
# Sexual and Reproductive Health in Emergencies

- A toolkit for implementation of activities -

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## Acronyms and abbreviations

| | |
|---|---|
| **ANC** | Antenatal care |
| **ARV** | Antiretroviral |
| **BEmONC** | Basic Emergency Obstetric and Neonatal Care |
| **CEmONC** | Comprehensive Emergency Obstetric and Neonatal Care |
| **CPD** | Cephalo-pelvic disproportion |
| **D&C** | Dilatation and curettage |
| **DOC** | Direct obstetric complication |
| **EmONC** | Emergency Obstetric and Neonatal Care |
| **ER** | Emergency Room |
| **FP** | Family planning |
| **HC** | Health centre |
| **HIV** | Human immunodeficiency virus |
| **HR** | Human resources |
| **IDP** | Internally displaced population |
| **IPC** | Infection prevention and control |
| **IPD** | Inpatient department |
| **IUD** | Intra-uterine device |
| **KMC** | Kangaroo mother care |
| **LBW** | Low birth weight |
| **LLIN** | Long lasting insecticide treated bed net |
| **MCH** | Mother and child health |
| **MoH** | Ministry of health |
| **MSF** | Médecins Sans Frontières |
| **MUAC** | Mid-upper arm circunference |
| **MVA** | Manual vacuum aspiration |
| **MWH** | Maternity waiting home |
| **NCU** | Neonatal care unit |
| **OPD** | Outpatient department |
| **PHC** | Primary health care |
| **PLW** | Pregnant and lactating women |
| **PMTCT** | Prevention of mother to child transmission of HIV |
| **PNC** | Postnatal care |
| **RH** | Reproductive health |
| **RTI** | Reproductive tract infection |
| **SGBV** | Sexual and gender based violence |
| **SRH** | Sexual and reproductive health |
| **STI** | Sexually transmitted infection |
| **SV** | Sexual violence |
| **SVV** | Sexual violence victim |
| **TBA** | Traditional birth attendant |
| **ToP** | Termination of pregnancy |
| **VVF** | Vesico vaginal fistula |
| **WHO** | World Health Organization |

# Introduction to the pocket guide

"Reproductive Health (RH) and Sexual Violence (SV) complications are the leading cause of morbidity and mortality worldwide for women of childbearing age. Women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, the complications of pregnancy and childbirth, sexually transmitted infections (STI) including HIV, sexual violence (SV) and other reproductive health related problems. The burden of poor health is even higher in certain groups of women, such as refugees, internally displaced persons, migrants and commercial sex workers and service delivery strategies should be adapted to their needs."[1]

Typical emergency approaches react upon events such as armed conflicts, natural disasters, disease outbreaks or famine, often involving population displacement. After several years of experience of MSF managing emergency interventions, we propose an approach which considers women's health needs from the beginning of the emergency.

The MSF policy for RH and SV care aims to guide actions according to the potential impact on maternal and newborn mortality and suffering. In 2014 the policy was revised and an order of priority headed by obstetric, newborn, post partum and abortion care and followed by essential preventive action was included. Other key Sexual and Reproductive Health (SRH) document, the SRH Core Package of Activities aims to clarify for operations (headquarters, coordination and field teams) which type of SRH activity should be implemented in the different MSF projects.

- It consists of a Minimum Package: services that should be available from the commencement of a project in emergency settings until further activities are implemented.
- Furthermore, there is the Core Package itself: detailing the activities in addition to the minimum package, they constitute a complete service.

In addition, this pocket guide has been developed to provide a practical approach for implementing SRH activities during the emergency phase of an intervention, and is laid out as follows:

- **Chapter 1**: activities to prioritize during the emergency phase of an intervention.
- **Chapter 2**: guidance on how to conduct an assessment.
- **Chapter 3:** provision of SRH care at the early start of an emergency.
- **Chapter 4**: focuses on general organizational aspects.
- **Chapters 5 to 7**: practical advice for the implementation of different SRH activities
- **Chapter 8**: monitoring of the implemented activities.

Completing this pocket guide, there is **a CD/USB key containing the 'sheets' referred to in this guide**. They include checklists, templates, easy to print files and protocols, primarily designed for practitioners with limited experience in SRH. Still, it is recommended to have a skilled and experienced MSF midwife at the start of the emergency response.

This version of the toolkit includes **only essential newborn care and basic neonatal resuscitation** that are considered the Minimum Neonatal Care package to be provided during an emergency. If intermediate or higher level of care is needed later, refer to separate neonatology specific tools for the care of sick and low birth weight/preterm neonates. Consult your paediatric advisors.

Any comments on this pocket guide or the tools are more than welcome. You can send your comments to the SRH advisor in Brussels through your responsible. Your comments will help to make this guide better adapted to the needs of the field.
Contact address: eva.deplecker@brussels.msf.org
Enjoy your mission!

[1] SRH policy, 2014

# Chapter 1: SRH in emergencies: priorities

Implementation of SRH activities during an emergency intervention has the objective to reduce maternal and newborn mortality and morbidity. Priority has to be given to these SRH activities with the biggest impact on reducing mortality. This chapter aims to provide guidance for the assessment of the situation and to explain what the potential impact off a particular SRH activity on reducing mortality can be. If more detailed information is required it is recommended to read the SRH policy.

## SRH activities:

### 1. Emergency Obstetric and Neonatal Care (EmONC)

EmONC is a package of care that responds to the main causes of maternal mortality

### Why?

- **When** are women dying?
    - 60% of maternal mortalities occur just before, during or just after delivery.
    - 45% of women die within the first 24 hours following delivery[2].
- **Why** are women dying?
    - Over 80% of maternal deaths are due to Direct Obstetric Complications[3]. Haemorrhage (35%), Hypertensive disorders (18%), unsafe abortion (9%) and sepsis (8%).
- And **Neonates**?
    - The 3 most important causes of neonatal death are all linked to care during pregnancy, delivery and the immediate postnatal care: preterm birth complications, birth asphyxia and sepsis.

### What?

**EmONC** services focuses on stabilizing and managing these obstetric emergencies and neonatal complications. Two levels of EmONC exist:

- **BEmONC** or **Basic** Emergency Obstetric and Neonatal care, at primary health care level.
- **CEmONC** or **Comprehensive** Emergency Obstetric and Neonatal Care, at secondary health care level (hospital).

Both constitute a specific package of activities (explained in chapter 5) requiring a skilled birth attendant[4].

### When?

**B/CEmONC** activities can be provided by MSF when these are no longer available through the local 1st and/or 2nd health care level.

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[2] SRH policy, 2014.

[3] DOCs = haemorrhage (antepartum and postpartum), prolonged and obstructed labour, postpartum sepsis, complications of abortion, pre-eclampsia and eclampsia, ectopic pregnancy and ruptured uterus.

[4] "A **skilled attendant** is an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."

- E.g. immediately after the 2010 earthquake in Haiti MSF provided CEmONC at different places in Port Au Prince as hospitals had literally collapsed.
- As mentioned above if you want to have an impact on maternal mortality women should have immediate access to EmONC.

## 2. Referral system

- Women and neonates are not only dying from the causes itself, but also because of delays in reaching care or in taking the decision to seek care.
- Organizing a **referral system** is particularly crucial as complications can lead quickly to death:
    a. E.g. Between the onset of a complication and the time of death there are in average 2 days for eclampsia and little as 2 hours for postpartum haemorrhage.
- Due to the nature of emergencies, delays can frequently take several days.
    b. E.g. Armed conflict can make that women needing care cannot cross certain zones; MSFs impartiality allows an MSF ambulance sometimes more 'freedom' to bring patients from a health centre (or mobile clinic) to a (MSF supported) hospital.

## 3. Provision of contraceptives

### Why?

- The impact is indirect but the **2nd best strategy to reduce maternal mortality!**
- Provision of contraceptive services has the potential to reduce maternal mortality by 30% (90% of the abortion-related and 20% of the obstetric-related mortality[5]
- 2 in 5 pregnancies in the developing world are unintended
- Contraceptives can prevent mortality and suffering related to unwanted pregnancy and unsafe abortion

### What?

- During an emergency phase of an intervention provision of contraceptive services will include a choice of methods, medical information and counseling adapted to patient needs.
- Different contraceptives as condoms, pills, IUD's and implants should be available at the start of an emergency. Promotion and organisation of contraceptive services can be adapted to local context

### When?

- Contraceptive counselling can be done post-delivery or post abortion, during ANC, general OPD and mobile clinic activities.
- Contraceptive methods should be strongly recommended to all women post-delivery or post abortion.

