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UNFPA

OPERATIONAL GUIDELINE ON
THE MINIMUM INITIAL SERVICE PACKAGE (MISP) FOR REPRODUCTIVE HEALTH IMPLEMENTATION IN HEALTH CRISIS

Ministry of Health – The Republic of Indonesia
2017

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1. Judul I. REPRODUCTION
II. ORGANIZATION AND ADMINISTRATION
III. DELIVERY OF HEALTH CARE

OPERATIONAL GUIDELINE ON MINIMUM INITIAL SERVICE PACKAGE (MISP) FOR REPRODUCTIVE HEALTH IMPLEMENTATION IN HEALTH CRISIS

Ministry of Health – The Republic of Indonesia
2017

FOREWORD
DIRECTOR FOR FAMILY HEALTH

Praises be to God for His blessings and grace that **"The Operational Guideline on the Implementation of theMinimum Initial Service Package (MISP) for Reproductive Health in Health Crisis"** can be completed. This guideline is produced to update the one published in 2015.

This Guideline on the Implementation of the Minimum Initial Service Package (MISP) for Reproductive Health in Health Crisis details operational steps for the implementation of MISP for use by humanitarian relief providers in disaster/crisis situations, specifically in the reproductive health (RH) sector. This guideline is practical and easy to applythat it can be used as a reference for the provision of RH services in times of disasters, which is often neglected.

This guideline provides basic knowledge on health crisis, basic understanding of Minimum Initial Service Package (MISP) for RH and RH logistics as well as the role of RH subcluster coordinator in the implementation of MISP for RH. This guideline also contains measures for theprevention and management of sexual violence, HIV transmission prevention, prevention of excess maternal and neonatal morbidity and mortality as well as planning forintegrated comprehensive RH care into primary health services in post crisis situations. In addition, this guideline also details additional priority activities for MISP, how to conduct MISP assessment and monitoring and evaluation.

To all parties who have contributed to the development of this guideline, we express our thanks and highest appreciation. We welcome feedbacks and comments to continuously improve this guideline. Hopefully, this guideline is useful in the collective effort to improve RH services in health crisis.

Jakarta, October 2017
Director for Family Health,

dr. Eni Gustina, MPH

FOREWORD
MINISTRY OF HEALTH – THE REPUBLIC OF INDONESIA

In normal situations, reproductive health issue remains a health challenge to address in Indonesia, let alone in disaster situations where availability and accessibility of RH services are disrupted. The need for RH services is often neglected and is not considered a priority in disaster management effort, when in reality, RH services in times of disasters/health crisis are still needed, and the needs likely increases due to the unstable social situations.

In an effort to provide reproductive health services in disaster/health crisis, since 2008 the Ministry of Health has been working with the United Nations Population Fund (UNFPA) to develop the Minimum Initial Service Package (MISP) for RH, which was adapted from *the Inter Agency Working Group (IAWG) on Reproductive Health in Crisis* guideline. Although it has been developed for almost ten years now, however, MISP for RH has not yet been properly understood or implemented in health crisis.

Since 2014, disaster management effort in Indonesia has adopted the cluster system approach from the international disaster management and response. This cluster approach aims to improve coordination, harmonization as well as effectiveness and efficiency in disaster response. The Ministry of Health acts as the health sector coordinator and coordinatesthe subclusters under the health, one of which is RH subcluster whose function is to provide RH services.

I welcome the publication of this **Operational Guideline on the Minimum Initial Service Packages (MISP) Implementation in Health Crisis** which can be used as a reference in ensuring the availability of RH services in disaster situations through the cluster approach. With the development of this guideline, all organizations, agencies and partners, RH services providers can work incoordination that ismore effective, integrated and comprehensive within the RH subcluster.

My highest appreciation to all who have contributed to the development of this guideline. Hopefully, efforts to fulfill RH rights can be continuously improved, especially to assist vulnerable groups, such as women in pregnancy, childbirth and postpartum; children, adolescents and women at reproductive-age in health crisis.

Jakarta, October 2017
Director General for Public Health

dr. Anung Sugihantono, M.Kes

FOREWORD
UNFPA REPRESENTATIVE IN INDONESIA

Indonesia is one of the most disaster-prone countries in the world. Located on the Pacific Ring of Fire, Indonesia frequently faces natural disasters – including earthquakes, tsunamis, volcanic eruptions, floods, landslides, droughts, and forest fires – and often with devastating effects. Indonesia's vulnerability to disaster requires preparedness at all levels.

Disasters have great potential to impact general health, including reproductive health. The need for RH services remains and may increase during a disaster with an increased risk of sexual violence and HIV transmission. Childbirth can occur during evacuation and displacement and a lack of access to emergency obstetric care can increase the risk of maternal death. Furthermore, a lack of access to family planning services can increase unwanted pregnancies during times of disaster.

Since 2008, UNFPA has worked with the Ministry of Health (MoH) to integrate the Minimum Initial Service Package (MISP) for reproductive health in emergencies into the existing National Health Emergency Preparedness and Response System, under the coordination of the Health Crisis Center. As part of the programme in 2014, with support from UNFPA, the MoH developed a technical guideline on the MISP in health crises. The guideline describes the rationale why the MISP is very important, objectives and components of the MISP, logistics to support the MISP, and monitoring and evaluation related to the MISP. After two years of guideline implementation and feedback from several emergency responses in Indonesia, an MISP operational guideline is developed to support the Provincial and District Health Offices (PHO and DHO) in responding to disasters. Developed through a consultative process, including field consultative meetings conducted in disaster affected areas, this guideline focuses on the programme management aspect complementing the MISP technical guideline developed in 2014. It provides very detailed guidance and step-by-step actions with a clear timeframe to implement each component of the MISP in the acute phase of a disaster.

I hope that this operational guideline will be used to assist affected provinces and districts for timely and quality implementation of the MISP to meet the reproductive health needs of people affected by disasters in Indonesia, and particularly to save the lives of women and girls.

Jakarta, October 2017

Dr. Annette Sachs Robertson
UNFPA Representative in Indonesia

CONTENT

ACRONYMS AND ABBREVIATIONS

IUD	:	Intra Uterine Device
ARV	:	Antiretro Viral
BDRS	:	Bank Darah Rumah Sakit – Hospital Blood Bank
BKKBN	:	National Population and Family Planning Board
BNPB	:	National Disaster Management Agency
BPBD	:	Provincial Disaster Management Agency
CBR	:	Crude Birth Rate
CPR	:	Contraceptive Prevalence Rate
HIV	:	Human Immunodeficiency Virus
IAWG	:	Inter Agency Working Group
IBI	:	Indonesian Midwives Association
STIs	:	Sexually-Transmitted Infections
IEC	:	Information, Education and Communication
NSPK	:	Norms, Standards, Procedures, and Criteria
PLWHA	:	People Living With HIV/AIDS
P2TP2A	:	Integrated Child Protection and Women's Empowerment Center
PFA	:	Psychological First Aid
PIK-KRR	:	Adolescent Reproductive Health Information and Counseling Center
PKBI	:	The Indonesian Planned Parenthood Association
PKK	:	Health Crisis Center
BEONC	:	Basic Emergency Obstetric and Neonatal Care
CEONC	:	Comprehensive Emergency Obstetric and Neonatal Care
MISP	:	Minimum Initial Service Package
PPP/PEP	:	Post Exposure Prophylaxis
PWS KIA	:	Local Area Maternal and Child Health Surveillance
RHA	:	Rapid Health Assessment
RH Kit	:	Reproductive Health Kit
SGBV	:	Sexual, Gender-Based Violence
UTD	:	Blood Transfusion Unit
WRA	:	Women at Reproductive Age

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CHAPTER 1
INTRODUCTION

1. Background

In 2008, the Ministry of Health of the Republic of Indonesia developed a programme for reproductive health (RH) services in disaster situations which was then implemented throughout Indonesia. At that time, the implementation was based on the guideline on reproductive health in disaster situations, translated from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises international guideline. Since 2014, the guideline has been adapted to suit Indonesia's context with the publication of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. This MISP for RH guideline was developed based on field experiences and practices in the provision of reproductive health services in crisis situations from the tsunami that struck Aceh in 2004 until more recent disasters in 2017.

In the period of 2008-2012, the MISP guideline had been disseminated to heads of health agencies at provincial and district levels and to other relevant sectors and partners. In addition, trainings for MISP for reproductive health have been conducted in 33 provinces with participation from health personnel, including midwives and nurses. To date, MISP for RH has been continuously updated and so far has been integrated into the health crisis management policy at the Ministry of Health with the issuance of Ministry of Health Regulation No. 64/2013 on Health Crisis Management. MISP trainings for health workers/providers have been conducted by provincial authorities and partners. Trainings were held for 9 regional level and 2 sub-regional level health crisis centers as well as the development of MISP modules as part of local content of midwifery school curriculum.

For almost a decade, provision of RH services in crisis situations has been conducted; however, the implementation in the field has yet to meet expectations. Challenges in MISP implementation include the lack of understanding on the importance of RH services in crisis situations/health crises among the stakeholders, the lack of training of health officers, staff turnover, etc. In addition, intersectoral coordination and coordination among partner organizations and agencies working for the provision of RH services in health crises is still weak.

In 2014, Indonesia started to implement the cluster system in disaster management efforts. The cluster approach aims to improve the quality of services in disaster management through partnership with various elements under the coordination of the National Disaster Mitigation Board (BNPB) and Regional Disaster Mitigation Agency (BNPD). The health cluster consists of several sub-clusters, each responsible for specific health issues. One of these is the Reproductive Health sub-cluster in charge of RH services provision.

With the cluster system, hopefully the provision of RH services through the MISP implementation in crisis situations can be improved due to stronger coordination among clusters and among members in each subcluster to optimally mobilize all resources for the fulfillment of reproductive health rights, especially of vulnerable groups such as women in pregnancy, women in childbirth, women in post-delivery, newborns, adolescents, and women at reproductive age.

The development of this Guideline on MISP for RH Implementation in Health Crises serves as a reference for all sectors, organizations, and agencies to work in a coordinated approach so that services can be provided in a comprehensive, effective, and efficient manner.

2. Objective

This MISP guideline is developed as a technical guideline for the RH sub-cluster in coordinating efforts for the availability of RH services in health crises.

3. Target users

1. The person in charge for the Reproductive Health/FamilyHealth Programmes at national and regional levels.
2. The person in charge of health crisis management at national and regional levels.
3. BNPB and BPBD.
4. The Indonesian Military and Police involved in disaster management.
5. Hospitals, Primary Health Centers (Puskesmas), clinics, and private health service providers.
6. Educational institutions.
7. Professional organizations, non-governmental organizations (NGOs), and community-based organizations.
8. Health workers/personnel and community/field counselors.

CHAPTER 2
BASIC KNOWLEDGE ABOUT HEALTH CRISES

1. Health Crisis

A health crisis is an event or a series of events representing a threat to the health of individuals or a community as a result of disasters and/or potential disasters.

2. Phases of Health Crisis Activities

Health crises activities are divided into 3 phases:

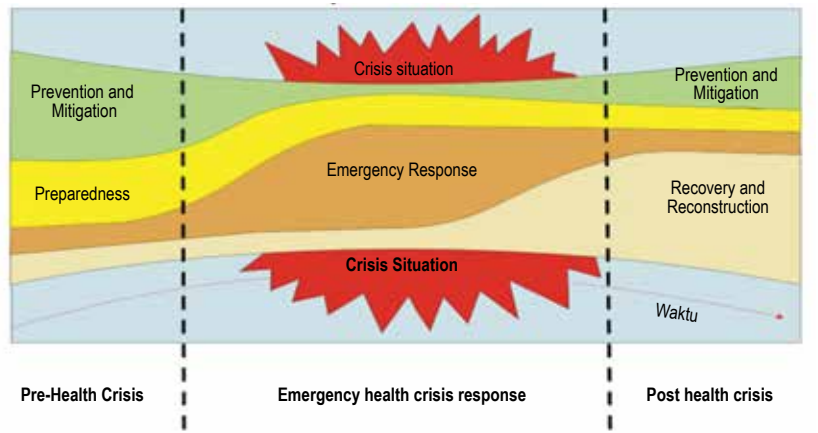
a. **Pre-health crisis:** a series of health crisis preparedness activities conducted before the onset of a disaster or in situations prone to disaster. The activities cover planning for health crisis management, health crisis risk reduction, education and trainings, establishment of criteria for technical standards, and analysis of health crisis management, preparedness, and health mitigation.

b. **Emergency health crisis response:** a series of activities launched immediately following a disaster to address health impacts, including rescue and evacuation of survivors, basic needs provisions, survivors' protection and recovery support, and immediate provision of basic infrastructure and healthcare facilities.

c. **Post-health crisis:** a series of activities undertaken after the acute phase of a crisis to repair, restore, and/or rebuild local health infrastructure and facilities.

The duration of emergency response period is determined by the government based on the recommendations of BNPB and BPBD. The phase of the health crisis can be described as below:

Image 1: Phases in Health Crisis



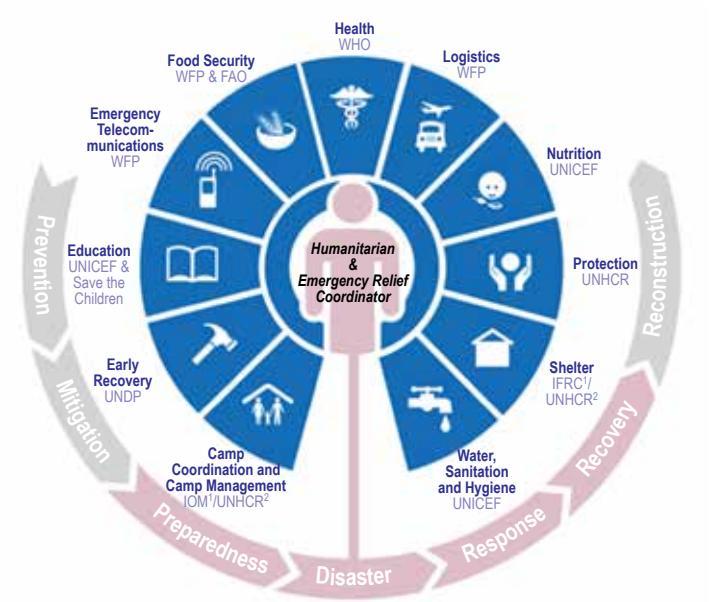
3. The Cluster Approach in Disaster and the Disaster Mitigation Board/Agency

In disaster management efforts, coordination and close cooperation among various national, international, governmental, private, and community actors are needed. A cluster is a group of agencies, organizations, and/or institutions who work together to achieve a common goal and to address the needs of a particular sector (e.g. health) following a disaster. The cluster approach is one of the coordinating approaches that bring together all relevant parties, both government and non-government, in a disaster management effort to minimize gaps and overlaps in delivering humanitarian aid/services.

1. International Cluster System

The international cluster is a group of humanitarian organizations, both UN and non-UN, with its own role in the main sectors of humanitarian action. They are appointed by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination. The international cluster is chaired by the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). There are 11 (eleven) international clusters, including the health cluster, led by the World Health Organization (WHO), and the nutrition cluster, led by the United Nation Children's Fund (UNICEF).

