EMERGENCY PREPAREDNESS AND RESPONSE GUIDE FOR SEXUAL AND REPRODUCTIVE HEALTH IN EMERGENCY SITUATION

MINISTRY OF HEALTH,
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Foreword

Ethiopia has been challenged with natural as well as human made disasters, and the Government of Ethiopia was highly committed to provide timely and appropriate humanitarian or emergency response to the affected citizens. Armed conflicts in different regions of the country and natural disasters, mainly drought, were the major challenges which forces millions of peoples to be displaced from their homes as well as their villages.

Sexual and reproductive health (SRH) service availability, safety, and security will be disrupted during such kind of situations and women and mothers, children and adolescents are the most vulnerable segment of the population who will be largely affected by the emergencies. The Ministry of Health has been providing emergency or humanitarian responses based on the context and the situation of the emergencies that occurred, but it was observed or reported that the responses provided by different humanitarian actors is not aligned and coordinated. The Emergency Preparedness and Response Guide for Sexual and Reproductive Health in Emergency Situation is developed to coordinate the national emergency response for SRH and to minimize duplication of efforts among all humanitarian actors. Hence, Implementing this guideline by coordinating all humanitarian actors is one of the strategies to ensure quality SRH service delivery to the affected population through well prepared and organized humanitarian response.

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Acknowledgement

Emergency preparedness and response guide for sexual and reproductive Health in Emergency situation is developed considering the impact of natural and humanitarian disasters on reproductive health. Women, children and adolescent girls and boys are most frequently the victims; and when protracted disaster situations prevail, the effect on the SRH services of the country will be profound.

This SRH preparedness and response guide in emergency situation is developed in collaboration with a wide group of experts from various government and international organizations. The Ministry of Health would like to acknowledge international organizations for the technical and financial support (PIE, WHO, UNFPA, UNICEF, FGAE, and Baobab Research Programme Consortium), technical support (World Vision, JSI-L-10K, IOM, and Care Ethiopia), professional associations (EMwA, ESOG, and ISO), agencies (EPHI and EPSSA), and different directorates in Ministry of health for their technical inputs to finalize this important guide.

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Executive Summary

Humanitarian Emergency around the world are growing in magnitude, frequency, and duration, as it is the need for assistance in meeting the SRH needs of the community. Globally, nearly 100 million people are in need of humanitarian assistance. Of these, approximately 26 million are women of reproductive age groups. Natural disasters, man-made emergencies, and protracted conflicts disrupt the SRH. In these settings; education, social support, and health systems are suspended or unavailable which leave people without access to SRH information and services.

A significant portion of Ethiopia's population urgently needs humanitarian support due to armed conflict, climate change and continuing socioeconomic impacts of COVID-19 made over recent years. Many of Internally Displaced People are living in overcrowded settlements, at heightened risk of gender-based violence, economic hardship and lack of access to basic services. On top of this; the absence of peace and stability predisposes people, who are already at risk and marginalized, to experience heightened insecurity and related protection concerns. Currently, the national policy documents including the HSTP II and RH endorsed the country's risk mitigation during humanitarian emergencies.

With the given national context and a risk profile, this guideline has rationales as summarized in 4 major areas: Guiding health sector national strategic documents (the country has pre-identified directions to guide SRH responses in humanitarian setting), existing practical experiences on SRH in humanitarian setting (humanitarian SRH response, and care for survival of sexual violence practices in the country weak due to: poor reporting, documentation, less coordinated and diverse intervening actors, shortage of

human resources, lack of medical equipment and supplies; in adequate essential health facilities operational and working modality), an imperative to ensure quality of care (Equity and quality of care are among the strategic directions of the HSTP II. Lack of equity in resource allocation, service provision, referral linkages, etc. are major reasons for poor quality of SRH services in humanitarian settings), and SRH responses in humanitarian setting are not sustainable due to lack of coordination, resource and premature transition of service packages to regular health facilities.

The scope of this guideline is to address the implementation of all SRH service packages in humanitarian setting including coordination, service delivery and transition into regular services through various service delivery modalities such as mobile health and nutrition teams, outreaches, IDP service sites and others as required.

Acronyms

SRH	Sexual and Reproductive Health
HSTP II	Health Sector Transformation Plan II
RH	Reproductive Health
WASH	Water Sanitation and Hygiene
GBV	Gender-Based Violence
IDP	Internally Displaced Population
EMS	Emergency Medical Service
CSO	Civil Society Organization
MOH	Ministry of Health
MCC	Motivated Compassionate and Competent
MISP	Minimum Initial Service Package
EDRMC	Ethiopian Disaster Risk Management Commission
SADD+	Disability-Disaggregated Data
PHEM	Public Health Emergency Management
DRM	Disaster Risk Management
EPHI	Ethiopian Public Health Institute
INGOs	Internationals Non-Government Organization
NGO	Non-Government Organization
UN	United Nations
TORs	Term of Reference
COOP	Create a Continuity of Operations Plan

SOPs	Standard Operating Procedures
STIs	Sexual Transmission Infections
HIV	Human Immunodeficiency Virus
SGBV	Sexual Gender Based Violence
IPC	Infection Prevention and Control
ARVs	Antiretrovirals
PMTCT	Prevention of Mother to Child Transmission
SBCC	Social and Behavior Change Communication
HLMs	Health and Learning Materials
WHO	World Health Organization
EmONC	Emergency Obstetric and Newborn Care
IEC	Information, Education, and Communications
RH Kits	Reproductive Health Kit
RHCTs	Reproductive Health Coordination Teams
TWG	Technical Working Group
DOH	Department of Health
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
SAC	Safe Abortion Care
PAC	Post Abortion Care

I
Introduction

Background

Humanitarian crisis around the world is growing in magnitude, frequency, and duration, and so is the need for assistance in meeting the SRH needs of the community. Globally, nearly 100 million people are in need of humanitarian assistance. Of these, approximately 26 million are women of reproductive age groups. Natural disasters, man-made emergencies, and protracted conflicts disrupt the SRH. In these settings; education, social support, and health systems are suspended or unavailable which leave people without access to SRH information and services.[1] Conflicts and situations of instability exacerbate pre-existing patterns of discrimination against women and girls, exposing them to heightened risks of violation in human rights.[2] According to Global Humanitarian overview report in 2022, 274 million people needed humanitarian assistance and protection. This was a significant increase from 235 million people who were in need of assistance a year ago; this number had already been the highest figure in decades.[3]

The Middle East, North Africa, and West Central Africa continue to have the most humanitarian needs due to protracted crisis that show no signs of abating. over the past two years, sharp increases in needs are evident in Asia and the Pacific; Latin America and the Caribbean; and Southern and East Africa.[4] In Eastern Africa, conflict

[2] OHCHR | Women's human rights and gender-related concerns in situations of conflict and instability
[3] https://gho.unocha.org/
[4] Global Humanitarian Overview 2022, United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator -

and violence continued to force people to flee their homes in 2021. This includes around 9.6 million internally displaced people, and 4.7 million refugees and asylum seekers. Every country in the region has either faced conflict or neighbored a country in conflict. In 2021, the crisis in Ethiopia drove millions of people from their homes, causing a spike in displacement in the region. Similarly, the crises in Somalia, South Sudan and Sudan had already forced millions of people to flee in recent years. The Horn of Africa also remains to be a major route for mixed migratory movements to and from the Arabian Peninsula and to Europe.[5]

In the horn of Africa, over 20 million people from Ethiopia, Somalia, and Kenya alone face humanitarian crisis or worse outcomes due to conflict and drought. A third consecutive poor rainfall season in late 2021 has led to significant crop and livestock losses across rural areas of Southern and Southeastern Ethiopia, Somalia, Eastern and Northern Kenya. Large-scale emergency food, water, and livelihoods assistance are urgently needed to prevent food consumption deficits; elevated levels of acute malnutrition; and hunger-related mortality that results in displacement.[6]

Displacement caused by the conflict in a different part of Ethiopia is the main driver of humanitarian needs. This displacement trend has increased over the last three years from 3.2 million to 4.2 million respectively in 2018 and at the end of 2021. [7]

A significant portion of Ethiopia's population urgently needs humanitarian support due to armed conflict, climate shocks, disease outbreaks, a desert locust invasion and continuing socioeconomic impacts of COVID-19 made over recent years.[7] Many of Internal Displaced Peoples are living in overcrowded settlements; at heightened risk of gender-based violence, economic hardship and lack of access to basic services. on top of that, because of the absence of peace and stability, people who are already at

[5] https://gho.unocha.org/appeals/southern-and-east-afric

[6] East Africa Key Message Update: Very high humanitarian assistance needs are likely to persist in East Africa in 2022 (January 2022), OCHA, Feb 2022

[7] https://gho.unocha.org/ethiopia

risk and marginalized will experience heightened exposure to insecurity and related protection concerns.[8]

The impacts of frequent and extreme weather events continue to negatively affect access to food from cultivated crops; access to land for pasture; livestock production; and market functionality. Several hundred thousand people are typically displaced each year due to floods. on average approximately three million people experience crisis levels of food insecurity due to rainfall scarcity or drought conditions.

Currently, the national health sector strategic documents including the HSTP II, RH and other strategic documents endorsed the country's risk mitigation for humanitarian crisis. The strategic documents clearly stated the country is likely prone to natural and manmade shocks, stresses, and experience cyclical hazards that affect households, infrastructure, and health system resilience. [9]

Rationale

With the given national context and a risk profile, this guideline has rationales as summarized in 4 major areas: guiding health sector national strategic documents; existing practical experiences on SRH in humanitarian setting; an imperative to ensure quality of care; and sustainability through proper transition to development interventions.