[5] WHO, USAID, Repositioning Family Planning: Guidelines for advocacy and action, 2008

## 4. Care to victims of sexual violence

### Why?

- Destabilization of contexts often results in increased levels of violence, including sexual violence.
- Sexual violence is particularly complex and stigmatising and generates long-lasting consequences.
- Challenges are multiple and need to be considered as part of MSF emergency care: legal considerations, confidentiality, protection, stigma and perception as well as access to, and acceptance of, assistance.
- Even if sexual violence affects predominantly to women, it is crucial not to forget that men can be also victims and services should be adapted accordingly.

### What?

- MSF assistance focuses primarily on the medical care for victims of sexual violence: treatment of injuries, prevention of infection (sexually transmitted diseases, HIV, hepatitis B, tetanus), management of unwanted pregnancy, psychological support and provision of a medical certificate
- Preventive protection measures to minimize the risk of sexual violence through logistic measures: site planning, sanitary facilities...
- Other forms of support as social and legal, community awareness and advocacy are advised
- As a minimum, measures should be taken to raise awareness about the medical consequences of rape and the existence of assistance.

### When?

- A minimum package of care (detailed in chapter 6) to victims of sexual violence is to be set up within the first days of all emergency interventions.

## 5. Additional activities:

- **Antenatal Care:**
    - Antenatal care alone cannot reduce maternal and neonatal mortality and must be implemented as a complement to EmONC.
    - ANC is often the entry door to emergency care. The objective is to identify women with complications, treat accordingly and link to EmONC.
    - During ANC we can provide clean delivery kits to visibly pregnant women to assure clean home deliveries when access to health facility cannot be assured (during night) due to insecurity or other.

- **Postnatal Care:**
    - About 45% of post partum maternal deaths occur within 1 day of delivery, more than 65% within 1 week, and more than 80% within 2 weeks[6]

[6] http://www.who.int/maternal_child_adolescent/epidemiology/maternal/en

- MSF encourages women to stay in a health facility at least 24 hours following vaginal delivery to detect and manage early post partum complications of the mother and/or baby and to help initiate breastfeeding
- MSF can offer subsequent post-natal care consultations either at health facility level or through home visits.

## 6. Transversal activities:

- **Reproductive Tract Infections**: effective prevention, diagnosis and treatment of sexually transmitted infections should be standard components of care.

- **Rapid MUAC Assessment**: emergency contexts will frequently be prone to situations with malnutrition, especially amongst young children and pregnant and lactating women. Therefore, it is standard to do a rapid MUAC assessment in the first days and to include nutrition activities in the package of care accordingly.

- When there is an **important HIV prevalence (≥ 1%)** amongst the pregnant target population, and resources allow, **PMTCT services** should be offered. Continuing an already existing program that is now weakening (e.g. the provision of ARVs to pregnant women who know their status or who are already on ARVs) could be continued.

- Reduce HIV transmission by ensuring **safe blood transfusion**, respecting **standard precautions** and availability of **free condoms.**

- Provide adapted treatments for pregnant women with **cholera**.

# Chapter 2: Needs assessment

***"A needs assessment is a systematic process for determining and addressing needs, or "gaps" between current conditions and desired conditions[7]".***

A needs assessment is made to establish what must be done to improve the situation and which resources will be required to do so. This should be done at the start of the intervention, and often, due to fast changing situations, it may be necessary to undertake new assessments later. Assessments are done by members of the team who have the technical skills, training and experience on the topic or, if not possible, by anyone in collaboration with the person with the adequate level of expertise.

**Gathering information will be done to assess:**

a. The SRH needs of the target population.
b. The capacity of the existing health system/structure to respond to those needs.
c. Health seeking behaviour.
d. Accessibility to the existing health system/structure.
e. Rapid MUAC assessment in pregnant and lactating women (PLW).
f. Retrospective mortality combined with Rapid MUAC Assessment.

**From the gathered information a plan can be drawn:**

a. Which SRH component will be implemented to respond to the identified needs?
b. What are the activities to improve or provide the selected SRH component? E.g. provision of equipment & drugs, support, supervision & training of health staff, …

**To undertake an assessment, different tools can be used:**

- Existing information: demographic and health survey data, availability of SRH services, health facility data, national strategic plans, etc.
- Key informant interviews and focus group discussions.
- Health facility assessments.
- Rapid surveys: to gather population based data.

Because of the nature of MSF's (emergency) interventions, SRH needs won't be difficult to identify. Referring to the list of SRH priority interventions in emergency settings (chapter 1) and after assessing possible collaborations with other actors working on the topic, SRH component(s) can be selected. Once the operational strategy is set, the focus will be on: what is the capacity of the structure and what can MSF do to provide quality care and how to make the offered care accessible.

[7] Wikipedia

*Table 1: Tools to conduct the needs assessment.*

| Sheet nb. | Name | What is it used for? |
|---|---|---|
| **1** | Assessment tool SRH program | To describe a health facility, identify the SRH components provided & quality, availability of human resources and supplies … |
| **2** | Assessment tool safe abortion care | To describe a health facility, identify the Safe abortion care components (post abortion care and TOP) provided & quality, availability of human resources and supplies… |
| **3** | EmONC equipment check-list | To identify non-medical/medical equipment, stationary and items needed for a referral system required to implement EmONC. |
| **4** | SRH consultations equipment check-list | To identify non-medical/medical equipment and stationary required to implement SRH consultations. |
| **5** | Health seeking behaviour: list of possible questions | Questionnaire for patient interviews to assess health seeking behaviour. |

# Chapter 3: Provision of SRH care at the early start of an emergency

## Why?

At the start of an emergency intervention, when assessment and/or implementation of activities are ongoing and MSF provided/supported services are not yet functional, it may occur that a patient presents to seek medical care.

For example:

- During an exploratory mission in a refugee camp the chief introduces you to a woman in labour and a young girl who was yesterday raped in the camp. Additionally, he informs you that a few kilometres away there is a functional health centre.

- You arrive in a village after an earthquake. The TBA of the village introduces you to a woman who started labour 2 days ago and has started to develop fever. The health centre in town has been destroyed, the hospital is still functional but is lacking medical supplies.

In the above situations basic medical care can be provided. In order to have an impact on maternal and neonatal mortality, it is vital that health care services and skilled attendance are available.

## What?

In order to provide guidance to the team, the following tools have been newly developed:

- **Flowcharts for assessment and management of a pregnant woman and a sexual violence victim** (table 2).

- **Different kits,** including **drugs and medical supplies,** that can be used according to the situation encountered (table 3).

*Table 2: Flowcharts and kits for SRH care at an early start of an emergency*

| Sheet Nb. | Name | What is it used for? |
|---|---|---|
| 6.1. | Introduction | To provide a brief explanation on the purpose of the tool. |
| 6.2. | Flowchart assessment and management of a pregnant woman | To understand the treatment options after initial assessment**. Sheet 15**: obstetrical flowcharts 2015 and **sheet 29**: obstetrics maternal referral criteria can be supporting tools for the flowchart. |
| 6.3. | Flowchart assessment and management of a sexual survivor | To know the treatment options after initial assessment. Additionally, it is recommended to consult chapter 6 of this toolkit on sexual violence. |
| 6.4. | Clean delivery kit | Content of a clean delivery kit for 10 cases. |
| 6.5. | Health structure delivery kit | Content of a health structure delivery kit for 10 cases. |
| 6.6. | Complicated delivery kit | Content of a complicated delivery kit for 10 cases. |
| 6.7. | Rape management kit | Content of the rape management kit for 10 adults & 11 children. |

*Table 3: Objective of the kits*

| Sheet Nb. | Name of kit | Objective of the kit |
|---|---|---|
| 6.4. | Clean delivery kit | - Provision of hygienic care during a delivery.<br>- Prevention of hypothermia in the newborn. |
| 6.5 | Health structure delivery kit | - Provision hygienic care during a delivery.<br>- Prevention of hypothermia in the newborn.<br>- Conduction of a safe delivery.<br>- Performance of active management of third stage of labour. |
| 6.6. | Complicated delivery kit | - Provision of hygienic care during a delivery.<br>- Prevention of hypothermia in the newborn.<br>- Conduction of a safe delivery.<br>- Performance active management of third stage of labour.<br>- Prevention and treatment of complications: i.e. post-partum haemorrhage, infection, pre-eclampsia and obstructed/prolonged labour… |
| 6.7 | Rape management kit | - Treatment of 10 adults and 11 children according to the MSF international SV protocol. |