Image 2: International Cluster System

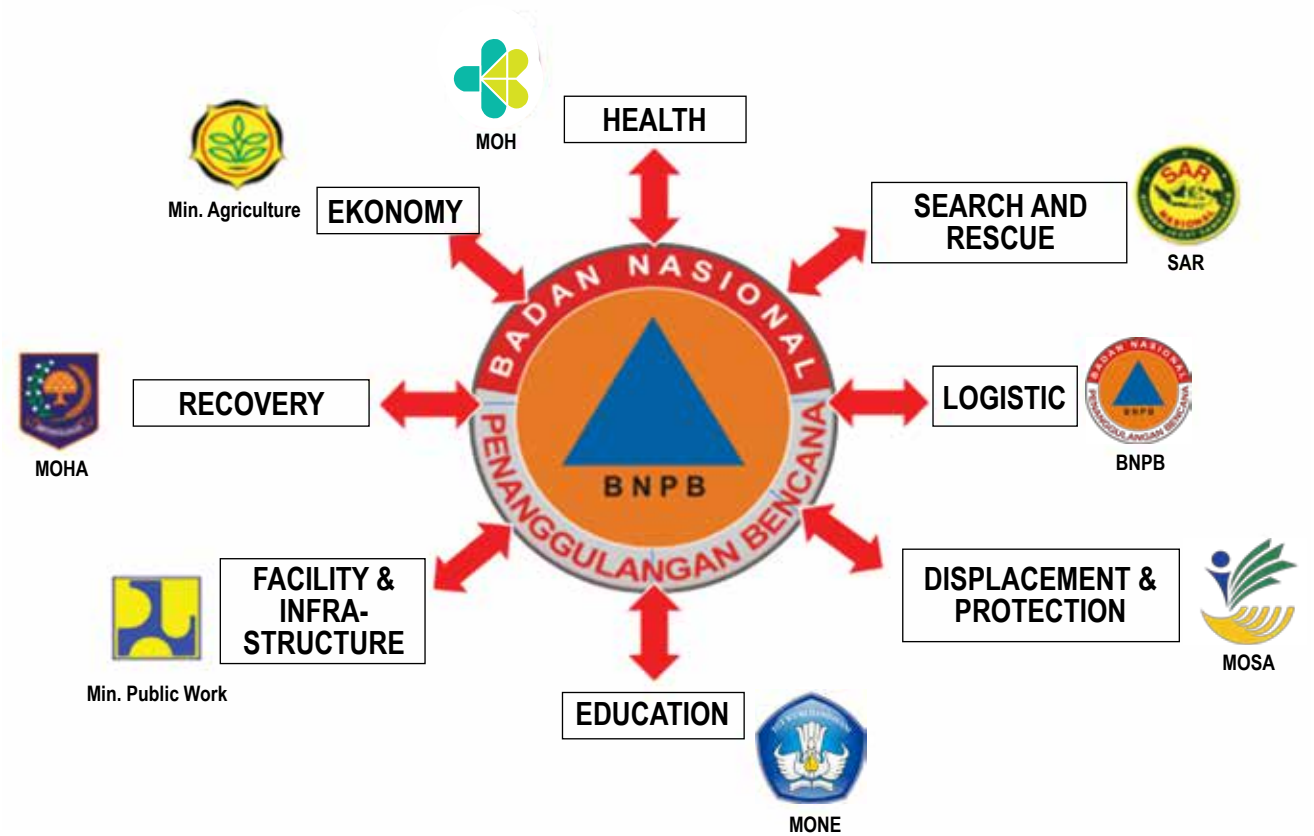


2. National Cluster System

In Indonesia, the international cluster system has been implemented in disaster response and rehabilitation efforts after the earthquake in Yogyakarta in 2006 and West Sumatra in 2009. Lessons learned from the implementation of the cluster sytem in Indonesia showed that disaster management efforts have been better coordinated and more effective.

In 2014, the BNPB and the relevant ministries/organizations agreed to establish a national cluster system as stipulated in the Decision of the Head of BNPB no. 173 in 2015, comprising of 8 clusters, namely: 1. Health, 2. Education, 3. Displacement and Protection, 4. Facility and Infrastructure, 5. Early Recovery, 6. Economy, 7. Logistics, and 8. Search and Rescue. At the national cluster level, the health sector is under the health cluster and the Ministry of Health acts as the lead agency.

Image 3: National Cluster System



3. National Disaster Management Board (BNPB)

BNPB is a ministrial level, non-departmental, government agency whose function is to formulate and implement policies for disaster response and IDPs management in a timely, appropriate, effective, and efficient manner; and, to coordinate the implementation of disaster management activities in a way that is thoroughly planned, integrated, and comprehensive at the national level.

4. Regional Disaster Management Agency (BPBD)

BPBD is a regional agency, established to carry out duties and functions related to disaster management efforts at the sub-national level. At the provincial level, the BPBD is led by an official who reports to the governor or equal to echelon Ib (one b); and the BPBD at the district/municipality level is led by an officer reporting to the regent/mayor or echelon IIa (two a). The Head of BPBD is an ex officio position of the Regional Secretariate who reports directly to the head of local administration.

5. National Health Cluster

The health sector disaster response is conducted based on the cluster/sub-cluster and territorial/regional approach. The Minister of Health establishes 6 (six) health sub-clusters, chaired by the head of the Health Crisis Center. Each sub-cluster is responsible for coordinating disaster management efforts in line with its respective duties and responsibilities. Members of the health cluster and sub-clusters can represent government and non-government, sharing mandates and goals in the same domain.

To improve preparedness and strengthten coordination, the health sub-cluster approach is replicated at the provincial and district/city levels.

Table 1: National Health Sub-Clusters

NO	SUB-CLUSTER
1	Health services sub-cluster
2	Disease and environmental health control sub-cluster
3	Nutrition sub-cluster
4	Reproductive healthsub-cluster
5	Mental health sub-cluster
6	Disaster Victim Identification (DVI)
Plus the establishment of the following teams:	
	Logistics Team
	Data and Information

Apart from the establishment of the above sub-clusters, to accelerate services availability and bring health services closer, 9 (nine) regional health crisis centres (PKK) are established across Indonesia. The regional PKK functions as

a health unit/team in the management of health crisis in its respective region and acts as a medical assistance command center, referral center, and health information center.

Image 4: Regional Health Crisis Center

6. Reproductive Health Sub-Cluster

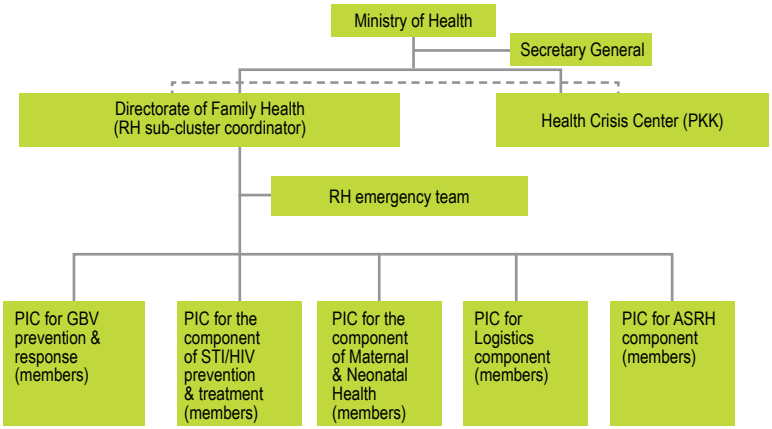
The reproductive health sub-cluster is part of the health cluster, responsible for ensuring availability and proper running of reproductive health services during a health crisis to reduce excess reproductive health morbidity and mortality among vulnerable groups. The reproductive health sub-cluster is established at the central and district levels in a hierachical structure. It functions and works in coordination in pre-crisis, during crisis, and post-crisis situations.

Members of the reproductive health sub-cluster can represent governmental, private, and profession-based organizations, and community groups working to promote reproductive health. The reproductive health sub-cluster is headed by a coordinator who is responsible for coordinating the MISP for RH components, including the gender-based violence, prevention of HIV transmission, maternal and neonatal health, logistics, and adolescent reproductive health. For each of the MISP for RH components, a person in charge is appointed.

At the national level, the RH sub-cluster coordinator is an official or holder of structural position of echelon 2 level who is responsible for the reproductive health programme, namely Director for Family Health at the Ministry of Health. The person-in-charge for each MISP component is an echelon 3 official who is responsible for the programme and whose roles and functions corespond to a specific MISP component.

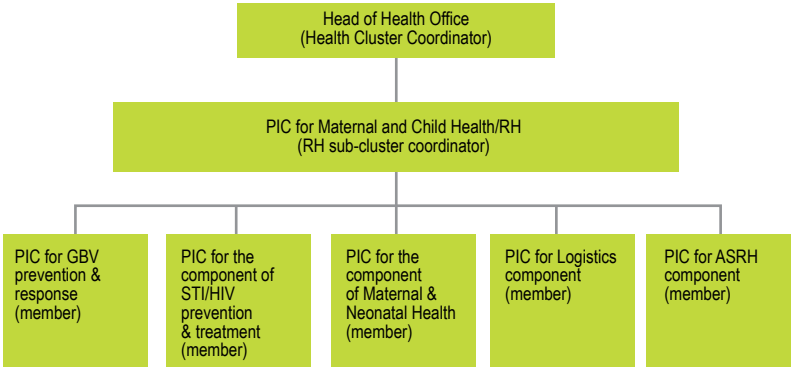
In addition, to facilitate the work of the reproductive health sub-cluster at the regional level, especially when a major disaster breaks out, the RH Emergency Team is established at the national level and is to be activated only when the local authority is unable to address RH issues in the disaster-affected area. This RH Emergency Team consists of governmental and private organizations and individuals working in the reproductive health sector, specifically in crisis situations.

Image 5: Structure of RH Sub-Cluster at the National Level



At the provincial and district/city levels, acting as reproductive health coordinator is echelon 3 or official-in-charge for Family Health/RH programme at the District Health Office.

Image 6: Structure of RH Sub-Cluster at Regional Level



CHAPTER 3

MINIMUM INITIAL SERVICE PACKAGE (MISP) AND LOGISTICS FOR REPRODUCTIVE HEALTH

1. MISP for reproductive health

The availability of reproductive health services at the earliest onset of a disaster/health crisis is ensured through the implementation of MISP for RH. The MISP targets population with reproductive health vulnerabilites such as newborns, pregnant women, women in childbirth and post delivery, breastfeeding mothers, girls, adolescents, and women at reproductive age.

MISP is a set of priority RH activities to be immediately implemented in the earliest phase of health crisis emergency response in order to save the lives of vulnerable groups . MISP for RH is implemented when the existing health service facilities are unable to deliver services and/or access to RH services is difficult to reach for disaster-affected communities.

The MISP for RH is implemented in all types of disaster settings, both natural and non-natural. The needs for RH services is calculated based on the rapid needs assessment result, conducted by the health workers in the field or members of RH sub-cluster. Failures to implement MISP for reproductive health may result in the following consequences: 1. increased maternal and neonatal deaths, 2. An increased risk of sexual violence cases and complications, 3. An increased risk for sexually transmitted infections (STIs), 4. Unintended pregnancies and unsafe abortions, 5. HIV transmission.

Table 2: Description of MISP for Reproductive Health

Package	Activities, coordination, planning, and logistics. The term package does not mean a box but refers to a strategy that includes coordination, planning, supplies, and activities for sexual and reproductive health services
Service	Reproductive health services provision to the affected population
Initial	To be implemented immediately based on the result of the rapid health assessment
Minimum	Basic, limited

[1] Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health in Health Crises, 2015

Table 3: Phases of MISP for Reproductive Health Implementation in Health Crises

Health crisis phases	Activities
Pre-Health Crisis	☑ Establishment of RH sub-cluster ☑ MISP advocacy and socialization ☑ MISP training ☑ Policy development ☑ Guidelines development ☑ MISP logistics provision
Emergency response to health crisis	☑ Implementation of MISP for reproductive health (PPAM)
Post-Health Crisis	☑ Planning for comprehensive reproductive health

2. MISP Component and Time Frame

The MISP is implemented to answer the needs of disaster-affected groups with RH vulnerabilities, like women in pregnancy, women in childbirth and post-delivery, newborns, children, and women at reproductive age. Components ofthe MISP for RH are immediately conducted after the results of the RHA team are available.

MISP consists of the following 5 components:

1. Identify the coordinator for MISP for reproductive health
2. Prevent and manage sexual violence
3. Prevent HIV transmission
4. Prevent excess maternal and neonatal morbidity and mortality
5. Plan for integrated comprehensive reproductive health services into local primary health care when the situation becomes stable in post-health crisis

In addition to the above components, there are additional priority activities for MISP components to be made available:

1. Ensure adequate supplies for continued contraceptive use for family planning
2. Implement adolescent reproductive health in all components of MISP
3. Distribute individual kits

Table 4: MISP Activities and Time Frame for Implementation

MISP COMPONENT	ACTIVITY	TIME FRAME
Component 1: Identify RH sub-cluster coordinator (MISP coordinator)	a. Appoint (activate) a coordinator to coordinate inter-agency effort of local and international organizations for MISP for RH implementation b. Host/conduct coordination meeting to support and appoint a person in charge for each of the MISP components c. Report/share reproductive health related challenges and data, availability of resources, and logistics in the coordinating meetings d. Ensure availability and distribution of RH kits	a. 1x24 hours b. 1x24 hours c. 2x24 hours d. 1x24 hours
Component 2: Prevent and manage sexual violence	a. Implement protection measures for population affected by disaster, particularly women and children b. Provide medical services for survivors including provision of Post Exposure Prophylaxis (PEP) and emergency contraceptives (within 72 hours) and psychological first aid (PFA) for rape survivors c. Ensure that community is aware of clinical service availability, Psychosocial First Aid (PFA), referral for protection, and legal aid d. Ensure availability of network for sexual violence prevention and management	a. 1x 24 hours after a disaster strikes (especially disaster caused by social conflict) b. Services available within the first 24 hours after the disaster and prophylactic treatment is administered within 72 hours after rape c. 48 hours d. 72 hours

MISP COMPONENT	ACTIVITY	TIME FRAME
Component 3: Prevent HIV transmission	a. Ensure availability of safe blood transfusion b. Facilitate and ensure compliance with universal precaution (1 x 24 hours) c. Administration of Post Exposure Prophylaxis (PEP) d. Ensure ARV availability e. Ensure condom availability	a. 1x 24 hours post-disaster b. 1x 24 hours post-disaster c. within 72 hours d. within 72 hours e. in coordination with logistics team for availability of contraceptive supplies
Component 4: Prevent excess maternal and neonatal morbidity and mortality	a. Ensure availability of maternity rooms in a number of places like health posts, at IDPs camps, or other appropriate locations b. Ensure availability of services (by competent personnel and with proper equipment and supplies to meet standard) for normal delivery and emergency obstetric and neonatal care (BEONC and CEONC) at primary health centers and referral facilities c. Set up referral mechanism to facilitate transportation and communication from community to primary health centers (puskesmas) and from the puskesmas to hospital d. Ensure the availability of delivery kit (pregnancy kit, postdelivery kit, clean delivery kit) to be given to women in later pregnancy and expecting childbirth soon e. Ensure that the community is aware that childbirth services and emergency obstetric and neonatal care are available f. Ensure adequate contraceptive supplies	All steps for component 4 are conducted within 24 hours after disaster

MISP COMPONENT	ACTIVITY	TIME FRAME
Component 5: Plan for integrated comprehensive reproductive health services into the primary health care when situation has become stable	a. Identify the needs for reproductive health equipment and supplies based on estimated target b. Collect real data for target population and service coverage c. Identify health facilities for provision of comprehensive reproductive health services d. Assess the capacity of health providers to deliver comprehensive reproductive health services and develop training plan	Transition from emergency response to recovery
Additional priorities: 1. Ensure availability and continued use of contraceptive for family planning	Ensure availability of contraceptives to ensure continued contraceptive use by FP acceptors	72 hours post-disaster
2. Adolescent Reproductive Health in all MISP components	Ensure MISP for adolescent reproductive health is available (see the chapter on additional priorities)	As soon as possible consistent with the time frame for MISP's components above
3. Distribute individual kits	Ensure individual kits (pregnancy kit, post-delivery kit, newborn kit, and hygiene kit) are well distributed to the target population	As soon as possible according to the result of rapid needs assessment.

To facilitate the implementation of MISP for RH in the field, a cheat sheet/a chart of the objectives of the implementation of MISP in a health crisis should be developed. The chart should contain the 5 components of MISP for RH, the objectives of each component and RH kits, and logistics needed to support all activities of each of the RH components.

CHART:IMPLEMENTATION OF THE MINIMUM INITIAL SERVICE PACKAGE FOR REPRODUCTIVE HEALTH

(The complete information on this chart can be found in the Operational Guideline for MISP for Reproductive Health)

Additional Priorities

a. Integrate youth programme and adolescent reproductive health in all aspects
b. Ensure continuation of Family Planning programme
c. Management of indications of sexually-transmitted infections
d. Ensure continued access to HIV treatment andmedicines
e. Distribute hygene supplies and sanitary napkins

COMPONENT 1

RH Kit 0

Identify an agency coordinator for MISP for reproductive health.

a. Appoint a coordinator for reproductive health for inter-programme, inter-sectoral, and local and international organizations for the implementation of MISP for reproductive health.
b. Host coordinating meeting to support and appoint person in charge for each of the MISP components (SGBV, HIV, Maternal and Neonatal as well as logistics)
c. Share reproductive health related issues and data, availability of resources and logistics in coordination meetings.
d. Ensure availability and distribution of RH Kits

Key word: reproductive health sub-cluster coordinator, data on vulnerable population, data obtained by partners of reproductive health sub cluster

Reproductive Health Logistics (RH Kit and individual kit) are devices/tools, medicines and other equipment used for provision of reproductive health in emergency health crisis response.

