# IMPLEMENTING MINIMUM INITIAL SERVICE PACKAGE 'MISP' IN HUMANITARIAN CRISIS LEARNING FROM EXPERIENCES

## A Process Report from ASSAM, INDIA

DOCTORS FOR YOU
THERE TO CARE

TISS
Tata Institute of Social Sciences

LFE

# Learning from Field Experiences

GOVT. OF ASSAM.
OFFICE OF THE DEPUTY COMMISSIONER, CHIRANG DISTRICT::::::::::;KAJALGAON

**TO WHOEVER IT MAY CONCERN.**

The District Administration of Chirang is thankful to **Doctors For You (DFY)** for rendering medical services in the relief camps in the district, more specifically the MISP (Minimum Initial Service Package) project for ensuring safe and institutional delivery among the pregnant mothers in the relief camps.

Quality services provided and follow up of all registered pregnant cases and malnourished children, professional approach and the experience of the DFY team member in disaster scenario deserves great appreciation.

I wish them the best in their all future endeavors.

27/11/12

Deputy Commissioner
Chirang, Kajalgaon.

Deputy Commissioner,
Chirang : Kajalgaon

I have been working in situations of disasters worldwide for the past 20 years. As a doctor I have struggled to deliver health care to the most destitute and am well aware of the immense challenges and obstacles that agencies face in the field. It is therefore with sincere and humble admiration that I read the report “IMPLEMENTING ‘MISP’ IN HUMANITARIAN CRISIS, A PROCESS REPORT FROM ASSAM, INDIA" from TISS and Doctors for You. I am impressed by what they have managed to accomplish during the year!

Provision of health care to the sick is one of the most tangible and essential human rights. The most vulnerable in a displaced population are women and children and basic programmes such as maternal health and nutritional surveillance are cost effective interventions that save lives. I think that TISS and Doctors for You have focused on appropriate and cost effective interventions in this difficult context. I wish them continued success, while hoping that the situation stabilizes so that their services will not be needed.

**Johan Von Schreeb, MD, PhD**
**Department of Public Health**
**Karolinska Institutet**
**Stockholm, Sweden**

The Tata Institute of Social Sciences (TISS) is proud to present this process report in collaboration with Doctors for You (DFY). Through its 65 years of work in disaster response, TISS has been involved in more than 20 interventions, consolidating 600 student volunteers and 150 faculty members totaling 450 days of disaster response.

The faculty, students of Disaster Management, the people over at DFY have made the creation of this document possible. The TISS-DFY engagement in implementing the Minimum Initial Service Package to address maternal and child health issues in the districts of Kokrajhar, Dhuburi and Chirang has borne fruit through concrete results as well as specific findings, all of which have been touched upon in this report. We are confident that our involvement has brought some definite change in the public health status of the people of the BTAD districts. We are convinced that this report will do justice to the hard work that has been put in during this intervention and look forward to our continued association with DFY in the future.

**Prof. T. Jayaraman, PhD**
**Dean, School of Habitat Studies**
**Tata Institute of Social Sciences**
**Mumbai,India**

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# Learning from Field Experiences

The TATA INSTITUTE OF SOCIAL SCIENCES (TISS) was established in 1936. Since then, TISS has been an institution of excellence in higher education that continually responds to changing social realities, towards creating a people centred, ecologically sustainable and just society that promotes and protects dignity, equality, social justice and human rights for all. TISS has always reached out to support people affected by natural and human-made crisis. The Institute has worked closely with State Governments and the district administration. In recent years, NGOs have also recognised the role of the Institute and its volunteer teams and have sought to work in a concerted effort through collaboration and cooperation.
For more details on TISS please do visit www.tiss.edu

DOCTORS FOR YOU (DFY) formed by doctors, medical students and like-minded people, is a humanitarian organisation based in India. Since its inception in 2007, the organisation has been working extensively with vulnerable communities in six states of India providing efficient, effective and equitable distribution of health care for all. The organisation has received several awards such as The SAARC Award (2010) and The British Medical Journal Group Award (2009) for its outstanding contribution to the humanitarian field. Presently, there are more than 500 members and 1000 registered volunteers assigned with the organisation who are ever ready to support in situations of crisis following a major disaster. DFY is also engaged in developing world class Disaster Management, Emergency and Trauma care services along with Training and Capacity building programmes throughout India.
For more details on DFY please do visit www.doctorsforyou.org


## Acknowledgement

*Doctors for You (DFY) wishes to acknowledge the following people who have been of immense help in the process of creating this MISP process document. Mr. Mahesh Kamble, for his valuable support during our initial period of contact with the Tata Institute of Social Sciences. We would like to express our deepest thanks to Dr. Nobhojit Roy for his critical inputs and continuous involvement. Ms. Sheena Arora from RedR, Pune for her large contribution in preparing this document. Her well rounded expertise in all aspects of the Humanitarian sector is well appreciated. Dr. Samrat Sinha, for sharing his most valuable knowledge about conflict, security and Humanitarian Aid management as well as operational suggestions and advice outside of and on the field in Assam. Mr. Yogesh Sadhwani & Mrs. Aditi Sharma for their kind suggestions and inputs on starting this project as well as projecting it in social media. Dr. Mridul Deka, Dr. Palash Misra, Ms. Sukhreet Bajwa and Mr. Sunny Burgahoin, all the doctors and field staff over at DFY-NERO for the immense efforts that have bene put by them since the Initial Rapid Assessment days. Finally, We would also wish to acknowledge the support of the students and staff of the Jamsetji Tata Centre of Disaster Management, School of Habitat Studies for their valuable contribution to the relief efforts. Our Assam intervention would not have been possible without all your help.*



**Dr. Ravikant Singh**
*President*
*Doctors for You (DFY)*

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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 |

# 1. INTRODUCTION

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

The political undertones to these clashes soon materialised in the form of the issue of illegal immigration of Bangladeshis in the region, mirroring the movement in Assam from the 1980's[2] . The ensuing developments not only created a tense atmosphere in Assam but also had nation-wide implications. Text messages fueling regional tensions led to the mass exodus of the people of 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.

