Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City, Jordan

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An Evaluation of the Minimum Initial Service Package

March 17-22, 2013

Boston University School of Public Health,
United Nations High Commissioner for Refugees,
United Nations Population Fund,
US Centers for Disease Control and Prevention,
Women's Refugee Commission

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List of Acronyms

ANC	Antenatal care
ARV	Antiretroviral
BPRM	US Bureau of Population Refugee and Migration
CDC	US Centers for Disease Control and Prevention
CERF	Central Emergency Response Fund
DFID	UK Department for International Development
DRC	Danish Refugee Council
ECHO	Humanitarian Aid and Civil Protection department of the European Commission
FGD	Focus group discussion
GBV	Gender-based violence
GFS	Gynécologie Sans Frontières
HFA	Health facility assessment
HIS	Health information system
HIV	Human Immunodeficiency Virus
IAFM	Interagency Field Manual
IAWG	Interagency Working Group on Reproductive Health in Humanitarian Crises
IDP	Internally displaced persons
IEC	Information education campaign
IUD	Intrauterine device
JHAS	Jordan Health Aid Society
JWU	Jordanian Women's Union
KII	Key informant interviews
MMR	Maternal mortality ratio
MCH	Maternal and child health
MISP	Minimum initial service package
MOH	Ministry of Health
MFH	Moroccan field hospital
NGO	Nongovernmental organization
NRC	Norwegian refugee council
OCP	Oral contraceptive pill
RH	Reproductive health
RMS	Royal Medical Service
PEP	Post-exposure prophylaxis
PHC	Primary health care
PLHIV	Persons living with HIV
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
SDC	Swiss Agency for Development and Cooperation
STI	Sexually transmitted infection
SV	Sexual violence

UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WRC	Women's Refugee Commission

Executive Summary

Introduction

The civil war between the government of Syria and rebel forces, initiated in mid-March 2011, resulted in an estimated one million refugees fleeing Syria to neighboring countries, including Lebanon, Jordan, Turkey, Iraq and Egypt, by March 2013. Of this total, some 355,493 were registered or awaiting registration in Jordan in mid-March, according to United Nations High Commissioner for Refugees (UNHCR).

The status of Syrian women's reproductive health (RH) has suffered due to the destruction in the health infrastructure and uncertain access and availability of services. Therefore, documentation is urgently needed on the type and amount of RH services that are currently available in Jordan in order to keep up with the growing demand for these services as the refugee population continues to swell.

Evaluation purpose

The Minimum Initial Service Package (MISP), a standard of care in humanitarian emergencies, is a coordinated set of priority activities designed to prevent excess newborn and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive RH services.

As part of the Global Evaluation of Reproductive Health in Crises for the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, representatives from Boston University School of Public Health, the US Centers for Disease Control and Prevention (CDC), United Nations Population Fund (UNFPA) and the Women's Refugee Commission (WRC) conducted an evaluation of the MISP from March 17-22, 2013. The purpose of this study was to examine to what extent the MISP services were in place for Syrian refugees living in Jordan in order to improve the response and meet the RH needs of the refugees.

Methods

The MISP study team used both quantitative and qualitative technique methods, including focus group discussions (FGD), key informant interviews (KII) and health facility assessments (HFA). Two Syrian refugee populations were included, one living in Zaatri refugee camp (n=164,365) and one in Irbid Governorate (n=40,339). FGDs among the Syrian refugee population (women and adolescent girls, aged 15-49 years) were conducted to assess knowledge and attitudes of RH and access to RH services. KIIs (with health directors, managers, physicians and nurses) assessed RH policy issues and guidelines initiated and supported by the Ministry of Health (MOH) and by relief agencies including the UN High Commissioner for Refugees (UNHCR) and UNFPA. Health facility assessments were conducted in collaboration with medical doctors, nurses and other facility representatives who serve the needs of the refugee population in primary health care clinics, hospitals and referral centers.

Key Findings

- Key informants were aware of the five MISP objectives . However, there was very limited understanding of the additional priorities of the MISP such as ensuring contraceptives are available to meet the demand; treatment for sexually transmitted infections (STIs) is available to people

presenting with symptoms; antiretrovirals (ARV) are available to current users; and menstrual hygiene supplies are available. .

- A number of key elements to support implementation of the MISP were in place, including a dedicated lead agency to support MISP implementation within the health sector, a focal point for RH coordination, regular RH coordination meetings in Amman and Zaatri camp, and RH kits and supplies, and funding for MISP implementation were noted. However, key informants reported that RH coordination was insufficient for the urban areas; not all key stakeholders participated in coordination; protocols for care for survivors of sexual violence were incomplete or STIs did not exist; and that key informants would like UNFPA to share the information that it collects from stakeholders among stakeholders.
- Syrian refugee women discussed security fears that they had in relation to using the latrines at night due to a lack of lighting. While services existed to manage sexual violence (SV), they were limited, and community and provider knowledge of the services was low.
- Safe blood transfusion practices and standard precautions were in place; however, condom distribution was limited.
- Clinical services to prevent excess maternal and newborn morbidity and mortality were in place and utilized.
- Planning was underway for expanding to have more comprehensive RH services.
- Baseline data collection and routine monitoring of RH indicators were limited.
- In terms of additional priorities to the MISP, modern methods of family planning was available (although condom distribution limited), syndromic treatment for people presenting with symptoms of STIs was not available, the situation of continuing ARVs for refugees already on ARVs was unknown and menstrual hygiene supplies were insufficient.
- Although there was a high level of specialty clinical care available, primary care clinics and outreach to the community was limited.
- Refugee women and adolescent girls that participated in the FGDs perceived clinical services negatively and they complained about not being included in the humanitarian relief response.
- MISP contingency plans were established but not activated. Jordan has undertaken some activities on disaster risk reduction although it was unclear if there have been initiatives to address health and RH.
- Barriers to MISP implementation included a lack of adequate staffing in urban areas and of clear RH protocols, particularly on care for survivors of SV, and management of STIs); less focus by the RH working group in Amman on urban populations compared with the camp population; and lack of capacity to implement the MISP contingency plan.

Key Recommendations

There are a number of interventions that can be implemented immediately and include the following:

- Strengthen coordination in Amman to address the RH needs of urban refugee populations; facilitate the participation of key stakeholders such as the MOH, WHO, local NGOs, unfunded partners and inter-agency protection and gender-based violence (GBV) working groups in both Amman and Zaatri meetings; address RH protocols, particularly, finalize the clinical care for SV survivors protocol; identify STIs management and protocols for referral of and caring for person living with HIV (PLHIV); improve data collection and use of data for action; and support information, education and

communication (IEC) campaigns on the benefits to seeking care and the availability, location and hours of services in both urban areas and Zaatri refugee camp.

- Improve free condom distribution with sensitivity to cultural norms.
- Scale up the availability of clinical care for survivors of SV at service delivery sites and consider integrating the protocol into the Family Protection Department where forensic doctors are available and could be trained.
- Strengthen community outreach, participation and services along with information and education, including for adolescents and people with disabilities, by utilizing existing IEC campaign resource materials on the MISP and family planning, and ensuring all service delivery is physically accessible and inclusive of people with disabilities.
- Improve the health care environment with adequate staffing, particularly female doctors and by addressing the interactions between health care providers and Syrians so that Syrian women feel comfortable while seeking care. Advocate for Syrian health care providers to be involved in providing health care services to the refugees.

Conclusion

In spite of the steady influx of refugees into Jordan that has strained the resource capacity of this humanitarian emergency response, the agencies that provide RH services have been able to implement the MISP for the most part, although there is need for some key improvements. In this setting, the study team found some challenges, such as balancing the increasing demands for services while maintaining quality and managing information flow among multiple stakeholders. It is vital to stay informed and listen to the needs of Syrian refugees in Jordan to improve RH outcomes in the months to come.

1. Introduction

The Inter-Agency Working Group (IAWG) on Reproductive Health in Crises works to address the reproductive health (RH) needs of those displaced by conflict and natural disasters. IAWG members include United Nations (UN) and governmental agencies, nongovernmental organizations (NGOs), universities and donors. The IAWG was formed in 1995 and currently has 1,500 individual members from 450 agencies worldwide. From 2012 through 2014, the IAWG is reviewing the state of RH services for populations affected by crises worldwide. The last review took place between 2002 and 2004; IAWG is interested in understanding what has changed, as well as how services can continue to be improved for communities in an emergency. [1]

As part of the current Global Evaluation of RH, members of the IAWG, representing Boston University School of Public Health (BUSPH), the US Centers for Disease Control and Prevention (CDC), United Nations Population Fund (UNFPA) and the Women's Refugee Commission (WRC), conducted an assessment of the Minimum Initial Service Package (MISP) of RH in one urban area (Irbid City) and one refugee camp (Zaatri) in Jordan from March 17-22, 2013. The MISP is a coordinated set of priority activities designed to prevent excess newborn and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive RH services. The purpose of this evaluation was to examine to what extent the MISP RH services were in place for Syrian refugees living in Jordan in order to address gaps in services and improve response and scaling-up of services.

1.1 Overview of reproductive health in Jordan

In general, there is good access to health services in Jordan.[2] There are 12 health centers per 100,000 persons, with an average travel time of 30 minutes to the nearest health center.[3] The health sector also consists of 24.5 physicians and 29.4 nurses per 10,000 persons, which provides reasonable coverage for the Jordanian population.[4] The Ministry of Health, (MOH) also provides "free primary health care [PHC] services, such as maternal and child health, immunization and school health services."[5]

The Jordanian Government has established policies around the provision of reproductive health education and services. Reproductive health and family planning services are integrated into the PHC system;[6] however, reproductive health and family planning education and services are provided to men and women only after they are married.[7] The MOH, in collaboration with the Health Systems Strengthening (HSS) and UNFPA, created the *Reproductive Health/Family Planning Clinical Guidelines* to establish standards around reproductive health, family planning and maternal and newborn care.[8]

1.1.1 Maternal and newborn health

Jordan's Maternal Mortality Ratio (MMR) has been declining steadily since 1990 and is currently at 59 per 100,000 live births.[9] Jordan has clinical guidelines around the implementation and delivery of maternal and

[1] UNFPA, *Interagency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons,* November 2004. http://www.iawg.net/resources/2004_global_eval/, last accessed September 18, 2013.
[2] World Health Organization (WHO). "Jordan Reproductive Health Profile: 2008." http://wrc.ms/18yU3ul, last accessed September 18, 2013.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Issa S. Almasareweh, "Adolescent Reproductive Health in Jordan: Status, Policies, Programs, and Issues," *Policy Project* (January 2003): 1.
[8] The Hashemite Kingdom of Jordan Ministry of Health. *Reproductive Health/Family Planning Clinical Guidelines.*
[9] World Bank. http://siteresources.worldbank.org/INTPRH/Resources/376374-1282255445143/Jordan52511web.pdf.

newborn care in the following areas: antenatal care (ANC), high-risk pregnancy, postnatal care and post-abortion care.[10] Virtually all pregnant women in Jordan (99%) receive ANC and have their births attended by skilled medical personnel.[11]

Abortion in Jordan is illegal unless justified by a medical reason.[12] The *Reproductive Health/Family Planning Clinical Guidelines,* used by maternal and child health and primary health care providers, outlines protocols for first aid for complications of abortion, including post-abortion counseling.[13] An abortion induced for nonmedical reasons is categorized as a "criminal abortion" in the guidelines.[14]

1.1.2 Family planning

The Jordanian MOH has established guidelines around the provision of family planning services by health care providers in the following areas: counseling for reproductive health and family planning, family planning methods, and the management of infertility.[15] The *Reproductive Health/Family Planning Clinical Guidelines* outlines permanent, temporary and emergency family planning methods and provides a description of the method, how to use it, who should use it, side effects and effectiveness.[16] The use of emergency contraceptive pills (ECP) is also described in the family planning methods with instructions about the prescribed dosage per drug and how and when to start temporary family planning methods after its use.[17] The manual provides information on the combined oral contraceptive pills for ECP;[18] however, there is no registered product for ECP in Jordan.[19]

There are high levels of contraceptive knowledge among women in Jordan (99% of married women know all modern methods and 94% know where to receive contraception), yet the modern contraceptive prevalence rate remains low[20] at 59.3%.[21] Of the women who are using some form of contraception, 38% are using the intrauterine device (IUD), 14% the oral contraceptive pill (OCP) and 16% are using another modern method.[22] In comparison data from 2002 in Syria shows a contraceptive prevalence rate of 54%. The main form of method is the IUD followed by oral contraceptive pills, 43% and 26% respectively. In addition, most couples make a joint decision to use a modern method and use for spacing childbirth, 63% and 73%, respectively.[22] The Jordanian Government developed the *Reproductive Health Action Plan* to meet the contraception and family planning needs of Jordanians.[23]

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[10] The Hashemite Kingdom of Jordan Ministry of Health. *Reproductive Health/Family Planning Clinical Guidelines.*
[11] World Bank. http://siteresources.worldbank.org/INTPRH/Resources/376374-1282255445143/Jordan52511web.pdf.
[12] S. Almasareweh, "Adolescent Reproductive Health in Jordan: Status, Policies, Programs, and Issues," *Policy Project* (January 2003): 11.
[13] The Hashemite Kingdom of Jordan Ministry of Health. Reproductive Health/Family Planning Clinical Guidelines.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] International Consortium for Emergency Contraception. http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/jordan/.
[20] Japan International Cooperation Agency, *Comprehensive Study on Family Planning and Women in Development Projects in Jordan: Analysis from a Capacity Development Perspective* (November 2006). http://jica-ri.jica.go.jp/IFIC_and_JBICI-Studies/english/publications/reports/study/capacity/200611/pdf/200611.pdf, last accessed September 18, 2013.
[21] World Bank, http://siteresources.worldbank.org/INTPRH/Resources/376374-1282255445143/Jordan52511web.pdf.
[22] Farzaneh Roudi-Fahimi, Ahmed Abdul Monem, Lori Ashford, and Maha El-Adawy, *Women's Need for Family Planning in Arab Countries* (UNFPA Arab States Regional Office. July 2012). http://www.unfpa.org/worldwide/family-planning-arab-countries-2.pdf, last accessed September 18, 2013.
[23] USAID, Stories *from the Field: Jordan Moves Toward FP Self-sufficiency*, (December 2006). http://www.healthpolicyinitiative.com/Publications/Documents/JOR_CS%20MoU%20Dec%202006_FINAL.pdf, last accessed September 18, 2013.

1.1.3 HIV/ AIDS

Jordanian law states that refugees who are HIV positive can be deported, which may reduce HIV testing and availability of treatment among refugee populations.[24]However, Jordan has a strong political commitment to reduce HIV/AIDS transmission among their citizens.[25] A national strategy to combat HIV/AIDS was introduced on World AIDS Day in 2006 by her Royal Highness Princess Mona Al-Hussein.[26] The MOH runs a hotline that provides free counseling and testing for people living with AIDS[27] and "HIV testing has been available in Jordan since 1987."[28] In addition to counseling and testing, the Jordanian Government provides free ARVs for both males and females.[29] Jordan's national health insurance policy was also amended to provide coverage for ARVs and treatment for any opportunistic infection.[30] Although treatments are provided without discrimination, women still face barriers to receiving care due to their desire to travel outside of their communities for treatment so as to not be recognized.[31]

1.1.4 Gender-based violence

There is no unified policy in Jordan to handle gender-based violence (GBV) or to care for survivors of sexual violence,[32] but there are some policies and programs to help survivors of domestic violence. In 2000 the National Committee for Family Safety and the Unit of Family Protection was created to monitor and protect vulnerable family members who experience domestic violence.[33]

1.2 Syrian refugee population in Jordan

At the time of this MISP evaluation in mid-March 2013, civil unrest in Syria that started in March 2011 had resulted in two million internally displaced persons (IDP) and four million people in need of humanitarian assistance. Further, more than one million Syrians had fled the violence and its aftermath to neighboring countries, including Jordan, Lebanon, Iraq, Turkey and countries in North Africa.[34]

There were also an estimated total of 355,493 Syrian refugees in Jordan with 298,025 registered by the United Nations High Commissioner for Refugees (UNHCR) and 57,468 awaiting registration at the time of the evaluation. An overwhelming majority of unregistered refugees were residing in urban areas. The majority (55.2 %) of registered refugees were residing in Zaatri camp, with an additional 47,087 (15.2%) and 39,339 (13.2%) residing in Irbid and Amman governorates, respectively. Refugee influxes continued at an average of more than 1,500 arrivals per day during March 10 -17, 2013. Within that time frame, females aged 18-35 years represented the majority of new arrivals (at nearly 30% of the total registered), with females of all ages comprising 53% of those registered during that time.[35]

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[24] UNHCR Standard Operating Procedures for Prevention of and Response to SGBV, Amman, Jordan UNHCR. May 6, 2009.
[25] Nisreen Qatamish and Jenine Jaradat, *UNGASS Country Report Hashemite Kingdom of Jordan*, (January 2008): 19. http://data.unaids.org/pub/report/2008/jordan_2008_country_progress_report_en.pdf, last accessed September 18, 2013.
[26] Ibid.
[27] Issa S. Almasareweh, "Adolescent Reproductive Health in Jordan: Status, Policies, Programs, and Issues," *Policy Project* (January 2003): 9.
[28] Nisreen Qatamish and Jenine Jaradat, *UNGASS Country Report Hashemite Kingdom of Jordan*, (January 2008): 27.
[29] Ibid. 28.
[30] Ibid.
[31] Ibid.
[32] Women's Refugee Commission, *Reproductive Health in Jordan: Follow-up Report*, (2009): 6. http://wrc.ms/1f7pgfa, last accessed September 18, 2013.
[33] Issa S. Almasareweh, "Adolescent Reproductive Health in Jordan: Status, Policies, Programs, and Issues," *Policy Project* (January 2003): 12.
[34] OCHA Syria Humanitarian Bulletin Issue 21, 5 March– 18 March, 2013. http://www.unocha.org/crisis/syria, last accessed on September 13, 2013.
[35] UN Weekly Inter-agency Situational Report JORDAN, Syrian Refugee Response Update: March 10-17, 2013.

Almost 30% of this population, or 74,493[36], are women of reproductive age (WRA). Due to the disruption in health services in Syria, many refugee women use refugee clinics for overdue medical attention. In camps set up in areas bordering Syria, the MOH, UNHCR, UNFPA, NGOs and other agencies assist in providing lifesaving RH care services and psychosocial support. Relief agencies ensure that the specific needs of women and girls are factored into the humanitarian response in the region. It is estimated that one in five women of childbearing age is likely to be pregnant.[1] Conflict typically puts these women and their newborns at risk of poor health outcomes due to deteriorating health services. In Syria and in neighboring countries, UNFPA deployed emergency supplies and equipment to make childbirth safer and to support medical interventions.

1.2.1 Reproductive health context

A literature review undertaken by the WRC prior to this evaluation showed that Syrian refugees who are registered with UNHCR are able to access public health services for free in Jordan.[37] However, due to limited information regarding the current situation for Syrian refugees living in Jordan, especially with respect to their ability to access RH services, some studies on the Iraqi refugee population living in Jordan were examined. For example, Iraqi refugees were not legally recognized by the Jordanian Government.[38] Jordan also did not have a national strategy to provide comprehensive assistance from state, religious and community-based organizations.[39] Humanitarian agencies that were not already active in Jordan faced resistance from the Jordanian government to provide social and health services to the Iraqi refugees out of fear that this would only encourage Iraqis to stay in Jordan instead of returning to their home country.[40] As a result, organizations that already existed, like a Catholic-based international organization, were one of the few international aid organizations available to provide services.[41] And while these Catholic faith-based organizations provided basic health services, they did not provide any support around family planning or emergency contraception and no "maternal health services to pregnant women and girls who could not produce a marriage certificate."[42] A government-run health clinic was also available, but due to high demand, the wait for a visit was up to two months.[43] There was a demand for family planning among Iraqi refugees that went unmet; "One-quarter of Iraqi women reported a need for contraception, citing costs and access to reproductive health services as key barriers."[44] Iraqi refugees are treated as uninsured Jordanians when accessing health services in the public sector and while they are able to attend public clinics, the high cost for health services for the uninsured makes it difficult for refugees to cover their co-payments and medications.[45] A study conducted by UNHCR, the WRC and the CDC also found that out of seven clinics visited in Amman, three did not provide family planning services.[46] Examining the experiences of Iraqi refugees provides a context for understanding some of the challenges that Syrian refugees may currently be

[36] Syrian Refugee Crisis Data. http://data.unhcr.org/syrianrefugees/country.php?id=107.
[37] Un Ponte Per. *Comprehensive Assessment on Syrian Refugees Residing in the Community in Northern Jordan*. (August 2012). http://wrc.ms/19edOK3.
[38] Sarah K. Chynoweth, "The Need for Priority Reproductive Health Services for Displaced Iraqi Women and Girls," *Reproductive Health Matters*, vol. 16, no. 31, 2008: 95. http://www.rhmjournal.org/article/S0968-8080(08)31348-2/fulltext, last accessed September 18, 2013.
[39] Ibid.: 98.
[40] Ibid.: 98.
[41] Ibid.: 95.
[42] Ibid.: 95.
[43] Ibid.: 95.
[44] Scott Harding and Kathryn Libal, "Iraqi refugees and the humanitarian costs of the Iraq war: What role for social work?" *International Journal of Social Welfare*, 21, (2012): 98. http://wrc.ms/169Qlxs, last accessed September 18, 2013.
[45] Susan F. Martin and Abbie Taylor, *Urban Refugees in Amman: Mainstreaming of Healthcare*, Institute for the Study of International Migration, 2012. http://wrc.ms/1aLfvAy, last accessed September 18, 2013.
[46] UNHCR, the Women's Refugee Commission, CDC, *Baseline Study: Family Planning Among Iraqi Refugees in Amman, Jordan,* (2011). http://wrc.ms/1epvJDE, last accessed September 18, 2013.

facing in Jordan; however, the major difference being that Syrian refugees are recognized by the Jordanian MOH and government at large.

1.2.2 Disaster risk reduction

The Swiss Agency for Development and Cooperation (SDC) has been providing services to refugee populations in Jordan since 2001, when "Switzerland and Jordan signed an agreement regarding cooperation in Disaster Risk Reduction and Preparedness."[47] The SDC has supported and is currently supporting a number of programs to improve access to water and education for refugee populations;[48] however, none of these efforts focus specifically on the basic health and reproductive health for Syrian refugees. While refugees are able to access public hospitals and health centers in Jordan, they face higher fees, which could limit their ability to access these services.[49]

1.3 Minimum Initial Service Package

In order to provide effective RH care services to populations in crisis the MISP was established by the IAWG as a set of priority activities to be taken in a coordinated manner by trained staff at the onset of an emergency.[50] When implemented in the early days of an emergency, the MISP is intended to save lives and prevents illness, especially among women, newborns and girls. MISP includes priority actions and guidelines to: 1) conduct coordination; 2) prevent and respond to sexual violence; 3) reduce HIV transmission; 4) prevent excess maternal and newborn morbidity and mortality; and 5) plan for comprehensive reproductive health (integrated into primary health care (see Appendix D).

