

Frequently Asked Questions

1. *Humanitarian staff do not have time for activities that are not imperative for saving lives. Are RH services important to reducing mortality and morbidity?*

Yes, providing RH services saves lives. The MISIP has been created to prioritize which of the many RH activities should be undertaken and are the most important to reduce morbidity and mortality in emergencies, particularly among women and girls.

2. *How do I advocate for the MISIP to my colleagues?*

Initially, some humanitarian actors may not see RH as a priority, but pointing out that the MISIP is a Sphere standard and using the information contained in this module to educate colleagues about the risks women and girls face in emergencies and some of the basic tasks that can be undertaken to reduce these risks can be very effective in getting people to give RH the attention it deserves in crisis situations.

3. *My agency is not involved in the provision of health care services, so why should I be concerned about the MISIP?*

The MISIP is not limited to the health sector. For example, comprehensive prevention of sexual violence requires action not only on the part of health staff but also from the community services, site planning, water and sanitation, and protection/legal sectors. To prevent sexual violence, all sectors should be involved in supporting the safety and security of displaced populations, particularly women and girls. To reduce HIV transmission, all agencies and sectors can assist in making condoms free, available and visible to the conflict-affected population and their staff. Emergency obstetric care services may require that the camp management agency support the transportation of pregnant women to a referral facility. Multi-sectoral implementation of the MISIP objectives will help to reduce death and disability as much as possible in the earliest days of an emergency.

4. *Is emergency contraception (EC) part of the MISIP?*

Yes, EC should be made available to rape survivors and women and girls who want to avoid an unintended pregnancy following unprotected sexual intercourse. EC is available in kit 3, the post-rape kit and kit 4, the oral and injectable contraceptives kit. EC may also be available locally: *Not-2-Late.com*, a website on EC, provides a list of locally available EC in countries worldwide. It can also be given using regular contraceptive pills and procured through agencies' usual medical supply systems. A useful resource that provides detailed information on EC regimes is *Emergency Contraception for Conflict-affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module*.⁹⁹

5. *Wouldn't it be offensive to offer condoms to a displaced population that is very conservative?*

It could be offensive to undertake a mass distribution of condoms in the early days and weeks of new emergencies without knowing people's knowledge and attitudes. It is not easy to judge whether a population is conservative. However, there may be some segments of the population who are less conservative. Therefore, it is better to make condoms available in a crisis setting even if condoms are offered in less public places where they can be obtained privately (for example, in toilet areas). As soon as the situation stabilizes and the MISIP is fully implemented, more in-depth assessments can be done to determine how to conduct IEC and condom distribution campaigns.

⁹⁹ www.rhrc.org/resources/general_fieldtools/er_contraception/welcome.htm

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6. *Why should condoms be made available if the displaced population doesn't know how to use them and the HIV prevalence rate is very low?*

Even if the percentage of people in the community that is knowledgeable about condoms is low, ethically, condoms should still be made available so those who wish to can access them.

7. *Will setting up antenatal care services help health workers identify women at risk of emergency obstetric complications?*

No, screening women during antenatal care visits will not identify most women who will develop unpredictable complications of pregnancy and delivery. Therefore, it is essential to ensure that all pregnant women can access EmOC services so those who experience complications can get the life-saving services they need.

8. *As a health worker, how do I know whether the blood supply I'm providing patients is screened?*

This information should be available at the health facility or from the MOH but may be available from other NGOs or UN agencies working in the area. It is the responsibility of all health workers to verify that all blood for transfusion in their facility, and facilities to which they refer patients for care, is safe. If needed, you can order RH Kit 12, which includes tests to screen blood prior to transfusion for HIV and other blood-borne diseases.

9. *How does the community know where and how to report incidents of sexual violence? Or to refer women who have complications at birth?*

Once services for survivors of sexual violence and for EmOC are established, the health and community services sectors should inform the community about the availability of these services, and the urgency for survivors of sexual violence to present to these services as soon as possible, as well as about the procedures for referring women who develop complications of pregnancy and delivery.

10. *Isn't training TBAs and midwives on how to perform clean and safe deliveries an important part of reducing maternal and neonatal death and disability?*

Although TBAs should be encouraged to make appropriate referrals during the earliest days and weeks of new emergencies, it is not a good use of time and resources to train TBAs and midwives on how to perform clean and safe deliveries. This type of in-depth training should wait until a more stable phase has been reached.