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

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 2012[3] , with this number reducing to 40,000 by 27th November[4] .

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

[1] *Time of India, 15th November, 2012, 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

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 lentils, 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.

## a. Government Health Response

The district administration's health response was rapidly operationalised 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, immunisation 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.

## b. DFY-TISS Response

In this context, Doctors for You, with support from The 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 of 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 specific efforts towards advocacy through using this data. The nutrition surveillance included MUAC tests, height and weight, immunisation 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

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

Hydrogen Sulphide tests. In addition to the surveillance, essential dietary information was provided to mothers of Severely Acute Malnourished (SAM) / Moderately Acute Malnourished (MAM) children. SAM children were referred to the nutritional rehabilitation centre (NRC), where present, or the public health centre; 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.

DFY-TISS was supported in carrying out these activities by students from TISS JTCDM (School of Habitat Studies) who provided surveillance, community mobilisation and engagement, logistics, data entry and documentation support to the project. During response, because of security concerns in the conflict affected region and for smooth functioning of DFY-TISS team two guidelines were formulated. These guidelines helped the teams to work in coordination with each other (see Annex 1 for the guidelines).

## 2. THE MISP PROJECT

*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.*

### a. 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 recognised 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".

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

## b. Why MISP in this context?

The developing humanitarian situation in lower Assam saw a disruption in the availability of almost 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, 4,000 pregnant women in relief camps, and only 117 doctors, the reproductive health needs of the displaced population were largely unmet. While health centres 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 centres. Where health centres were functional, access to these centres was a problem. The rising fears of camp inhabitants prevented them from visiting health centres located near settlements of the other ethnic groups. For example, the Kokrajhar Civil Hospital is the nearest secondary referral centre (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.

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 immunisation 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 labour 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 centre.

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[9] *Reuters, 6th August 2012, Fleeing violence, Assam's displaced face disease, death in camps*
[10] *Government of Assam (2003) Assam Human Development Report*
[11] *ICSSR Baseline Survey of Minority Concentrated Districts (Chirang, Dhubri, Kokrajhar)*

***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 who didn't survive. Similar instances of camp deliveries have been reported from Chirang and Kokrajhar, including an ASHA worker in Mojabari Camp received no ambulance assistance when she went into labour.*

Additionally, the practice of immunisation for neonates was found to be very limited. While many under-5 children were found to have not been immunised, indicating low levels of immunisation 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 centres and emergence of risky coping mechanisms, the minimum initial service package was introduced to plug gaps for the period of the crisis.

Ensuring people's right to reproductive health in emergencies through provision of MISP is not only recognised but also mandated by the Sphere Standards. 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 contextualisation and implementation in the Indian context. Thus, such a process of contextualisation was carried out and implemented in accordance with the existing guiding principles.

## c. Project Objectives

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

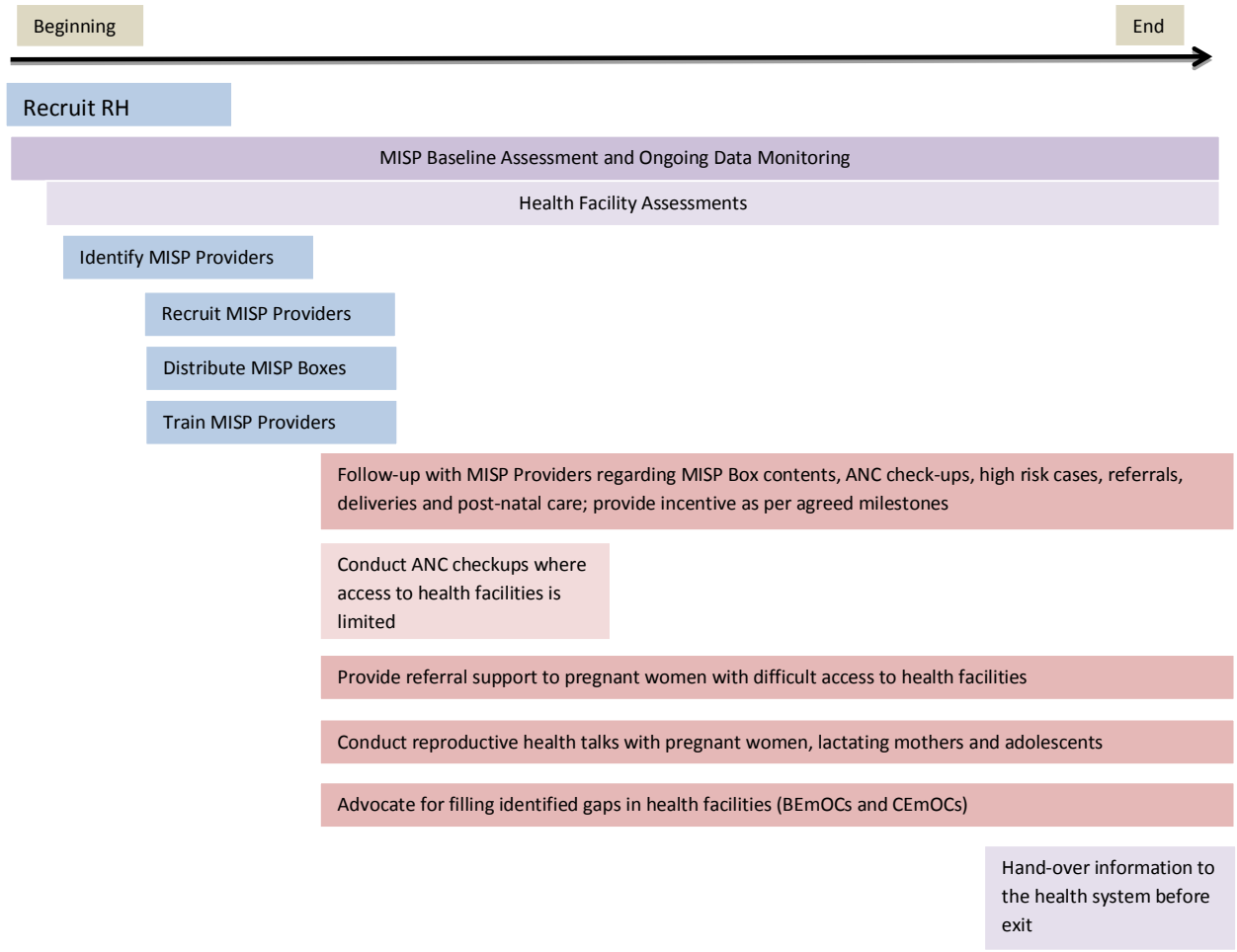
- Priority reproductive health services of Minimum Initial Service Package (MISP) are accessed by all the pregnant women in selected camps
- Effective, safe and quality institutional obstetric care is accessed by 80% of the registered pregnant women in selected camps
- Priority sexual health services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