To support implementation of the MISP, UNFPA designed a pre-packaged set of Inter-Agency RH kits that contain essential drugs, supplies and equipment.[51] The Inter-Agency RH kits are intended for the early stage of an emergency as the contents of the kits are designed for three months and for a particular number of people. The emergency RH kits have been formulated so that each kit responds to the priority activities of the MISP, such as rape medical treatment kits, blood transfusion kits, clean delivery kits and midwife delivery kits.

Previous assessments of MISP implementation were conducted in Pakistan (2002), Chad (2004), Indonesia (2005), Kenya (2007) and Haiti (2010). Key findings from those assessments showed gaps such as poor overall coordination, lack of availability of standard protocols and procedures for health care providers, lack of donor support, inadequate knowledge of MISP priorities and activities, poor quality and/or availability of referral services for emergency obstetric care, and inadequate monitoring of service delivery.[52,,53,54] The assessments also revealed wide variations within camps and IDP settlements with regard to the availability

[47] Swiss Agency for Development and Cooperation (SDC). http://www.swisscooperation.admin.ch/syria/en/Home/SDC_in_the_Region/SDC_Jordan.
[48] Ibid.
[49] U.S. Committee for Refugees and Immigrants, *World Refugee Survey* (2009) http://www.refugees.org/resources/refugee-warehousing/archived-world-refugee-surveys/2009-wrs-country-updates/jordan.html.
[50] Minimum Initial Service Package for RH in Crisis Situations. http://misp.rhrc.org/, last accessed on January 30, 2013.
[51] Inter-Agency RH Kits for Use in Crisis Situations 5th edition 2010.

http://www.unfpa.org/webdav/site/global/shared/procurement/06_for_customers/02_gccp-erhkits/RH%20Kits%20Manual%202011.pdf, last accessed on January 30, 2013.
[52] Women's Commission for Refugee Women and Children, *Still in Need: Reproductive Health Care for Afghan Refugees in Pakistan*. New York, October 2003. http://wrc.ms/1epvY1g, last accessed September 18, 2013.
[53] Women's Refugee Commission/UNFPA, *Lifesaving Reproductive Health Care: Ignored and Neglected, Assessment of the Minimum Initial Service Package (MISP) of RH for Sudanese Refugees in Chad*, New York, August 2004. http://wrc.ms/1eQM9Ww, last accessed September 18, 2013.
[54] Women's Refugee Commission, *Assessment of the Minimum Initial Services Package in Tsunami-affected areas of Indonesia,* New York, March 2005. http://wrc.ms/1f7rz1O, last accessed September 18, 2013.

of trained staff and the supplies needed for the prevention and response to sexual violence, HIV prevention, and maternal and newborn morbidity and mortality reduction (see Appendix D). However, significant progress has been made in MISP policy and guidelines at the global level, such as the inclusion of the MISP as a standard of care in the *Sphere Minimum Standards in Humanitarian Response*[55] and in the Global Health Cluster *Health Cluster Guide*.[56]

1.4 Purpose of the evaluation

In general, the operational evidence to inform humanitarian responders in MISP implementation is insufficient and little is known about how standards in RH services are in fact implemented in a crisis setting, which factors facilitate or inhibit implementation, and to what extent MISP implementation is accelerated when resources become available. The purpose of this study was to examine to what extent the MISP services were in place for Syrian refugees living in Jordan in order to improve the response and meet the RH needs of the refugees.

Objectives

The objectives of this evaluation of the MISP were to:

- assess the extent to which MISP has been implemented
- identify the availability, accessibility and use of MISP services
- describe the facilitating factors and barriers to the implementation of MISP services
- describe demographic characteristics of the population and collect existing data on RH indicators collected at health facilities.

Methods

3.1 Study design

The evaluation was a multi-method approach consisting of key informant interviews (KIIs), health facility assessment (HFAs), and focus group discussions (FGDs). The evaluation was conducted from March 17--22, 2013. Members of the study team were epidemiologists from the CDC, an Assistant Professor of International Health from BUSPH, a senior Technical Adviser on RH in Emergencies from the UNFPA and the Director of the Reproductive Health Program, WRC. In addition, seven local study staff that were recruited by UNFPA and UNHCR assisted with translation (n=3), facilitating (n=2) and recording FGDs (n=2), and assisting with the HFAs (n=2). Evaluation sites included Zaatri Refugee Camp and facilities in Irbid and Mafraq cities that were providing services to urban refugees not living in Zaatri camp.

Prior to pilot testing and data collection, the study team held a meeting with key partners to introduce the purpose of the study and to provide training for field coordinators, translators and note takers on study purpose, objectives, methods, recruitment procedures, study instruments, data collection techniques and study logistics. The meeting allowed staff from the partner agencies to provide additional contextual

[55] Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. http://www.sphereproject.org/handbook/, last accessed September 18, 2013.
[56] Inter-Agency Standing Committee (IASC) Global Health Cluster, *Health Cluster Guide*, 2009. http://whqlibdoc.who.int/hq/2009/WHO_HAC_MAN_2009.7_eng.pdf, last accessed September 18, 2013.

information on the current situation, as the situation was very fluid. Lastly, the evaluation was reviewed and approved by the CDC and determined to be program evaluation and not human subjects research. Preliminary findings of this evaluation were presented to stakeholders as immediate feedback on the status of RH program for Syrian refugees living in Zaatri camp and Irbid city non-camp refugees. The findings from this evaluation did not go beyond the scope of the refugee population and were used to improve RH programs and service.

3.2 Study measures

The study included tracking, documenting and summarizing the inputs, activities, outputs and short-term outcomes of the MISP implementation. Our choices of measures used in this evaluation were based on the universal MISP objectives and priority activities (see Appendix A):

- **Coordination of the MISP** included an assessment of meetings held on RH, use of RH protocols and guidelines, funding activities, RH kits supplies and use, community participation and access to RH services.
- **Prevent and manage the consequences of sexual violence (SV)** included an assessment of measures put in place to protect affected populations, particularly women and girls from SV, age at marriage, clinical care available for survivors of rape, and awareness of available services.
- **Reduce the transmission of HIV** was measured on safe blood transfusion practices, facilitate and enforce respect for standard precautions, and condom availability.
- **Prevent excess maternal and newborn morbidity and mortality** included measures of the availability of emergency obstetric care (EmOC) and newborn care services, availability of skilled attendants and supplies for normal births, management of obstetric and newborn complications, recognition of danger signs during pregnancy/delivery and in newborns, establishment of a referral system to facilitate transport and communication from the community to the health center and between health center and hospital, and provision of clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.
- **Plan to integrate comprehensive RH services into PHC** included collection of existing background data, identification of suitable sites for future service delivery of comprehensive RH services, refugee perceptions of health care services, and provision of community education about the benefits of obtaining RH services and how to access such services.
- **Additional priorities of MISP** measured were to ensure contraceptives were available to meet demand, syndromic treatment of sexually transmitted infection (STIs) is available to patients presenting with symptoms, antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for the prevention of mother-to-child transmission (PMTCT).
- The study team also measured integration of RH into disaster risk reduction (DRR) and emergency preparedness that included an assessment of procuring and pre-positioning RH supplies and kits and training of responders.
- Lastly, general concerns among Syrian refugee women were assessed, including basic needs, education and livelihoods.

3.3 Data Collection Procedures

3.3.1 Key informant interviews

The study team purposively selected key informants (managers, physicians, nurses) from a UNHCR and UNFPA mapping of health and RH partners shared in February 2013. Invitations to participate in a KII were sent via email to the Jordanian MOH, UN agencies that were based in Jordan, international and local NGOs health and RH coordinators, and program managers and directors. The KIIs were scheduled prior to the period of in-country evaluation and confirmed once the study team was in-country. Informed consent was obtained for all KIIs. Key informant meetings were confirmed by email or telephone upon arrival in Jordan.

The questionnaire comprised of both open-ended and closed-ended questions and was modified from a questionnaire used in past MISP studies (Appendix B)[57, 58, 59]. Three pilot tests of the study tool were undertaken, with one in Jordan. A member of the study team conducted the interviews in English and recorded notes during the interview. Interviews took on average one hour

3.3.2 Health facility assessments

A list of facilities was compiled for Zaatri camp and Mafraq and Irbid cities that provided RH services to the Syrian refugees by level (primary, secondary and tertiary). Each facility was informed and UNFPA Jordan sought authorization prior to the evaluation. The study team visited facilities were beforehand to review the assessment procedure and provide an opportunity for questions/answers. During the assessment, one relevant staff of the facility assisted the assessment teams. The HFAs consisted of semi-structured interviews with health facility representatives and used a standardized check list for availability of equipment and supplies at the various departments of the facility. The HFA took about 60-90 minutes with questions simultaneously translated during the interviews. The interview guide and check lists were adapted from the evaluation tools used by Reproductive Access Information and Services in Emergencies (RAISE)[60] (Appendix C).

3.3.3 Focus group discussions

Partner relief agencies that worked with the Syrian refugees recruited all the participants for the FGDs. They selected a purposive sample of female youth (18-24 years of age) and older women (aged 25-mid-70's). In Zaatri camp, the groups included those that lived near (within 20 minutes walking distance) and farther away (greater than 20 minutes walking) from health facilities, and newly arrived refugees (who had arrived within the past two months). Discussions were held in private rooms within health clinics in the camp. Discussions in the urban areas were held in private rooms hosted by local partner nongovernmental organizations. The tool used in this evaluation was modified from a tool used in prior MISP evaluations (Appendix D). The FGDs were conducted in Arabic, with translation occurring during the discussions so that the study team member who was supervising the activity could clarify information, if needed or ask additional questions. Each FGD had one to two note takers recording the participants' responses. Verbal informed consent was obtained

[57] Inter-agency MISP assessment conducted by CARE, International Planned Parenthood Foundation, Save the Children and Women's Refugee Commission, *Priority Reproductive Health Services in Haiti,* February 2011. http://wrc.ms/19efjaW, last accessed September 18, 2013.
[58] Women's Refugee Commission, *Reproductive Health Coordination Gap, Services Ad Hoc: Minimum Initial Services Package Assessment in Kenya*, September 2008. http://wrc.ms/18btFZG, last accessed September 18, 2013.
[59] Women's Refugee Commission*, Reproductive Health Priorities in an Emergency, Assessment of the Minimum Initial Services Package in Tsunami-affected Areas in Indonesia*, February-March, 2005.
[60] RAISE Initiative. *Needs Assessment of Reproductive Health Care*. New York: RAISE Initiative, 2008.

from all FGD participants both for their participation in the group and permission to take written notes during the group (Appendix D).

The FGD tools were translated and back-translated from English to Arabic and back to English. The study team pilot tested the FGD methods and modified data collection procedures and study instruments as needed.

3.4 Data analysis procedures

3.4.1 Key informant interviews

The global study member who conducted the KII interviews used a qualitative approach to discern themes and patterns in the data. Data were reviewed across questions and study sections including: MISP background and knowledge; DRR; emergency preparedness and response; and by agency type to identify any specific patterns. Quantitative data from the KIIs were analyzed descriptively and entered into an Excel spreadsheet. The KII interview data were compared with the data from the FGDs to examine similarities and differences. KII data were used to supplement and verify the FDG group data.

3.4.2 Health facility assessments

Data from the HFAs were entered into tables and presented as simple numeric data providing descriptive analysis and results; as the number of facilities visited in each setting (Zaatri camp, Irbid city and Mafraq hospital) were too small to use percentages. Quantitative data entry from the HFA was also done in an Excel spreadsheet.

3.4.3 Focus group discussions

Following the completion of all FGDs, the supervisory member of the study team reviewed each question with the facilitator and note taker(s) to supplement any data that the note takers(s) failed to record. At the end of each day, the study team member held a debriefing with the field team members to assess any problems or issues related to questions not being understood, ease of interviews, congruence with language translation, and any other management issues that might impact analysis of the data. Initial data analysis began in these debriefing sessions, which allowed the field team and study team member to identify themes and constructs from the data.

Notes from the focus group sessions were translated while in the field and then typed into text files. The study team members coded text into broad themes and sub-topics and discerned patterns emerging from the data. A question-by-question approach was used to summarize participant comments into multiple themes. Additionally, nonverbal observations and relevant off-topic comments were included as background contextual material. During the coding process, data were continuously reviewed, emerging patterns noted, and relationships between constructs and themes identified. Findings were analyzed within and between the two geographical areas (Zaatri camp and Irbid city) by age, distance to health facilities and length of time since arrival. The two study team members who coded the FGD data met on numerous occasions to review the themes and gain consensus on interpretation of the results. Data were compared across sites, across age groups and across registered/unregistered status.

3.5 Ethical considerations

3.5.1 Informed consent

The respondents in the FGDs, KII and HFA were asked to participate and were read a consent form (see Appendices B, C and D). Only those who gave informed consent were interviewed. Verbal permission was obtained from the FGD participants and written and/or verbal permission was obtained from those participating in the KII and HFA.

3.5.2 Confidentiality

Only evaluation personnel organizing the FGDs and KIIs had access to identifying information, such as contact information, as this was necessary to communicate about the timing and location of the study. All instruments, as well as notes from FGDs and KII, were stored under lock and key during the evaluation and in the researchers' home agency offices during analysis. No identifying information was written down. The analyzed qualitative data were reported as aggregate consensus data whenever possible. Verbatim quotes were used to illustrate concepts but those statements were written in a manner so as to not identify any individual.

4. Results

The MISP evaluation findings are presented in eleven sections:

1. Description of sample
2. MISP awareness and knowledge
3. Coordination of the MISP
4. Prevent and manage the consequences of SV
5. Reduce the transmission of HIV
6. Prevent excess maternal and neonatal morbidity and mortality
7. Plan to integrate comprehensive reproductive health into primary health care
8. Additional priorities of the MISP
9. Integration of reproductive health into disaster risk reduction and emergency preparedness
10. Facilitating factors and barriers to the implementation of the MISP
11. General concerns among Syrian refugee women

4.1 Description of sample

This section describes the sample used in the evaluation for the KII, HFA and FGD.

4.1.1 Key informant interviews

The study team conducted 11 KIIs with staff working as program directors, coordinators and managers in health, including RH and protection, in response to the Syrian refugee crises in Jordan. On average, respondents had been working with their organizations for approximately two years, and on the Syrian refugee crisis specifically, for just over nine and one half months. In addition, six informal meetings were held with some participants that focused on the agencies' overall work and, as much as possible, on RH services for Syrian refugees. Lastly, one interview combined an informal meeting and a structured KII.

4.1.2 Health facility assessments

Five health facilities were visited in Zaatri camp, one hospital in Mafraq city, and seven facilities in Irbid. Mafraq hospital was estimated to serve a total population of about 300,000, including Syrian refugees. It was not possible to establish the exact numbers of Syrian refugees served by Mafraq hospital because the facility did not collect these data (see Tables 1 and 2).

Table 1. Health facilities assessed at 5 facilities in Zaatri Refugee Camp and at Mafraq hospital.

Facility Assessed	Type of facility	Type of Operating Agency	Population covered
1. Gynécologie Sans Frontières (GSF)	Maternity Hospital	Nongovernmental organization (NGO)	The population at the Zaatri refugee camp, at the time of assessment, was reported at 164,509 Mafraq hospital, ~300,000.
2. Moroccan Field Hospital (MFH)	Camp Hospital	Camp referral hospital	
3. Royal Medical Services (RMS)	Intermediary Clinic	Jordanian Military	
4. Jordan Health Aid Society (JHAS)	Health Center	NGO	
5. Physicians Across Continents	Clinic	NGO	
6. Mafraq Hospital	National Hospital	Government	

Table 2. Health facilities assessed in Irbid City.

Facility Assessed	Type of facility	Type of Operating Agency	Population covered (+ Syrian refugees)
Clinics			
Naemeh Comprehensive Health Care Centre	Health Center	Government	30,000 (+ 4,500 Syrians)
Dahyet Al-Hussein Primary Health Care Centre	Health Center	Government	63,000 (+ ?)
JHAS clinic Irbid	Clinic	NGO	(> 60,000 unregistered Syrian refugees)
Family Protection Unit, Irbid	Clinic	Government	NA
Referral level			
Al Ramtha General Hospital	Regional Hospital	Government	170,000 (+ 30,000 Syrians)
Princess Badea Maternity Hospital	Maternity Hospital	Government	1,000,000 (2nd level referral)
Irbid Central Blood Bank	Blood Bank	Government	Provides blood for 11 referral hospitals

At Zaatri camp, among the five facilities assessed, three provided strictly out-patient services: Royal Medical Services (RMS), Jordan Health Aid Society (JHAS) and Physicians Across Continents. Gynécologie Sans Frontières (GSF) provided out-patient and in-patient maternity services. The RMS was a military clinic funded by the Italian government. The main departments at RMS were internal medicine, surgery, pediatrics, gynecology, emergency services and radiology. Services were provided in tents.

Physicians Across Continents has also a fully equipped outpatient clinic. It had specialized departments, including cardiac, internal medicine, pediatrics, gynecology, general surgery, dermatology, psychiatric care, psychological support, orthopedics, general medicine, a pharmacy and a well-equipped laboratory. An antenatal clinic is the only pregnancy service provided at Physicians Across Continents. The representative indicated that there are future plans to offer more gynecology and obstetrics services. Also, it was the only clinic that employed Syrian health specialists (nurses, doctors and others). Services were provided in well-furnished prefabricated containers that looked clean.

The Moroccan Field Hospital (MFH) was a referral hospital within the camp. All services were provided in large tents divided by departments. Services included out-patient and in-patient services (male and female); cardiology, pharmacy (three tents), orthopedics, psychology, dentistry (with a dental chair), pediatrics, gynecology/obstetrics, ophthalmology, general surgery, neurosurgery, plastic surgery, radiology, emergency room (four beds), laboratory, intensive care unit, and a full-fledged operating theater.

Water and electricity were available at all facilities visited, although the researchers were told the flow was not always regular. At Zaatri camp, electricity was supplied by generators, while water was delivered by trucks. The MFH bought electricity directly from an Irbid electrical company, bought water from tanks and provided bottled water for staff and patients. At Irbid, the health facilities used the piped community water supply.

All the facilities visited at Zaatri refugee camp and Irbid City and Mafraq hospital were open during the time of the assessment. None of the facilities at study sites had the signs of hours of operation posted. Signs regarding the availability of RH services, such as ANC, delivery and postnatal care at GSF, and antenatal and postnatal at JHAS in the camp were available. In Irbid, only one facility, Princess Badea Maternity Hospital, had visible signage indicating the availability of RH Services. Princess Badea Maternity Hospital is entirely devoted to obstetrics and gynecology services. JHAS and GSF clinics in Irbid had brochures to give individual clients as needed but brochures or handouts were not available in any other facilities in Zaatri camp or Irbid.

Beds: Many facilities visited had beds, both for in-patient and some for out-patient observations. In Zaatri, the number of beds per visited facility ranged from zero to 48 and at Irbid from zero to 98. There were more beds at facilities with in-patient departments. For instance, at Zaatri camp, GSF maternity had 10 beds and MFH had 48 beds. In Irbid, Princess Badea had 98 beds and Al Ramtha hospital had 110 beds. Table 3 below shows the number of beds in facilities at each study site.

Table 3. Number of beds at facilities in Zaatri Camp and Irbid City.			
IRBID CITY		**ZAA'TRI REFUGEE CAMP**	
Facility	**# of beds**	**Facility**	**# of beds**
Naemeh Comprehensive Health Care Centre	0	Gynécologie Sans Frontières (GSF)	10
Dahyet Al-Hussein Primary Health Care Centre	0	Moroccan Field Hospital (MFH)	48
JHAS clinic Irbid	0	Royal Medical Services (RMS)	0
Family Protection Unit, Irbid	0	Jordan Health Aid Society (JHAS)	2
Al Ramtha General Hospital	110	Physicians Across Continents	12
Princess Badea Maternity Hospital	98	Mafraq Hospital	120
Irbid Central Blood Bank	NA		
Total	**208**		**192**

4.1.3 Focus group discussions

The study team conducted FGDs with 14 groups of Syrian women (8 in Zaatri and 6 in Irbid), whose ages ranged from 15 - 49 years. In Zaatri, the study team spoke to 101 women (three of whom were older than 49 or considered past reproductive age), while in Irbid, there were 58 women in the FGDs. The women had lived in Jordan between two days and one and a half years. The average size of the FGDs was 11 participants in both Zaatri camp and in Irbid. The discussions lasted approximately 60-90 minutes.

4.2 MISP awareness and knowledge

Information pertaining to overall MISP awareness and knowledge was gathered in the KIIs. All but one respondent was aware of the MISP and five of eleven knew all five MISP objectives. The most commonly reported MISP objective was the prevention of maternal and newborn morbidity, followed by prevention and management of sexual violence and reduction of HIV transmission. The objectives of identifying a lead agency to support implementation of the MISP and planning for comprehensive RH services were least commonly cited by five of eleven respondents.

Six out of nine respondents said that their agency's response was undertaken within one to two weeks of the onset of this humanitarian crisis. All of these respondents reported that the first activities to be implemented included maternal and newborn health services. Less than half of respondents also reported services for family planning and to prevent and respond to sexual violence.

Other services mentioned by a local NGO informant included the following: mammograms, referrals to the MOH for complications, HIV awareness campaigns, distribution of condoms (although it was noted that the demand for condoms was limited), treatment of vaginal infections, and family planning, including pills, intrauterine devices (IUDs) and implants.

4.3 Coordination of the MISP

KIIs: The majority of respondents reported that the Jordanian agency responsible for coordinating RH services was the MOH and/or UNFPA. One person reported multiple Jordanian agencies, including the Ministry of Protection Office and Maternal Child Health (MCH) in the MOH National Emergency Health Coordination Division and the MOH RH departments, but noted that there was limited coordination among them.

When asked about the roles of the lead RH organization, more than half of the respondents included hosting stakeholder meetings and sharing information on RH among participants of coordination meetings. Under half of respondents reported that other priority activities included reporting back to the health sector/cluster and nominating an RH officer. Other responses included: policies, protocols and standards, pre-positioning of supplies by UNFPA, establishing a referral system, advocacy focused on protocols, and working with national partners. Respondents mentioned additional coordination activities included developing standard operating procedures, such as securing referral pathways; ensuring cooking fuel is available; and establishing women's groups and safe spaces.

Of the 10 people responding, nine reported that UNFPA hosted RH coordination meetings weekly in Zaatri camp and monthly in Amman. A UN representative reported that UNFPA attends weekly MOH health sector meetings, monthly inter-agency health meetings in Amman, and twice weekly health meetings in Zaatri camp. UNFPA's participation in health sector meetings was confirmed by several organizations. Of eight respondents, the majority reported that on a scale of 0 to 3 where 0 equals no RH coordination and three equals very good coordination, the rating was 1 with some measure of coordination, while two people reported there was no coordination.