[8] https://gho.unocha.org/ethiopia#footnote-paragraph-1007-1
[9] HSTP II, MOH 2020

GUIDING NATIONAL HEALTH SECTOR STRATEGIC DOCUMENTS

The country has preidentified directions to guide SRH responses in humanitarian setting. The HSTP-II recognizes "women and children are disproportionately affected" during humanitarian setting and require support.[10] The RH strategy identified four strategic initiatives to meet the objectives: to ensure RH standards, guidelines and services packages; enhance capacity building to health workers; improve RH services provisions; and strengthen partnership with stakeholders working in humanitarian setting.[11]

EXISTING PRACTICAL EXPERIENCE

In the country, humanitarian SRH response and care for survival of sexual violence practices is weak due to poor reporting and documentation; less coordinated and diverse intervening actors; shortage of human resources; lack of medical equipment and supplies; and in adequate essential operational health facilities and working modality. As a result, there is increased burden on the health system, community volunteer workforce and health staff. Inadequate participation of stakeholders and poor coordination of multisectoral organizations working in humanitarian interventions such as Nutrition and WASH, SRH and GBV activities has affected the humanitarian SRH response. Apart from improving efficiency, streamlined services reduce duplication of efforts and waste of resources.

QUALITY OF CARE

Equity and quality of care are among the strategic directions of the HSTP II. Lack of equity in resource allocation, service provision, referral linkages etc. are major reasons for poor quality of SRH services in humanitarian settings. Health facilities in humanitarian context do not function well due to damage of health facilities, human resources displacement, shortage of health supplies and commodities.

SUSTAINABILITY

[10] HSTP II, MOH 2020
[11] RH Strategy, MOH 2021

SRH responses in humanitarian setting are not sustainable due to lack of coordination, resource and premature transition of service packages to regular health facilities. The development of this guideline mainly resolves fragmented service delivered by different stakeholders and facilitates to standardize the response given during humanitarian crisis. This guide aims to support IDP coordinators, health care providers and emergency planners in achieving the continuity of essential SRH services, well-coordinated implementation of facility operations at every level, clear and accurate internal and external communication, swift adaptation to increased demands, effective use of scarce resources, and creating safe environment for patients and health-care workers.

This implies that, this is a high time to have SRH preparedness and response guide during emergency situation to lead the situation in a coordinated and well prepared way to control the situation in the country.

Scope of the Guideline

The scope of this guideline is to address the implementation of all SRH service packages in humanitarian setting including coordination, service delivery and transition into regular services through various service delivery modalities such as mobile health and nutrition teams, outreaches, IDP service sites and others as required. It also includes fixed healthcare facilities where regular services were disrupted and/or compromised. Hence, this guideline serves as a reference to SRH coordinators, health care providers, emergency response planners, public and private health facilities, civil society organizations, private organizations and other international and local humanitarian partners that have mandates and interests in the delivery of SRH services throughout the preparedness, response, recovery and rehabilitation phases of an emergency.

Definition of Terms

Emergency: A sudden and usually unforeseen event that calls for immediate measures to mitigate impact.

Disaster: A serious disruption of the functioning of society, causing widespread human, material or environmental losses, which exceed the ability of the affected society to cope using its own resources.

Preparedness: The knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent, or current hazardous events or conditions.

Emergency response plan: A set of written procedures that guide emergency actions, facilitate recovery efforts and reduce the impact of an emergency event.

Response: The provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduces health impacts, ensure public safety and meet the basic subsistence needs of the people affected.

Recovery: Restoring or improving the functions of a facility affected by a critical event or disaster through decisions and action taken after the event.

Disaster Risk Reduction and Management: The systematic process of using administrative directives, organizations and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the probability of disaster.

Gender-Based Violence (GBV): Any harmful act directed against a person based on gender. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty

Humanitarian Crisis: An event or series of events that represent a critical threat to the health, safety, security and wellbeing of a community or other large group of people usually over a wide area.

Vulnerability: the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard.

First responders: traditionally, ''first responders'' refers to fire fighters, law enforcement officials or emergency medical service (EMS) personnel. More recently, the concept has expanded to include other personnel such as communities at large, emergency room clinicians and nurses, epidemiologists, infectious disease specialists, and hospital and public health administrators.

Coordination: is the degree to which the activities, program and policies of agencies are integrated for maximum effectiveness and efficiency

Internally displaced persons (IDP): Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

Guiding Principles

The following guiding principles underpin the implementation of SRH services in humanitarian settings. The key guiding principles are:

COORDINATION

For SRH services to be equitable, effective, and efficient in humanitarian settings, coordination must occur across all levels of health service providers with strong referral linkage and across different stakeholders (various government sectors, non-governmental organizations, CSOs, and other development partners).

COMMUNITY PARTICIPATION

Community participation implies the involvement of key stakeholders in all aspects of the program cycle (assessment, design, implementation, monitoring, and evaluation). In addition, it is essential to assure the participation of all groups

including religious and community leaders, elders, women, men, adolescents and youth; and involvement should be transparent, free of coercion and open to all.

COMMUNICATION

This involves agents who transmit information through appropriate channels (e.g., counselling, consultations, posters, radio, person-to-person, social media, etc.) so that people get the information they need, when they need it, in the way that makes sense to them, so that they can make practical decisions.

QUALITY OF CARE

Good-quality SRH care involves providing comprehensive, equitable, accessible, and inclusive health services to address the SRH needs of all persons without discrimination. To meet the needs of the people, to ensure technical and managerial competence and to expand SRH programs, improvements within an organization is necessary. Provision of high quality and ethical health care is ensured by practicing the main principles of ethics as described in the MOH's MCC initiative while maintaining professional integrity and ethics to execute duties according to the set ethical standards and principles including respecting privacy, dignity and confidentiality of service.

ADVOCACY

Advocacy is a good strategic option to influence ideas within the public realm to ensure that laws, policies and social norms are enabling to enjoy rights to access SRH services. Effective SRH advocacy can influence decision makers to guide policy development and enact policies of sexual and reproductive health rights. Advocacy also influences community leaders whose opinions affect peoples' reproductive rights.

Humanity: Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.

Neutrality: Humanitarian actors must not take sides in hostilities or engage in

controversies of a political, racial, religious or ideological nature

Impartiality: Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no adverse distinction on the basis of nationality, race, gender, religious belief, class or political opinion.

Independence: Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.

Objectives

1. Provide guidance to the coordination of initiation, planning, resource mobilization, implementation and monitoring of humanitarian SRH service
2. Ensure quality SRH service provision through available means including outreaches, mobile services and IDP service sites and others as required.
3. Ensure smooth transition of humanitarian SRH services into Comprehensive SRH services

II
Emergency Preparedness & Response Planning

Sexual Reproductive Health (SRH) preparedness reflects the actions undertaken so that, at a minimum, timely and quality essential SRH services are provided at the onset of an emergency. SRH preparedness must be linked to wider health emergency preparedness efforts. The stages to consider when undertaking SRH preparedness during emergency situation include **Initiating, Assessing** and **Implementing.**

Stage 1: Initiating SRH Preparedness

This stage involves ensuring accessibility of quality, inclusive and timely essential SRH services at the onset of an emergency which contributes ultimately to overall health system strengthening and resilience building.

While initiating SRH preparedness in emergency situation, consider the following points:

1. ADOPT A SYSTEMS APPROACH TO SRH PREPAREDNESS

   such as through linkage of SRH preparedness activities at all levels (national, regional, zonal, woreda, and community levels.)

2. TREAT SRH PREPAREDNESS AS A COMPONENT OF HEALTH SYSTEM STRENGTHENING AND RESILIENCE BUILDING

   As part of the humanitarian development peace nexus, SRH preparedness can benefit from and contribute to activities designed to strengthen health systems, including efforts to achieve SRH, with shared responsibility across government, humanitarian, peace, development actors and support from funding agencies.

3. USE THE MISP AND EDRM FRAMEWORK TO GUIDE SRH PREPAREDNESS ACTIVITIES

The MISP clearly outlines what is needed, at minimum, during an emergency, and so provides important guidance to the areas that SRH preparedness should focus on. The health Disaster Risk Management framework is broader and outlines 10 priority components and functions. These components are helpful to ground SRH and the MISP in the overall health system and in broader emergency risk mitigation, management, and capacity building.

4. CONTEXTUALIZE AND TAILOR PREPAREDNESS BASED ON THE HEALTH SYSTEM CAPACITY AND ON THE TYPES OF CRISIS AND DEGREES OF RISK

Preparedness activities must be defined by what makes sense in the context, in careful consideration of existing capacity of health system and community resources. Risk assessments can clarify the different types and degree of crisis faced and the level of preparedness required.

5. BUILD RIGHTS-BASED, PEOPLE-CENTERED, AND INCLUSIVE SRH PREPAREDNESS:

- ***Work from a rights-based and people-centered approach.*** Recognize that SRH is a human right and that everyone has the right to access quality SRH care. Care should be available across all communities in a compassionate and respectful way.
- ***Recognize that everyone has multiple and intersecting identities*** that lead to a diversity of needs and affect their access to services.
- ***Ensure inclusion is seen as a priority at every stage and level of preparedness:*** Emergencies disproportionally affect the most marginalized and underserved members of communities. At every levels of preparedness, marginalized groups should be represented on the coordination and planning body to ensure that the MISP will meet the specific needs of those groups during an emergency. Consider inclusion at each step from policies to coordination, from health workforce trainings to community engagement to ensure more equitable SRH care and access across the humanitarian development peace nexus

- ***Engage and follow the leadership of marginalized groups:*** Most Often Marginalized group are excluded from emergency humanitarian planning and response activities.