## d. 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.

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

## STEPS UNDERTAKEN FOR IMPLEMENTING THE MISP PROJECT




### e. The different components of this project are discussed below:

#### ❖ Assessments

Beginning with the initial rapid assessment, ongoing and adapted assessments were carried out 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 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 utilised by DFY-TISS for their response. While the initial response was launched

*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*

after an initial assessment, the process continued in Kokrajhar and Dhubri as the number of displaced people and relief camps increased in August.

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 finalised. 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 operationalised for carrying out detailed capacity mapping of the identified health facilities towards provision of reproductive health services, especially for pregnant women in the camps.

### ❖ 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 centres 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 in the cases of Kokrajhar and Chirang as well as those who had been deployed on special relief camp duty in the case of Dhubri. Initial discussions with these community health providers revealed that they were willing and available to engage in a reproductive health programme, 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.

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

Following the initial discussions, and based on the experience of distributing MISP boxes to few identified health workers, it was recognised 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:

- **The MISP Provider**

This MISP Provider was at the core of the MISP project, reaching out to the displaced communities with information on reproductive health, 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. 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 (NRHM). However, every group of MISP Providers 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 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.

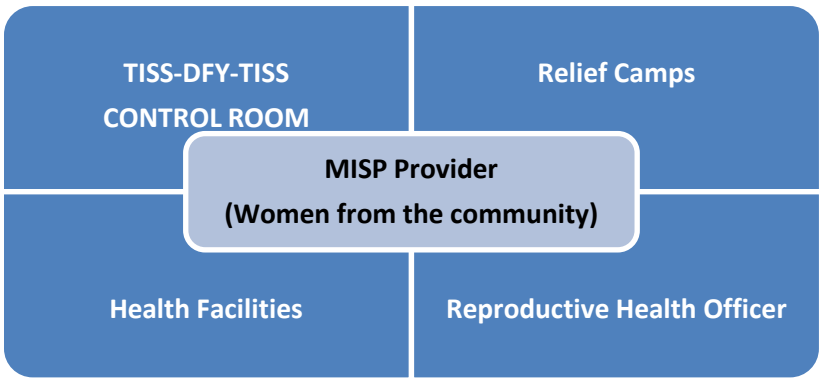
- **The RH Officer**

This MISP Provider was at the core of the MISP project, reaching out to the displaced communities with information on reproductive health.

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:




### ❖ 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:

- **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 the least, safe. Every MISP box contained 5 kits which contained a blade, soap, pair of free-size gloves, cord clamp, cloth for wrapping the newborn and a plastic sheet for facilitating the delivery.
- **An Ante-Natal Care Kit –** This included calcium, iron-folic acid and vitamin supplements for pregnant women.

- **An RTI/ STI Kit**

- **A Family Planning Kit –** The components of this kit included oral contraceptives, condoms, and a pregnancy test kit.

- **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 MISP Box was standardised using real-time inputs from implementation of the project*

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] .

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

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

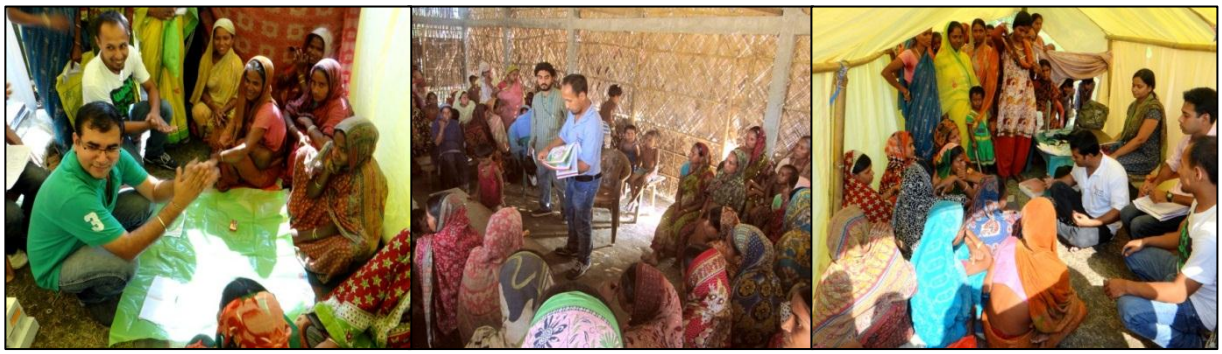
| Sr. No. | Component | Unit Cost (INR) | Quantity per box | Total Cost (INR) |
|---|---|---|---|---|
| 1. | Steel Box (22.5x14x6 in) | 240 | 1 | 240 |
| 2. | Scissors | 35 | 1 | 35 |
| ***Delivery Kit*** | | 86.73 | 5 | 343.65 |
| 3. | Plastic Packet (to store kit) | 3 | 5 | 15 |
| 4. | Blade | 0.98 | 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 |
| 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 28) | 3 | 5 | 15 |
| 16. | Condoms (packet of 10) | 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.

