IMPLMENTING 'MISP' IN HUMANITARIAN CRISIS

A PROCESS REPORT FROM ASSAM, INDIA

This report has been compiled by RedR India as a part of their engagement with the TISS-DFY program for process documentation.

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CONTENTS

ACRONYMS

ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
BEmOC	Basic Emergency Obstetric Center
CEmOC	Comprehensive Emergency Obstetric Center
EDD	Expected Date of Delivery
FGD	Focus Group Discussion
MAM	Moderate Acute Malnutrition
MCH/N	Maternal and Child Health/ Nutrition
MISP	Minimum Initial Service Package
MUAC	Mid-Upper Arm Circumference
NRHM	National Rural Health Mission
OPD	Out-Patient Department
PNC	Peri-Natal Care
RH	Reproductive Health
RTI	Reproductive Tract Infection
SAM	Sever Acute Malnutrition
WASH	Water Sanitation Hygiene

INTRODUCTION

In July 2012, violent clashes between the Bodo and Muslim communities erupted causing close to 100 deaths and displacement of about 4,00,000[1] people in relief camps in Chirang, Kokrajhar and Dhubri districts of western Assam. The clashes involved killings and arson of dwellings from both communities. Paramilitary troupes and the army were deployed soon after to restore law and order.

The political undertones to these clashes soon materialized in the form of the issue of illegal immigration of Bangladeshis in the region, mirroring the movement in Assam from the 1980[2]s. The ensuing developments not only created a tense atmosphere in Assam but also had nation-wise implications. Text messages fueling regional tensions led to the mass exodus of people from the north-east residing in major Indian cities, especially Bangalore, Chennai and Pune. The nearing elections, engagement of political parties and long-standing grievances of both the communities escalated the conflict, thereby creating a context of insecurity, fear and restricted access to essential services.

Large scale displacement presented unique humanitarian challenges, both for the government and humanitarian agencies in the region. 133,000 people were still in relief camps as of October[3] 2012, with this number reducing to 40,000[4] by 27th November.

Over 4,00,000 people were displaced in lower Assam, in about 270 relief camps

While the central and state governments responded to the situation, establishing and maintaining relief camps across three districts, the displaced populations continued to live with limited access to essential services and grave health risks. News channels reported[5] in early August of an impending medical emergency in the camps, writing that "according to the state government, out of the over 8000 children in relief camps, 6000 are sick." Initial assessments[6] by humanitarian agencies also reported of unfavorable environmental hygiene conditions, with heightened risks of water-borne diseases amongst the population. While food rations were being provided, this only included *dal*, *rice* and *salt* and were reported to be insufficient in quantity, in addition to being nutritionally inadequate. The limitations on movement, perceptions of insecurity, high density of population in the camps and underlying vulnerabilities of the displaced populations created further challenges for meeting the needs of the people.

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[1] Time of India, 15th November, *Violence continues in Assam, death toll rises to six*
[2] The Hindu, 7th August, 2012, *It's locals vs. outsiders in Assam, says Gadkari.*
[3] Center for American Progress (2012) *Climate Change, Migration, and Conflict in South Asia Rising Tensions and Policy Options Across the Subcontinent*
[4] Radio Australia, 27th November 2012, *Thousands flee violence in India's Assam for government-run relief camp*
[5] NDTV, 5th August 2012*, 6000 children in Assam relief camps reported 'sick'*
[6] Oxfam Situation Report 1, 9th August 2012, Ethnic Conflict in Assam

Government Health Response

The district administration's health response was rapidly operationalized with the displacement and settlement of people in camps. In Chirang district, this included daily visits by doctors to the relief camps for OPD and provision of basic medicines and referrals. Given the existing shortage of doctors in medical facilities, 5 doctors were sent by the central government and 60 from neighboring districts and medical colleges. Doctors from medical colleges were deployed on a rotational basis, and by mid-October there were 11 doctors remaining in the district for relief duty. While the response was mostly curative, bleaching powder, halogen tablets, phenyl, DDT spraying, and mosquito nets were also provided in some camps. In some camps, immunization drives were also held (see annex for details). Additionally, Mamta kits and Mother's Horlicks have been provided in every camp to mothers with children below 2 years. However, the number of reported distributed Mamta kits was very low[7]. Despite similar initiatives by the administration in the other two districts, the medical needs and health risks in all three districts remained high. The specific maternal and child health risks are discussed in sections below.

DFY-TISS Response

In this context, Doctors for You, with support from Tata Institute of Social Sciences, intervened in the area to complement ongoing efforts to meet the needs of the displaced population. An initial rapid assessment was carried out in early August, following which the Minimum Initial Service Package project was implemented towards ensuring reproductive health rights to the women and adolescent girls in the camps. In response to other emerging needs, nutrition and water quality monitoring was carried out in selected camps, in addition to specific efforts towards advocacy using this data. The nutrition surveillance included MUAC tests, height and weight, immunization and dietary information; while the WASH data included information about the structure, location and disinfection status of water sources in camps. Water-quality testing was also done using Hydrogen Sulphide tests. In addition to the surveillance, essential dietary information was provided to mothers of SAM/MAM children; SAM children were referred to the nutritional rehabilitation center (NRC), where present, or the public health center; and hygiene promotion activities were carried out with children in every camp. In Chirang district, data from the nutrition surveillance was presented to the District Administration. This resulted in immediate action, whereby nutritious packages were procured in consultation with the NRC and distributed to families with SAM children.