However, more than three-quarters of respondents reported that financial resources, RH focal points, a mapping of health facilities, and IEC messages were in effect to ensure better coordination and implementation of the MISP. One person added that, although mapping was done of health facilities, an assessment of health facility capacity was not undertaken. Moreover, the MOH and inter-agency partners would be undertaking an assessment of health facilities, including RH in urban areas, in April 2013 to determine needs based on the continued Syrian refugee influx.[61]

4.3.1 Meetings to discuss RH implementation

KIIs: The agenda of the RH working group meetings was reported most often to address general RH topics and MISP implementation, and least often to include an orientation to the MISP or use of data for action, particularly in the urban areas. Participants reported a variety of topics covered within the RH working group meetings including: a) coordination mechanisms; b) data collection issues (although it was noted that there was greater emphasis on Zaatri camp data); c) general updates; d) health capacity assessments; e) MISP implementation; f) problem solving; g) protocols; h) resource availability; i) technical topics; j) production of materials and training opportunities; k) the four W's of **who** is doing **what**, **when** and **where**; l) gaps; and m) inter-agency reporting, although feedback on agency reporting was said to be lacking.

[61] UNHCR's Ann Burton confirmed assessment was undertaken and draft report produced with final report expected in mid-August 2013.

Of eight informants responding to whether RH meetings included all of the stakeholders, half said yes and half said no, citing representation from the MOH, WHO, local NGOs in Zaatri and the inter-agency-based protection working group as missing. A UN agency informant also said that NGOs that are not funded are missing from coordination meetings, and the meetings should include all NGOs, not just those that receive funding. In addition, several respondents said that RH coordination for urban areas was lagging behind camp coordination.

4.3.2 Use of RH protocols

KIIs: The majority of eight respondents reported that MOH and/or WHO protocols were available to support MISP implementation. These included care for survivors of sexual violence, emergency obstetric and newborn care, family planning, HIV prevention, and treatment of STIs. However, with regard to the care for survivors of sexual violence protocol, a few respondents reported other available protocols, including inter-agency protocols, UNHCR, the Interagency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) and standard approaches around referrals for GBV. A UN informant said that there is a challenge with post-exposure prophylaxis (PEP) for HIV and, therefore, Kit 3 (Rape Treatment) because the sexual violence protocol is in the process of getting official MOH approval. Another respondent said that psychosocial first aid is not provided by MOH or the Family Protection Department and that the working model on care for survivors of sexual violence currently includes antibiotics and birth control pills because of a lack of a dedicated product for emergency contraception in Jordan. However, MOH was working on a package of care for survivors, which included psychosocial first aid.

Additional comments about RH protocols were that the focus of HIV prevention is on high-risk groups until the humanitarian situation stabilizes. One respondent said that advocacy is undertaken with the MOH on syndromic treatment of STIs. Another respondent said that there was a problem in the refugee camp with an organization applying country-specific protocols for emergency obstetric and newborn care. In terms of making anti-retrovirals (ARVs) available to current users, one respondent said that ARVs are only available to Jordanians with a small number of exceptions, such as people who are married to Jordanians.

One international NGO representative said:

> *"It is very difficult to know what Jordanian health protocols are; for example, HIV/AIDS, we need a much stronger discussion around RH protocols."*

This representative's perceptions regarding the host country's policy on HIV/AIDS was that any foreigner who works or stays in the country must be HIV tested and, if the test result were positive, the individual would be deported. It is unclear how this policy would currently apply to refugees. According to this representative, UNFPA is advocating with the Jordanian government and the government was listening to their concerns. In addition, another UN representative said that refugees seem to be treated differently and that the MOH reports there are refugees on ARVs and they are not deported. This representative also said that an NGO representative said that they know of HIV positive refugees on ARVs. Each situation was currently being addressed on a case-by-case basis.

4.3.3 Funding of RH activities

KIIS: All respondents reported that funds were made available for an RH response in this crisis, with just over half of respondents citing UNFPA as the source of funding. Other sources of funding included donor appeals such as the Central Emergency Response Fund (CERF), US Bureau for Population Refugees and Migration

(BPRM), UK Department for International Development (DFID), Humanitarian Aid and Civil Protection Department of the European Commission (ECHO), Norwegian Refugee Council **(**NRC**),** Danish Refugee Council (DRC) and the United Nations Children's Fund (UNICEF). In some situations, the funding was reported to be available for health services more broadly, including RH and primary health care.

4.3.4 RH Kits and supplies available and used

KIIs: Three quarters of respondents reported that RH Kits were available and adequate for this response. Only three respondents did not know if they were or were not available. One local NGO respondent commented, however, that the kits were inadequate because they do not have vitamins and folic acid. Six respondents reported most commonly available kits were Kit 1 (male/female condoms), Kit 4 (Oral/Injectable Contraceptives) and Kit 7 (Intrauterine Device). Six of eight respondents also said that the RH kits were distributed through a private logistics company.

One international NGO respondent reported that although kits are available, there is high staff turnover that results in stock outs because consumables are not replaced. This respondent suggested that systems need to be established so that consumables are replaced. A UN representative also reported that the Health Information System (HIS) does not account for forecasting RH supply needs and possible ruptures of supplies, but it is now aiming to ensure that referral facilities and other providers would be able to forecast their supply needs.

FGDs: In both settings, all groups reported that delivery kits were not distributed. All the women in Zaatri camp received a single distribution of hygiene products upon their arrival. Women in seven of the groups did not know why regular distributions were not provided. When asked their thoughts about the distributions, both women living closer to and further away from the health facilities noted that supplies were inadequate. The group of newly arrived women complained that staff at the distribution sites were rude to them. Participants were divided on their knowledge about who distributed the hygiene kits — some identified UNHCR, Jordanian Women's Union (JWU), or Caritas as the distributor and others did not know the source.

The majority of women in all six FGDs in Irbid said they did not receive any distributions of hygiene products, with younger women (less than 25 years of age) specifically reporting they did not ask for RH supplies and sanitary pads were expensive and not covered by vouchers. One young woman stated:

> *"My husband was too embarrassed to ask for them [sanitary pads] and he is the one that goes for distributions."*

Only one woman in each group noted that she received sanitary pads upon arrival in Irbid. Half of the women had heard about distributions at registration but, when they returned for additional supplies, they were told that no RH supplies were available.

4.3.5 Community participation in service delivery

FGDs: In the FGDs, when asked about community outreach by relief agencies, the majority of women in the Zaatri groups agreed that agencies had not communicated directly with the refugees about the emergency response. Only three women mentioned being contacted directly by agencies, with two of the three stating that it happened once at the beginning, with no follow-up. When asked about whether the participants knew if women had been involved in designing or delivering services to meet their needs, no one had any

knowledge of women being involved. The newly arrived women felt that they could not answer this question.

Across the groups in Irbid, most women reported that they were not contacted by agencies and learned about services through their community. A few individuals reported that charities and UN agencies had contacted them or other refugees to receive supplies upon arrival in Irbid. While most participants had no knowledge of women's involvement in planning services, in both the registered and unregistered groups, a few women said that Syrians voluntarily engage with agencies and share the information with their community. The group of young women said that mainly men, if any, are involved in the distribution and design of services.

4.3.6 Access to RH services

HFAs: At Zaatri camp, all facilities were open and convenient for adolescent females. Male reproductive health services such as STI treatment were not available in the camp (other than the provision of condoms), nor did any of the agencies have an appropriate entrance for clients with disabilities. None of the five facilities visited provided RH outreach services. A government agency not visited during the assessment reportedly provided some limited mobile outreach RH services but details could not be confirmed.

In Irbid, unmarried women or girls could attend most clinics, but they would not be provided with contraceptives. Most facilities had a disabled-friendly entrance, except at the JHAS clinic. Opening hours for PHC clinics were between 0800 and 1600, including Friday. Referral hospitals were open 24 hours a day, seven days a week. All primary care clinics visited (Dahayet Al-Hussein Health Care Centre, Naemeh Comprehensive Health Care Centre, JHAS) had outreach services. However, services were limited to RH health education. The blood bank had a vehicle for outreach blood drives, but its main mobile unit was out of service and outreach could only be conducted once a week instead of three to four times per week.

FGDs: Of the eight groups in Zaatri, women in only three of the groups knew of adolescent centers in the camp. Of the women that knew about centers, they were unclear as to whether the centers offered RH services. Identified services included Save the Children, Oasis Center and a UNFPA center that was said to be not yet open. The women were attractive to the identified centers as they taught life skills (such as sewing) and offered recreational activities (such as drawing), in addition to giving RH lectures.

In Irbid, the majority of women were not aware of any centers for adolescents. A few of the registered refugees identified agencies offering psychosocial counseling and life skills classes for adolescents, such as Save the Children, but acknowledged they would not allow their daughters to attend mixed gender classes.

4.4 Prevent and manage the consequences of sexual violence

4.4.1 Put in place measures to protect affected populations, particularly women and girls, from sexual violence

KIIs: Seven key informants reported knowledge about the priority activities to prevent and manage sexual violence, including measures to protect the population and to ensure clinical care services are available. A representative of an international NGO informant reported that the GBV working group, recently separated from the Child Protection working group, meets every two weeks in Amman and in Zaatri and that this working group should be better linked to the RH working group. This respondent said that GBV is not taken

into account as part of emergency response in either the health or the protection sector. She also reported that Syrians are starting to talk about the GBV that occurred in Syria and the impact on them. Although individuals are aware of mandatory reporting in Jordan, the key informant explained that actual disclosure of GBV takes a longer period of time, as people have a fear of disclosure. However, she explained that the discussion on violence brings out the issue of cyclical forms of violence, providing a window of opportunity to discuss GBV in general to make changes now and for repatriation.

One UN key informant said that early marriage in camp is a concern and that they have been told men from other countries come into the camp to look for girls. Another key informant from an international NGO said that advocacy on child marriage/trafficking is not useful or informed and has affected capacity to address other issues because of sensitivities and its impact on Syrians. She further explained there are not enough specialized organizations working on these issues, so just strong advocacy becomes dangerous as it creates a backlash from the Syrians about their cultural practices and slows efforts in addressing other areas of GBV.

FGDs: Women voiced safety concerns in both settings. Women said that they were fearful of telling their families of SV due to fears of honor killing, being disowned by family or having the victim disappear if the police were involved. The women discussed what they perceived as more cases of domestic violence in the camp than what they observed while living in Syria. They also feared being divorced or experiencing additional violence if they came forward to tell their stories. In Zaatri camp, women noted that there were increasing tensions within the Syrian community resulting in physical fighting among the refugees. Tensions with the host Jordanian community were noted by the refugees living in Irbid, and were described as being related to the increasing costs of living in Jordan and harassment received from service providers, host community members and the police. The Syrian women felt that the tension reflected Jordanian resentment of the aid being given to Syrians.

4.4.2 Age at marriage

FGDs: As noted by the key informants, the issue of early marriage was also mentioned by women in the FGDs. The participants in Zaatri and Irbid noted that the most common age to marry was approximately 15, with a range from 13 to 20, depending on the area of Syria in which they had previously resided. Most felt that the age of marriage had not changed since displacement, although a few groups mentioned that men from other countries were coming into the camp to marry young girls and fathers were allowing their daughters to marry to ease some of the economic hardships of refugee life. As some of the women described in camp:

"The fathers are marrying off the young girls as they want the girls to be other people's problem."

In Irbid, women described reasons such as fathers wanting someone to protect their daughters from bad security in the camp or not having responsibility in the situation of their daughters being raped.

4.4.3 Make clinical care available for survivors of rape

KIIs: One key informant from an international NGO expressed concerns about woman and girls who got pregnant from rape in Syria and are now in Jordan. She explained that abortions are illegal in Jordan, wondered what could be done to increase security, and questioned when the humanitarian agencies were going to discuss these matters. She added that when a woman gives birth in Jordan, there has to be a male to give the newborn citizenship. In cases of rape, citizenship for newborns is problematic.

HFAs: At Zaatri camp, the representative interviewed at the MFH explained that they had not received any case of SV in the hospital. Cases did not come forward due to confidentiality and stigma. Culturally, SV was not talked about because families did not want this phenomenon to be exposed. It was also believed that exposing SV affected the marriageability of the female victims. JHAS clinic was the only facility where there were protocols to manage SV survivors in the camp. While this service was not advertised, if a patient presented for care, she was treated. After receiving treatment, the police were called so that the survivor could register a statement.

At Mafraq hospital, there was no formal care for SV survivors. If a survivor came to the maternity unit, she was treated as an emergency depending on the types of injuries. At the time of this assessment, only one case had been treated at the maternity unit during 2013, although the facility representative did not give details of the type of treatment that the patient received following the sexual violence. After emergency treatment, the patients were referred to either the Prince Hamza or the Mafraq general hospital, where forensic data collection was available.

In Irbid, there was a formal referral protocol for SV survivors from the health centers to the Family Protection Unit, with a standard incident reporting form summarizing the incident and the findings on the examination. The client was received at the Family Protection Unit, where she was seen by a medical provider, who decides to bring in the police and refer the survivor to a forensic specialist, if this is relevant. The Family Protection Unit was close to the Princess Badea Maternity Hospital where the forensic specialist would see the survivor.

There was no clear MOH protocol for clinical management of SV survivors. Of the gynecologists the study team talked to, only one working in the JHAS clinic had been trained in clinical management of rape survivors (CMORS) and she was fully aware of the minimum standards of medical care for rape survivors. However, she had not seen any case in the previous three months. The chief of the maternity unit in Princess Badea hospital reported that some doctors were currently undergoing training. The director of the Family Protection Unit and several gynecologists informed the study team that MoH is working on a national protocol for CMORS, after by Jordanian MoH staff attended the recent regional MISP training of trainers, held in Cairo. As noted earlier in the section on the use of RH protocols, some key informants were aware that there was a WHO protocol for the care of survivors of SV.

FGDs: When asked whether health care services should be offered for rape survivors, six groups in Zaatri said yes, while two groups said no. Services that were desired were mostly psychosocial services, in addition to prevention and medical care. The questions about whether or not health care services should be made available to women who had experienced violence prompted a lot of discussion in the groups. One group asked for assistance in:

> *"… simply surviving day-to-day camp life."*

While most women in the camp FGDs stated that they wanted RH services, a few women further explained why they felt that these services were not needed:

> *"There is no use for physician services [in this area] as the doctors do not hear us. Psychiatric care is a luxury."* — FGD participant living far from health services

> *"Are you kidding? A lot of stuff is more important [than this], we need basic services!"* – newly arrived FGD participant

Most groups in Irbid, including psychologists, lawyers and doctors, felt that services should be available for women who experienced violence.

When asked whether women would be comfortable using these services, the responses from the camp participants were mixed. For those who thought women would use the services, the women described various conditions that they perceived as necessary in order for women to use the services. The women said that they would: a) have to lie or not tell the their husbands what they were doing; b) access services only during the day as it would be too dangerous to walk to the centers at night; c) services would need to be located adjacent to residential areas; and d) women would need to walk in groups to reach the services, as it was culturally unacceptable to walk alone as a female.

In Irbid, only one woman reported that she would feel comfortable using services. Nearly all women across the groups in Irbid agreed that they would not feel comfortable for reasons including no benefits to using services, a need to protect their reputations, and family stigmatization or isolation. Additionally, all groups with young women said that they would not tell anyone if they experienced violence (physical and/or sexual).

4.4.4 Ensure the community is aware of the available services

FGDs: Most of the women in the camp FGDs (7/8 groups) were unaware of any services for rape survivors, and one newly arrived group did not answer the question. In Irbid, nearly all groups reported that no services were available for survivors of violence, with the exception of two women, who reported the police and the Family Protection Unity as service providers.

4.5 Reduce HIV transmission

KIIs: Only three respondents were able to identify all of the priority activities to reduce HIV transmission. Ensuring standard precautions and the availability of free condoms to the community were most commonly reported (five of 11 respondents) followed by ensuring safe blood transfusion (three of 11 respondents), while four others did not know any.

FGDs: When asked about HIV transmission, all groups from Zaatri and five groups (one group was not asked the question as it was perceived to be “too sensitive”) in Irbid stated that they knew about HIV/AIDs. In Irbid, less than 5% of the 48 women in the groups did not know about HIV/AIDS. Most groups mentioned multiple sources of transmission, including blood and having sex without using protection. The majority of women in all FGDs in Zaatri and some in Irbid replied that they were worried about contracting the disease.

Most women in the Zaatri FGDs who were worried about contracting HIV/AIDS did not respond when asked about how to prevent the illness. The few that responded noted that there should be no sharing of razors or other things (like toothbrushes) with someone who is HIV-positive.

4.5.1 Ensure safe blood transfusion practice

HFAs: At Zaatri camp, only MFH performed blood transfusions. The blood supply came from a blood bank in Amman, where screening for transfusion transmissible diseases was done. At the MFH, the obstetrician/gynecologist was responsible for doing the transfusions.

At Irbid facilities, blood for transfusions was obtained from the Irbid central blood bank, which tested for HIV, syphilis, and hepatitis B and C, and provided to the 11 referral hospitals in the larger region. Donors

were recruited from family members (50%), volunteers and people who seek (and are offered) six months' health insurance (50 %) for volunteering to be a blood donor. Only Jordanian citizens were recruited as blood donors. There was a pre-donation questionnaire to screen out risk (including questions on risky sexual behavior). There was, on average, one case of positive *Treponema pallidum* Haemaglutination Assay [TPHA (syphilis)] per 20,000 units of blood screened annually and no positive HIV tests.

FGDs: Women in FGDs in Zaatri camp were worried about safe blood transfusion practices. The newly arrived groups were the most vocal about prevention and their fears that blood products used in camp were not being tested for HIV. As one woman described:

> *"In Zaatri, we are less worried about HIV from sex compared to the chance that we will get it from a blood transfusion."*

4.5.2 Facilitate and enforce respect for standard precautions

HFAs: At Zaatri camp, observance of standard precautions was done to some extent. There were no signs of hand washing protocols, incinerators, or waste pits in the camp. According to a UN representative, the MOH did not allow incinerators or waste pits and required that medical waste be transferred off site by a contractor. Sharps bins (boxes) were used at all facilities and they were also disposed off-site with other medical waste. All sterilization of medical equipment in the camp was primarily done via autoclave. The government referral facility, Mafraq hospital, used a centralized steam sterilizer. Most facilities used disposable medical supplies (e.g., syringes and needles).

In an event of an exposure, the Jordanian MOH supported the MFH to manage post-occupational exposures. Limited post-occupational exposure treatment (hepatitis B vaccine and immunoglobulin) was available at two facilities: RMS in Zaatri camp and Mafraq referral hospital in Mafaq town. At these two facilities, if a staff member was injured, blood samples were taken to the laboratory. However, PEP was not given routinely and was not available. Exposures found to be HIV-positive were referred to another hospital in Amman.

In contrast to Zaatri camp, use of standard precautions was excellent in Irbid. All centers visited had sufficient supplies to enforce standard precautions. There were visible protocols on hand washing and injection safety in about half of the centers. Sharps boxes were available everywhere and were not re-used. Medical waste management was done in one incinerator in the city, and there was an efficient system of medical waste transport from the clinics/hospitals to this site.

Most health care settings had an incident report procedure for occupational exposure. Staff were referred for further management. The main concern was with hepatitis B, for which most staff were vaccinated, and hepatitis C. There was no access to PEP for occupational exposure as far as the informants were aware.

Sterilization was done by autoclave, hot-air sterilizer or steam sterilizer in all facilities, either in one central location or in several of the wards and outpatient departments. . All these were used at least once a day and seemed to be in good working order. Chemical sterilization with ethylene oxide was available in the maternity hospital.

4.5.3 Make free condoms available

KIIs: Eight of 10 informants reported that condoms were distributed in the camp, with the majority reporting they were distributed through RH clinics. In addition, community-based distribution, women's safe places, local NGOs and sex workers were mentioned. Other comments included:

> *"Yes, condoms are distributed, but not enough."*

Another informant explained that in Zaatri camp, a gynecologist or midwife writes a prescription and the refugee then has to get it filled in a pharmacy. Finally, one informant commented that condoms were too sensitive for the military hospitals to provide.

HFAs: At Zaatri camp, male condoms were observed to be in stock but female condoms were not available. In facilities in Irbid, condoms were not supplied to non-married women in most clinics but men could buy condoms from the pharmacies.

FGDs: Of the FGDs in Zaatri, only one group knew where to find condoms. This group noted that one had to ask to receive the condoms, but knew they were free and learned where they were located through a hospital seminar. One woman complained that

> *"You can barely find medications, how could you find condoms?"*

Several women spoke about the cultural issues involved with asking for condoms, saying that they feared being overheard by men if they asked for condoms. Another young woman mentioned:

> *"I am too shy to ask, even from a female doctor, they [health care providers] should just supply them to us and not make us ask for them."*

In Irbid, regardless of age and registration, most participants knew you could find condoms at the pharmacy but the condoms were generally not free. One group of older women said they were unaware of where to find condoms because they use IUDs. Only one woman was aware that free condoms are available at JHAS and the JWU, and one young woman did not know what condoms were.

4.6 Prevent excess maternal and newborn morbidity and mortality

KIIs: Approximately half of the key informants could identify the priority activities within the objective to prevent maternal and newborn morbidity and mortality, including access to a skilled birth attendant, providing basic and comprehensive obstetric care and newborn care, and establishing referral services that operated 24 hours per day, seven days per week. Fewer informants reported the distribution of clean delivery kits. Two respondents incorrectly noted that ANC and postnatal care are priority activities in the MISP to prevent maternal and newborn morbidity and mortality.

FGDs: The majority of women in Zaatri camp said that they would use the military hospitals and NGOs for maternal health care, including pregnancy and delivery. Three women stated they had gone for services while pregnant but had been turned away for unknown reasons or they had been told that the clinic was closed, although it was only midday. Only one of the newly arrived women said she did not know where a woman would go in order to deliver her baby. The majority of groups noted that they would go to a hospital in the camp, noting that there were no midwives in the community that could assist them. One group said

that there were Syrian midwives that helped women deliver in the tents. Zaatri participants all noted that pregnancy and delivery services had been available since they arrived in camp, although a few women described deterioration in the quality of services as the camp refugee population surged.

In Zaatri camp, information about newborn care was less uniform, with the women uncertain as to where to go or whether to go at all, due to their dissatisfaction with health care services in general. While all the groups described using the formal health care services in camp for newborns, one newly arrived group did not know where to go for newborn care. Similar to the concerns raised about health services in general, complaints were again raised about poor quality of EmOC and newborn care services, including mentioning a lack of physical examinations, drugs, and qualified physicians. In all eight FGDs in Zaatri, the women reported that fellow Syrians were the source of information about where to obtain maternal health services. When asked specifically about their perceptions of pregnancy and delivery services there were mixed responses — more women voiced complaints about services as compared with the few who said that services were good.