### ❖ 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, immunisation, 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, immunisation, feeding, nutrition
- RTIs/ STIs – prevention and cure



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

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 utilisation. Towards this end, many methods were used by the DFY-TISS-TISS programme. One of the popular and successful methods included an awareness-generation play conceptualised and conducted by volunteering students from TISS. The play involved MISP Providers, RH Officers, students, and other volunteers and was centred 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 internalisation 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 sterilisation after discussions about the play.

### ❖ Advocacy

Discussions with the district health authorities, health personnel primary health centres, and other linked service providers like ambulance drivers was an integral part of the project. This not only enabled optimal utilisation 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-centres and primary health centres 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 contextualised 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 recognised 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 centres. This was done through the following:

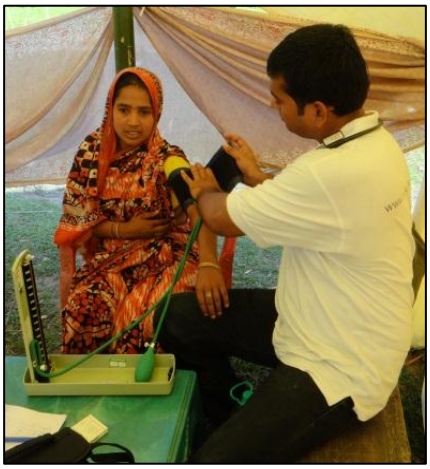
**Advocacy for health system strengthening**

*Johura Khatoon, MISP Provider in Mojabari Camp of Chirang district 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 list of DFY-TISS's MISP Providers was recognised by the authorities, ensuring they don't face institutional hurdles while carrying out their services.*

Health facility assessments were undertaken in identified centres 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, Ashma Khatoon, 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.

### ❖ 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) such as 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.*

## 3. Lessons Learnt

In addition to adopting national and international frameworks, DFY- 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:

### a. Contextualisation is Key

The value of an MISP intervention in a crisis has been recognised 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 programme 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 contextualisation of the guiding frameworks. For example, the first proposed objective of MISP[16] 'Ensure the health sector/cluster identifies an organisation to lead implementation of the MISP' has to be adapted in light of existing health systems, institutions and infrastructure in India.

The value of contextualisation 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 programme 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 recognised 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 was 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 been prevalent which never came to light. Yet, no conclusive programmatic action was taken in this regard. 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.

### b. 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.

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

### c. 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 for barriers to accessing health institutions, both physical and social as well as establishing linkages with health authorities and supporting MISP Providers for effective utilisation of these services.

### d. 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 6,000 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 centres 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 centres.

### e. 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.

# APPENDIX 1

## DFY-TISS HUMANITARIAN RESPONSE CONTROL ROOM ROLE AND RESPONSIBILITIES

### 1. THE NEED TO SCALE UP CONTROL ROOM

The Control Room is the nodal point of the current DFY-TISS Response. Because the current political instability and insecurity is combined with scale and severity, the DFY-TISS response requires heightened situational awareness and coordination among the various teams deployed in Districts who are working under the Programme Leads **[PL]**.The field experience until now has shown that the following issues in information flows, data management and coordination.

- No standardisation in Data Collection Formats and Reporting Mechanisms.
- Multiplicity of Reports and High Volume of Reports throughout the day, which obstructs decision making and reduces situational awareness.
- Communication gaps and coordination gaps between teams in the districts which obstructs directional flow of work.
- With increasing scaling up of programme and with the need to extend integrated programme of MISP to areas that are **more remote or insecure, there will be further need for enhanced communication and reporting system to minimize programme implementation errors arising out of miscommunication or breakdown in communication**.
- Also, there is a severe need to streamline the reporting system between the District Teams and the Central Team operating in Chirang.
- In the pre-review situation, District Teams were facing the problem of documentation whereby post-fieldwork they were spending excessive time on writing non-standardised reports and then struggling with internet connectivity.
- In addition excessive reports being sent in at different times to the Control Room left very little time for systematic documentation and analysis.
- In terms of mobile phone connectivity, it has been also found that on occasion district teams when trying to contact control room, have been unable to do so, as the only dedicated phone was continuously engaged in other calls.
- In addition, MISP Inventory Management is closely connected with implementation and is also a key component of the response. This is also an added function that the Control Room has to monitor in order to ensure coordination between field teams and central team.

## 2. ROLE OF CONTROL ROOM

- The Control Room will Collate, Analyze and Disseminate all daily reports being received from the PL/Humanitarian Team Members [HTM] operating in the field.
- All PL/HTM Daily Reports will be sent to the dedicated E-Mail Address set up for the purpose of communication for the Control Room.
- No Daily Reports will be sent to persons other than the DFY-TISS Control Room and Designated TISS authorities, without authorisation from Response Manager [RM] due to ethical aspects of the data being collected.
- In order to maintain regular communication with TISS, DFY-TISS Control Room will forward the Collated Daily Reports in Standardised Format to TISS.
- Additionally, All Daily Reports will be compiled at the End of the Week and Forwarded to TISS-Authority as Weekly Report As Well. The Weekly Report should be Analytical Versus Descriptive.
- Control Room is also responsible for Inventory Management in Warehouse.
- DISTRICT PL will LOG Demand Request in Specified Format for MISP Replenishment OVER PHONE/DEDICATED E-MAIL. This will be addressed based on logistical situation of Inventory Team.

