP services may need to be specifically tailored to meet the needs of male users. Activities to encourage men's involvement include couples counselling, condom promotion, special health facility times for men, peer-group sessions and RH information at male social groups.

## 3.14 Advocacy

RH officers and programme managers should advocate for provision of family planning whenever possible. Knowing the baseline contraceptive use of the host population as well as the displaced population is helpful background information.

Meeting with the local Ministry of Health officials, private donors and other agencies to present data on unmet needs and the potential cost savings and health benefits of providing FP services is an effective advocacy tool.

# 4 Human rights and legal considerations

## 4.1 Human rights standards

Under international law, universal access to FP 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, governments agreed to make RH care available to all, including a full range of FP 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 FP". **

The right to family planning is closely linked with other human rights:

- Access to contraception will reduce unwanted pregnancies and will help ensure a woman's right to health and right to life.
- Everyone has a right to privacy and the right to equality and nondiscrimination. These rights are sometimes denied in the context of family planning when, for example, someone is denied access to contraception because she or he is not married.
- Everyone has a right to impart and receive information on family planning. This right includes reproductive health and sexuality education for adolescents. Adolescents have a right to access FP services and information. Refusing FP information or contraception to adolescents based on age, marital status or parental or guardian consent may constitute a denial of adolescents' right to health and right to nondiscrimination. (See Chapter 4: Adolescent Reproductive Health for more information.)
- Everyone has a right to enjoy the benefits of scientific progress and its applications. This means that everyone has a right to benefit from developments in contraceptive technology, such as emergency contraception (EC).

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* Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), art. 16(1).

** Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 12.

- 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 freely decide on the number and spacing of their children.

## 4.2 Challenges and opportunities

In some cases, service providers may face difficult decisions or dilemmas. They may find that their ability to provide FP information and services is restricted by national legislation, social or cultural norms or medical misconceptions. For example, the following may happen:

- A woman is not provided with FP services without her husband's consent.
- A woman is not permitted to choose to be sterilized without her husband's authorization or she must meet other requirements before she can be sterilized, such as bearing a certain number or children or being of a certain age.
- A woman is refused access to contraception without her husband's authorization.
- A woman is refused access to contraception because she is not married.
- Adolescents are denied IUDs based on the inappropriate medical claim that IUDs will cause infertility unless the patient can demonstrate that she has had a child or is pregnant.
- Women are denied access to emergency contraception because it is wrongly believed to be a form of abortion, which is contrary to local religious and social norms.

Such norms, laws and practices can be in conflict with internationally accepted human rights principles. An RH manager or service provider is likely to face such dilemmas. You must be aware of your agency/organization position on these RH issues and include it as part of your analysis of the situation and possible next steps. When faced with a difficult situation you should first and foremost give priority to the client's safety and health, and your own safety and that of colleagues. Then, you may wish to:

- talk to your supervisor;
- discuss options with your client:
  - For example, if you are unable to provide certain modern methods of contraception to a woman, you can counsel her on natural family planning methods, such as fertility awareness and the lactational amenorrhea method (LAM);
- find out whether your agency is engaged in advocacy on the issue and how you can contribute;
- explore linkages with and referrals to local organizations that might be able to help your client further;
- while respecting the confidentiality of your client, identify with colleagues and other RH providers how to avoid/handle such situations in the future;
- raise these concerns in health coordination meetings.

## 5 Monitoring

Maintain a daily activity register and individual client forms 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 on a client form:

- Date
- User name — or, if required for confidentiality, a number code
- User information (age, address, parity)
- Type of user (new, repeat, etc.)
- Method selected (and brand name)
- Side-effects experienced
- Date of next visit (for follow-up)
- Date and reason for discontinuation

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. They can be translated for expatriate staff, if these initially provide the service. Train all staff on maintaining appropriate records and on how the information collected is used in their FP programme.

**Indicators** to be collected — see Assessment, Monitoring and Review for indicator guidance:

- Indicators to be collected at the health-facility level:
  - proportion of clients offered FP counselling in addition to being given a method of contraception
  - contraceptive prevalence (CP)
    CP is the percentage of women who are using (or whose partner is using) a method of contraception at a given point in time.
- Indicators to be collected at the programme level:
  - the number of FP service delivery points that maintain a minimum of 3 month's supply of OCPs, injectables, IUDs or implants;
  - the number and proportion of providers appropriately implementing family planning services.

## 6 Further reading

*Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNG ECPs).* WHO. 2010. http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.06_eng.pdf

INFO Project, Johns Hopkins Bloomberg School of Public Health. *Family Planning, a Global Handbook for Providers*. USAID, WHO, 2007. http://www.infoforhealth.org/globalhandbook/index.shtml#contents

*The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs.* John Snow Inc./DELIVER, for the U.S. Agency for International Development (USAID), Arlington, VA, 2004. http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/LogiHand.pdf

The INFO Project, *USAID's Maximizing Access and Quality Initiative IUD Toolkit*. http://www.maqweb.org/iudtoolkit/index.shtml.

*Training and Reference Guides for Family Planning Screening Checklists.* Family Health International, 2008. http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/Guides.htm



# 6

CHAPTER SIX

# Maternal and Newborn Health

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## 1 Introduction

Globally, one in seven women will face a complication during pregnancy or childbirth. There are over 500 000 maternal deaths each year, 99% of which occur in the developing world. Of the 130 million babies born every year, an estimated 4 million die in the first four weeks of life (neonatal period). A similar number of babies are stillborn, dying in utero during the last three months of pregnancy. [*]

These global maternal and neonatal mortality statistics are used because there is a relative lack of data for humanitarian settings. However, it is well established that countries in conflict or experiencing other forms of instability have the highest maternal and neonatal mortality. For example, Sierra Leone has the world's highest maternal mortality ratio (MMR) at 2100 maternal deaths per 100 000 live births. Afghanistan, which has endured more than 20 years of conflict, has an MMR of 1800. The lifetime risk of maternal death in both countries is 1 in 8, when compared to 1 in 8200 in the UK or 1 in 11 000 in Canada.[**]

Most maternal and neonatal deaths occur around the time of labour, delivery and the immediate postpartum period. The primary causes of maternal and neonatal death are depicted in Figures 5 and 6.

Many of these causes are preventable, or could be managed by skilled providers with adequate resources at the facility level.

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[*] Lawn, Joy E, et. al. "4 million neonatal deaths: When? Where? Why?" *The Lancet*. March 2005. www.who.int/child_adolescent_health/documents/pdfs/lancet_neonatal_survival_paper1.pdf.

[**] *Countdown to 2015 Tracking Progress in Maternal, Newborn, and Child Survival. The 2008 Report.* www.countdown2015mnch.org/reports-publications/2008report.

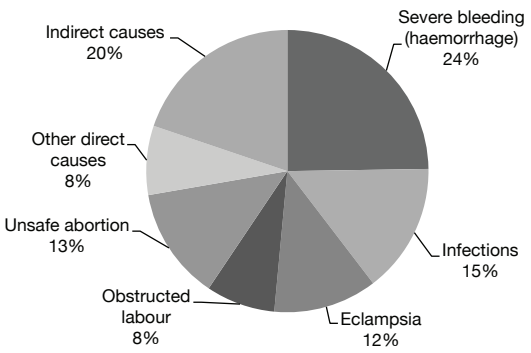
# Maternal and Newborn Health

**Emergency Obstetric Care (EmOC) and Emergency Obstetric and Newborn Care (EmONC)**

In this manual we use the acronym EmOC (Emergency Obstetric Care). The reason for this is that the list of "signal functions" used for monitoring emergency obstetric care (life-saving emergency interventions performed by skilled providers to manage the majority of maternal complications in pregnancy, childbirth and postpartum period) includes only one signal function related to newborn care: basic neonatal resuscitation, using bag and mask, to treat asphyxia. WHO, UNFPA, UNICEF and AMDD refer to the package as EmOC.

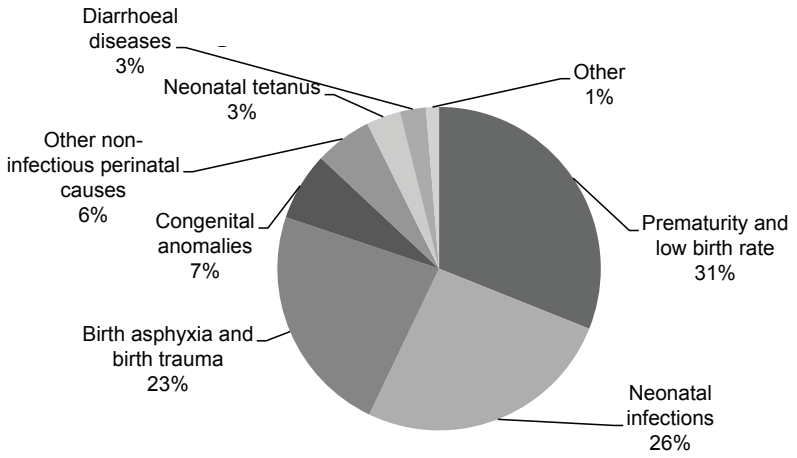
However, it is important to ensure midwives are able to perform not only "emergency obstetric functions", but also a range of essential newborn care interventions, such as resuscitation, thermal protection, promoting early and exclusive breast feeding, treatment of neonatal sepsis, and care of preterm and low birth weight babies. Therefore, some agencies use the acronym EmONC (Emergency Obstetric and Newborn Care) when advocating for the importance of linking maternal health interventions with newborn health interventions as part of the implementation of a comprehensive continuum of care for maternal and child health in humanitarian settings.

**Figure 5: Causes of Maternal Death ***




* World Health Report 2005. WHO. p. 62. http://www.who.int/whr/2005/en/index.html.

**Figure 6: Causes of Neonatal Death ***




## 2 Objectives

The objective of this chapter is to assist reproductive health (RH) officers, managers and service providers to

- plan for and implement comprehensive maternal and newborn health (MNH) services in humanitarian settings;
- understand key barriers that impact on maternal and newborn deaths;
- take into consideration evidence-informed interventions along the continuum of care for maternal and newborn health.

## 3 Programming for comprehensive MNH

Because most maternal and neonatal deaths occur around the time of labour, delivery and the immediate postpartum period, the Minimum Initial Service Package (MISP) components related to MNH (see Chapter 2) aim to reduce morbidity and mortality associated with these complications by ensuring that:

- emergency obstetric and newborn care services are available, including that:
  - nurses and midwives attending births in health centres have all the supplies they need to attend normal births and to manage obstetric and newborn complications (BEmOC);
  - skilled medical staff and supplies are available at referral hospitals to manage all obstetric and newborn complications (CEmOC);
- a referral system is in place to facilitate transport and communication from the community to the health centre and between health centre and hospital for women with obstetric complications;
- clean delivery supplies are provided to obviously pregnant women who may not be able to reach a health centre for delivery.

This chapter describes approaches for RH officers, managers and service providers to program for comprehensive MNH services as soon as the situation allows, building upon the MISP interventions. Comprehensive MNH programming has **three strategic priorities:**

- Understand and remove barriers to MNH services;
- Increase availability of evidence-informed

* http://www.who.int/child_adolescent_health/media/causes_death_u5_neonates_2004.pdf.

Most maternal and perinatal deaths are due to a failure to get skilled help in time to address complications of pregnancy and delivery. Even with the best antenatal and childbirth care, any birth can face complications and require emergency interventions. Therefore, skilled care during childbirth with access to emergency care for maternal and newborn complications (both basic emergency obstetric care (BEmOC) and newborn care, and comprehensive (CEmOC)) are crucial to saving women's and newborn's lives and preventing disabilities.

MNH services;
- Improve utilization and demand for MNH services.

While this chapter provides guidance on programmatic approaches and service components of MNH, it is not meant to provide detailed comprehensive clinical management guidelines. The Further Reading section provides more information.

Comprehensive maternal and newborn health programmes have three service components:

1. Antenatal or pregnancy care
2. Childbirth care (labour, delivery and immediate post-partum care)
3. Postnatal maternal and newborn care.

**Quality of care** underpins all components of comprehensive MNH services (See Chapter 1 Fundamental Principles). Elements of quality MNH services include:

- **Availability of EmOC and newborn care facilities:** there must be at least 5 EmOC and newborn care facilities (including at least one CEmOC facility) for every 500 000 population. They must be open 24 hours per day and 7 days per week (24/7), as childbirth and complications can occur any time.
- **Geographic accessibility:** services are reachable by roads or waterways and affordable means of transport can be found.
- **Provision of evidence-informed interventions** to improve maternal and newborn health and survival in pregnancy, childbirth and postnatal care (see Annex 1 for detailed information).
- **Acceptability:** the services need to be:
  - **affordable** — 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;
  - **respectful** of each woman and considerate of her concerns.

## 3.1 Needs assessment

After the MISP is in place, integrate MNH considerations into needs assessments for comprehensive RH planning in order to design an appropriate and comprehensive MNH programme. Using a combination of tools, RH officers need to collect or estimate the following information, in coordination with other health sector/cluster actors:

**Population characteristics**

- The number of affected population and their geographical distribution.
- Demographic indicators about the MNH status of the affected population prior to the crisis, for example, the maternal mortality ratio (MMR), crude birth rate (CBR), general or total fertility rate (GFR, TFR), contraceptive prevalence (CP), 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.

**Health services and service delivery staff characteristics**

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 EmOC and newborn care, 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 centres and hospitals.
- Which among these facilities provide MNH services, including BEmOC and CEmOC.
- Availability of functioning equipment, supplies and medicines for MNH service delivery.
- Provisions for standard precautions, including medical waste and placenta disposal facilities.
- Number and type and skills levels of health staff (see also Box 26: Skilled Birth Attendants Versus Traditional Birth Attendants).
- Availability of MNH protocols and guidelines.
- On referral mechanisms:
  - Distances from community to BEmOC facilities
  - Distances from BEmOC to CEmOC facilities
  - Feasible transport options
  - Means of communication
  - 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.

### Box 26: Skilled Birth Attendants Versus Traditional Birth Attendants

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, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns"*

Although **traditional birth attendants (TBAs),** either trained or untrained, cannot be considered skilled providers, they often hold a special place in the community. Training of TBAs as 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, they can play a role in promoting reproductive health, addressing barriers to care, facilitating referrals to health facilities and providing labour support to mothers. This can optimize community acceptance of MNH services and help build linkages between families, communities, local authorities and reproductive health services.

* From: *Making pregnancy safer: the critical role of the skilled attendant* : a joint statement by WHO, ICM and FIGO. WHO 2004.

## National legislation and policies

RH officers, managers and service providers must also be familiar with national legislation and policies related to MNH. For example: Are there laws, regulations or policies regarding:

- reducing maternal mortality?
- access to and provision of MNH services? Pay particular attention to provisions on:
  - routine performance of maternal, perinatal and neonatal death audits and reviews;
  - licensing for skilled birth attendants;

  - traditional birth attendants;
  - use, distribution and provision of medicines essential for maternal and neonatal health.
- 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 Mutilation (FGM) and /or other harmful practices that have damaging consequences to maternal health?
- the elimination of early marriage, forced marriage, the minimum age of marriage and/or free and full consent to marriage?

## 3.2 Reduce barriers to utilization of MNH services

To make sure that the services provided are appropriate, of the highest quality and fully utilized, RH officers and programme managers must ensure that:

- barriers to service utilization are reduced;
- MNH service components are provided by skilled staff who have appropriate and sufficient supplies and who receive refresher trainings and close supervision;
- service providers understand and discuss community beliefs and practices and health-seeking behaviours related to pregnancy and childbirth, such as nutrition, birthing positions, presence of relatives for support and traditional practices both positive (breastfeeding) and harmful (FGM);
- All women and their families know where to obtain assistance for antenatal care and childbirth, and how to recognize signs of complications.

Because most maternal and perinatal deaths are due to a failure to get skilled help in time for complications of childbirth (see Box 28), 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 surgical facilities. 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 complications of childbirth.

RH officers and programme managers can use the model of the Three Delays to identify relevant interventions to reduce barriers to service utilization in their setting (See Figure 7). This may include, for instance, ensuring an appropriate referral system and putting in place communication systems such as radios and mobile phones. A referral system requires protocols specifying when and where to refer and an adequate record of referred cases. This implies effective coordination and communication as well as trust and understanding between the community, service

### Box 27: Improve Accessibility of Facilities: Maternity Waiting Homes

Maternity waiting homes are residential facilities, located near a qualified medical facility, where women defined as "high risk" can await their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier should complications arise. Many consider maternity waiting homes to be a key element of a strategy to "bridge the geographical gap" in obstetric care between rural areas, with poor access to equipped facilities, and urban areas where the services are available. As one component of a comprehensive package of obstetric services, maternity waiting homes may offer a low-cost way to bring women closer to needed obstetric care.

From: *Maternity waiting homes: a review of experiences,* WHO, 1996. www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM_96_21/en/index.html

### Box 28: The Three Delays Model: Identify Barriers to Service Utilization

While the availability of emergency obstetric care services is necessary to reduce maternal mortality, this is not sufficient. Each setting has features that may hinder the community from using a health facility. Even when services are functioning well, women with obstetric complications face a variety of barriers to using them. Some of these barriers are economic – e.g. lack of money to pay for transport or services, some of the barriers are cultural – e.g. the low value placed on women's lives, some are geographic – e.g. long distances and poor roads. Anything that causes delay in getting treatment may cost women their lives.