Stage 2: Assessing SRH Preparedness

This stage covers steps for assessing SRH preparedness. While assessing SRH preparedness, consider the following points:

1. IDENTIFY AND COLLABORATE WITH KEY STAKEHOLDERS TO JOINTLY ASSESS PREPAREDNESS

The delivery of lifesaving SRH care during emergencies requires collaboration and coordination among various stakeholder. This is also true for SRH preparedness. Identifying the different actors from community, community-based organizations, health workforce and army, and policymakers is critical to ensure efficient implementation of preparedness activities and shared responsibility. As a result, during this stage of SRH preparedness, identify the range of stakeholders' engagement and jointly assess preparedness.

2. USE AVAILABLE TOOLS TO ASSESS PREPAREDNESS

Stepwise assessment of the national, regional, zonal, woreda and community readiness can help prioritize resources for preparedness.

3. INFORM ASSESSMENTS USING AVAILABLE SRH-RELATED DATA AND RELEVANT PREVIOUS OR REGIONAL LEARNING

Collect and analyze SRH related data to identify gaps and needs that will inform SRH preparedness for advocacy and planning. The source of data can be from facility assessments, disability-disaggregated data (SADD+) or other health and population data such as the health information management system or the demographic health survey.

Stage 3: Implementing SRH Preparedness

The third stage of SRH preparedness covers steps for implementing SRH preparedness actions. The steps are categorized under the ten Health-EDRM Framework components and functions to assist users in structuring their SRH preparedness within the Framework. These ten components are described below:

1. POLICIES, STRATEGIES, AND LEGISLATION

- ***Integrate the SRH/MISP into existing health policies, strategies, and legislation at national and regional levels:*** Integration is a long and iterative process that requires considerable advocacy on the importance of SRH. Map out the relevant policies, strategies, and legislation, and assess whether they would enable or hinder the MISP during response. Identify policies, strategies and legislation related to SRH/MISP integration. SRH and DRM actors often collaborate when undertaking the MISP Readiness Assessment.
- ***Monitor the revisited schedule of targeted policies, strategies, and legislation.*** Be familiarized with the policy review process to identify opportunities to integrate SRH/MISP language when revisions are scheduled.
- ***Integrate the MIDP into the relevant national SRH or GBV policies, strategies, and laws*** to ensure SRH in emergencies is properly covered across the humanitarian development-peace nexus. Identify any further policies or strategies, for youth and marginalized communities that could be targeted for integration

2. PLANNING AND COORDINATION:

- ***Foster multi-agency and multi-sectoral collaboration for SRH preparedness.*** Activities to advance SRH preparedness require multiagency and multi-sectoral collaboration. Identify stakeholders relevant to the context, the types of risks, crisis faced, and the structure of the existing EDRMC system. Consider representatives from:
    - SRH (from all MISP technical fields) and overlapping sectors such as gender and protection
    - EDRMC, MOH and EPHI
    - Ministry of finance and economics development, Ministry of education, and Ministry of women and social affairs, Ministry of Justices etc.
    - Relevant humanitarian, development INGOs, UN agencies, humanitarian response clusters, relevant local NGOs and civil society, including those representing marginalized groups
    - The private sectors.
    - Front line responders (such as health providers, the army, emergency service providers, and the National Red Cross/Red Crescent society)
- ***Establish or strengthen coordination bodies to advance SRH preparedness:*** Sexual and reproductive health preparedness can be integrated into existing coordination bodies; such as national SRH technical working groups, humanitarian preparedness and response forums, or committees in charge of SRH emergency response. Coordination bodies should be institutionalized to assure sustainability and avoid challenges with staff turnover. Members should represent SRH and EDRMC representatives. Consider opportunities to link with other coordination groups to build MISP awareness across different sectors to avoid overlapping activities.
- ***Use joint action plans and/or terms of references (TORs) to advance SRH preparedness work.*** Preparedness efforts are best supported by multi

stakeholder coordination and a collaborative model that enables different actors to contribute to different aspects of preparedness. Having joint TORs with action plans can help clarify and advance preparedness work. These plans should be monitored for accountability and consulted when activating a response.

- ***Coordinate at all levels of the health system.*** Establish and connect link coordination bodies at the national, regional subnational, zonal, woreda and community levels. On the community level, engage local government officials (including those focused-on disaster and health) as well as health providers, women's groups, community leaders, schools, religious leaders, youth networks, and other organizations representing marginalized populations.

3. HUMAN RESOURCES

- ***Invest in regional, zonal, woreda and community actors.*** Support local champions because local champions can be instrumental in advancing SRH preparedness plan; they facilitate the integration of the MISP advocating attention to SRH by district health officials. Once champions are identified, provide meaningful support for their continued engagement to help them carry their work forward.
- ***Build workforce capacity.***
    - *Prepare the health workforce to be first responders:* All Health services providers, should understand the importance of SRH in emergencies. Health workers who are not working in the area of SRH should be trained to provide the MISP when challenged by resource or mobility constraints. Identify, where possible, opportunities for SRH/ emergency response simulations and other trainings. Attend to the safety, health, and wellbeing of first responders to support their work and reinforce their commitment.

- *Develop surge capacity:* Develop and Link a national roster to a regional surge capacity when the need arises. This includes how trained and experienced providers will be deployed to affected areas, and who will ensure that providers are ready. Providers must be trained on the MISP, including follow-up trainings (in person or online) to ensure quality service provision. Professional associations/society should be leveraged to build surge capacity and maintain rosters at national and regional levels.
- *Integrate the MISP into pre-service and in-service curricula:* In collaboration with ministry of education, health, teaching institutions and other relevant stakeholders, identify training curricula where the MISP can be integrated. Consider opportunities for the accreditation of trained health providers on the MISP.
- *Invest in national networks:* National and regional networks with members from health workers, program managers, professional associations/societies, women, youth, religious and community leaders and other relevant stakeholders as need be for surge and coordination during emergencies.

4. FINANCIAL RESOURCES

- ***Identify government and external funding sources:*** Funding for national readiness often depends on a combination of domestic and external sources. The government and partners need to have allocate dedicated budget for SRH response.
- ***Tap funding (resources mobilization) for coordinated activities.*** Use existing funding to support the joint activities specified in the MISP readiness assessment. Where resources are constrained, focus on cost-effective and high-impact activities such as advocacy and partnership building.

5. INFORMATION AND KNOWLEDGE MANAGEMENT

- ***Ensure that SRH and related gender considerations are integrated into surveillance systems and related monitoring.*** Ensure community level early warning systems that leverage women, youth networks, local EDRMC and community leaders and, link to SRH/EDRMC framework to stay up-to-date and informed.
- ***Integrate SRH into EDRMC assessments on risks, vulnerabilities, and capacities at the national, regional, zonal, districts and community levels.*** Identify opportunities with relevant stakeholders to integrate SRH into any risk assessments and vulnerability assessments to be carried out during the preparedness stage.

6. RISK COMMUNICATIONS

- ***Develop an effective communication strategy.*** Ensure that affected communities receive accurate and timely information. Communities must be informed on current risks, the importance of seeking care for essential SRH services, where to seek care, and ways to stay safe and healthy. During developing the risk communication strategy, collect data on knowledge and perceptions related to SRH, communication patterns, at-risk populations, language, religion, influencers, and available health services. Coordinate and collaborate with other stakeholders to ensure consistent, culturally and technically appropriate messaging. Ensure effectiveness by using influencers, a variety of mediums, and tailored approaches for specific populations. Collaborate with different members of the community to design and pilot communication approaches.
- ***Ensure communications are accessible.*** Use different communications mechanism to ensure addressing all community members regardless of their language, abilities, literacy, sex or age have access to information. Explore with each community group (for example, adolescents, women, people living with HIV, women and girls with different disabilities) how they receive and

communicate emergency health information, using Mass media, electronic and print messages, and local commutation platforms.

7. HEALTH INFRASTRUCTURE AND LOGISTICS

- ***Assess facilities at every level of the health system:*** This helps to ensure that health facilities can remain intact, accessible and functioning during emergencies.
- ***Create an enabling environment for supply chain preparedness.*** Advocate policies, political will, and financing to include SRH commodities on essential medicine lists and standard treatment guidelines. Streamline processes to allow for easy importation, fast-tracking, and prepositioning, during routine deliveries and in preparation for emergencies. Ministry of health should work with national authorities on preauthorizing the import of Inter-Agency Reproductive Health kits. Improve coordination among government, NGOs, donors, and the private sector to support and align supply chain preparedness activities by engaging existing coordinating bodies. Make sure that all strategies include SRH preparedness component. The key organizations should be included to coordinating bodies to discuss on strategies, improve policies, and mobilize funding to support preparedness. Advocate the inclusion of SRH and commodity security in the country's existing emergency preparedness activities for the wider health sector and beyond.
- ***Develop continuity of operations for essential supply chain functions.*** Create a continuity of operations plan (COOP) for the supply chain which includes a plan to secure the availability of key RH/FP products in case of an emergency by maintaining essential supply chain functions and the key resources that support them; carrying out risk assessments; and developing contingency plans for specific risk scenarios and processes to build redundancy and resilience into the supply chain.

The COOP should be the overarching plan that includes all preparedness plans and actions, including indicators and standard operating procedures (SOPs), to ensure the continuity of all logistics operations. Update and disseminate the COOP on a regular basis to all key stakeholders.

- *Identify key health products that will be secured.* In addition to adding key SRH products to existing essential medicine lists and standard treatment guidelines and streamlining processes for importation, review all the products required to maintain comprehensive SRH services through existing programming. Determine the ideal list of products that will be provided during an emergency, with upper and lower thresholds of the range of products that will be managed.
- *Make plans to maintain critical resources for all essential supply chain functional areas that need to be maintained in an emergency.* The key operations or functions that need to be maintained include product selection, forecasting and quantification, procurement, inventory strategy, distribution and warehousing.
- *Carry out risk assessments for all essential functional supply chain areas.* As part of the COOP, conduct risk assessments for each supply chain. The risk assessments should identify any actual or potential weaknesses or threats (internal or external) to the supply chain.
- *Develop and continuously update contingency plans:* Based on the risk priorities from the assessment, identify strategies for managing risks and develop a small number of specific contingency plans to address vulnerabilities from most likely scenarios.