### 2.1. Reporting Mechanism for PL/HTM in areas where Internet Connectivity is Weak

- First, every day designated District/HTM member will call at specific time allotted by Control Room and Provide the Daily Report with Essential Information to Control Room Handler: Summary of Activity, Camps Visited, No. of Cases of Critical Indicators, Gaps Found and any other information including security incidents.
- This will be noted down, in the specified format by the Control Room Handler and Logged in the Process Documentation Record.
- The District Team/HTM will still maintain the Daily Record in the Field.
- This Record will be transferred to Control Room during monitoring visits, or as opportunity provides itself for data transfer.

### 2.2. Phone Policy for Control Room to Ensure 24*7 On Call Support for Field Teams

- There will dedicated phone numbers to support Field Teams.
- Daily Reporting will be at designated time. There will be Emergency Phone Number available throughout.
- In addition, in emergency Response Manager must be informed immediately as well.

- During the Field Visit the Control Room must track the location of where the Field Teams are working BEFORE entering the CAMP/WORK-SITE.

- In addition, monitoring during transit of all district field teams between camps/work-site and base, is responsibility of Control Room.

- Control Room will process Queries from Families of HTM if required. The Control Room Numbers will be shared with Family of HTM

## 3. MONITORING OF MISP IMPLEMENTATION BY COMMUNITY WORKERS IN AREA OF RESPONSBILITY [AOR] OF CENTRAL TEAM/CHIRANG

- Daily Phone Check on Associated Community Health Workers and enquiring about their well-being, daily activities and challenges.

- List of community workers implementing MISP and related Programmes will be available to the Control Room at all times.

- Control Room will also handle calls of ANM/ASHAs for replenishment of MISP Kits in the AOR of Chirang Team.

## 4. FIELD INCIDENT REPORTING SYSTEM

- All untoward incidents in the field that involve any aspect of welfare and security of individual student/PL must be reported to Control Room.

- Any incident or information from an external source regarding or related to perceptions of DFY-TISS RESPONSE MUST BE REPORTED IMMEDITAELY TO CONTROL ROOM.

## 5. SECURITY MONITORING COMPONENT

- The CONTROL ROOM is responsible for the Security Analysis/Monitoring for the District Teams.

- This monitoring will also include inputs and incidents reported from District Teams.

- Local Sources (NEWSPAPER/NEWS) will be used for baseline data.

- Additional inputs from FIELD INCIDENT REPORTING SYSTEM will make up the security analysis.

# APPENDIX 2

## Guidelines for Programme Leads and Humanitarian Team Members

## DFY-TISS "Humanitarian Team Resource Management" (HTRM)[17]

### 1. Introduction

DFY-TISS Medical Humanitarian Response with a focus on providing Maternal and Childcare through the implementation of MISP (Minimum Initial Service Package) in the affected districts of Chirang, Kokrajhar and Dhuburi. The current areas of operations for MISP-implementation in the region are included in the Appendix. DFY-TISS response is significant because it involves integration of disaster medicine and public health specialists with TISS response team members who have social science analytical capabilities as well previous training in diverse multi-disciplinary backgrounds (social science, medicine, engineering etc). Critical to the functioning of the MISP programme has been the need to ensure that disaster medicine/public health specialists (i.e. DFY-Doctors) who are the lead programme implementers in the affected districts (and sub-divisions) utilize the resources and capabilities of TISS team members. Similarly, TISS team members have to integrate themselves and understand the technical aspects of the response, especially the medical (curative, preventive, promotive) dimensions to MISP. Other challenges include:

- Working in conflict context, whereby insecurity and political instability is visible.
- Programme implementation in relief camps with unprecedented numbers of displaced persons.
- Geographical remoteness, access to camps and distance between programme teams.
- Resource constraints relative to scale of problem, as well as available human resources.

Critical to smooth integration of medical/public health capabilities with TISS students is the need to build a **cohesive, unified, efficient and ethical organisational culture** within each response team that will facilitate problem-solving capabilities in the complex humanitarian situation. The **DFY-TISS Humanitarian Team Resource Management (HTRM) Guidelines** has been created to ensure that Specialists (Leads Programme Heads) and team members have a set of standards and procedures that will facilitate decision making.

[17] Please note that HTRM concept has been influenced by "AirCrew Resource Management" (CRM) which is mandatory training for civil aviation pilots in India. CRM refers to the manner by which small teams (aircrew) build on existing human resources (capabilities) of subordinate aircrew and flight-staff for maximizing problem solving in high pressure situations. Acknowledgement to a senior Indigo Airlines first officer for introduction of concept.

Also Note the Following Terms:

- **Programme Lead [PL]:** Is the Disaster Health Specialist deployed by DFY who will be implementing the programme in various Districts and Sub-Divisions. PL can also include Consultants who are appointed from time to time by RM.

- **Response Manager [RM]:** Is the President of DFY: Dr. Ravikant Singh and any designated personnel as designated by the President in his absence.

- **Humanitarian Team Member [HTM]:** Is a team member who is deputed from JTCDM for response work

## 2. Guidelines for Specialists [Programme Leads in Districts]

### 2.1 Team Resource Management for PL: Responsibilities towards Team/Induction Stage

- First and foremost, Programme Leads must understand that team members possess resources (non-material) that must be deployed to achieve the best possible outcomes. On arrival of the team, Programme Lead must be fully familiarised with the background (education and cultural background, including linguistic capabilities) of the team members.