COMPONENT 5

RH Kit 4 | RH Kit 5 | RH Kit 7

Plan for reproductive health services that are comprehensive and integrated into primary health centers when situation stabilizes/in recovery phase. Support agencies/organizations to:

a. Identify the needs for reproductive health logistics based on estimated target
b. Collect real data of target population and scope of services
c. Identify health facilities for provision of comprehensive reproductive health services
d. Assess competency of health workers for comprehensive reproductive health services and develop training plans.

Key word: Data collection on vulnerable population, mapping of health facilities (facilities, infrastructure and health workers), planning for comprehensive reproductive health service in recovery phase.

COMPONENT 2

RH Kit 3 | RH Kit 9

Prevention and Management of Sexual Violence:

a. Ensure protection for the affected population, especiallywomen and children
b. Provide medical services and psychosocial support for rape survivors
c. Ensure community knows that information is available on medical care, psychosocial, reference for protection, and legal aid
d. Ensure availability of network for the prevention and management of sexual violence.

Key word: safe tents, safe toilet, hotline for prevention of sexual violence, network for prevention and supports for survivors

Objectives:
Prevent deaths, morbidity, and disability of the crisis-affected population (refugees, internally displaced people, local community)

COMPONENT 4

RH Kit 2 | RH Kit 6 | RH Kit 8 | RH Kit 9

Prevent excess maternal and neonatal morbidity and mortality:

a. Ensure availability of maternity facility in places like health posts, IDPs camps,and other appropriate areas
b. Ensure availability of childbirth services and emergency maternal and neonatal care (BEONC and CEONC) at primary health center and referral health facilities
c. Establish referral system to facilitate transportation and communication between community and primary health center and from primary health center to hospital
d. Ensure availability of childbirth kits for women in late pregnancy
e. Ensure community is aware of availability of childbirth services and maternal and neonatal emergency care
f. Availability of contraceptives to meed the need

RH Kit 10

RH Kit 11

Key word: childbirth facility, 24-hour emergency maternal and neonatal care, referral system, hotline,contraceptive supplies

COMPONENT 3

RH Kit 1 | RH Kit 12

Prevention of HIV transmission:

a. Ensure availability of safe blood transfusion
b. Facilitate andensure universal precaution standard compliance
c. Ensure availability of condom supplies
d. Ensure availability of safe blood andsafe transfusion (SAME AS A. ABOVE)
e. Obtain data on numberof current ARV users
f. PreventHIV and HIV transmission to children
g. Meet the needs of people with STIs

Standard Precautions Kit 1-12

Key word: implementation of standard precautions, safe blood transfusion, prophylaxis, post exposure prophylaxis, ARV, condom availability, hotline for ARV service providers

Reproductive Health Logistics:

	CRISIS	POST-CRISIS
	Crude mortality rate > 1 death/10,000/day	Mortality returns to level of surrounding populations
SUBJECT AREA	**MINIMUM (MISP) RH SERVICES**	**COMPREHENSIVE RH SERVICES**
FAMILY PLANNING	• Provide contraceptives, such as condoms, pils, injectables and IUDs, to meet demand	• Source and procure contraceptive supplies • Provide staff training • Establish comprehensive family planning programs • Provide community education
GENDER-BASED VIOLENCE	• Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters • Provide clinical care for survivors of rape • Inform community about services	• Expand medical, psychological, social and legal care for survivors • Prevent and addness other forms of GBV, including domestic, violence, forced/early marriage, female genital outting • Provide community education • Engage men and boys in GBV programming
MATERNAL AND NEWBORN CARE	• Ensure availability of emergency obstetric and newborn care services • Establish 24/7 referral system for obstetric and newborn emergencies • Provide clean delivery packages to visibly pregnant women and birth atlendants • Inform community about service	• Provide antenatal care • Provide postnatal care • Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care • Increase access to basic and comprehensive emergency obstetric and newborn care
STIs, INCLUDING HIV, PREVENTION & TREATMENT	• Ensure safe and rational blood transfusion practice • Ensure adherence to standard precautions • Guarantee the availability of free condoms • Provide syndromic treatment as part of routine clinical services for patients presenting for care • Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible	• Establish comprehensive STI prevention, and treatment services, including STI surveilance systems • Collaborate in establishing comprehensive HIV services as appropriate • Provide care, support and treatment for people living with HIV/AIDS • Raise awareness of prevention, care, treatment services of STis

The RH Kit is designed for use for a 3-month period for a varying population number and is divided into three "blocks" as follows:

Block 1
Six kits to be used at the community and primary health care level for 10,000 persons/ 3 months

Kit Numbers	Kit Name	Color Code
Kit 0	Administration	Orange
Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
Kit 3	Rape Treatment	Pink
Kit 4	Oral and injectable Contraception	White
Kit 5	STI	Turquoise

Block I contains six kits. The items in these kits intended for use by service providers delivering RH care at the community and primary 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
Five kits to be used at the community and primary health care level for 30,000 persons / 3 months

Kit Numbers	Kit Name	Color Code
Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
Kit 7	IUD	Black
Kit 8	Management of Complications of Abortion	Yellow
Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
Kit 10	Vacuum Extraction for Delivery (Manual)	Grey

Block 2 is composed of five kits containing disposable and reusable matterial. The items is this kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.

Block 3
Two kits to be used at referral hospital level for 150,000 persons / 3 months

Kit Numbers	Kit Name	Color Code
Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
Kit 12	Blood Transfussion	Dark Green

Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the refellal (surgical constetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 have two parts A and B, which are usually used together but which can be ordered separately.

Note: Agencies should not depend solely on the inter-agency RH Kits and should plan to integrate the procurement of MISP/RH supplies in their routine health procurement systems.

Resources:

- Reproductive Health in Humanitarian Settings: An Inter-agency Field Manual: http://www.iawg.net/resources/field_manual.html
- MISP Distance Learning Module: http://misp.rhrc.org
- SPRINT Facilitator's Manual for SRH Coordination: www.ippfeseaor.org/en/Resources/Publications/SPRINTFacilitatorsManual.htm
- UNFPA/Save the Children Adolescent Sexual and Reproductive Health Toolkit in Humanitarian Settings: A companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: www.unfpa.org/public/publications/pid/4169
- RHRC Monitoring and Evaluation Toolkit: www.rhrc.org/resources/general_fieldtolls/toolkit/
- CDC RH Assessment Toolkit for conflict-Affected Women: http://www.cdc.gov/reproductivehealth/Refugee/RefugeesProjects.htm
- Inter-agency Working Group on Reproductive Health in Crises: www.iawg.net
- Reproductive Health Response in Crises (RHRC) consortium: www.rhrc.org

3. MISP logistics

For optimal reproductive health services delivery, the availability of kits and equipment for MISP should be ensured. There are 3 (three) types of kits: individual kits, clean delivery kits, and reproductive health kits, as well as tools and supportingequipment. These kits should be available in the pre-health crisis phase as part of emergency preparedness. Availability and distribution of these kits can be done independently by the government or other parties. The following is information about the types of kits and MISP logistics:

1. Individual kits

- Contains personal needs for specific reproductive health target groups.
- Packaged in a color-coded bags, including pregnancy kit (green bag), post-delivery kit (orange bag), newborn kit (red bag), and hygiene kit for women at reproductive age (blue bag).
- The kits are immediately distributed in the earliest phase of a health crisis as indicated by rapid needs assessment results.

The person in charge of MISP component for logistics prepares and distributes individual kits by:

(1) Calculating the needs for individual kits using real data from the field, or in case data is not available, estimation can be made using of estimated target populations from the total IDPs population in a specific area. Please see Table 9: Making estimates for RH target populations.

(2) Distributing individual kits to specific target populations, namely:

- Pregnancy kit for women in their third trimester of pregnancy
- Post-delivery kit for women who just give birth
- Newborn kit for babies up to 3-months old
- Hygiene kit for women at reproductive age

(3) When individual kits are not yet available, the person in charge of MISP can coordinate efforts to meet these needs with various humanitarian organizations or donors working in a health crisis.

2. Clean delivery kits

- Contains equipment, medicines, and disposable items to assist delivery. It is advisable to ensure that all equipment and medicines are in the kit as well as to check the expiration date of the medicines.
- The kits are distributed to the midwives working in the affected area or IDP camps. Make sure that transportation is available and the affected location is accessible.
- The kits are provided when delivery equipment/midwifery kits are not available, damaged, or lost during the disaster.

3. Reproductive health kit

- This kit is only used in major-scale disasters where health infrastructures are seriously damaged, out of service, and unable to deliver health services. It includes equipment, medicines, and disposable items packaged, numbered, and color-coded according to types of medical interventions to make it easier for service providers. There are 12 types of reproductive health kits (please see Table 5).
- The kit contains health equipment and disposable items for primary health centers and hospitals. The reproductive health kit consists of 3 blocks, each for a different type/level of health facilities.
- The kit is designed to last for a 3-month period to serve a specific number of the affected population.
- The reproductive health kit is adapted from the international standard and modified according to reproductive health policies and standards in Indonesia. The list of equipment and medicines contained in the reproductive health kit can be found in the Guideline on Logistical Support for the Implementation of MISP for Reproductive Health in Health Crisis.
- The need for this kit depends on the number of displaced people, types of services to provide, and estimated duration of displacement.

The RH sub-cluster coordinator and the person in charge of logistical components manage the availability and distribution of reproductive health kits through:

(1) Coordination of mapping of health facilities that are damaged and out of service

(2) Requesting RH kit provision through local provincial/district/city health office

- Provincial/district/city health office can procure RH kits in-line with the Guideline on Logistical Support for the Implementation of MISP for Reproductive Health
- Local health office can make an official request for RH kits provision by sending an official letter to Ministry of Health c.q. Director for Family Health. The Ministry of Health will forward the request to UNFPA Indonesia to facilitate provision of RH kits from international logistical warehouse in Copenhagen.
- The provincial or district/city health office can coordinate with organization/institution/other parties working in humanitarian sector for procurement of RH kit.

(3) Ensuring transportation is available and the location for kit distribution is accessible

(4) Preparing appropriate site/location for temporary storage of RH kit (warehouse) prior to distribution

(5) Checking the content of the RH kit; making sure that it contains all equipment and medicines as well as checking the expiration dates using the checklist attached to the RH kit before distribution

(6) Distributing RH kit according to the criteria of the health facility (primary health center and different levels of referal facilities, etc.)

(7) Providing clear information on how to use the reproductive health kit

(8) Transferring the kit to the person in charge/head of the primary health center and/or hospital by signing of the handover form

Below is a list of logistical issues to understand in the provision of RH kits, among others:

(1) Custom clearance (for kits from Copenhagen)

(2) Monitoring of cold chain medicines

(3) Distribution plan

(4) Mode of transportation

(5) Warehouse

(6) Coordination with local organizations and authorities

Table 5: Adapting Reproductive Health Kit for Indonesia's Context

International Reproductive Health Kit			Reproductive Health Kit for Indonesia's context		
Block 1	Kit 0	Administration kit	Block 1	Kit 0	Administration kit
	Kit 1	Condom kit		Kit 1	Condom kit
	Kit 2	Individual clean delivery kit (Part A & B)		-*	*In Indonesia Kit 2 is not adapted*
	Kit 3	Rape Kit		Kit 3	Rape Kit
	Kit 4	Oral and injectables contraception		Kit 4	Oral and injectables contraception
	Kit 5	Sexually-transmitted infection kit		Kit 5	Sexually-transmitted infection kit
Block 2	Kit 6	Delivery kit for health facility	Block 2	Kit 6	Delivery kit for health facility
	Kit 7	Intra Uterine Device and removal kit		Kit 7	Intra Uterine Device and implant removal kit

International Reproductive Health Kit			Reproductive Health Kit for Indonesia's context		
Block 2	Kit 8	Management of misscarriage complication kit	Block 2	Kit 8	Management of misscarriage complication kit
	Kit 9	Suture of tears (cervical & vaginal) and vaginal examination		Kit 9	Suture of tears (cervical & vaginal) and vaginal examination
	Kit 10	Vacuum extraction delivery kit		Kit 10	Vacuum extraction delivery kit
Block 3	Kit 11	Kit for referral reproductive health facility	Block 3	Kit 11	Kit for referral reproductive health facility
	Kit 12	Blood transfusion kit		Kit 12	Blood transfusion kit

Table 6: Method of Calculating the Needs for Reproductive Health Kit

Reproductive health kit is designed to meet the need of a specific number of the population. When placing an order for reproductive health kits, it is not necessary to calculate each of the supplies and medicines; the information needed is the number of displaced people and the estimated duration of displacement.

For example:

- Block 1 for 10,000 population over 3-month period
  If the displaced population is about 50,000 people, then the number of kits to order is 50,000:10,000 = 5 kits
- Block 2 for 30,000 people over 3-month period
  If the total displaced population is 50,000 then the number of kits to order is 50,000:30,000 = 1.6 ⇒ to order 2 kits

The kit cannot be ordered in parts: e.g. 1.6 kits. The need should be rounded upand the extra medicines and dispossable supplies can be used to last longer than 3 months.

**for complete information on how to calculate the need for reproductive health kits please refer to Guidelines on Logistics Management for MISP for Reproductive Health*

4. Other equipment and supporting facilities

(1) Reproductive health tent

When there is no room/tent for RH services at local health post then a reproductive health tent should be set up. The minimum required space is 4x6 meters. This tent is used to provide Maternal and Neonatal Healthcare/Antenatal Care, delivery, and reproductive health and breastfeeding counselings. In this RH tent, privacy should be protected.

(2) Reproductive Health Information, Education and Communication (IEC) Media

In times of health crises, displaced people should be provided with information about RH services availability in displaced people camps, including information about location, types of reproductive health services and operating hours, aid distribution, and various RH awareness-raising activities. The IEC materials with RH topics can be in the forms of posters, banners, mobile information services, radio advertisements, and other types of media that are useful for displaced people such as paper fans and shirts. It is not recommended to distribute IEC materials like leaflets/brochures/flyers as they are likely to end up as wastes in the camps.

Image 7: Example of Placement of IEC Material at IDPs Camp

(3) Other supporting equipment

This supporting equipment is used to support provision of RH services in a health crisis like generators, ob/gyn beds, waste management, etc.

(4) Protective tools

In times of a health crisis and disaster where the situation is unstable, sexual violence can occur and even tend to increase, especially among vulnerable groups including women and girls. The mechanism for prevention and self-protection should be improved. For example, women and girls can be provided with simple tools to prevent sexual violence, such as a torch (for lighting), a whistle (as danger signal), etc.

Image 8: Examples of Solar-Powered Radio-Torch and Whistle

CHAPTER 4

REPRODUCTIVE HEALTH SUB-CLUSTER COORDINATOR

The reproductive health sub-cluster coordinator is a member of the disaster management team in his/her respective area and in charge of the Reproductive Health/Family Health programme at the local health agency. A coordinator should have coordination skills, basic knowledge of reproductive health service, and ensure that MISP for reproductive health is in place and implemented.

STEPS TO REMEMBER

1) Identify agencies and organizations working on reproductive health as members of RH sub-cluster in disaster-affected area
2) Conduct coordination meeting to select persons in charge for MISP components consistent with his/her area of work
3) Conduct MISP for reproductive health socialization and develop a work plan
4) Conduct regular meetings for RH sub-cluster and report to health cluster coordinator
5) Participate in regular health cluster meetings and share information discussed to the members of RH sub-cluster
6) Ensure that reproductive health services are available and functioning properly at IDPs camps/affected communities
7) Coordinate the distribution of reproductive health kits

Steps for MISP for reproductive health coordination activities:

1. Identify agencies and organizations working on reproductive health as members of RH sub-cluster in disaster-affected area

The identification and mapping of existing capacities and resources of each organization is done in the pre-crisis period, so that when a health crisis occurs, the reproductive health coordinator can imediately activate the local reproductive health sub-cluster and mobilize all organizations and agencies in the area. Below is an example table of identifying organizations, agencies, and capacities related to reproductive health services. The table can be adjusted to meet local needs as agreed upon by members of the reproductive health sub-cluster.