# Chapter 4: Organization

This chapter aims to provide answers to questions such as:



## 1. Different ways to offer SRH care

Based on the findings of your assessment, different SRH activities can be implemented. Several combinations of services to be offered are possible, some examples are:

a. MSF is working in a hospital and will provide CEmONC.
b. MSF is working in a health centre and will provide BEmONC and will ensure a referral system to a CEmONC facility.
c. MSF establishes SRH activities at OPD level (ANC, PNC, FP) + Emergency room, including stabilization of obstetric emergency cases before referral.
d. MSF is providing SRH care in the context of primary health care through mobile clinics (ANC, PNC, FP, RTI treatment, STI/HIV prevention and or treatment and health promotion). EmONC patients can be referred to EmONC facilities.
e. Sexual violence as a stand-alone activity or integrated with any other SRH activity.
f. Any combination of the above are possible, this will depend on the findings of the assessment and identified priorities.
g. …

For each scenario, SRH consultations can be an additional part of the care offered. In the SRH package of activities, sexual and reproductive health consultations are presented as 'standalone' activities: ANC, PNC, FP, and RTI. At the start of an emergency intervention it can be more practical to 'group' the different SRH consultations as '**sexual reproductive health consultations or *women's health consultations'***. Depending on the context, but in most places, it is recommended that a female consultant provides these consultations. For the setup, there are different possibilities:

a. Reproductive health consultation at OPD level with a 'consultation room only for women's health' with a female consultant trained for this type of consultations.
b. A reproductive health consultation room close to the maternity ward – creating a 'women's health' unit in the hospital.
c. Reproductive health consultations integrated in general OPD activities; however this is not the best option because it is more likely that the person providing the consultation is not specifically trained in women's health topics. Women from their side may also feel less at ease to express a 'female' problem in a 'general' consultation; perhaps even to a male consultant.
d. Reproductive health consultations provided through mobile clinics.

## 2. Integration of SRH activities during an emergency intervention at different levels.

Once a set of SRH activities to be implemented is selected, they should be integrated in the overall plan of the emergency intervention. Table 4 shows how these activities can be integrated in the different levels of care MSF may be working during the intervention.

*Table 4: Integration of SRH activities in health care services during the emergency phase of an intervention.*

| Level of care | SRH activity |
|---|---|
| Community | • Collect data on mortality: maternal and neonatal.<br>• Referral of pregnant women to ANC, women who delivered to PNC, referral for delivery, FP, etc.<br>• Follow up of low birth weight (LBW) and premature infants after discharge<br>• Referral of women/men for specific care as SV victims, women with complications of unsafe abortion, …<br>• Health promotion, TBA meetings, … |
| Health post and/or mobile clinic | • SRH consultations: ANC, PNC, FP (first and/or follow-up), SV[8], …<br>• Follow up of LBW and premature infants after discharge from the HC/hospital. Or if LBW and premature infants are born at home, referral to HC/hospital.<br>• Referral of women and newborns with complications to health centre or hospital.<br>• Data collection.<br>• Health promotion. |
| Health centre | • SRH consultations: ANC, PNC, FP, SV, …<br>• BEmONC.<br>• Essential newborn care and basic resuscitation after birth<br>• Kangaroo mother care[9]<br>• Provision of antibiotics to neonates (before referral)[10].<br>• Referral of women and newborns with complications to hospital.<br>• Data collection and analysis. |
| Hospital | • CEmONC.<br>• Neonatal unit (provision of specific treatments for sick and LBW neonates).<br>• Data collection and analysis. |

[8] Providing care to SV victims requires to ensure confidentiality even more than other services. Logistically, this can already be challenging at health post or mobile clinic level. Perhaps it is better to refer to a 'higher' level of service. However, if this is the only available level of care for the victim, medical care and psychological support can be provided at this level.

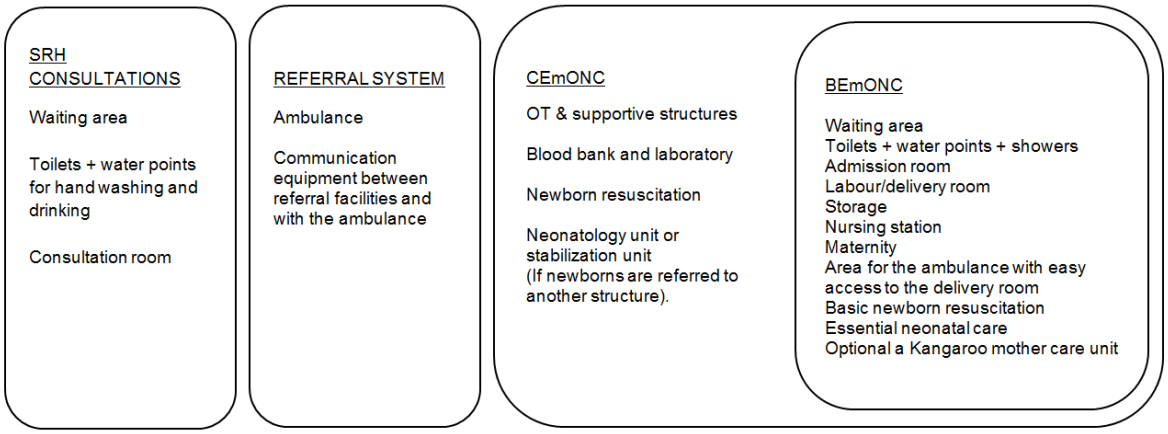
[9] KMC: Prevention of hypothermia and prevention of hypoglycaemia through promotion and assistance of skin to skin contact and breastfeeding

[10] For provision of antibiotics to a neonate, or other treatments, refer to the Neonatal Care MSF Guideline, 2015.

## 3. Structural considerations.

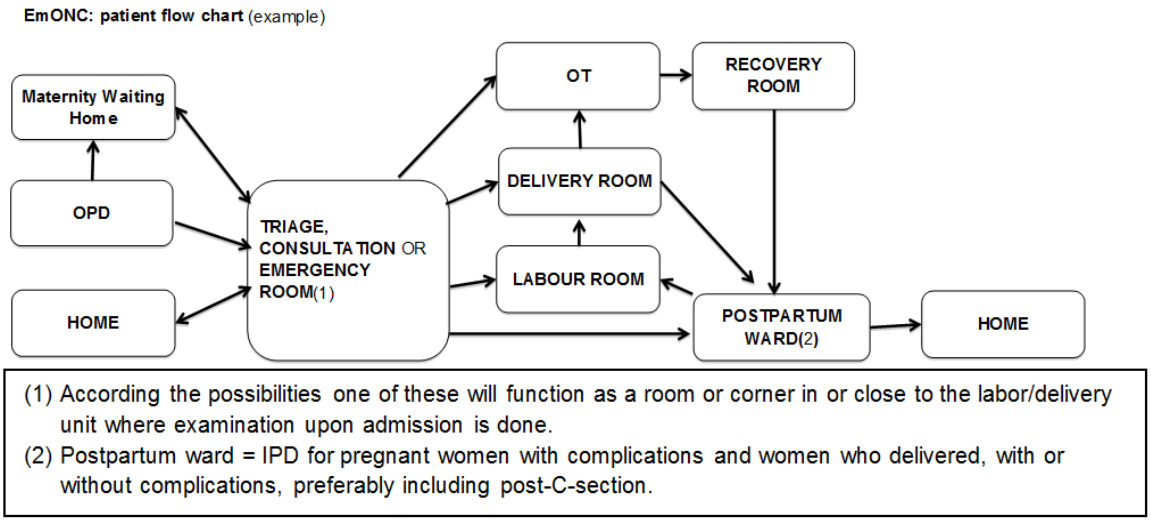
To be able to implement the selected SRH activities, frequently the structure needs to be adapted. Different department components to consider are listed in figure 1.

*Figure 1: Department components related to SRH activities.*




The organization of the different department components in relation to one another will depend on the patient flow[11]. A logical flow in a structure providing EmONC is shown in figure 2. This figure can be used as a blue print to organize the department components. When you start from zero, you can plan an ideal concept, but this will not always be the case. Often an structure already exists, limiting possibilities.

Figure 2: Example of an EmONC patient flow chart.