While there are many factors that can cause delay, they can be grouped using a simple model called The Three Delays. The model specifies the three types of delay that contributes to the likelihood of maternal death:

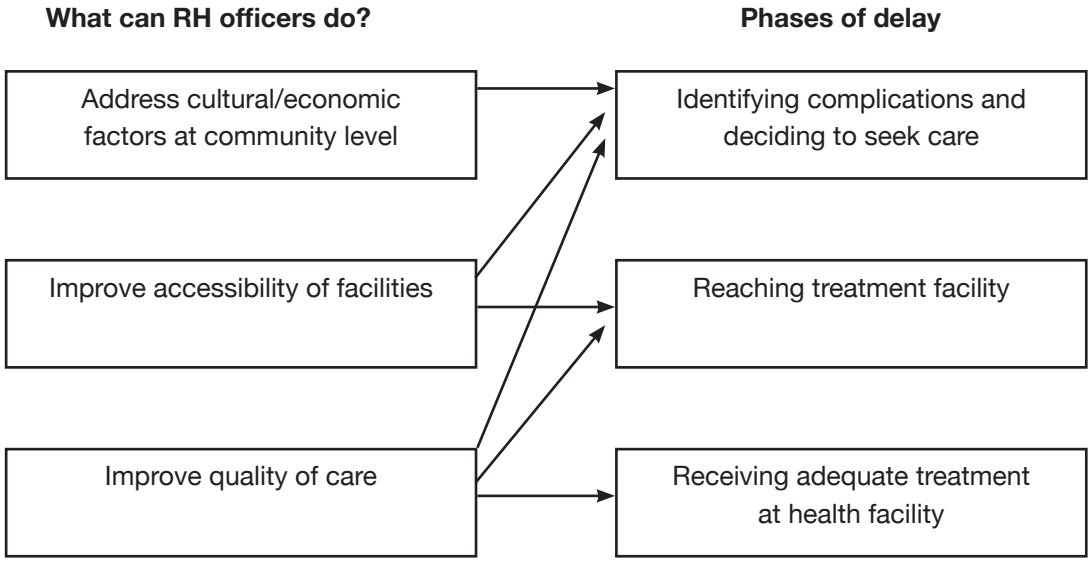
1. **Delay at the community level** in identifying complications and deciding to seek care.

2. **Delay in reaching a treatment facility** (inability to get transport, poor road conditions, insecurity, check points, curfews, etc.).

3. **Delay in receiving adequate treatment at the facility** (absence of staff, lack of drugs or other materials, high costs of treatment, need for down payment prior to receiving treatment, etc.).

Adapted from: *The Design and Evaluation of Maternal Mortality Programs,* Center for Population and Family Health, School of Public Health, Columbia University. 1997.

### Figure 7: Addressing the Three Delays




Adapted from: *The Design and Evaluation of Maternal Mortality Programs,* Center for Population and Family Health, School of Public Health, Columbia University. 1997.

providers, health centre and the hospital.

## 3.3 Antenatal care

An ideal antenatal care package consists of four antenatal visits for uncomplicated pregnancies, with the first visit early in pregnancy, the second from 24-28 weeks, the third at 32 weeks, and the fourth around 36 weeks. This number of recommended visits may vary based on national policies.

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;
- manage women who require special care during delivery, such as women who have had a previous caesarean section or female genital mutilation (refer to 3.6 Special issues).

For an overview of antenatal care interventions see the table in Annex 1.

**Prevention and treatment of malaria**

Malaria is the cause of 2-15% of anaemia 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:

- Encourage all pregnant women to sleep under an insecticide-treated bed nets (ITN) from as early in pregnancy as possible and to 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 (IPT) in areas of stable falciparum malaria transmission. Give all pregnant women at least two doses of sulfadoxine-pyrimethamine as soon as possible after the first foetal movement. Give the doses at an interval of at least one month apart.
- 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.

Assess any pregnant woman with anaemia and/or fever who has been exposed to malaria and treat her for malaria according to country guidelines.

**Screening for syphilis**

All pregnant women have to be screened for syphilis at the first antenatal visit. Syphilis contributes to maternal morbidity and negative pregnancy outcome. Every year, maternal syphilis causes half million stillbirths and miscarriages and is responsible for at least half a million

### Box 29: Syphilis Testing

In most countries, the rapid plasma reagin (RPR) test is used to screen for syphilis. RPR is difficult to use in many humanitarian settings, because it requires refrigeration, electricity and skilled laboratory staff. Rapid diagnostic tests (RDT) for syphilis have become commercially available in the last few years. 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. For more information on RDTs, see Chapter 9: Sexually Transmitted Infections.

* Malaria prevention and treatment, Integrated management of pregnancy and childbirth (IMPAC). Standards for Maternal and Neonatal Care 1.7. WHO 2006. www.who.int/making_pregnancy_safer/publications/Standards1.7N.pdf.

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 screening tests for syphilis are now available with results immediately available so that women testing positive can be treated without delay at the point of care.

**Screening for HIV and prevention of maternal-to-child transmission (PMTCT)** *

An estimated 430 000 children were newly infected with HIV in 2008, over 90% of them through mother-to-child transmission (MTCT). Without treatment, about half of these infected children will die before their second birthday. Without intervention, the risk of mother to child transmission ranges from 20% to 45%. With specific interventions, the risk of MTCT can be reduced to less than 2% in non-breastfeeding populations, and to 5% or less in breastfeeding populations.

Key recommendations and principles of PMTCT:

1. Offer all pregnant women voluntary HIV counselling and testing.
2. Start lifelong antiretroviral therapy (ART) for all pregnant HIV positive women with severe or advanced clinical disease, or with a CD4 count at or below 350 cells/mm3, regardless of symptoms
   - Pregnant women in need of ART for their own health should receive ART.
   - CD4 testing is critical for determining ART eligibility and should be widely available.
3. For women not eligible for ART, provide combination ARV prophylaxis (with either AZT or triple ARV prophylaxis) beginning in 2nd trimester and linked with postpartum prophylaxis.
4. In settings where breastfeeding is the preferred infant feeding option, provide prophylaxis to either the mother or infant during breastfeeding (see 3.4).

For more information on PMTCT, see Chapter 10 HIV.

**Disease prevention and health promotion**

In addition to the above, preventive measures also include tetanus immunization and presumptive treatment of hookworm.

Health education and promotion aim to:

- increase healthy self-care including adequate nutrition, avoidance of potentially harmful substances, hygiene to prevent infection, adequate rest and activity, prevention of STIs/HIV, malaria, and anemia;
- promote breastfeeding and preparation for breastfeeding;
- support care-seeking behavior, including recognition of danger signs and where to go for help;
- promote postpartum family planning or birth spacing, and newborn care (including nutrition, cord care, and immunization).

**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, vitamin A 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 1000 to 1200 kcal if provided as a take-home ration. Pregnant women must receive daily supplements of iron (60 mg/day) and folic acid (400 µg/day). Lactating women must receive vitamin A supplements

* From: *PMTCT strategic vision 2010–2015: preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals.* WHO 2010. www.who.int/hiv/pub/mtct/strategic_vision.pdf.

(400 000 IU in 2 doses of 200 000 IU with an interval of at least 24 hours within six weeks after delivery). Promote exclusive breastfeeding during the first 6 months and continued breastfeeding up to two years and beyond (see 3.4).

**Birth preparedness**

Antenatal care gives the opportunity to the woman and her health-care provider 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 (transport, place of referral, emergency funds). As most complications during labour 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.

**Recording of clinical data**

All clinical findings and treatments provided during antenatal care must be recorded, preferably on a record that stays with the woman. Good record-keeping is essential to facilitate appropriate decision-making and interventions.

## 3.4 Childbirth care

***The first few minutes after birth are critical for both the mother and newborn.***

Childbirth includes labour, delivery and the immediate postpartum period. Childbirth should take place in a health facility that ensures privacy, secure, safe and equipped with the necessary supplies, drugs, personnel, and which has access to transport to and communication with referral hospitals for obstetric and newborn emergencies. RH officers must ensure that all health-care 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 standard precautions must be maintained.

**Partograph**

The partograph must be used for each birth for close monitoring of labor progress, maternal and fetal conditions, and as decision-making tool for further intervention of referral (see Annex 2).

**Prevention of postpartum haemorrhage**

One of the leading causes of maternal mortality is postpartum hemorrhage. Active management of the third stage of labor (AMTSL) reduces the risk of retained placenta and postpartum hemorrhage. Skilled attendants must offer AMTSL to all women. It consists of:

1. administration of a uterotonic drug, preferably oxytocin to the woman within one minute of the birth of the baby;
2. controlled traction of the umbilical cord;
3. external massage of the uterus following delivery of the placenta.

Oxytocin is the recommended uterotonic for the prevention and treatment of atonic postpartum haemorrhage. However, in some settings it may not be possible to offer the full package of interventions for AMTSL because of absence of skilled staff, difficulties in ensuring safe injection practices and/or lack of refrigeration, all of which prevent the use of oxytocin. In these settings, the use of misoprostol is recommended. Health workers who administer misoprostol must be trained in avoiding administration before birth, correct use (misoprostol 600 micrograms orally immediately after the birth of the baby), and identifying and managing side-effects. In such cases no active intervention to deliver the placenta should be carried out. [*]

[*] WHO Statement regarding the use of misoprostol for postpartum haemorrhage prevention and treatment. WHO. 2009. www.who.int/reproductivehealth/publications/maternal_perinatal_health/misoprostol/en/.

| Table 17: Signal Functions for EmOC and Newborn Care | |
|---|---|
| **Basic Emergency Obstetric and Newborn Care (BEmOC)** | **Comprehensive Emergency Obstetric and Newborn Care (CEmOC)** |
| 1. Administer parenteral antibiotics | Perform signal functions 1–7, plus: |
| 2. Administer uterotonic drugs (i.e., parenteral oxytocin) | 8. Perform surgery (e.g. caesarean section) |
| 3. Administer parenteral anticonvulsants for preeclampsia and eclampsia (i.e., magnesium sulfate). | 9. Perform blood transfusion |
| 4. Manually remove the placenta | |
| 5. Remove retained products (e.g. manual vacuum extraction, dilation and curettage) | |
| 6. Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) | |
| 7. Perform basic neonatal resuscitation (e.g., with bag and mask) | |
| A BEmOC facility is one in which all functions 1–7 are performed.<br><br>A CEmOC facility is one in which all functions 1–9 are preformed. | |

From: *Monitoring emergency obstetric care, a handbook.* WHO/UNFPA/UNICEF/AMDD. WHO. 2009.

**Emergency obstetrics and newborn care**

In addition to essential care during childbirth care for normal childbirth, basic emergency obstetric care (BEmOC) and newborn care must be provided at the health centre level to address the main complications of childbirth, including newborn problems, or stabilize the woman before referral to a hospital. Ensure health providers are trained in emergency obstetric and newborn care procedures. Publicly display protocols and make relevant medicines, equipment and supplies available in all health centers. As with maternal emergencies, neonatal emergencies cannot always be predicted. For example, it is possible that the baby will not breathe and therefore staff must be prepared for neonatal resuscitation at every birth. Furthermore, maternal complications can cause significant neonatal compromise so that staff should prepare accordingly prior to the birth.

"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. Table 17 describes the signal functions in relation to BEmOC and CEmOC services. Some critical services are not mentioned but included within these signal functions. For example, carrying out caesarean sections implies that anesthesia is provided.

**Initial newborn care**

Neonatal deaths are up to seven times more frequent than maternal deaths. The three main causes of neonatal mortality are birth asphyxia, infections and complications of prematurity and low birth weight (LBW). These conditions are preventable and can be managed if women have access to EmOC and newborn care. Staff must be trained to recognize neonatal emergencies and refer to higher levels of care if needed.

Initial care of normal babies includes:

- Keep the baby dry and warm, and ensure skin-to-skin contact with mother.
- Encourage breastfeeding, within one hour of birth if baby and mother are ready.
- Monitor closely for umbilical bleeding, breathing difficulty, pallor and cyanosis.
- Provide eye care to prevent ophthalmia neonatorum.
- Provide immunization (Hepatitis B and/or BCG according to national protocol).

Prevention and management of the main causes of neonatal mortality include:

- **Birth asphyxia:** 5-10% of all newborns need some type of resuscitation at birth. Newborn resuscitation consists of a range of interventions: from simple, such as keeping the baby dry and warm, stimulation, positioning and clearing airway (suction), to more complex such as ventilation (bag-and-mask resuscitation). All newborns must be closely monitored following resuscitation.
- **Infections:** mainly sepsis, pneumonia, tetanus, and diarrhea. Preventive measures include implementing infection prevention practices during childbirth, tetanus toxoid immunization during pregnancy, proper cord care, keeping the baby warm and early and exclusive breastfeeding.
- **LBW/preterm birth:** 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 or skin-to-skin care, keeping babies warm, immediate and exclusive breastfeeding, feeding assistance, prevention of infection and early identification and appropriate treatment of infections and complications.

## 3.5 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. 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 further observation or treatment. Inform families to know the danger signs for postpartum mothers and newborns in order to seek care early if needed.

The postpartum visit provides an occasion to assess and discuss hygiene, breastfeeding and appropriate methods and timing of family planning (see Chapter 4: Adolescent Reproductive Health). Ensure health providers support early and exclusive breastfeeding, and discuss appropriate nutrition with the mother. Iron and folate tablets must be continued and Vitamin A and iodised oil or salt provided when necessary. The postpartum visit also provides an opportunity to weigh the newborn and discuss his or her care. Newborns must be referred to the under-five clinic for immunisations, growth monitoring and other well-child services.

**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 water and fuel. In these situations breast milk may be the only safe and sustainable source of food for infants. The warmth and care provided during breastfeeding is crucial to both mothers and children. Since breastfeeding is also an important traditional activity for women, it can help uprooted women preserve a sense of their self-worth. Therefore, it is important to initiate breastfeeding within one hour of birth, promote exclusive breastfeeding, encourage frequent, on-demand feeding (including night feeds) with no

restrictions on the length or frequency of feeds. On-demand breastfeeding during the first six months also provides contraceptive protection, provided menses has not returned and no other food is given to the baby (see Chapter 5: Family Planning).

Support women who are HIV-positive to make an informed decision about infant feeding. Ensure women testing positive are counselled and have access to AIDS care or ART prophylaxis (PMTCT) and the baby is treated after birth (see 3.4). In settings where replacement feeding (with breast milk substitutes) carries very significant risks of illness, malnutrition and death, infant health outcomes will be better if a mother living with HIV breastfeeds her infant.

Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first six months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast-milk can be provided* (see Chapter 10: HIV for more information).

## 3.6 Special issues

**Safe abortion and post-abortion care**

For information on safe abortion and post-abortion care, please refer to Chapter 7: Comprehensive Abortion Care.

**Obstetric fistula**

It is estimated that more than 2 million women suffer from untreated obstetric fistula and at least 50 000 – 100 000 new women are affected each year.** The vast majority of fistula cases are caused by prolonged or obstructed labour (one of the leading direct causes of maternal mortality and morbidity).

RH officers must ensure that national fistula programmes reach refugee and IDP 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 and improving access to emergency obstetric care — especially caesarean section. All components must be incorporated into fistula campaigns and programmes.

**Female Genital Mutilation (FGM)**

FGM-associated complications during pregnancy can be identified through history taking and pelvic examination during antenatal care (ANC). Where Type III FGM*** is common, the vulval area should be routinely inspected at the first ANC visit. Opening up of the infibulation is performed during the second trimester, after careful counselling of the woman and her partner. Once the infibulation has been opened up, episiotomy should only be performed if necessary during labour.

When a woman with an unopened Type III FGM gives birth, the formation of rigid scar tissue around the vaginal opening is likely to lead to delay in the second stage of labour, which may endanger both the woman and the baby. An anterior episiotomy, cutting the scarred infibulations, possibly extended into lateral episiotomies, may be needed to allow for safe delivery. Alternatively the baby may need to be delivered by caesar-

* *Infant feeding in the context of HIV. Key Messages.* WHO. 2009. www.who.int/hiv/pub/paediatric/advice/en/.

** *Obstetric Fistula: Guiding principles for clinical management and programme development.* WHO, 2005. www.who.int/reproductivehealth/publications/maternal_perinatal_health/9241593679/en/.

*** Type III FGM: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Approximately 15% of women and girls who are subjected to FGM undergo this type.

ean section. 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 counselling to understand and accept the changes after deinfibulation. For more information on FGM, see Chapter 8 on Gender-based Violence.

## 4 Human rights and legal considerations

The rights to safe pregnancy and to survive pregnancy are included in the international human rights *to life, to health and to be free from discrimination,* and their importance is recognized in the Millennium Development Goals (MDGs).

The fulfilment of other human rights, such as the right to adequate food, shelter, clean water, privacy, information and education, are also key to ensuring the survival and health of mother and child.

The protection and fulfilment of human rights related to maternal health include:

- taking all necessary measures to reduce maternal mortality among all mothers, including adolescents;
- ensuring access to antenatal, delivery and postpartum care, including emergency obstetric and newborn care for all women, including adolescents, poor women, women living in rural areas;
- reducing mother-to-child transmission of HIV through the provision of appropriate antenatal and perinatal care, including access to ARV medication;
- registering newborns immediately after birth;
- eliminating traditional practices harmful to women and newborns, such as FGM, dietary restrictions of pregnant women, preferential feeding and/or care of male children and early and forced marriage and pregnancy. Early marriage can have a negative impact on maternal mortality and morbidity, including an increased risk of obstetric fistula. Prevention of early marriage includes ensuring primary school enrolment for girls and ensuring that married and pregnant girls are not forced to leave school;
- eliminating discriminatory employment practices relating to pregnancy. For example, requiring a pregnancy test before employment is a violation of the right to privacy. Special protection relating to employment should be accorded to mothers for a reasonable period before and after childbirth and working mothers should be accorded leave with appropriate pay and/or social security benefits.

### 4.1 Challenges and opportunities

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:

- Social norms may prevent women from leaving their homes to go to a health facility for MNH services, including safe delivery.
- Laws on age of marriage may be different for boys and girls and girls may therefore not be adequately protected from early and/or forced marriage.
- Certain groups of people in a humanitarian setting (e.g. refugees and IDPs) may not be able to access EmOC and newborn care services through government-sponsored programmes.

Such norms, laws and practices can be in conflict with internationally accepted human rights principles. As a RH manager or service provider you may find yourself facing such dilemmas. You must be aware of your agency's/organization's position on these RH issues and include it as part of your analysis of the situation and possible next steps. When faced with a difficult situation

you should first and foremost give priority to the client's safety and health, and your own safety and that of colleagues. Then, you may wish to:

- talk to your supervisor;
- discuss options with your client;
- find out whether your agency is engaged in advocacy on the issue and how you can contribute;
- explore linkages with and referrals to local organizations that might be able to help your client further;
- while respecting the confidentiality of the client, identify with colleagues and other RH providers how to avoid such situations/ handle them in the future;
- raise these concerns in health coordination meetings.