- This also means that Programme Leads have to have an initial group meeting and tell the students about not only their background, but also the technicalities of the programme and challenges in implementation.

- Programme Leads must provide the existing data to the team members on arrival. Included in this orientation should be a familiarisation with the challenges in implementation including success and failure.

- Also students must be made aware of logistical challenges faced by Programme Leads in setting up team base/vehicle etc.

- Programme Leads must also ensure that students conduct a pilot visit in order for area familiarisation so that they are oriented to geographical range.

- Programme Leads must ensure that at least a strategic project plan [SPP] for their area of responsibility is formulated PRIOR to arrival of students. This SPP should cater to a time window of at least 2 weeks in order to cater to current turnover of TISS students. This will also allow for students to be placed pre-assigned tasks.

- At the same time the plan should as much as possible, be kept in view of students capabilities such as education background etc.

### 2.2 Team Resource Management For PL: Integration Process

- Programme Leads must ensure that students' capabilities are integrated in order to support their programme goals (the goals also require validation by response manger).

- Data collection tasks for students must be integrated for Programme Goals which is defined by the Nature of Integrated MISP Response and additional activities as decided by Leads and Response Manager.

- Generation of basic research or conduct of full-fledged research project by students during response, unless assigned by response manager, cannot be the focus of student activities in the immediate response period.

- At the same time any specific short-term research as required by Programme Lead must be communicated and implemented by team members based on availability of resources/capabilities.

- A small feedback session where the team reviews outcomes must be followed at the end of every day. Effort must be made to take into account viewpoints of team members, and integrate their views after assessment.

- Programme Lead must ensure that humanitarian team is also delegated specific tasks ranging from community mobilisation, maintenance of accounts, documentation and logistics.

- The aim of HTRM for the central lead decision makers in the team is to minimize the impact of inter-personal or organisational culture disruptions on programme implementation.

### 2.3 Team Resource Management: Key Guidelines

- The Key Guideline for Programme Leads is creating a sense of Ownership of the Humanitarian Programme among team members.

- At the same time given that the field situation is difficult, Programme Leads must be sensitive to the following possible problems becoming visible among team members: occurrence of stress, health issues, severe disruptive behavior, inability of team member to conduct fieldwork, the disrupting of relations and rapport with community, unbecoming conduct in the field, anger management, and other possible behavior that cannot be solved at the level of programme lead. Also possible security issues as well to be kept in focus.

- In addition Programme Lead must be prepared with Contingency and Exit Plan in case of Section 2.2.

### 2.4 Escalation Process from Programme Lead [PL] to Response Manager [RM] in the Eventuality of Disruption in/among Team Members that IMPACTs Programming. In case of solution that cannot be found at the level of Programme Lead in terms of previous section the following process is to be implemented.

- Report Occurrence of Problem to Response Manager [RM] Immediately.

- RM must log the complaint and make a quick record of the complaint.

- Based on Consultation with RM (and other Programme Leads if required) implementation of Exit Plan.

- Team Member must be communicated the decision immediately and all consultations regarding the severity of the problem will only be done at the level of RM/PL and in the Central Control Room/Central Base Camp.

# 3 Guidelines for Humanitarian Team Members (HTM)

## 3.1 Context

- First and Foremost the HTM is one of the most important components after PL.

- The execution of the humanitarian programme is dependent on an ethical, cooperative, respectful and efficient organisational culture. This is critical especially if response is to be conducted in a proper outcome based manner.

- It must be pointed out that given the complex and specialised nature of DFY-TISS response in terms of MISP and additional disaster health activities being conducted in the field, with serious implications for beneficiary communities, the organisational culture aspects are extremely critical as it requires high detail to attention, due diligence and ability to cope with stress arising from the security context as well as in terms of conditions of the camp.

## 3.2 Team Resource Management: Individual Responsibilities

- Cordial relations among team members and minimizing of inter-personal/organisational culture disruptions is extremely important keeping in view the severity of the emergency situation as well as the constraints in terms of human resources availability, extent of severe humanitarian problems in the camps, and most importantly in the context of conflict/ethnic polarisation.

- In terms of HTRM the most important key learning is that team members have to create a Sense of Ownership in the Humanitarian Programme.

- Humanitarian Team Members must understand the individual initiative is the key to successful programming.

- In addition students must strive to ensure Situational Awareness, sensitivity to the community and must constantly ensure that they are aware of the team resources that can be used for problem solving.

- In terms of fieldwork, team members must strive to constantly communicate with other team members and PL in the field in order to ensure that all team members know where the PL/HTM is operating.

- IN ADDITION CONSUMPTION OF ALCOHOL, CIGARETTES OR NARCOTICS SUBTSANCE IS STRICTLY NOT PERMITTED UNDER ORGANISATIONAL NORMS AND ANY REPORTS WILL BECOME PART OF COMPLAINT MECHANISM.

### 3.3 Team Resource Management: Responsibilities of team members towards PL

- They also have to ensure that they display a sense of respect and understanding as well as sensitivity towards Programme Lead [PL] who is supervising the team.

- Moreover, in terms of the position of the PL, as the PL is responsible for the safety, security and welfare of the team, the members of the team must facilitate the operationalisation of this responsibility.

- At the same time the team members are ALSO responsible for the safety, security and welfare of the PL.

- Team members must be aware of any security constraints as well as health problems being faced by the PL and adjust the programme implementation accordingly.

- Moreover, in the eventuality that the PL is facing extreme hardship or requires immediate evacuation, the team members must become responsible for the implementation of Exit Plan.

### 3.4 Team Resource Management: Relations among Members

- In terms of relations among team members, the members must be respectful of opinion, culture, gender, standpoint, and moreover, be respectful and understanding in terms of the tasks that are assigned by the PL/RM to the students.