Remember, patient flow is not only about construction and logistics. When your patient 'moves' in the facility, she will meet other people. Example: a woman coming for a delivery will probably not mind to tell the watchman why she came to the facility. But a sexual violence victim, or an adolescent coming for STI treatment, will only come if confidentiality can be assured. This is not only obtained by respecting the medical secret, but also through your patient flow. Some suggestions, especially for sensitive issues:

[11] Organizing a patient flow demands to think of the different department components the patient will go through between admission and discharge; and to organize these in a logical order.

- Discuss with the national staff about the sensitivity of the topic and the importance of providing care. Also, about how to address it, how things are 'called' and defined and specially how they can contribute in stimulating women to seek care.
- Ask the watchman to refer all women to the 'women's unit'.
- Use a code word at the entrance/reception[12]. For example in Kibera, Kenya, in outreach activities, people are advised to ask for 'Tumaini' (this means hope in Swahili and is also a common female name) at reception so the patient can be seen immediately by the right person without the need to explain why she comes.
- Train all the staff on the concept and relevance of confidentiality.
- Organize a 'one-stop, one provider' service: consultation, taking lab samples, provision of treatment and counselling is all done at the same place, by the same staff.
- Have a suitable location for the consultation guaranteeing privacy and confidentiality.

*"When all people in the chain receive training, and each step is thought through, it will make a strong chain".*

## 4. Beds and examination/delivery tables: *estimated* needs

An automatic calculator (**sheet 7)** has been developed to determine the beds´needs (delivery tables, labour beds, postpartum beds, …). There are no rules. The outcome of these calculations will provide a rough guidance, only useful when starting up. However these numbers will need to be adapted as the situation evolves and own statistics become available.

*Table 5: Example of bed´s needs when 100 deliveries per month are expected.*

| Department | Example | Minimum nb of beds needed |
|---|---|---|
| Delivery room | 100 (expected) deliveries per month | 2 delivery tables<br>+ 1 exam table<br>2 newborn resuscitation tables |
| Labour room | | 2 labour beds |
| Postnatal room | | 4 beds for postpartum<br>2 beds for the observation of at-risk newborns |

Delivery room:

In table 6, the number of delivery tables recommended according to the number of expected deliveries is presented (extracted from **sheet 7**). In addition to the delivery tables, it is advisable to foresee 1 examination table in an admission room/corner in order to allow the delivery tables to remain free and clean for delivery and other procedures. Furthermore, foresee also 1 newborn resuscitation table for every delivery table.

*Table 6: Number of delivery tables recommended according to the number of expected deliveries.*

| Number of (expected) deliveries / month | Number of delivery tables recommended |
|---|---|
| < 50 deliveries/month | 1 |
| 50 - 200 deliveries/month | 2 - 3 |
| 200 - 350 deliveries/month | 3 - 4 |
| 350 – 500 deliveries/month | 4 - 5 |
| >500 deliveries/month | Add 1 table per every 150 extra deliveries |

[12] Using a code word can be particularly useful for victims of sexual violence. Perhaps it can also be useful for women asking termination of pregnancy on request, …

Organize the delivery room with appropriate spaces (e.g. warm, drought-free, well lit, and equipped) to provide basic resuscitation to the neonate. Whenever possible, routine newborn care should be provided with the baby in skin-to-skin contact with the mother.

Post-partum ward

Surveillance of healthy babies with or without risk factors should be done on the post-partum ward, keeping the mother and baby together. It is recommended to re-group at-risk[13] babies in a specific area of the post-partum ward since these babies need additional monitoring.

Neonatal care for sick and low birth weight/preterm babies

Typically, 10-15% of newborns will require admission to a neonatal care unit (NCU)[14].
The proportion is higher when the proportion of complicated deliveries is higher, such as in a CEmONC. The NCU comprises a KMC unit and a unit for sick neonates. Ideally, the NCU is located near the maternity ward. If located within the maternity, the NCU (or the KMC sub-unit) must form an independent component, distinct from the maternal components and strict access control must be ensured. Depending on the context, a full NCU for sick and LBW/preterm babies may not be possible nor the priority in the early phase of an acute emergency.

## 5. Human resources

Estimation of HR needs.

An automatic calculator, **sheet 7,** has been developed to determine the *number of medical staff* needed for each position There are no rules. The outcome of these calculations will provide a rough guidance, only useful when starting up. However these numbers will need to be adapted as the situation evolves and own statistics become available.

*Table 7 summarizes some examples of the number of staff needed according to the type of activity:*

| Type of activity | Example | Staff required |
|---|---|---|
| SRH consultations | 100 per day | 4 (for 5/7 days a week consultations) |
| Labour and delivery room | 100 (expected) deliveries per month | 4 to cover 24/7 services |
| Postnatal ward | 6 beds | 4 to cover 24/7 services |
| Additional post-partum beds for healthy 'at-risk' babies | 2 observation beds | 4 to cover 24/7 services |

Despite the availability of this calculator, estimating HR needs is not easy and several variables will influence it:

- The *type of staff*, according level of education. Depending on: availability of different levels of staff, ability to work independently, type of deliveries and complications and so the required skills, cultural/traditional appropriateness.

[13] Examples of at-risk neonates include **asymptomatic babies** with risk factors for hypo glycaemia e.g. macrosomic (large) babies; risk factors for infection; or who received a short period of basic resuscitation at birth.
[14] Within OCB the terms neonatal unit, neonatal care unit and neonatology unit are used to identify the same service. These terms are used interchangeably in the different documents available such as the admission forms, the data collection tools…

- The total *number of staff* needed, depending on: workload including case load of direct obstetric complications (DOCs), MSF labour regulation of the mission, national laws regulating labour, …

And:

1. Can, for instance, a professional midwife be expected to come and work in a rural area? Or is training of motivated lower skilled providers more realistic?
2. Regarding security contexts: how will the staff come to the facility, what are acceptable hours to change shifts, …

When recruiting staff, the different profiles and levels of health care professionals may exist in the country or in the country of origin of the target population (in case of refugee camps).

Answering the below questions will help to fill in the different positions (find examples in S**heet 10)**:

1. Are there professional midwives[15], nurses with obstetrical skills, nurse aids, midwife assistants, …?

   For example, in South Sudan few professional midwives exist. As a consequence, one has to decide at the start of activities whether to recruit regional professional midwives or to have more expatriate midwives.

2. For each level, which skills are they trained for?

   Vacuum delivery and manual vacuum aspiration are two skills of the BEmONC signal functions. In many countries midwives are not (sufficiently) trained to perform this act. If this is known in advance, a professional midwife to give specific training could be a good decision. In many countries, midwives are not sufficiently trained in newborn care. An experienced midwife or nurse skilled in neonatal care or a paediatrician is recommended to train staff on essential newborn care.

3. For each level, which acts are they allowed/not allowed to perform?

   In some countries nurses or midwives are legally not allowed to sign the medico legal certificate provided to victims of sexual violence. This will influence the need of hiring a medical doctor who is allowed to sign the certificate.

4. How many years of training did they receive?

   Training duration for different levels of health care providers differ widely from country to country. Some countries invested in specific professions related to SRH: e.g. Pakistan, lady health visitors: 2 years of education, focused on reproductive and child health. They are trained for normal deliveries, but still need supervision and support for complicated cases.

5. Who are the traditional care providers?

   - Are there village midwives, TBAs?
   - What is their status in the community? What are they consulted for?
   - Did they receive any training, equipment?
   - What is there role according MoH?

[15] In this document a 'professional midwife' means a person who had medical training and specific SRH skills training complying with the requirements of being a skilled birth attendant.

To make duty rosters, it should be decided if 24 hours coverage of care will be organized in 8 or 12 hour shifts. This does not influence the number of staff you need (an example in **sheet 11** ).

**Cleaners:** for the labour and delivery room there should be at least one cleaner 24/7, so 4 cleaners in total. According to the workload this person can also be responsible for cleaning the maternity or other wards, consultation rooms… Frequently, more cleaners will be necessary so cleaning protocols can be respected.
Keep in mind that again in some places only *female* cleaning personnel will be culturally acceptable in e.g. the delivery room.

Medical profiles and skills

Per group of activities, a certain level of training and skills (= *type of staff*) is suggested in table 8.