## 5 Monitoring

***Investigate every maternal and perinatal death.***

Death reviews and near-miss reviews are critical components of a maternal health programme for reflective learning; to promote and monitor change in practice; and to advocate for measures to prevent adverse complications and deaths. There are several approaches recommended to conduct maternal death review and near-miss review, such as verbal autopsies and surveys of severe morbidity. Starting with a no-name/no-blame assessment of preventable factors associated with maternal deaths, stillbirths and neonatal deaths in facilities will provide information on how to improve programmes. (For an example of a Maternal Death Review Form, see Annex 4 in Chapter 3: Assessment, Monitoring and Evaluation).

The following indicators can be used to monitor MNH programmes:

1. Percentage of pregnant women who had at least four antenatal visits during pregnancy.

2. Availability of emergency obstetric care: basic and comprehensive care facilities:

3. Proportion of all births in emergency obstetric care facilities.

4. Meeting the need for emergency obstetric care: proportion of women with major direct obstetric complications who are treated in such facilities.

5. Caesarean sections as a proportion of all births.

6. Direct obstetric case fatality rate.

For more information on monitoring see Chapter 3: Assessment, Monitoring and Evaluation.

## 6 Further reading

• Integrated Management of Pregnancy and Childbirth (IMPAC)*: Pregnancy, Childbirth, Post partum and Newborn Care: A guide for essential practice.* WHO. 2006. www.who.int/making_pregnancy_safer/documents/924159084x/en/index.html.

• *Integrated Management of Pregnancy and Childbirth (IMPAC): Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors.* WHO. 2005. www.who.int/making_pregnancy_safer/documents/9241545879/en/index.html.

• *Integrated Management of Pregnancy and Childbirth (IMPAC): Managing Newborn Problems: A guide for doctors, nurses and midwives.* WHO. 2003. www.who.int/making_pregnancy_safer/documents/9241546220/en/index.html.

• *Monitoring emergency obstetric care, a handbook.* WHO/UNFPA/UNICEF/AMDD. WHO. 2009. www.who.int/reproductivehealth/publications/monitoring/9789241547734/en/index.html.

• *Cochrane reviews*. www.cochrane.org/reviews.

## Annexes

Annex 1: WHO Recommended Interventions for Improving Maternal and Newborn Health

Annex 2: Partograph

## Annex 1: WHO Recommended Interventions for Improving Maternal and Newborn Health

**Table 18: Care in Pregnancy, Childbirth and Postpartum Period for Mother and Newborn Infant**

| | Routine care (offered to all women and babies) | Additional care (for women and babies with moderately severe diseases and complications) | Specialized obstetrical and neonatal care (for women and babies with severe diseases and complications) |
|---|---|---|---|
| **Pregnancy care, 4 visits**<br><br>*Essential* | • Confirmation of pregnancy<br>• Monitoring of progress of pregnancy and assessment of maternal and foetal well-being<br>• Detection of problems complicating pregnancy (e.g. anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy)<br>• Respond to other reported complaints<br>• Tetanus immunization, anaemia prevention and control (iron and folic acid supplementation)<br>• Information and counselling on self-care at home, nutrition, safe sex, breastfeeding, family planning, healthy lifestyle<br>• Birth and emergency planning, advice on danger signs and emergency preparedness<br>• Recording and reporting<br>• Syphilis testing | • Treatment of mild to moderate pregnancy complications<br>‣ mild to moderate anaemia<br>‣ urinary tract infection<br>‣ vaginal infection<br>• Postabortion care and family planning<br>• Pre-referral treatment of severe complications<br>‣ pre-eclampsia/eclampsia<br>‣ bleeding<br>‣ infection<br>‣ complicated abortion<br>• Support for women with special needs (e.g. adolescents, women living with violence)<br>• Treatment of syphilis (woman and her partner) | • Treatment of severe pregnancy complications<br>‣ anaemia<br>‣ severe pre-eclampsia/eclampsia<br>‣ bleeding<br>‣ infection<br>‣ other medical complications<br>• Treatment of abortion complications |
| **Situational** | • HIV testing and counselling<br>• Antimalarial intermittent preventive treatment (IPT) and promotion of insecticide-treated nets (ITN)<br>• Deworming<br>• Assessment of female genital mutilation (FGM) | • Prevention of mother to child transmission of HIV (PMTCT):<br>‣ antiretroviral treatment (ART)<br>‣ infant feeding counselling<br>‣ mode of delivery advice<br>• Treatment of mild to moderate opportunistic infections<br>• Treatment of uncomplicated malaria | • Treatment of severe HIV infection<br><br>• Treatment of complicated malaria |

| Table 18: Care in Pregnancy, Childbirth and Postpartum Period for Mother and Newborn Infant | | | |
|---|---|---|---|
| **Childbirth care (labour, delivery, and immediate postpartum)**<br><br>*Essential* | • Care during labour and delivery<br>▸ Diagnosis of labour<br>▸ Monitoring progress of labour, maternal and foetal well-being with partograph<br>▸ Providing supportive care and pain relief<br>▸ Detection of problems and complications (e.g. malpresentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection)<br>▸ Delivery and immediate care of the newborn baby, initiation of breastfeeding<br>▸ Newborn resuscitation<br>▸ Active management of third stage of labour<br>• Immediate postpartum care of mother<br>▸ Monitoring and assessment of maternal well being, prevention and detection of complications (e.g. hypertension, infections, bleeding, anaemia)<br>▸ Treatment of moderate posthaemorrhagic anaemia<br>▸ Information and counselling on home self care, nutrition, safe sex, breast care and family planning<br>▸ Advice on danger signs, emergency preparedness and follow-up<br>• Recording and reporting | Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction; breech presentation, episiotomy, repair of genital tears, manual removal of placenta)<br>• Pre-referral management of serious complications (e.g. obstructed labour, foetal distress, preterm labour, severe peri- and postpartum haemorrhage)<br>• Emergency management of complications if birth imminent<br>• Support for the family if maternal death | • Treatment of severe complications in childbirth and in the immediate postpartum period, including caesarean section, blood transfusion and hysterectomy:<br>▸ obstructed labour<br>▸ malpresentations<br>▸ eclampsia<br>▸ severe infection<br>▸ bleeding<br>• Induction and augmentation of labour |
| *Situational* | • Vitamin A administration | • PMTCT by mode of delivery, guidance and support for chosen infant feeding option | • Management of complications related to FGM |
| **Postpartum maternal care (up to 6 weeks)**<br><br>*Essential* | • Assessment of maternal well-being<br>• Prevention and detection of complications (e.g. infections, bleeding, anaemia) | • Treatment of some problems (e.g. mild to moderate anaemia, mild puerperal depression) | • Treatment of all complications<br>▸ severe anaemia<br>▸ severe postpartum bleeding |

| Table 18: Care in Pregnancy, Childbirth and Postpartum Period for Mother and Newborn Infant | | | |
|---|---|---|---|
| | • Anaemia prevention and control (iron and folic acid supplementation)<br>• Information and counselling on nutrition, safe sex, family planning and provision of some contraceptive methods<br>• Advice on danger signs, emergency preparedness and follow-up<br>• Provision of contraceptive methods<br>• Promotion of ITN use | • Pre-referral treatment of some problems (e.g. severe postpartum bleeding, puerperal sepsis) | ▸ severe postpartum infections<br>▸ severe postpartum depression<br>• Female sterilization |
| *Situational* | • Promotion of ITN use | • Treatment of uncomplicated malaria | • Treatment of complicated malaria |
| **Newborn care (birth and immediate postnatal)**<br><br>*Essential* | • Promotion, protection and support for breastfeeding<br>• Monitoring and assessment of well-being, detection of complications (breathing, infections, prematurity, low birthweight, injury, malformation)<br>• Infection prevention and control, rooming-in<br>• Eye care<br>• Information and counselling on home care, breastfeeding, hygiene<br>• Advice on danger signs, emergency preparedness and follow-up<br>• Immunization according to the national guidelines (BCG, HepB, OPV-0) | • Care if moderately preterm, low birth weight or twin: support for breastfeeding, warmth, frequent assessment of well-being and detection of complications e.g. feeding difficulty, jaundice, other perinatal problems<br>• Kangaroo Mother Care (KMC) follow-up<br>• Treatment of mild to moderate:<br>▸ local infections (cord, skin, eye, thrush)<br>▸ birth injuries<br>• Pre-referral management of infants with severe problems:<br>▸ very preterm babies and/or birth weight very low<br>▸ severe complications<br>▸ malformations<br>• Supporting mother if perinatal death | • Management of severe newborn problems - general care for the sick newborn and management of specific problems:<br>▸ preterm birth<br>▸ breathing difficulty<br>▸ sepsis<br>▸ severe birth trauma and asphyxia<br>▸ severe jaundice<br>▸ KMC<br>• Management of correctable malformations |
| *Situational* | • Promotion of sleeping under ITN | • Presumptive treatment of congenital syphilis<br>• Prevention of mother-to-child transmission of HIV by ART<br>• Support for infant feeding of maternal choice | • Treatment of:<br>▸ congenital syphilis<br>▸ neonatal tetanus |

| Table 18: Care in Pregnancy, Childbirth and Postpartum Period for Mother and Newborn Infant | | | |
|---|---|---|---|
| **Postnatal newborn care (visit from/at home)**<br><br>*Essential* | • Assessment of infant's well-being and breastfeeding<br>• Detection of complications and responding to maternal concerns<br>• Information and counselling on home care<br>• Additional follow-up visits for high risk babies (e.g. preterm, after severe problems, on replacement feeding) | • Management of:<br>▸ minor to moderate problems<br>▸ feeding difficulties<br>• Pre-referral management of severe problems:<br>▸ convulsions<br>▸ inability to feed<br>• Supporting the family if perinatal death | • Management of severe newborn problems:<br>▸ sepsis<br>▸ other infections<br>▸ jaundice<br>▸ failure to thrive |

## Annex 2: Partograph



PARTOGRAPH

USE THIS FORM FOR MONITORING ACTIVE LABOUR

CERVICAL DILATATION

10 cm
9 cm
8 cm
7 cm
6 cm
5 cm
4 cm

| FINDINGS | TIME | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hours in active labour** | | | | | | | | | | | | | |
| Hours since ruptured membranes | | | | | | | | | | | | | |
| Rapid assessment B3-B7 | | | | | | | | | | | | | |
| Vaginal bleeding (0 + ++) | | | | | | | | | | | | | |
| Amniotic fluid (meconium stained) | | | | | | | | | | | | | |
| Contractions in 10 minutes | | | | | | | | | | | | | |
| Fetal heart rate (beats/minute) | | | | | | | | | | | | | |
| Urine voided | | | | | | | | | | | | | |
| T (axillary) | | | | | | | | | | | | | |
| Pulse (beats/minute) | | | | | | | | | | | | | |
| Blood pressure (systolic/diastolic) | | | | | | | | | | | | | |
| Cervical dilatation (cm) | | | | | | | | | | | | | |
| Delivery of placenta (time) | | | | | | | | | | | | | |
| Oxytocin (time/given) | | | | | | | | | | | | | |
| Problem-note onset/describe below | | | | | | | | | | | | | |

Sample form to be adapted. Revised on 13 June 2003.

7

CHAPTER SEVEN

# Comprehensive Abortion Care

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## 1 Introduction

The World Health Organization (WHO) estimates that 42 million pregnancies end annually in induced abortion; 20 million of these are estimated to be unsafe — 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 families and entire communities. Globally, unsafe abortion accounts for 13% of maternal deaths, 99% of which occur in the developing world. Making pregnancy safer includes the provision of or referral for safe abortion services to the full extent allowed by the applicable law 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 and legal abortion services:

- Women and adolescents may not be able to continue with their contraceptive method because they lost it during displacement.
- Families may want to delay childbearing until their security and livelihoods are assured, but not have access to contraceptives due to disruption of health services.
- Rape and other forms of sexual violence are increasingly documented in conflict settings.

To help governments, planners and service providers implement their commitments

# Comprehensive Abortion Care

to women's health and rights, the WHO issued technical guidance in 2003 to strengthen the capacity of health systems to provide safe abortion care (SAC) and postabortion care (PAC).

PAC is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion and comprises five elements:

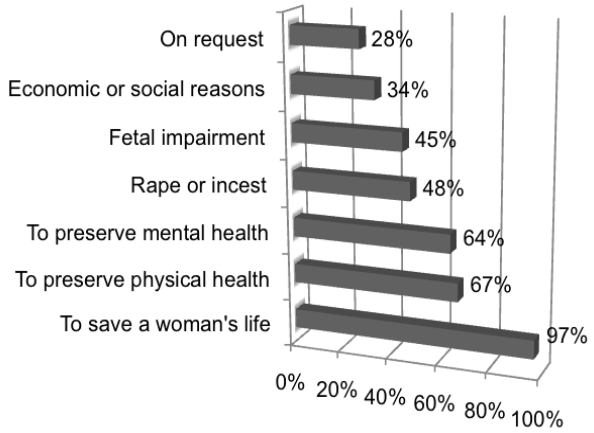
- **Treatment** of incomplete and unsafe abortion and complications that are potentially life-threatening.
- **Counselling** to identify and respond to women's emotional and physical health needs and other concerns.
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing.
- **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 prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion) and ensuring that health services reflect and meet community expectations and need.

Comprehensive abortion care (CAC) includes all of the elements of PAC as well as safe induced abortion for all legal indications (i.e. as allowed by national law). These elements all contribute to reductions in maternal mortality.

A range of technological options exist to help women prevent or cope with an unwanted pregnancy, including emergency contraception, vacuum aspiration and medical abortion. Also, an increasing number of countries have reformed their abortion laws to expand the legal indications for abortion, including rape and incest.

## 2 Objectives

**Grounds on which abortion is permitted — percentage of countries (n=195)**




n=195: 195 countries were included in the study

From: *World Abortion Policies*. New York, UNPD. 2007. www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007_WallChart.pdf

The objectives of this chapter are to provide RH officers, programme managers and service providers with:

- programming information on safe and legal abortion services and referral to

such services to the extent allowed by the law;
- basic clinical information to guide service delivery;
- the framework to obtain accurate information and understand the administrative and regulatory boundaries related to abortion in the country where they are working;
- an understanding of the social, cultural and religious norms surrounding safe abortion services;
- the tools to educate communities on their rights.

## 3 Programming

The following sections outline basic guidelines for ensuring the provision of high-quality comprehensive abortion services.

The addition of safe induced abortion services for all legal indications to the elements of the PAC model results in a comprehensive approach that supports women in exercising their sexual and reproductive rights. Ideally, these services are provided as an integrated, comprehensive package.

Comprehensive abortion care services need not be dependent on the availability of obstetricians/gynaecologists or surgeons. With appropriate training and support, nurses, midwives and other midlevel health workers can safely provide first-line safe abortion and PAC services, even in outpatient settings. (See Table 19.)

### 3.1 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. However, even where abortion is legal, 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 others, pregnancy termination is available on request and on broad medical and social grounds. Virtually every country in the world allows safe and legal abortion in some circumstances.

RH officers, programme 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 on termination of pregnancy/availability and accessibility of safe abortion services? Pay particular attention to:
  - grounds on which abortion is allowed (e.g. therapeutic, fetal impairment, rape, incest, mental health, personal grounds);
  - time limit within which an abortion can be performed and whether there are situations in which the time limit can be waived;
  - availability of different abortion methods (e.g. surgical, such as electric or manual vacuum aspiration; medical, such as mifepristone and misoprostol) and distribution and provision of medicines for abortion and postabortion care;
  - counselling requirements;
  - settings where abortion can be performed and/or the level of provider who can perform an abortion or provide abortion methods;
  - provisions on the cost of an abortion;
  - regulations or expectations that require others (husbands, parents, guardians) to give permission for the procedure (third-party authorization);
  - mandatory reporting requirements;
  - requirements for health providers who object to performing abortions (conscientious objection) to refer to a colleague who will provide abortion services.
- Is there a law that prohibits/criminalizes abortion?
  - Is there any law and/or regulation concerning the provision of postabortion

| Table 19: Comprehensive Abortion Care | | | |
|---|---|---|---|
| | **Community level** | **Primary care level** | **Hospital level** |
| Education and information on prevention and consequences | ✓ | ✓ | ✓ |
| Recognition of abortion complications | ✓ | ✓ | ✓ |
| Transportation to safe abortion services and for management of complications of unsafe abortion | ✓ | ✓ | ✓ |
| Referrals for pregnancy, safe legal abortion care or postabortion care | ✓ | ✓ | ✓ |
| Referral of survivors of rape or incest to health and/or social services | ✓ | ✓ | ✓ |
| Vacuum aspiration or medical treatment for incomplete abortion or safe abortion up to 12 weeks of pregnancy | | ✓ | ✓ |
| Contraceptive methods, including emergency contraception and postabortion contraception | | ✓ | ✓ |
| Emergency treatments, such as IV fluid replacement, oxytocics, haematocrit/haemoglobin testing and antibiotics 24 hours/day | | ✓ | ✓ |
| Referral and transport of women with the most severe abortion complications (septicaemia, peritonitis, renal failure) | | ✓ | ✓ |
| Second trimester abortion, laparotomy, safe blood transfusion, voluntary sterilization, screening for hepatitis, syphilis and HIV | | | ✓ |
| Management of severe abortion complications | | | ✓ |

care, including emergency care after an unsafeabortion? Pay particular attention to referral and reporting requirements.
- Is there a law/regulation/policy that states that at least information on safe/unsafe abortion services and postabortion care must be provided?

In addition to the social and legal context, also consider:

- epidemiological context
- staff training, qualifications and capacity
- supplies and equipment
- health facility condition
- emergency transport system
- the capacity of the referral facility.

## 3.2 Counselling and voluntary 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 and consent for treatment. High-quality counselling provides the woman with emotional support and contributes to the effectiveness of the procedure. Effective counselling is structured completely around the woman's needs and concerns and occurs before, during and after the procedure.

Voluntary informed consent, obtained either by writing or verbally, 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, without pressure or coercion of any type. Service providers can document this by obtaining the woman's signature on a consent form. In some settings it may be more appropriate to confirm agreement verbally.