Table 7: Example of mapping of organizations and resources

Organization name	Programme / Activities	Working area	Contact detail	Resources	Remark
			Name: Address: Phone:		

2. Conduct coordination meetings to select the persons in charge for MISP components consistent with his/her area of work

1) The reproductive health sub-cluster coordinator should conduct the initial reproductive health sub-cluster meeting to appoint the persons in charge for each of the MISP components.

(1) Person in charge of **gender-based violence**

The person in charge of gender-based violence should come from organizations or agencies working in the violence against women and girls area, such as Integrated Center for Women Empowerment and Child Protection (T2TP2A), Pulih Foundation, etc.

(2) Person in charge of **prevention of HIV transmision**

The person in charge of prevention of HIV transmission should come from institutions working in the prevention of STIs and HIV transmission, such as the Indonesian Red Cross (PMI), Indonesian Planned Parrenthood (PKBI), etc.

(3) Person in charge of **maternal and neonatal health**

The person in charge of maternal and neonatal health component should come from institutions specializing in maternal and neonatal health services, such as profession-based organizations, including the Indonesian Midwives Association (IBI), the Indonesian Obstetricians and Gyneacologists Association (POGI), and the Indonesian Doctors Association (IDI).

(4) Person in charge of **adolescent reproductive health**

The person in charge of adolescent reproductive health should be a person in charge or manager of an adolescent reproductive health programme (KIA) at a local health agency, such as PKBI, the Independent Youth Alliance (ARI), Information and Counseling Center for Adolescent Reproductive Health (PIK-KRR), the National Population and Family Planning Board (BKKBN), etc.

(5) Person in charge of **MISP logistics**

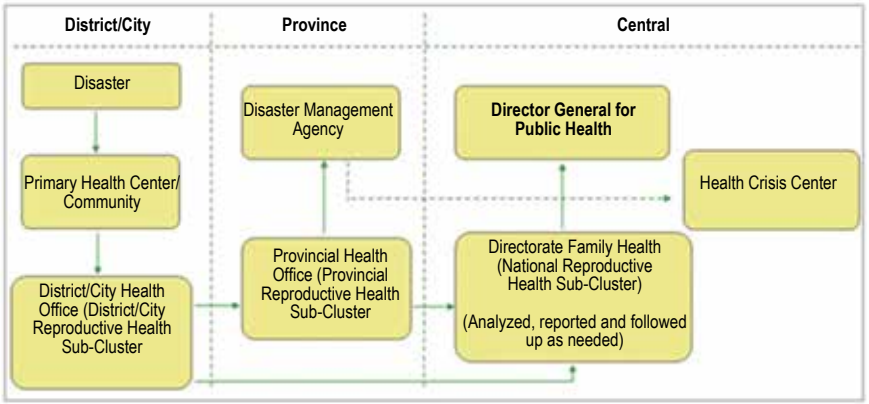
The person in charge of MISP logistics should come from local health agency.

Routine meetings with all members are then conducted to improve coordination in the field based upon a mutually agreed schedule.

- If in a disaster-affected area, the reproductive health sub-cluster has been established, the team will immediately implement the MISP for reproductive health in a disaster situation.

- If reproductive health sub-cluster is not yet established, then the coordinator has to identify, coordinate, and establish cooperation with local, national, and international organizations and agencies working in reproductive health and establish the reproductive health sub-cluster.
- Decision to group the members of reproductive health sub-cluster is made based on the activities and contributions of each respective agency and organization to each of the MISP components.
- It is worth noting that an organization or agency can be involved in more than one component because there are cross-cutting issues, such as a survivor of sexual violence may be exposed to IMS. In a case like this, both gender-based violence and prevention of HIV transmission components are involved.
- The implementation of the reproductive health sub-cluster activities should be integrated with activities being conducted under the coordination of the local health cluster. Should a problem related to reproductive health occur and cannot be handled at local district/mayoralty level, then support from the reproductive health sub-cluster at the provincial level should be provided. Similarly, in the case where the provincial level reproductive health sub-cluster is unable to cope with the problem at hand, then assistance from the national level will be given.

Image 9: Flowchart on the Management of Reproductive Health in Emergency Health Crisis Response



3. Disseminate MISP reproductive health and develop work plans

MISP for reproductive health is not widely known among the stakeholders in disaster management at provincial/district/city level, even after MISP dissemination activities and trainings have been conducted. To address this, awareness raising activities should be conducted in the pre-crisis, crisis, and post-health crisis phases.

- In pre- and post-health crisis, activities conducted include:

☑ Advocacy: to ensure reproductive health as priority.
☑ Dissemination: spreading of information at coordination meetings.
☑ MISP trainings and orientation (only in pre- and post-health crisis).

- In a health crisis: provide brief introduction on MISP using cheat sheet/chart on the objectives of MISP for reproductive health, detailing MISP objectives/components, phases for MISP components implementation, and the list of reproductive health kits as explained in Chapter 3.

4. Host routine reproductive health sub-cluster meetings and report to health cluster coordinator

- Coordination meeting is organized to report progress, improve coordination, and address resource challenges within the sub-cluster.
- Coordination meeting in pre-health crisis is held based on the mutually agreed upon schedule, considering the frequency of meetings and scale of the disaster (e.g.: once every 3 months or 6 months). While in an emergency health crisis situation, meetings can be conducted every day in a gradually declining frequency as the situation returns to normal.

Table 8: Schedule for Reproductive Health Sub-Cluster meetings

Type of Meeting	Pre-Crisis	Emergency Response	Post-Crisis
Sub-Cluster	As mutually agreed	Once a day or as mutually agreed	As mutually agreed
Plenary with all clusters	As mutually agreed	Once a day or as mutually agreed	As mutually agreed

- Reproductive health sub-cluster coordinator should have secondary data from the health cluster coordinator, compiled by the BPBD post in the area. The data collected includes:

1) Basic information (number of vulnerable populations)

   Basic information that should be collected includes data on demography and health of the affected vulnerable groups. If in the early emergency health crisis response it is difficult to collect data on the target population for reproductive health like the number of women at reproductive age, pregnant women, sexually active men, etc., then statistical estimates can be made from the size of IDPs population. In the early phase of disaster, data on specific population (like pregnant women, women in childbirth, WRA, etc.) can be calculated using the following approach:

Table 9: Estimating target population for reproductive health

No.	Variable	Formula	Exampe	Remarks
1	Crude Birth Rate (CBR)	Number of newborns per 1000 population in 1 year	CBR 23/1000 of 10,000 displaced population	If CBR data is not available, it can be estimated at 4% of displaced population (usually it's too high for Indonesia) CBR 23/1000 (IDHS 2012)
2	Women of reproductive age	25% of total displaced population	25% x 10,000 = 2,500	Estimated WRA based on the Indonesia's Population Projection 2010-2035 is around 26.8%
3	**Estimated number of pregnant women**			
A	Estimated number of livebirths in one year	CBR x number of IDPs = (a)	23/1000 x 10,000 = 230	4/100 x 10,000 = 400 (if CBR data not available)
B	Estimated number of births per month	(a) : 12	230 : 12 = 19	400 : 12 = 33 (If CBR data not available)
C	Estimated number of still births or miscarriages (estimated at 20% of pregnancies or 25% of livebirths)	(a) x 0.25	230 x 0.25 =58	400x 0.25 = 100 (if CBR data not available)
D	Estimated number of pregnancies in one year	(a) + (c) = (d)	230 + 58 = 288	400 + 100 = 500 (if CBR data not available)
E	Estimated number of pregnant women in a particular month (70% of d)	70% x (d)	70% x 288 = 202	70% x 500 = 350 (if CBR data not available)

2) The result of initial needs assessment is used for:
   - Assessing the existing condition of the health service facilities (functional capacity, compliance with standard) including for emergency maternal and neonatal care
   - Assessing the existing health personnel in the affected area (number of health personnel, condition, types of profession)
   - Assessing the availability of health equipment, medicines, and disposable items to support reproductive health services

3) Develop and implement intervention plan

   Following collecting data on reproductive health target populations and conducting initial needs assessment, a plan for implementation of MISP in health crisis situation is developed. The implementation of the intervention plan is conducted according to data, the assessment result, and the conditions in the field.

4) Monitoring of intervention implementation

   Each of the persons in charge for MISP components shares an activity report, such as activities for maternal and neonatal component which includes mobile clinic antenatal care and distribution of individual pregnancy kit using the attached form (see annex).

5. Participate in routine health cluster meetings and share what was discussed to reproductive health sub-cluster members

- The coordinator for the reproductive health sub-cluster should participate in routine health cluster meetings to share information on progress of MISP activities and challenges. Updates from the meeting are then shared to members of the reproductive health sub-cluster.
- For technical coordination, the coordinator needs to know the flow of request for disaster-allocated fund to BPBD.This disaster fund is managed by BNPB/BPBD and can be requested by the local health office/health cluster coordinator in line with the Head of The National Disaster Management Board Regulation no.6.A/2011 on the Guideline for the Utilization of Disaster Fund in Emergency Status.

6. Ensure availability of reproductive health services in IDPs camps

The reproductive health services provision in a health crisis situation should be continuously available. The provision of reproductive health services in camps should be conducted in coordination with relevant intersectoral players, e.g. displacement and protection and health clusters. It is recommended to ensure availability of reproductive health services in IDPs camps, covering at least the following:

1) Medical service for survivors of sexual violence and referral service
2) Maternal and neonatal health services
3) Delivery and emergency maternal and neonatal services
4) Referral service, when needed
5) Prevention and management of STIs and HIV

6) When resources are available other reproductive health services can be provided, such as antenatal care (ANC), post delivery care, contraception and family planning, adolescent reproductive health services (MISP for Adolescent Reproductive Health), etc.

When planning for reproductive health service provision, the sub-cluster coordinator should work in coordination with officers in the field to ensure:

(1) Availability of a special room for consultation and service provision that respects privacy and patient confidentiality
(2) Adherence to SOP for service provision
(3) Availability of medical equipment, support, and logistical supplies that meet the standard
(4) Availability of services and 24-hours referral mechanism to hospital
(5) Information dissemination on availability of reproductive health services, including types of services, location, and working hours. Use communication media suitable for local situation and condition (e.g. through midwife, health cadres, public leaders, radio broadcast, or other media like banners or public information boards)
(6) Competent health service providers
(7) Provision of integrated reproductive health services by optimally enhancing services in one specific location and include provision of awareness raising/counseling

7. Coordinate availability and distribution of reproductive health logistics

- Based on the result of the initial needs assessment, the need for reproductive health logistics (and supplies) can be identified. The following should be ensured:
    1) The quantity and types of individual kits needed and distribution to target population (for the list of individual kits, please see Annex 1)
    2) Availability of clean delivery kit for midwives or doctors to provide delivery assistance when health facilities are not functioning.
    3) Availability of reproductive health kit only when major-scale disaster occurs and a majority of local health facilities are unable to deliver services
    4) Availability of reproductive health supporting equipment to be integrated into local health services. When unavailable, coordination is conducted to ensure immediate availability

    The health cluster coordinator needs to ensure that medicines, disposable items, and health equipment/tools inside the kit can be integrated into the services of the local health post in the field.
- If in the disaster-affected area the reproductive health kit is not available and it cannot be procured locally, then the local health office should send a letter of request for reproductive health kit provision to the Ministry of Health.
- When requesting the reproductive health kit, the following details are needed: the number of target populations, distribution plan taking into account the local geography and existing infrastructure, mode of transportation to use, and a warehouse for temporary storing. Further information on reproductive health logistics, please refer to the Guideline for Logistical Support for MISP Implementation.

CHAPTER 5

PREVENTION AND MANAGEMENT OF SEXUAL VIOLENCE

In a disaster situation where the condition is unstable, the risk for sexual violence tends to increase, especially when the situation develops into social conflict. Prevention and management of cases of sexual violence is one of the MISP priorities to ensure that emergency response addresses women and girls' vulnerabilites early in the disaster situation and that adequate protection mechanisms are in place when a case of violence does occur. Sexual violence can cause long-term physical and psychological impacts and can be life threatening, if not handled properly. Sexual violence can take place in different areas, for example in IDPs camps, it can occur when vulnerable groups areaccessing public toilet or getting clean water for daily needs. Vulnerable groups for sexual violence in health crisis include:

- Women who lost their family members
- Women headed households
- Boys and girls who lost their family members
- Boys and girls with special needs (difable), etc.

Actions to take for the prevention and management of sexual violence include:

PRIORITY ACTIONS FOR SEXUAL VIOLENCE PREVENTION AND MANAGEMENT:

1. Conduct advocacy to BPBD and Social Affairs Office through health cluster coordinator to support measures to prevent sexual violence through safe tent and/or temporary shelter management.
2. Engage displaced women and agencies/organizations working in women's empowerment for sexual violence prevention and management.
3. Coordinate with BPPD and Social Affairs Office for the provision of culturally-sensitive facilities that protect privacy and allow married couples to lead a normal sexual life while in the IDPs camps.
4. Ensure availability of health services by competent personnel to handle cases of sexual violence.
5. Disseminate information on availability of services for sexual violence survivors with 24-hour hotline service. Information can be disseminated through various media like posters, banners, etc.
6. Coordinate with intersectoral actors to ensure availability of referral mechanism to access psychosocial support, legal aid, survivors protection, and other support.

1. Conduct advocacy to BPBD and Social Affairs Office through health cluster coordinator to support measures to prevent sexual violence through safe tent management.

The following are topics to discuss with BPBD and Social Affairs Office for the prevention of sexual violence by ensuring safe tent management:

1) Protection: assign security officers with equal numbers of male and female officers and activate security system involving the community. Security system in the IDPs camps is very important to protect vulnerable groups from risks of sexual violence. Security watch should be available 24 hours/7days.

2) Education: in a disaster situation, displaced girls and boys should continue their education. It is important to ensure a security arrangement is in place to allow kids to safely get to school and hours of operation prevent children from the risks of sexual violence.

3) Water and Sanitation: women spend more time in the toilet than men and daily domestic chores like getting clean water and doing the laundry are mainly done by women. It is important to consider:

   (1) Planning for toilet facilities not too far from the IDPs camps/tents and to build safe toilets
      - Separate toilets for women and men
      - Female and male toilets are built in separate locations (not adjacent)
      - Access to these toilets should be adequately lighted
      - Toilet should be equipped with (a) lamp(s) or adequate lighting
      - Toilet door can be locked from inside
      - Number of female toilet facilities should be higher than male toilets to avoid long queue.

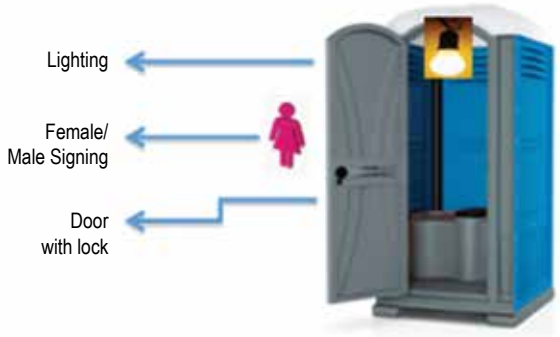
   (2) Setting up separate facilities for bathing, washing, and clean water for women and men.

4) Management of tents or temporary shelters: when planning or developing tent/temporary shelters management, it is important to consider the needs of the vulnerable goups by:
   - Ensuring families can live in the same tent/temporary house/shelter
   - Accommodating women-headed households and children who are separated from their families in one temporary shelter, located close to a security post. When it is impossible, these groups can be accommodated in one shelter equipped with partitions.

Image 10: Example of Shelter with Partitions

Image 11: Example of Family Tent

Image 12: Example of Safe toilet with door that can be locked from inside and adequate lighting



2. Engage displaced women and agencies/organizations working in the women's empowerment for prevention and management of sexual violence.

Women should be involved as active group in the planning and decision making process, so as to ensure that women's specific needs can be met and risks of sexual violence can be reduced.

3. Coordinate with BPBD and Social Affairs Office for the provision of culturally-sensitive facilities that protect privacy and allow married couples to lead a normal sexual life while in the IDPs camps.