*Table 8: Summary of ideal level of skills according to SRH activity.*

| Activity | Suggested level of training |
|---|---|
| **EmONC** | • BEmONC: skilled birth attendants (number will depend on workload-**sheet 7**) + ideally a doctor available (on call) for non-obstetrical related complications<br>• CEmONC: skilled birth attendants + doctor with obstetrical surgical skills or gynaecologist available 24/7.<br>• Nurse-aids and TBAs are complementary staff and should always work under the supervision of a skilled birth attendant. |
| **Essential Neonatal care[16]** | • All midwives/nurses should be trained on essential newborn care, basic newborn resuscitation and observation of at-risk babies.<br>• Specific staff may be needed to support breastfeeding (nurse aids). |
| **SV** | • Female nurse or midwife with special training on SV.<br>• A doctor is often required for signing the medico-legal certificate.<br>• A gynaecologist –when available- can also support this activity. |
| **PNC, RTI, FP** | • Skilled birth attendant or nurse. This person can also be the one in charge. |
| **ANC** | • Nurse aid(s): with the support of a person in charge. |

## 6. Equipment and drugs

*Table 9 summarizes the available tools related to medical/non medical equipment and drugs.*

| Sheet nb | Name of sheet | What is it used for? |
|---|---|---|
| **3** | EmONC equipment check-list | To identify medical/non-medical equipment, stationary and items required to implement EmONC and its referral system. |
| **4** | SRH consultations equipment check-list | To identify non-medical/medical equipment and stationary required to implement SRH consultations. |
| **8** | SRH order calculator | To calculate the required amount of medical items necessary to implement the minimum package[17] of SRH activities. |
| **9** | Standard order for 100 deliveries for BEmONC | To calculate the required amount of medical items necessary to set up a BEmONC structure for 100 deliveries. |

[16] If a NCU is to be set up, additional profiles/skills will be needed (refer to neonatology tools).
[17] For the items needed for the treatment of sick and low birth weight/preterm babies (including pre-referral treatment), refer to neonatology tools.

*Table 10 summarizes the tools related to this chapter:*

| Sheet Nb | Name of tool |
|---|---|
| **3** | EmONC equipment check-list |
| **4** | SRH consultations equipment check-list |
| **7** | Formulas and calculator for estimation of beds and human resources needs. |
| **8** | SRH in emergencies order calculator (drugs and supplies( |
| **9** | Standard order for 100 deliveries in BEmONC |
| **10** | Human resources: examples of SRH positions needed |
| **11** | Example of a dutyroster |
| **12** | Examples for test-questions + answers when recruiting staff |
| **13** | Template job descriptions for different SRH staff<br>On the MSF career platform (http://career.msf.be/) you can find all information related to technical skills, transversal competencies, standard job descriptions, … |

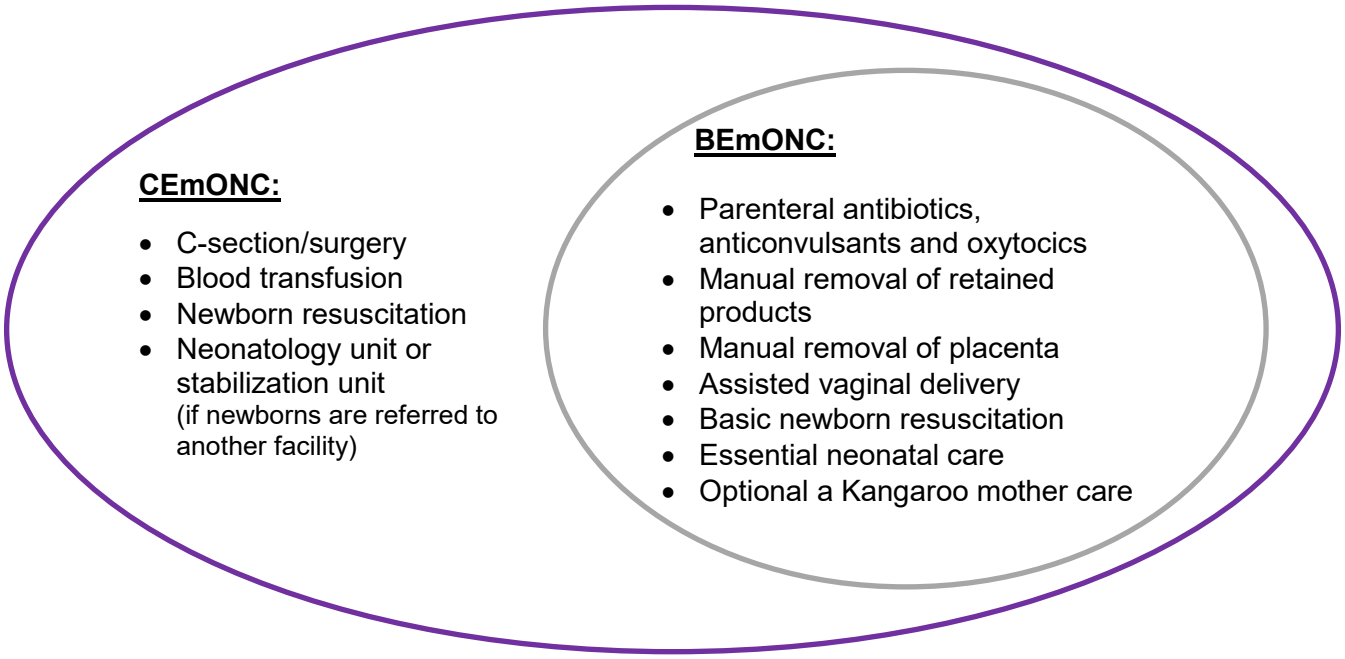
# Chapter 5: Emergency Obstetric and Neonatal Care + referral system

**Which are the lifesaving skills?**
As stated in chapter one, globally, 80% of maternal mortalities are due to DOCs globally and neonatal deaths are caused predominantly by low birth weight/preterm births, infection and intrapartum-related complications (asphyxia).

The package of emergency obstetric and neonatal care consists of maternal life saving skills in response to these DOCs and existing evidence-based interventions to reduce neonatal morbidity and mortality.The priority should always be the provision of skilled birth attendance, essential newborn care and basic resuscitation correctly (if needed) as this will have the greatest life-saving impact.

In figure 3, the activities in the inner circle are BEmONC. CEmONC consists of the BEmONC activities + the 4 additional activities in the outer circle.

*Figure 3: B/CEmONC signal functions.*




Typically, on a BEmONC level we provide essential newborn care and basic newborn resuscitation, and we refer sick and LBW babies. With a CEmONC, there is usually a NCU to provide care for sick and LBW babies. Due to the current set-up and designs of our projects/emergencies, this division is not absolute. It can happen that in a BEmONC we provide more than the essential package (for example, case management of neonatal sepsis). Conversely, at CEmONC level, sick and LBW newborns are sometimes referred to another structure (after stabilization).
A KMC unit can be an option at BEmONC level. However, even when there is no KMC unit, small babies without complications who have a birth weight above 1800 grams (sometimes even lower) can be cared for with their mothers on the normal postpartum ward or at home.

Three levels of neonatal care are proposed for MSF settings (essential, intermediate and advanced). Each level has specifications in terms of human resources, medical equipment and drugs, and diagnostic support (see “levels of neonatal care” document on the OOPS (Paediatrics).

Essential neonatal care (priority in emergencies):

- Basic newborn resuscitation according to the “Helping Babies Breathe” algorithm.
- Routine newborn care: thermal protection, cord and eye care, birth vaccination, vitamin K administration, early initiation and support of breastfeeding.
- Identification of risk factors and, observation on the post-partum ward of healthy babies “at-risk” (**sheet 19)**
- Skin to skin care on the post-partum ward (for low birth weight babies not needing admission to a NCU).
- Prevention of transmission of HIV, where relevant
- Systematic examination of the newborn and recognition of newborn danger signs.

Intermediate care: this includes capabilities at the essential level plus:

- Advanced resuscitation
- Curative care for neonates with non-complex medical problems (such as for example newborn sepsis, transitional breathing problems)

Advanced care: this includes capabilities at the essential and intermediate levels plus:

- Capability to provide care for neonates with more complex medical problems
- Possible capacity for non-invasive ventilation, advancing care in a step-wise fashion.

## Emergency Obstetric Care

**How to implement lifesaving skills?**

- Check structural requirements, medical equipment, drugs and supplies (chapter 4)
- Organize staff – maximum possible skilled birth attendants or professional nurses who can be trained
- If not existing, make a patient file, **(sheet 14)** is an example of a comprehensive file. This one can be adapted/translated to local needs and understanding.
- Print the MSF obstetrical flow charts **(sheet 15)** and stick them to the wall of the delivery room, they are very useful for bedside training and will guide staff with less experience.