In Irbid, when asked about at-home deliveries, responses varied. Both groups of registered young women preferred delivery by a community member, whereas two groups of older women preferred hospitals for delivery. One woman stated,

"Do you think women don't give birth at home? If it's an emergency they will do it."

For newborn care, women across all groups in Irbid identified private clinics as the source of care, in addition to a few reports of public hospitals (e.g., Princess Basma). Most of the women understood that a UN card was needed to get free services and two of the six groups said that JHAS could expedite registration cards for those who were pregnant. As with Zaatri camp, the women in the urban FGDs noted that, although services were free if you were registered, there was some reluctance to use the services as they were perceived to offer "bad" quality of care. Young female participants expressed a lack of trust in free services and preferred private clinics, with reports of 300-500 Jordanian dinars for deliveries, despite registration status. Maternal and newborn health services were available when they arrived in Irbid, although two groups described the quality of services as deteriorating. Other comments specific to maternal health services included lack of privacy and female providers, sharing delivery rooms with multiple women, and negative interactions with health providers. Similar to Zaatri, all groups reported the Syrian community as the main source of information for maternal health services, as well as other outside sources (e.g., radio, registration desk and Princess Basma social workers).

Types of deliveries: All women in both settings uniformly said that they preferred natural births over giving birth by Caesarean Section (C-section). One group of young women in Irbid explained that C-sections were painful and should only occur in emergencies. However, in Irbid, when asked about changes in delivery following displacement, two groups thought Syrian women now preferred C-sections due to lack of family presence or support.

4.6.1 Ensure the availability of emergency obstetric care (EmOC) and newborn care services

HFAs: At Zaatri camp, all deliveries and other basic emergency obstetric and newborn care functions were conducted at the GSF maternity clinic. Obstetric emergencies needing C-Section, other basic and comprehensive EmOC and newborn care procedures were referred to the MFH (see priority action referral section below for discussion). At the other clinics, normal deliveries may be conducted but only in an

emergency, for example, if a woman arrived in the second stage of labor. Registered nurse midwives conducted all normal deliveries at GSF maternity. Midwives use partographs to monitor labor. All components of active management of third stage of labor (AMTSL), including immediate oxytocin, immediate misoprostol, controlled cord traction, and uterine massage, were administered as needed, including antibiotics given as necessary. Parenteral uterotonics, such as oxytocin, ergometrine and misoprostol were given as needed, for example, to prevent postpartum hemorrhage. Anticonvulsants, including magnesium sulphate and diazepam, were available. Obstetricians and gynecologists performed manual removal of placenta and pediatricians resuscitated newborn, as needed. There was staff trained to encourage breastfeeding (early and exclusive), newborn infection management (including injectable antibiotics), thermal care, Kangaroo care for newborn and special delivery practices for PMTCT.

At JHAS and Physicians Across Continents in Zaatri camp, plans were underway to offer more obstetrics services, including for normal deliveries. During the assessment, these clinics were able to respond and attend to limited obstetric emergencies (e.g., normal deliveries). In case of emergencies, they were capable of conducting all obstetric activities including delivery, AMTSL, parenteral treatment and also provide IV fluids. After stabilizing the patients, the facilities referred the women to the GSF.

For the refugees in Irbid, normal deliveries, basic obstetric emergency care, and comprehensive emergency obstetric care were only available in the two referral hospitals (see priority action referral section below for discussion).

4.6.2 At health facilities, ensure there are skilled attendants and supplies for normal births and management of obstetric and newborn complications

HFAs: In all the RH facilities in Zaatri camp, medical personnel were present for various shifts. Obstetricians/gynecologists, registered nurse midwives, and nurses covered most of the shifts. At the MFH, for example, all staff stayed at the compound 24 hours a day, seven days a week and were easily reached in case of an emergency. At the JHAS clinic, there were two shifts, 0800 to 1600 and 1600 to 0800.

At Mafraq hospital staff worked in rotations. For instance, at the maternity unit of Mafraq hospital there were obstetricians/gynecologists and nurse midwives on call 24 hours a day, seven days a week. At GSF maternity, the staff worked in teams composed of one obstetrician/gynecologist and two registered nurse midwives who worked for 24-hour shifts, after which a similar team took over. Each team stayed on site (at the camp) for three weeks, after which a new team came to replace them.

In Irbid, there was a comprehensive set of staff with relevant skills for the functioning of each facility. However, in all facilities, staff complained about an increased case load and a lack of human resources since the onset of the Syrian crisis.

Table 4 displays the number and type of staff that were available at the time of the assessment. None of the facility representatives complained about staff shortages.

Table 4. Human resources at Zaatri Camp and Mafraq Hospital.						
	Health Facilities			Referral Facilities		
	RMS	Physicians Across Continents	JHAS	GSF	Moroccan	Mafraq Hospital
Type of health worker						
Obstetrician/ Gynecologist	1	1	1	2	4	8
Pediatrician	1	1			2	5
General Medical Doctor	1	2	6			
Nurse-Midwife	0					
Registered nurse-midwife	0	1	8			17
Nurse	1	7		4	>10	
Clinical Officer		1	3			
Medical Assistant						
Psychosocial counselor/psychiatrist		1			1	
Anesthetist					2	
Surgeon	1				4 (trauma & visceral surgery)	
Emergency Ward					11	
Facility Assistant					1	
Radiologist		1				
TOTAL	**5**	**15**		**6**	**25**	**30**

Post-abortion Care

HFAs: At Zaatri camp, only two facilities out of the six visited provided post-abortion care. Of note is that abortion care was provided only in cases of emergency, for example, hemorrhage, as induced abortion is illegal in Jordan. All cases from the camp that needed abortion care were referred to the MFH. If the MFH could not deal with complications, they referred to Mafraq hospital. None of the hospitals used manual vacuum aspiration for uterine evacuations. Dilation and curettage (D&C) and dilatation and evacuation (D&E) were the two methods of choice for uterine evacuations. The study team was informed that management at both hospitals had not embraced manual vacuum aspiration, as they did not think it was important. Mafraq and Moroccan hospital representatives mentioned that they gave misoprostol but did not specify why. Physicians performed all the D&C and D&E. Nurse midwives provided counseling services to patients before the procedure. The representative interviewed did not mention post-abortion counseling.

In Irbid, comprehensive abortion care, including access to abortion (within the law) and post-abortion care are available from both referral hospitals, Al Ramtha and Princess Badea. Both electric and manual vacuum aspiration and misoprostol are used. Misoprostol is used only for dilatation of the cervix and it is always followed by a surgical evacuation. Gynecologists and medical residents are the only health care professionals providing this service.

Recognition of danger signs during pregnancy/delivery and in newborns

FGDs: All participants from Zaatri were able to describe what they perceived as danger signs that occur during pregnancy or delivery, including bleeding, lack of fetal movement and vomiting. The women living closest to the health care facilities noted that they thought that miscarriages, diabetes and hypertension were additional danger signs. Women in the Zaatri FGDs described respiratory illness, fever and jaundice as serious health problems in a newborn.

The common danger signs for pregnancy and delivery, reported across groups in Irbid, were bleeding, water breaking early, back pain and lack of fetal movement. Young women reported additional symptoms as danger signs, including stress, morning sickness and vaginal infections, whereas, older women reported hypertension and anemia, while simultaneously emphasizing they do not want to get pregnant at this time. For newborns, the primary danger signs reported included jaundice, child not breastfeeding and infected umbilical cord. Additional responses about danger signs in newborns varied across groups including choking, diarrhea, vomiting, difficulty breathing and bloating.

4.6.3 Establish a referral system to facilitate transport and communication from the community to the health center and between health center and hospital

HFAs: At Zaatri camp, all maternity cases with complications and those needing admission were referred to the GSF maternity or MFH, both located inside the camp. If there was a patient who could not be managed at the MFH, she was referred to Mafraq hospital in Mafraq city. Although both GSF and Moroccan field hospital were inside the camp, due to traffic congestion, referrals could take 30 minutes or more from one part of the camp to the facility. Hence, delays were always expected. Referral generally took 10 to 45 minutes at Irbid, for example, from Naemah health center (located outside Irbid) to Al Ramtha hospital.

At Zaatri camp, ambulance transportation, which was the most common mode of patient transport for both the camp and in Irbid, was coordinated by JHAS and services provided by the Civil Defense Department of the Government of Jordan. There were three ambulances in the camp including one JHAS ambulance and two Civil Defense ambulances: one used for internal transport and one for external transport. At Irbid, ambulances were called from the Civil Defense Unit. Al Ramtha hospital had three functioning ambulances of its own.

At Zaatri camp, the mode of communication was through mobile phones, which, for the most part, were personal phones. The mobile phone network was functioning well. At Irbid, land-lines were the most used communication method supplemented by mobile phones.

FGDs: In Zaatri, participants in all eight groups said they would call an ambulance for transport to the hospital, although participants reported delays in pick-up, no transport following discharge, and multiple

stops during transport [referring to the ambulance as more of a “bus” than an emergency service]. Rare mentions of other transport services included walking, paying for an expensive private car rental or having someone carry the woman. Similarly, for newborn emergencies, mothers would take their newborns by ambulance or walk to the hospitals, with no differences on weekends, nights or holidays.

In contrast, the women in Irbid noted that taxis were most frequently used for transport to the hospitals, although participants reported long waits, harassment and costs as barriers to using taxis. Consistently, all groups stated they could get care for maternal health emergencies at Princess Badea Hospital or a private clinic 24 hours a day, seven days a week. A few registered women individually reported walking, calling an ambulance, taking the bus or calling the Civil Defense, if there was an emergency.

4.6.4 Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible

KIIs: No key informants reported that clean delivery packages were distributed, although one respondent later clarified that the packages were distributed in the beginning, but subsequently stopped to prevent encouraging home deliveries. The established norm in Jordan was health facility deliveries.

FGDs: As with the key informants, in both settings, all groups reported that delivery kits were not distributed.

4.7 Plan to integrate comprehensive RH services into primary health care

4.7.1 Collect existing background data

KIIs: Just under half of the respondents were not aware of any priority activities to plan for comprehensive RH services. Among those who responded, assessing and addressing staff capacity to provide comprehensive RH services were most commonly reported, followed by coordinating the ordering of RH equipment and supplies; collecting background data; and identifying sites for future RH service delivery. Others mentioned priority activities to establish comprehensive RH services included: determining which RH protocols to follow in the humanitarian response; addressing any provider knowledge and service gaps, and implementing monitoring, evaluation and sustainable approaches.

A few key informants mentioned that RH data were collected. One person further reported that an HIS exists in the camp, but not in the urban areas. Local NGOs were reportedly said to collect some data. A UN agency representative said that data are collected on RH indicators, but that data collection was a major problem. RH data were poor because the focus needed to be on data quality, which is a fundamental coordination issue. Another informant said that the quality of the data collected was questionable. Another informant reported that the UNHCR HIS was a challenge because the age groups used by UNFPA are different than those used by UNHCR. Lastly, one participant stated that the hospital occupancy can be recorded up to 120% by UNFPA, while HIS only allows up to 100%.

HFAs: At Zaatri camp, most MISP indicators were not collected, though some RH data were available and a monthly RH reports were prepared and sent to the Jordanian MOH. All facilities in Irbid reported data for refugees to the MOH separately. However, it was very difficult to get access to actual data. All facilities in Irbid city reported data for Syrian registered and unregistered refugees to UNHCR and the data collection unit of the MOH. Facilities in Irbid reported data for refugees to the MOH separately from those of the non-refugee population. Unfortunately it was not possible to get access to the actual data.

4.7.2 Identify suitable sites for future service delivery of comprehensive RH services

KIIs: One UN representative said that something must be done to improve the reported low delivery of ANC and the high percent of C-sections (of note per another UN representative: the C-section rate within Zaatri camp is within acceptable range). She also explained that Save the Children provided all of the newborn care in the camp, including breast feeding spaces and education in the waiting areas of health facilities. Another key informant said that JHAS is trying to open a delivery unit in Zaatri camp; however, as most of the staff were working in the MOH, they were awaiting information from the MoH to second staff.

FGDs: Women strongly perceived numerous barriers to seeking health care services in both settings. Health care services were perceived to be insufficient or of poor quality. Both camp and urban participants reported common problems of long wait lines, disrespect by health care providers, and costs of transportation. In both settings, women requested additional doctors, including those specializing in primary care, pediatrics, and eye and dental care.

In the camp, there were many complaints about lack of medications, while in Irbid, complaints focused on the cost of medications. In Zaatri, requests were made to increase services for special needs populations and vulnerable community members, such as the elderly, children with disabilities and war-injured refugees. Comments from one group in the camp illustrated the frustrations with the long waits:

> *"You stand in line a long time. They [the agency] call your name and, if you do not hear them or if you complain, they simply shred your papers and go to the next person in line."*

In Irbid, the main reasons for not seeking health care among registered and unregistered refugees were the disrespect shown to the women by providers, limited or inappropriate medicine and no physical exams. Registered women specifically reported lack of female doctors, costs of medications, unclear referral pathways, and no registration card as barriers to seeking care, whereas unregistered women also identified long waits for care.

Supplies to implement the MISP

As part of the Health Facility Assessment, an evaluation was made of the services and supplies available for MISP implementation.

In general, all the facilities at Zaatri camp were well equipped to provide the available services (those that they provided at the time). The maternity unit at Mafraq hospital was also well equipped. The outpatient rooms at all the facilities had the necessary equipment listed in the questionnaire. For example, at Physicians Across Continents, there were IEC materials for family planning, breastfeeding and safe delivery. Basic items, such as sphygmomanometers, stethoscopes, examination couches, syringes, needles and gauze were available. Items for infection prevention, such as soap, non-sterile gloves and trash bins, were available at all facilities.

Table 5. Availability of relevant departments.						
	MFH	**Mafraq Hospital**	**RMS**	**JHAS**	**Physicians Across Continents**	**GSF**
Outpatient	Yes	Yes	Yes	Yes	Yes	Yes
Operating Theatre	Yes	Yes	No	No	No	No
Laboratory	Yes	Yes	No	No	Yes	No
Pharmacy	Yes	Yes	No	Yes	Yes	No
Sterilization room	Yes	Yes	Yes	No	No	No
Labor/Delivery	Yes	Yes	No	No	No	Yes

Table 6. Family planning commodities.						
	MFH	**Mafraq Hospital**	**RMS**	**JHAS**	**Physicians Across Continents**	**GSF**
Daily OCP	Unclear	Yes	Yes	Yes	Yes	Yes
Daily Progestin only pills	Unclear	Yes	No	No	No	No
Projestin Injectable	Unclear	Yes	No	No	Yes	No
IUDs	Unclear	Yes	No	Yes	Yes	No
Male Condoms	Unclear	Yes	Yes	No	No	No
Female Condoms	Unclear	Yes	No	No	No	Yes
Emergency Contraceptive Pills	Unclear	Yes	No	Yes	No	No

In Irbid, all facilities reported that supplies were sufficient, apart from a lack of certain medicines. In all facility pharmacies, there was a shortage of medicines for chronic diseases but no reported stockouts of RH medicines. Supplies were normally ordered from the central store according to a quota per health facility. However, the quota for these supplies had not changed, despite the influx of Syrian refugees.

Payment for services

HFAs: No refugees paid for services in the Zaatri camp. Refugees referred to Mafraq hospital from Zaatri camp had their services paid by UNHCR. UNHCR had a system in place to ensure that payments were made on time.

Registered refugees did not have to pay for clinical services as they are covered by the MOH. In most government clinics, unregistered refugees, unless they were referred by JHAS and UNHCR covered the cost, paid similar fees to uninsured Jordanians. However, in the Princess Badea maternity hospital, unregistered Syrians paid twice as much for a normal vaginal delivery as did Jordanian citizens (80 JD vs. 40 JD). Government health facilities submit photocopies of the refugee registration to get reimbursed from the

MOH Insurance Department. For unregistered refugees referred by JHAS/UNHCR, the invoice is sent to the Insurance Department and paid by JHAS with UNHCR funds.

FGDs: The women in Zaatri camp recognized that all health care services in camp were free, although one group, dissatisfied with the quality of the services, noted:

> *"We would prefer to pay for the services as it [the payment] gives you respect."*

4.7.2 Provide community education about the benefits of obtaining RH services and how to access such services

KIIs: Seven of eight respondents reported informing the community of the benefits to seeking RH services and where and how to locate such services. The majority stated that this was undertaken through IEC materials, but also by using community health workers, peer educators and the radio (for example, Yarmouk University had broadcasted messages of available services in Irbid to inform refugees).

One UN agency informant said that inter-agency service guides on health and protection services had been developed for 10 Syrian refugee-impacted governorates of Jordan. A UN agency representative reported that IEC was provided to new arrivals through service booklets, given to JHAS who subsequently distributed them to refugees, including unregistered refugees. In addition, a UNHCR help desk was available.

Another UN agency representative explained that an extensive inter-agency IEC initiative was undertaken where 50 existing messages were gathered, including some from Syria, on six essential services. This informant also said that peer educators and spaces for interactive activities existed for boys and girls in Zaatri.

4.8 Additional priorities of MISP

4.8.1 Ensure contraceptives are available to meet demand

KIIs: The majority of respondents did not know any of the additional priority activities of the MISP. Only one person could identify three of the four additional priority activities to the MISP. Four respondents reported ensuring family planning was an additional priority activity. Of note, three respondents incorrectly reported that ANC is part of the MISP.

HFAs: In Zaatri camp, all family planning methods were given at MFH, Physicians Across Continents and JHAS. The methods included OCP, injectable contraceptives, IUD, emergency contraceptives, and condoms. Although GSF stocked family planning methods, they stated that the women did not want family planning. This was contrary to the findings from other clinics that stated that the demand for family planning methods was high.

A wide range of methods were available to married couples in Irbid. Contraceptive methods, provided by all outpatient clinics, included OCP, injectables, IUDs and male condoms. Only JHAS had female condoms. For the most part, unmarried women could not access contraceptives. Exceptions included two clinics where the midwives said that they would not ask about marital status and the JHAS clinics where a woman would be provided with the method of her choice. The director of one of the clinics told the study team that the

national policy had recently changed and that all demands for contraceptives must be met without discrimination, but that not all staff was aware of this yet.

Emergency contraception dedicated product (levonorgestrel or Yuzpe) was not freely available in most national facilities in Irbid. In other clinics, if emergency contraceptiveis provided, the multiple progesterone-only pill regimen was used. Most providers working in family planning services noted that they would not give emergency contraceptiveto a rape survivor or an unmarried woman. Condoms were available, free of charge, for registered refugees, and for a small fee for non-registered refugees attending family planning clinics.

FGDs: When asked about prevention of pregnancy, most of the groups in Zaatri mentioned using OCP. Similar to the findings from the HFAs, women were interested in family planning. Women were adamant in voicing their concerns about the potential for pregnancy while being a refugee:

"We do not want to get pregnant in this camp!"

Other frequently used techniques mentioned by the women in Zaatri camp included using IUDs or the "natural" way, which meant not having intercourse with their husbands. Women reported that sex was difficult due to husbands being away fighting in Syria, having no privacy in their tents, and husbands being impotent from stress. Responses were mixed in terms of who the women trusted for information about family planning – half of the groups said that they did not know where to go to get this information, while others recognized NGO clinics. Of those that could mention a trusted source of information, there was agreement that these services were free in camp. When asked what women would do if they were pregnant but did not want to be, most mentioned that they would try to self-abort through lifting heavy objects. Two participants answered that women were taking pills they brought from Syria in order to abort.In one group, this question was perceived to be too sensitive to ask as there were multiple unmarried young women in the group. Prevention of pregnancy questions generated a large amount of discussion regarding the freedom that the refugee women lost when they entered Jordan. Many of the refugee women participants described abortions being performed legally in Syria up to 40 days post-conception and how conservative Jordan was in comparison to Syria, as abortions are not legal in Jordan.

Similar to Zaatri, Syrian refugees in Irbid reported the most common methods of family planning were IUDs, the "natural" way and OCP. Other responses included breastfeeding, a vaginal insert, and the calendar method. Both age groups openly discussed that living conditions and stress prevented them from having sex. Women reported that they learned about family planning while in Syria or they sought information from private doctors in Jordan. Additionally, three young women received information from the Family Planning Center, community health workers from JWU and a UN handout. Even though several women said they brought OCP from Syria or had IUDs inserted before leaving, no group could identify a place to receive free contraceptives.

4.8.2 Make syndromic treatment of sexually transmitted infection (STIs) available to patients presenting with symptoms

HFAs: None of the facilities visited in Zaatri camp mentioned performing syndromic diagnosis and treatment of RH tract infections. In Irbid, most of the specialists treated a suspected STI before they had lab results, but none of them treated for more than one infection. Although they mentioned that there was a national

protocol, this was not available, nor could anyone find a copy of it. Most providers said that STI cases were rarely seen. Any cases were anonymously reported. There was no antenatal screening for syphilis.

FGDs: Women in both the Zaatri and Irbid FGDs had little specific knowledge about STIs, other than HIV/AIDs. They mostly spoke of 'genital' infections but could not offer any specifics about the infections, except one woman who reported syphilis as an infection. In Zaatri, most agreed that health care services were available in the camp for STIs and they learned about them from other community members. Two groups in Irbid reported being unaware of STIs because they were not common in their community. When asked what they would do if they had an STI, the answers varied across the groups and included visiting a physician (e.g., gynecologist) or using at-home treatment (e.g., washing themselves more and using chamomile). In Irbid, young women would visit private clinics for treatment.

4.8.3 Antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for the prevention of mother-to-child transmission

HFAs: None of the facilities at Zaatri camp provided ARVs, including Mafraq hospital. Those needing to continue ARVs were referred to facilities in Amman, where they were available. Persons who were HIV-positive were also referred to other hospitals in Mafraq and Amman. In Irbid, none of the providers had seen patients who were HIV-positive. The blood bank had never had a positive HIV test from any donor.

FGDs: The question pertaining to continued ARVs was dropped from the FGD guide as none of the women in the FGDs had any direct experience with HIV/AIDS or persons receiving ARVs and, thus, the question did not make sense to them.

4.9 Integration of reproductive health into disaster risk reduction (DRR) and emergency preparedness

KIIs: Just over half of key informants reported that there was a national DRR agency/unit in Jordan while fewer respondents were aware of the name of the agency. The responses elicited several names of the DRR agency in Jordan, including the Ministries of Jordan [non-specified], the MOH, UNHCR and Higher Civil Council for Disaster and Risk Management, which included the Jordan Red Crescent Society and Civil Defense. The majority of respondents did not know if a health risk assessment had been undertaken or whether there were DRR health policies or strategies in place. However, two people noted that a health risk assessment had been undertaken and that there were DRR health strategies in place, although they were outdated and did not include RH. Less than half of 10 respondents reported that RH was incorporated into multi-sectoral and health emergency risk management policies and plans at the national and local levels.