## 3.3 Clinical assessment

Service providers should conduct a complete clinical assessment, consisting of:

- a thorough reproductive health history (including history of sexual violence);
- a careful physical and pelvic examination (ultrasonography (US) and testing for pregnancy are not a precondition or minimum requirement for offering termination of pregnancy services. A pregnancy can be detected during a bimanual pelvic examination as early as 6 to 8 weeks);
- a psychosocial assessment.

Women presenting for treatment of incomplete abortion or abortion complications (postabortion 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 centre where she is seen. Her condition should be stabilized before she is transferred

### Ectopic Pregnancy

It is important to consider other potential life-threatening conditions that cause shock, including ectopic (tubal) pregnancy. An ectopic pregnancy can be life-threatening; treat the woman or transfer her as soon as possible to a referral hospital where the diagnosis can be confirmed and the appropriate treatment provided.

## 3.4 Infection prevention

As with any invasive 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 (see Chapter 2: MISP, paragraph 3.3.2, p. 37). Iatrogenic infection is prevented by following standard precautions, using aseptic techniques and ruling out or treating cervical infection before performing transcervical procedures.

All women undergoing uterine evacuation by vacuum aspiration should be given a prophylactic dose of antibiotics to reduce the risk of infection. The lack of prophylactic antibiotics, however, does not preclude the performance of vacuum aspiration. Routine antibiotics are not necessary or recommended for women who undergo uterine evacuation through medical methods. In this case, antibiotics should be reserved for cases where the woman exhibits signs and symptoms of infection.

## 3.5 Pain management

Medication should always be offered for pain management. The goal of a pain management plan is to help the woman remain as comfortable as possible. Vacuum aspiration should be conducted with local anaesthesia and/or oral analgesia (such as ibuprofen). General anaesthesia is rarely necessary and puts the woman at greater risk.

## 3.6 Uterine evacuation

**Induced abortion**

In the first trimester, the preferred methods of uterine evacuation for induced abortion are:

- Electric vacuum aspiration (EVA) or manual vacuum aspiration (MVA) through 12 completed weeks of pregnancy (12 weeks since the woman's last menstrual period (LMP))
  - Examine the products of conception after the procedure to exclude the possibility of ectopic or molar pregnancy or incomplete abortion.
- Medical methods through nine completed weeks of pregnancy
  - A combination of mifepristone followed by a prostaglandin such as misoprostol is preferred. 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. There is not sufficient evidence to recommend these regimens for abortion beyond nine completed weeks.

Women in middle- or late-second trimester should be referred to a hospital with surgical facilities for treatment.

### Medical methods for induced abortion up to 9 weeks since LMP

**Mifepristone and Misoprostol**

200 mg mifepristone orally, followed after 36 - 48 hrs by 800 µg misoprostol vaginally or sublingually

**Misoprostol alone**

can induce abortion in early pregnancy but repeated doses are needed, such as 800 µg misoprostol vaginally or sublingually repeated every 12 hours up to three doses. Misoprostol alone, however, is less effective than mifepristone and misoprostol combined and generally causes side-effects.

**Postabortion Care (PAC)**

Both vacuum aspiration and misoprostol are safe, effective and acceptable methods for

evacuation of the uterus for postabortion care.

Misoprostol reduces the cost of PAC services, as it does not require the immediate availability of sterilized equipment, operating theatres or skilled personnel. Misoprostol for the treatment of incomplete abortion is an important option in humanitarian settings where it is difficult to maintain MVA equipment and appropriately trained providers, and where referral for surgical uterine evacuation may be delayed.

**Dilatation and curettage (D&C)**

Also known as "sharp curettage" with metal instruments, D&C is no longer recommended except in cases where vacuum aspiration or medical methods are not available. Where D&C is currently practised, all possible efforts should be made to replace it with vacuum aspiration or medical methods to improve the safety and quality of care.

The use of misoprostol for obstetric indications is rapidly evolving. RH programme mangers and service providers should stay abreast of the evolving clinical and technical literature. (See Further Reading.)

The use of mifepristone and/or misoprostol for safe abortion and postabortion 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.

**Misoprostol for incomplete abortion up to 12 weeks since LMP**

600 microgram misoprostol orally (one dose) is effective and safe.

No published studies have investigated the use of misoprostol to treat women with septic abortion.

## 3.7 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. A booster injection of tetanus toxoid (TT) should be given to women who have been previously vaccinated. Tetanus immunoglobulin (TIG) and TT should be administered to women who have not been previously immunized or whose last dose was more than five years ago. If there is any uncertainty regarding the patient's vaccination history, both TIG and TT should be administered. If vaccine and immunoglobulin are given at the same time, use separate needles and syringes and different sites of administration. Patients should be advised to complete the vaccination schedule (second TT dose at four months, third TT dose at six months to one year).

## 3.8 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, but it is important to follow up all patients, as there is a small risk of infection or haemorrhage. 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 referral service.

## 3.9 Postprocedure counselling 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

**Table 20: Gestation Timing and Uterine Evacuation Options**

| | Completed weeks since last menstrual period | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| **Preferred methods for induced abortion** | | | | | | | | | | | | | | | | | | |
| **Vacuum aspiration** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Refer women in mid- or late-second trimester to a hospital with surgical and full emergency backup for treatment | | | | | | | | | |
| **Mifepristone and misoprostol** | ✓ | ✓ | ✓ | ✓ | ✓ | Under investigation | | | | | | | | | | | | |
| **Misoprostol alone** | ✓ | ✓ | ✓ | ✓ | ✓ | Under investigation | | | | | | | | | | | | |
| **Preferred methods for postabortion care (PAC)** | | | | | | | | | | | | | | | | | | |
| **Vacuum aspiration** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | Refer women with incomplete abortions in mid- or late-second trimester to a hospital with surgical and full emergency backup for treatment | | | | | | | | | |
| **Misoprostol alone** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |

Adapted from: *Safe abortion: technical and policy guidance for health systems*, WHO, Geneva 2003.

normal recovery and signs and symptoms of possible complications that require immediate attention. They should also provide detailed information about postabortion contraception and protection from sexually transmitted infections. A return visit should be scheduled for 10 to 14 days later.

**Postabortion contraception**

Lack of access to adequate family planning services is a major contributor to the problem of unsafe abortion. Conversely, unwanted pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective family planning services. Contraceptive acceptance and continuation rates are higher when offered at the site of initial treatment. Ensure that all staff providing PAC know how to counsel on and provide family planning methods.

At a minimum, all women receiving abortion care must understand that:

- ovulation can occur as early as 10 days after an abortion, resulting in pregnancy even before menses returns;
- contraception, including an IUD or hormonal methods, may be started immediately after uterine evacuation;
- sexual intercourse should be avoided for a few days after bleeding has stopped because of the risk of infection.

(Refer to Chapter 5: Family Planning for further details on family planning services.)

## 3.10 Integration of services

Service providers must identify other RH needs each woman may have and refer her or offer information on relevant services, such as management of reproductive tract infections (see Chapter 9: Sexually Transmitted Infections) or post-rape care (see Chapter 2: MISP and Chapter 8: Gender-based Violence).

## 4 Human rights and legal issues

A systematic lack of access by crisis-affected persons to comprehensive abortion care is a denial of their equal rights and protection as mandated under international human rights law. The following statement from the International Conference on Population and Development (ICPD) underpins the guidance given in this chapter:

"All Governments and relevant intergovernmental and nongovernmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancy must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling....[W]here abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion."

*Programme of Action of the ICPD, paragraph 8.25, Cairo, 1994,*

The respect, protection and fulfilment of human rights related to abortion include:

- taking positive steps to reduce maternal mortality, which can be caused by unsafe abortion;
- ensuring that States give information to help women prevent unintended pregnancies;
- making safe abortion services available (in circumstances where abortion is legal);
- removing punitive provisions for women who undergo abortion, because criminalizing abortion may lead women to seek unsafe procedures with subsequent risks to their life and health.

The following are circumstances in which human rights abuses occur:

- Forcing a woman to carry an unwanted or unviable pregnancy to term is considered degrading and causes mental suffering (especially in cases of rape or incest).
- Denying medical treatment to a woman suffering from complications of unsafe abortion unless she provides information on the person who performed the unsafe abortion constitutes cruel and degrading treatment.
- Laws that require service providers to report women who have had an abortion or needed treatment for unsafe abortion violate women's right to privacy.
- Lack of confidentiality in the health system or requirements for third party consent to the procedure may deter women or girls from seeking health services.
- Forcing women (of ethnic minorities or with disabilities) to undergo abortions is discriminatory.
- Forced pregnancy is a human rights violation and, in some situations, a war crime.

## 4.1 Challenges and opportunities

RH programme managers and service providers may face difficult decisions or dilemmas regarding abortion. They may find that their ability to provide comprehensive abortion care is restricted by national legislation, social or cultural norms or medical misconceptions.

For example, even where it is legally permitted, safe abortion may not be easily accessible; there may be additional requirements regarding consent and counselling, and countries often impose a limit on the period during which abortion may be performed. Other challenges may include judgmental or discouraging attitudes of health-care providers, insufficient service capacity to meet the demand or unevenly distributed or poor-quality services. Also, women themselves may be unaware of the availability of abortion services or their right to access them within the legal framework.

As an RH programme manager or service provider, you are likely to find yourself facing such challenges. You must be aware of your agency/organization position on these issues and include it as part of your analysis of the situation and possible next steps.

Train and equip all RH service providers to provide CAC information and services or refer to safe and legal abortion services within the framework of the law. It is essential that RH officers, programme managers and service providers understand clearly what is allowed under the law in the country where they are working. Efforts by policy-makers must address administrative and regulatory barriers to safe abortion and post-abortion care.

When faced with a difficult situation, your first priority must be the best interest of your client, focusing on her/his safety and health. It is also important to consider your own safety and the safety of your colleagues. Then, you may wish to:

- discuss options with your client (e.g. if you are unable to provide certain methods of abortion, you can counsel her where she can obtain services);
- explore linkages with and referrals to local organizations that might be able to help your client further;
- while respecting the confidentiality of your client, identify with colleagues and other RH providers how to avoid and manage such situations in the future;
- raise these concerns in health coordination meetings;
- talk to your supervisor.

## 5 Monitoring

Continuously monitor and evaluate safe abortion and PAC services. 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, provide feedback to staff and intervene to correct any problems identified.

For more information on monitoring see Chapter 3: Assessment, Monitoring and Evaluation.

## 6 Further reading

**Essential reading**

*Safe abortion: technical and policy guidance for health systems*. WHO, Geneva, 2003. http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf

*Managing complications in pregnancy and childbirth: a guide for midwives and doctors.* WHO, Geneva, 2003. http://www.who.int/reproductive-health/impac/index.html

**Additional reading**

Herrick J et al. *Woman-centered postabortion care (trainer's and reference manuals).* Ipas,

**Table 21: Indicators to Monitor Availability and Effectiveness of Safe Abortion and PAC Services**

| Name | Definition | Formula | Type | Data Source | Remarks |
|---|---|---|---|---|---|
| | | **Numerator and Denominator** | **Process, outcome or impact** | | |
| **Abortion services* performed with appropriate technology** | Proportion of abortion services* performed with appropriate technology (vacuum aspiration or medical methods) | Number of abortion services* performed with appropriate technology/total number of abortions x 100 | Outcome | Facility records | "Abortion services"* include treatment of abortion complications (resulting from both spontaneous or induced/ unsafe abortion) as well as provision of induced abortion procedures. |
| **Women accessing abortion services* who receive contraception prior to discharge from the facility** | Proportion of women receiving abortion services* who receive contraception prior to discharge from the facility | Number of women who received contraceptive services prior to discharge from the facility/number of women who were treated for abortion x 100 | Outcome | Facility records | **Recommendation:** At least 60% of all women receiving abortion services* will receive a contraceptive of their choice before discharge from the facility |
| **Extent to which induced abortions are being provided** | Proportion of women who receive abortion services* that receive induced procedures | Number of women receiving induced abortion procedures at facility in a given period/number of all women receiving abortion services* in facility in the same time period x 100 | Outcome | Health service records — but potential problems with underreporting (i.e. omission of cases not admitted to facilities) and misclassification | Over time, a shift toward a higher proportion of women receiving induced abortion as a part of all abortion services* in facility **Recommendation:** approaching 100% |

Chapel Hill, NC, 2004. http://www.ipas.org/Publications/Woman-centered_postabortion_care_Trainers_manual.aspx

Hyman A et al. *Woman-centered abortion care (trainer's manual).* Ipas. Chapel Hill, NC, 2005. http://www.ipas.org/Publications/Woman-centered_abortion_care_Trainers_manual.aspx

Misoprostol in Obstetrics and Gynecology. www.misoprostol.org

*Frequently asked clinical questions about medical abortion.* World Health Organization, 2006. http://www.who.int/reproductivehealth/publications/en/



8

CHAPTER EIGHT

# Gender-based Violence

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## 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.

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. Around the world, GBV has a greater impact on women and girls than on men and boys.

The term "gender-based violence" is often used interchangeably with the term "violence against women" and "sexual and gender-based violence". The term, "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, including sexual violence (SV), particularly when they are subjected to torture and/or detainment.

GBV includes:

- Sexual violence, including rape, sexual abuse, sexual exploitation and forced prostitution
- Domestic violence
- Forced and early marriage
- Harmful traditional practices such as female genital mutilation, honour crimes, widow inheritance
- Trafficking

# Gender-based Violence

**Box 30: Gender-based Violence in Humanitarian Settings***

- Approximately 50 000 to 64 000 internally displaced women in Sierra Leone reported experiencing sexual violence at the hands of armed combatants. And half of internally displaced women who had face-to-face contact with combatants reported experiencing sexual violence.
- Twenty-five percent of Azerbaijani women surveyed in 2000 by the U.S. Centers for Disease Control and Prevention acknowledged being forced to have sex; those at greatest risk were among Azerbaijan's internally displaced populations.
- According to a 1999 government survey, 37% of Sierra Leone's prostitutes were under age 15; of those, over 80% were unaccompanied or children displaced by the war.
- The majority of Tutsi women in Rwanda's 1994 genocide were exposed to some form of gender-based violence; of those, it is estimated that between 250,000 and 500,000 survived rape.
- It is estimated that between 20 000 and 50 000 women were raped during the war in Bosnia and Herzegovina in the early 1990s.
- In the aftermath of natural disasters, field reports of social impacts include abuse, as in this account of an Australian flood: "Human relations were laid bare and the strengths and weaknesses in relationships came more sharply into focus. Thus, socially isolated women became more isolated, domestic violence increased and the core of relationships with family, friends and spouses were exposed". Increased violence against women was also noted in reports from the Philippines after the Mount Pinatubo eruption; in Central and North America after Hurricane Mitch; and in several countries after the 2004 tsunami.

* *From:* Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. *Inter-agency Standing Committee (IASC), 2005.*

The nature and extent of specific types of GBV vary across cultures, countries and regions. Although GBV in humanitarian settings is underreported, it has been documented during humanitarian crises (see Box 30).

The consequences of GBV can result directly from violent acts or can be the result of long-term effects:

- The **physical consequences** range from relatively minor injuries to severe injuries leading to death or permanent disabilities; unintended pregnancies; unsafe and complicated abortion; adverse pregnancy outcomes, including miscarriage, low birth weight and fetal death; sexually transmitted infections, including HIV; pelvic inflammatory disease, infertility, chronic pain syn-

dromes; urinary tract infections.
- **Psychological consequences** include: anxiety disorders, 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.
- GBV also has a large impact on the **social health** of the individual and the community in terms of stigma, isolation and rejection (including by husbands and families); losses in women's income potential; interrupted education of adolescents; and homicide (e.g. honour killings or female infanticide).

## 2 Objectives

This chapter focuses on the responsibility of RH officer, programme staff and service providers in preventing and responding to health consequences related to GBV. The objectives of this chapter are to assist them to

- be aware of the different types of GBV;
- understand the multisectoral approach to prevention and response to GBV;
- support the integration of GBV prevention and response elements into the health sector/cluster.

## 3 Programming

Prevention of sexual violence and the provision of confidential clinical care for rape survivors is part of the Minimum Initial Service Package of Reproductive Health in Crises (see Chapter 2: MISP). As soon as the MISP is in place, RH officers and programme managers, in collaboration with other relevant sectors/clusters, must work to expand clinical and psychological care and social support for survivors of rape and other forms of GBV, as well as support initiatives to prevent GBV.

### 3.1 Coordination

To date, the **multisectoral programming model** forms the "best practice" for prevention of and response to GBV in humanitarian settings. Key characteristics of the multisectoral model include full engagement of the affected community, interdisciplinary and interorganizational 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.

Because of the importance of multisectoral collaboration in GBV programming, RH officers and programme 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 (see Further Reading).

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 multisectoral model, the responsibilities of the heath sector/cluster include: providing care of the health and psychological needs of survivors of rape, female genital mutilation (FGM) or other forms of GBV; collecting forensic evidence where appropriate; referring survivors for further health or psychosocial support; providing testimony in cases where a survivor chooses to pursue legal action; and raising awareness of GBV.

## 3.2 Needs assessment

Integrate GBV considerations into needs assessments for comprehensive RH service planning. Within the multisectoral framework, RH officers and programme 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.

At the programme level:

- international and local actors working on GBV;
- the existence of national, multisectoral 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);
- RH programme staff and health-care provider training needs;
- types and number of cases of GBV reported at health services.

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 a very small proportion of the actual number of incidents of GBV.

Any inquiry into SV 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, analysing and reporting on GBV information (see Box 31).

At the national level:

- national protocols related to GBV medical care and referral;
- national laws related to GBV: Types of GBV mentioned (for example, female genital mutilation/cutting, forced marriage, honour crimes, sexual assault, sexual abuse of children, forced prostitution);
- the legal definition of rape. The legal age of consent for sexual activity. Does it differ for boys and girls?
- national laws on termination of pregnancies resulting from sexual assault;
- mandatory reporting laws for cases of sexual abuse and sexual assault;
- cadres of health service providers authorized to collect forensic evidence and the range of forensic evidence admissible in courts of law;
- national plans/policies to eliminate GBV. What types of GBV does the plan target?

## 3.3 Reproductive health care for GBV survivors

RH officers and programme managers must en-

### Box 31: Safety, Ethical and Methodological Recommendations for Documenting and Sharing Information on GBV Cases Reported to RH 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.
- RH service providers caring for GBV survivors must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
- 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 which 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.