**Particular challenges:**

- The **partogram** should be used for correct detection and management of prolonged and obstructed labour; and to set the indication for assisted vaginal delivery or caesarean section for CPD.
- **Assisted vaginal delivery** is preferably done by vacuum extractor and training of this particular skill will be needed.
- **Abortion care**: a complete package of abortion care includes both post-abortion care (management of complications of abortion, both spontaneous and induced) and provision of safe termination of pregnancy (ToP).
- During an emergency intervention focus will be on **post-abortion care**. For removal of retained products following abortion, manual vacuum aspiration is the recommended technique instead of D&C. With specific training this can be done by midlevel providers such as nurses and midwives, including local anaesthesia.
- The provision of **ToP**[18] will often be delayed because it is recommended to do a context analysis before implementation. However, sometimes it can be provided:
  - Countries were MSF is already working and a context analysis or risk assessment (**in library**) was done, application of the same modus operandi is validated (**in the library**).
  - Referral to another actor providing ToP (E.g. Marie Stopes).

## Emergency Neonatal Care

**How to implement neonatal care?**

- Assess the environment and needs (e.g. presence of other actors, estimated deliveries in the area, etc.)
- Organize the staff: skilled birth attendants, midwives or professional nurses in sufficient numbers, sensitized and trained in essential neonatal care including basic neonatal resuscitation.
- Organize the space: resuscitation areas in the delivery rooms; separation of sick and non-sick newborns. Keep the mother and baby together whenever possible.
- Order and prepare the medical equipment, drugs and supplies. Refer to neonatology tools.
- Put in place standard protocols and procedures.
- Put in place data collection tools for analysis.

[18] MSF documentation of Safe Abortion Care, in the library, contains the main documents needed to implement the TOP component.

**What does neonatal care in emergencies mean?**

In the acute phase of an emergency, simple life-saving interventions with the greatest life-saving potential are prioritized:

- Essential newborn care should always be implemented first. It is not useful to step up to higher levels of care before the basics are well covered. Much can be achieved with relatively simple means.
- When referral options are absent, treatment of neonatal sepsis should be implemented as soon as possible, as this is a relatively simple intervention that can save many newborn lives. Simplified protocols for managing neonatal infection can be considered.

Newborn care starts before delivery. A special emphasis should be placed on ensuring that the woman receives interventions proven to reduce neonatal deaths (such as antenatal corticosteroids for suspected premature births, intravenous antibiotics in case of maternal risk factors,…).

**Particular challenges:**

- **Basic newborn resuscitation skills** are acquired with practice and regular coaching/training. However, training birth attendants in basic newborn resuscitation before or at the beginning of the project can help save newborn lives and prevent disability.
- **Kangaroo Mother Care**: is a "simple" life-saving intervention. It is important that the staff fully understands the rationale and the advantages of KMC in order to be successful. Sufficient time for training and discussion should be planned.
- Support to early and **exclusive breastfeeding**: make sure midwives and nurses are well trained in the basics of breastfeeding support with an emphasis of good attachment and positioning.
- Newborns are particularly **vulnerable to infection**. An emphasis should be placed on ensuring **adequate basic IPC measures** even in the early phase of an acute emergency.

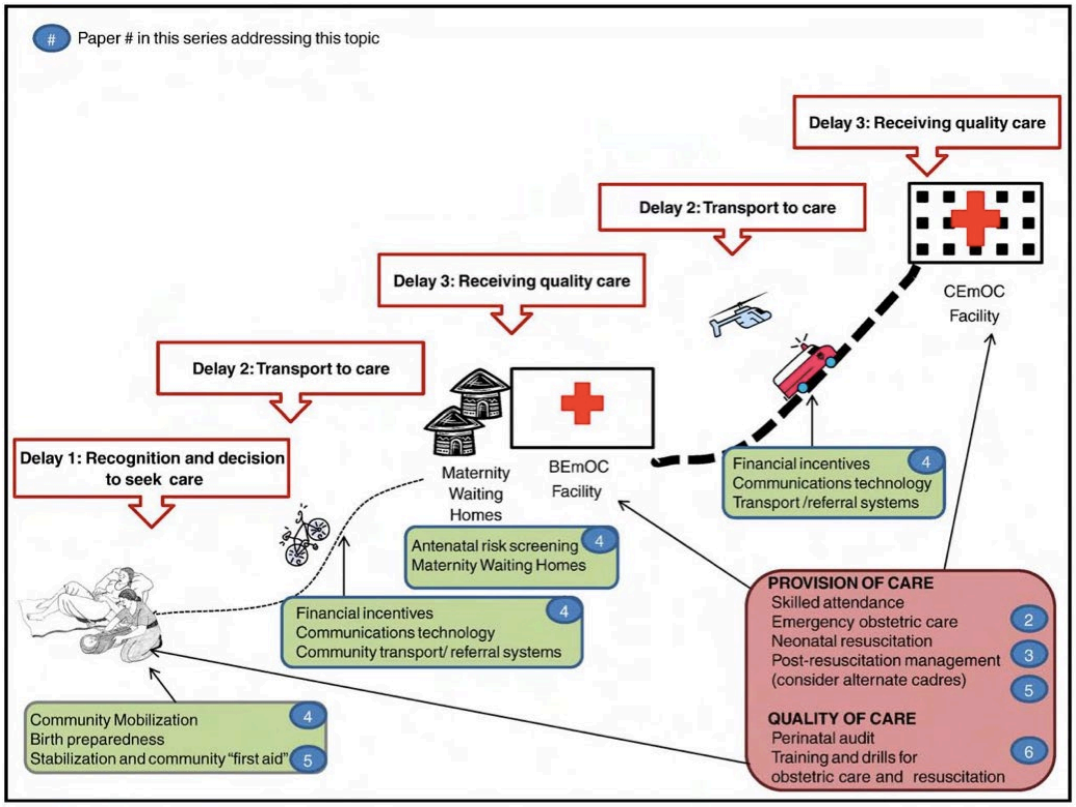
*Table 11: existing material to help implementation of the signal functions in obstetric and neonatal care:*

| | BemONC | CemONC | Neonatal care |
|---|---|---|---|
| **Protocols** | - Obstetric flow charts **(sheet 15)**<br>- Termination of pregnancy. MSF 2015 **(sheet 16)**<br>- Msf documentation on Safe Abortion Care **(library)** | - Caesarean section protocol. MSF 2014. **(sheet 17)** | - Admission criteria to neonatology **(sheet 19)**<br>- Managing newborn complications **(library)**<br>- Monitoring of newborns on the maternity ward: considerations **(sheet 18)**<br>- Preparing for the transfer of a newborn **(sheet 31)** |
| **Guidebooks** | - Essential obstetric and newborn care **(library)**<br>- Pregnancy, Childbirth Postpartum and newborn Care: a guide for essential practice. WHO **(library)** | - Blood transfusion guideline. MSF 2010 **(library)**<br>- Essential obstetric and newborn care **(library)** | - Neonatal Care Clinical & Therapeutic Guideline, MSF OCB (Intersectional version upcoming) **(library)**<br>- Essential obstetric and newborn care, MSF **(library)** |
| **Training support** | - The different mannequins for practical work stations***** | | - Training kit helping babies breathe*****<br>- Neonatal training package |
| **Patient files** | - EmONC patient file **(sheet 14)**<br>- Labour & delivery file – working with TBA, example. **(sheet 20)**<br>- Birth certificate example **(sheet 21)** | - Maternity daily follow up-file **(sheet 22)**<br>- Blood transfusion request form **(sheet 23)**<br>- Blood transfusion follow-up **(sheet 24)** | - Sick or LBW newborns monitoring sheet **(sheet 25)**<br>- Neonatal admission / referral paper **(sheet 26)**<br>- Weight monitoring sheet for low birth weight babies **(sheet 27)** |

***** ITC codes, full labels of items and an indication on its price for the above mentioned books and training support can be found in the SRH in emergencies order (drugs and supplies) calculator **(sheet 8).**

## Referral system

*Figure 4: Delays in receiving quality care for women with obstetrical emergencies.*




Source: J.E. Lawn et al. / International Journal of Gynecology and Obstetrics 107 (2009) S5–S19

Strategies to reduce delays are crucial to effectively link mothers and babies to skilled obstetric and newborn care. In MSF interventions following activities can be considered:

**Delay 1:**

- ANC and PNC are excellent opportunities to inform women on signs of complications during pregnancy and post-partum. Assisting the woman to make a plan on how to come in case problems arise is an important ANC activity (**sheet 28** gives an example of a birth plan).
- Through working with TBAs[19] we can support them in their role of promoting reproductive health services (e.g. ANC, facility based delivery…), facilitating referrals to health structures and providing labour support to mothers. Additionally, TBAs are key persons in identifying and addressing barriers to care.