CAPACITY AND RISK ASSESSMENT

- **Type of disaster*:*** determine what types of disaster are likely to occur and analyze their impacts.

- **Entry point/access**: be informed on the different sea/air/land entry points. Existing transport infrastructure have a good knowledge of the existing transport routes and determine how they could be affected by a disaster.
- **Resources available**: assess and determine your existing logistics capacity. Definition of logistics needs of potential response scenario: determine your additional logistics needs in case of an emergency in line with planning scenarios.

Procurement

- Establish a list and specification of the programs and support items required for an emergency response.
- Identify suppliers of standard essential items for emergency response locally/ internationally
- Assess their delivery capacity/time.
- Develop master contract (frame work agreement).
- Have the contents and specification of emergency kits already defined (operations and program kits).
- Ensure that a simplified emergency tendering process exists, which can be adopted once emergency has been declared by the government
- Ensure that the procurement process is as fast and as streamlined as possible. Check what exceptions can be made for the emergency period to speed up the process while staying within the audit requirement. Be familiar with donor exceptions for emergency contexts.

Identification of resources and partners

- Shipping forwarder: identify freight forwarder to be able to import and transport internationally required items.
- Transporter: have a good knowledge of the local transport market and identify potential transport partners.
- Government agencies: identify government agencies with an emergency mandate and their focal points.
- Distribution partners: identify potential local partners to implement the emergency response.

- Humanitarian actors: establish link with other humanitarian actors so that there is a coordinated log response, and share resources and information through the logistics cluster whenever activated.

Transport

- Define your transport requirements for personnel and supplies
- Consider all transport modes and always establish alternative options

Vehicles (for example: cars, trucks, and motorbikes)

- Assess the number of vehicles (type, condition) that could be available
- Evaluate your requirements in case of emergency response
- Assess your sourcing options to meet your requirements (for example: renting, local or international purchase, or loan)
- In case of a significant increase in the fleet size, consider hiring an experienced fleet manager, assess the capacity to scale-up maintenance
- Check what the supply of spare parts is like
- Check fuel availability and, if necessary, consider having contingency stocks

Air charter

- Check the possibility of chartering aircraft for cargo (type, payload, cost)
- Ensure that you are prepared to face the logistics involved in air operations
- Know the procedure and regulations to receive charter aircraft with cargo (customs, handling, landing strips, permits, etc.).

Sea transport

- Assess the sea shipping entry point (warehousing, handling)
- Check if risk areas are reachable by boat (type of boat, payload)
- Identify where you can find these boats and the cost.

Warehousing

- Determine what surface and volume would be needed in case of emergency
- Identify where you can hire/borrow/share warehouse space at short notice
- Check the possibilities of finding temporary mobile warehousing structures

- Ensure that you have a well-functioning monitoring system to track and report on movement of supplies (waybill, bin card, stock report)
- Ensure you have staff with skills in warehouse management
- Identify where you can get additional resources (forklift, extra laborers).

Customs

- Be aware of customs procedures and regulations for importing goods
- Have a good shipping forwarder, customs clearing agent or someone who understands customs regulations to help ease the customs process
- Check the possibility of a tax exemption
- Do you have the relevant documentation required if goods need to be imported?

Distribution

- Consider identifying a local partner for distributions

NB: Logisticians can assess the logistic capacities and assist in training/capacity building when needed

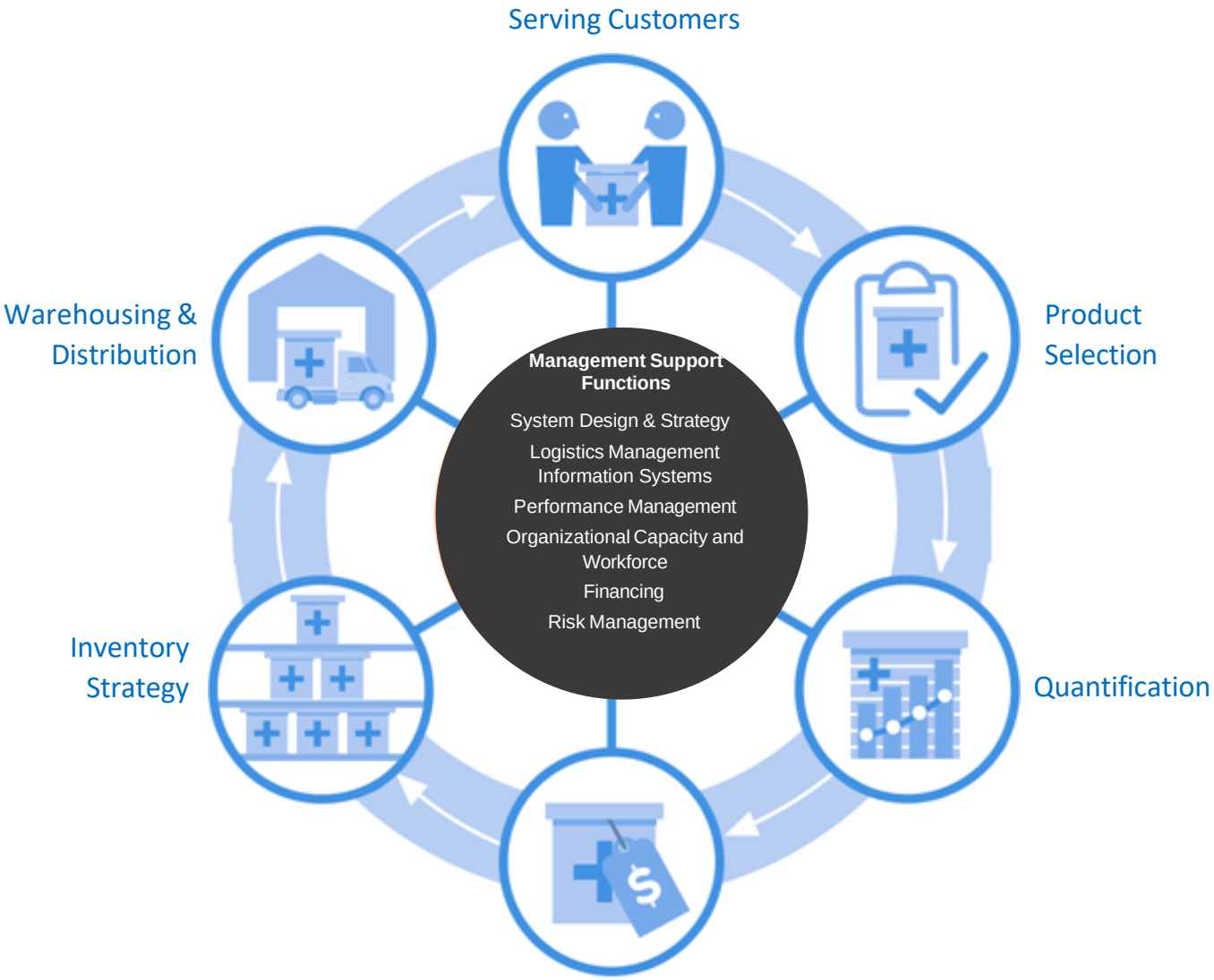


Figure 1: THE LOGISTICS CYCLE

Adapted from The Supply Chain Manager's Handbook: A Practical Guide to the Management of Health Commodities, John Snow

8. HEALTH AND RELATED SERVICES

- ***Address service delivery availability.*** It is vital to maintain continuity of essential SRH services. Ensure that women seeking care for time sensitive lifesaving services, like delivery, do not face additional delays such as new checkpoints or mobility restrictions. Prepare for MISP provision in consultation with other health facilities and stakeholders.

- ***Plan for service adaptation for each MISP component in view of potential risks.***

    - Consider task shifting/sharing policies and the training required
    - Recognize the role of community health workers
    - Consider service delivery shifts

- ***Address service delivery quality and access:*** SRH service must be of high-quality during emergencies. Beyond clinical MISP trainings, people centered care or compassionate, clinical mentorship, values clarification exercises, and refresher trainings can further equip health providers to provide high-quality care for all community members.

- ***Address service delivery gaps in the MISP components:*** During emergencies, all MISP components, implemented. To overcome barriers to service provision across MISP components, preparedness efforts should consider direct and indirect factors that lead to uneven care. Services to prevent GBV and offer clinical care for survivors, safe abortion care, and the provision of all family planning methods. These gaps lead to higher risks of morbidity and mortality.

9. COMMUNITY CAPACITIES FOR HEALTH-EDRM

- ***Engage and build relationships with communities as critical first responders.*** Before external assistance arrives, it is often the community that responds, and the community's preparedness plan will influence its ability to address immediate concerns. Identify community leaders and organizations to build relationships based on trust and collaboration, keys to fostering more sustainable and effective preparedness.
- ***In close partnership with community members, develop a community assessment of risks and capacities and create an action plan***
    - Identify key stakeholders
    - Conduct a community capacity needs assessment
    - Conduct a MISP/training: -
    - Develop a community action plan based on the need's assessment
- ***Seize opportunities to advance preparedness quickly at local levels.*** Local level preparedness efforts are sometimes more efficient than national level efforts. In some countries it is easier to foster collaboration between SRH and DRM actors on, regional, zonal, woreda and community levels, and these efforts can be showcase to inspire national efforts.
- ***Link communities to national preparedness systems.*** Community level preparedness efforts and community-based organizations and networks will be more effective and sustainable if linked to national preparedness efforts for strengthening, collaboration, support, and follow up. Foster national, regional zonal and woreda support for community-level preparedness initiatives.
- ***Leverage community networks.*** In addition to leveraging the networks of community members who are part of national networks leverage community-

based networks to plan and undertake community preparedness activities.