*Adapted from: WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies and Stop Rape Now. UN Action against Sexual Violence in Conflict. Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries, "Do's and Don't's".*

## Box 32: 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. (See also "sexual exploitation.")

**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. (See also "sexual abuse".)

**Domestic violence (also referred to as intimate partner violence)**
Domestic violence takes place between 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 mutilation**
Female genital mutilation 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 also referred to as "female circumcision" or "female genital cutting""

**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.

*From: Guidelines for GBV Interventions in humanitarian settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, Inter-agency Standing Committee (IASC), 2005 and GBV Tools Manual for Assessment and Programme Design, Monitoring and Evaluation in conflict-affected settings, RHRC Consortium, 2004*

sure that service provider are trained to provide competent, confidential and compassionate clinical care for survivors of GBV and that they have the supplies to do so.

For definitions of different types of GBV, see Box 32.

**Rape**

Rape is often underreported or not reported at all, including in humanitarian settings. However, RH service providers in all settings must be prepared to provide care to survivors of rape from the onset of the humanitarian response. Prevention of and response to sexual violence is a component of the MISP. For more information on clinical management of rape survivors, see Chapter 2: MISP, paragraph 3.2.3, p. 25.

**Domestic/intimate partner violence**

In a WHO study on women's health and domestic violence it was found that between 15% and 71% of women report physical or sexual violence by a husband or partner; between 4% and 12% of women reported being physically abused during pregnancy; trafficking of women and girls for forced labour and sex is widespread and often affects the most vulnerable; and up to one in five women and one in ten men report experiencing sexual abuse as children.*

RH providers can play a crucial role in detecting, referring and caring for women living with violence. Abused women often seek health care, even when they do not disclose the violent event. Thus, interventions by RH providers can potentially mitigate both the short- and long-term health effects of GBV on women and their families. In collaboration with health coordinators, ensure that:

- all clinic and reception staff are aware of GBV issues;
- 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.

Train all RH providers to recognize signs of domestic violence and how to respond to suspected or reported abuse, including:

- If abuse is suspected (if the provider sees unexplained bruises or other injuries), providers may probe for more information in a private, caring and nonjudgemental 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, especially if the abuser learns that the matter has been reported. Help her to assess her present situation: "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 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 if needed.

**Female genital mutilation/cutting**

An estimated 100 to 140 million girls and women have undergone some form of female genital mutilation (FGM) and 2 million girls are at risk of being subjected to the practice each year The majority of these girls and women live in sub-Saharan Africa, although some live

* Fact sheet N°239, Violence against women. WHO, November 2008. www.who.int/mediacentre/factsheets/fs239/en/print.html.

in the Middle East, Asia and other regions. RH officers and programme managers must be aware that FGM and health consequences related to FGM may be common among the population in the setting they work in.

FGM is classified as follows:

> **Type I:** Excision of the prepuce of the clitoris with or without excision of part or all of the clitoris.
> **Type II:** Excision of the clitoris with partial or total excision of the labia minora.
> **Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Approximately 15% of women and girls who are subjected to FGM undergo this type.
> **Type IV:** Unclassified. This type includes pricking, piercing or incision of the clitoris and/or labia, burning of the clitoris, scraping of the vaginal orifice or cutting of the vagina, and any other procedure performed on a woman's genitalia for non-medical reasons.

*Health consequences*

Girls and women undergoing the more severe forms of FGM are particularly likely to suffer serious and long-lasting complications. Some of the effects are immediate; others become apparent only years later. Documentation and studies are available on the nature of the physical complications, but there has been little study of the sexual or psychological effects of FGM or of the frequency with which complications occur. The mortality rate of girls and women undergoing FGM is unknown.

Immediate complications include: haemorrhage (one of the most common complications); shock; infections — including tetanus and HIV; urine retention; injury to neighbouring organs, such as the urethra, vagina or the rectum; fistulae.

Long-term complications include: bleeding after deinfibulation (opening up of the vagina to allow sexual intercourse of childbirth); menstrual difficulties; difficulty in passing urine; recurrent urinary tract infections; incontinence; chronic pelvic infections causing abortion or infertility; abscesses and dermoid cysts; increased risk of transmission of HIV and other sexually transmitted infections (STIs); reduced sexual sensitivity; and painful intercourse. Problems during pregnancy and childbirth are common in women who have undergone Type III FGM, because of the rigidity and obstruction of scar tissue. Prolonged or obstructed labour, neonatal asphyxia, maternal lacerations, haemorrhage, fistulae and infection may result.

The psychological trauma of the procedure may leave an emotional scar for life and reduced trust in care givers. The physical and psychological impact of FGM 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 FGM 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 FGM.

*Clinical care*

RH service providers must be able to interview and conduct a physical examination of women who have undergone FGM, recognize and provide appropriate information, counselling, support, treatment and/or referral for further management of the complications of FGM in a confidential, private and nonjudgemental manner.

In settings where Type III FGM is common, RH programme managers must ensure that RH

> The medicalization of FGM — 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.

service providers are trained in opening up an infibulation when indicated, or know when and where to refer for this procedure.

**Family planning** is as appropriate for girls and women with FGM as it is for any other client (see Chapter 5: Family Planning). Women who have undergone infibulation may have difficulties in using a method that has to be inserted vaginally, such as an intrauterine device (IUD), female condoms or vaginal rings. Since women with FGM of any type are often prone to infections of the genital tract, an IUD can be inserted only after careful consideration.

Ensure RH service providers who have midwifery duties are trained to assess and manage women with complications due to FGM during **pregnancy, labour and delivery and the postpartum period**. (For more information see Chapter 6: Maternal and Newborn Health.)

*Prevention*

Where FGM is widely practised, it is supported by both men and women and can be understood as a social convention, governed by rewards and punishment. The practice is often upheld by beliefs relating to religion, women's maturity and sexual morality, and considered necessary for marriageability. Therefore RH programme managers must work in close collaboration with local stakeholders, particularly women's NGOs, as well as professional organizations, aiming at a joint decision by the community to abandon the practice. Organize discussion and information sharing in the community aimed at empowerment, respect for girls and women and problem solving, providing information on women's body functions, the harmful consequences of the practice and the benefits of abandoning it. Care for women with FGM must be included in the programme.

**Forced early marriage**

Where early marriage is common, ensure that RH providers are aware of the RH risks for adolescents, including pregnancy-related complications such as obstructed labour and sexually transmitted infections, including HIV. RH providers should be trained in appropriate counselling for adolescents and understand how early marriage can alter a girls' mobility and her participation in school. The information provided on first contact with young married girls is critical because she might not be able to access RH services frequently. For more information see Chapter 4: Adolescent Reproductive Health.

## 3.4 Psychosocial support

Note: This section is adapted from *Guidelines for Gender-based Violence Interventions in Humanitarian Settings,* Action sheet 8.3. Inter-Agency Standing Committee (IASC), 2005.

Survivors of GBV may experience an array of psychological consequences, such as sadness and depression; self-blame; somatic distress; sexual problems; mood swings, anger and anxiety-related problems (sleeplessness, fearfulness, stress, and fear of "going crazy"). For most survivors, these experiences are normal emotional responses to trauma. Especially with social and emotional support, many survivors learn to cope and the distress decreases over time.

There are also social consequences. Most societies tend to blame victims of sexual violence. Social stigma, isolation and rejection — including by husbands and families — are serious consequences, often making emotional recovery difficult due to withdrawal from day-to-day activities and from social support.

Ensure close coordination between clinical and psychosocial support 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 and refer as needed and agreed by the survivor.

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 TBAs, midwives, women's groups, religious leaders and community services programmes. to know how to support survivors.
- Develop women's support groups. (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 centres 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 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 FGM and women who were forced into early marriage. The organization and labelling of such support must be adapted because FGM and early marriage are socially sanctioned and people may not see themselves as survivors.

## 4 Human rights and legal considerations

GBV goes against many fundamental human rights and can be a serious impediment to the realization of human rights and fundamental freedoms. A number of human rights principles contained in various international human rights instruments serve as the basis for protection from GBV. These include the rights to:

- **life, liberty and security of the person** — this right is threatened when a person is raped or subjected to female genital mutilation (FGM);
- **the highest attainable standard of physical and mental health** — this right may be restricted if a person is denied access to appropriate medical care following rape;
- **freedom from torture or cruel, inhuman or degrading treatment or punishment** — FGM, rape, severe forms of domestic violence, forced sterilization and forced abortion, as well as denial of access to safe abortion services to women who have become pregnant as a result of rape and human trafficking violations, can constitute torture or cruel, inhuman or degrading treatment or punishment;
- **be free from all forms of discrimination** — this right may be restricted where laws fail to protect women and girls from gender-based violence 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 discrimination against them;
- **enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution** — forced marriage is a denial 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.

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 FGM.

The survivor of GBV has 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.

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.

## 4.1 Challenges and opportunities

At times, RH programme managers and service providers may face difficult decisions when caring for survivors of GBV. They may find that their ability to provide services is restricted by national legislation or social or cultural norms. For example:

- In some societies, it is common that the family and/or the authorities force the woman or girl to marry the perpetrator in cases of sexual violence.
- 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 her at risk of reprisals and continued violence.
- 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.

**Guiding principles**

Reproductive health managers or service providers facing a similar dilemma must prioritize the safety of the client, as well as their own and their colleagues' safety. Other principles to ensure are respecting the wishes of the client, ensuring non-discrimination and guaranteeing confidentiality. These guiding principles also have to be taken into account when assisting minors.

Then, they 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.

## 5 Monitoring

Monitoring and reporting on cases of GBV, information sharing; incident documentation and data analysis must be agreed upon as part of the Standard Operating Procedures. Collecting and analyzing information on GBV can provide valuable information if it is conducted and shared ap-

propriately (see also Box 31, p. 161).

**Indicators to be collected at the health-facility level:**

- Number of reported cases of sexual violence reported to health services (per month).
- Timing of emergency contraception (EC) provision (percentage of eligible rape survivors presenting to the health services within 120 hours who receive EC pills).
- Timing of PEP provision (percentage of eligible rape survivors who present to the health services within 72 hours and receive PEP).

**Indicators to measure annually:**

- Number of health workers trained in clinical management of rape survivors.

## 6 Further reading

**Essential**

*Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies.* Inter-agency Standing Committee (IASC), 2005. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/default.asp?bodyID=1&publish=0

*GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide).* IASC Sub-Working Group on Gender & Humanitarian Action, May 2008. http://clinicalcare.rhrc.org/docs/gbv_sop_guide_final_may_2008.pdf

*Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons.* Revised edition. UNHCR/WHO, 2004. http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/

*Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery, a teacher's guide.* Geneva, World Health Organization, 2001. WHO/RHR/01.16. http://www.who.int/reproductivehealth/publications/fgm/RHR_01_16/en/index.html

**Additional**

*Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies.* http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

*Guidelines on Mental Health and Psychological Support in Emergency Settings.* IASC, 2007. http://www.who.int/hac/network/interagency/news/mental_health_guidelines_checklist/en/index.html

*Gender-based Violence Tools Manual for Assessment & Programme Design, Monitoring & Evaluation in conflict-affected settings*. RHRC Consortium. 2004. http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html

*Multi-country study on domestic violence.* http://www.who.int/gender/violence/who_multicountry_study/en/index.html

*Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries: Dos and Don'ts* (UN Action Guidance Note). www.stoprapenow.org/pdf/UN%20ACTION_Dosand-Donts.pdf



9

CHAPTER NINE

# Sexually Transmitted Infections

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## 1 Introduction

### Box 33: Terminology: STI versus RTI

Not all sexually transmitted infections (STIs) are reproductive tract infections (RTIs); and not all reproductive tract infections are sexually transmitted:

- **STI refers to the way of transmission**

whereas

- **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. Because STIs in most cases have much more severe health consequences than other RTIs, 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.

# Sexually Transmitted Infections

Sexually transmitted infections (STIs) cause a large proportion of the global burden of ill-health. WHO estimates that more than 340 million new cases of four curable STIs (gonorrhoea, chlamydia, syphilis and trichomoniasis) occurred in 1999. If viral (noncurable) STIs, such as human papillomavirus (HPV), herpes simplex virus (HSV), hepatitis B and HIV infections are included, the number of new cases may be three times higher. Among women, non-sexually transmitted reproductive tract infections (RTIs), such as yeast infection or bacterial vaginosis, are even more common.

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 behaviour. Therefore, the burden of STIs/RTIs varies greatly from region to region and from community to community. For example:

- STIs such as syphilis, gonorrhoea and chancroid may spread more rapidly in places where communities are disrupted, migrant labour is common and commercial sex networks are active.
- Iatrogenic infections (caused by medical procedures or examination) 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 postabortion 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 (truck drivers, peace keepers), transactional sex, alcohol and drug use, lack of information and access to condoms and high population density in camps.

## 2 Objective

The objective of this chapter is to assist reproductive health (RH) officers, programme staff and service providers in humanitarian settings to:

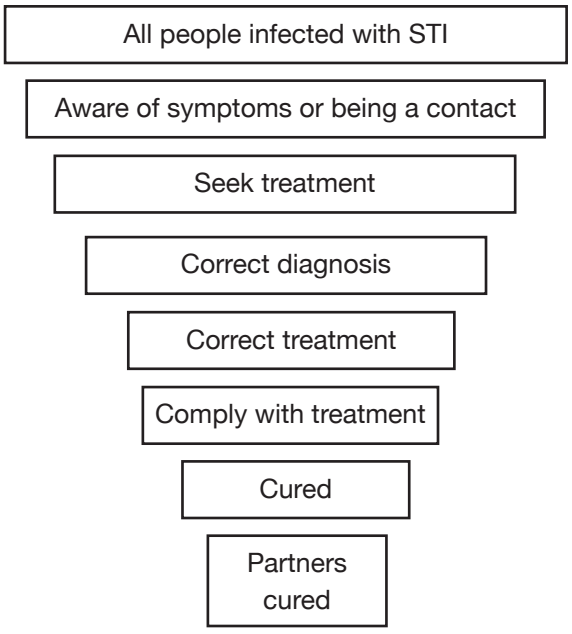
- meet the needs of individuals infected by RTIs/STIs or who may be at risk of RTIs/STIs;
- support the implementation of effective public health approaches to reduce the transmission of STIs.

## 3 Programming

### 3.1 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. Figure 8 shows these challenges: many people are asymptomatic or not aware that they have an STI (e.g. STIs are more often asymptomatic in women) and therefore do not seek care. 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 8:**
**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 programmes must not only ensure accessible, good-quality health services that provide comprehensive STI case management, but also address biological, behavioural and social factors that influence the spread of STIs.

The complete public health package includes:

**At community level**

- Safer-sex promotion campaigns (see 3.3.1)
- Condom programming (see 3.3.2)
- Public awareness of STIs and promotion of early use of clinic services (see 3.3.3)

**At health service level**

- Comprehensive STI case management at first contact (see 3.4)
- Specific services for populations at risk, including sex workers, adolescents, military and prisoners (see 3.4.6)

**Integration of STI management**

- Integrate STI prevention, screening and care into other services (see 3.5)

### 3.2 Needs assessment

Although STI programming is not part of the Minimum Initial Service Package (MISP), it is important to make treatment available for patients presenting with STI/RTI symptoms as part of routine clinical services at the onset of the humanitarian response.

After the MISP is in place, integrate STI considerations into needs assessments for comprehensive RH service planning in order to design appropriate and comprehensive STI prevention, treatment and control programmes. RH officers

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 programmes and 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 take 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 RTIs/STIs. This information can be obtained through qualitative research using focus groups, interviews and, if possible, KAP surveys (knowledge, attitudes and practices).
- Existence of a reliable and sustainable medical commodity supply chain that can support the implementation of STI/RTI services.

RH officers 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?
- 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 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 programmes?

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 RH services that should integrate it.

## 3.3 Community interventions

The community-level approach to prevention and control of STI/RTI 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.

### 3.3.1 Safer sex promotion

The best approach to prevent STIs is to avoid exposure which 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. 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 at lower cost than when first introduced. They have the advantage of giving the woman control over their use.

**Limiting the number of sex partners** can help reduce exposure to STI. 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 to 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 STI.

**Delaying sexual activity.** 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.

### 3.3.2 Condom programming

Good-quality condoms are essential for the protection of the consumer and the credibility of the RH programme. 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 must be available on request in health facilities, distribution centres (such as food and non-food item distribution areas), community centres, shops, bars, 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 (see Chapter 2: MISP). 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 (such as Population Services International - PSI).

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.

### 3.3.3 Public awareness of STIs

Community education and outreach are needed to promote early use of health-care services to cure STIs/RTIs and prevent complications.

Develop messages to teach people how to recognize symptoms and when and where to seek care. Disseminate the messages through public advertisements, radio, papers, teaching sessions at clinics, etc.

## 3.4 STI/RTI 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 it will be transmitted to other people. Appropriate treatment of STIs at the first contact between patients and health-care providers is therefore an important public health measure. In the case of young people (see Chapter 4: Adolescent Reproductive Health), there is a potential to influence future sexual behaviour 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 stop taking their medicines as soon as they start to feel better or they fail to arrange for their sex partners to be treated or they do not use condoms or abstain from sex during treatment. Drug resistance may also be a reason for treatment failure. Therefore comprehensive case management must take place at first contact and include:

- diagnosis
- prompt and effective treatment according to protocols
- education and counselling of the patient, including condom provision
- partner notification and treatment
- follow-up as appropriate
- quality of care.

### 3.4.1 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 three 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 do not exist. Most available tests do not give immediate results, which will lead to delays in treatment or in 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 (see Chapter 10: HIV) and syphilis (Rapid Plasma Reagin (RPR) test or the Rapid Diagnostic Test (RDT)). These tests can be conducted by health-care staff with minimal training and give results in a short time. They can be used for screening (see 3.5, integration of services).