A TISS-JTCDM volunteer takes the height and weight measurements of children at a relief camp

DFY-TISS was supported in carrying out these activities by students from TISS JTCDM (School of Habitat Studies) who provided surveillance, community mobilization and engagement, logistics, data entry and documentation support to the project.

[7] Only 2432 as of 11/10/12

This process report documents the MISP component of DFY-TISS's response in lower Assam, providing insights into the context, processes, and indicative impact of this reproductive health initiative.

THE MISP PROJECT

What is MISP?

The Minimum Initial Service Package (MISP) for Reproductive Health (RH) was first articulated in the 1997 *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* and recognized as a Sphere standard in 2004 as a priority intervention to be implemented at the onset of every new emergency. It is[8] "a set of priority activities to be implemented from the onset of a humanitarian crisis (conflict or natural disaster), and further scaled up and sustained to ensure equitable coverage throughout protracted crisis and recovery while planning is undertaken to implement comprehensive RH as soon as possible".

Why MISP in this context?

The developing humanitarian situation in lower Assam saw the disruption of all essential services in varying degrees for the displaced populations. While this included health services as well, the reproductive health scenario presented further challenges for the populations as well as service providers. With an estimated[9] displaced population of 5,00,000, 4000 pregnant women in relief camps, and only 117 doctors, the reproductive health needs of the displaced population were largely unmet. While health centers in Chirang, Kokrajhar and Dhubri were not fully staffed[10] even before the conflict, the displacement of doctors and health workers further hampered the provision of health services through these centers. Where health centers were functional, access to these centers was a problem. The rising fears of camp inhabitants prevented them from visiting health centers located near settlements of the other ethnic groups. For example, the Kokrajhar Civil Hospital is the nearest secondary referral center (or CEmOC, for deliveries) for the Muslim inhabitants of camps in Gossaigoan. However, people preferred to stay inside the camps even in cases of medical emergencies, rather than going to the hospital traveling through Bodo areas.

Deliveries in camps were reported even from relief camps located near primary health centers

[8] WRC (2011) Minimum Initial Service Package (MISP) *for* Reproductive Health *in* Crisis Situations: *A Distance Learning Module*
[9] Reuters, 6th August 2012, *Fleeing violence, Assam's displaced face disease, death in camps*
[10] Government of Assam (2003) Assam Human Development Report

The health authorities had taken immediate steps to ensure services in the camps, for example, deployment of existing staff and doctors from other districts to conduct OPDs in camps. Yet, the reproductive health needs could not be met for a number of reasons. There were seldom private spaces in camps where ANC check-ups could be done, almost all the doctors deployed were male, and the community-based ASHAs who could bridge these gaps were also displaced in many camps. Further, cultural beliefs regarding immunization and institutional deliveries[11] were further lowering health-seeking behavior in pregnant women, lactating mothers and their families.

Existing vulnerabilities of women and girls of reproductive age were exacerbated in the camp-settings with limited access to environmental health, nutrition, private space, and health services. In the 40 camps visited by DFY-TISS team, there had been 135 deliveries from August-September, out of which 43 had been in camps. There had also been 10 neonatal deaths and 2 maternal deaths in the two months. Deliveries in the camps were reported to be either conducted with support from *dais* or whoever was available in-case the *dai* had not moved to the camp. Additionally, since a majority of the identified pregnant cases were multipara, the time period between start of labor and delivery was very less. Because of this, a number of deliveries were reported to have happened in corridors, staircases or en-route to a health center.

Deliveries in Relief Camps

Baby Abiya (left) was born on 20th September on the staircase shown on the right. 14 children have been born in this (Bilasipara College) relief camp in Dhubri since August, 3 of whom didn't survive. Similar instances of camp deliveries have been reported from Chirang and Kokrajhar, including an ASHA worker in Mojabari Camp who wanted to go to the nearest health center but no ambulance/ vehicle was to available to take her when she went into labour.

Additionally, the practice of immunization for neonates was found to be very limited. While many under-5 children were found to have not been immunized, indicating low levels of immunization even before the displacement, deliveries in the camp situation was further hampering this process. Further, preliminary interviews with existing ASHA workers revealed a shortage of contraceptives in the government stores despite a high demand of the same from the camp inhabitants.

In this context of disrupted reproductive health service provision resulting from large scale displacement (including that of health providers), limited access to health centers and emergence of risky coping mechanisms; the minimum initial service package was introduced to plug these gaps for the crisis period.

Ensuring people's right to reproductive health in emergencies through provision of MISP is not only recognized in the Sphere Standards but also mandated by national*. The MISP has been implemented in Haiti after the earthquake in 2010 and in Kenya during the post-election violence, however, there was limited existing information regarding its

[11] ICSSR Baseline Survey of Minority Concentrated Districts (Chirang, Dhubri, Kokrajhar)

contextualization and implementation in the Indian context. Thus, such a process of contextualization was carried out and implemented in accordance with the existing guiding principles.