In health crisis situation, affected people may have to spend a certain period of time living in IDPs camps sharing a tent with one or more families. During this period, it would be difficult for married couples to lead a normal sex life and facilities need to answer this need. To address this problem, facilities should be designed to protect privacy so

couples can lead normal sexual life. The person in charge of gender-based violence should:

1) Coordinate with local community and IDPs camp leaders to discuss the type of facility that meet their needs, including its management.
2) Coordinate with reproductive health sub-cluster coordinator to discuss provision of such facilities in coordination with coordinators for health and protection and displacement clusters.

4. Ensure availability of health services by competent personnel to handle cases of sexual violence.

In the effort to provide health services in the management of cases of sexual violence, the following activities should be available:

1) Provide area for service provision that protects privacy and confidentiality of rape survivors.
2) Ensure clear SOP is implemented and adequate availability of equipment and logistics.
3) Ensure all survivors receive medical services that they need.
4) Ensure health service providers can deliver services to respond to cases of sexual violence in the IDPs camps in line with the following checklist.

Table 10: Checklist for Clinical Care for Survivors

No	Checklist for Clinical Care for Survivors	Yes	No
1	Provide counseling and psychosocial support for survivors		
2	Make a record of the incident and physical examination		
3	Collect and record forensic materials as evidence		
4	Protect confidentiality		
5	Ensure availability of medicines to support the survivors: • Emergency contraceptives • STIs prevention • Post Exposure Prophylaxis for prevention of HIV • Treatment of injuries and tetanus prevention • Hepatitis B prevention		
6	Provide Psychological First Aid		
7	Ensure access to referral services, e.g. health, psychology, and social		

5) Ensure adherence to the safety, confidentiality, respect, and non-discrimination principle when assisting survivors

6) The person in charge should comply with the proceedure for setting up a health facility by ensuring the following:
   (1) 24/7 services provision
   (2) a special room with privacy for consultaion
   (3) a safe filing cabinet with a lock
   (4) should not keep the survivors waiting
   (5) make sure that all equipment is ready to use
   (6) give clear information to the survivors about the services to be provided and request informed concern prior to performing any activity/medical intervention to the survivors
   (7) provide information about types of services available including when to access, location, and contact in case of emergency
   (8) provide new clothes, when needed
7. Ensure provision of Psychological First Aid (PFA) or initial psychological support to reduce or prevent the onset of mental health and psychosocial problems. In addition, health service providers need to have the capacity to plan for follow-up activities after this initial intervention, such as conducting early identification and referral when needed.
8. Make sure that when the survivors need referral services, the coordinator ensures that those services are available at the referral health facility.
9. Prior to providing services to survivors it is important to:
   - Protect confidentiality: all staff should sign and comply with the code of conduct, staff regulation, and safe access.
   - Ensure that health workers are trained in delivering post-rape services, equipped with proper information, and able to speak local language.
   - Ensure that the health worker is of the same sex as the survivor or the survivor is accompanied by a counselor of the same sex when physical examination is performed by health practitioner of the opposite sex. It is important to ensure the presence of a trained counselor of the same sex as the survivor.
   - The survivor is allowed to have someone she/he trusts be present during examination.
   - Room arrangement:
     - Special room is set up with all necessary equipment ready to use so as to avoid the need to leave to find equipment. Avoid having too many people present in the room.
     - The room should have easy access to a bathroom with running water.

5. Disseminate information on availability of services for sexual survivors with 24-hour hotline service. Information can be disseminated through various media such as posters, banners, etc.

In order to protect women and girls from sexual violence, the person in charge for GBV component should ensure:

1) Availability of information on access to services for rape survivors, disseminated to community. The information should be placed in public locations with good visibility: e.g. toilet or other locations in and around the IDPs camps.

Image 13: Example of Information of Services

24-hour Crisis Center for Violence against Women and Children	
24 hour hotline no.	: +62 21 ….
Short text messages service	: 08…
Call centre telp. no.	:
Address	:
Website of service provider(s)	:
Social media (WhatsApp/LINE)	:

2) Dissemination of information on sexual violence prevention to community using different forms of media like banners or other useful objects to convey messages on violence against women and children such as paper fans or shirts.

3) Availability of IEC materials on prevention of sexual violence targeting women and girls as vulnerable groups through radio broadcast or other channels.

4) Availability of self-protection tools like:

   a. Rechargeable solar-powered radio, if electricity is not yet restored. Radio is an effective channel for information dissemination in the camps.

   b. Whistle, to be worn around the neck. In case of emergency, the whistle can be blown to get immediate help. Make sure to teach children on the utilization of the emergeny whistle and when to use this emergency whistle.

   c. Torch, to ensure adequate lighting in the evening especially when going outside of the tent: such as to the toilet and/or clean water facility, etc.

6. Coordinate with relevant sectors for availability of access to referral mechanisms for psychosocial support, legal aid, survivors protection, and other support.

Survivors of sexual violence need more than one service. Minimum services for sexual violence management require involvement of multisectoral actors, including:

1) Health by Ministry of Health

2) Psychosocial by Ministry of Social Affairs

3) Protection/safety by Police
4) Law/justice by Ministry of Law and Human Rights
5) Joint ministries (Ministries of Women's Empowerment, Health, Social Affairs, Law and Human Rights)
6) Organizations/agencies working on women's issues, civil society organizations, and National Commission for Violence Against Women
7) Members of community or grassroot organizations, community leaders, such as religious leaders and village heads.
8) Law enforcement apparatus (police, legal aid, attorney, and judge)

After receiving medical services, it is recommended to accommodate the survivors in a safe shelter at an undisclosed location. For the availability of safe shelter, the person in charge needs to coordinate with protection and displacement cluster. It is impotant to make sure that the survivor is accompanied by a counselor/facilitator who will assist her/him to access all the services she/he needs.

CHAPTER 6

PREVENTION OF HIV TRANSMISSION

In a disaster situation, exposure to HIV transmission is likely to increase because of the following factors: e.g. 1) difficulties to adhere to precaution standard due to the lack of equipment and supplies, 2) increased cases of sexual violence that may increase HIV transmission, 3) increased risk of unsafe blood transfusions, and 4) unprotected sex.

HIV can be transmited through:

1. Having sexual intercourse with people living with HIV
2. Sharing of needles and other HIV-contaminated sharp objects
3. Receiving HIV contaminated blood transfusion
4. Transmission from mothers with HIV to babies through pregnancy, delivery, or breastfeeding.

Prevention of HIV transmission in a health crisis is mainly focused on

1. Health workers
2. Survivors of sexual violence
3. Recipients of blood transfusionfor treatment of injury or for pregnant women with bleeding problem

PRIORITY ACTIONS FOR PREVENTION OF HIV TRANSMISSION

1. Ensure safe and rational blood transfusion by specialist agency/organization, e.g. the Indonesian Red Cross (PMI)
2. Ensure compliance with universal precaution early in the coordination effort
3. Ensure availability and provision of post exposure prophylaxis
4. Ensure availability of condom in coordination with organizations and agencies working on reproductive health and family planning (government and non-government)
5. Ensure provision of ARV treatment especially to women enlisted in the Prevention of Mother to Child HIV Transmission (PMTCT) programme
6. Disseminate information with 24-hour service center for continued ARV treatment and other routine medicines

Preventive measures for HIV transmission include:

1. Ensure safe and rational blood transfusion by specialist agency/organization, e.g. the Indonesian Red Cross (PMI)

1) Ensure blood supplies are obtained from official agencies, namely Blood Transfusion Unit (UTD) at PMI, UTD at government health facilities or Blood Bank Hospital (BDRS) to make sure safe blood is used and safe transfusions are performed by health facilities with proper equipment and competent health workers. In case this criteria is not met, blood transfusion should not be performed.
2) Conduct coordination to identify contact person/person in charge at UTD at local PMI and government-run health facilities and BDRS to monitor blood availability.
3) Adhere to rational use of blood transfusion principles including:
   (1) Blood transfusion is only performed in life threatening situations and there is no other alternative
   (2) Consider use of medicines to prevent or reduce active hemorrage (e.g. oxytocin, tranexamic acid, etc.)
4) Coordinate with local primary health centers or hospital for availability and use of blood replacement liquid like crystalloid-based fluid

2. Stress the importance of universal precaution early in the coordination effort and ensure compliance

1) Coordinate with relevant partner organizations or agencies to ensure compliance with univesal precaution standard at all time, including in a health crisis situation
2) Coordinate with the health cluster for the availability of tools, supplies, and IEC materials for precaution standard implementation (e.g. mask, protective gloves/handscoon, apron, boots, leaflet, poster, etc.)

3. Ensure availability and provision of post exposure prophylaxis (PEP)

1) Ensure availability of PEP at health facilities
2) Ensure health workers are aware that PEP is a standard precausion to reduce the risk of occupational transmission (identify and appoint health officer in charge of PEP service)
3) Display first aid information in work areas and teach all staff on how to access post exposure treatment
4) Organize orientation session at health facilities on precaution standard for all health officers and other staff
5) Establish supervisory system and conduct observation using a simple checklist to ensure compliance to universal precaution standard, e.g. proper handwashing, disposal of sharp objects, cleaning up blood, and body fluid, etc.

Both the source and the victim to exposure of HIV infection should undergo HIV test at the latest 3 days after exposure as a basis for provision of PEP treatment.

In the case that the source of exposure is unknown, PEP is usually only prescribed for serious cases, e.g. big cut/ wound from use of big syringe, deep puncture wounds and contact with contaminated medical tools/equipment (e.g. scissors, syringe, etc), mucous membrane and non-intact skin exposure as well as exposure from blood or semen.

4. Ensure availability of condoms in coordination with organizations and agencies working on reproductive health and family planning (government and non-government)

Because of its effectiveness for the prevention of STIs and HIV, the coordinator needs to ensure condom availability in the early phase of emergency, in coordination with local health agency, BKKBN or other organizations.

1) Ensure distribution of condoms is done using a culturally sensitive approach (e.g. no mass distribution to community but through local health facilities). Condoms are provided to sexually active groups, people living with STIs and HIV, high-risk groups to STIs and HIV infections.
2) Provide information on how to use condoms to raise public awareness. It is not recommended to provide female condoms as they are not widely known and used.

5. Ensure provision of ARV treatment especially to women, enlisted in the Prevention of Mother to Child HIV Transmission (PMTCT) programme

1) Ensure availability of data on PLWHA, ARV treatment, and other HIV/AIDS services in the area. The data can be obtained from primary health centers, NGOs, or peer support groups for ARV treatment. ARV treatment is provided at primary health centers and hospitals and by trained health officers.
   (1) Primary health center: provide ARV to PLWHA without complication
   (2) Hospital:
      a. Provide ARV treatment to HIV+ pregnant women
      b. Provide ARV prophylaxis for newborns of HIV+ mothers
      c. Patients with opportunistic infections being treated at the hospital
2) In times of crisis, ARV treatment provision should continue uninterupted and the person in charge for prevention of HIV transmission component should establish good coordination with ARV service providers.

6. Disseminate information with 24-hour service center for continued ARV treatment and other medicines

Information about availability of ARV and other medicine needs to be disseminated to PLWHA to assist them in continuing their therapy. Person in charge of the prevention of HIV transmission ensures:

1) Every health facility is equipped with information, detailing the name of on-duty officer, contact number and location to access ARV, and other supporting medicine.
2) Announce at community meetings and disseminate information about how to access ARV treatment and other supporting medicine at IDPs camps.

CHAPTER 7

PREVENTION OF EXCESS MATERNAL AND NEONATAL MORBIDITY AND MORTALITY

Pregnant women, women in delivery, and newborns are vulnerable groups, especially in times of crisis. They have specific needs and require specific interventions e.g. nutrition, special observation for management of high risk pregnancy and post-delivery, etc. In normal situations, maternal and infant mortality rates are relatively high and in a crisis situation, the rates are likely to increase. Therefore, efforts to prevent excess morbidity and mortality should be part of the top priorities.

In health crisis situations, access to reproductive health can be disrupted or even unavailable, while the needs of vulnerable groups (women, newborns, and adolescents) for such services continue, and even tend to increase. Women at later stage of pregnancy and those with high risk pregnancies need quality reproductive health services to ensure safe pregnancy, delivery, and post-delivery period. The person in charge of the maternal and neonatal health component needs to ensure that all pregnant women, those who will give birth soon, and newborns have access to quality services.

PRIORITY ACTIONS FOR PREVENTION OF EXCESS MATERNAL & NEONATAL MOBIDITY AND MORTALITY

1. Do data collection and mapping of women in pregnancy and post-delivery and newborns in IDPs camps.
2. Do mapping of health centers: primary health centers and hospitals.
3. Ensure that health workers can provide services to displaced pregnant women and that services are made available in one location to properly assist those in later stage of pregnancy with safe delivery services.
4. Coordinate with nutrition sub-cluster for provision of breastfeeding counseling in IDPs camps.
5. Ensure access to emergency maternal and neonatal services and 24/7 referral services.
6. Ensure adequate nutritional intake for vulnerable populations: pregnant and breastfeeding women, newborns, and under-five year old babies/children.

A series of activities to prevent excess maternal and neonatal morbidity and mortality include:

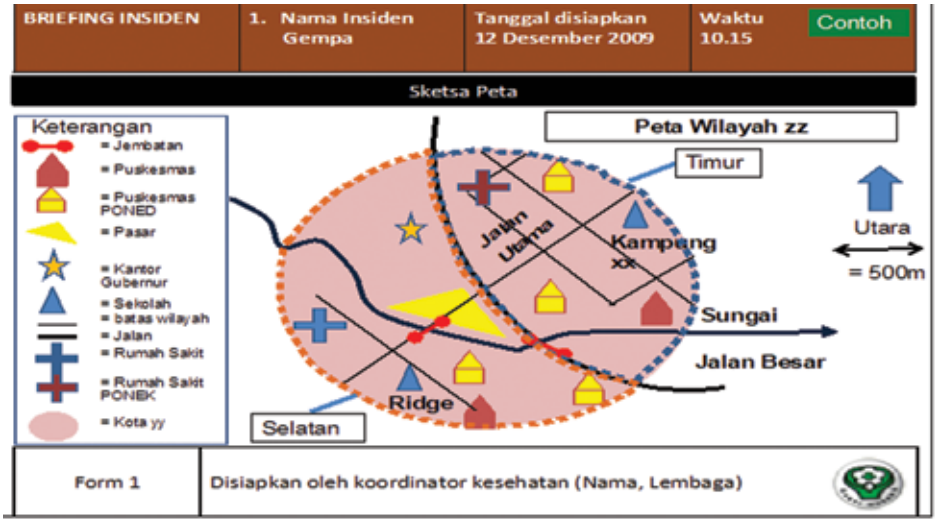
1. Do data collection and mapping of women in pregnancy and post-delivery, and newborns in IDPs camps

Data collection and mapping of pregnant women, those who recently gave birth, and newborns in IDPs camps should be conducted at the early onset of a disaster by the person in charge for this component and with active involvement of all sub-cluster members. The result: number of vulnerable population/groups and their locations are used to plan for health services provision and monitoring.

A series of activities to conduct for data collection and mapping of women in pregnancy and post-delivery period:

1) Collect secondary data from maternal and neonatal health programme at local primary health centers.
2) Get a map of local area and mark the locations and number of pregnant and postpartum women and newborns.
3) Do re-registeration of target populations in the affected location and IDPs camps by collecting primary data based on the actual data from the field. Use the format for pregnancy and postpartum questionaire.
4) Do thematic mapping using the overlay method. Overlay mapping is developed with several indicators such as the number of pregnant women and postdelivery women and the number of newborns. Other indicators can be added as needed.
5) Do mapping for planning and implementation of quick response for reproductive health services provision in the field.

Image 14: Example of area mapping



2. Do mapping of primary health centers and hospitals

Mapping and assessment of primary health centers with inpatient unit and level C hospitals are conducted by the person in charge for maternal and neonatal health component to get information about ease of access and capacity of health facilities in provision of reproductive health services in-line with the standards. The following includes aspects to observe:

1) Condition of the facility and its fitness for provision of reproductive health services.

2) Availability of equipment, medicines, and human resources: to know the capacity of health facilities in delivering reproductive health services and proper procedure for referral, including patient stabilization prior to transfer.

3) Geographical condition, including ease of access to health facilities in terms of distance and time spent to get to a health facility. In the case of difficulty to get to health facility in short time there is a need to consider the use of a medical emergency call center or Public Safety Center (PSC 119). It is important to provide information on health service procedures, stating when, where, and how to refer patients with maternal and neonatal health emergencies to referral facility.