**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 (see Table 22: STI Syndromes).

It is often difficult to know exactly what organism is causing the syndrome and treatment

**Table 22: STI Syndromes**

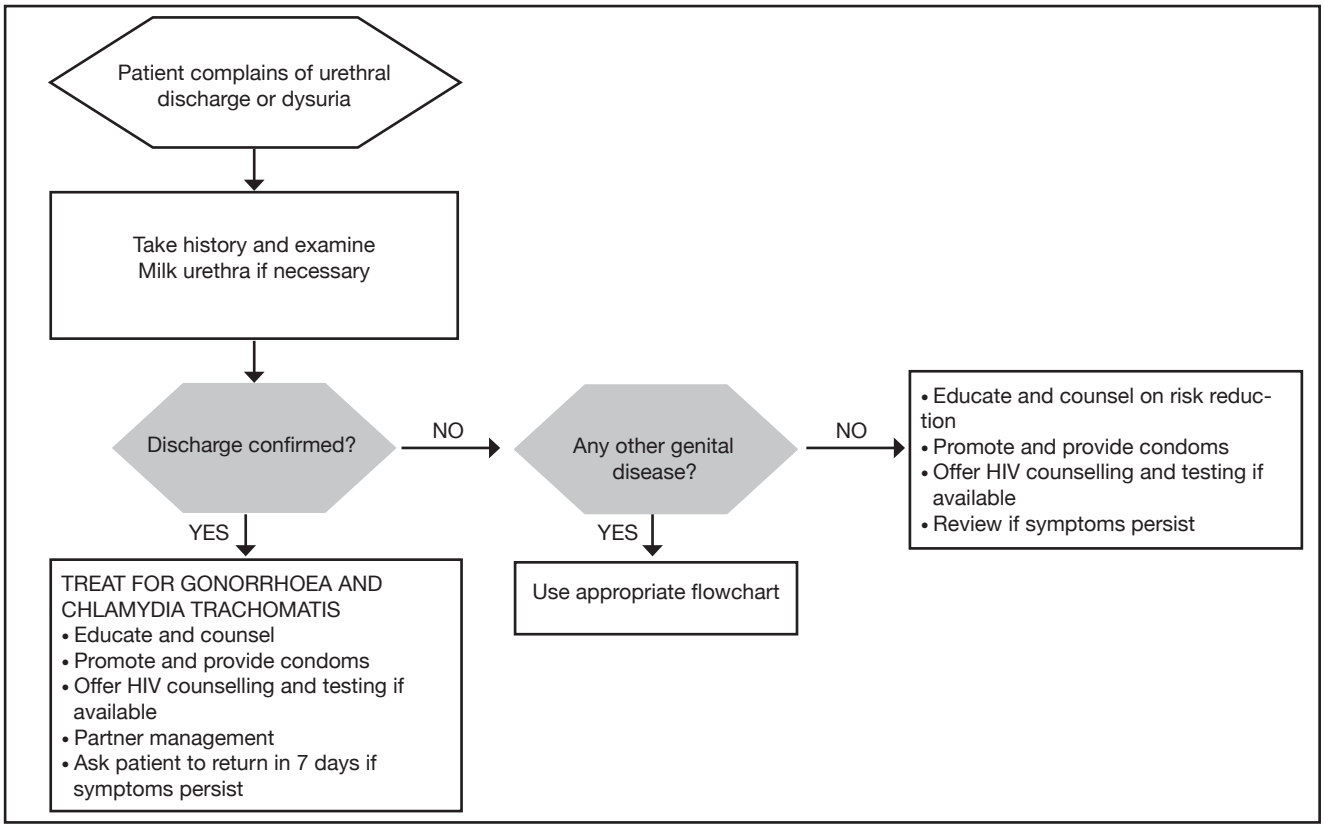
| Syndrome | STI/RTI |
|---|---|
| Genital ulcer (for both men and women) | • Syphilis<br>• Herpes<br>• Chancroid<br>• Granuloma inguinale<br>• Lymphogranuloma venereum |
| Urethral discharge (in men) | • Gonorrhoea<br>• Chlamydia |
| Vaginal discharge | • Bacterial vaginosis<br>• Yeast infection<br>• Trichomoniasis<br>• Gonorrhoea<br>• Chlamydia |
| Lower abdominal pain (in women) | • Gonorrhoea<br>• Chlamydia<br>• Anaerobic infections |
| Inguinal bubo (in men and women) | • Chancroid<br>• Lymphogranuloma venereum<br>• (Granuloma inguinale or Donovanosis where prevalent) |
| Other common STIs/RTIs include **ano-genital warts** and **infestations**, such as pubic lice and scabies. **Scrotal swelling** in men under 35 is commonly a complication of STIs and can be treated in the same way as urethral discharge. However, scrotal swelling can be due to other causes and can be an emergency. If the patient reports a recent history of trauma, if the testicle appears elevated or rotated, or whenever you are suspicious of testicular torsion, refer immediately for surgical evaluation. | |

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 Figure 9 for an example).

**Figure 9: Flowchart for Urethral Discharge in Men**




The advantages of the syndromic approach:

- Patients are treated at the first contact with the health-care 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.

The 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.
- If the patient is not counselled properly, there may be an increased risk of domestic violence (see Box 35: RTIs/STIs and Stigma).

### Box 34: 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 gonorrhoea 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 gonorrhoea (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 (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 (see Table 23).

**Table 23: Some Examples of STI/RTI Detection and Treatment Strategies**

| Method | Example — no missed opportunities |
|---|---|
| History-taking | Ask about STI/RTI symptoms or concerns at each RH 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<br>Pap smear for early detection of cervical cancer<br>Voluntary counselling 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.<br>Survivors of sexual violence<br>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 |

### 3.4.2 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 behavioural practices.

In the early days of the humanitarian response, it may be necessary to use the WHO standard treatment guidelines with antimicrobials that are known to be effective globally (see 6: Further Reading). Some recommended antimicrobials from these guidelines are included in the Inter-agency RH Kit 5 (see Chapter 2: MISP). In many countries the Ministry of Health (MoH) has developed standard national STI protocols. It is important to encourage the use of the appropriate protocol in the setting you work in as soon as possible. Such standardized treatment guidelines will facilitate staff training and procurement of supplies for STI programmes and this will help ensure that all patients receive adequate treatment.

Therefore, RH officers must implement national STI protocols where these exist. Where they do not exist, encourage discussions between the MoH and WHO to develop an adapted national or regional protocol.

### 3.4.3 Patient education and counselling

Patient education and compassionate and confidential counselling are essential components of STI/RTI management and include:

- explaining of 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 behaviour. People may adopt safer sexual behaviours following treatment of an STI. Therefore, each clinic visit is an opportunity to promote future prevention;
- 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 35).

#### Box 35: STI/RTI 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 their relationship. Violence, distrust and divorce are possible consequences of partner notification if not managed correctly.

### 3.4.4 Partner management

**Principles**

When managing sexual partners, service providers must be sensitive and respectful, ensure confidentiality and offer a voluntary and noncoercive 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 two to three months. Partner management includes notification, referral and treatment.

**Figure 10: Example of Partner Referral Slip**

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: dd/mm/yyyy Code: ABCD

**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 (avoid long waiting times, waive normal clinic fees, etc.).

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 Figure 10).

**2) Provider referral.** Service providers with training in contact-tracing techniques notify partners and arrange for necessary treatment.

**3) A combination of 1) and 2**) can be used where patients are first asked to contact partners themselves (patient referral). If unsuccessful after one to two 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).

**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 three possible strategies to ensure the treatment of partners can be applied:

1. 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)

2. Immediate treatment and taking specimens for laboratory testing

WHO recommends immediate treatment with the same antibiotic regimen as for the index patient.

### 3.4.5 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 (two to three days for pelvic inflammatory disease). Patients with genital ulcers have to return after seven days if not getting better. Treatment should be prolonged beyond seven 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 centre.

### 3.4.6 Quality of care

In order to ensure the quality of STI programmes, services must be available, accessible, affordable and appropriate. RH officers and programme managers can achieve this by reducing barriers to services (e.g. appropriate opening times; private, confidential, respectful and technically good-quality care, etc.) and reaching out to people who may not typically use STI services: sex workers and their clients, military, 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 RH officers and programme managers:

- post standard national STI management protocols in examination rooms;
- put in place a confidential and voluntary partner tracing system;
- arrange for training of service providers to become proficient in both technical and counselling skills;
- 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 training.

## 3.5 Integration of services

RH officers need to aim for the integration of STI/RTI services into primary health care and other RH programmes, including:

- STI assessment in family planning services, by ensuring that service providers:
  - discuss STI/RTI 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/treatment in post-rape care services (see Chapter 2: MISP)
- STI/RTI programming in adolescent healthcare services
- STI/RTI assessment and management in the antenatal, delivery and postpartum period (see Chapter 6: Maternal and Newborn

Health). For example:

- STI/RTI risk assessment for all clients in antenatal care, including syphilis screening and HIV voluntary counselling and testing (see Box 36: Rapid Diagnostic Tests for Syphillis Screening).
- 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;
- Prophylaxis for ophthalmia neonatorum is given routinely to all newborns.

- prevention of cervical cancer activities in comprehensive RH services (see Box 37).

### Box 36: Rapid Diagnostic Tests for Syphillis 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 is 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 (see Chapter 6: Maternal and Newborn Health).

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. Please look for updates on www.iawg.net.

### Box 37: HPV and Cervical Cancer

Human papillomavirus (HPV) 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 precancer) 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 five to ten 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. Newer techniques such as Visual Inspection using Acetic Acid (vinegar) (VIA) or Visual Inspection using Lugol's Iodine (VILI) have recently 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 three doses and produces a very high immune response that lasts for at least five 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 programmes 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 an important barrier to widespread access and the expected costs and benefits need to be considered in the overall health budget.

## 4 Human rights and legal issues

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 medication 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 programmes for behaviour-related health concerns such as sexually transmitted diseases".
  - STI management in antenatal care is essential in protecting both the rights of the mother 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 may not be respecting that child's human rights.
- The right to privacy requires that health workers act in such a way to make patients feel safe and protected when receiving diagnosis, treatment or counselling 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 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.
- 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 VIA, cryotherapy and HPV vaccine).

## 4.1 Challenges and opportunities

At times, providing appropriate 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 centres 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 nonconfidential partner tracing.

It is important to remember that many barriers to STI care and treatment access are against internationally accepted human rights principles. Be aware of your agency's position on these issues and include it as part of your analysis of the situation and possible next steps.

Reproductive health programme managers or service providers facing a similar 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 your 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;
- 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 them in the future;
- raise these concerns in health coordination meetings.

## 5 Monitoring

Indicators to monitor STI programmes include

- The proportion of service providers who received training in ST/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).

For more information on monitoring and evaluation see Chapter 3.



## 6 Further reading

**Essential reading**

*Integrating STI/RTI Care for Reproductive Health. Sexually Transmitted and Other Reproductive Tract Infections, a guide to essential practice*. World Health Organization (WHO), 2005. whqlibdoc.who.int/publications/2005/9241592656.pdf

*Guidelines for the management of sexually transmitted infections.* WHO, 2003. http://www.who.int/reproductive-health/publications/mngt_stis/index.html

*Training modules for the syndromic management of sexually transmitted infections* (2nd edition). WHO, 2007. http://www.who.int/reproductive-health/publications/rtis/9789241593407/en/index.html

**Additional reading**

*Comprehensive cervical cancer control, A guide to essential practice.* WHO, 2006 http://www.who.int/reproductive-health/publications/cervical_cancer_gep/index.htm

For more information on prevention of congenital syphilis: www.who.int/reproductivehealth/topics/rtis/syphilis/en/

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CHAPTER TEN

# HIV

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## 1 Introduction

Since the 1980s, the human immunodeficiency virus (HIV) has been the cause of one of the most alarming and devastating pandemics in history. In addition to being a considerable health problem, it threatens the economic and social fabric of many communities.

In the past, humanitarian programmes paid relatively little attention to HIV prevention, treatment and care because HIV was not perceived as an immediate threat to life and therefore not a relief issue. However, the characteristics that define a complex emergency, such as conflict, social instability, poverty, environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV by:

- reducing access to HIV prevention services; breaking down health infrastructure;
- disrupting social support networks; increasing exposure to sexual violence (rape) and sexual abuse (demanding sex in return for food or shelter);
- population movement to an area of higher HIV prevalence.*

Studies have shown that the factors that affect HIV transmission in humanitarian settings are complex, and depend on many dynamic and interacting factors, including the HIV prevalence 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 level of isolation of the displaced population (e.g. urban versus camp-based

* UNAIDS and UNHCR. *Strategies to support the HIV related needs of refugees and host populations*. Geneva, 2005. http://data.unaids.org/publications/IRC-pub06/jc1157-refugees_en.pdf.

# HIV

refugees).

When planning HIV programming in humanitarian settings, RH officers and programme managers must consider:

- the combined impact of humanitarian emergencies and HIV, including factors that may increase vulnerability to HIV;
- existing policy and practice in humanitarian response that 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 (PLHIV), including interruption, restarting or continuation of antiretroviral treatment;
- stigma and discrimination against people infected and affected by HIV.

## 2 Objective

The objective of this chapter is to assist RH officers, programme managers and service providers to plan for and implement comprehensive HIV prevention, care and treatment services as part of the humanitarian response.

## 3 Programming

Priority HIV interventions in a humanitarian response deal with the prevention of HIV transmission, and are included in the MISP (see Chapter 2: MISP). These are:

- Facilitate and enforce respect for standard precautions.
- Make postexposure prophylaxis to prevent HIV transmission (PEP) available (as part of clinical care for rape survivors and occupational exposure).
- Ensure safe blood transfusion practice.
- Make free condoms available.

Also ensure that antiretrovirals (ARVs) are available to continue treatment for people already on ARVs prior to the crisis, including for the prevention of mother-to child-transmission (PMTCT) (See page 192,ART).

When planning for comprehensive HIV prevention, care and treatment services, address the following programme components:

- Needs assessment
- HIV awareness
- HIV prevention
- HIV counselling and testing
- Prevention of mother-to-child transmission (PMTCT)
- The use of antiretroviral (ARV) for prevention and treatment purposes
- Care for PLHIV
- Care for children living with HIV
- Management of opportunistic infections, STIs and tuberculosis.

### 3.1 Needs assessment

RH officers and programme managers must collect or estimate the following information for the setting they work in, in coordination with other health sector/cluster actors:

**Population characteristics**

- HIV prevalence (for both displaced and host populations). This can be found on the UNAIDS website, with the local Joint UN Team on AIDS, as well as with the National AIDS Control Progamme.
- Number of PLHIV from the affected

population whose HIV treatment services were disrupted (e.g. PMTCT and antiretroviral therapy (ART) programmes) and who are in need of continuation of ARV regimens.
- Behavioural and environmental factors that might place vulnerable subgroups at increased risk of HIV transmission.

**Health services characteristics**

- Health facility staff with experience in HIV prevention, treatment and care and training needs of staff.
- National ARV protocols for prevention (PEP, PMTCT) and treatment (ART) and available ARVs.
- Availability of laboratory services.
- Existence of a reliable supply chain that can support sustainable access to HIV commodities.

**National legislation and policies**

Reproductive health programme managers and service providers must also be familiar with national legislation and policies related to HIV, assess how refugees and 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 counselling. Are there mandatory testing laws?
- Laws and/or policies related to condom distribution, injecting drug users (IDUs) and harm reduction in the context of injecting drug use.
- Laws and/or policies regarding HIV transmission.
- Laws and/or policies regarding health-care provider disclosure of HIV status.
- Laws and/or policies governing provision of and access to ART.

**HIV epidemic characteristics**

To have an impact on HIV prevalence, programme efforts must be targeted appropriately. As a useful programming guide, WHO and UNAIDS have categorized HIV epidemics in different countries broadly as: low level, concentrated level and generalized epidemics (see Table 24).

## 3.2 HIV awareness

Incorporate efforts to prevent HIV in humanitarian settings into communication campaigns relevant to the population and the situation. Communication efforts in the early humanitarian response focus on informing people where they can access basic services. As soon as possible, take into account the characteristics of the population to tailor communications concerning HIV. For example:

- What level of HIV knowledge and common misconceptions of HIV do the people have?
- What common practices put people at risk of HIV transmission?
- What elements of the new situation create risk for HIV transmission?
- What are the common attitudes and beliefs regarding people infected with HIV?

Tailor communication campaigns to create generalized awareness about HIV and acquired immunodeficiency syndrome (AIDS). In addition, design specific communications campaigns to:

- target people who may be vulnerable to practices that increase the risk of HIV transmission. Displaced people face risks because protective community systems are interrupted, sexual networks change and youth often initiate onset of sexual activity earlier;
- reduce discriminatory behaviour and assure care and support of PLHIV.

Community groups, such as health clubs at schools, post-test clubs (including anyone who has been tested for HIV, regardless of serostatus) and Stop-AIDS associations in the police and military, can be effective in motivating their members to practise safer sexual behaviours. Associations of PLHIV can be powerful catalysts

| Table 24: 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 behaviours, networks and other factors indicating the potential for HIV spread — such as rates of other sexually transmitted infections — is essential for prevention planning |
| **Concentrated** | HIV prevalence is high enough (5% or more) in one or more sub-population, such as men having sex with men, injecting drug users 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<br>• the size of the vulnerable sub-population(s) and<br>• the frequency and nature of interactions between them and the general population |
| **Generalized** | HIV prevalence is between 1% and 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 (e.g. norms that decrease girls' access to education and information) are directly implicated in the epidemic dynamics and need to be addressed |
| An exceptional situation exists in the southern African region, where large numbers of people — over half of them girls and women — are living with HIV. In this hyperendemic scenario, HIV prevalence exceeds 15% in the adult population. These situations require exceptional effort and resources to mobilize entire communities to change sexual behaviours. | | |

for change of individual and community-wide attitudes.