Project Objectives

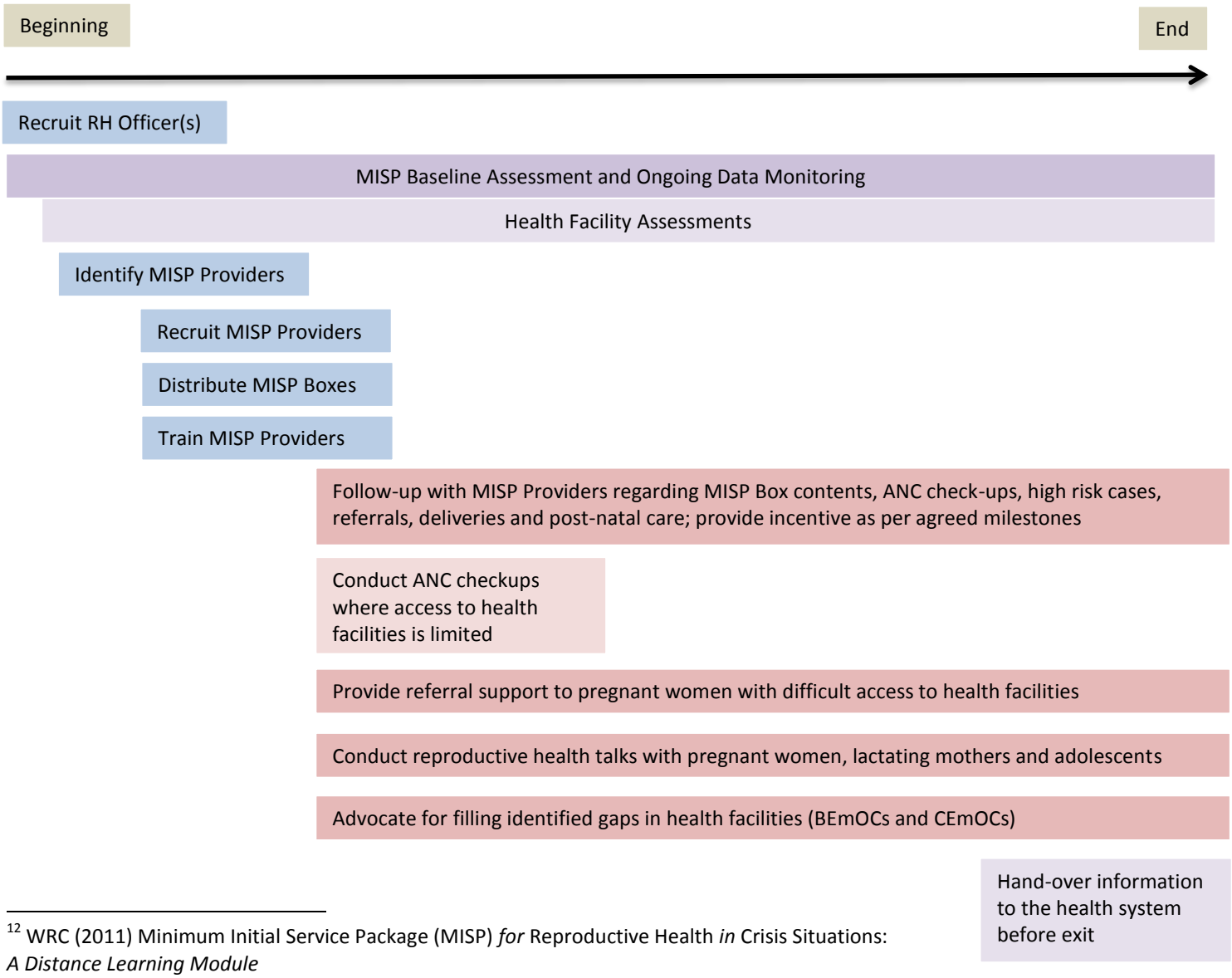
The objectives of the MISP Project implemented in lower Assam were:

1) Priority reproductive health services of Minimum Initial Service Package (MISP) are accessed by all the pregnant women in selected camps
2) Effective, safe and quality institutional obstetric care is accessed by 80% of the registered pregnant women in selected camps
3) Priority sexual health services are accessed by at least 80% of women and girls of reproductive age in selected camps

How was it done?

DFY-TISS's MISP project started with a preliminary assessment of the situation, yet, with the fundamental premise[12] that "the MISP can be implemented without an in-depth RH needs assessment because documented evidence already justifies its use". Given the rapidly changing scenario and the differences in the context across three districts, the project has evolved along with these changes. This flexibility has not only ensured contextual solutions to people's needs, but also resulted in clarity about implementing an MISP project in the Indian context.

STEPS UNDERTAKEN FOR IMPLEMENTING THE MISP PROJECT



[12] WRC (2011) Minimum Initial Service Package (MISP) *for* Reproductive Health *in* Crisis Situations: *A Distance Learning Module*

The different components of this project are discussed below:

1. **Assessments**

Beginning with the initial rapid assessment, assessments were ongoing and adapted at different stages of the project to ensure that relevant details informed the planning and implementation of the same. These varied from informal to formal, and brief to detailed depending upon the stage of the project at which they were conducted.

Initial rapid assessments were conducted in the late July and early August by the DFY-TISS team in Bongaigaon and Chirang districts. These not only included an assessment of the developing camp situation but also a rapid appraisal of the health scenario in discussion with health authorities at the district level and visits to the camps. In discussion with the Joint Director of Health, Bongaigaon, information was also sought about the government's planned response to the crisis and available resources that can be utilized by DFY-TISS for their response. While the initial response was launched after an initial assessment, the assessment was ongoing in Kokrajhar and Dhubri as the number of displaced people and relief camps increased in August.