4) Mode of transportation and availability of transportation to access health service facility for 24-hours, especially for referral of maternal and neonatal emergency cases. The person in charge of this maternal and neonatal component needs to ensure that there is an on-duty officer and mode of transport for referral service.

3. Ensuring health workers can provide/bring services to displaced pregnant women and that services are made available in one location to properly assist those in later stages of pregnancy with safe delivery services

Determining the special location in IDPs campsfor pregnant women and newborns should be done with careful consideration because of the risks of complications such as hyperemesis, misscarriage, early rapture of amniotic sac, and infections among newborns due to environmental factors. Conducting outreach service helps ensure that health workers can provide optimal services and makes it easier for them to do health monitoring. The person in charge of the maternal and neonatal health component needs to:

1) Group all pregnant women in the 3rd semester of pregnancy and/or those with high risks in one location, sited close to health post.

2) Ensure availability of transportation for referral when maternal and neonatal emergency occurs. Transport arrangement includes availability of on-duty officer, driver, and fuel.

3) Provide supporting health facility with special attention to safety and comfort for pregnant women and newborns in IDPs camps (sufficient clean water supplies, ideal temperature, proper ventilation, privacy, conducive situation for pregnant women's psychological condition, etc.)

4) Pregnant women in third semester of pregnancy should receive an individual kit (pregnancy kit). Outreach services for pregnant women and newborns in IDPs camps help facilitate the delivery of proper services for immediate management of pregnancy related problems.

5) Ensure privacy during antenatal care (door closed) and when any danger sign of pregnancy and childbirth is detected, immediately transfer to referal service.

6) Educate mothers, husbands, and families on danger signs in pregnancy, childbirth, and post-delivery. When a danger sign is detected, immediately contact a health worker. Use the MNH recording book to educate women, husbands, and families.

4. Coordinate with nutrition sub-cluster for provision of breastfeeding counseling in IDPs camps.

After pregnancy, women should be encouraged to breastfeed their babies. Women who have just given births in camps are also advised to give exclusive breastfeeding. In such difficult situations, women may not be able to consistently or optimally breastfeed their babies. For this reason having a breastfeeding counselor in IDPs camps may be needed. Breastfeeding counselors should not be limited to health workers but can also involve members of the community who have been trained as breastfeeding counselors. Husbands and families need to support women to breastfeed their babies. Breastfeeding counselors can provide information and motivation and educate women and families to give breastmilk, exclusively in first 6 months and continue breastfeeding for 2 years, while living in the camps.

The person in charge of the maternal and neonatal component coordinates with coordinators of reproductive health and nutrition sub-clusters for

- Posting breastfeeding counselors when needed.
- Organizing breastfeeding counseling in groups or individually, depending on the camps conditions and the number of women who participate in the counseling.
- Developing schedule, time, and location for breastfeeding counseling.

5. Ensure access to emergency maternal and neonatal services and 24/7 referral services.

1) All pregnancies can develop complications at anytime which can lead to maternal and neonatal emergencies. The person in charge of the maternal and neonatal component needs to ensure availability of:
   - Trained health workers providing 24/7 services
   - Equipment, medicines, and supplies for emergency care
   - Well functioning referral system (transporation, radio communication, stabilization of patient, and readiness of referral facility to respond)
2) In the case where a 24/7 referral system is unavailable, the person in charge of the maternal and neonatal component needs to assign a health officer at the primary health center who can provide maternal and neonatal emergency care with guidance from and in consultation with health expert(s)
3) Misscarriage management services and counseling

6. Ensure adequate nutritional intake for vulnerable populations: pregnant and breastfeeding women and newborns

Ensuring adequate nutritional intake among vulnerable groups is important. Pregnant and breastfeeding women are recommended to consume various types of food for a balanced and proportional diet. The person in charge of maternal and neonatal component needs to ensure:

1) Adequate nutrition for vulnerable groups, especially pregnant and breastfeeding women, conducted in coordination with coordinators for nutrition and protection and displacement sub-clusters for provision of balanced diet.
2) Food is handled and cooked in-line with hygiene standards and consideration is given to locally produced food items.
3) Use of MNH book to monitor nutritional intake.
4) When there is a pregnant woman identified with nutrition deficiency, the person in charge of the maternal and neonatal component should coordinate with the nutrition and health services sub-clusters for the provision of Supplementary Feeding Programme (PMT) for pregnant and breastfeeding women.

CHAPTER 8

PLANNING FOR INTEGRATION OF COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES INTO PRIMARY HEALTH CENTERS IN A POST-CRISIS SITUATION

At the end of an emergency phase, comprehensive reproductive health services should be available as in a non-crisis situation. Comprehensive reproductive health services focus on the provision of a full-range of services in a life cycle approach to meet the need of fetuses, newborns, under 5 five-year-old children, adolescents, adults, and elderly. Services are provided in an integrated manner: promotive, preventive, curative, rehabilitative, and integrated with other programmes (e.g. MNH-FP, IMS-HIV, sexual violence, adolescent reproductive health, etc.). This is to ensure that reproductive health services in normal situations can deliver a one-stop service for a comprehensive intervention through the integrated reproductive health services.

The coordinator for the reproductive health sub-cluster needs to develop a human resources plan, plan for health service facilities and infrastructure needed before the end of an emergency phase so that comprehensive reproductive health services can be immediately available, implemented, and used by community members.

PRIORITY ACTIONS TO PLAN FOR COMPREHENSIVE RH SERVICES PROVISION

1. Develop plan for comprehensive reproductive health services.
2. Collect data on target community and coverage of comprehensive reproductive health services. At the emergency health crisis, estimates can be used and in a normal situation, real data should be used.
3. Identify health facilities for provision of comprehensive reproductive health services.
4. Assess the capacity of health workers for the provision of comprehensive reproductive health services.

The following are steps to:

1. Develop a plan for comprehensive reproductive health services

1) Identify target groups with reproductive health vulnerabilities and types of comprehensive reproductive health services needed by each of these affected groups.
2) Identify the locations of target groups, taking into account the duration of displacement to plan for immediate provison of comprehensive services that answer their needs.
3) Identify health facilities for the provision of comprehensive services, taking into consideration ease of access and mechanisms for provision of health services.
4) Conduct self-asessment for the services provided and whether they meet the need of the affected community. If a facility only has the capacity to provide maternal health and family planning services, it is important to immediately plan for recruitment, capacity training for health officers, and set up the facilities and infrastructure needed for the provision of the other reproductive health services.

2. Collect data on target populations and coverage to plan for provision of comprehensive reproductive health services. During the emergency health crisis response, estimates can be used and after the situation returns to normal, real data should be used.

Data collection on the size and characteristics of target populations is an important part of a comprehensive reproductive health programme. The purpose is to determine the following important issues:

- What are the types of services most needed by community members?
- What are the types of services most needed but are not yet provided/available?
- What are the types of services needed, available, and ready to be implemented?

Services provided is based on the need of each of the target groups of the affected populatlion. Activities include:

1) The reproductive health sub-cluster should collect secondary data such as population size, number of pregnant women, number under-5 children, women at reproductive age, number of adolescents, couples at reproductive health, etc. The collected data is aggregated based on sex and age, obtained from official sources, like basic population data at the sub-district, local area monitoring for MNH (PWS KIA), etc.
2) Identify local reproductive health issues in the area and initiate a reproductive health case study, including reproductive health cases not reported to the primary health center and/or hospital: e.g. number of sex workers in the affected area, unwanted pregancies, premarital sex, etc.
3) Develop a list of services available at local primary health centers and hospitals and do an evaluation of services, such as on-going services and the services no longer provided.

3. Identify health facilities and plan for proper provision of comprehensive reproductive health services.

1) Do mapping of health facilities providing reproductive health services. Health facilities should be easy to reach from different locations.
2) Identify/assess existing equipment, medicines, and human resources in local health facilities and develop plan to equip them with necessary facilities and infrastructure for comprehensive reproductive health services provision.
3) Identify health facilities and prepare them to deliver comprehensive reproductive health services to affected communities.
4) Identify referral services and other implementing partners for the provision of comprehensive reproductive health services and establish a mutually agreed upon referral mechanism.

4. Assess the capacity of health workers for the provision of comprehensive reproductive health services.

1) Assess the capacity and competency of health workers to deliver reproductive health services and develop a training plan to increase the capacity of health workers to respond to local health needs.
2) Develop training plans and targets for delivering comprehensive reproductive health services like maternal and neonatal emergency care, prevention and management of violence against women and children (by PPKtPA), etc.

CHAPTER 9

PRIORITY ACTIVITIES IN ADDITION TO THE MINIMUM INITIAL SERVICE PACKAGE (MISP) FOR REPRODUCTIVE HEALTH

In line with the revised global guideline for MISP, there are additional priority activities to be implemented at the earliest onset of health crisis to meet reproductive health needs of couples, adolescents, and women as vulnerable groups.

The additional activities of the MISP include:

1. Continued contraceptive use
2. Adolescent reproductive health
3. Distribution of individual kits

1. Continued contraceptive use

According to IDHS 2012, around 31.9 percent of couples at reproductive age uses injectables and 10.3 percent use pills for family planning methods. Both FP methods have higher rates of dropouts. The FP dropout rate based on the IDHS 2012 is relatively high at 27 percent.

Difficult access to contraceptives has been a problem for women/couples who prefer to delay pregnancy in a health crisis situation. Therefore, contraceptive availability is important to prevent discontinued FP use and prevent unwanted pregnancies.

The reproductive health sub-cluster coordinator needs to developa logistics management system to secure adequate supplies of contraceptive equipment and medicines, such as condoms, pills, injectables, and IUDs, integrated into the reproductive health commodity security to answer the needs of the affected communities.

Assessment of FP/contraceptive needs and resources can be done by calculating the number of WRA, FP coverage, types of contraceptives used, competency of service providers, and local social-cultural condition. FP services-related data can be obtained from local primary health centers using the FP cohort record, FP F1, and other records. Contraceptive supplies and logistics can be planned using contraceptive data, estimates and procurement, record systems, and management of procurement, distribution and inventory.

2. Adolescent reproductive health

In a health crisis, access to reproductive health for adolescents is very limited. In fact, adolescents are also impacted because of the loss of family members and friends and some have to take up the role as head of households. This is the reason why MISP for adolescentre productive health (MISP for ARH) is needed to address issues faced by adolescents in a crisis situation.

MISP for ARH helps address their vulnerabilities in a disaster situation and focus is given to several adolescent groups:

- 10-14 years old
- Adolescent girls
- Adolescent mothers or married girls, orphaned
- HIV positive adolescents
- Those who survive sexual violence

- Those with disabilities
- Other marginalized adolescents

The implementation of MISP for ARH in principle is similar to MISP for RH. The differences between the two are as follows:

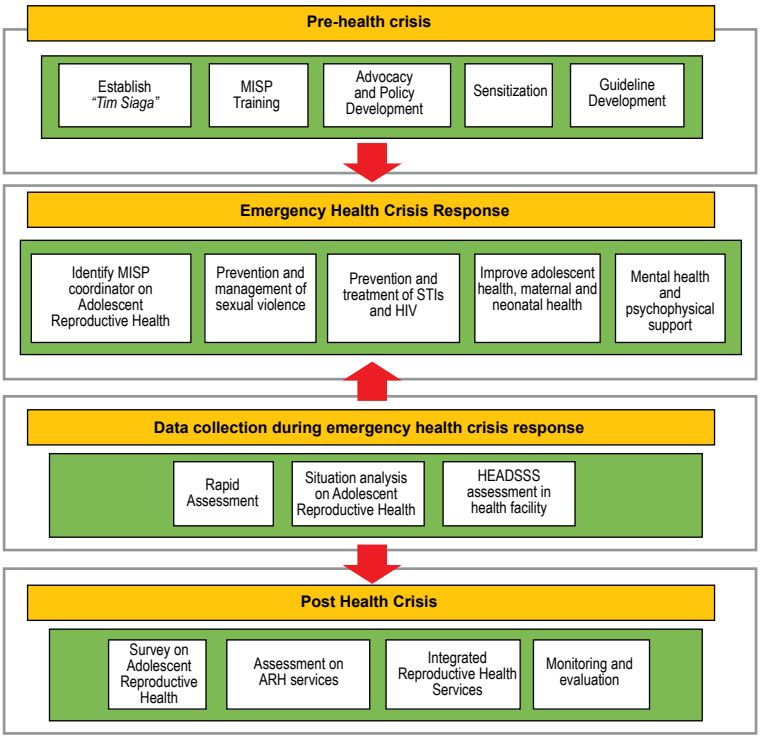
Table 11: Differences between MISP for RH and ARH

	MISP	MISP for ARH
Target groups	Disaster affected population, with the main focus on women aged 15-49 years old	Adolescents aged 10-18 years old Young people aged 10-24 years old
Approach	General reproductive health intervention	Intervention provided through the youth-friendly adolescent reproductive health (PKRR)
Needs assessment tools	In emergency phase: - Use of MISP needs assessment form	In emergency phase: - Use of MISP for ARH form - Facility-based reporting system (assessment of HEADSSS/Home –Education-Eating-Activities-Drugs-Sexuality-Self Image-Safety)
Component	Component 5: Planning for comprehensive reproductive health services, integrated into primary health centers in post crisis	Component 5: Provision of mental health services and adolescent psychosocial support

MISP for ARH can be provided optimally when implemented with active involvement of adolescents in all process. Their involvement in ARH programme in health crisis situation helps health workers to develop, design, implement, and monitor and evaluate the MISP for RH implementation.

The main principles for effective cooperation with adolescents is by fostering adolescent participation, partnership, and leadership so they can take active roles in all activities.

Image 15: Phases of MISP for Adolescent Reproductive Health Activities



For a complete information, please refer to the National Guideline for Minimum Service Initial Service Package (MISP) for adolescent reproductive health in crisis situation, published by the Ministry of Health in 2017.

3. Distribution of individual kits

When a disaster strikes, personal items like clothes, bathing items, and medicines are difficult to obtain. Individual kits are distributed to specific groups with RH vulnerabilities, like women in pregnancy and childbirth, newborns, and WRA. The contents of these kits are designed to meet the specific needs of each of these groups: e.g. pregnancy kit contains duster/maternity clothes, underwear with adjustable band, etc.).

These much-needed individuals kits are immediately distributed to the target groups in the earliest onset of emergencies to address their vulnerabilities. The needs for these kits can be calculated using estimates from total displaced population. Further information on individual kits can be found in the Guideline for MISP for reproductive health logistics.

CHAPTER 10

NEEDS ASSESSMENT FOR MISP FOR REPRODUCTIVE HEALTH

During a health crisis response, an assessment should be conducted to obtain information about the condition of the affected population or displaced population. Especially for reproductive health, the lack of awareness on reproductive health leads to failures to adequately address RH needs as part of the disaster response; when in fact based on field observation, RH needs still exists, if not increase in a crisis. The needs assessment for MISP should capture the existing needs and RH vulnerabilities following a crisis.

In addition, there is no need to identify what types of intervention are needed because reproductive health intervention in emergency response is conducted through the MISP implementation. Data collection on the size of target populations for RH (pregnant women, women in childbirth, etc.) in the early phase of a health crisis is not conducted because based on experience, they are difficult to obtain. The RH sub-cluster coordinator can get data on target populations for RH services by making statistical estimates from the total displaced population.

Data on a displaced population is collected from the RHA team, using Form B1 (Annex 1). However, the coordinator needs to conduct an assessment on the condition of health workers, health facilities, availability of equipment and medicines, the function of health referral system, services availability, and the vulnerable target groups in the IDPs camps. This data and information is used to develop a MISP for reproductive health implementation strategy.

1. A series of activities to conduct assessment

The following are steps in carrying out an RH needs assessment

1) Collect secondary data/basic data before the crisis: target groups, indicators related to RH like crude birth rate, childbirth by health practitioner, data on health facilities (see Annex 2). This is done to get an understanding on the RH condition before the crisis.
2) Make an estimate of the RH target groups to plan for an emergency response. This estimate is based on data on the total displaced population collected by the RHA team (see Table 6).
3) Conduct an assessment on the current condition of health facilities, health workers, and availability of equipment and medicines for RH services provision (see Annex 4).
4) For a major-scale disaster, collect data on agencies/organizations/NGOs working in the RH sector in the emergency phase. This data can be obtained in close coordination with the health sector (see Annex 5). This is done to identify and delegate tasks among the organizations and agencies working in RHin the disaster-affected areas and avoid gaps and overlaps in delivering assistance.
5) Collect data on the condition of displaced pregnant women and those in need of childbirth services in IDPs camps by interviewing 2-3 pregnant women/who just gave birth in the camps (see Annex 6). This data is gathered to understand the availability of services provided to pregnant women and those who just gave birth in the camps.