**Delay 2a:** activities for referral between community / health post or centre and BEmONC facility:

- Women can be accompanied by a TBA.
- Transport organized by the community.
- Transport via mobile clinic or ambulance system.
- Use of taxi vouchers.
- 24/7 referral should be aimed for.
- Maternity Waiting Home[20]: in emergency contexts, an already existing MWH can be supported by MSF, MWH are typically located near a BEmONC with referral options or are located near a CEmONC. By this, the delay in travelling to care is reduced.

[19] Find the TBA guidance paper in the library (in EmoONC & Referrals).
[20] Find the Maternity Waiting Homes in MSF paper in the library (in EmoONC & Referrals).

**Delay 2b:** Referral between BEmONC and CEmONC facility:
- Fully equipped ambulance available 24/7
- Driver and (nurse-) midwife available to accompany the woman
- Referral criteria and referral paper (**sheets 29 & 30**).
- Functioning communication system: VHF radio, cell phones…

**Delay 3a:** at BEmONC level:
- Equipment and drugs are available
- Health staff is trained both to respond to normal delivery and newborn care and to manage obstetric complications through the BEmONC signal functions.
- Health staff is trained in recognizing and stabilising complications needing referral to a CEmONC facility.
- Pathways with referral criteria, a patient referral form and clear procedures on when, where to and how to refer, have to be in place.
- Appoint an overall responsible for referrals; follow-up of the referred patient will be one of the tasks
- 24/7

**Delay 3b:** at CEmONC level:
- Have a system in place with a qualified health staff to respond to emergency calls (radio, phone…)
- Health staff is trained, equipment and drugs are available 24/7 to respond to normal delivery and newborn care and are able to manage obstetric complications through the activities defining CEmONC.
- Feedback information is provided to the referring facility, at latest at the time the woman is discharged.

Note: When referring to a B/CEmONC facility, an assessment regarding provision of quality care should be conducted and positively evaluated first. Also, check on cost of care: is it for free (everything – always)? Will MSF pay if not?
Frequently during the first phase of an intervention activities are focused on the 3rd and sometimes 2nd delay. It is good to keep in mind that as soon as resources and the situation allows, further activities can be implemented to reduce 2nd and 1st delays.

*Table 12: Summary of main forms used to set up a referral system:*

| Sheet nb | Name of sheet | What is it used for? |
|---|---|---|
| **1** | Assessment tool SRH program | To assess SRH component in MSF project. Same elements are assessed of a potential referral facility – so it can be used for this purpose too. |
| **2** | Assessment tool safe abortion care | To describe the health facility, identify the Safe abortion care components (post abortion care and TOP) provided, give information on provision and quality of care, staffing, … |
| **29** | Obstetric / maternal referral criteria | To highlight the risk factors for obstetric complications requiring (urgent) referral. |
| **Annex to 29** | Obstetric / maternal referral: table of actions | To summarize the specific actions to be taken before referral of an identified complication. |
| **30** | Obstetric / maternal referral and counter referral form | To document key information needed for the referral and counter referral of a patient. |
| **31** | Preparing for the transfer of a newborn | To provide guidance on key elements for the safe transfer of a newborn. |

# Chapter 6: Sexual Violence

An important part of the emergency interventions is the provision of emergency care to internally displaced persons (IDP) or refugees resulting from conflicts.[21]

- "Refugees and displaced persons are particularly vulnerable to sexual violence throughout the period in which they live as refugees or displaced persons."[22] Consequently, MSF should **be prepared to receive the first victim** when coming.
- **Rape *is* an emergency**, and requires therefore **urgent** appropriate care.

During the emergency phase of an intervention, focus is to offer a **minimum package** of care to victims of sexual violence (SV), which is implemented within the first days:

1. Appoint a person in charge for the set-up and implementation and an another one (national) for the provision of care.

2. Organize a team meeting; discuss on: why to offer this care, exchange of experiences, what needs to be done and gather information on the context (extent of the problem, national protocols, legal aspects, available services) and perception of SV. SV can also affect men and access to care should be planned acordingly.

3. Order drugs and equipment; print files and protocols.

4. Organize training for directly involved staff:
    a. Identification/active screening of victims: frequently victims present in ER or OPD with vague complaints.
    b. Medical care: examination and treatment.
    c. Psychological care: emotional support by the medical care giver.

5. Prepare a consultation room: to provide safety and to keep confidentiality this has to be a separate room (think of windows: to be seen or heard), though not per se a SV care only room.

6. Establish a patient flow: between entering the gate and reaching the right person for the consultation: how can this go smooth, without having to tell why the victim comes. Think of female consultations (waiting area), code words, …

7. Raise awareness and establish community links:
    a. Women's groups, TBAs, police, community elders and other key persons in the community.
    b. Raising awareness focuses on explaining what is offered (medical and psychological care) and why (to prevent further medical illness) explain the importance of seeking care as soon as possible.

Preventive protection measures to minimize the risk of sexual violence can be done through logistic measures: site planning, sanitary facilities, distribution of non-food items.

According to needs, advocacy that highlights the scope of the problem and exposes gaps in the response can be carried out.

[21] OCB medical activity report 2011, pg 19.
[22] Care for victims of sexual violence – situation with displacement of population. Version 3.0 / January 2013, pg 5.

For detailed and very practical assistance in the set-up on how to provide care for victims of SV, the **Care for victims of SV-OCB pocket guide** is *the* one to consult[23] as well as the **Legal toolkit** (library).

*Table 13: Tools to facilitate implementation of care to victims of SV*

| Sheet nb | Name | What is it? |
|---|---|---|
| **NA** | Medicines Rape Management, 50 part A (code: KMEDMHMI13A) | A kit with all medication needed to treat 50 adults and 26 children |
| **NA** | Medicines Rape Management, 50 C-Chain (code: KMEDMHMI13B) | Cold chain part of the kit |
| **Library** | Care for victims of sexual violence. Situation with displacement of population. MSF-OCB, 2013. | Practical guideline, conceived on the model of a "quick start manual". *Technical sheets* linked to it with more in depth information, protocols, checklists, forms, … |
| **32** | Medical SV protocol | Medical protocols for care to SVV – 4 languages (English/French/Spanish and Arabic) |
| **33** | "Be prepared" – A 10 steps guide | Offering a minimum package of care to SVV in 10 steps |
| **34** | SGBV files | MSF International standard SGBV files |
| **Library** | SV response in MSF-OCB projects. Analysis and recommendations. | The abstract provides a summary of barriers and recommendations – to get inspired. |
| **Library** | Legal tool box. OCB, 2017. | All legal related items and docs regarding SGBV can be found here. |

[23] Be aware that several tools of this pocket guide have been updated and are available on the Legal tool box (also in the library) or somewhere else.