Approximately two-thirds of respondents reported that their organization undertook preparedness for this humanitarian crisis. Prevention of and response to sexual violence was included in the types of programming that organizations prepared in advance. Other preparedness activities included undertaking advocacy, assessment, capacity development, including training, coordination, storage of kits and supplies, consideration of mobile medical teams, and development of work plans. For example, one international NGO representative said that their agency worked with the Jordanian MOH to address RH policies, emergency preparedness and a national response plan.

Training

Just under half of nine respondents reported that trainings were offered to health workers (nurses, doctors, midwives, etc.) in Jordan to prepare for a humanitarian crisis. Of eight respondents, six indicated that a MISP curriculum was available for health professionals in their organization or site, and that MISP trainings had taken place in Jordan through seminar workshops. Specific curricula mentioned included the SPRINT initiative known as the Sexual and Reproductive Health Programme in Crisis and Post-crisis Situations , IASC *Guidelines for the Prevention of Gender-based Violence*, *Inter-Agency Field Manual* (IAFM) *on Reproductive Health in Humanitarian Settings* and an agency's own curricula. One person reported there was a national MISP training in June 2011 and several respondents indicated that there was a MISP regional "trainer of trainers" training in Cairo in December 2012 with three follow-on or "echo" trainings in Jordan since that time, which included a day focused on advocacy with high-level officials. Another person said that the Cairo training included Jordanian and Syrian representatives, the military and the UNFPA. A two-day MISP training was reported to have taken place in Zaatri camp for representatives of service delivery organizations, including JHAS, Physicians Across Continents, MFH, GSF and RMS. In addition to training for health professionals, a respondent said that the MoH and UNFPA offered GBV training for police, including border police.

A UN representative reported that in 2012, Jordanian forensic doctors were trained on the clinical management of survivors of sexual violence. The training covered content of the international standard and what is available in terms of services at the national level. An international NGO representative also reported that, together with JHAS, they provided training for providers on the national standards for comprehensive RH.

Procuring and Pre-positioning Reproductive Health Supplies and Kits

Four out of nine respondents reported that RH supplies were procured and pre-positioned prior to this humanitarian crisis. Five out of 10 respondents reported that RH kits were procured and pre-positioned. However, a representative from the agency responsible for procuring and pre-positioning supplies and kits noted that these items were not pre-positioned. In addition, five of 10 respondents reported that there was an established logistics system for health supplies. Two respondents reported that there was a problem with MOH approval for official utilization of the kits, while one agency was involved in bilateral conversations for making the supplies available.

One respondent offered that contingency planning exists in Jordan and the government is strong in logistics and distribution, but that it is not linked to implementation at the onset of an emergency. This respondent further added that condoms and contraceptives are provided through the MOH to the clinics. Others also said that the national health system provided supplies that could be procured locally. However, it was noted that the system was overloaded with the growing number of refugees and supplies.

4.10 Facilitating factors and barriers to the implementation of the MISP

4.10.1 Facilitating Factors

KII: The facilitating factors to MISP implementation in both settings were:

- adequate RH materials and supplies;
- the Government of Jordan's pre-existing level of infrastructure, health care systems and willingness to address RH among Syrian refugees;

- a dedicated agency (UNFPA) within the health sector to lead RH coordination and integration with MOH and Health Sector;
- funding for RH from a variety of donors to engage a humanitarian coordinator for RH at UNFPA and to support some international and local NGO partners;
- capacity development through MISP trainings for MOH and other humanitarian actors responding to the Syrian refugee crisis and undertaken by UNFPA and through the SPRINT initiative in Cairo with several follow-on in-country "echo trainings" were also factors smoothing the progress of MISP implementation in Zaatri camp and Irbid;
- relative concentration of people in Zaatri camp;
- effective coordination and complementary activities among individuals; and
- well educated and hardworking staff.

One UN agency representative said,
"The providers are amazing and sometimes they are working twenty-four hours a day, seven days a week!"

4.10.2 Barriers

KII: The following were stated as barriers to MISP implementation:

- lack of sufficient funding for this emergency;
- lack of adequate staffing and clear protocols—including on care for survivors of sexual violence—given the lack of government legislation on emergency contraception and post-exposure prophylaxis;
- low applicability of some components of the MISP to developed countries;
- limited supplies distribution;
- the crisis occurring before Jordan had the opportunity to implement their MISP contingency plan;
- the lower level of focus on the urban communities compared with the camp was problematic for effective MISP implementation.

One international NGO representative said there was a focus on the war-wounded and not enough advocacy at the onset of the emergency to raise attention about the importance of RH services.

> *"People forget that the majority of the population is women and children and they need specific services. It is disenfranchising that RH does not make the list of priorities."*

Women's cultural backgrounds were also reported as a barrier by one UN respondent who commented:

> *"They [Syrian women] are used to cesarean sections and high quality hospital services, pregnancy is like disease, and they are not used to breastfeeding. They also believe pregnancy is a private issue and there is low awareness of pregnancy risks. In addition, there are cultural barriers to women and girls participation."*

One respondent added that it is a challenge to secure female doctors to work in the camp to support MISP implementation in this cultural context because of their other commitments and the need to travel long distances to reach the camp.

4.10.3 Suggestions for improving the MISP in Jordan

KII: There were multiple suggestions for improving the MISP in all phases of an emergency, including preparedness and response. Four of eight respondents suggested increased funding for the MISP and MISP training. Other recommendations included increasing human resources and improved coordination, particularly on RH issues in urban areas, protocols and logistics. Other responses included: encouraging UNFPA to develop and share reports; integrating the MISP into the national emergency plans, identifying an MOH focal point; undertaking advocacy, particularly for MISP inclusion in the preparedness phase, and funding organizations to implement the MISP. Other suggestions focused on capacity development through training midwives and community health workers and requiring a pre-requisite training on the Code of Conduct against sexual exploitation and abuse for all of those involved in humanitarian response, particularly through the development of very basic training materials.

One local NGO respondent said funding should be provided "equitably to all NGOs" because all funding is currently going to one or two local NGOs, while other NGOs have the capacity but lack resources to implement. This respondent also said that non-registered refugees outside the camp, particularly refugees in the Jordan Valley, should be given access to more services through the support of mobile teams. A representative of an international NGO said that a lot more community outreach needs to be undertaken to facilitate access to services, especially for unregistered refugees. This representative added that there is a need to focus on preventive services because there are issues of illiteracy among the population, low levels of education and low family planning uptake that results in large family sizes. These factors have resulted in high-risk pregnancies based on the four dangers, that is, too many children, too close together, too young and too old. Finally, one UN agency representative said she felt very strongly that "we need to move on from the MISP and address comprehensive RH."

In a comment about the overall situation in Zaatri camp, one UN representative explained that there needs to be a fundamental shift in how services are delivered to decentralize services and increase the community's access to services. This representative said that UNHCR is planning 11 primary health care units for 5,000 people, one unit in each area with an accredited partner.

4.11 General concerns among Syrian refugee women

Although the primary purpose of the FGDs was to gather information on RH services, the Syrian women who participated in the discussions had a strong desire to share additional information that was pertinent to them.

4.11.1 Meeting basic needs

Nearly every group in Irbid and Zaatri mentioned the lack of basic necessities. Participants described a need for hygiene products, including soap, shampoo and sanitary pads, in addition to milk, diapers (including adult diapers for the elderly or disabled), clean toilets, clean water, clothing, electricity (or an alternate power source, such as a flashlights), blankets, among other items. Women described distributions as being unscheduled and random, with concerns about whether the distribution system was equal and fair for all Syrian refugees. In Zaatri, some participants reported that the community leaders were distributing goods to relatives first, rather than establishing a fair system. In Irbid, most women voiced concerns about the distribution of goods by charities and noted they were unequal, with distributions seemingly based upon

refugees' city of origin or personal relationships. The voucher system in Irbid was described as limited in options and access to certain food and non-food items, particularly cleaning supplies, milk and diapers.

4.11.2 Livelihoods

All women who participated in the discussions expressed economic hardships that reflect the harsh realities of being displaced from home. In both settings, participants were concerned about the higher cost of living in Jordan as compared with Syria. Among those in Irbid, this impacted their ability to pay rent and utilities, buy clothes and use taxis (particularly to take children to school as buses were reported unsafe). Although residents in Zaatri did not have to pay rent or utilities, they suffered from high costs of supplemental food in the camp markets and felt they were unable to buy clothing. The desire to work and earn an income was common in both settings. Of particular concern was the inability of most refugees to work. Although a few refugees reported being able to work, for most, work permits are expensive and difficult to get. In the camp, participants complained that there were few jobs available, and the process to secure jobs was unfair and based on favoritism. Even offers to volunteer, such as in the camp-based schools, were ignored by the agencies responsible for the schools. Urban participants expressed concerns about working long hours with low salaries and fearing deportation if they were found working without a permit.

4.11.3 Education

A high level of frustration was expressed at not having proper documentation to verify previous education or work experience. One woman in Zaatri camp said:

> *"When they are bombing your house, you don't think about finding diplomas or certificates, you just run."*

In addition to their concerns about the lack of work opportunities, young women in Zaatri expressed deep concern that there were no opportunities to continue secondary or university studies. In Irbid, schools were considered to be expensive and far away, which caused additional worry over transporting children to school safely.

4.11.4 Additional concerns

Across urban and camp FGDs, women voiced multiple concerns for safety and health services. For example, in Zaatri camp, women pointed out that, on a daily basis, tent fires occur. They also felt that they were not protected from the heat and cold. The Zaatri participants were also concerned about the tension between the refugees and the local staff that worked in the UN distribution system, noting that the Syrian women were disrespected and called derogatory names.

5. Discussion

In general, respondents reported good awareness of the MISP objectives that translates into better advocacy of services and faster response rates in a crisis. In addition, lifesaving measures were prioritized and included both immediate and comprehensive RH services, although with some gaps and challenges. The following section discusses these issues as measured by the five MISP objectives.

5.1 Coordination of the MISP

The primary responsibility for coordinating humanitarian assistance rests with national authorities. In this situation, the MOH identified UNFPA to be the lead agency for RH coordination and was also supporting a full-time humanitarian coordinator for RH. Appointing a RH lead early in an emergency indicates strong commitment to the issue by the MOH. This action ensures that there is predictable RH leadership and accountability in the response and strengthens system-wide preparedness and technical capacity to respond to RH in this situation. Strong coordination is the lynchpin of all future activities and will influence RH response in the months to come.

A range of topics were included in the meetings. This is key to facilitating a comprehensive response that is flexible to the changes in information grounded in the reality of the situation. It is important to cover these changing issues, especially human resources, training and data collection for action, in order to remain on track as the needs change. Despite this effort, some gaps in coordination occurred and need to be addressed. For example, there is need to improve information flow among coordinating agencies, to support training, and for more human resources. A major concern for most agencies was the continued influx of refugees and the need to keep pace with these demands for services. Another identified gap by key informants was the need for protocols for care for survivors of SV and STIs/HIV/AIDS. Key informants were more aware of the five major objectives of the MISP and many of the related specific priority activities compared with any previous MISP assessment undertaken by the WRC, including with partners. However, the majority of respondents were not aware of the Additional Priorities of the MISP, first articulated in the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revised Version* (IAFM). This is likely because not everyone has reviewed the revised IAFM nor re-certified themselves in the updated MISP Distance Learning Module 2011 version.[62]

Reproductive health and supplies were mostly available at health facilities for providers with some specific gaps in equipment and medicines detailed in this report. key informants and service providers had very few complaints compared with other MISP assessments about the lack of supplies to implement the MISP. However, there were clear gaps in coordination and availability of some MISP services, including the need to focus on the urban population in RH coordination meetings in Amman; address gaps in SRH protocols on STIs/HIV/AIDS; finalize the protocol on care for survivors of sexual violence; scale up the availability of care for survivors of sexual violence; prevent HIV and other STIs by making free condoms more accessible; provide post-abortion care with manual vacuum aspiration; train and implement syndromic treatment of STIs; and inform and engage communities including adolescents and people with disabilities, about the availability (including the hours of operation) and location of these services at Irbid and Zaatri camp.

While relatively high-level health services were available in Zaatri camp, the women and girls were dissatisfied with the quality. Refugee women wanted more primary and pediatric care, more attention to the regular health evaluations, which included health histories and queries about drug allergies, and more health education. They also wanted more providers and, specifically, more female providers. Fortunately, the MOH, UNFPA and UNHCR were already working to redress these issues. For example, there was a newly opened community health post for maternal and child health care and planning was underway to have primary health clinics, one per 5,000 populations, throughout Zaatri camp.

[62] MISP Minimum Initial Service Package for reproductive health in crises. http://misp.rhrc.org/, last accessed on August 18, 2013.

5.2 Prevent and manage the consequences of sexual violence

Rape and sexual violence in war is now recognized, codified and prosecuted as the most serious of international crimes: war crimes and crimes against humanity.[64] The field knows that discussed cases represent only part of the whole picture and the international community's response is simply inadequate to protect women and girls from these horrific acts.[63]

Therefore, even if women are not coming forward to report SV, it is important to have prevention measures and treatment protocols in place especially in a conflict-affected population.

The findings from this evaluation did not focus on documenting these acts but looked at the ways to prevent violence and treat survivors. For example, ensuring refugees have safe access to their basic needs, such as safe access to latrines and hygiene materials, can prevent SV. Protocols for the management of GBV were in place, including referral and incident reporting forms. Mandatory reporting is in place but women have a fear of disclosure. In addition, not all providers are trained in the use of the protocols. Most FGD participants were not aware of the benefits of seeking health services and the stigma associated with seeking services further prevented them from seeking health services. Typical restraints to accessing services were varied. Survivors will not seek health services unless they recognize the benefit to doing so (e.g., emergency contraceptives to help prevent pregnancy and presumptive antibiotics for STIs). A further challenge for the stakeholders is that many of these issues require long-term solutions such as getting a husband's permission or changing the location of the clinic. Other issues can be addressed more rapidly, such as community outreach about the benefits of seeking health services using existing IEC materials, improving privacy at the clinic, and training of providers. Awareness of the services and improved quality of the service will effect utilization and is key in helping women who have survived SV to access services. The stigma and fear of reporting SV is a universal phenomenon and one step to addressing this issue is by including women and men early on in the discussion of SV prevention and response.[64]

A robust SV response includes reporting, documenting, emergency contraceptives, presumptive treatment for STIs and prophylactic treatment for HIV, forensic data collection, and prosecution. The IASC GBV guidelines[65] specifically detail minimum interventions for prevention of and response to SV to be undertaken in the early stages of an emergency. Twenty-five action sheets have been developed in 10 functional/sectoral areas. In addition, interventions include a multi-sectoral approach and need participation of both female and male refugees in the discussion in order to improve response. Despite challenges in implementing SV response programs, it is equally necessary to discover the causes of SV and simultaneously include prevention activities included into the response.

5.3 Reduce the transmission of HIV

Jordan is characterized by a low-prevalence HIV epidemic, both among the general population and among key populations at higher risk of HIV exposure. The total number of HIV-infected cases registered within the period 1986-2011 was 847 (29% Jordanians and 71% foreigners). The total number of HIV-infected cases registered in 2010 and 2011 was 36 (78% males and 22% females). Sexual contact remains the main mode of

[63] Stop Rape Now. Analytical and conceptual framing of conflict-related sexual violence. http://www.stoprapenow.org/uploads/advocacyresources/1321456915.pdf, last accessed on August 18, 2013.
[64] Farwell N. "War rape new conceptualizations and realizations." *Affilia* 2004 19: 389. http://aff.sagepub.com/content/19/4/389.full.pdf+html, last accessed on August 18, 2013.
[65] Interagency Standing Committee (IASC) ,*Guidelines on Gender-Based Violence Interventions in Humanitarian Emergencies*. http://humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv, last accessed on August 18, 2013.

HIV transmission, accounting for almost 65% of HIV-infected persons.[66] Syria also has a low-prevalence HIV epidemic, with very low levels of HIV among the general population. Between 1987 and December 2011, a total of 762 HIV/AIDS cases were reported. In 2010 and 2011, 66 and 69 new cases of HIV/AIDS were found, respectively. In Syria, sexual contact is the main mode of HIV transmission.[67]

While current HIV rates remain low, various factors may increase vulnerability to HIV and STIs. Social and political conflicts uproot millions of people each year and may constitute important aggravating factors in the HIV epidemic. STIs and HIV may spread more quickly in communities where there is social disruption and instability, combined with poverty and other conditions that are often at their most extreme during armed conflicts.

Our findings showed that activities to prevent HIV, such as safe blood transfusion and standard precautions to prevent the transmission of infections, were implemented. The use of condoms correctly and every time is one way to prevent the transmission of HIV. Free condom supply seemed to be an issue despite availability at multiple locations. Attention should also be given to culturally appropriate ways of distributing the condoms.

5.4 Prevent excess maternal and newborn mortality

Safe motherhood programs are designed to reduce the high numbers of deaths and illnesses resulting from complications of pregnancy and childbirth. In too many countries, maternal mortality is a leading cause of death for women of reproductive age. Most maternal deaths result from hemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed labor. Approximately 15 per cent of pregnant women will develop complications that require emergency obstetric care, and at least five percent of pregnant women will require a caesarian section.[69] The following ratios have been found to be successful in many situations: one health post/clinic with trained community health workers and traditional birth attendants able to identify problems and refer for every 5,000 people; one equipped health center providing basic essential obstetric care for every 30,000-40,000 people; one operating theater and staff, capable of performing 24-hour comprehensive essential obstetric care, for every 150,000 to 200,000 people.[68] Delays in obtaining help may be at the community level (in identifying and referring women with difficulties); en route to the referral facility (inability to get transport, poor road conditions); or on arrival at the referral facility (absence of staff, lack of drugs or other materials).[69] Refugee women reported delays in reaching the referral facility in Zaatri camp due to high demand, intermittent ambulance service and traffic congestion in the camp that caused delays in getting to care. There was a lack of distribution of clean delivery kits because providers were concerned this would promote home deliveries instead of the established norm of facility-based deliveries in Jordan. The main challenge is to keep high quality care and improve the provider interactions with women as the need for services increases with the influx of refugees.

[66] Global AIDS response progress reporting country progress report Hashemite Kingdom of Jordan January 2010-December 2011. http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_JO_Narrative_Report%5b1%5d.pdf, last accessed on August 18, 2013.

[67] Country progress report Syrian Arab Republic January 2010-December 2011. http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SY_Narrative_Report[1].pdf, last accessed on August 18, 2013.

[68] Reproductive health services for refugees and internally displaced persons. Report of an inter-agency global evaluation 2004. http://www.iawg.net/resources/2004_global_eval/documents/REPORT/report-toc.pdf, last accessed on September 18, 2013.

[69] "The three delays model." Maternity Worldwide. http://www.maternityworldwide.org/what-we-do/three-delays-model/, last accessed on August 18, 2013.

The physical health of displaced women is often seriously depleted as a result of the trauma and deprivation associated with flight. Underlying risk factors for maternal deaths and illness, particularly severe in emergency situations, include inadequate prenatal care, which is necessary for the early detection of complications; under-nourishment; undesired pregnancies; induced septic abortion due to SV; interruption of family planning services; insufficient staff and resources for hygienic nonemergency deliveries; inadequate referral systems and/or transportation for obstetric emergencies; unsafe delivery; and postpartum follow-up practices that cause infections. The findings of this MISP evaluation showed that most of these services were in place, but it is important to note that women exposed to one or more of the above risk factors may face an obstetric emergency.[70]

Our findings confirmed that a referral system was in place, though with some challenges due to the increase in demand as the population increased in size. An appropriate referral system requires referral protocols specifying when and where to refer and an adequate record of referred cases. This implies coordination, communication, confidence and understanding between the midwives and between the health center and the hospital with surgical facilities. An effective referral system will also have to take into account security, geographical and transport constraints.[71]

Poor quality of care, lack of female providers, and lack of knowledge about newborn care can contribute to negative health outcomes. It was interesting to discover that a predictor of satisfaction of services was that fee for service was perceived as better than free care. One approach to improve quality of care may be by enhancing provider skills and improving provider/client interactions.

5.5 Plan for comprehensive reproductive health services

Planning for comprehensive reproductive health services was underway at the time of this assessment. Reproductive health data collection was underway but some obstacles were apparent, such as data quality, flow, standardized indicators across agencies and use of data for action. These types of issues are common factors that affect many HIS in crisis settings. Establishing a robust RH surveillance requires knowledge and experience in indicators. A good RH HIS provides the underpinnings for decision-making and has four key functions: data generation; compilation; analysis and synthesis; and communication and use. The HIS collects data from the health sector and other relevant sectors, analyses the data and ensures their overall quality, relevance and timeliness, and converts data into information for health-related decision-making. A good HIS brings together all relevant partners to ensure that users of health information have access to reliable, authoritative, useable, understandable and comparative data.[72]

In Irbid and Zaatri camp, there were gaps in planning and activities to expand to comprehensive RH services and to facilitate community outreach and participation. There was an expressed need for more agencies to come and focus on expanding RH services, such as ANC and newborn care. It is really important that agencies are discussing these issues now and planning for the months ahead. In addition, requests for

[70] *Reproductive health care. Public health guide for emergencies.* The Johns Hopkins and the International Federation of Red Cross and Red Crescent Societies. http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-response/publications_tools/publications/_CRDR_ICRC_Public_Health_Guide_Book/Chapter_4_Reproductive_Health_Care.pdf, last accessed on August 18, 2013.

[71] Needs assessment of emergency obstetric and newborn care, Averting Maternal Death and Disability. http://www.amddprogram.org/d/content/referral-systems, last accessed on August 18, 2013.

[72] Guidelines for evaluating surveillance systems. Prepared by Douglas N. Klaucke, M.D., James W. Buehler, M.D., Stephen B. Thacker, M.D., R. Gibson Parrish, M.D., Frederick L. Trowbridge, M.D., Ruth L. Berkelman, M.D. and the Surveillance Coordination Group. http://www.cdc.gov/mmwr/preview/mmwrhtml/00001769.htm, last accessed on August 18, 2013.

additional support were reasonable given the health needs of the population and the demands on the health care infrastructure. Again notable was the pace at which the need for additional resources is changing rapidly due to increases in demand for services. Payment for services by UNHCR in the camps is well covered but could become an issue as the population increases in size and needs increase as well. Patients could fall through the cracks so monitoring systems for payment need to be enhanced.

While almost all Syrian refugee women deliver in hospitals and maternal mortality is low, preventable maternal deaths may still occur due to failures in technique or support systems. In order to improve service quality, training needs to be addressed. Staff capacity is built through didactic and on-the-job training followed by supportive supervision takes time and funds.[73] Many women feel more at ease in seeing a female doctor, especially when dealing with RH issues. The discussion of sexual and reproductive health is often taboo and unmarried young people do not seek advice or RH services. Typically, a strategy is to put in place female doctors and train staff in the cultural norms of the refugees.

As mentioned above, FGD participants' perception of care was negative. If the beneficiaries' perceptions are negative this will influence their health-seeking behavior and agencies could see a decline in positive health outcomes. It will be important to address these concerns so perceptions can change and women feel positive about their health care experience.