Assessments included appraisal of health facilities for their suitability to conduct safe deliveries, especially since some of them were being used as relief camps during the crisis

With the progression of the reproductive health response, an MISP data-collection format (see annex 1) was developed and introduced for collecting specific reproductive health related information from every camp. This format included demographic details, information regarding the number and status of pregnant women and newborns in the camp, the details of health facilities and service providers and the rates of contraceptive demand/ usage, amongst other components. Data was collected for 40 camps in 3 districts, including the ones visited before the format had been finalized. An analysis of this data provided essential information about the needs and available resources for reproductive health and planning the project for the same.

In addition to the MISP format, a health facility assessment format was adapted[13] and operationalized for carrying out detailed capacity mapping of the identified health facilities towards provision of reproductive health services, especially for pregnant women in the camps.

2. **MISP Human Resource**

The rapid assessments and detailed MISP forms revealed both the gaps and capacities of health service providers during the crisis. Paucity of doctors in the health centers was found to be a reality across all districts, but especially in the newly formed Chirang district. At the same time, available ASHA workers and ANMs were identified through this process. This included ASHA workers who had moved to camps along with their communities, as in Kokrajhar and Chirang, as well as,

[13] Women's Commission for refugee women and children, *Assessment of "Minimum Initial Services Package" Implementation*

those who had been deployed on special relief camp duty, like in Dhubri. Initial discussions with these community health providers revealed that they were willing and available to engage in a reproductive health program, and that they would be best suited to reach out to the women and adolescents from their own communities. In camps where ASHA workers were not present, other frontline workers like Anganwadi Sevikas or suitable volunteers were identified.

Following the initial discussions, and based on the experience of distributing MISP boxes to few identified health workers, it was recognized that the role of a Reproductive Health Officer will be critical for coordinating the work of the MISP providers. Henceforth, the following human resource systems were put in place in the MISP Project:

1) <u>The MISP Provider</u>

This MISP Provider was at the core of the MISP project, reaching out to the displaced communities with reproductive health information, contents of the MISP box, and referral support.

- *Profile*: The available ASHA in the camp was the first choice for this position. Where not available, other frontline workers like Anganwadi Sevikas or suitable volunteers were identified.
- *Role*: The role of the MISP provider included the identification of pregnant women in the camp and facilitating their ANC checkup, facilitating safe motherhood by accompanying women for delivery and ensuring adequate perinatal care, provision of family planning and menstrual management essentials in the camp. A detailed role description can be viewed in Annex 2.
- *Recruitment*: The MISP Providers were remunerated for their engagement with the project. This decision was taken in cognizance of the fact that ASHA workers were also facing stressors from the crisis, either due to personal displacement or because of camp-duty in addition to their villages. Without The incentives were based upon four milestones – registration of pregnant women in the camp, 1st and 2nd ANC check-up for all identified women, institutional delivery, and perinatal care.
- *Capacity Building*: Since most of the MISP Providers were ASHAs, they were already trained through the national rural health mission. However, every group of MISP Provider was oriented towards the use of the MISP box and their activities during distribution of the box, and during subsequent visits. This included information about distribution and use of contents of the MISP box, especially the safe delivery kit; and mechanisms for restocking, facilitating referrals, and safe institutional deliveries. The discussion around the use of safe delivery kits was especially critical because it was essential to

Distribution of MISP Boxes to MISP Providers in Dhubri underway after training them on its usage

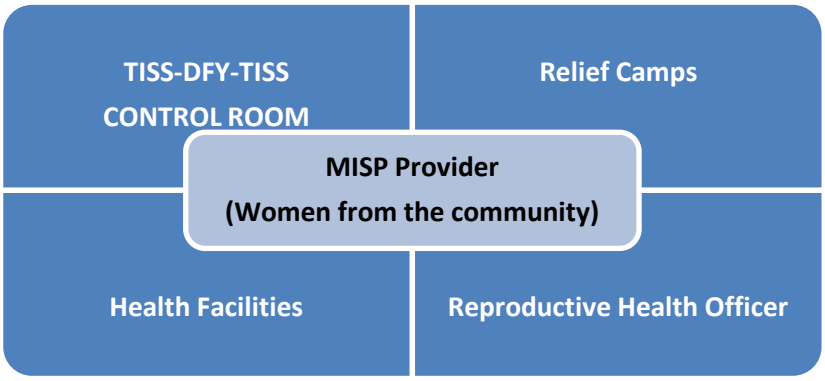
curtail motivations to choose a home/camp delivery over institutional deliveries. It was established that institutional deliveries are the safest, and most desirable. However, for emergency situations, especially in far-flung camps in the night times, a delivery kit ensures a clean and safe delivery in the given circumstances.

2) The RH Officer

An RH Officer was recruited for every district to ensure the management of the work being undertaken by the MISP Providers. The role of the RH Officer included:

- Distribution of MISP Boxes and follow-up on re-stocking
- Daily follow-up with the MISP Provider, and reporting to the district control room
- Monitoring and reporting on reproductive health indicators in the camps
- Reproductive health promotion in the camps, along with the MISP Provider
- Establishing linkages with the health facilities, and strengthening transportation/ referral mechanisms

The overall management of the MISP project in every district was overseen by the district coordinator. Based out of the district control room, the coordinator was supported by an MBBS doctor by provision of technical inputs to towards the project. In some cases, the coordinator was also an MBBS doctor. With the MISP Provider at the core of the project, the human resource framework can be represented as follows:



3. The MISP Box

Based on the initial rapid assessment and existing knowledge about the reproductive context in Assam, an initial package was put together. This included:

1. A safe-delivery Kit – With the recognition that the crisis in lower Assam presented certain conditions that would result (as evidenced in the rapid assessment) in camp deliveries despite ongoing efforts towards promotion of institutional deliveries, this component of the MISP box was included to ensure that these deliveries were at least

safe. Every MISP box contained at least 5 of these kits, which included a blade, soap, pair of free-size gloves, cord clamp, cloth for wrapping the newborn and a plastic sheet for facilitating the delivery.