10. MONITORING AND EVALUATION

- ***Monitor action plans and TORs.*** Establish systems and indicators to monitor preparedness efforts like action plans and TORs. Include community platform in monitoring the programs that engage them.
- ***Collect and manage SRH-related data***. Integrate SRH indicators into existing health data management systems during the preparedness phase, and strengthen data management systems to include SRH and ensure agility to adapt to emergency response systems.
- ***Document and share preparedness learnings.*** It is important to share and learn about experiences with SRH preparedness globally and regionally.
    - *Document learnings from responses to inform and strengthen preparedness:* Conduct reviews of previous responses to inform and strengthen preparedness efforts as well as to document the impact of preparedness on response and such reflective learnings would greatly contribute to SRH preparedness.
    - *Document cases when preparedness did not impact response:* Documented learning is also helpful on when preparedness did not facilitate stronger or effective responses, or contingency plans did not anticipate the subsequent emergencies
    - *Research or develop evidence for further guidance on SRH preparedness:* New evidence generation through research is vital to inform the development of new or revised further guidance on SRH preparedness

III

Minimum Initial Service Package
(for Reproductive Health in Humanitarian Setting)

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of life-saving SRH services and priority activities to be implemented during the onset of every humanitarian emergency. These services are to be scaled up and sustained to ensure equitable coverage throughout the emergency and recovery while planning to integrate comprehensive SRH into primary health care as soon as possible. The MISP is essential in reducing death, disability and illness, particularly among women, neonates, children, and adolescent. Youth and adolescent girls are especially vulnerable to sexual violence with high risk of unwanted pregnancy, unsafe abortions and STIs including HIV. Hence, MISP should be implemented in coordination with all relevant stakeholders12. as early as 48 hours after the onset of humanitarian crises without the need to assess the situation on the crises setting.

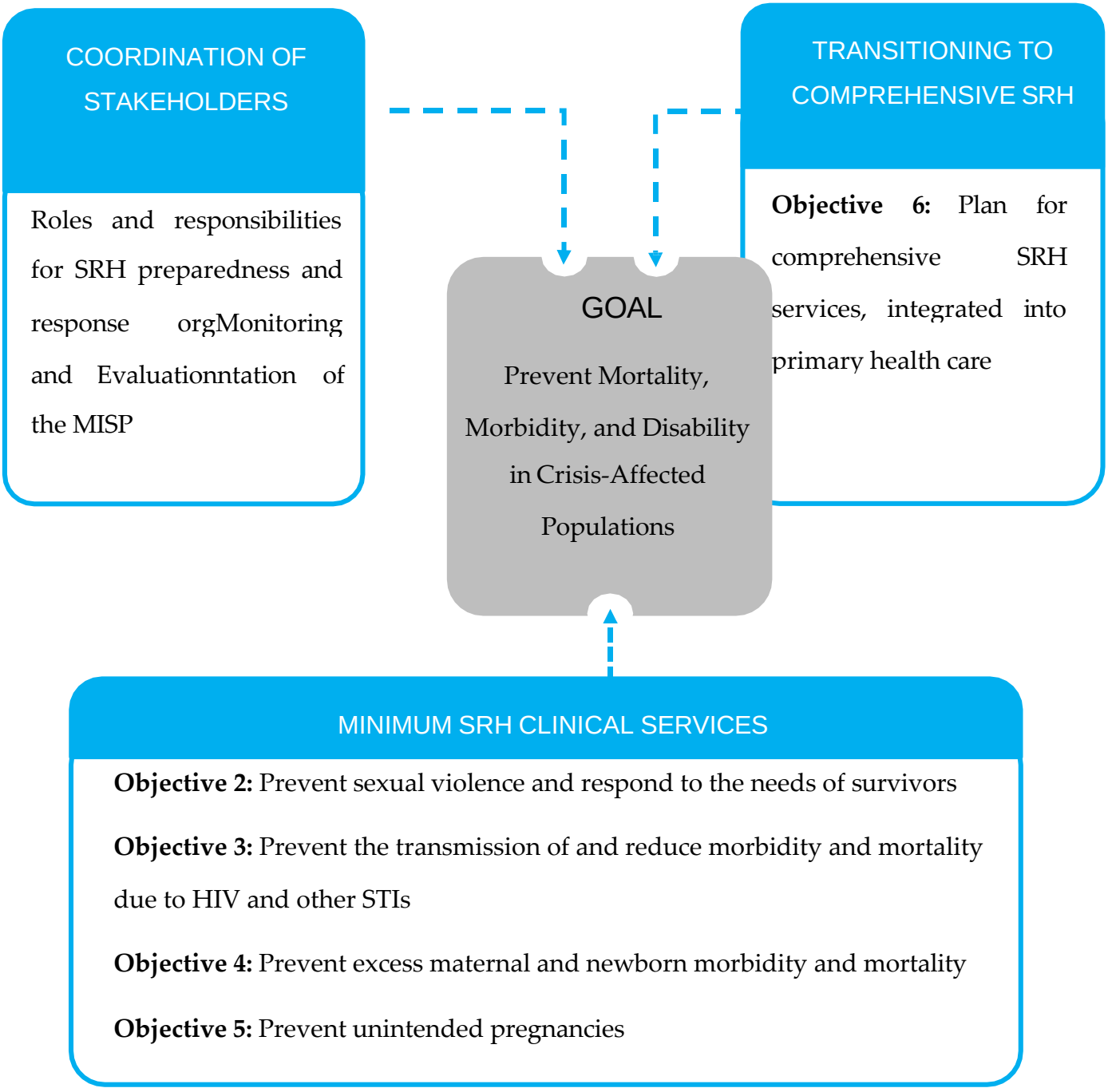
The MISP has six objectives classified under three categories (fig)

Category 1: Coordination of Stakeholders

Category 2: Minimal SRH Clinical Services

Category 3: Transitioning to Comprehensive SRH

[12]Minimum Initial Service Package for Sexual and Reproductive Health, Inter-agency working group



During the implementation of MISP, monitoring and evaluation system should be in place. The MISP monitoring Checklist (annexed) can be used to assess existing response and monitor the implementation of MISP at each humanitarian sites. It is important to conduct a comprehensive package of MISP process evaluation as required. To monitor the service utilization, at least monthly data should be made

available to inform regular programming decisions, though more frequent data reports may be necessary depending on the stage.

There are six MISP for SRH objectives which are explained below in detail. Under each objective, there are list of interventions, activities and services that should be implemented to meet the objectives of MISP.

3.1 MISP Objectives

OBJECTIVE 1

ENSURE THE HEALTH SECTOR OR CLUSTER IDENTIFY AN ORGANIZATION TO LEAD THE IMPLEMENTATION OF THE MISP

In each humanitarian setting, the health sector/cluster must identify a leader organization for SRH preparedness and response in emergency situation to ensure proper coordination. It can be the Ministry of Health, and/or assigned organization. The nominated organization, which is the one identified as having the greatest capacity to fulfill this role, immediately dedicates a full-time SRH coordinator for a minimum period of three to six months. The SRH Coordinator provides operational and technical support to health partners and facilitates planning to ensure the prioritization and effective provision of MISP for SRH services. The assigned coordinator should have sufficient technical knowledge of MISP for SRH components and coordination skills. Under this objective, the health sector or cluster will be responsible to implement the following list of interventions. Assign lead SRH organization responsible to plan and coordinate MISP activities. Establish and lead SRH coordinating unit to provide technical and operational support to all stakeholders'/partner organizations providing health services.

- Assign lead organization for SRH preparedness and response in emergency situation responsible for planning and coordination of MISP activities

- Establish and lead SRH coordinating unit to provide technical and operational support to all stakeholder's/partner organizations providing health services
- Hosts regular meetings with all relevant stakeholders to ensure implementation of the MISP.
- Reports back to the MCH directorate, emergency response team, health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- Identify effective and confidential referral mechanisms between health service delivery points and other service sectors
- In tandem with health/GBV/HIV coordination mechanisms, ensures mapping and analysis of existing SRH services.
- Advocate/ create awareness about the availability of SRH services and the location of service delivery point to the community.
- Employ appropriate communication channels such as leaflets, radio, and text messages
- Inform the affected population to look for SRH care services as soon as possible after sexual violence incident using community-lead outreach
- Ensure the regional SRH unit coordinate and lead the regional sexual and reproductive health implementation

OBJECTIVE 2

PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS

Sexual violence is among the most prevalent forms of violence and is a major public health concern. It is exacerbated in situations of humanitarian crises. Anyone can experience sexual violence, including women, men, adolescents, and persons with disabilities, young children, elderly and others. All actors responding in an emergency should be aware of the risks of sexual violence and coordinate multi-sectoral activities

to prevent and protect the affected populations. The health sector and humanitarian actors must also ensure survivors of sexual violence receive clinical care, psychosocial support, legal protection, and other supportive services as soon as possible after the incident.

Ensure the following key interventions are provided for prevention and response of SGBV.