5.6 Limitations

There were several limitations to this evaluation. The data were cross-sectional, which limits the ability to compare the findings to different points in time. The evaluation was conducted in the context of an ongoing crisis and a rapidly evolving emergency that resulted in a large influx of refugees each day into the study areas. As the situation was evolving, the findings need to be interpreted within this context, which was characterized by large population displacement that strained the humanitarian agencies' abilities to meet the needs for services, including health. For example, women in the focus groups may have been more likely to focus on immediate needs such as shelter, food, and water rather than worry about their own health issues. In addition, given the crisis, our field time was limited so as to not burden the stakeholders who were busy with the response efforts. Security issues, especially in Zaatri camp, varied each day, which affected the study teams' movement in and out of the camp and the length of time spent in camp.

The adaptation of the KII tool from a qualitative interview to a mixed quantitative and qualitative tool presented challenges. The interviewer was subsequently compelled to convene informal meetings instead of KIIs in seven instances. Time constraints also impacted the completion of one questionnaire.

The HFA tool presented challenges. The interviewers were compelled to change the questions and change the order of questions to improve logical flow of the interview. The tool was too long and the questions were too detailed for the context of Zaatri camp, Mafraq hospital and Irbid city. Although the facility representatives were helpful during the assessment, most were very busy and not able to take the interviewers to each department as required. Part F (equipment and supplies) of the tool was not administered in its entirety because of time and practicality of checking/observing for availability of each piece of equipment at various departments. For this section, the interviewers relied on the verbal information provided by the facility representatives and reported availability of the equipment in aggregate. For example, if C-section or delivery kits were available, the study team simply noted that the kits were

[73] Quality Assurance in the Jordan Primary Health Care System - Best Practices, Edited by: Donna Bjerregaard, 2004, USAID and the Primary Health Care Initiative. http://www.who.int/management/quality/assurance/en/, last accessed on August 18, 2013.

available, instead of giving details about the equipment contained inside the kit. This method may not have provided an accurate inventory of equipment and supplies at the facilities.

For the FGDs, the study team had to train our field team and translators, none of whom had previously conducted FGDs and only a few of whom had a professional health care background. During the FGDs, abbreviated time in the field meant that the study team could not do any in-depth probing of issues, which limited in-depth understanding of some issues. Due to language limitations, the FGD guide had to be translated. Language could have been a barrier. Although the study team translated and back translated all tools and hired bilingual staff, the social and cultural nuances that are inherently important to qualitative analysis could have been affected since the study team was able to conduct only preliminary data analysis in the field. To counter this, daily debriefings were held with members of the field team to confirm meanings of words and phrases and to ensure that all text was recorded in as much detail as possible. The study team tried to differentiate viewpoints that may have differed by length of time respondents were refugees, although it was not always possible to do so.

Lastly, the participants were chosen by NGO staff in advance of our visit and did not necessarily meet our age inclusion criteria. However, given the length of time it took for the women to walk to the FGDs, it would have been socially inappropriate to ask them to leave, as well as it could have jeopardized their relationships with the NGO staff that had asked for their participation. Attention was given to any age/power dynamics that may have occurred due to differences in age of the participants, but none were observed.

6. Conclusions

The Syrian crisis during the time of this evaluation was continuing to evolve and the steady influx of refugees into Jordan taxed the abilities of all involved agencies to meet the needs of the population. In relation to RH needs of Syrian refugees in Jordan, this translated to a need to simultaneously strengthen specific components of the MISP, particularly care for survivors of SV, with ongoing new arrivals in mind and further planning, implementing and scaling up of comprehensive RH services. Specifically, the findings translate into immediate and medium- and long-term public health activities that could be implemented to improve RH service delivery. Still, as is often the case, considerable uncertainty attends any major humanitarian response. Challenges sometimes go beyond the scope of service delivery and include funding, policy, political and social issues. Therefore, an important strategy to address the gaps discovered in this MISP evaluation is to remain focused on the tangible public health lifesaving interventions that women and girls so desperately need in this ongoing crisis.

7. Recommendations

The MOH and UNFPA, in collaboration with the RH working group, should implement the results found from the MISP evaluation. One challenge is to effectively translate the findings from the evaluation into meaningful RH services. The following recommendations are made:

7.1 Immediate

- Strengthen the RH coordination meetings by facilitating representation from the MOH, WHO, local NGOs, unfunded partners and the inter-agency protection and GBV working groups.
- Encourage UNFPA to report back to all of its stakeholders on information collected from the health agencies, perhaps through meeting minutes which could also serve to encourage missing participants by maintaining a record of progress.
- Address the needs of the urban population in all meetings, particularly the RH meeting in Amman
- Provide for women's hygiene needs, including menstrual hygiene products.
- Inform all health care providers, and protection and Family Protection Department staff about the availability and location of SV care.
- Review, establish and disseminate RH protocols on care for survivors of SV and management of STIs, prevention of HIV and standards of care for PLHIV regularly in both Amman and Zaatri.
- Post the hours of operation at health facilities in Zaatri camp.
- Identify and secure basic IEC materials on the MISP from the IAWG website http://iawg.net/iec-misp/ on the MISP and the code of conduct against sexual exploitation and abuse from http://www.pseataskforce.org/.
- Strengthen newborn care by enhancing standard newborn care practices such as early (within 30-60 minutes) initiation of breastfeeding, immediate thermal care, and hygienic cord and skin care including through home visits by community health volunteers and by conducting neonatal death audits in Zaatri to examine preventable factors and improve documentation.
- Establish Basic EmOC services throughout Zaatri, including staff and supplies to reduce the need for referrals.
- Ensure timely, accessible and affordable transport options 24 hours a day and seven days a week for emergency obstetric and newborn care.
- Given the long-term status of Zaatri refugee camp, maintain the MISP for new arrivals and transition to comprehensive RH services, including improving the quality of ANC according to national protocols, such as the detection and management of anemia in pregnancy, tetanus toxoid coverage, syphilis and rubella screening, and use of standard documentation of ANC visits.
- Conduct additional MISP trainings targeting local and international NGOs that have limited knowledge of the humanitarian architecture and provide MISP refresher discussions in RH working group meetings, with a focus on planning and transitioning to comprehensive RH.

7.2 Medium term

- Improve systematic RH HIS data collection and discuss the use of data for action, particularly in urban areas.
- Identify additional funding forSRH and support additional local NGOs that are providing RH services for Syrian refugees in urban areas and the Jordan Valley.
- Discuss unsafe abortion and access to post-abortion care in coordination meetings.
- Address physical accessibility for people with disabilities to health facilities in Zaatri camp.
- Locate SV services in safe and private spaces.
- Provide clear protocols and training on clinical management of SV.

- Provide care for survivors of SV, particularly in urban areas through collaboration with MOH and relief organizations.
- Improve knowledge of and use of standard precautions including monitoring of adherence to standard precautions in Zaatri camp.
- Inform the community, using culturally appropriate approaches, on where to access free condoms and other forms of family planning services.
- Train health care staff on manual vacuum aspiration and syndromic management of STIs.
- Disseminate and discuss the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings,* 2010 Version.
- Achieve certification in the 2011 version of the MISP Distance Leaning Module to better understand the Additional Priorities of the MISP.

7.3 Long-term

- Improve MOH contingency plan for activation.
- Continue efforts to establish community health post and community outreach in both Irbid and Zaatri camp with a view to engaging the community, including adolescents and people with disabilities, in the delivery of services.
- Maintain quality of newborn and basic and comprehensive EmOC.
- Maintain skilled staff in basic and comprehensive EmOC.
- Improve health care environment, including interactions between health care providers and Syrians, so that Syrian women feel comfortable seeking health care. Facilitating involvement of Syrian health workers with this population would be a major step forward.
- Identify and support more health care providers, particularly female providers;
- Encourage the introduction of comprehensive post-abortion care.
- Develop culturally appropriate mechanisms for improving knowledge about and attitudes toward available clinical services for survivors of violence.
- Identify national DRR policies and integrate SRH into national policies and guidelines.

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Appendix A. Minimal Initial Service Package (MISP) Objectives, Activities & Indicators[74]

<u>MISP OBJECTIVE 1</u>: ENSURE the health sector/cluster identifies an organization to lead implementation of the MISP.

A lead reproductive health (RH) organization nominates an RH officer to provide technical and operational support to all agencies providing health services; hosts regular stakeholder meetings to facilitate MISP implementation; reports back to the health sector/cluster meetings on any issues related to MISP implementation; shares information about the availability of RH resources and supplies.

PRE-IMPLEMENTATION OF MISP

OUTPUT	INDICATOR	MEASUREMENT TOOL
Background data on current emergency, country policies, and pre-crisis RH service availability and accessibility are assessed	o Current emergency ▪ Barriers and facilitating factors identified in previous MISP assessments ▪ Context of disaster or conflict ▪ Demographic and economic characteristics of the crisis-affected population ▪ Ministry of Health structure and function/status ▪ Government disaster response agency/department in existence ▪ Number and type of health facilities and RH services ▪ Mapping of who is doing what where on RH in response to the crisis ▪ Numbers displaced and where o Population-based health indicators (pre-crisis) ▪ Maternal mortality ratio ▪ Neonatal mortality rate ▪ Total fertility rate & Age-specific fertility rate ▪ Contraceptive prevalence ▪ Unmet need for family planning ▪ Births attended by trained personnel ▪ Adult HIV prevalence ▪ # People living with HIV/AIDS ▪ Prevalence of gender-based	• Literature review and background questionnaire • Key Informant Interviews (KII)

[74] MISP Distance Learning Module: http://misp.rhrc.org.

	violence, including sexual violence (SV) and child marriage	
	o Reproductive Health Infrastructure Pre-Crisis ▪ Availability of emergency obstetric care (EmOC) and basic EmOC facilities ▪ Safe blood supply ▪ Access to family planning (including condoms) ▪ Referral system for sexual violence ▪ Presence of clinical care for survivors of sexual violence ▪ Development and local organizations active in RH prior to the crisis ▪ RH as a percent of health sector budget o Enabling and restrictive laws and policies on MISP components (SV; EmOC, HIV; Referrals and comprehensive RH)	
OUTCOME: Effective coordination of MISP implementation		
OUTPUT	INDICATOR	MEASUREMENT TOOL
RH incorporated into multi-sectoral and health emergency risk management policies and plans at national and local levels • Financial resources are dedicated to RH preparedness and response • RH is included w/in disaster risk reduction (DRR) policies/plan • Identify RH focal points and familiarize with coordination and response system	o Extent to which national policies incorporate SRH within DRR (scale: 0=no DRR policy to 5=DRR policy inclusive of the MISP) ▪ Five Major MISP Components: o Coordination o Prevention of and response to sexual violence o Prevention of HIV o Prevention of excess maternal and newborn morbidity and mortality o Planning for comprehensive SRH ▪ Scale: 0=DRR policies; no components of the MISP 1=includes one of five major components of MISP 2= includes two 3= includes three 4=includes four 5=includes five o Amount of funding dedicated to MISP	KII (interview first Ministry of Health (MOH) and lead agencies, e.g., WHO/UNFPA/UNHCR, etc.)

	implementation preparation and response (total amount allocated, total amount received, sources of funding) o # MISP kits and supplies procured, stored and disseminated o MISP included in health sector situation reports	
SRH integrated into health risk assessment and provide early warning for communities and vulnerable groups • Involve communities, incl. vulnerable populations	o # national/local risk assessment conducted in past 5 years o Extent to which SRH was included in national/local risk assessment (scale: 0=no assessment to 5=assessment inclusive of all MISP priorities) ▪ Five Major MISP Components: o Coordination o Prevention of and response to sexual violence o Prevention of HIV o Prevention of excess maternal and newborn morbidity and mortality o Planning for comprehensive SRH ▪ Scale: 0=DRR policies; no components of the MISP 1=includes one of five major components of MISP 2= includes two 3=includes three 4=includes four 5=includes five o Number of the major RH risks identified in the risk assessment that were addressed o Extent of community involvement in local early warning systems (scale 0-5) ▪ 0=Communities are not informed nor involved in the development or implementation of early warning systems ▪ 1=Communities have been informed of early warning systems, but there remains a lack of clarity of appropriate actions when warning system is activated. Communities have not been involved in their	KII

	development or implementation. ▪ 2=Communities have been informed of early warning systems and are clear about their actions/response when such a system is activated. Communities have not been involved in their development or implementation. ▪ 3=Community members have been involved in the development of early warning systems and they understanding these systems and how they are meant to respond ▪ 4=Community members involved in the development and implementation of early warning systems and they understanding these systems and how they are meant to respond. ▪ 5=The development and implementation of early warning systems has been led by community members.	
Environment of learning and awareness is created around RH in emergencies and risk reduction • MISP trainings for DRR teams, providers, and community-based organizations (CBOs)	o # of MISP trainings conducted in country/site in past two years, by target audience (DRR teams, providers, and CBOs) o Percent of current humanitarian response health workers certified in MISP distance learning module o Percent of key informants who can cite at least three components of the MISP o # Dedicated staff for RH in emergencies, by cadre o Amount of funds for RH preparedness in country/site. o Level of community awareness of the MISP (benefits and reasons for seeking care for survivors of sexual violence and EmOC/newborn care and, the location and hours for services) o Level of community awareness of RH	KII Focus group discussions (FGD)

	preparedness activities and response o MISP in curricula of MOH health professionals (midwives, nurses, doctors)	
Existing SRH services are prepared to absorb impact, adapt, respond to and recover from emergencies. • Supplies are pre-positioned (RH kits, etc.) • RH staff are identified for crisis response (surge capacity) • Health services including the MISP are functional?	o Type and number of MISP kits available in region/country/site o Logistics system established to support emergency distribution of health supplies, including RH supplies o List of available RH responders is maintained	KII
Organization identified by the health sector/cluster to lead implementation of the MISP	o Presence of RH lead	KII
Weekly/bi-weekly meetings are facilitated to implement the MISP	o Frequency of MISP coordination meetings o Stakeholders involved in meetings o Orientation for staff unfamiliar with MISP	KII
Health cluster is informed of MISP implementation progress and barriers (including supplies/equipment)	o Frequency of RH updates to health cluster	KII

<u>MISP OBJECTIVE 2</u>: PREVENT & MANAGE the consequences of sexual violence.

Put in place measures to protect affected populations, particularly women and girls, from sexual violence; make clinical care available for survivors of rape; ensure the community is aware of the available clinical services

OUTCOME: Sexual violence is prevented, and the consequences are managed.

OUTPUT	INDICATOR	MEASUREMENT TOOL
Measures are in place to protect affected populations from sexual violence	o Adequate lighting for patient safety and security at health facilities (scale) o Health facilities have separate male and female latrines (lockable from the inside) and washing areas	Health Facility Assessment FGD
Clinical care is available for survivors of rape	o Percent of facilities that state that they are ready to provide emergency contraceptive pills (ECP) within 120 hours (trained staff + supplies + protocols) o Percent of facilities that have provided	Health Facility Assessment

	ECP within 120 hours in the past three months o Percent of facilities ready to provide post-exposure prophylaxis (PEP) within 72 hours (trained staff + supplies +protocols) o Percent of facilities that have provided PEP within 72 hours in the past three months o Percent of facilities ready to provide survivors sexually transmitted infection (STI) presumptive treatment <2 weeks (staff + supplies + protocols) o Percent of facilities that have provided survivors STI presumptive treatment in last three months o Percent of facilities with a clear protocol for referral for survivors of gender-based violence (GBV) psychological, medical, legal or any other form of support o Percent facilities that have referred at least one survivor of GBV psychological, medical, legal or any other form of support	
Community is aware of the available clinical services	o Community awareness about the benefits and location of care for survivors	FGD

<u>MISP OBJECTIVE 3</u>: REDUCE HIV transmission.

Ensure safe blood transfusion practice; facilitate and enforce respect for standard precautions; make free condoms available

OUTCOME: HIV transmission is reduced.

OUTPUT	INDICATOR	MEASUREMENT TOOL
Safe blood transfusion practice	o Percent of facilities with protocol for rationale blood transfusion o Blood screened for at least HIV 1 and 2, hepatitis B and C, and syphilis o Percent of referral hospitals that have sufficient HIV rapid tests to ensure all blood for transfusion is screened	Health Facility Assessment
Facilitate and enforce respect for	o Percent of facilities with standard	Health Facility

standard precautions	precaution protocols in place o Percent of health delivery sites with sufficient supplies to ensure standard precautions can be practiced	Assessment
Condoms are available, free & visible	o Percent of facilities with condom stock-out in condom distribution rate (number of male condoms distributed/total population/month) o Free condoms visibly available at health facilities o Community r**e**ports a gap in access to condoms	Health Facility Assessment FGD KII

MISP OBJECTIVE 4: PREVENT excess maternal and newborn morbidity and mortality:

Ensure availability of emergency obstetric care (EmOC) and newborn care services:

- *At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications*
- *At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies*

Establish a referral system to facilitate transport and communication from the community to the health centre and between health centre and hospital; provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible; ensure contraceptives are available to meet demand; ensure syndromic treatment of STIs is available to patients presenting with symptoms; ensure antiretrovirals (ARVs) are available to continue treatment for people already on ARVs (including for prevention of mother-to-child transmission); ensure culturally appropriate menstrual hygiene protection materials are distributed to women and girls

OUTCOME: Excess maternal and neonatal death is prevented.

OUTPUT	INDICATOR	MEASUREMENT TOOL
Underlying vulnerabilities for communities and SRH services are identified and reduced	o # of public health interventions implemented in past 1yr related to improving SRH in the community	KII (interview MOH and lead agencies, e.g., WHO/UNFPA/UNHCR)
EmOC and newborn care is available	o Number of health facilities with basic and comprehensive emergency obstetric care (EmOC): (EmOC/500,000 population) o Percent of health facilities with skilled birth attendants for normal births and management of basic EmOC and newborn complications 24 hours per day 7 days per week o Percent of health facilities with supplies for normal births and management of basic EmOC and	Mapping Health Facility Assessment

	newborn complications o Percent of referrals hospitals with skilled medical staff for comprehensive EmOC 24 hours per day 7 days per week o Percent of referral hospitals with supplies for management of comprehensive EmOC and newborn emergencies o Referral system established to facilitate transport and communication from the community to the health center and between health center and hospital functioning 24 hours per day 7 days per week o Percent of facilities with EmOC services within 1 hour's transport time	
Clean delivery kits distributed to birth attendants and to visibly pregnant women	o % pregnant women interviewed with clean delivery kits o % birth attendants interviewed with supply of clean delivery kits	KII
Condoms, pills, injectables and intrauterine devices (IUDs) available to meet demand	o Family planning methods available by type and access point	Health Facility Assessment
Syndromic treatment of STIs established	o Percent of health facilities where syndromic treatment protocols followed	Health Facility Assessment
ARVs are available to continue treatment for those on ARVs (*including for prevention of mother-to-child transmission [PMTCT])*	o Network of distribution for ARVs is functional o PMTCT protocols are followed at facilities	Health Facility Assessment
Culturally appropriate menstrual protection materials (usually packed within "hygiene kits") are distributed to women and girls	o Percent coverage of menstrual protection materials. Number of distributions, availability of distributions to targeted populations.	Existing data from distributing agency

<u>MISP OBJECTIVE 5</u>: PLAN for comprehensive RH services, integrated into primary health care (PHC), as the situation permits.

Support the health sector/cluster partners to: coordinate ordering RH equipment and supplies based on estimated and observed consumption; collect existing background data; identify suitable sites for future service delivery of comprehensive RH services; assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff

OUTCOME: Comprehensive RH services are planned for, and integrated into primary health care		
OUTPUT	INDICATOR	MEASUREMENT TOOL
Coordinate orders of RH equipment and supplies based on estimated and observed consumption	o Staff capacity assessed for comprehensive reproductive health (CRH) o Sites identified for CRH o Percent staff reporting beginning to plan for CRH. Percentage of facilities assessed that have appropriate logistical records to determine estimated and observed consumption	KII
Collect existing background data	o HIS collecting data on the MISP or other RH indicators	KII
Identify suitable sites for future service delivery of comprehensive RH services	o Future site possibilities considered	KII
Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff; fundraise, or secure funding for continuation of CRH	o Staff capacity to provide CRH assessed o Plans undertaken for training/retraining of staff o Funding secured for CRH	KII Health Facility Assessment

MISP RESPONSE		
OUTCOME: MISP response is…		
OUTPUT	INDICATOR	MEASUREMENT TOOL
Barriers and facilitating factors to MISP implementation are assessed	o The number and types of health facilities/services o The number and types of staff addressing RH o Percent of key informants citing MISP budget constraints o Percent of key informants citing inadequate supplies o Percent of key informants citing a lack of MISP specific protocols o Percent of key informants citing a lack of qualified health workers to provide MISP services o RH lead agency identified within the health cluster/sector o RH lead agency representative participating in health sector/cluster meetings regularly o Percent of key informants citing RH coordination meetings hosted regularly e.g., weekly; bi-weekly; monthly o Number and type of agencies participating in coordination o Percent each of MOH staff; local non-governmental organizations (NGOs); humanitarian and, development NGOs participating in MISP response o RH coordination meetings include an agenda specific to supporting MISP coverage o RH coordination meetings include orientation to the MISP for all new participants o RH coordination minutes available o RH coordination minutes disseminated to participants and health sector/cluster o Percent of key informants citing efficient communication with RH leads	Background questionnaire KII

	& other focal points o Barriers and facilitating factors to effective coordination identified	

Appendix B. KII Consent Form and Questionnaire

Hello, My name is_____. I work for the Women's Refugee Commission. This interview is to determine the extent to which priority sexual and reproductive health services and coordination systems have been available and accessible as outlined in the Minimum Initial Service Package (MISP) in response to this emergency. In addition, we would like to learn the facilitating factors and barriers to the availability, use and plans for MISP. During the interview, I will be asking questions about your experience in the implementation of MISP during this humanitarian emergency from this questionnaire. Throughout the process I will be writing your answers on the questionnaire. The answers you provide will be used to inform a report which might potentially be published or presented in one or more public health forums. Your identity will not be included in the report. If you are uncomfortable with any of this, you are free to opt out of participating now or at any time during the interview. In addition, you may choose not to answer any of the questions that I ask if you find them uncomfortable. Also, you can stop me at any time during the interview if you have questions or concerns, and I will answer them to the best of my ability. I anticipate that this interview will take about 45 minutes to complete.