2. An Ante-Natal Care kit – This included calcium, iron-folic acid and vitamin supplements for pregnant women
3. An RTI/ STI kit
4. A Family Planning kit – The components of this kit included oral contraceptives, condoms, and a pregnancy test kit
5. Menstrual Management Essentials – Every MISP box was stocked with ten packets of sanitary napkins, to be provided to those who use sanitary napkins. Since the use of napkins was reported to be limited to adolescent girls and a few older women, 1 meter of marking cloth was also provided along with a pair of scissors for distribution.

The experience of distributing the first few boxes enabled real-time changes to ensure the contents remain relevant and user-friendly. For example, the initial boxes included RTI-kits to address the reported cases of reproductive tract infections. However, it was found that the MISP Providers (mostly ASHAs) were not equipped to prescribe these medicines and follow-up on the same. Upon receiving this feedback, this component was removed from the MISP boxes, and the medicines were only prescribed by doctors during their camp visits. Similarly, the emergency pill was removed from the standard box upon receiving feedback about its improper usage. In some cases, when the MISP Provider reported the demand of the same, the pill was provided along with a briefing on its usage to the MISP Provider and with the condition that it be consumed in front of the provider herself[14].

The MISP Box was standardized using real-time inputs from implementation of the project

After making contextual changes, the standardized MISP Box had the following components:

Sr. No.	Component	Unit Cost (INR)	Quantity per box	Total Cost (INR)
1.	Steel Box (22.5x14x6 in)	240	1	240
2.	Scissors	35	1	35
Delivery Kit		86.73	5	343.65
3.	Plastic Packet (to store kit)	3	5	15
4.	Blade	0.98	5	4.9
5.	Soap	4.75	5	23.75
6.	Gloves	11.5	5	57.5
7.	Baby Cloth (0.5mx1m)	18	5	90
8.	Cord Clamp	14	5	70

[14] To avoid consumption after the prescribed 72 hours.

9.	Plastic Sheet (1mx1m)	16.5	5	82.5
Ante-Natal Care Kit		217.5	1	217.5
10.	Plastic Box (to store medicines)	25	1	25
11.	Iron-Folic Acid Tablets (strip of 15)	15	5	75
12.	Calcium Tablet (strip of 15)	9.5	5	47.5
13.	Multi-vitamin Capsules (strip of 10)	14	5	70
Family Planning Kit		170	1	170
14.	Plastic Box (to store medicines)	25	1	25
15.	Mala-D (strip of xx)	3	5	15
16.	Condoms (packet of xx)	100	10	100
17.	Pregnancy Test	12	5	60
Menstrual Management Materials				
18.	Sanitary Napkin (packet of 8 pads)	20	10	200
19.	Marking Cloth (1m)	20	1	20
NET COST OF 1 MISP BOX				**1256.15**

In addition to the contents, every box listed important contact numbers, including that of the DFY-TISS district control room for ready reference of the MISP Provider.

4. Reproductive Health Messaging

In addition to provision of essential supplies and services, reproductive health messaging was incorporated through different avenues of interaction with the displaced population and health service providers. Using NRHM IEC material and demonstration, this included, but was not limited to, the following key messages:

- Essentials of ante-natal care for pregnant women, including adequate nutrition, immunization, rest and check-ups
- Key elements of a safe delivery; usage of safe delivery kit (when, why, how, who)
- Essentials of perinatal care – exclusive breastfeeding, immunization, feeding, nutrition
- RTIs/ STIs – prevention and cure

Reproductive health messaging plays a key role in all stages of the initiative, but becomes extremely important once all the relief items and services have been provided to ensure their adequate utilization. Towards this end, many methods were used by the DFY-TISS-TISS program. One of the popular and successful methods included an awareness-generation play conceptualized and conducted by volunteering students from TISS. The play involved MISP Providers, RH Officers, students, and other volunteers and was centered on awareness generation for accessing reproductive health services. Specifically, the benefits of registration of pregnancies, ANC check-ups, and institutional deliveries were enacted alongside the potential negative repercussions of not using these services. Performed in 8 camps in Dhubri to an audience of 150 people each, the play also factored for pre and post-play interactions to enable internalization of messages. Family planning was also discussed, though the willingness amongst the audience to discuss this issue was lesser as compared to other topics. Regardless, the team received feedback about five women who had undergone laparoscopic sterilization after discussions about the play.