- Provide services for survivors of SGBV
- Establish a private consultation area with a lockable filing cabinet
- Put in place clear protocols and sufficient supplies and equipment
- Deploy male and female service providers, fluent in local languages, or, assign chaperones and translators
- Engage women and adolescents in decisions on accessibility to services and on an appropriate name for the services
- Ensure the services and a referral mechanism to a hospital for life-threatening complications are available 24 hours /7 days a week
- Once services are established, inform the community why, where and when (as soon as possible after sexual violence) these services should be accessed
- Use communication channels appropriate to the setting (e.g., through midwives, community health workers, community leaders, radio messages or information leaflets in women's toilets).
- Health facilities and the camp/IDP sites must be designed and located in a way that does not put service seekers at increased risk.
- Ensure the affected population easily access the health service delivery point and the availability of separate and secure latrines and washing facilities in the center.
- Avail adequate path lighting at night time

- Consider better accessibility of services for people with disabilities, adolescents, and other marginalized people in consultation with the populations and groups representing them.
- Consult with program or facility managers and clients about security and safety concerns within health facilities and camp/ IDP sites
- Involve women, adolescent girls and other at-risk groups in the design and delivery of health programming before and during a crisis to prevent SGBV

OBJECTIVE 3

PREVENT THE TRANSMISSION AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS

HIV transmission in humanitarian settings is complex and dependent on a variety of factors: HIV prevalence and the vulnerability of some groups within the population (female sex workers); the level of interaction between displaced and surrounding local communities; the duration of displacement; and the location and extent of isolation of IDPs.

Sexually transmitted infections (STIs), including HIV has the potential to boom under crisis conditions where access to means of prevention, treatment, and care are limited. Addressing HIV prevention and care remains an ongoing challenge, particularly in humanitarian contexts.

It is necessary to do everything possible to contribute to the efforts to stop new infections and provide treatment to those in need.

Major interventions for prevention and care of HIV and other STIs:

- Establish safe and rational use of blood transfusion
- Make sure standard precautions or infection prevention and control (IPC) measures in place using SOPs and necessary supplies.

- Ensure the availability of free of charge condoms for the prevention of STIs, including HIV at culturally acceptable condom outlets
- Support the provision of antiretroviral (ARVs) for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients already diagnosed with HIV
- Ensure availability of STIs syndromic management in the health facilities
- Design culturally appropriate and context fitting social and behavior change communication (SBCC) and /or health and learning materials (HLMs) campaigns on STIs, including HIV.
- Target key populations (female sex workers) who are highly vulnerable to STIs, including HIV

OBJECTIVE 4

PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY

Excess morbidity and mortality refer to the number of deaths from all causes during a crisis that is beyond what we would have expected to see under normal condition. Two- thirds of preventable maternal deaths and 45% of newborn deaths take place in countries affected by recent conflicts, natural disasters, or both.

In any crisis-affected population, approximately 4% of the total population will be pregnant at any given time. Out of these pregnant women, approximately 15% will experience an obstetric complication, such as obstructed or prolonged labor, preeclampsia/ eclampsia, infection, or severe bleeding. The World Health Organization (WHO) estimates that 9% to 15% of newborns will require lifesaving emergency care. In humanitarian situations, the interruption of health systems can

cause increases in maternal and newborn deaths due to untreated complications that can be prevented in stable situations. This objective addresses the main causes of maternal and newborn mortality and morbidity and the lifesaving interventions that must be available in any humanitarian crisis. Ensure the following key interventions to achieve the intended objective.:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services, small and sick newborn (SNB) care including through deployment of mobile health service and community structure to safely reach pregnant, postnatal women and newborns.
- Establish 24/7 referral system to facilitate transport and communication from the community to the health center and hospital.
- Ensure availability of post-abortion care in health centers and hospitals.
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable.

OBJECTIVE 5

PREVENT UNINTENDED PREGNANCIES

Unintended pregnancy is a public health problem in Ethiopia. It is associated with adverse physical, mental, social and economic outcomes. It is a global problem that affects the health of women, families and relatives. Unintended pregnancy occurs due to non-use or inconsistent uses of contraceptives or method failure.

Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions, and pregnancy-related morbidities. The provision of contraception and its lifesaving effects are understood by the health sector, humanitarian actors and service providers to be part of essential health

programming from the earliest phase of an emergency through recovery.

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

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

OBJECTIVE 6

PLAN FOR COMPREHENSIVE SRH SERVICES INTEGRATED INTO PRIMARY HEALTH CARE

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

The implementation of the MISP not only entails coordination to make life-saving clinical services available but also it starts addressing comprehensive SRH as soon as possible. This requires vision, leadership, effective coordination skills, and a sound

understanding of the local situation and opportunities related to health system reconstruction.

To fully achieve this objective of the MISP and support local and international stakeholders in planning for the delivery of comprehensive SRH services, several critical aspects need to be considered are:

- ***Communication*** - Communication among decision-makers (including national governments) and implementing partners.
- ***Adequate financing*** - A good health financing system is a critical building block in the effort to sustain comprehensive SRH care such as community-based health insurance.
- ***Effective coordination and integrated planning with stakeholders*** - Work with national authorities, the affected community, and where appropriate camp management experts, to identify possible new sites for delivery of comprehensive SRH services, such as family planning clinics, STI outpatient rooms, or focused adolescent responsive SRH services.
- ***Strengthen supply chain management.***
- ***Human resources management and capacitate the health workforce***- When planning for training or retraining of staff, work with national authorities, academic institutes, and training organizations and take into consideration existing curricula.
- ***Advocacy*** - Advocate with governments to recognize the full range of SRH in policies and protocols and to mobilize resources to invest in SRH.
- ***Awareness creation and demand generation*** - Communities understand their rights and participate in the design and implementation of SRH services, create demand and enforce accountability.
- ***Monitoring and evaluation*** – incorporate the Comprehensive SRH service indicators in the existing platform.

- ***Strengthen health information system*** - the system of information sharing, feedback, and accountability to the affected community.

3.2. Emergency Reproductive Health Kits and commodities

To ensure the implementation of Minimum Initial Service Package (MISP) for Sexual and

Reproductive Health (SRH) service objectives in an emergency situation, it is critical that the necessary SRH supplies are made available. After the acute phase of an emergency, the health sector/SRH Coordinator should assess the SRH needs of the affected population, coordinate with the health sector/cluster, and attempt to order supplies based on consumption. This will help to avoid supply shortages and wastage. Additionally, it will help to ensure the SRH program can be sustained. The Reproductive Health (RH) in Crises, has specifically designed a prepackaged set of kits containing all the medicines, devices, and commodities necessary to facilitate the implementation of the MISP. The RH Kits are designed for use at the onset of the humanitarian response, even in the most conflict-affected areas

The supplies contained in the RH Kits are calculated to be sufficient for a three-month period for the population size covered by the health facility level targeted by each RH Kit. The RH Kits are divided into 3 categories with respect to their population coverage and service coverage.

- **RH Kits 1 to 5:** Community and primary health care level: Health facility coverage for 10,000 persons/ supplies for 3 months
- **RH Kits 6 to 10**: Primary health care and referral hospital level: Health facility coverage for 30,000 persons/ supplies for three months
- **RH Kits 11 and 12**: Referral hospital level: Health facility coverage for 150,000 persons/ supplies for 3 months (Detail list of RH kits – Annex 3)

3.3 Newborn Care Supply Kits for Humanitarian Settings

Newborn Care Supply Kits include the medicines, commodities and supplies to support safe births and newborn survival in the immediate postnatal period.

The following are list of newborn kits for use in humanitarian setting.

- 5A: Community Newborn Kit - Newborn kits for use at home for 10,000 people for 3 months. The Community Newborn Kit is complementary to the RH Kit 2.
- 5B: Clinic or Primary Health Facility Newborn Kit - for use in health facilities together with the Inter-agency Reproductive Health Kit 6 (Parts A and B) For one facility serving a population of 30,000 for 3 months.
- 5C: Hospital Newborn Kit - For one referral facility serving a population of 150,000 for 3 months.

DIGNITY KIT

The purpose of providing dignity kits to women and girls during a crisis is to help them preserve their dignity during times of humanitarian crisis. These kits, called "dignity kits," have become a significant part of humanitarian response activities. The dignity kits can be given out at refugee camps, IDP sites, or any other similar locations where women and girls dwell. Generally, dignity kits consist of several supplies that include menstrual pads, bath soap, multiple pairs of underwear, detergent powder, sanitary napkins, a flashlight, toothpaste, a whistle, a toothbrush, and a comb, all housed inside a backpack or easy-to-carry bucket.

Fig. Dignity Kit

IV
Roles and responsibilities for SRH preparedness and response

3.3. Monitoring MISP implementation

The health sector through the SRH Coordinator monitor the provision of each SRH services in humanitarian setting as part of overall health sector/cluster monitoring and evaluation. At the onset of the humanitarian response, monitoring is done weekly and reports should be shared and discussed with the overall health sector/ cluster. Once services are fully established, monthly monitoring is sufficient. Discuss gaps and overlaps in service coverage during SRH stakeholder meetings and at the health sector/ cluster coordination mechanism to find and implement solutions.

To address sexual and Reproductive health problems during emergency situation multiple stakeholders need to act harmoniously for better health outcomes. Adopt a multi-sector team approach by getting the right partners on board from agencies, directorates, NGOs/donors, and disaster management sectors, community-based organizations (including women, youth, and people with disabilities) and other sectors.

MINISTRY OF HEALTH

- Establish SRH unit under the emergency response team to lead the implementation of the emergency preparedness and response guide for sexual and reproductive health.
- Support the regional health bureaus to establish local RHCTs (Reproductive health Coordination teams)
- Coordinate the overall SRH response team from national to community level

- Lead in the facilitation of international humanitarian assistance
- Communicate with EDRMC whenever need arises
- Budget allocation for SRH emergency preparedness and response during humanitarian crisis settings
- Mobilize resources (domestic and external sources)
- Facilitate the deployment of RH kits, women's kits/dignity kits and supplies during the emergency
- Mobilize human resource to support emergency response as needed
- Establish digitalized data center at all levels

RH EMERGENCY RESPONSE UNIT

- provide Secretariat support to the Reproductive Health Coordination teams (RHCT) at all level
- Link the national SRH response team with the Ethiopia Disaster Response and Management Commission (EDRMC)
- Update/announce any humanitarian crisis situation signals to whom?
- Call upon international humanitarian organizations and coordinate accordingly if humanitarian crisis happens
- Availing temporary/mobile clinics for SRH services while humanitarian crisis arises
- Assist the International Humanitarian Cluster of the Department of Foreign Affairs in the registration of all international health humanitarian agencies providing assistance during emergencies
- Mobilize resources for the implementation of emergency preparedness and response guide for SRH in crisis situation.