Essential messages include:

- HIV, the virus that causes AIDS, spreads through: unprotected sexual intercourse (intercourse without a condom) with someone who is infected with HIV; transfusions of HIV-infected blood; reusing needles and syringes contaminated with HIV; and from an HIV-infected woman to her child during

pregnancy, childbirth or breastfeeding.
- Everyone must know about HIV and AIDS and how to prevent it because AIDS is not curable, only preventable.
- There is an effective treatment for HIV and AIDS that, although it is not a cure, can prolong life if taken lifelong.
- Having a sexually transmitted infection (STI) (e.g. gonorrhoea or syphilis) increases one's risk of transmitting or acquiring HIV.
- The risk of infection through sexual intercourse can be reduced by: using condoms correctly every time; maintaining a mutually monogamous relationship with an uninfected partner; or abstaining from sexual intercourse.
- Everyone who may have been exposed to HIV should consult a qualified health worker for voluntary information, counselling and testing to protect their health.
- Pregnant women should access HIV voluntary counselling and testing (VCT). If infected, they will be offered appropriate medication to reduce the risk of transmitting the infection at delivery or through breastfeeding to their infants.
- Stigma, discrimination, wrong information and negative attitudes towards PLHIV increase the potential for suffering and for the HIV epidemic to spread. Discrimination against PLHIV is a human rights violation.

For more information on communication campaigns, see Chapter 1: Fundamental Principles.

## 3.3 HIV prevention

It is essential that RH officers and programme managers understand the characteristics of the settings they work in and the population's knowledge and behaviours in order to match HIV programming to those factors. In humanitarian settings, people may engage in behaviours that place them at higher risk of exposure to HIV, even if they do not identify themselves as belonging to an at-risk group.

This section discusses three specific vulnerable groups: injecting drug users (IDUs), men who have sex with men (MSM) and sex workers. Each of these groups has unique characteristics and is discussed separately, although the following elements are consistent for all programmes targeting vulnerable groups:

- Involve vulnerable groups from the start in programme design, implementation and monitoring.
- Locate programme activities in places frequented by the group of interest (clubs, neighbourhoods, etc.).
- Create safe virtual (telephone hotlines) or physical (drop-in centres) spaces tailored to each group where people can comfortably seek information and referrals for care and support.
- Promote consistent and correct use of male and female condoms and ensure their availability, affordability and reliable supply.
- Train health and social workers to provide high-quality, client-friendly, HIV-related services to PLHIV and their partners and families, including STI treatment, VCT, PMTCT, family planning and treatment for tuberculosis (TB) and AIDS.
- Address structural barriers, including policies, legislation and customary practices, that discriminate against the group and prevent access and utilization of appropriate HIV prevention, treatment and care services.

**Injecting drug users**

While sharing syringes and other equipment for drug injection is a well-known route of HIV transmission, injecting drug use also contributes to the epidemic's spread beyond the circle of those who inject. Sexual partners of an IDU are at risk through sexual transmission. Children born to mothers who contracted HIV through sharing needles or having sexual intercourse with an IDU may become infected as well.

HIV can spread explosively through sharing of contaminated needles among IDUs (prevalence

can expand from 5% to 50% in one year). IDUs may have additional HIV transmission risks such as sex work and imprisonment. The criminalization of injecting drug use can lead to social marginalization and limit access to services. All this can further fuel the epidemic

Harm-reduction measures, such as access to sterile injection equipment, drug dependence treatment, community-based outreach and provision of HIV-prevention information, are among the most effective measures to prevent the spread of HIV. Programmes aiming to reduce IDU-related HIV transmission must provide adequate coverage of sterile injection equipment (including in prisons), good-quality, noncoercive treatment for drug dependence, user-friendly RH and PMTCT services for women IDUs and for sexual partners of IDUs and training for service providers on HIV-related services for IDUs.

Peer-led public health outreach prevention programmes have been shown to work. Key messages may include:

- If you inject drugs, you are at high risk for HIV. Consider getting help from trained professionals to reduce your risk. A drug-addiction treatment programme and counselling are the first steps towards HIV prevention, care and treatment
- If you are on HIV medication, getting "high" increases your chance of forgetting to take the medication. Get a drug buddy/friend to help you remember to take your HIV drugs on schedule.

**Men having sex with men (MSM)**

MSM refers to all men who have sex with other men, regardless of how they identify themselves (gay, bisexual or heterosexual). MSM practices vary around the world. In order to design appropriate programmes for MSM among displaced populations, it is necessary to understand local social networks and common practices. It is estimated that fewer than one in 20 MSM worldwide have access to HIV prevention, treatment and care services. Stigmatization, criminalization and discrimination, along with lack of understanding about behaviours and attitudes, are significant barriers to implementing effective programmes.

Where social, cultural and religious attitudes stigmatize MSM, programmes to meet their needs can result in criticism from community leaders and members. However, with funding and support, RH officers and programme managers can design programmes to reverse the spread of HIV among MSM. For example:

- Determine the size and characteristics of the community of MSM among the affected population and involve them in designing and implementing targeted activities.
- Offer specific information on prevention and risk-reduction strategies in communication campaigns, such as consistent and correct use of condoms. Ensure reliable access to condoms and water-based lubricants.
- Offer access to medical and legal assistance for boys and men who experience sexual coercion or violence. Clinical care for both male and female rape survivors is part of the MISP (see Chapter 2: MISP).
- Promote the integration of alternative sexual communities in public awareness campaigns to decrease homophobia.

**Sex workers**

The exchange of sex for money or goods is present in all communities, including in displaced communities. This includes children and women who do not consider themselves sex workers but who struggle to survive. Therefore, it is of utmost importance to ensure safety, protection and access to food and support for vulnerable people, such as orphans and women as single heads of families.

Protecting sex workers from HIV infection benefits them and the general population. Successful programmes situate their activities in the locations where sex workers can be reached. Programming considerations are:

- Ensure the consistent availability of quality male and female condoms. To see an effective reduction of HIV transmission through sex work requires >90% compliance of correct use of condoms among sex workers and their nonregular sex partners.
- Integrate violence reduction strategies in sex work settings. Programmes should work with law enforcement to ensure the sex workers' ability to protect themselves and to ensure safer sex practices by their clients.
- Engage communities and sex workers in enforcing child protection policies and regulations.
- Link sex workers and their families to support mechanisms, including the provision of assistance and incentives for women to leave sex work through a range of legal, economic and social services.
- Address the "demand" side of sex work — work to change the behaviour of sex workers' clients. Humanitarian staff, peacekeepers, civil police and members of the general population are clients of sex workers in humanitarian settings.

## 3.4 Voluntary counselling and testing

HIV voluntary counselling and testing (VCT) is not a priority intervention at the onset of a humanitarian response because it is not an immediately life-saving intervention. As soon as the situation is stabilized however, it is important to offer VCT for people who want to know their serostatus. VCT 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 counselling to prepare clients for their test result and to encourage behaviour change, whatever the test outcome.

Mandatory HIV testing should NEVER be supported.

*This comprises a violation of a person's rights.*

**Provider-initiated HIV testing and counselling**

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 counselling should be offered by health-care providers as part of standard clinical care. If there are resource and capacity constraints, a phased implementation of this provider-initiated testing and counselling will be needed. The following is a priority list for phased implementation:

1. TB clinics
2. STI services
3. Antenatal, childbirth and postpartum health services
4. Medical inpatient and outpatient facilities

In **low-level and concentrated epidemics**, health-care providers *should not initiate* VCT with every patient attending a health facility, since most people will be at low risk. VCT facilities should be made available in stabilized humanitarian settings, either through established services or mobile clinics.

Some behaviours that put people at a higher risk of exposure to HIV, such as sex work or injecting drug use, also make people more susceptible to coercion, discrimination, violence, abandonment, incarceration or other negative consequences upon disclosure of an HIV-positive test. Health-care providers require special training and supervision to uphold standards of informed consent and confidentiality for these populations. HIV VCT for these groups should be accompanied by the implementation of a supportive social, policy and legal framework.

**Quality VCT services**

Whether client- or provider initiated, the follow-

ing programme components ensure quality VCT 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. VCT must never be imposed on anyone under any circumstance.
- Make services available free of charge.
- Ensure pre- and post-test counselling is part of all VCT 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 programmes.
- VCT 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 counselling and follow-up. This supports the decentralization of VCT. Consider local storage conditions and order rapid tests that do not require refrigeration where appropriate.

## 3.5 ARV and ART interventions

It is important to plan the provision of essential antiretroviral drugs (ARV) and antiretroviral therapy (ART) programmes. 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 programmes, ART must be linked to prevention, care and support programmes. It should not be implemented as a parallel intervention but rather as an integrated programme linked to other services (e.g. health, nutrition, education, social services and water and sanitation).

Where ART is available it is important that counselling covers the risks and benefits of ART and the importance of adhering to the treatment schedule.

The essential interventions that use ARVs are:

- Postexposure prophylaxis (PEP)
- Prevention of mother-to-child transmission (PMTCT)
- ART

**PEP**

RH programme managers must ensure that the prompt administration of PEP (within 72 hours) to reduce the likelihood of HIV transmission is included in protocols for the following two situations:

- Services for rape survivors: In order to prevent and manage possible health consequences of rape, survivors must have access to clinical care, including supportive counselling. This care includes the provision of PEP.
- Occupational exposure: Despite standard precautions put in place and adhered to in health-care 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 standard precautions package that reduces the likelihood of HIV transmission after such an exposure.

The recommended PEP regimen is a 28-day combination therapy with two nucleoside-analogue reverse-transcriptase inhibitors (NRTIs), often zidovudine and lamivudine. For more detailed information on PEP, please refer to Chapter 2: MISP, p. 32.

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 (see Chapter 9: Sexually Transmitted Infections, section 3.3, STI prevention);
- prevention of unintended pregnancies among women living with HIV (see Chapter 5: Family Planning, section 3.11, FP for people 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 RH programmes, all four components must be implemented in order to reach the overall goal of improving maternal and child health (MCH) in the context of HIV.

**PMTCT**

This should be read in conjunction with Chapter 6: Maternal and Newborn Health.

In the absence of prophylaxis, the probability that an infant born to an HIV-positive mother will become infected ranges from 20% to 45% among breastfeeding women. Administration of a single dose antiretroviral drug reduces this figure by approximately two-thirds, while using complex regimens of triple-ARV therapy and/or elective caesarean section and avoidance of breastfeeding reduce the probability to less than 2%.

Where a woman who is known to be living with HIV presents for antenatal, delivery or postpartum care, actively pursue the opportunity to prevent transmission of HIV to her infant. For the implementation of a mother-to-child transmission programme, the following must be established:

- Antenatal care services
- Maternal and child health care, including safe delivery care
- Provider-initiated HIV testing and counselling, using opt-out approach, that is, individuals must specifically decline the HIV test after receiving pretest information if they do not want the test to be performed
- Counselling on infant feeding
- Availability of ARVs and PMTCT protocols (see Table 25).

**Infant feeding***

The risk of infants acquiring HIV through breastfeeding must be balanced against the higher risk of death from other causes, such as malnutrition, diarrhoea and pneumonia among non-breastfed infants. Evidence on HIV transmission has shown that exclusive breastfeeding for up to six months is associated with a three- to four-fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding.

RH officers should discuss within the health sector/cluster and with national health authorities to promote a single infant feeding practice across communities as the standard of care. Women who are HIV positive should be counselled and supported to either:

- Breastfeed and receive ARV interventions

**Or**

- When replacement feeding is **acceptable, feasible, affordable, sustainable and safe,** avoid all breastfeeding, because this will give infants the greatest chance of HIV-free survival.

The provision of ARVs to pregnant and breastfeeding women living with HIV and the infant who is breastfeeding is strongly recommended

* This section is based on: *Infant feeding in the context of HIV. Key Messages,* WHO 2009. www.who.int/hiv/pub/paediatric/advice/en/.

and the health sector/cluster should strive to introduce them (see oral antiretroviral prophylaxis below). However, the absence of ARVs does not change the recommendations regarding breastfeeding:

- Exclusive breastfeeding for the first six months of life is recommended for HIV-infected mothers (whose infants are HIV uninfected or of unknown HIV status) unless replacement feeding is acceptable, feasible, affordable, sustainable and safe. At six months, introduce appropriate complementary foods and continue breastfeeding for the first 12 months of life. All breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
- If infants and young children are known to be already HIV infected, mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years of age or beyond.
- Whatever the feeding decision, health services should follow up all HIV-exposed infants, and continue to offer infant feeding counselling and support, particularly at key points when feeding decisions may be reconsidered, such as the time of early infant diagnosis and at six months of age.

For more information on breastfeeding see Chapter 6: Maternal and Newborn Health.

**Oral antiretroviral prophylaxis**

Mothers known to be HIV-infected should be provided either with life-long ART or antiretroviral (ARV) prophylaxis through pregnancy and breastfeeding.

Prophylactic ARV regimens should start from as early as 14 weeks gestation or as soon as possible when women present late in pregnancy, in labour or at delivery.

- At minimum, the mother should receive a single dose of Neviraprine (Sd-NVP) 200 mg at the onset of labour and the infant should receive Sd-NVP 2 mg per kg of body weight orally as soon as possible, but no later than 72 hours following birth. While not considered the optimal preventive regimen, the simplicity of this method makes it suitable for humanitarian settings. Programmes using Sd-NVP are a short-term interim measure and steps must be taken to enable more effective regimens to be delivered as soon as possible.
- If the woman is seen in antenatal care and she is not in need of ART for her own health or if triple ARV drugs are not available, ARV prophylaxis should begin at 14 weeks gestation or as soon as possible thereafter, continuing through delivery and breastfeeding, and after delivery for the infant.

Table 25 provides recommended prophylactic ARV options recommended for HIV-infected women who do not need treatment for their own health.

Follow up children born to mothers living with HIV: initially for post-partum prophylaxis and later to assess their HIV status and offer antiretroviral therapy if needed.

Involve partners in programmes for PMTCT. This is key to ensure support within families.

Where feasible, ensure mothers living with HIV have access to ART (see below). When a pregnant woman meets the criteria,[FN] start ART as soon as possible. If antiretroviral therapy cannot be started when the mother has developed AIDS, Sd-NVP should NOT be provided to the mother for PMTCT to prevent development of viral resistance to NVP.

If the supply of ARV drugs is insufficient to

[FN] Start lifelong ART for all pregnant HIV positive women with severe or advanced clinical disease (WHO clinical stage 3 or 4), or with a CD4 count at or below 350 cells/mm3, irrespective of gestational age.

**Table 25: ARV Prophylaxis Options Recommended for Pregnant Women Who Do Not Need Treatment for Their Own Health ***

| Option A: Maternal AZT | Option B: Maternal triple ARV prophylaxis |
|---|---|
| **Mother** | **Mother** |
| • Antepartum daily AZT (>14 weeks gestation)<br>• sd-NVP at onset of labour*<br>• AZT + 3TC during labour and delivery*<br>• AZT + 3TC for 7 days postpartum*<br>*sd-NVP and AZT+3TC intra- and post-partum can be omitted if the mother receives more than 4 weeks of AZT during pregnancy | Triple ARV drugs starting > 14 weeks gestation until one week after breastfeeding has completely stopped. Recommended regimens include:<br>• AZT + 3TC + LPV/r<br>• AZT + 3TC + ABC<br>• AZT + 3TC + EFV<br>• TDF + (3TC or FTC) + EFV |
| **Infant** | **Infant** |
| ***Breastfeeding infant***<br>NVP daily from birth until one week after all exposure to breast milk has ended<br><br>***Non-breastfeeding infant***<br>AZT or NVP daily from birth to 6 weeks | ***Breastfeeding infant***<br>NVP daily from birth to 6 weeks<br><br>***Non-breastfeeding infant***<br>AZT or NVP daily from birth to 6 weeks |

*AZT: Azidothymidine, zidovudine; 3T: Lamivudine; Sd-NVP: Single-dose nevirapine; LPV/r: Lopinavir/ritonovir; ABC: Abacavir, EFV: Efavirenz.*

*All regimens are administered by mouth. Paediatric formulations exist for AZT, 3TC and NVP.*

* From *Rapid advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants.* WHO. 2009. www.who.int/hiv/pub/mtct/advice/en/index.html.

commence antiretroviral therapy for the mother, prophylaxis for the baby may still be offered.

**ART**

**From the beginning of the humanitarian response, ensure continuation of ARV drugs for people who were already enrolled in an ART programme 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. The following are recommended:

- An HIV test — or 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 changed 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 (see 3.6).
- Provide adherence counselling and support in light of the new circumstances.

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 counselling and ART programmes as soon as possible.** Before initiating ART services it is important to consider the following questions:

- 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 programmes?
- What are potential procurement and drug management constraints?
- What is the mobility of the population? What are the security situation and future likelihood of displacement that could lead to treatment interruption?
- What is the laboratory capacity (at the health centre and/or the referral level)?

Initiating a minimum package of ART services requires preparation. Ensure that the following are in place:

- Policies, standard operating procedures and standard treatment protocols. 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 counselling and community mobilization.
- A six-month start-up supply of medicines, including ARV, co-trimoxazole, TB treatment and treatment for other opportunistic and co-infections (see 3.6); and a procurement system to assure an uninterrupted supply of required medicines.
- Diagnostic supplies and laboratory capacity, including at least HIV diagnostics, haemoglobin or haematocrit determination, CD4 cell counts, tuberculosis (TB) diagnostics, malaria and syphilis testing.
- 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.
- Information packages for patient counselling, education and community mobilization.

## 3.6 Comprehensive care for PLHIV

Comprehensive care for PLHIV 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 PLHIV
- Patient information and education
- TB treatment and prophylaxis for opportunistic infections
- Family planning
- Community-/home-based care
- Palliative care

**Support to PLHIV**

Develop confidential programmes to provide psychosocial support for PLHIV. This may include individual counselling and support, support groups or friends of PLHIV and families to whom the patient has disclosed his/her HIV status.

Ensure that PLHIV have nondiscriminatory access to necessary food supplements and nutrition counselling through food assistance programmes. Listing all eligible people without divulging reasons for their inclusion on the supplementary feeding lists helps avoid discrimination.

In humanitarian settings, PLHIV 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 PLHIV with a Long Lasting Insecticidal Net (LLIN) to reduce the risk of contracting malaria in endemic areas.

**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 programmes to ensure access for PLHIV 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 PLHIV, 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 four to six 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**

PLHIV must have access to family planning methods and counselling. Offer quality counselling on issues such as contraceptive methods when living with HIV, dual protection with both condoms and another method, emergency contraception, termination of pregnancies and availability of pregnancy support. For more information, see Chapter 5: Family Planning.

**Community-/home-based care**

It is important to establish a community- or 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 PLHIV must go hand in hand.