MISP Providers and RH Officer enact a scene from the play at a relief camp in Dhubri

5. Advocacy

Discussions with the district health authorities, health personnel primary health centers, and other linked service providers like ambulance drivers was an integral part of the project. This not only enabled optimal utilization of existing resources, but also ensured that the materials used were locally relevant and already in use. Specific examples of channeling existing resources for the same include:

- The Kajalgaon Civil Hospital was used as the base for the first team to set up a control room in Chirang. Discussions with the health authorities not only enabled the provision of office and residential space for the Chirang team at the hospital, but also warehouse space for all the supplies. Proximity to the hospital also enabled the team to facilitate the MISP Providers when they accompanied women from the camps for deliveries.
- Initially, while the procurement of materials for the safe delivery kit was underway, the NRHM delivery kit was provided as safe delivery kits. While its intended use is in sub-centers and primary health centers without adequate space for delivery, provision of these kits in the initial stages ensured that deliveries at the camps were safe despite the lack of provisions to ensure institutional deliveries. Later, a simpler and more user-friendly kit was contextualized and included in the MISP box.
- Supplies of Mala-D and Condoms in the MISP box were sourced from the government drug stores. Similarly, essential basic medicines were made available to DFY-TISS by the health authorities for administration by doctors in case of requirement during camp visits.

- NRHM IEC material, including flash-cards for reproductive health and posters for hygiene promotion were used for health promotion by the team. Using this material not only ensured that the images and language was locally relevant, but also saved time that would be involved in developing material, since it was readily available for use.

In addition to resource sharing, advocacy was used to enable plugging of gaps in the health system. It was recognized that strengthening community-based reproductive health capacities will not be enough to ensure the rights of pregnant women unless forward linkages are established with the health centers. This was done through the following:

Advocacy for health system strengthening

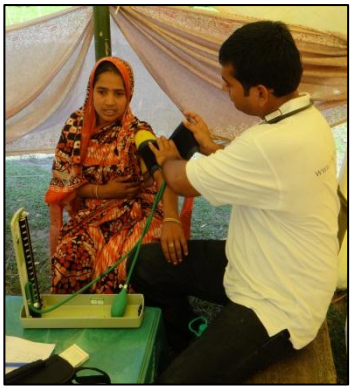
xx, MISP Provider in xx Camp brought a pregnant woman for delivery to the hospital. When the doctor demanded a fee for carrying out the delivery, which in principle cannot be chargeable in any government institution, the MISP Provider sought help from the DFY-TISS team. The team intervened and ensured a safe delivery without payment. Additionally, this was reported at the district administration, who immediately issued an order that no deliveries should be charged in any government institution. Additionally, the delivery kit by the MISP Provider list of DFY-TISS's MISP Providers was recognized by the authorities, ensuring they don't face institutional hurdles while carrying out their services.

Health facility assessments were undertaken in identified centers and where possible, existing gaps were reported to the health authorities.

Referral services were strengthened through discussions with doctors and ambulance drivers. The ambulance (108, 104, PHC ambulances) drivers' numbers were shared with MISP Providers. In some cases, this link was strengthened through the control room. For example, xx, MISP Provider in Basugaon Camp, Chirang called the RH Officer on October to report that one of the pregnant women in her camp had gone into labour. However, the ambulance driver was not available to help with the transportation to the hospital. The RH officer then facilitated this referral by directly calling the driver and ensuring that an ambulance reached the camp as soon as possible.

DFY-TISS district coordinators work with the MISP Providers to facilitate the referral and service provision at health centers

6. Clinical Support



In recognition of the fact that, despite efforts towards facilitating access to reproductive health supplies and facilities, the health system will not be equipped to provide the requisite services to women of reproductive age; clinical services were provided by doctors on the DFY-TISS team. Primarily, this involved conducting ANC check-ups for pregnant women in camps, and administering RTI/ STI medicines. Identified high risk cases were also referred to the nearest CEmOC and counseled for seeking institutional delivery well in advance of their EDD.

Additionally, any emergency medical cases in the camps were attended to and/or referred.

Reproductive Health Impact

One of the key components of the MISP project was an ongoing monitoring of key reproductive health indicators (see Annex 1 for the monitoring sheet) like the number of pregnant women in camps, number of deliveries and their location, the use of safe delivery kits, amongst others. Additionally, feedback was sought from the MISP Providers and pregnant women regarding the process and impact of the ongoing work. While the constant movement of population made accurate data collection difficult, indicative impact of the project may be projected based on available data. Since the beginning of the project, until November 10th, over 400 pregnant women had been registered across 70 camps in 3 districts. Since early October, of the 32 deliveries of the registered pregnant women in camps, 24 used safe delivery kits provided by the MISP Providers. Additionally, 23 successful referrals had been facilitated through the DFY-TISS team in the two month period. Discussions with women who had recently delivered, revealed that they had benefitted from the presence of an MISP Provider to help them through the delivery process in these difficult times, through referrals, contacting ANMs, or ensuring usage of safe delivery kits in cases of emergency.

MISP Provider facilitates a camp delivery

Isiron Bibi came into the Bengtol CHC camp in August, 2011 after the conflict broke in her district. In September, she was registered by Azeema Bewa, the MISP Provider of her relief camp as one of the pregnant women in the camp. After registration, her ANC check-up was carried out by doctors from Doctors for You. Like all the women in her camp who were in their third trimester, she was provided with a safe delivery kit by the MISP Provider.

On 14th October, when Isiron experienced labour pains, Aseema called the ANM living nearby to facilitate the delivery since that CHC has become dysfunctional since the establishment of a relief camp in its premises. However, the ANM refused to help with the delivery, saying the Isiron should be taken to Bongaingaon Civil Hospital 20 kms away for delivery instead. Aseema then tried calling three different ambulance drivers, including 108, but neither these nor private vehicles, were available for transportation that night. As Isiron's labour progressed, it became clear that the delivery will happen at the camp itself. Azeema, then facilitated the delivery using the safe delivery kit. During the delivery, when the placenta was not coming out, she sought guidance from doctors from DFY-TISS over the phone to facilitate this process.