- Provide technical assistance, consultative and advisory services on reproductive health (nutrition and mental health programs for emergencies
    - Integrate MISP on RH during emergencies and disasters in existing policies and programs
    - Assist in the development and implementation of MISP training modules, monitoring and evaluation tools and communication and advocacy materials
    - Evaluate SRH response and document lessons learned and good practices
    - Lead the Emergency SRH TWG

EPHI- PHEM

- In collaboration with the ministry of health, coordinate the overall preparedness, early warning and response for SRH services at national level in a line with existing response mechanism
- Conduct a Vulnerability Assessment and Risk Mapping in context of SRH
- Capacity building for workforce to handle SRH response
- Provision of timely and effective information to the public and to emergency SRH response team
- Documenting finding and knowledge sharing for anticipation and responding further SRH emergencies
- Utilize after-action reports to support validation and revision SRH Preparedness and Response Plan
- Jointly monitor the implementation of SRH response per the defined standard

REGIONAL HEALTH BUREAU

- Establish RH emergency team

- Mobilize human resources (Officers and community volunteers etc) in the execution of POPCOM's roles and responsibilities in relation to MISP implementation
- Resource mobilization
- Support zonal and woreda health Offices to ensure integration implementation, monitoring and evaluation of the Emergency SRH Guideline
- Collaborate with other regional sectors
- Update the national response team on the existing emergency SRH response
- Ensure the implementation of Emergency SRH response guideline at all level
- Lead the Emergency SRH coordination meetings and provide feedback to the implementers at all level
- Monitor the implementation of SRH response in collaboration with the national team
- Ensure the availability of the SRH services in the temporary stations or IDPs
- Establish emergency SRH TWG
- Capacitate the health care providers at the IDP sites
- Establish digitalized data center at all levels
- Performance report to the national level

ZONAL ADMINISTRATION (ZONAL HEALTH DEPARTMENT OR ZONAL ADMINISTRATION)

- Ensure the implementation of Emergency SRH response guide
- Coordinate the overall Emergency SRH response at zonal level
- Monitor the implementation of SRH emergency response
- Reviewing performance and organize reports
- Data organization and Performance report to the region

- Establish SRH emergency team
- Distribute medical equipment and supplies to the health facilities (emergency sites)
- Resource mobilization

WOREDA ADMINISTRATION (WOREDA HEALTH OFFICE OR WOREDA ADMINISTRATION)

- Coordinate the overall implementation including stakeholders' coordination
- Distribute medical equipment and supplies to the health facilities (emergency sites)
- Monitor the implementation and submit performance report to the next level
- Supervise and support the temporary IDP sites and other service outlets in collaboration with the regional health bureau and health facilities
- Engage in the IDP site selection and other preparatory activities
- Resource mobilization
- Distribute the RH kits and Dignity kits to the temporary stations in the collaboration with humanitarian actors

HEALTH FACILITY AND OTHER SERVICE OUTLETS

- Implement the emergency SRH guideline during crisis situation
- Provide guidelines for the establishment of functional Women and Children Protection Units (WCPUs) at all facility levels
- Assist the zonal and regional health bureau in the operationalization of the ASRH program in emergencies, prepositioning, warehousing and distribution of RH commodities and supplies and in the monitoring and evaluation of MISP implementation
- Provide quality emergency SRH Service as per the standard (clinical service provision and health education)

- Data organization and Performance report to the next level (woreda, zone, RHB)
- Work in collaboration with the temporary service delivery points and other mobile clinics
- Assign mobile team to support those who doesn't have access for the health service/ consider outreach program
- Document activities to the regional and national RHCTs
- Distribute the RH kits and Dignity kits to the temporary stations in the collaboration with humanitarian actors

LOGISTICS MANAGEMENT DIVISION ADMINISTRATIVE SERVICE (LMD-AS)

- Preposition an adequate supply of reproductive health kits, women's kits and other RH commodities for emergency situations
- Facilitate the timely distribution of RH goods and commodities
- Develop partnerships with the private sector for transportation and safe warehousing of RH emergency supplies
- Proper documentation of imported and distributed logistics using the logistic management information system (LMIS)

INTERNATIONAL HUMANITARIAN PARTNER/ACTORS

- Active Participation as part of the RH emergency response team at all levels
- Provide technical assistance to implement the RH emergency response guideline RMNCAYH-Y services during emergencies situation
- Augment the RH supply requirements of the DOH such as RH kits, women's kits/dignity kit, maternity tents, as needed by procuring and deploying the commodities
- Procure and distribute RH supplies such as RH kits, women's kits/dignity kit, maternity tents, as needed

- Support the availability of and strengthen EmONC services at health facilities in the affected areas
- Support capacity building activities especially on MISP (SRH, BEmONC and Family Planning) (FPCBT) of health service providers in disaster-affected areas.
- Assist the DOH in resource mobilization through the preparation of SRH proposals for submission to international humanitarian donors during the call for Flash Appeals or Consolidated Appeals
- Financial and technical support for the functionality of mobile team

PROFESSIONAL ASSOCIATIONS

- Map and mobilize resources
- Mobilize, capacitate and deploy the volunteers in the affected areas
- Capacitate health care providers and support staff on emergency SRH response
- Support Establish mobile clinics on BEmONC and malnutrition management for children, adolescent and women (pregnant and lactating)
- Support the health care providers to provide quality Psychosocial support for the survivors
- Engage in the emergency SRH TWG at all level

IDP SITE HEALTH PROVIDERS

- Provide MISP services as per the guideline
- Refer to the appropriate level for comprehensive SRH services
- Proper documentation and prepare progress and performance report
- Communicate report to the relevant organizations (woreda health office, partners)
- Communicate to Woreda and zonal responsible if logistics and supply shortage ahead

- Timely requesting of logistics before
- Engage in the emergency SRH TWG
- Work with local partners, woreda health office, volunteers and other relevant organizations

V
Monitoring and Evaluation

Indictors of SRH Emergency Response

IMPACT INDICATOR

Proportion of clients that received Emergency SRH services provided as per the MISP guidelines

OUTCOME INDICATORS

1. SRH emergency response Coordination platform established at nationally and subrationally
2. Emergency SRH data collected, analyzed for gap and need identification
3. Emergency SRH/MISP integrated in to existing emergency health strategy
4. MISP integrated in to pre-services and in services curricula
5. Professional Association/society, academic institutions, research institutes and other networks engaged in SRH preparedness activity
6. Emergency SRH response Key messages developed, tested and disseminated
7. Emergency SRH response trained health force pool (roster) developed
8. Essential SRH services maintained
9. Best practices, lesson learned, opportunities, challenges documented and communicated for action or revision.

OUTPUT /IN PUT

1. Developed TOR for SRH emergency response
2. SRH emergency preparedness assessment conducted jointly with key stakeholders
3. Resources mapping for SRH preparedness conducted
4. MISP redness assessment conducted at national and subnational level
5. Emergency SRH Community need assessment conduct
6. Community action plan developed based on SRH need assessment
7. Health facility redness on emergency SRH response conducted
8. Supply chain continuity plan developed at national and subnational level
9. List of key SRH product identified
10. Ensure the availability and accessibility of SRH kits at national and subnational level

ANNEX 1: MISP CALCULATOR

MISP Calculator (2019) Guidance Note
What is the MISP calculator?
At the very onset of an acute humanitarian emergency, data on the affected population can range significantly depending on the quality of the information available before the emergency and based on the known demographic mix of the target population. The Minimum Initial Services Package for SRH in Humanitarian Settings (MISP) Calculator is a tool that can help coordinators and programme managers determine affected population demographics for advocacy, fundraising and programming at the very onset of an emergency. The MISP calculator ONLY requires from the user affected population numbers. The MISP calculator works by automatically providing the user with a simple way to access the 'best available data' for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population..
How to use the MISP Calculator
1. Click on the tab 'MISP calculator'
2. Select the country of origin of the target population (This may be different for IDPs, Refugees, or host population)
3. Select the national or subnational level of the target population (in some settings you may be able to choose from provincial or municipal level)
4. Enter the number of persons affected
5. OPTIONAL: Enter any site specific information that you may have
6. Data will be calculated for MISP-related indicators including maternal and newborn health, contraceptives, sexual violence, HIV and other STIs

7. Click on the 'Visualizations' tab to see basic graphics on your data that can be used/adapted for advocacy and fundraising

How is this version of the MISP Calculator (2019) different from previous versions

This version of the MISP calculator has four major differences compared to previous versions.

1. The indicators provided are updated based on the revised MISP (2018)
2. There is a new functionality to allow for country specific data (if it exists) on the affected population to override the global constants if no site specific information is available
3. There is now a basic visualization of the data that can be used for advocacy purposes
4. The user should re-download the excel based tool every few months as UNFPA data branch will continuously update the national and sub-national data available for the tool to pull from.

What data will I recieve from the MISP Calculator

The MISP calculator works by automatically providing the user with a simple way to access the "best available data" for each population in a country and/or subnational area. If no quality data on that affected population exists from prior to the emergency the tool defaults to estimated global constants to base the response on. If there is national- or subnational-specific data, the online tool will automatically replace the global constants with the 'best available data' (based on available census, survey and other relevant data sources) at the applicable level of administrative boundary (i.e. country, region, province, or municipality). The source of this information can be found in the "sources" box of the tool.