Do you agree to participate in this interview? Yes No

Signature _____

SECTION I. PRELIMINARY INFORMATION (Complete this section before the interview begins)	
P1 Survey # (Code)	P1___ ___ ___ ___ ___
P2 Consent for interview granted IF No, why?	P2 1=Yes *(Proceed)* 2=No *(STOP)* If no, why: _____
P3 Today's date (dd/mm/yyyy)	P3 ____/____/2013
P4 Location of the interview	P4
P5 Interviewer's name	P5
P6 Respondent's organization	P6
P7 Respondent's position in organization	P7
P8 Respondent's # of years in organization	P8
P9 # of months working with Syrian refugee crisis?	P9 Months_____
P9 Time started interview:	P9 _____: _____ (00:00 – 24:00)
P10 Time ended interview	P10 _____: _____ (00:00 – 24:00)

SECTION II. BACKGROUND (Some information may be available prior to interview. Complete as necessary)	
Question	**Response**
1. What Jordanian agency is responsible for coordinating Reproductive Health (RH) services for Syrian refugees? ***(enter name of agency)***	
2. Is MISP offered within the host country RH package?	1 =Yes 2 =No 99 =Don't Know
3. Is there a list of organizations implementing RH response to this crisis?	1 =Yes 2 =No 99 =Don't Know
4. May I see a copy of the list of organizations implementing RH response to this crisis?	1 =Yes 2 =No, (specify)_____
COMMENTS BY INTERVIEWER:	

SECTION III. MISP TRAINING	
Question	**Response**
5. Have you ever heard of the Minimum Initial Service Package (MISP) for reproductive health?	1= Yes 2= No → **SKIP to Q22**
6. How did you learn about the MISP? ***(Circle all that apply)***	1= Through my current organization 2= MISP Distance Learning Module online course 3= MISP course at a university 4= Experience in the field 5= Reading the *Inter-agency Field Manual on Reproductive Health in Humanitarian Setting*

	6= Other (specify) _____
7. When was the first time you got involved with MISP in this crisis? ***(Include month and year)***	_____Month _____Year
8. In what way have you been involved with RH and MISP issues? ***(Mark all that apply)***	1= None 2= RH in emergencies Policy Plans 3= DRR program within the organization 4= MISP implementation 5= MISP monitoring 6= MISP evaluation 7= Direct patient care 8= Other (specify) _____
9. Is there a MISP curriculum available for health professionals in this organization/site?	1= Yes 2= No 99= Don't Know
10. Has there been any MISP training in this country or region for key health personnel?	1= Yes 2= No→ **Skip to Q14** 99= Don't Know
11. How was the MISP training conducted?	1= Classroom based on site 2= MISP distance learning module 3= Seminar/workshop 4= Other (specify) _____ 99= Don't Know
12. When was the last MISP training offered in this country or site? ***(Include month and year)***	_____Month _____Year
13. How many people were trained during the last MISP training?	Number trained _____

	99= Don't Know
14. How many health personnel within the organization have been assigned to the implementation of MISP?	Number assigned _____ 99= Don't Know
COMMENTS BY INTERVIEWER:	
SECTION IV. KNOWLEDGE OF MISP OBJECTIVES	
15. Please name all the objectives of MISP that you know. ***(*circle all that apply)**	1= Ensure the health sector/cluster identifies and organization to lead implementation of the MISP 2= Prevent and manage the consequences of sexual violence 3= Reduce HIV transmission 4= Prevent excess maternal and newborn morbidity and mortality 5= Plan for comprehensive RH services, integrated into primary health care as the situation permits 6= Other (specify) _____ 99= Don't Know
16. What are the additional priorities of the MISP? ***(*circle all that apply)**	1= Ensure contraceptives are available to meet demand 2= STI treatment is available to patients presenting with symptoms 3= Antiretrovirals (ARVs) are available to continue treatment for people already on ARVs including for prevention of mother-to-child (PMTCT) transmission 4= Ensure that culturally appropriate menstrual protection materials are distributed to women and girls

	5= Other (specify) _____ 99= Don't Know
COMMENTS BY INTERVIEWER:	
SECTION V. KNOWLEDGE ON MISP ACTIVITIES	
17. Please name the roles of the **LEAD ORGANIZATION** for implementation of the MISP in an emergency. **(Circle all that apply)**	1= Nominates an RH officer to provide technical and operational support to all agencies providing health services 2= Hosts regular stakeholder meetings to facilitate implementation of the MISP 3= Reports back to the health sector/cluster meetings on any issues related to MISP implementation 4= Shares information about the availability of RH resources and supplies 5= Other (specify) _____ 99= Don't Know
18. What are the MISP activities to **PREVENT AND MANAGE** the consequences of sexual violence? **(Circle all that apply)**	1= Put in place measures to protect affected populations, particularly women and girls, from sexual violence in access to health services 2= Make clinical care available for survivors of rape 3= Ensure the community is aware of the benefits and availability of clinical services 4= Other (specify) _____ 99= Don't Know
19. What are the MISP activities to **REDUCE HIV transmission**? **(Circle all that apply)**	1= Ensure safe blood transfusion practice 2= Facilitate and enforce respect for standard precautions 3= Make free condoms available

	4= Other (specify)_____ 99= Don't Know
20. What are the MISP activities to **PREVENT excess maternal and newborn morbidity and mortality:** **(Circle all that apply)**	1= Ensure availability of skilled birth attendants and supplies for normal births 2= Basic emergency obstetric (EmOC) and newborn care services at primary health facilities 3= Ensure availability of comprehensive emergency obstetric (EmOC) and newborn care services at referral hospitals 4= Distribute clean delivery kits to visibly pregnant women 5= Set up 24/7 referral services 6= Other (specify) _____ 99= Don't Know
21. How should organizations **PLAN FOR COMPREHENSIVE RH SERVICES** integrated into primary health care (PHC) as the situation permits. **(Circle all that apply)**	1= Coordinate ordering RH equipment and supplies based on estimated and observed consumption 2= Collect existing background data 3= Identify suitable sites for future service delivery of comprehensive RH services 4= Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff 5= Other (specify) _____ 99= Don't Know
COMMENTS BY INTERVIEWER:	

INTERVIEWER: It is essential that you explain to the respondent that you will be asking a series of questions that fit into three different phases. The first phase of questions address MISP Disaster Risk Reduction in this setting, the second phase of questions address Emergency Preparedness for this crisis and the third phase of questions address MISP Response in this crisis.

SECTION VI: DISASTER RISK REDUCTION & ASSESSMENTS

	Response
22. Is there a national disaster risk reduction (DRR) agency or department?	1 =Yes 2 =No → **Skip to Q24** 99 =Don't Know → **Skip to Q24**
23. What is the name of the agency or department? **(e*nter name)***	Name_____
24. Are there DRR health policies or strategies in place?	1 =Yes 2 =No → **Skip to Q26** 99 =Don't Know → **Skip to Q26**
25. Do these policies include reproductive health and vulnerable populations?	1 =Yes 2 =No 99=Don't Know
26. Has the MOH or other organization conducted a health risk assessment for purposes of providing early warning to communities?	1 =Yes 2 =No → **Skip to Q31** 99 =Don't Know → **Skip to Q31**
27. When was the assessment conducted? ***(Enter Month and/or Year)***	Month_____ Year _____ 99 =Don't Know
28. Please rank the extent to which reproductive health was included in this assessment: 0=no RH assessment and 5=RH & all MISP components included. ***(*enter rank)** The five major components of the MISP include: 1. Coordination	0=no components of the MISP 1=includes one of five major components of MISP 2= includes two 3= includes three

2. Prevention and response to sexual violence 3. Prevention of HIV 4. Prevention of excess maternal and newborn morbidity and mortality **5.** Planning for comprehensive SRH	4= includes four 5= includes five
29. What were the major reproductive health risks identified from the assessment? **(list all the risks identified)**	
30. How were the risks mentioned in above (Q29) addressed before this humanitarian crisis? **(enter description)**	
31. Describe how the communities have been involved in early warning systems**. (enter description)**	
COMMENTS BY INTERVIEWER:	
SECTION VII: PREPAREDNESS	
Question	Response
32. Did your organization make any prior preparations or arrangements for RH activities for this humanitarian crisis?	1= Yes 2= No → **Skip to Q34** 99= Don't Know
33. What are the RH programs that were prepared in advance for response to this humanitarian crisis? **(Circle all that apply)**	1= Maternal health 2= Neonatal health 3= Condom distribution 4= Access to Safe Blood 5= Standard Precautions 6= Prevention of Sexual Violence 7= Response to Sexual Violence 8= STIs

	9= Family Planning 10= ARVs for continuing users 11= Other (specify)_____ 99= Don't Know
34. Are trainings offered to health workers (nurses, doctors, midwives, etc.) in the host country to prepare for a humanitarian crisis?	1= Yes 2= No 99= Don't Know
35. What types of training do the health workers (nurses, doctors, midwives, etc.) in the host country undergo in preparation for a humanitarian crisis **(List all)**	
36. Are the following MISP activities in effect to ensure effective coordination and implementation of the MISP: 1. Incorporated RH into multi-sectoral and health emergency risk management policies and plans at national and local levels 2. There are financial resources dedicated to RH preparedness and response 3. There are RH focal points identified 4. Mapping, vetting and support of health facilities for MISP services done 5. Information, education and communication materials available to alert community of priority needs and available services 6. Data is collected on RH indicators **(Circle all that apply)**	1= Incorporated RH into multi-sectoral and health emergency 2= Financial resources dedicated to RH 3= RH focal points identified 4= Mapping, vetting and support of health facilities 5= Information, education and communication 6= Data is collected on RH indicators 7= Other (Specify) _____ 99= Don't Know
37. Were reproductive health **supplies** procured and pre-positioned prior to this humanitarian crisis?	1= Procured 2= Pre-positioned 3= Procured and Pre-positioned 4= No 99= Don't Know
38. Were reproductive health **kits** procured and pre-positioned prior to this humanitarian crisis?	1= Procured 2= Pre-positioned 3= Procured and Pre-positioned 4= No 99= Don't Know
39. Was a logistics system established in preparation to support	1= Yes

emergency distribution of health supplies including RH supplies?	2= No 99= Don't Know
COMMENTS BY INTERVIEWER:	

SECTION VIII. RESPONSE	
Question	Response
40. At what point during the present humanitarian crisis did your organization's implementation of reproductive health response begin: 1= within 1-2 weeks 2= within 3-4 weeks 3= after 4 weeks 4= or when?	1= Within 1-2 weeks 2= Within 3-4 weeks 3= After 4 weeks 4= Other (Specify) _____ 99 =Don't Know
41. What were the first RH activities to be implemented? **(circle all that apply)**	1= Maternal health 2= Neonatal health 3= Condom distribution 4= Access to Safe Blood 5= Standard Precautions 6= Prevention of Sexual Violence 7= Response to Sexual Violence 8= STIs 9= Family Planning 10= ARVs for continuing users
42. Does your organization maintain a list of host country OR other dedicated reproductive health staff to respond to new emergencies?	1= Yes 2= No
43. What are the types of health personnel in the list of	1= Doctors

responders? ***(*Circle all that apply)**	2= Nurses 3= Midwives 4= EMT 5= Other (specify) _____
44. Have any funds been made available for RH response during this humanitarian crisis? **(If YES)** How much?	1= Yes, Amount in USD:_____ 2= No 99= Don't Know
45. From which organization(s) has the funding come? **(Circle all that apply)**	1= Flash, Cap or other Donor Appeals 2= UNHCR 3= MOH 4= UNFPA 5= WHO 6= Foundations 7= Other (specify) _____ 99= Don't Know
46. What percentage of your agency's funding for this emergency setting has been allocated for reproductive health? **(Enter percent)**	1= 0-25% 2= 25-50% 3= 50-85% 4= More than 85% 99= Don't Know
47. To date, what percentage of this funding has been received? **(Enter percent)**	1= 0-25% 2= 25-50% 3= 50-85% 4= More than 85% 99= Don't Know
48. Are there RH kits available for RH response?	1= Yes 2= No → **Skip to Q53** 99= Don't Know

49. What types of RH kits are available for RH response in this emergency? **(check all that apply)**	1= Kit0: Administration 2= Kit1: Condoms (male/female) 3= Kit2: Clean delivery 4= Kit3: Post rape 5= Kit4: Oral/Injectable contraceptives 6= Kit6: Delivery 7= Kit7: IUD 8= Kit8: Management of complications of abortion 9= Kit9: Suture of tears 10= Kit10: Vacuum extraction for delivery 11= Kit11: Referral for RH 12= Kit12: Blood transfusions
50. Are the RH kits adequate for this emergency?	1= Yes → **Skip to Q52** 2= No 3= Don't Know
51. Please explain some of the reasons the kits are not adequate.	
52. Please describe the mechanisms used to distribute the RH kits.	1= Pick them up from UNFPA storage with own pickup 2= Pick them up from MoH storage with own pickup 3= Pick them up from WHO storage with own pickup 4= Get them delivered by MoH transport 5= Get them delivered by WFP transport 6= Get them delivered by private company transport 99= Don't Know

53. Are condoms distributed in the camp?	1= Yes 2= No 99= Don't Know
54. How are the condoms distributed in the camp?	1= In non-food item distribution 2= In dignity/hygiene packages 3= Through community based distribution (youth, women's groups) 4= Through clinics 5= Distributed to sex workers 6= Other (specify) _____ 99= Don't Know
55. Are clean delivery packages distributed?	1= Yes 2= No 99= Don't Know
56. How are the clean delivery packages distributed?	1= To pregnant women at registration 2= Distributed at the clinic if women come for an ANC visit 3= Distributed by TBAs 4= Other (specify) _____ 99= Don't Know
57. Who is the reproductive health lead agency for this emergency?	1= Name _____ 2= No RH Lead Agency 99= Don't Know
58. On a scale of 0 to 3 where 0=no coordination and 3=very good coordination, rank how effective the NGOs were coordinating with each other. **(Enter rank)**	0= No coordination at all 1= Some NGOs coordinated by occasional meeting among themselves 2= Some NGOs coordinate by weekly meetings among themselves 3= There is very good coordination, including the RH working weekly meetings

59. How often does the RH lead agency host the RH coordination meetings	1= Never 2= Weekly 3= Bi-weekly 4= Once a month 5= Whenever they are called 6= Other (specify) _____ 99= Don't Know
60. How often does the lead agency representative attend the health sector or cluster meetings?	1= Never 2= Weekly 3= Bi-weekly 4= Once a month 5= Whenever they are called 6= Other (specify) _____ 99= Don't Know
61. What is normally included in the agenda of the RH working group meeting?	1= General topics in RH situation among the displaced populations 2= MISP implementation 3= Information on orientation to the MISP for staff not familiar with it 4= Data collection issues on RH indicators 5= Using data for action 6= Other (specify) _____ 99= Don't Know
62. Do you think that the meetings organized by the RH lead agency include all the stakeholders (e.g., MOH, international NGOs, local NGOs and development agencies)?	1= Yes →**Skip to Q60** 2= No
63. What types of organizations are missing from the RH meetings? **(Circle all that apply)**	1= MOH 2= International NGOs 3= Local NGOs 4= Development Agencies

	5= Other (specify) _____
64. Have you identified the following protocols to support MISP implementation: A=Care for Survivors of Sexual Violence B=EmOC and newborn care C=Family Planning D=HIV prevention (blood screening; universal standards) E=STI treatment F=ARV for continuing users G=Any other protocols **If YES →** Is it MOH, WHO or other?	64.A 1= MoH 2=WHO 3=Other _____ 64.B 1= MoH 2=WHO 3=Other _____ 64.C 1= MoH 2=WHO 3=Other _____ 64.D 1= MoH 2=WHO 3=Other _____ 64.E 1= MoH 2=WHO 3=Other _____ 64.F 1= MoH

	2=WHO 3=Other _____ 64.G 1= MoH 2=WHO 3=Other _____ 99= Don't Know
65. Has your organization specifically informed the community about the benefits of seeking MISP services and where and how to locate them?	1= Yes 2= No → **Skip to Q63** 99= Don't Know → **Skip to Q63**
66. Please describe how this was done.	1= IEC materials 2= Peer educators 3= CHW 4= Radio 5= Cell phone 6= Other (specify) _____
67. Do you have any suggestions for improving MISP? Please think about all phases of MISP in an emergency – preparedness, response and implementation.	1= Disaster risk reduction policies including RH 2=More training of people on the MISP 3= Stockpiling supplies 4= Improved logistics system for distributing supplies 5= Improved coordination 6= Improved MISP protocols 7= Increase funding 8= Increase in number of Kits 9= More human resources 10= Improved skills of providers to address basic EmOC

	11= Improved skills of providers to address comprehensive EmOC 12= Improved referral system 13= Improved skills of providers to provide clinical care for survivors of sexual violence 14= Other (specify) _____
68. What factors have worked well in terms of implementing a RH response in this emergency? **(Circle all that apply)**	1= Lead RH agency 2= Adequate funding for response 3= Adequate supplies 4= Adequate staffing 5= Clear protocols for the MISP 6= Preparedness for the emergency through trainings on the MISP 7= Preparedness via stockpiling supplies 8= Preparedness via distribution of supplies 9= Other (specify) _____
69. What are some of the barriers to effective RH response to this emergency? **(Circle all that apply)**	1= Lead RH agency 2= Adequate funding for response 3= Adequate supplies 4= Adequate staffing 5= Clear protocols for the MISP 6= Preparedness for the emergency through trainings on the MISP 7= Preparedness via stockpiling supplies 8= Preparedness via distribution of supplies 9= Other (specify) _____
70. We talked about a lot of things today; do you have any final comments or questions?	

COMMENTS BY INTERVIEWER:

Thank you very much for your time

Appendix C. Health Facility Assessment Consent and Questionnaire

IDENTIFICATION INFORMATION

ID1: Facility Name	ID2: District Name	ID3: Region Name

ID4: Date of data collection				
Day	Month	Year		

ID5	Type of facility *(circle one)*	National hospital 1 Regional hospital 2 District hospital 3 Maternity 4 Health center 5 Clinic 6 Other (specify)_____7
ID6	Type of operating agency *(circle one)*	Government 1 Private 2 NGO 3 Religious Mission 4 Other (specify)_____5
ID7	Population in the catchment area of this facility	_____

A. GENERAL

INSTRUCTIONS: *Upon entering the facility, please answer the following questions based upon your observation.*

No.	Item	Response	Skip to
A1	Was the facility open at the time you arrived? ***[arrival time should be after 8am]***	No 0 Yes 1	
A2	Is there a sign posted stating the times when the facility is open?	No 0 Yes 1	
A3	Are there clearly visible signs or posters advertising the availability of Reproductive Health services? ***[Defined at minimum, as a signboard outside the facility describing Reproductive Health services at the facility]***	No 0 Yes 1	
A4	Are brochures/handouts on reproductive health services available in the facility or waiting room?	No 0 Yes 1	

INSTRUCTIONS:

Find an appropriate staff member (facility SUPERINTENDENT or officer in charge) and introduce yourself and proceed with the assessment tool as indicated. This staff member should be capable of linking you to additional resources as needed.

No.	Item
	Hello, My name is ..... I am representing ……[insert NGO], who is working at health facilities in this area. We thank you for taking the time to review our introduction letter which explained this visit, and for allowing us to visit this facility and speak with your staff. Your participation in this assessment is completely voluntary, and responses will not be connected with individuals at this facility in any way. We are grateful for your time. Do you have any questions? May I continue with the interview? _____(Data collector Initials)

First, I'd like to ask you some basic questions about the facility itself			
No.	**Item**	**Response**	**Skip to**

5	How many beds are available for patients in this facility (in all departments)? ***[Write number]***	____ ____ ____ ____	
A6	Does this facility have power?	No 0 Yes 1	→ **A10**
A7	What is the source of power for this facility? ***[Probe for all sources. Ask if there is a back-up generator]***	***1=mentioned, 0=not mentioned*** a. Power lines 1 0 b. Solar 1 0 c. Generator 1 0 d. Other(specify)_____ 1 0	
A8	Can you turn on the lights at any time of day or night as needed (for example, to handle a delivery during the night)?	No 0 Yes 1	
A9	Does this facility have clean water?	No 0 Yes 1	→**A12**
10	How is the facility's clean water supplied? ***[Probe for all sources of water]*** ***[Circle all that apply]***	***1=mentioned, 0=not mentioned*** a. Inside plumbing (external source) 1 0 b. Inside plumbing (from within the facility) 1 0 c. Outdoor pump 1 0 d. Outdoor protected well 1 0 e. Rainwater catchment 1 0 f. Water delivery 1 0 g. Other (specify) _____ 1 0	
A11	Is the system for water functioning any time of day or night as needed?	No 0 Yes 1	

TRANSPORT AND COMMUNICATION

Now I would like to ask you about the extent to which communication and transportation are available.				
No.	**Item**	**a. Availability** *(for each item circle one option below)*		
		Not Available	**Available but NONE functional**	**At least 1 available and functional**
A12	Land telephone(s) (external lines)	0	1	2
A13	Mobile phone(s)	0	1	2
A14	Satellite phone(s)	0	1	2
A15	Radio communication	0	1	2

No.	**Item**	**Response**	**Skip to**
A16	Is mobile network reception available at or near the facility?	No 0 Yes 1	
A17	Does this facility have any means of transportation?	No 0 Yes 1	**→A50**

No.	**Item**	**a. Availability** *(for each item circle one option below)*			**b. Quantities** *(please fill in number)*
		Not Available	**Available but NONE functional**	**At least 1 available and functional**	**How many available and functional?**
A18	Designated Emergency Vehicle (Ambulance)	0	1	2	_____
A19	Other motor vehicle (4 wheel)	0	1	2	_____
A20	Motorcycle	0	1	2	_____
A21	Boat	0	1	2	_____

No.	Item	a. Availability *(for each item circle one option below)*			b. Quantities *(please fill in number)*
		Not Available	**Available but NONE functional**	**At least 1 available and functional**	**How many available and functional?**
A22	Bicycle	0	1	2	_____
A23	Animal-drawn cart	0	1	2	_____
A24	Other:_____	0	1	2	_____
A25	Total number of vehicles				_____

If the facility has an ambulance, go to A46. If they have no ambulance or vehicle for emergencies, please go to A50.