While delivery by an ASHA worker or volunteer is not ideal or encouraged, in this case, it was instrumental in ensuring that safe materials and actions were taken during the crisis.

Lessons Learnt

While guided by national and international frameworks, DFY-TISS-TISS's MISP project has also evolved through the course of its implementation through real-time changes based on received feedback. The structures and systems documented in this report were put in place through a gradual progression, with an ongoing stock-taking of what's working well and what isn't. The experience of implementing such a process has also resulted in lessons regarding the implementation of MISP. Some of these are presented below:

1. *Contextualization is Key*

The value of an MISP intervention in a crisis has been recognized globally, and implemented in the recent past as well. Efforts towards building knowledge in this area have been ongoing, evidenced by the recent release of the distance learning module[15] on MISP for reproductive health in crisis situations. At the same time, despite the existing resources, implementation of such a program in the Indian context could not have been based on the information available in these resources. The MISP project in Assam highlighted the need for contextualization of the guiding frameworks. For example, the first proposed objective of MISP[16] 'Ensure the health sector/cluster identifies an organization to lead implementation of the MISP' has to be adapted in light of **existing health systems**, institutions and infrastructure in India.

The value of contextualization was also observed with respect to the **contents of the box**, the IEC material and profile of the MISP Providers. The dynamic nature of population movement and variations in settlements (urban/ rural; host community/ displaced community) also demanded that adaptations in the program be made accordingly.

The project also highlighted the need for strengthening knowledge, skills and services for addressing **sexual and gender-based violence** in emergencies in the Indian context. The importance of this component of MISP was recognized during the planning of the project, yet, it could not be implemented due to limitations of skilled personnel and institutional structures for redressal. During the implementation of MISP in Bilasipara sub-division of Dhubri district, news of cases of sexual violence were reported to the DFY-TISS team by the MISP providers. One MISP provider, Mrs Samina Khatun, ASHA Worker in Satapara and Kasuagaon camps reported that she had heard about three different cases of sexual violence from her camps. However, none of them had been reported to the authorities. All three cases resulted in the marriage of the victims with the accused. Another MISP provider from Bangalipara camp reported one case of sexual violence in which the accused was punished by the community. This case was also not reported to the authorities. Another similar incident was reported from a camp in Gossaigaon in Kokrajhar District. The MISP providers were of the opinion that many more case might have which never came to light. Yet, no conclusive programmatic action was taken in this regard.

[15] WRC (2011) Minimum Initial Service Package (MISP) *for* Reproductive Health *in* Crisis Situations: *A Distance Learning Module*
[16] Ibid.

The DFY-TISS team reported that the absence of a trained person and female members to handle such cases, socio-cultural barriers and rapid changes in camp population were limitations faced by them in implementing this component of the project.

2. *The MISP Provider plays a critical role in ensuring reproductive health rights of displaced populations*

As individuals closest to the communities, often living within the same settlements, the MISP Providers were integral to the implementation of the MISP Project. In the Indian context, the ASHA worker is best suited for this role as she acts as a link between communities and the health system. Investing in the ASHA worker, through capacity building and incentives, can ensure that this vital link is not broken during a crisis.

3. *Peripheral services have to be strengthened in addition to core reproductive health service provision*

Referral services and strengthening health facilities to cater to the demands of the displaced populations is equally important to ensure that the reproductive rights of the displaced population are met. This involves finding solutions towards barriers to accessing health institutions, both physical and social; establishing linkages with health authorities and supporting MISP Providers for effective utilization of these services.

4. *Providing RCH services in urban areas requires innovative strategies*

The outbreak of violence in the BTAD districts of Chirang and Kokrajhar resulted in the displacement of people not just within these districts, but also towards the neighboring district of Dhubri. Unlike, the former two, Dhubri also witnessed the formation of urban camps in Bilasipara town. In early October, about xx people were estimated to be taking shelter in the town's college, lower primary/ middle/ high schools, madarsas and other available pucca buildings. This context presented challenges different from the rural scenario. The dense living spaces, absence of traditional community health workers, and inhibitions of the rural displaced regarding use of urban health centers further compounded the reproductive health scenario. Here, a different strategy had to be used in comparison to the rural areas, with more investment in identifying and training volunteers and establishing linkages with the urban health centers.

5. *Relationships in preparedness period help during response*

The team's pre-crisis association with health professionals in the three districts was instrumental in launching a timely response during the crisis. This not only enabled resource sharing, but also permissions for carrying out activities as planned in the districts. This lesson can be useful one to take forward with specific efforts towards building relationships for an effective MISP response.