**Palliative care**

Palliative care should cover the management of both acute and chronic symptoms and terminal care. Important elements are pain control, other symptom management, terminal care, backup to any community-/home-based care provided, information and education.

## 3.7 Care for children with HIV

The following actions are recommended for the care of children with HIV:

- 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 around four to six weeks of age or on first contact with health services.
- Where polymerase chain reaction (PCR) monitoring is not available, and in children under 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.

## 4 Human rights and legal considerations

Ensuring that human rights are respected and protected is critical both for reducing exposure to HIV and to 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 programmes, where sexual violence and reduced access to HIV prevention, care and treatment services increase the risk of HIV transmission. Key rights issues are:

- **The right to access HIV and AIDS health care:** 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 programmes 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 sexual and reproductive health.
- **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 be ensured access to HIV prevention, treatment and care services.
- **The right to voluntary health interventions:** All persons should have 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, as well as the right to provide informant consent and to be free from mandatory HIV testing.
- **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.

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 RH care and services and appropriate counselling and treatment in all cases of sexual and gender-based violence.

Children are entitled to special protection under the law, as highlighted by the UN Committee on the Rights of the Child. In particular the Convention on the Rights of the Child should guide the responses in all cases involving children, including: nondiscrimination; best interests of the child; the right to life; survival and development; and participation of the child.

### 4.1 Challenges and opportunities

RH officers, programme 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 law or policies or even social and cultural misconceptions. It is important to discuss potential dilemmas with teams and supervisors and decide on the type of engagement of your organization. Important immediate steps service providers can undertake are to ensure that 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.

* Declaration of commitment on HIV/AIDS (General Assembly Resolution A/RES/S-26/2 of 2 Aug 2001). Paras 14,37,58-62.

## 5 Monitoring

The following indicators can be used to monitor comprehensive HIV programmes:

- Quality of blood donation screening: The proportion of donated blood units that were screened for HIV in a quality assured manner
- Condom use rate: The proportion of sexually active people who reported condom use at last intercourse
- VCT post-test counselling and result: The proportion of VCT clients tested for HIV, who received their post-test result and counseling
- PMTCT coverage: The proportion of first ANC visit clients who were pre-test counseled
- Coverage of ARV in PMTCT programmes: The ratio of mother-newborn pairs that swallowed ARV on time

For more information on monitoring and evaluation see Chapter 3.

## 6 Further reading

**Essential reading**

*Priority interventions: HIV/AIDS prevention, treatment and care in the health sector.* World Health Organization (WHO), Geneva, 2008. http://www.who.int/pmnch/topics/hiv_aids/priorityinterventions/en/

Rapid advice documents: *Antiretroviral therapy for adults and adolescents; use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants, Infant feeding in the context of HIV*. www.who.int/hiv/pub/mtct/advice/en/index.html

*Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access: recommendations for a public health approach.* WHO, Geneva, 2006. http://www.who.int/hiv/pub/guidelines/pmtctguide-

lines3.pdf

Engender Health. *HIV Prevention in Maternal Health Services; Programming Guide.* United Nations Population Fund, 2004. http://www.engenderhealth.org/pubs/hiv-aids-sti/hiv-prevention-in-maternal-health.php

*Clinical Guidelines for antiretroviral therapy management for displaced populations. Southern Africa.* Southern African HIV Clinicians Society/ UNHCR, 2007. http://www.unhcr.org/4683b0522.html

*UNHCR and Infant Feeding in Emergencies. Guidance on infant feeding and HIV in emergencies for refugees and displaced populations.* UNHCR, Geneva, 2008. http://www.ennonline.net/ife

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Annex 1

## Glossary

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| **Acute phase** | Phase during an emergency situation when death rates are high and the humanitarian response priorities are related to survival. |
| **Adolescent** | Person aged 10-19. |
| **Affected population** | Populations of concern, including but not limited to host populations, internally displaced persons and refugees. |
| **Allied Health** | Clinical healthcare professions distinct from medicine, dentistry and nursing. |
| **Amenorrhea** | No bleeding at all at expected bleeding times. |
| **Consolidated Appeals Process (CAP)** | A tool used by aid organizations to plan, coordinate, fund, implement and monitor their activities. As a coordination mechanism, the CAP fosters closer cooperation between host governments, donors, aid agencies and, in particular, between NGOs, the Red Cross movement, IOM and UN agencies. Working together in the world's crisis regions, they produce a Common Humanitarian Action Plan (CHAP). |
| **Common Humanitarian Action Plan (CHAP)** | A strategic plan for humanitarian response in a given country or region.<br>It provides:<br>• a common analysis of the context in which humanitarian takes place;<br>• an assessment of needs;<br>• best, worst, and most likely scenarios;<br>• identification of roles and responsibilities, i.e. who does what and where;<br>• a clear statement of longer-term objectives and goals;<br>• a framework for monitoring the strategy and revising it if necessary.<br>The CHAP is the foundation for developing a Consolidated Appeal, and is as such part of the Coordinated Appeals Process (CAP). |

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| **Central Emergency Response Fund (CERF)** | A multilateral funding tool created by the United Nations to pre-position funding for humanitarian action. CERF has up to US $500 million, including a grant facility of up to US $450 million and a loan facility of US $50 million. CERF grant component has two windows; one for rapid response and one for underfunded emergencies. CERF is funded by voluntary contributions from around the globe from Member States of the United Nations, private businesses, foundations and individuals and is managed by Emergency Relief Coordinator (ERC), head of the Office for the Coordination of Humanitarian Affairs (OCHA). |
| **Community-based distribution** | Provision of contraceptive methods by trained community members. Lay workers take family planning services to women and families, reaching those who cannot access health facilities. |
| **Community health staff** | A lay person or volunteer who works in health but who is not a clinician. |
| **Contraceptive methods** | Include clinic and supply (modern) methods and non-supply (traditional) methods. Clinic and supply methods include female and male sterilization, intrauterine devices (IUDs), hormonal methods (oral pills, injectables and hormone-releasing implants, skin patches and vaginal rings), condoms and vaginal barrier methods (diaphragm, cervical cap and spermicidal foams, jellies, creams and sponges). Traditional methods include rhythm, withdrawal, abstinence and lactational amenorrhoea. Surgical sterilization is usually considered to be contraception only if the operation is performed at least partly to avoid having more children (sterilization is also carried out solely for health reasons). |
| **Contraceptive prevalence (CP)** | The proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time. |
| **Dual protection** | Protection against both unintended pregnancy and STIs, including HIV. |
| **Family planning counselling** | Discussions with clients who have attended a health facility for any reason, the benefits of spacing or limiting pregnancy, methods available to do so and providing help to choose and correctly use a suitable contraceptive method. |
| **Female genital mutilation** | Procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. |
| **Focal point** | The person responsible for reproductive health. |
| **Gender-based violence** | 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. |
| **Health cluster** | The Global Health Cluster, under the leadership of the World Health Organization, is made up of more than 30 international humanitarian health organizations. The Cluster is activated during an emergency, whereby a RH coordinator and/or RH officer are appointed by the Health Cluster lead agency in the country, usually WHO. |
| **Health sector** | A part of the economy dealing with health-related issues in society. |
| **Humanitarian crisis** | An event or series of events that represents a critical threat to the health, safety, security or well-being of a community or other large group of people, usually over a wide area. Armed conflicts, epidemics, famine, natural disasters and other major emergencies may all involve or lead to a humanitarian crisis. |

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| **Humanitarian setting** | Any situation where normal coping mechanisms are not functioning to cope with the outside stressor. |
| **Infertility** | The inability of a couple to produce living children. |
| **Informed consent** | A legal condition whereby a person can be said to have given consent 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 adequate reasoning faculties and be in possession of all relevant facts at the time consent is given. Impairments to reasoning and judgement that would make it impossible for someone to give informed consent include such factors as severe mental retardation, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease or being in a coma. |
| **Internally displaced persons** | Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.<br>From: Deng, Francis. "The guiding principles on internal displacement". E/CN.4/1998/53/Add.I, February 11, 1998. New York, NY: United Nations. |
| **Mid-level provider** | Nonphysician clinicians — midwives, nurse practitioners, clinical officers, physician assistants and others — whose training and responsibilities differ among countries but who are trained to provide basic, clinical procedures related to reproductive health. These procedures include bimanual pelvic examination to verify the existence of a pregnancy and the positioning of the uterus; uterine sounding; transcervical procedures; and the performance of an abortion in early pregnancy. [Definition agreed upon by participants at a WHO Technical Consultation in September 2000.] |
| **Menstrual cycle** | A repeating series of changes in the ovaries and endometrium that includes ovulation and monthly bleeding. Most women have cycles that each last between 24 and 35 days. |
| **Opinion leaders** | Key informants, who can include community leaders, tribal chiefs, etc. |
| **Postabortion care** | Postabortion care (PAC) is the global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. |
| **Postpartum** | The first six weeks after childbirth. |
| **Progestogen (Progestin)** | Any of a large group of synthetic drugs that have effects similar to those of progesterone. Some are used in hormonal contraceptives. |
| **Programme manager** | A field-level agency employee in charge of his/her agency's reproductive health programming. |
| **Programme staff** | Anyone in an agency involved with clinical or nonclinical programming, administration, management, finance and monitoring and evaluation. |

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| **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. |
| **Refugee** | A person who flees to a foreign country or power to escape danger or persecution owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country.<br>1951 Convention Relating to the Status of Refugees. |
| **Reproductive health** | 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 to its functions and processes. |
| **Reproductive health lead agency** | The agency, identified by the health cluster or sector as the organization which has the most capacity to provide operational and technical support to the health partners to ensure the prioritization of reproductive health. |
| **Reproductive tract Infection (RTI)** | 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. |
| **Service provider** | Any agency or person that provides a service, including clinical care and counselling. |
| **Sex, sexual intercourse** | Sexual activity in which the penis is inserted into a body cavity:<br>• anal intercourse involving the anus<br>• oral intercourse involving the mouth<br>• vaginal intercourse involving the vagina |
| **Sexually transmitted infection (STI)** | Any of a group of bacterial and viral infections and parasites that are transmitted during sexual activity. |
| **Spotting** | Any bloody vaginal discharge outside of expected bleeding times. |
| **Traditional birth attendant (TBA)** | A community-based provider of care during pregnancy and childbirth. TBAs are not trained to proficiency in the skills necessary to manage or refer obstetric complications. |
| **Vaginal bleeding** | Any bloody vaginal discharge (pink, red or brown) that requires the use of sanitary protection (pads, cloths or tampons). Different vaginal bleeding patterns include:<br>• Breakthrough bleeding: Any bleeding outside of expected bleeding times (i.e. outside of regular monthly bleeding) that requires use of sanitary protection.<br>• Heavy bleeding (menorrhagia): Bleeding that is twice as heavy as a woman's usual bleeding.<br>• Infrequent bleeding: Fewer than two bleeding episodes over three months.<br>• Irregular bleeding: Spotting and/or breakthrough bleeding that occur outside of expected bleeding times (i.e. outside of regular monthly bleeding).<br>• Menstrual bleeding: Monthly bleeding, that takes place, on average, for three to seven days about every 28 days.<br>• Prolonged bleeding: Bleeding that lasts longer than eight days. |
| **Youth** | Person aged 10-24. |

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ANNEX 2

# Acronyms & Abbreviations

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|---|---|
| AFASS | acceptable, feasible, affordable, sustainable and safe |
| AIDS | acquired immunodeficiency syndrome |
| ANC | antenatal care |
| ARH | adolescent reproductive health |
| ART | antiretroviral therapy |
| ARV | antiretroviral(s) |
| BEmOC | basic emergency obstetric care |
| BMI | body mass index |
| CAC | comprehensive abortion care |
| CAP | Consolidated Appeals Process |
| CBD | community-based distribution |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CEmOC | comprehensive emergency obstetric care |
| CERF | Central Emergency Response Fund |
| CHAP | Common Humanitarian Action Plan |
| CIC | Combined injectable contraceptive(s) |
| COC | combined oral contraceptive(s) |
| CP | contraceptive prevalence |
| CRC | Convention on the Rights of the Child |
| CT | counseling and testing |
| CuIUD | copper-bearing intrauterine device |
| CYP | couple years protection |
| D&C | dilatation and curettage |
| DMPA | depot medroxyprogesterone acetate |
| DNA | deoxyribonucleic acid |
| EC | emergency contraception |
| ECP | emergency contraceptive pill(s) |
| EmOC | emergency obstetric care |
| EVA | electric vacuum aspiration |
| FP | family planning |
| GBV | gender-based violence |
| HAP | Humanitarian Accountability Partnership |
| HBV | hepatitis B virus |
| HIV VCT | HIV voluntary counselling and testing |
| HEADSSS | home, education/employment, activities, drugs, sexuality, suicide and depression, safety |
| HIV | human immunodeficiency virus |
| HLD | high-level disinfection |
| HPV | human papilloma virus |
| HRB | Humanitarian Response Branch |
| HSV | herpes simplex virus |
| IAFM | Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings |
| IASC | Inter-Agency Standing Committee |

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| IAWG | Inter-agency Working Group on Reproductive Health in Crisis Situations |
| ICPD | International Conference on Population and Development |
| IDU | injecting drug users |
| IEC | information, education and communication |
| IEHK | inter-agency emergency health kit |
| IM | intramuscular |
| IU | international units |
| IUD | intrauterine device |
| IUI | intrauterine insemination |
| IV | intravenous |
| LAM | lactational amenorrhoea method |
| LMP | last menstrual period |
| LNG-IUD | levonorgestrel intrauterine device |
| M&E | monitoring and evaluation |
| MCH | maternal and child health |
| MISP | Minimum Initial Service Package |
| MNH | maternal and newborn health |
| MOH | Ministry of Health |
| MSM | men who have sex with men |
| MTCT | mother-to-child transmission |
| MVA | manual vacuum aspiration |
| NET-EN | norethisterone enanthate |
| NGO | nongovernmental organization |
| NRTI | nucleoside-analogue reverse-transcriptase inhibitor(s) |
| OCP | oral contraceptive pill(s) |
| PAC | postabortion care |
| PAP | Papanicolaou |
| PCP | pneumocystis pneumonia |
| PCR | polymerase chain reaction |
| PEP | postexposure prophylaxis |
| PHC | primary health care |
| PID | pelvic inflammatory disease |
| PLHIV | people living with HIV/AIDS |
| PMTCT | prevention of mother to child transmission |
| PSB | procurement services branch |
| PSI | Population Services International |
| RDT | rapid diagnostic test |
| RH | reproductive health |
| RhD | Rhesus D |
| RPR | rapid plasma reagin |
| RTI | reproductive tract infection(s) |
| SAC | safe abortion care |
| SC | subcutaneous |
| Sd-NVP | single dose Neviraprine |
| SEA | sexual exploitation and abuse |
| SOP | standard operating procedure(s) |
| STI | sexually transmitted infection(s) |

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| TB | tuberculosis |
| TBA | traditional birth attendant(s) |
| TIG | tetanus immunoglobulin |
| TT | tetanus toxoid |
| TTI | transfusion transmissible infection(s) |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNHCR | Office of the United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| UTI | urinary tract infection |
| VCT | voluntary counselling and testing |
| VDRL | venereal disease research laboratory |
| VIA | visual inspection using acetic acid (vinegar) |
| VILI | visual inspection using Lugol's iodine |
| WBC | white blood cells |
| WHO | World Health Organization |
| YCBDA | youth community-based distribution agent(s) |

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ANNEX 3

# Sample Code of Conduct

## Sample Code of Conduct

In accordance with the mission and practice of [ORGANIZATION] and principles of international law and codes of conduct, all [ORGANIZATION] staff, including both international and national, regular full- and part-time staff, interns, contractors and volunteers, are responsible for promoting respect for fundamental human rights, social justice, human dignity and respect for the equal rights of men, women and children. While respecting the dignity and worth of every individual, the [ORGANIZATION] worker will treat all persons equally without distinction whatsoever of race, gender, religion, colour, national or ethnic origin, language, marital status, sexual orientation, age, socioeconomic status, disability, political conviction or any other distinguishing feature.

[ORGANIZATION] workers recognize that certain international standards of behaviour must be upheld and that they take precedence over local and national cultural practices. While respecting and adhering to these broader frameworks of behaviour, [ORGANIZATION] specifically requires that [ORGANIZATION] workers adhere to the following Code of Conduct.

Commitment to [ORGANIZATION] Code of Conduct

(1) A [ORGANIZATION] worker will always treat all persons with respect and courtesy in accordance with applicable international and national conventions and standards of behaviour.

(2) A [ORGANIZATION] worker will never commit any act that could result in physical, sexual or psychological harm to the beneficiaries we serve.

(3) A [ORGANIZATION] worker will not condone or participate in corrupt activities or illegal activities.

(4) [ORGANIZATION] and [ORGANIZATION] workers recognize the inherent unequal power dynamic and the resulting potential for exploitation inherent in humanitarian aid work, and that such exploitation undermines the credibility of humanitarian work and severely damages victims of these exploitative acts and their families and communities. For this reason, [ORGANIZATION] workers are prohibited from engaging in sexual relationships with beneficiaries.* Sexual activity with children (persons under the age of 18) is strictly prohibited.

(5) A [ORGANIZATION] worker must never abuse his or her power or position in the delivery of humanitarian assistance, neither through withholding assistance nor by giving preferential treatment, including requests/demands for sexual favors or acts.

(6) It is expected of all [ORGANIZATION] workers to uphold the highest ethical standard of integrity, accountability and transparency in the delivery of goods and services while executing the responsibilities of their position.

(7) A [ORGANIZATION] worker has the responsibility to report any known or suspected cases of alleged misconduct against beneficiaries to senior management (as outlined in the reporting pathway) immediately. Strict confidentiality must be maintained to protect all individuals involved.

I, the undersigned, hereby declare that I have read and understand this Code of Conduct. I

commit myself to exercise my duties as an employee of the Gender-based Violence Programme in accordance with the Code of Conduct. I understand that if I do not conform to the Code of Conduct, I may face disciplinary sanctions.

Employee's name, function and signature, date

Manager's name and signature, date

*Adapted from:* Gender-based Violence Tools Manual for Assessment and Programme Design, Monitoring and Evaluation. *RHRC Consortium, 2004.*