6) Gather information about the condition of the IDPs camps including various factors that increase the risks of gender-based violence (see Annex 7).

7) Collect data on the number of displaced adolescents (see Annex 8).

2. Who conducts the assessment?

The RH needs assessment is conducted by the coordinator or members of the RH sub-cluster or by officials in charge for RH programme/family health programme at a local health office, in-line with the steps explained above.

3. How to analyze, utilize and disseminate the assessment results

1) Analysis

Using the completed assessment forms, the coordinator or member of the RH sub-cluster analyzes the condition by comparing the pre-crisis data and the RHA result on:

- The number of displaced population collected by the RHA team
- Assess the condition of health facilities, health workers, and availability of equipment and medicines for RH services provision
- Do mapping of agencies/organizations/NGOs working in RH in the emergency phase
- Collect data on pregnant women and those who are about to give birth in the IDPs camps
- Identify factors that increase the risks of gender-based violence
- Collect data on displaced adolescents

2) Utilization and dissemination of assessment results

Following a thorough analysis exercise, a strategy for implementation of the MISP in a crisis situation is developed, including steps to implement MISP and logistical support according to the needs of local displaced populations. The result of the analysis can include recommendations on how to ensure MISP intervention as stated in the format for report (see example of format of assessment report in Annex 9).

The recommedations are then widely disseminated to all organizations working in emergency response and to community members through the health coordination mechanism and reporting system in a crisis situation.

CHAPTER 11

MONITORING AND EVALUATION

Monitoring and evalution are conducted in all phases of a health crisis. For MISP for RH implementation, monitoring and evaluation are used as a basis to develop programme activities to observe the following:

1. Monitor progress and lack of progress in the MISP implementation, including identifying challenges and obstacles
2. Ensure accountability and transparancy
3. Ensure the use of RH kits at primary health centers and hospitals
4. Ensure readiness for comprehensive reproductive health services

In conducting monitoring and evaluation, the RH coordinator may encounter the following challenges:

1. Determining the appropriate timing for transition from MISP implemention to comprehensive reproductive health services
2. Determining the appropriate timing to disseminate monitoring and evaluation results. The results will be used as a basis for accountability and decision making to determine activities in the transition period and the implementation of comprehensive reproductive health services. Proper utilization of the monitoring result will help ensure that activities will be conducted in a way that is sustainable and appropriate to local context and needs.

1. How to conduct MISP monitoring

MISP monitoring is conducted in 2 phases of a health crisis:

1) In the emergency health crisis, monitoring is done periodically, one or two weeks after the MISP for RH implementation depending on the progress from emergency response and the needs of each of the organizations involved. At least, monthly data should be available for programme design. Monitoring is done for each MISP component using qualitative and quantitative indicators in line with the table in Annex 10.
2) In the post-crisis phase or when the condition has become more stable, monitoring is conducted using the routine mechanism, called the local area monitoring of MNH (PWS KIA) conducted every month.

2. Evalution

The objective of evaluation is to analyze programme efficiency and effectiveness. Evaluation is conducted by comparing programme activities and services provision (output) withthe benefits (result/outcome) and impact of MISP programme in meeting the target goals.

3. Timing of evaluation

Evaluation is carried out at the end of activities' implementation.

4. Instrument for evaluation

Evaluation is done using systematic assessment methods to measure qualitative and quantitative aspects of service provision. One of the methods that can be used is conducting interviews with key information sources, such as the head or members of the affected community to gather information related to the quality of programme and a community's assessment/opinion of the programme implementation.

Evaluation on the quality and access to services includes analysing the operational documents (like local reports, trip reports, supervisory reports, and training documents) as well as the checklist for qualitative health services. Review of data from monitoring system should be considered as part of evaluation process.

5. Data needed for evaluation

A number of aspects to highlight in the evaluation of MISP implementation are as follows:

1) Programme effectiveness: do programme activities achieve the goals?
2) Programme efficiency: are existing resources used efficiently: e.g. human resources, equipment, funding, etc.?
3) Programme relevance: are the programme activities being implemented suitable/do they answer the needs of the disaster-affected population?
4) Impact and sustainability of programme: does the programme have positive impacts to the community and can it be continuously conducted in a post-crisis phase?
5) Challenges: what are the challenges faced during programme implementation and what are the solutions to address them?
6) Learning process: what are the lessons learned from the programme implementation to be used for future improvements?
7) What are the recommendations to improve the quality of services provided?

Please see Annex 11 of the evaluation form.

6. Person responsible for evaluation

The evaluation should be objective and unbiased. If the evaluators/people conducting the evaluation are also involved in the coordination or programme management, it would be difficult for them to stay neutral and be impartial during the exercise.

7. Analysis and dissemination of evaluation result

The evaluation should analyze what has (or has not) been done properly so that the result can be useful for improvements through programme planning and design. Feedbacks should be given to the person in charge/ programme manager and service providers during monitoring and evaluation to ensure that all identified challenges can be immediately addressed to avoid further problems or to minimize risks.

DEFINITIONS

BEONC: is short for Basic Emergency Obstetric and Neonatal Care provided by primary health centers wtih adequate facilities and competence to handle basic obstetric and neonatal emergencies. BEONC primary health centers provide 24-hour service and provide referral servicestopatients who are transfered from nearby childbirth posts and primary health centers.

CEONC: is short for Comprehensive Emergency Obstetric and Neonatal Care with the capacity to provide BEONC services at district/city hospitalsfor obsteric care and with the capacity to perform blood transfusion and cesarean section with 24-hour services.

Disaster: an event or a series of events that represent as a threat to life and livehood of communities due to natural and non-natural factors as well as human factors that may result in loss of human lives, environmental damage, loss of assets, and psychological impacts.

Disaster-prone area: an area with high risk for disaster due to geographical, geological, and demographical conditions and human activities.

Disaster-prone: a condition or geological, biological, hydrological, climatological, geographical, social, cultural, political, economic, and technological characteristics in a territory at a certain period of time that reduce the ability to prevent, mitigate, build preparedness, and respond to negative impacts of certain dangers.

Displaced people: an individual/group of people who – due to a disaster/crisis – are forced to or have no choice but to flee their houses to go to safe locations for an uncertain time period in order to save their lives.

Double protection: protection against unwanted pregnancy and STIs, including HIV.

Emergency Response Team: a special team immediately deployed to disaster-affected locations to provide health services for the survivors.

External refugees: an individual or a group of people who because of reasonable fear of abuse on the basis of race, religion, nationality, his/her association to a certain social organization or political views, live in another country and due to their fear, are unable or unwilling to seek protection from his country of origin.

Gender-based violence: a term for acts that inflict harm perpetrated to another due to difference of socially-accepted (gender) norms between men and women.

Health crisis emergency: a series of activities immediately conducted at the early start of a disaster to address the impact to health, covering rescue and evacuation, basic needs provision, survivors' protection and rehabilitation, health facilties, and infrastructures.

Health crisis: is an event or a series of events that represent a health threat to individuals or public caused by disaster and/or factors that lead to/potential disasters.

Health personnel: all individuals working in health sector with knowledge and/or skills from health education, who depending on level of responsibility have the authority to perform health intervention.

Health referral system: health service referral system ismanagement of service provision to handle transfer oftasks and responsibilities in a reciprocal manner both vertically and horizontally in the provision of health services.

Health service facilities: equipment and/or places used to provide health services for promotive, preventive, curative and rehabilitative purposes, run by the government, regional government and/or private sector.

Hepatitis B: and other infections can be spread through blood/body fluids1.

HIV Test with Initiative from Health Personel (TIPK): HIV test recommended or offered by health personnel to patients/service users as a standard component of health service in that health facility.

HIV: Human Immunodeficiency Virus which can cause AIDS by attacking white blood cells called CD4, damaging human immune system, and leaving it unable to defend itself against infections including less serious ones.

Human resources for health: an individual or a group of people, actively working in the health sector, with or without formal health education backgrounds, which for certain types of services require authorization to perform them.

Informed consent: permission given by client or family members after receiving information and explanation about medical interventions to be performed on the client.

Internally displaced people (IDPs): people or a group of people who are forced to and have no choice but to flee their houses or dwelling place, especially as a result of or as an attempt to save life from impacts of armed conflict, volatile situations due to violence, human rights violation, natural disaster or disasters caused by human activities that occur within the internationally recognized boundaries of a country.

Maternal emergency care: a life threatening condition during pregnancy, childbirth, and post-delivery period.

Maternal mortality: the death of a woman while pregnant or within 42 days after pregnancy, irrespective of the duration of the pregnancy and place of childbirth, from causes related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO).

Methods of contraception: methods or tools used to prevent, space pregnancy, or stop getting pregnant. Methods of contraception include short-term (injectables, pills and condoms) and long-term methods like IUD, subcutaneous/implants. Surgical procedure for male (MOP) and for female (MOW).

Minimum Initial Service Package (MISP) for Reproductive Health: is a series of priority activities for reproductive health that should be immediately implemented in the earliest onset of disaster/crisis to save lives, especially women and girls.

Natural disaster: disaster caused by a natural event or a series of natural events such as earthquakes, tsunamis, volcanic eruptions, floods, droughts, storms, and landslides.

Neonatal emergency: a situation where an infant (below 28 days old) in critical condition requires observation and proper health management for any detected life-threatening psychological changes and pathological conditions that may occur at anytime (Sharrief, Brousseau, 2006).

Neonatal/newborns: baby aged 0-28 days.

Non-natural disaster: an event or a series of event caused by human factor such as social conflict between groups or communities and terrorism.

Obstetric emergency cases: obstetric emergency cases that if not immediately managed will result in loss of life of mother and fetus. This condition is the main cause of death among mothers and newborns.

Post Exposure Prophylaxis (PEP): use of medicines to prevent infection following exposure to risks. It also relates to occupational or post rape exposure.

Post-health crisis: situation after a crisis or emergency response ends. At this phase, activities include rehabilitation and reconstruction.

Pre-health crisis: situation before a disaster/with a potential for disaster. At this stage, activities conducted include planning for health crisismanagement, health risk reduction, education and training, setting up technical standard criteria, and health risk management analysis, preparedness, and mitigation response.

Primary health centers: health facilities that provide services to community members and first level health intervention for individuals with an emphasis on promotive and preventive efforts to achieve highest degree of public health in its working area.

Rape/rape attempt: rape is sexual intercourse without consent. This term includes an attack on part of the body using sexual organ and/or attack on genital or anal organ with an object or body part. Rape and rape attempts involve the use of physical force, a threat to use physcial force, and/or coercion. An attempt by an individual to rape another that does not involve penetration is called a rape attempt.

Rapid Health Assessment Team (RHA): a team deployed together with or shortly after the emergency response team to assess the conditions and the needs for health services.

Reproductive health kit: a series of equipment and medicines to provide reproductive health services in an emergency situation in line with MISP objectives.

Reproductive Health Team: a special team dispatched with the RHA to assess the condition and reproductive health needs in an emergency situation.

Reproductive health vulnerable group: is a group of members of communities who are prone to reproductive ill health. There are RH vulnerabilities in all life cycles, hence people classified as a vulnerable group come from all age brackets. RH vulnerable groups consist of WRA, pregnant women, lactating women, and babies.

Reproductive health: a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmityat all aspects related to the reproductive system, functions, and processes.

Sexually Transmitted Infections (STIs): infections transmitted through sexual intercourse, including oral and anal sex.

SPGDT 119: Integrated Emergency Management System or Public Safety Service (PSC) can be accessed widely by public and free of charge by dialing 119 from mobile phone or landlines. Cases of emergency handled include daily emergency response (traffic accident, acute diseases) and disaster emergency response.

Survivor: comes from survive, meaning continue to live or able to defend own life. Therefore, survivor means a person who is able to stay alive following an experience that may cost a lives or a dangerous condition. Another term often used is victim, especially from the medical perspective.

Universal precaution: a guideline to prevent the spread of infections from blood/body fluid in the hospitals or other health facilities. The concept is that all blood/fluids should be treated as sources for HIV transmission.

Voluntary HIV counseling and test: clients on his/her own initiatives or refered to by others, and with various reasons, voluntarily seek counseling and HIVtest at a health facility or community-based HIV clinic.

SOURCES

1. The Family Health Directorate – The Ministry of Health Republic of Indonesiaand UNFPA, 2017, National Guideline on Minimum Initial Service Package (MISP) for Reproductive Health in Health Crisis, Jakarta, UNFPA
2. The Family Health Directorate – The Ministry of Health Republic of Indonesiaand UNFPA, 2017, National Guideline on Minimum Initial Service Package (MISP) for Reproductive Health in Health Crisis, Jakarta, UNFPA
3. The Indonesian Youth Alliance (ARI)and UNFPA, 2017, Pocketbook on Guideline on Youth in Health Crisis Situation, Jakarta, UNFPA
4. Maternal Health Directorate, The Ministry of Health Republic of Indonesia and UNFPA, 2015, Guideline on National Guideline on Minimum Initial Service Package (MISP) for Reproductive Health in Health Crisis, Jakarta, UNFPA
5. Health Crisis Management Center The Ministry of Health Republic of Indonesia, 2011,Technical Guideline for Health Crisis Management in Disaster, Jakarta, The Ministy of Health Republic of Indonesia
6. Directorate General for Disease Control and Environmental Health,The Ministry of Health Republic of Indonesia, 2015, National Guideline for Management of Sexually Transmitted Infections, Jakarta, The Ministry of Health Republic of Indonesia
7. Directorate for Child Health,The Ministry of Health Republic of Indonesia, 2011, Guideline for Youth Friendly Health Services at Primary Health Center, Jakarta, The Ministry of Health Republic of Indonesia
7. Inter Agency Working Group on Reproductive Health in Crisis, 2011, Inter-Agency Reproductive Health Kits for Crisis Situations edition 5, Jenewa, WHO
8. Inter Agency Working Group on Reproductive Health in Crises, 2010, Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings,
9. Inter Agency Working Group for Reproductive Health in Crisis Situation, 2010, Interagency Field Guideline for Reproductive Health in Emergency CrisisSituation, Bahasa Indonesia version, Jakarta
10. Save the Children and UNFPA, 2009, Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings,
11. Directorate for Maternal Health, The Ministry of Health Republic of Indonesia, 2004, Guideline for Emergency Contraceptives Services, Jakarta, The Ministry of Health Republic of Indonesia

ANNEX1

INDIVIDUAL KITS

Kit	Colour	Target
Hygiene kit	Blue	Women at reproductive age
Pregnancy kit	Green	Pregnant women (priority given to those in 3rd trimester)
Post delivery kit	Orange	Women in post-delivery
Newborn kit	Red	Newborns (until 30 months old)

Reproductive Health Individual Kit

ANNEX 2

FORM B-1 (FOR USE 1 DAY AFTER DISASTER)*

a. Name of Health Agency/PPK Sub Regional
b. Type of disaster
c. Date/Time of disaster
d. Description of disaster
e. Location of disaster

No	District/City	Subdistrict	Village/ Hamlet	Number of Affected Population	Topography
(1)	(2)	(3)	(4)	(5)	(6)

A. The number of victims

1. Deaths

No	Name	Sex	Age	Nationality (No Passport)	Address	Place of Death	Cause of Death
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

2. Missing victims

No	Name	Sex	Age	Nationality (No Passport)	Address	Place of Death
(1)	(2)	(3)	(4)	(5)	(6)	(7)

3. Survivors sustaining serious injury/in-patient facility and those with light injury/out patient treatment

No	Name of Health Facilities and Locations (District/City)	In patient			Out Patient		
		M	F	Total	M	F	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Total						

4. Displaced Population

No	Location	Family Card	Male	Female	Number of people
(1)	(2)	(3)	(4)	(5)	(6)
Total					

B. General Facility

Access to dissaster-affected locations
- o Easy to reach, mode of transport to use….
- o Difficult to reach, because….

Mode of Communication to use…..