- Moreover sustainable HTRM is also dependent on the way members coordinate with each other in the non-field setting. Duties must be assigned in terms of cleaning of rooms and bathrooms, arranging food for team, arrangement of transportation, and maintenance of accounts and expense. In addition personal hygiene is of utmost importance when functioning in small teams under high pressure.

- In terms of the occurrence of organisational disruptions referred to in section 2.1. [2nd last paragraph] team members must be able to identify the occurrence of such problems; especially those that threaten or obstruct the implementation of the programme by the PL/HTM.

- In case of the occurrence of organisational disruptions that may obstruct the implementation of the programme, the HTM must always report the situation immediately to the PL who will then conduct consultations with the RM and implement escalation procedures.

- DFY-TISS is not responsible for delays in reporting of individual problems that could have been solved through the reporting mechanism as outlined in the document.

### 3.5 Escalation Process

- Please Refer to Section 2.4. for overview of Escalation Process from PL to RM.

## APPENDIX 3
### MISP Providers of Chirang District

Adarjan Nessa
Basugaon Relief Camp
Mobile No. 7399410553

Asma Khatun
Basugaon Relief Camp
Mobile No. 8011586989

Jarina Begum
Basugaon Relief Camp
Mobile No. 9864899688

Kazeema Begum
Basugaon Relief Camp
Mobile No. 9957719488

Almina Khatun
Bengtal Relief Camp
Mobile No. 9954665421

Almina Khatun
Bengtal Relief Camp
Mobile No. 9954665421

Kohinoor Begum
Bengtal Relief Camp
Mobile No. 9957795600

Rohima Bibi
Bengtal Relief Camp
Mobile No. 9678520565

Asma Khatun
Mojabari Relief Camp
Mobile No. 9678520565

# APPENDIX 4

## MISP Providers of Dhubri District

Samina Khatun

Kasuagaon, Satapara Relief camps

Jamina Bibi

Baghmari ME, LP & High Madrassa Relief camps

Kawshalla Das
Barkanda Relief camp

Mobile No. 8876781155

Afroja Bibi
Patimari, Sholmari Relief Camps
Mobile No. 9613383020

Rafika Khatun
Dhemdhema, Narikolkhua Relief Camps
Mobile No. 9859294242

Hasina Begum
Jogirmahal, Panchayat, Sr Madrassa Relief Camps
Mobile No. 9577802454

Khurshida Bibi
Bangalipara Relief Camp
Mobile No. 9859415683

Sajan Bibi
Hapapara Relief Camp
Mobile No. 9957163676

Shirijan Begum
Borkanda Relief Camp
Mobile No. 9435224701

## APPENDIX 5
### MISP Providers of Kokrajhar District

Doli Rani Brahma

Gambaribil Relief Camp

Mobile No: 9864945274

Korimon Bibi

Bhomrabil No. 1 Relief Camp

Mobile No: 8011312280

Lata Purkayasta

Srirampur Relief Camp

Mobile No. 9957094138

Nurjahan Bibi
Serphanguri ME Madrasa
Relief Camp
Mobile No. 9957106451

Puspa Kerketa
Kathalguri Relief Camp
Mobile No. 7896847185

Rimala Musahary
Cold Storage Relief Camps
Mobile No. 9577241237

Roshina Bibi
Tulsibil Relief Camp
Mobile No. 9707713776

Rude Musahary
Gothaibari Relief Camp
Mobile No. 9859843322

Srimoti Hembrom
Grahampur Relief Camp
Mobile No. 9678777026

## APPENDIX 6: Logical Framework Analysis – MISP Project

| | | | | |
|---|---|---|---|---|
| **Goal** | Priority sexual and reproductive health services to be made available and accessible to displaced women, girls and newborns in 65 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 65 camps | - 80% institutional delivery<br>- 100% of camp deliveries using safe kits<br>- 80% of births registered and immunised | - RH Officer's monitoring sheet<br>- Health centre records<br>- Key informant interviews (KIIs) | - Movement of pregnant women and their families to 1) another camp 2) villages<br>- Movement of MISP Provider to another camp or their village<br>- Pregnant women unwilling to go to the health centre outside the camp due to fear<br>- Health centres are unequipped to provide ANC or safe deliveries |
| **Outcome 1.1** | ***Registration***<br><br>By 20th October, all the pregnant women in 65 camps have been identified and registered by the camp's MISP provider | - At least one MISP Provider is recruited for 65 selected camps<br>- One RH Officer per district has been recruited and trained<br>- MISP Providers have received and registered (at DFY-TISS control room) a MISP box<br>- 70 MISP Providers have been trained on the use and distribution of contents in the MISP box<br>- All pregnant women in 65 camps have had at least one meeting with MISP provider for registration | - Signed ToR of MISP Provider and RH Officer<br>- Log book with MISP registrations<br>- Camp-wise registration form submitted by MISP Provider<br>- KIIs | |
| **Outcome 1.2** | ***Ante-natal Care***<br><br>By 30th November, all pregnant women in 65 camps have undergone at least one ante-natal check-ups (ANCs) | - 100% high risk pregnancies are identified and referred<br>- All registered women in the third trimester have received safe delivery kits<br>- All pregnant women in 65 camps have received Calcium and Iron-Folic Acid supplements for 3 months<br>- At least 80% of the registered pregnant women have received 2 TT vaccinations | - Camp-wise ANC form submitted by MISP Provider<br>- RH officer's monitoring sheet<br>- ANC card provided by health centre to pregnant women<br>- KIIs | |