Logical Framework Analysis – MISP Project

Goal	Priority sexual and reproductive health services are available and accessible to displaced women, girls and new-borns in # relief camps in Chirang, Kokrajhar and Dhubri districts of Assam.			
Timeframe	**2 months (October-December, 2012)**			
	Intervention Logic	**Objectively Verifiable Indicators**	**Sources of Verification**	**Risks and Assumptions**
Objective 1	Priority reproductive health services of Minimum Initial Service Package (MISP) are accessed by all the pregnant women in selected # camps	- % institutional delivery - % of camp deliveries using safe kits - % of births registered and immunized - Infant and maternal mortality rates	- RH Officer's monitoring sheet - Health centre records - Key informant interviews (KIIs)	- Movement of pregnant women and their families to 1) another camp 2) villages - Movement of MISP Provider to another camp or their village - Pregnant women unwilling to go to the health centre outside the camp due to fear - Health centres are unequipped to provide ANC or safe deliveries
Outcome 1.1	***Registration*** By 20th October, all the pregnant women in # camps have been identified and registered by the camp's MISP provider	- At least one MISP Provider is recruited for # selected camps - One RH Officer per district has been recruited and trained - # MISP Providers have received and registered (at DFY-TISS control room) a MISP box - # MISP Providers have been trained on the use and distribution of contents in the MISP box - All pregnant women in # camps have had at least one meeting with MISP provider for registration	- Signed ToR of MISP Provider and RH Officer - Log book with MISP registrations - Camp-wise registration form submitted by MISP Provider - KIIs	
Outcome 1.2	***Ante-natal Care*** By 30th November, all pregnant women in # camps have undergone at least one ante-natal check-ups (ANCs)	- 100% high risk pregnancies are identified and referred - All registered women in the third trimester have received safe delivery kits - All pregnant women in # camps have received Calcium and Iron-Folic Acid supplements for 3 months - At least 80% of the registered pregnant women have received 2 TT vaccinations	- Camp-wise ANC form submitted by MISP Provider - RH officer's monitoring sheet - ANC card provided by health centre to pregnant women - KIIs	
Outcome 1.3	***Delivery*** All registered pregnant women in their third trimester experience safe motherhood during and post delivery	- # % births in the next two months happen in the presence of a skilled birth attendant, and safe delivery materials - All camp-births in # camps are registered within 10 days of birth - All new-borns in # camps are immunized within 10 days of delivery - All registered pregnant women have been trained about the importance of exclusive breastfeeding - All the new-borns in # camps are fed colostrum for first three days after birth	- RH Officer's monitoring sheet - Health centre records - MISP Provider's records - KIIs	

Objective 2	Effective, safe and quality institutional obstetric care is accessed by # % of the registered pregnant women in # camps	- % safe institutional deliveries - % of high risk cases that get emergency obstetric facilities - % of new-borns registered and immunized after birth - Rate of infant and maternal mortality	- RH Officer's monitoring sheet - Health centre records - KIIs	- Health centres may not be equipped or health professionals unwilling to provide quality obstetric services to referred women
Outcome 2.1	All registered pregnant women in their third trimester in # camps have information about and access to nearest BEmOC[17]	- At least one BEmOC is identified for # camps each and assessed for suitability for provision of obstetric care - At least one driver (ambulance or private) is identified for # camps each and linked with the respective MISP Provider	- District project coordinator's reports - RH Officers reports - Contact details of MISP Provider and Drivers	
Outcome 2.2	All registered high risk cases in # camps have information about and access to nearest CEmOC	- At least one CEmOC is identified for # camps each - At least one driver (ambulance or private) is identified for # camps each and linked with the respective MISP Provider		
Objective 3	Priority sexual health services are accessed by at least # % of women and girls of reproductive age in # camps	- Rate of contraceptive distribution - Rate of sanitary material distribution	- MISP Provider's distribution log - KIIs	
Outcome 3.1	# couples have access to relevant contraceptive measures	- # condoms have been distributed and received by # women - # contraceptive pills have been distributed and received by # women - # emergency pills have been consumed by women seeking them, in presence of MISP Provider	- MISP Provider's distribution log - KIIs	
Outcome 3.2	# adolescent girls and women have access to suitable materials for menstrual management	- # sanitary pads distributed and received by girls and women of menstrual age - # of menstrual cloth distributed and received by girls and women of menstrual age - # girls and women counselled for appropriate use and disposal of menstrual material	- MISP Provider's distribution log - KIIs	

[17] BEmOC: basic emergency obstetric care/ CEmOC: comprehensive emergency obstetric care. BEmOC functions include parenteral antibiotics, parenteral uterotonic drugs (oxytocin), parenteral anticonvulsant drugs (magnesium sulfate), manual removal of retained products of conception using appropriate technology, manual removal of placenta, assisted vaginal delivery (vacuum or forceps delivery) and maternal and newborn resuscitation. CEmOC functions include all of the interventions in BEmOC as well as surgery under general anaesthesia (caesarean delivery, laparotomy) and rational and safe blood transfusion (Sphere Standards 2011)

Activities
- Collect baseline reproductive health (RH) information from selected camps - Identify and recruit RH Officers - Identify and recruit MISP Providers - Distribute MISP Boxes to MISP Providers - Train MISP Providers in 1) use and distribution of contents in MISP kit, 2) ante-natal care essentials for pregnant women, 3) post-natal care essentials for mothers and new-borns - Monitor progress on MISP Providers' four milestones (registration, ante-natal check-up, delivery, post-natal care) in camps, and replenish contents of MISP box at regular intervals - Conduct ANCs in camps where access to health centres is restricted, including medical consultations and medicine provisions for RTI/ STI and other urgent cases - Identify referral drivers (ambulance/ private) and link them up with MISP Providers - Identify health centres for delivery (BEmOC) and for secondary referral (CEmOC), assess their suitability for obstetric services and advocate for gap-filling (where possible) - Monitor RH indicators in camps, in comparison to baseline

REPRESENTATION OF ACTION