Condition of electrical system/power supply
- o Good
- o Interupted
- o Not available

Source of water
- o Contaminated
- o Not contaminated

C. Condition of Health Facilities

No	Name of Health Facilities (Hospitals, Primary Health Centers, PUSTU, Pharmaceutical Storage Gudang Farmasi, Community Maternity Posts Polindes, Provincial/District Health Agency, Rumah Dinas, etc)	Condition		Services	
		Not Destroyed	Destroyed	Functioning	Not Functioning
(1)	(2)	(3)	(4)	(5)	(6)
	a……				
	b……..				
	c…. etc				

D. Emergency response Conducted

1. ……
2. ……

E. Health Services Challenges

1. ……
2. ……

F. Immediate Assistance Needed

1. ……
2. ……

G. Follow Up Plan

1. ……
2. ……

*Note:
Form B-1 is just a reference, data in this form will be collected by the Rapid Health Assessment (RHA) team from the health crisis management center.

ANNEX 3

BASIC REPRODUCTIVE HEALTH DATA IN PRE HEALTH CRISIS

Name of District/City:
Name of Province:
Period:

No	Indicator	Coverage	Target	Remark
1	K1			
2	K4			
3	Delivery by health personnel			
4	Number of maternal deaths			
5	Contraceptive Prevalence Rate (CPR)			
6	Crude Birth Rate			

PRE-HEALTH CRISIS DATA ON HEALTH FACILITIES

Name of Health Facilities	Types of Health Facilities	Public/ Private	Types of RH services (please tick)					Remark
			ANC	Normal Delivery	BEONC	CEONC	FP	

PRE-HEALTH CRISIS SERVICE PROVIDERS

Name of Health Facilities	Number of RH Services Providers						Remarks
	ObGyn	Pediatrician	GP	Midwives	Nurses	Others	

ANNEX 4

ASSESSMENT ON THE CONDITION OF HEALTH FACILITY, AVAILABILITY OF PERSONNELS, EQUIPMENT AND MEDICINES

Rh Health Facilities in The Affected Areas

Name of Health Facilities	Types of of Health Facilities	Public/ Private	Types of RH services (please tick)					Remarks
			ANC	Normal Delivery	BEONC	CEONC	FP	

Service Providers in The Affected Areas

Nama of Health Facilities	Number of RH Service Providers						Remarks
	Ob/Gyn	Pediatrician	GP	Midwives	Nurses	Others	

Availability of Equipment and Supplies for RH Services

Name of Health Facilities	Types of of Health Facilities	Public/ Private	Types of RH services (please tick)					Remarks
			ANC	Normal Delivery	BEONC	CEONC	FP	

Blood Transfusion	Yes	No
Availability of laboratory for bloodscreening test		
Hepatitis screening		
HIV screening test		
Syphilis screening test		
RH services		

Type of service	Availability of services		Nearest health facility providing the said services		Remarks
	Yes	No	Name of Facility	Distance (km)	
ANC					
Normal Delivery					
BEONC					
CEONC					
Contraception					
SGBV Treatment					
PEP kit					

Management of Sexual Violence and Services Provided

Activities	Remarks
Is there a coordination mechanism for treatment and management of sexual violence	
Number of reported cases of sexual violence	

ANNEX 5

LIST OF AGENCIES/ORGANIZATIONS/NGOs WORKING IN RH SECTOR

Place and Date : ……..

Name of Organization	Programme	Work area	Name and Address to contact		Remarks
			Name	Address/email/ telp	

ANNEX 6

FORM FOR PREGNANCY AND POSTPARTUM QUESTIONAIRES

Collected by:
Location:

a. Pregnancy Questionnaire

No	Description	Remarks
1	Name	
2	Age	
3	Pregnancy term	
4	Number of pregnancies	
5	Is pregnancy check/ANC available Location/distance to service provider? By whom?	
6	Planning for delivery (location and who provide assistance for delivery?)	
7	Planning for post birth family planning	

b. Postpartum Questionaire

No	Description	Remarks
1	Name	
2	Age	
3	Number of children?	
4	Age of baby?	
5	Birth weight?	
6	Delivery process: normal or C section, who provide assistance for delivery, place of delivery service?	
7	Is post partum services available? Where?	
8	Breastfeeding: Yesor No? Any difficulty for breastfeeding?	
9	Post delivery FP	

ANNEX 7

ASSESSMENT ON THE CONDITION OF DISPLACED PEOPLE CAMPS AND IDENTIFICATION OF SGBV RISKS

Collected by:
Location:

7.1. Assessment on Camp Management

Indicators	Yes	No	Remarks
Questions about IDPs Camps			
Vulnerable groups (pregnant women, newborns, under 5 y.o., elderly and people with disabilities) in one location and family close to that location Number of people in 1 tent			
Are you living with non family members?			
Do you feel comfortable or safe living in the temporary tent? Please explain.			
Questionaire about safe toilet			
Do you feel comfortable using the provided toilet facilities?			
Toilet and clean water facilities answer the need of displaced people.			
Are female and male toilets separated and equipped with clear signing			
Toilet door be locked from inside			
Sufficient lighting (in the camp, toilets and streets)			

Indicators	Yes	No	Remarks
Questionaire about health services and camp safety			
Is the health service easy to reach?			
Is there safety and security system implemented in the camp?			
If you hear about a sexual violence case in or around the IDPs camp, are you going to report it? If no, go to the next question. If yes, to whom are you going to report it?			
Have you ever received information about availability of health services providing support for sexual violence survivors?			
For married WRA, What is your opinion about fulfillment of sexual rights for you and spouse in the current condition of IDPs tent?			
Women's involvement in aid distribution			
Daily presence of female staff at the camp management office (for registration, security, protection)			
Information on availability and location of RH services for displaced people			

Indicators	Yes	No	Remarks
Information on availability and location of services for survivors of sexual violence			
Availability of counseling roomat the health post or female room (for changing, breastfeeding, etc)			

7.2 Identification of potential risks for SGBV

1. Number of women headed household: ……..……..……..……..……..……

2. Number of unaccompanied children: ……..……..……..……..……..……

Age group	Female	Male	Total
1 – 11 months			
1 – 4 years			
5 – 9 years			
10 – 14 years			
15 – 19 years			
Total			

Reporting of SGBV cases:

……..……

……..……

……..……

……

Briefly explain about existing support mechanism for management of SGBV consequences (medical services, psychosocial supports, safe shelter, legal aid):

……...……

……...……

……...……

……

SGBV Management conducted

……...……

……...……

……...……

……

Assistance needed

a. ……..

b. ……..

ANNEX 8

RAPID HEALTH ASSESSMENT (RHA) TOOL FOR ADOLESCENTS

RHA is conducted within the first 72 hours of health crisis with an aim to collect demographic data and to identify challenges in delivering immediate interventions for the wellbeing of the target beneficiaries. The implementation of rapid health assessment involves:

1. Data collection by officers who are members of RH team and with youth involvement.
2. If it is not possible to collect data directly to adolescents, Data no. 1, 2, 3 can be calculated from the estimated total IDPs population from the RHA team.
3. Data no. 4 and 5 are directly obtained from interview with adolescents.

Table: Rapid Health Assessment on Adolescent Reproductive Health

No	Adolescent Demographic Data	Female	Male	Remarks
1	Number of (10-14 years old), sex dissagregated			If not available, data on 10-19 years old can be estimated at 18.3% of the total IDPs population (not differentiated by sex)
2	Number of (15-19 years old), sex dissagregated			
3	Number of (20-24 years old), sex dissagregated			If not available, data on 10-19 year olds can be estimated at 27% of total IDPs population(not differentiated by sex)[4]
4	Number of adolescent with dissabilities			Can be obtained during data collectionby Adolescent Reproductive Health Team
5	Number of pregnant girls aged <15 years old and between 15-19 years old[5]			Can be obtained during data collectionby Adolescent Reproductive Health Team
	SUPPORTING INFORMATION	**Yes**	**No**	**Remarks**
11	Availability of mental health services and psychosocial supports			

No	Adolescent Demographic Data	Female	Male	Remarks
12	Are male and female toiles separated?			
13	Is each toilet equipped with a door that can be locked from inside?			
14	List of organizations or adolescent community groups in the vicinity of the camp			

Source: National Guidelines on MISP for Adolescent Reproductive Health in Health Crisis Situation, 2017

ANNEX 9

FORMAT AND CONTENT OF ASSESSMENT REPORT FOR REPRODUCTIVE HEALTH COORDINATOR AT NATIONAL/PROVINCIAL/DISTRICT LEVEL

Format and Content of Assessment Report

1. Title
2. Background
   - Brief introduction about the disaster/crisis; type, scale, location.
   - Objectives of assessment
3. Methodology

   Briefly explain the methodology used
4. Findings: analysis of the following information:

   4.1 Affected communities, dissagregated data (by age, sex, geographical location IDPs)
   4.2 Condition of IDPs camps
   4.3 RH services available: equipment and staff
   4.4 Potential risks for gender-based violence
   4.5 Special needs of affected communities
   4.6 Coordination
5. Recommendations

Preliminary report should not be longer than 5 pages to describe the above condition

ANNEX 10

MONITORING CHECKLIST: MISP INDICATORS

I. Identify Reproductive Health Coordinator

No	Qualitative Indicators	Yes	No
1.	Agencies and organizations working in reproductive health sector in emergency situation are identified.		
2.	Coordinating meeting conducted and participated by with agencies and organizations working in reproductive health sector to identify sub-coordinators with matching responsibilites and to obtain form B-1 data from Health Crisis Center.		
3.	Introduce MISP for reproductive health and workplan development .		
4.	Routine meetings conducted as soon as possible with the participation of multisectoral RH stakeholders and other relevant organizations for MISP for RH implementation.		
5.	Routine activities are repoted to members and other relevant organizations or sectors.		
6.	Reproductive health services at the IDPs camps available		
7.	Availability and distribution of RH logistics or RH and individual kits well coordinated		
8.	Meetings and coordination with Health Crisis Centers and BNPB attended.		

No	Quantitative Indicators	Coverage
1.	Number of RH coordination meetings conducted in the first 3 months	
2.	Number of health coordination meetings, attended by with RH team to report activity progress of MISP implementation, etc	

ii. Prevent and Manage Sexual Violence

No	Qualitative Indicators	Yes	No
1.	Coordinate with BNPB/BPBD and Social Affairs Office to ensure special site within the IDPs camp for vulnerable groups and ensure that one family shares one tent. Women headed households and unaccompanied children are grouped/gathered in one shelter.		
2.	Ensure RH services in IDPs camps are available		
3.	Ensure male and female toilets are separated in safe locations and with adequate lighting and doors can be locked from inside.		
4.	Coordination with person in charge of security conducted to prevent sexual violence.		
5.	Agencies/organizations working in women's empowerment and assisting displaced women in the planning and implementation of programme activities in IDPs camps are involved.		
6.	Information about availability of services for rape survivors with 24-hour call center. Information can be delivered through leaflet, pamphlets, radio, etc.		
7.	Personnel responsible for handling cases of sexual violence available.		
8.	Medical and psychosocial services by the participating organizations/ agencies and well-coordinated referral mechanism for protection and legal aid to assist survivors are available.		
9	Culturally-sensitive facilities to meet the need of married couples to lead normal sex life are provided		

No	Quantitative Indicators	Coverage
1.	Number of sexual violence cases reported	
2.	Number of sexual violence cases receving medical services within the first 72 hours a. Emergency contraceptive: b. Antibiotics for STIs prevention: c. Post Exposure Prophylaxis (PEP):	

No	Quantitative Indicators	Coverage
3.	Number of cases referred to other facilities: a. Hospital b. NGOs for legal aid	
4.	Number of facilities providing 24hours/7day services for rape survivors	
5.	Number of services for gender-based violence survivors	

iii. Prevent HIV Transmission

No	Indikator Kualitatif	Ya	Tidak
1.	Safe and rational blood transfusion by specialist agencies/organizations, e.g.: the Indonesian Red Cross.		
2.	Facilities, equipments and trained personnels available. If not available, blood transfusion should not be performed.		
3.	The importance of compliance with universal precaution since the begining of coordination is highlighted and compliance is ensured.		
4.	Free condoms availability in coordination with various organizations working in family planning, Ministry of Health, BKKBN, other NGOs.		
5.	Continued ARV treatment for users, including women enlisted in the PMTCT programme is ensured.		
6.	Information on 24-hour center for continued ARV treatment is available.		

No	Quantitative Indicators	Coverage
1.	Number of blood transfusion conducted	
2.	Number of blood screening conducted prior to transfusion	
3.	Number of PLWHA receiving continued ARV treatment	
4.	Number of sexually active men	
5.	Number of condoms distributed	
6.	Number of health facilities with equipment and supplies for proper implementation of universal precaution	

iv. Ensure Availability of Emergency Maternal and Neonatal Care (Beonc and Ceonc)

No	Qualitative Indicators	Yes	No
1.	Data on mapping of pregnant women and babies at IDPs camps available.		
2.	Mapping of primary health centers with BEONC capacity and hospital with CEONC capacity conducted. Need to assess building condition, geographical condition,transportation, equipment, medicinesand human resources availability.		
3.	Pregnant women can be easily reached by personnels and are gathered in one tent.		
4.	Breastfeeding counselor available		
5.	Midwifery kit, reprodudctive health kit, individual kits and Mother and Child Health bookdistributed as needed		
6.	BEONC and CEONC services available.		
7.	Coordination with local Office for Social Affairs and BPBD conducted to ensure availability of RH tent and breastfeeding room.		
8.	Coordination conducted to ensure referral system from community, primary health center and hospital.		
9.	Information on health services proceedure, detailing when, where and how to refer patients with emergency obstetric condition to referral health facility are available and displayed.		

No	Quantitative Indicators	Coverage
1.	Number of pregnant women in IDPs camps	
2.	Number of pregnant women accessing ANC service	
3.	Number of deliveries	
4.	Number of pregnant women giving birth at a health facility	
5.	Number of women with pregnancy complication	
6.	Number of women with pregnancy complication receiving assistance from BEONC primary health centers or CEONC hospital.	
7.	Number of maternal and neonatal deaths	
8.	Number of health facilities with BEONC and CEONC capacity providing services in IDPs camps.	

v. Planning for Integrated Comprehensive Reproductive Health Services Into Basic Health Service

No	Qualitative Indicators	Yes	No
1.	Plan for comprehensive reproductive health services developed and available		
2.	Data on target populations and coverage collected. In emergency health crisis, estimates can be used and after situation becomes more stable, real data is used.		
3.	Facilities that meet the criteria for provision of comprehensive reproductive health services identified		
4.	Equipment for BEONC and CEONC services available		
5.	Assessment of capacity of health personnels for provision of comprehensive reproductive health services conducted		
6.	Training plan for health personels developed		
7.	Reproductive health equipment and supplies for BEONC primary health centers and CEONC hospital available		

No	Quantitative Indicators	Coverage
1.	List of equipment and supplies needed	
2.	Data on reproductive health target populations available: a. Data on WRA b. Data on pregnant women c. Data on women in childbirth	
3.	Data on FP acceptors	
4.	List of trainings needed	

ANNEX 11

EVALUATION CHECKLIST

No	Aspects to Evaluate
1	**Programme Effectiveness**
	a. Have programmes been implemented as expected?
	b. Have objectives of each MISP components been achieved?
	c. Have the indicators and targets of each MISP components been achieved?
	d. Precentage of targets achieved out of the total set targets
	e. Has MISP implementation been conducted consistent with the time frame?
	f. Is there adequate technical and supporting staff available for MISP implementation
	g. Is there adequate logistics and supplies available to support MISP implementation
2	**Programme Efficiency**
	a. How has fund been utilized? Is the allocated fund appropriately spent?
	b. How is absorption of the allocated fund?
	c. Has fund been used efficiently?
3	**Programme Relevance**
	a. Have programme been implemented answer the needs of the affected population?
	b. Have activities been conducted consistent with the result of the needs assessment?
	c. What is the opinion of the beneficiaries about the programmes and services they receive? Are they satisfied withservices/programme provided?
4	**Impact and Sustainability**
	a. Do MISP implementation activities result in positive impact to the community?
	b. Will programme continue after the completion of MISP implementation?
	c. Will reproductive health services be continously provided in the post disaster phase?
5	**Challenges during programme implementation and solutions to address those challenges**
6	**Lessons learned from programme implementation**
7	**Recommendations**

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