| | | | | |
|---|---|---|---|---|
| **Outcome 1.3** | ***Delivery***<br><br>All registered pregnant women in their third trimester experience safe motherhood during and post delivery | - 100 % births in the next two months happen in the presence of a skilled birth attendant, and safe delivery materials<br>- All camp-births in 65 camps are registered within 10 days of birth<br>- All newborns in 65 camps are immunised within 10 days of delivery<br>- All registered pregnant women have been trained about the importance of exclusive breastfeeding<br>- All the newborns in 65 camps are fed colostrum for first three days after birth | - RH Officer's monitoring sheet<br>- Health centre records<br>- MISP Provider's records<br>- KIIs | |
| **Objective 2** | Effective, safe and quality institutional obstetric care is accessed by 80 % of the registered pregnant women in 65 camps | - 80% safe institutional deliveries<br>- 100% of high risk cases that get emergency obstetric facilities<br>- 80 % of newborns registered and immunised after birth<br>- Rate of infant and maternal mortality | - RH Officer's monitoring sheet<br>- Health centre records<br>- 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 65 camps have information about and access to nearest BEmOC[18] | - At least one BEmOC is identified for 65 camps each and assessed for suitability for provision of obstetric care<br>- At least one driver (ambulance or private) is identified for 65 camps each and linked with the respective MISP Provider | - District project coordinator's reports<br>- RH Officers reports<br>- Contact details of MISP Provider and Drivers | |
| **Outcome 2.2** | All registered high risk cases in 65 camps have information about and access to nearest CEmOC | - At least one CEmOC is identified for 65 camps each<br>- At least one driver (ambulance or private) is identified for 65 camps each and linked with the respective MISP Provider | | |

[18] 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)

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|---|---|---|---|---|
| **Objective 3** | Priority sexual health services are accessed by at least 80 % of women and girls of reproductive age in 65 camps | - Rate of contraceptive distribution<br>- Rate of sanitary material distribution | - MISP Provider's distribution log<br>- KIIs | |
| **Outcome 3.1** | 756 couples have access to relevant contraceptive measures | - 1316 packs of condoms have been distributed and received by 913 men<br>- 3060 strips contraceptive pills have been distributed and received by 1890 women<br>- 201 emergency pills have been consumed by women seeking them, in presence of MISP Provider | - MISP Provider's distribution log<br>- KIIs | |
| **Outcome 3.2** | 1211 adolescent girls and women have access to suitable materials for menstrual management | - 2014 sanitary pads distributed and received by girls and women of menstrual age<br>- 1800 meters of menstrual cloth distributed and received by girls and women of menstrual age<br>- 921 girls and women counseled for appropriate use and disposal of menstrual material | - MISP Provider's distribution log<br>- KIIs | |

## APENDIX 7: Details of MISP project in Chirang, Kokrajhar and Dhubri district from August 2012 to March 2013

| Serial No. | MISP outcome component | | | Total | Grand Total |
|---|---|---|---|---|---|
| 1 | Camps visited | | Chirang | 15 | 74 |
| | | | Kokrajhar | 14 | |
| | | | Dhubri | 45 | |
| 2 | Pregnant women registered | | Chirang | 396 | 1066 |
| | | | Kokrajhar | 320 | |
| | | | Dhubri | 350 | |
| 3 | Doctors involved | | Chirang | 6 | 15 |
| | | | Kokrajhar | 4 | |
| | | | Dhubri | 5 | |
| 4 | Deliveries enhanced | | Chirang | 115 | 241 |
| | | | Kokrajhar | 46 | |
| | | | Dhubri | 80 | |
| 5 | Delivery Kit distributed | | Chirang | 82 | 500 |
| | | | Kokrajhar | 105 | |
| | | | Dhubri | 313 | |
| 6 | General patients examined | | Chirang | 798 | 1713 |
| | | | Kokrajhar | 315 | |
| | | | Dhubri | 600 | |
| 7 | MISP Provider registered | | Chirang | 18 | 56 |
| | | | Kokrajhar | 13 | |
| | | | Dhubri | 25 | |
| 8 | MISP Box distributed | | Chirang | 29 | 86 |
| | | | Kokrajhar | 27 | |
| | | | Dhubri | 30 | |
| 9 | Medicines dispensed | Multivitamin cap (10 cap strip) | Chirang | 1676 | 3785 |
| | | | Kokrajhar | 678 | |
| | | | Dhubri | 1431 | |
| | | Calcium tab (15 tab strip) | Chirang | 1350 | 3259 |
| | | | Kokrajhar | 647 | |
| | | | Dhubri | 1262 | |
| | | Iron folic acid cap (15 cap strip) | Chirang | 1506 | 3481 |
| | | | Kokrajhar | 593 | |
| | | | Dhubri | 1382 | |
| | | OCP (1 cycle) | Chirang | 843 | 3088 |
| | | | Kokrajhar | 1190 | |

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|---|---|---|---|---|---|
| | | | Dhubri | 1055 | |
| | | Condoms (10s pack) | Chirang | 643 | |
| | | | Kokrajhar | 510 | |
| | | | Dhubri | 591 | |
| 10 | Families registered | | Chirang | 324 | 324 |
| | | | Kokrajhar | 0 | |
| | | | Dhubri | 0 | |
| 11 | Health talks | Personal and sanitary hygiene<br>ANC and PNC<br>Breast feeding<br>WASH<br>Family planning<br>RTI/STI | Chirang | 100 | 800 |
| | | | Kokrajhar | 300 | |
| | | | Dhubri | 400 | |
| 12 | Napkin distributed (1 pack each) | | Chirang | 1224 | 2492 |
| | | | Kokrajhar | 455 | |
| | | | Dhubri | 813 | |
| 13 | Markin clothes distributed (1 meter each) | | Chirang | 610 | 872 |
| | | | Kokrajhar | 152 | |
| | | | Dhubri | 110 | |
| 14 | Role plays conducted | | Chirang | 14 | 33 |
| | | | Kokrajhar | 4 | |
| | | | Dhubri | 15 | |