Additionally, the MISP calculator provides a space for the user to self input any site specific data that may be available on the target population in the green boxes. This data will overwrite global constants and national- or subnational-specific data and replace it as the 'best available data'.

What will the MISP Calculator not provide me

The MISP encompasses a minimum set of lifesaving SRH interventions that must be available from the very onset of every humanitarian emergency and expanded on as soon as the situation allows. The MISP calculator is designed for use at the onset of an emergency where funding, advocacy and programming is targeted at providing the MISP interventions. It is important to remember that the MISP includes the minimum essential services, not the only services that should be provided to affected populations. As soon as possible it is essential to expand on the MISP to a more context specific, comprehensive, SRH response. The MISP calculator will not provide all of the information on indicators beyond those included in the MISP for this component of the response.

The MISP calculator is designed to be a supportive tool to help SRH coordinators and programme managers in the earliest phases of an emergency. It will never be 100% accurate or the only programmatic guideline to base all decisions off of. The calculator outputs should be analyzed by SRH coordinators and programme managers together to take decisions about their response. Coordinators and programme managers need to think about their target populations and how the characteristics of that population may limit the applicability of the data provided in the MISP calculator. Particularly it is important to consider how the emergency may have impacted demographics or changed pre-crisis data.
If there are multiple target populations for the programme (e.g. refugee populations and host population) keep in mind you may need to work with the MISP calculator separately for each population as their indicators may differ significantly. Additionally, it is important to remember that some affected populations around the world are left out of national data collection for political or social reasons; if these groups are included in your programme consider the limitations of the data and make adjustments accordingly.

Where does the national or subnational data come from and who updates it?

The national or subnational data comes from different sources depending on the context. It can come from available census, survey or other data collected by various national or international statistical collection agencies. The source and year of the data is always indicated on the top of the calculator when you choose a country and/or region. The United Nations Population Fund (UNFPA) Population and Data Branch is continuously updating the information that the tool pulls data from; it is important for the user to re-download the tool every few months or for each new response to ensure that you are getting the most updated information available.

Where do the global constants come from and who updates it?

The global constants are determined based on an expert group assessment of low- and middle-income countries and/or humanitarian and fragile countries' averages. For more information, please contact the UNFPA Humanitarian Office.

Who can help me use the tool or answer any other questions that I have?

UNFPA Humanitarian Office and the UNFPA Population and Development Branch conducted a webinar on how to use the tool which can be found here.

Depending on the country you are operating in, the UNFPA regional humanitarian adivsor can provide support on the use of the MISP calculator. Additionally, please feel free to reach out to Humanitarian-SRHSupplies@unfpa.org for support from global UNFPA Humanitarian Office colleagues.

ANNEX 2: MISP FOR SRH MONITORING CHECKLIST

The SRH Coordinator implements the MISP for SRH Monitoring Checklist to monitor service provision in each humanitarian setting as part of overall health sector/cluster monitoring and evaluation. In some cases, this might be done by verbal report from SRH managers and/or through observation visits. At the onset of the humanitarian response, monitoring is done weekly and reports should be shared and discussed with the overall health sector/ cluster. Once services are fully established, monthly monitoring is sufficient. Discuss gaps and overlaps in service coverage during SRH stakeholder meetings and at the health sector/ cluster coordination mechanism to find and implement solutions.

1. SRH Lead Agency and SRH Coordinator			
		Yes	No
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster		
	Lead agency		
	SRH Coordinator		
1.2	SRH stakeholder meetings established and meeting regularly	Yes	No
	National (MONTHLY)		

	Sub-national/district (BIWEEKLY)		
	Local (WEEKLY)		
1.3	Relevant stakeholders lead/participate in SRH working group meetings	Yes	No
	Ministry of Health		
	UNFPA and other relevant United Nations agencies		
	International NGOs		
	Local NGOs		
	Protection/GBV		
	HIV		
	Civil society organizations, including marginalized		
1.4	With health/ protection/ GBV/ sectors/ cluster and national HIV program inputs, ensure mapping and vetting of existing SRH services		
2. Demographics			
2.1	Total population		

2.2	Number of women of reproductive age (ages 15–49, estimated at 25% of population)		
2.3	Number of sexually active men (estimated at 20% of population)		
2.4	Crude birth rate (national host and/or affected population, estimated at 4% of the population)		
3. Prevent Sexual Violence and Respond to Survivor's Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex- segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)	%	
3.3	Confidential health services to manage survivors of sexual violence	Yes	No

	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100	%	
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		

3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100	%	
		Yes	No
3.5	Information on the benefits and location of care for survivors of sexual violence		
4. Prevent and Respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		
4.4	Condoms available free of charge		
	Health facilities		
	Community level		
	Adolescents		

	Persons with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period Specify locations:		
4.7	Antiretrovirals available to continue treatment for people who were enrolled in antiretroviral therapy prior to the emergency, including PMTCT		
4.8	PEP available for survivors of sexual violence; PEP available for occupational exposure		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		
5. Prevent Excess Maternal and Newborn Morbidity and Mortality			
5.1	Availability of EmONC basic and comprehensive per 500,000 population	Yes	No
	Health center with basic EmONC, five per 500,000 population		

	Hospital with comprehensive EmONC, one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
	Hospital (to ensure comprehensive EmONC 24/7)	Yes	No
	One qualified health worker on duty per 50 outpatient consultations per day		
	One team of doctor, nurse, midwife, and anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care (PAC)		
	Coverage of PAC: (number of health facilities where PAC is available/number of health facilities) x 100		

	Number of women and girls receiving PAC		
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 (means of communication [radios, mobile phones])	Yes	No
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		
5.4	Functioning cold chain (for oxytocin, blood-screening tests) in place		
5.5	Proportion of all births in health facilities: (number of women giving birth in health facilities in specified period/expected number of births in the same period) x 100	%	
5.6	Need for EmONC met: (number of women with major direct obstetric complications treated in EmONC facilities in specified period/expected number of women with severe direct obstetric complications in the same area in the same period) x 100	%	
5.7	Number of caesarean deliveries/ number of live births at health facilities x 100	%	
5.8	Supplies and commodities for clean delivery and newborn care		

5.9	Clean delivery kit coverage: (number of clean delivery kits distributed where access to health facilities is not possible/ estimated number of pregnant women) x 100	%	
5.10	Number of newborn kits distributed including clinics and hospitals		
5.11	Community informed about the danger of signs of pregnancy and childbirth complications and where to seek care		
6. Prevent Unintended Pregnancies			
6.1	Short-acting methods available in at least one facility	Yes	No
6.2	Condoms		
6.3	EC pills*		
6.4	Oral contraceptive pills		
6.5	Injectables		
6.6	Implants		
6.7	Intrauterine devices (IUDs)		

6.8	Number of health facilities that maintain a minimum of a three-month supply of each	Number	
	Condoms		
	EC pills		
	Combined oral contraceptive pills		
	Progestin-only contraceptive pills		
	Injectables		
	Implants		
	IUDs		
7. Planning for Transition to Comprehensive SRH Services			
7.1	Service delivery	Yes	No
	SRH needs in the community identified		
	Suitable sites for SRH service delivery identified		
7.2	Health workforce	Yes	No

	Staff capacity assessed		
	Staffing needs and levels identified		
	Trainings designed and planned		
7.3	HIS	Yes	No
	SRH information included in HIS		
7.4	Medical commodities	Yes	No
	SRH commodity needs identified		
	SRH commodity supply lines identified, consolidated, and strengthened		
7.5	Financing	Yes	No
	SRH funding possibilities identified		
7.6	Governance and leadership	Yes	No
7.7	SRH-related laws, policies, and protocols reviewed		
8. Other Priority Activity: SAC to the Full Extent of the Law			

8.1	Coverage of SAC: (number of health facilities where SAC is available/number of health facilities) x 100	%
8.2	Number of women and girls receiving SAC	
8.3	Number of women and girls treated for complications of abortion (spontaneous or induced)	

9. Special Notes

10. Further Comments

Explain how this information was obtained (direct observation, report back from partner [name], etc.) and provide any other comments.

11. Actions (For the “No” Checks, Explain Barriers and Proposed Activities to Resolve Them.)

Number	Barrier	Proposed solution

ANNEX 3: SRH KITS

RH Kit No.	RH Kit Name	Color Code	Health care level
RH Kit 0	Administration and training	**Orange**	**Coordination**
RH Kit 1A	Male Condom	**Red**	**Community level/health post**
RH Kit 1B	Female condom		
RH Kit 2A	Clean delivery kit (Reusable)	**Dark Blue**	
RH Kit 2B	Clean delivery kit (consumable)		
RH Kit 3	Post-rape treatment	**Pink**	
RK Kit 4	Oral and injectable contraception	**White**	
RH Kit 5	Treatment of STI	**Turquoise**	

	RH Kit 6A	Clinical delivery assistance– midwifery supplies RH Kit 6A reusable	**Brown**	**Primary health-care facility level**
	RH Kit 6B	Clinical delivery assistance– midwifery supplies RH Kit 6B consumable		**(BEmONC)**
	RH Kit 7A	Intrauterine device	**Black**	
	RH Kit 7B	Contraceptive implant		
	RH Kit 8	Management of complications of miscarriage or abortion	**Yellow**	
	RH Kit 9	Repair of cervical and vaginal tears	**Purple**	
	RH Kit 10	Assisted delivery with vacuum extraction	**Grey**	
	RH Kit 11A	Obstetric surgery and severe obstetric complications kit RH Kit 11A reusable	**Fluorescent green**	**Referral Hospital (CEmONC)**
	RH Kit 11B	Obstetric surgery and severe obstetric complications kit RH Kit 11B consumable		
	RH Kit 12	Blood transfusion	**Dark green**	