# Chapter 7: Reproductive health consultations

*Table 14 shows the focus of each SRH activity and the recommended number of visits.*

| Activity | Focus on | Nb of visits |
|---|---|---|
| **ANC** | Detection of pregnancy related complications<br>Identification of potential complicated deliveries for early referral<br>Provision of treatment, counselling and education | 1 visit recommended for women in 2nd and 3rd trimester (visible pregnant)<br>Follow up visit in case of complication |
| **PNC** | Early detection and management of complications<br>Provision of treatment, counselling and support | 1st visit – 1 week after delivery<br>2nd visit – 6 weeks after delivery |
| **FP** | Providing a variety of methods for all women at the onset of emergency<br>Provide FP method for all women immediate after delivery or abortion<br>FP can be provided during mobile clinic and OPD activities | According to type of method chosen– see FP protocol, **sheet 35.** |

Start implementation after considering:

- Structural requirements
- Medical equipment
- Drugs and supplies
- Organise staff – maximum possible skilled attendants, if limited availability, TBAs can provide care under close supervision
- Train staff according to protocols
- Implement patient file

*Table 15 summarizes the existing material to support the implementation of different SRH consultation topics:*

| Activity | What to implement? | - Guidebook |
|---|---|---|
| **ANC** | ○ ANC patient file: **Sheet 36**.<br>○ ANC protocol, **sheet 35**:<br>- Practical checklist.<br>- Guidance for history taking and examination of a pregnant woman: signs observed and actions to be taken are listed.<br>- Designed for health care workers with limited experience in ANC. | - Essential obstetric and newborn Care. MSF **(Library).**<br>- Pregnancy, Childbirth, Postpartum and Newborn care. WHO **(Library).** |
| **PNC** | ○ PNC protocol, **sheet 35**:<br>- Activities, standard treatments, assessment and treatment of mother and newborn.<br>○ PNC patient file: **sheet 37.** | - Pregnancy, Childbirth, Postpartum and Newborn care. WHO **(Library).**<br>- Neonatal Care Clinical & Therapeutic Guideline, MSF OCB **(library).** |
| **FP** | ○ FP patient card: **sheet 38**.<br>○ FP protocol, **sheet 35**:<br>- How to welcome clients.<br>- Comparison of FP methods.<br>- Check if FP method meets the client's needs.<br>- How to manage common side effects.<br>- How to provide a FP method, etc.<br>○ Have different methods available: **condoms, injectables, pills (combined and progestin-only), include emergency contraception** (pills and IUD) and **implants**[24]<br>○ Health education on FP is part of ANC, PNC and in the EmONC facility. | - Family planning guidebook. WHO **(Library).**<br>- Medical eligibility criteria (wheel) WHO **(Library).**<br>- Videos for the insertion of implants & IUD **(Library).** |
| **RTI** | ○ Flowcharts on genital infections(the MSF clinical guideline **page 249 – 265):** urethral discharge, abnormal vaginal discharge, genital ulcer, lower abdominal pain and veneral warts.<br>○ Treatment for **cystitis in pregnancy** – Essential obstetric and newborn Care – **page 61** | - Essential obstetric and newborn Care. MSF **(Library)**<br>- Sexually Transmitted and Other Reproductive Tract Infections. WHO, 2016<br>○ Chlamydia<br>○ Gonorrhoea<br>○ Herpes simplex<br>○ Syphilis |

[24] Insertion of implants can be done by nurses, midwives and doctors who received training for this technique and FP consultation training. Implants can stay for up to 5 years (depending on the manufacturer). Removal of implants should be done when the women/couple wishes to become pregnant or when replacement or switching to another method is wished. Removal can be done by nurses, midwives and doctors. The presence of MSF in the location at the assumed time of removal is not a precondition to offer this method of FP. A leaflet with information on the implant and how to remove it can be given to the women, so she can show it to the care provider upon removal.

# Chapter 8: Monitoring

**"Monitoring is the ongoing, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of programme objectives." [25]**

- **Indicators:** Used to measure progress. For SRH activities in MSF projects, a standard indicator list was developed. As objectives during the emergency phase differ in focus from objectives in longer-term projects, a **minimum indicators list** is suggested.

- **Data collection:** from the register to a tally sheet adapted to the minimum indicators (**sheet 39).**

- **Encoding of data:** MINOS is recommended for this purpose. However, at the onset of an emergency, it is challenging to implement these data collection tools and train staff accordingly. That is why a **simplified data excel file (sheet 41**) where data can be encoded was developed; graphs will come up automatically and the minimum indicators will be calculated. The registers and tally sheet are adapted to the data collection excel file. If you have any confusion of which data collection tool needs to be implemented it is recommended to discuss this with E-pool, cell or technical referent.

- A second tool to monitor progress is **maternal, neonatal death or near miss reviews (sheet 42)**. Through these reviews gaps at different levels can be identified:
  - At community level, e.g. the woman and her family were unaware of the signs indicating a complication during pregnancy; it took a lot of time to find a driver agreeing on an affordable price to transport the woman to the facility, …
  - At health service level, e.g. the number of staff at night is too low to respond to an obstetric emergency; the needed medication was not available; the decision to call for help was taken too late, …

These reviews can be conducted both for deaths in the health facility and deaths at home. A broad range of people should be involved not to overlook or misunderstand different aspects. It will improve adapted solutions and prevent repetition of the same situation.

Note: Give feedback on results from the monitoring to the staff and involve health staff in analysing the data and formulating recommendations. Data collection will be more fun and quality will increase.

Table 16: tools for monitoring

| Sheet nb | Name | What is it used for? |
|---|---|---|
| **39** | SRH minimum indicators | To monitor activities during the *emergency phase* |
| **40** | SRH in emergency registers + tally sheets | Easy to print, used to gather data to calculate the set minimum indicators |
| **41a**<br>**41b** | SRH in emergency data collector:<br>a. E-pool data<br>b. Minimum indicator data | Excel sheet to put in your collected data<br>a. Data preferred by the e-pool medical coordinator (few indicators)<br>b. Data used to monitor and plan SRH activities<br>→ the program will calculate the indicators |
| **42** | Maternal death review form | Template for maternal death review |
| **NA** | MINOS | To encode data & summarize results[26]. |

[25] Inter-agency Field Manual on Reproductive Health in Humanitarian Settings. Inter-agency Working Group on Reproductive Health in Crisis. 2010 Revision for Field Review.
[26] In case of doubth, ask the MINOS team for advice.

## Resources and recommended further reading

These books and documents can be found in the 'SRH in emergencies library' on the SRH in emergency DVD/USB key.

**General**

- Inter-agency Field Manual on Reproductive Health in Humanitarian Settings. 2010; Revision for field review. Inter-agency Working Group on Reproductive Health in Crises (EN-FR-ES).

- Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. Making Pregnancy Safer. Department of Reproductive Health and Research. WHO, Geneva. 2004.

- Planning and design of health Care Facilities-Draft rev 01, MSF. 2013.

- Sexual and Reproductive Health Core package of activities in MSF projects. International Working Group on Sexual and Reproductive Health. Version 2. February 2009.

- Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.

**Priorities**

- Averting maternal death-safe care for termination of pregnancy on request, MSF international, 2015

- MSF Neonatal care policy. January 2016

- MSF Sexual and Reproductive Health policy. International Working Group on Sexual and Reproductive Health March 2014.

**EmONC and referrals**

- Blood transfusion guideline. MSF, 2010.

- Essential obstetric and newborn care. Practical guide for midwives, doctors with obstetrics training and health care personnel who deal with obstetric emergencies. 1st edition, 2015. MSF

- Neonatal Care. Clinical & therapeutic guideline. MSF-OCB. May 2015

- Malaria work group- administration of artesunate injection. EN and FR version.

- TBA collaboration in MSF guidance paper, 2017.

- Maternity Waiting Homes in MSF, 2014.

**SV**

- Legal toolkit 2017 ( + accompanying sheets).

- Care for victims of sexual violence. Situation with displacement of population. MSF-OCB, 2013. **Be aware that several tools of this pocket guide have been updated and have newer versions available on the Legal toolkit or somewhere else**.

- Care and Support of Male Survivors of conflict-Related Sexual Violence, 2011.

- International Protocol on the Documentation and Investigation of Sexual Violence in Conflict, 2014.

- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013.

- Sexual violence response in MSF-OCB projects. Analysis and recommendations, 2011.

- ITC list Rape management kit.

**TOP**

- Medical abortion patient file

- Termination of pregnancy on request. Context analysis. 2016.

- ToP Risk Assessment,2017. (En &FR).

- ToP data collection sheet

- # No woman denied. MSF documentation of Abortion Care.July 2017. TOP Task force. (EN & FR).

- MSF guidance for abortion at 13-22 weeks gestational age

- Modus operandi TRP-template (draft 2017).

**Reproductive health consultations**

- Family planning: A Global Handbook for Providers (2011 update), WHO/RHR and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP),WHO, 2011.

- Medical eligibility criteria wheel for contraceptive use – 2015 update, WHO.

- Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice. WHO Geneva, 2015.

- Sexually Transmitted and Other Reproductive Tract Infections. WHO, 2016.
    - Chlamydia
    - Gonorrhoea
    - Herpes simplex
    - Syphilis

- FP – Implant: learning video technique of insertion.

- FP – IUD: learning video technique of insertion.

- FP - Implant Removal- Pop Out Technique without instruments-video.

**Other**

- Clinical guidelines, MSF, 2016.
- Essential Drugs, MSF, 2016.
- Protocol treatment reusable devices, MSF.
- Personal protective Equipment for Maternity and Delivery Room, OCB, 2012.