No.	Item	Response	Skip to
A26	Who is responsible for ensuring that vehicles (or other transportation means) are in working order?	Facility director 1 Community 2 District health office 3 NGO 4 Other (specify) _____ 5 No one takes this responsibility 6	
A27	Are there funds available <u>today</u> for maintenance/repair if they were needed?	No 0 Yes 1	
A28	Is sufficient fuel available <u>today</u> for any motor vehicles, in case a patient requires emergency transport?	No 0 Yes 1	

A29	How do you contact the ambulance when a patient requires emergency transport?	With facility communication device 1 With personal mobile phone (facility provides credit) 2 With personal mobile phone (using my own credit) 3 Other (specify)_____ 4	
A30	How far is the nearest referral hospital within the camp?	_____km	
A31	How far is the nearest referral hospital outside the camp?	_____km	
A32	Consider the last time an emergency patient was transferred to the hospital. How long did it take from the time the decision to transfer was made until she reached the hospital? ***[Record hours OR minutes]***	_____hours _____minutes	
A33	If the time mentioned above is greater than the transfer time under normal circumstances, ask for the causes of delay.	**Causes of delay:**	

Outreach RH Services

No	Item	Response	Skip to
A34	Does this facility provide RH services through mobile teams?	No 0 Yes 1	→C77
A35	Which RH services are conducted through mobile clinics?	**1= Mentioned, 0= Not Mentioned** a. Distribution of clean delivery kits 1 0 b. Distribution of condoms 1 0 c .Distribution of other contraceptives 1 0 c. Post-abortion care 1 0 d. Ante-natal care 1 0 e. Other_____	

Access to RH Services

No	Item	Response	Skip to
A36	Is the facility open during hours that are convenient for adolescents - both female and male (particularly in the evenings or at the weekend)?	No 0 Yes 1	

No	Item	Response	Skip to
A37	Does the facility have a disabled-friendly entrance, (a ramp protected by a canopy or roof overhang)	No 0 Yes 1	
A38	Can adolescents /women be seen in the facility without the consent of their parents or spouses?	No 0 Yes 1	

Standard Precautions and Waste Management

Data collectors should ask and observe these components

Now I'd like to explore the ways this facility handles medical waste			
No.	**Item**	**Response**	**Skip to**
A39	Does this facility have an incinerator? ***[ask to see the incinerator]***	No 0 Yes 1	**→A41**
A40	Is the incinerator empty, half-full, or full? ***[Observation]***	Empty 0 Half-full 1 Full 2	
A41	Does this facility have a waste pit?	No 0 Yes 1	**→A46**
A42	Is the waste pit inside or outside the facility compound? ***[Ask to see the waste pit]***	Outside the facility compound 0 Inside the facility compound 1	
A43	Is the waste pit surrounded by a fence or wall?	No 0 Yes 1	
A44	Is the pit at least 50m away from any water source?	No 0 Yes 1	
A45	Is the waste in the pit currently covered (e.g., by soil or a lid)?	No 0 Yes 1	

A46	Is there another way, not yet mentioned, in which solid medical waste is disposed?	No other way 0 Dumped in pit latrine 1 Transported off-site 2 Other (specify) _____3	
A47	Are sharps bins/boxes used in this facility?	No 0 Yes 1	
A48	Where/how are sharps disposed? ***[if sharps bins are used, how do they dispose of them once the bins are full]***	In a pit latrine 1 Waste pit 2 Burned/incinerator 3 Other (specify) _____4	
A49	Are sharps bins/boxes re-used?	No 0 Yes 1	
A50	Which post-occupational exposure treatment does this facility provide to staff?	Nothing 0 PEP 1 Hep B vaccines 2 Hep B immunoglobulin 3	

Now I'd like to explore the ways this facility ensures sterilization			
No.	**Item**	**Response**	**Skip to**
A51	How does this facility sterilize its instruments? ***[Use section F for observation of sterilization devices]***	***1=mentioned, 0=not mentioned*** a. Autoclave 1 0 b. Hot air sterilizer 1..0 c. Steam sterilizer (electric) 1 0 d. Steam sterilizer/pressure cooker (non-electric) 1..0 e. High-level disinfection 1..0 Other (specify) _____1..0	
A52	Are funds available <u>today</u> for maintenance/repair if needed?	No 0 Yes 1	

A53	Are sufficient funds available <u>today</u> to buy kerosene or gas for pressure cooker-type steam sterilizer?	No 0 Yes 1	
A54	How many times per day is equipment sterilized for the operating theatre?	times	
A55	How many times per day is equipment sterilized for the labor ward?	times	
A56	Are gloves sterilized in this facility?	No 0 Yes 1	
A57	Are needles sterilized in this facility?	No 0 Yes 1	
A58	Are syringes sterilized in this facility?	No 0 Yes 1	

B. HUMAN RESOURCES

(Adapt list to local context)

Instructions: *The following questions should be directed towards the facility director and the person who is responsible for obstetrics/maternity. (Sections C and D could be addressed to the same person.) Record how many work in the maternity ward or operating theatre. If there is no maternity ward or operating theatre-write N/A in the appropriate column.*

Now, I would like to ask you about the staff currently working at this facility – particularly those who are providing RH services.				
No.	**Type of health worker**	**a. Total number in facility**	**b. Number in maternity ward***	**c. Number in operating theatre**
OBS	Obstetrician/Gynecologist			
PED	Pediatrician			
MD01	General medical doctor			
MID01	Nurse-midwife[75]			
MID011	Registered nurse-midwife			
NUR01	Nurse[76]			

[75] Add a row for every level of nurse-midwife, specifying the job title and answer for every type.
[76] Add a row for every level of nurse, specifying the job title and answer for every type.

CO01	Technical officer/clinical officer			
MA	Medical assistant			
PSY	Psychosocial counselor			
TBA	TBA (associated with the facility and supervised by midwife)			
	Other….. (list all that pertain to the country)			

* Including labor/delivery ward

Staff availability at this facility

No	Item	Response	Skip to
B1	What staff are *physically present in the facility* Sunday - Thursday during daytime hours?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	

B2	What staff are *physically present in the facility* Sunday - Thursday during nighttime hours?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
B3	What staff are *available* ***on call*** Sunday-Thursday during nighttime hours**? (off location)**	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	

B4	What clinical staff are *physically present in the facility* on Friday/Saturdays s during the day?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
B5	What clinical staff are *physically present in the facility* on Friday/Saturdays during the night?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	

B6	What staff are *available* ***on call*** on Friday/Saturdays during nighttime hours? **(off location)**	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	

<u>If rotation (shift) system is used, please describe below:</u>

C. RH SERVICE AVAILABILITY

The questions in this section should be directed to the director of obstetrics or midwives/clinical or medical officers.

1. *Training issues*
    a. *Authorized cadre is available, but not trained*
    b. *Lack of confidence in providers' skills*
2. *Supplies/Equipment Issue*
    a. *Supplies/equipment are not available, not functional, or broken*
    b. *Needed drugs are unavailable*
3. *Management Issues*
    a. *Providers desire compensation to perform this function*
    b. *Providers are encouraged to perform alternative procedures*
    c. *The directors of the facility do not allow the procedure*
4. *Not authorized to provide*
    a. *Required level of staff are not posted to this facility in adequate numbers (or at all)*
    b. *National policies do not allow function to be performed*
5. *No Indication- no client needing this procedure came to the facility during this time period*

Post-Abortion Care (PAC) Services

No	Item	Response	Skip to
C1	Are post-abortion care (PAC) services provided in this facility?	No 0 Yes 1	→ C15
C2	Has post-abortion care (PAC) with EVA/MVA been provided in the past three (3) months?	No 0 Yes 1	→C4
C3	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 *e.* No Indication/No clients 1 0	
C4	What staff *currently provide* post-abortion PAC with EVA/MVA in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C5	Has PAC using medication (misoprostol) been provided in the last 3 months at this facility?	No 0 Yes 1	→C7
C6	What is the main reason that this service is not provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 *e.* No Indication/No clients 1 0	
C7	What staff *currently provide* post-abortion care (PAC) with medication (misoprostol) in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C8	Has PAC (removal of retained products of conception) with any other method been provided in the past three (3) months?	No 0 Yes 1	→C10

No	Item	Response	Skip to
C9	What other method of PAC has been provided?	***1=mentioned 0=not mentioned*** a. Dilatation and curettage (D&C) 1 0 b. Dilatation and evacuation (D&E) 1 0 c. Other_____ 1 0	
C10	Has induced abortion been provided in the past three (3) months?	No 0 Yes 1	→C12
C11	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C12	What staff *currently provide* induced abortions in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C13	Is family planning offered to all clients who receive abortion services (PAC or induced) before they leave the facility?	No 0 Yes 1	→C15
C14	What is the main reason FP is not offered to all clients who receive abortion services (PAC or induced) before they leave the facility?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	

Basic & Comprehensive Emergency Obstetrics and Newborn Care (EmONC) Services

No	Item	Response	Skip to
C15	Has a normal delivery been performed in the past three (3) months?	No 0 Yes 1	→C17
C16	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 *e.* No Indication/No clients 1 0	

No	Item	Response	Skip to
C17	What staff *currently* perform normal deliveries in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C18	Has the partograph been used to manage labor in the past three (3) months?	No 0 Yes 1	→C19
C19	What is the main reason the partograph was not used?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C19	What staff *currently use* the partograph to manage labor in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C20	Is active management of 3rd stage of labor (AMTSL) performed at this facility?	No 0 Yes 1	
C21	What is the main reason AMTSL has not been performed?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C22	Which components of AMTSL are routinely done?	***1= Mentioned, 0= Not Mentioned*** a. Immediate Oxytocin b. Immediate Misoprostol c. Immediate Ergometrine d. Controlled cord traction e. Uterine massage f. Other_____	

No	Item	Response	Skip to
C23	Have parenteral antibiotics been administered for obstetric cases in the past three (3) months?	No 0 Yes 1	→C25
C24	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C25	What staff *currently make the decision to administer* parenteral antibiotics this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C26	Have parenteral uterotonics been administered (for post-partum hemorrhage [PPH]) in the past three (3) months? ***[Do not include routine use such as AMTSL.]***	No 0 Yes 1	→C28
C27	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C28	What type(s) of uterotonics were used?	***1= mentioned, 0= not mentioned*** a. Oxytocin 1 0 b. Ergometrine 1 0 c. Other (specify) _____ 1 0	
C29	What staff *currently make the decision to administer* parenteral uterotonics in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C30	Is a non-uterotonic such as Misoprostol ever used for PPH?	No 0 Yes 1	

No	Item	Response	Skip to
C31	Has intravenous fluid replacement been administered for obstetric cases in the past three (3) months?	No 0 Yes 1	→C33
C32	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C33	What staff *currently make the decision to administer* IV fluid replacement in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C34	Have parenteral anticonvulsants been administered in the past three (3) months?	No 0 Yes 1	→C36
C35	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C36	Which types of medication were used?	***1= mentioned, 0= not mentioned*** a. Magnesium Sulfate 1 0 b. Diazepam 1 0 c. Other (specify) _____ 1 0	
C37	What staff *currently make the decision to administer* parenteral anticonvulsants in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C38	Has manual removal of the placenta been performed in the past three (3) months?	No 0 Yes 1	→C40

No	Item	Response	Skip to
C39	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C40	What staff *currently perform* manual removal of the placenta in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C41	Has assisted vaginal delivery been performed in the past three (3) months?	No 0 Yes 1	→C43
C42	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C43	What instrument was used?	Vacuum extractor 1 Forceps 2 Both 3	
C44	What staff *currently perform* assisted vaginal delivery in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C45	Has newborn resuscitation (with ambu bag and mask) been performed in the past three (3) months?	No 0 Yes 1	→C47
C46	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	

No	Item	Response	Skip to
C47	What staff *currently perform* newborn resuscitation with bag and mask in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C48	Is at least one provider trained to provide the following elements of newborn care: **[READ LIST]**	***1=Yes , 0= No*** a. Encourage breastfeeding (early and exclusive) 1 0 b. Newborn infection management (including injectable antibiotics) 1 0 c. Thermal care (including immediate drying and skin-to-skin care) 1 0 d. Sterile cord cutting and appropriate cord care) 1 0 e. Kangaroo care for low birth weight babies 1 0 f. Special delivery care practices for preventing mother-to-child transmission of HIV	
C49	Has blood transfusion been performed in the past three (3) months?	No 0 Yes 1	→C51
C50	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C51	What is the source of the blood supply?	Blood comes from an external blood bank 1 Blood comes from facility blood bank 2 Blood is collected from family or friends as needed (live transfusion) 3 Other _____4	
C52	What transfusion transmissible diseases is blood screened for?	***1=mentioned 0=not mentioned*** a. HIV 1 0 b. Syphilis 1 0 c. Hepatitis B 1 0 d. Hepatitis C 1 0 e. Malaria 1 0	

No	Item	Response	Skip to
C53	What staff *currently perform* blood transfusion in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C54	Has a cesarean delivery been performed in the past three (3) months?	No 0 Yes 1	→C56
C55	What is the main reason that this service has not been provided?	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No clients 1 0	
C56	What staff *currently perform* cesarean delivery in this facility?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C57	What type of anesthesia is provided at facility?	***1= mentioned, 0= not mentioned*** a. General 1 0 b. Spinal (rachianesthesia) 1 0 c. Ketamine 1 0 d. Other (specify) _____ 1 0	

Clinical Care of Survivors of Sexual Assault

No.	Item	a. Performed in last 3 months?	b. If not performed in last 3 months, why?	
C58	Is clinical care of survivors of sexual assault provided in this facility?	No 0 → C65 Yes 1		

No.	Item	a. Performed in last 3 months?	b. If not performed in last 3 months, why?	
C59	Provide post-exposure prophylaxis (PEP) following sexual violence	No 0 Yes 1→C96	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C60	Provide emergency contraception following sexual violence	No 0 Yes 1→D1	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C61	Provide antibiotics to prevent sexually transmitted infections (STI) following sexual violence	No 0 Yes 1→D1	a. Training issues 1 0 b. Supplies/equipment issues 1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	

No	Item	Response	Skip to
C62	Is at least one provider trained to provide the following elements of care for survivors of sexual violence: **[READ LIST]**	***1=Yes , 0= No*** a. Confidential history and examination 1 0 b. Forensic evidence collection 1 0 c. Provision of PEP 1 0 d. Provision of Emergency Contraception e. 1 0 Provision of antibiotics to prevent STIs 1 0 f. Psychosocial counseling 1 0 g. Care of child survivors 1…0	
C63	What staff *currently* provide care for survivors of sexual violence?	***1=mentioned 0=not mentioned*** a. General medical doctor 1 0 b. Nurse-midwife 1 0 c. Registered nurse-midwife 1 0 d. Nurse 1 0 e. Technical/Clinical Officer 1 0 f. Medical assistant 1 0 g. Other (specify)_____ 1 0 h. Other (specify)_____ 1 0	
C64	Are there Standard Operating Procedures in place for referral of survivors of sexual violence	No 0 Yes 1	

Additional RH Services

Instructions: Please answer the following questions about these other RH services. Record whether the function has been performed in the past three (3) months, and if not, why not.

No.	Item	a. Performed in last 3 months?	b. If not performed in last 3 months, why?	
C65	Have OCPs been provided in the past three (3) months?	No 0 Yes 1	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	

No.	Item	a. Performed in last 3 months?	b. If not performed in last 3 months, why?	
C66	Have injectable contraceptives been provided in the past three (3) months?	No 0 Yes 1	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C67	Have IUDs been inserted or removed in the past three (3) months?	No 0 Yes 1	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C68	Has emergency contraception (EC) been provided for family planning in the past three (3) months?	No 0 Yes 1	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C69	Have condoms been available through the facility in the past three (3) months?	No 0 Yes .1	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	

No	**Item**	**Response**	**Skip to**
C70	Which type of condoms are provided?	Male 1 Female 2 Both 3	

No.	Item	a. Performed in last 3 months?	b. If not performed in last 3 months, why?	
C71	Has syndromic diagnosis and treatment of reproductive tract infections been provided?	No 0 Yes 1 → C91	a. Training issues 1 0 b. Supplies /equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C72	Have antiretrovirals been given to mothers in maternity/labor ward (PMTCT)?	No 0 Yes 1→C89	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C73	Have antiretrovirals been given to newborns in maternity/labor ward (PMTCT)?	No 0 Yes 1→C90	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	
C74	Has ART for PLWHA been provided?	No 0 Yes 1→C95	a. Training issues 1 0 b. Supplies/equipment issues1 0 c. Management issues 1 0 d. Not authorized to provide 1 0 e. No Indication/No Clients 1 0	

D. PAYMENT FOR SERVICES

Now I would like to ask you about payment for services and specifically during obstetric/gynecological emergencies			
No.	**Item**	**Response**	**Skip to**

D1	Is there a user fee (i.e., formal payment) required for consultation and/or treatment?	No 0 Yes 1	**→E1**
D2	In an obstetric/gynecological emergency, is any payment required before a woman can receive treatment (e.g., procedure)?	No 0 Yes 1	
D3	In an obstetric/gynecological emergency, is payment required for medications before a woman can receive them?	No 0 Yes 1	
D4	Is there a fee schedule posted in a visible and public place?	No 0 Yes 1	
D5	What is the standard, unadjusted cost (in local currency) of the following services or methods: 1. Outpatient consultation? 2. Manual vacuum aspiration (MVA)? 3. Dilation and curettage (D&C)? 4. Removal of retained products with medication (misoprostol)? 5. Combined oral contraceptives (COCs)? 7. Injectable contraceptives? 8. Emergency Contraception? 9. Male condoms? 10. Female condoms? 11. Normal delivery? 12. Vacuum delivery? 13. Cesarean section? ***Exchange Rate*** *US$1=_____ currency* **[Write NA if service not available]** **[Data entry: N/A =9999]**	_____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10 _____11 _____12	
D6	Are costs adjusted for clients who have limited resources?	No 0 Yes 1	
D7	Do the costs of care differ between refugees/displaced and the local population?	No 0 Yes 1	

E. MISP Indicators														
Instructions: *Review registers, medical records or other data sources to obtain monthly counts (for the last three months) of the services indicated below*														
	Year:	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
E1	Number of clients presenting for post-rape care													
E2	Number of days of stock-out of gloves													
E3	Number of days of stock-out of needles and/or syringes													
E4	Total number of blood transfusions													
E5	Number of blood transfu-sions screened for HIV													
E6	Number of condoms distributed													
E7	Number of clean delivery kits distributed													
E8	Number of deliveries in the facility													
E9	Number of cases with obstetric complications referred for CEmOC													
E10	Number of cesarean sections													

E11	To which Health Information System are RH data reported?	1. UNHCR HIS 2. MoH HIS 3. Other, please specify _____
E12	Do you received the HIS or MOH report?	1. Yes - 2. No 3. Don't know
E13	If you receive the report, do you use it to improve the RH services?	1. Yes 2. No
E14	Which other comprehensive RH data were collected in the last 3 months?	1. For ANC/PNC: 2. For FP: 3. For STI management: 4. For Gynaecology: 5. Other, please specify _____

Appendix D. Consent Form and Questionnaire for FGD

INTRODUCTION:

Good morning/afternoon: My name is _____ and I work at the Centers for Disease Control and Prevention. We are part of the Global Interagency working group for Reproductive Health in Crises. We are here to learn from you how the agencies in the camp can improve reproductive health services. The information discussed will be given to the agencies so that they can plan their programs.

I would like to now introduce my team. This is _____ (note taker) and _____ (translator).

Your participation is voluntary. No one is obligated to respond to any questions if s/he does not wish. Participants can leave the discussion at any time. No one is obligated to share personal experiences if s/he does not wish. Individual names should not be shared. Please be respectful when others speak. The facilitator might interrupt discussion, but only to ensure that everyone has an opportunity to speak and no one person dominates the discussion.

We will obtain informed consent for attending the session, then permission to write (record) everyone's responses. We are recording the responses only so that their valuable information is not missed. We will keep all discussion confidential. Do not share details of the discussion later, whether with people who are present or not. If someone asks, explain that you were speaking about the health concerns of women and girls.

We are conducting 8 focus groups in [place]. Your voice will represent the community but there will be no benefit to you directly for participating in this discussion.

Do you give us permission to begin the discussion?

Do you give us permission to take notes?

FOCUS GROUP DISCUSSION

MISP Assessment – Beneficiaries

FEMALES (18-24 years & 25-49 years)

Date:	Location of FGD: **NOTE: please record if this group of participants live closer or further away from the health care facilities. If possible, record the residential areas/blocks where most participants live:** **Closer:** **Residential Block/area:** **Further Away:** **Residential block/area:** **Is this a group of newly arrived (last 2-3 weeks) participants: Yes No** **Country:**
Focus group discussion facilitator**:**	
Recorder/s:	
Translation used for interview: Yes No	If yes, translation from _____ (language) to _____(language)

Number of Participants in this group (total):	Important note regarding gender: *Given the nature of these focus groups, it is recommended that women and men, boys and girls, be separated during focus group discussions. Focus group composition should be based upon the articulated research question.*
Sex of FGD participants**:** ☐ Female (specify number) _____ ☐ 15-24 years (specify number) _____ ☐ 25-49 years (specify number) _____	

I verify that the introduction to this focus group was read to all participants, and that informed consent for participation and recording was obtained from all participants in a language which was understood by all.

_____

(signature of facilitator)

QUESTIONS

A. First I would like to ask you some general questions about the situation for refugee women in this [camp/area of the city]

A1. What issues are of greatest concern among women within this [camp/area of the city]?

A1a. What could be done to improve these particular issues?

A1b. Have you seen any ways in which the agencies responding to this emergency have tried to communicate directly with members of the community about the emergency response? **Yes No**

IF YES, please describe:

B. Next, I would like to ask you some general questions about health services in this [camp/area of the city]

B1. Since arriving, have any reproductive health supplies (such as menstruation supplies, hygiene or delivery kits) been distributed to women or girls in the [camp/this area]? **Yes No [IF NO: SKIP to B1b]**

B1a. IF YES, what did the community think about these distributions?

B1b. IF YES, who did the distribution and where was it done?

B1c. IF NO, what reasons have you heard for not having these supplies?

B2. From your knowledge, to what extent have women or women's groups been involved in designing or delivering services to meet their needs in this [camp/area of the city]?

B2a. Are there any centers that are just for adolescents? [**PROBE**: have you ever visited a center that is specifically targeted for youth?] **Yes No**

B2b. Do these centers offer reproductive health services? **Yes No**

B2c. **FOR ADOLESCENT WOMEN (15-24 YEARS) FGD ONLY** What attracts you to the center?

B3. Are there any reasons why a woman would not seek health services? **Yes No**

IF YES: Can you please describe why she would not seek health services? (**PROBE**: any problems with clinic or hospital hours? providers? or medicines?)

B4. Where do women seek health care when they are **pregnant**?

B4a. Where do women seek health care **when they are giving birth**?

B4b. Where do women seek health care **after they give birth**?

B5.Do these services cost you any money? (**PROBE:** Are there costs of travel to get to the clinic or costs once at the clinic?) Yes No

IF YES, please describe what the costs are**:**

B6. What have you heard about the quality of services for pregnant women and for giving birth?

(**Skip if addressed**)

B7. How long has each participant been here?

B7a. Were services for pregnant women and for giving birth available when your arrived?

B8. How did you learn about these services for pregnant women and for giving birth?

B8a. Do women prefer a cesarean section or natural birth?

B9. What kinds of serious health problems (danger signs for pregnancy) can a woman have in pregnancy and childbirth? [**Probe**: Have you seen any serious health problems relating to women's experiences during pregnancy and childbirth since you arrived in this setting? **Yes No**

IF YES: can you please describe:

B11. If a woman is having problems with the delivery of her infant, what can she do?

B11a. Where can she go to receive care?

B11b. How will she get there?

B11c. How can women receive care if they need assistance with a delivery at night, during a weekend or a holiday?

B11d. Do women seek help for childbirth from anyone in the community? **Yes No**

IF YES, please describe the source/s of help (for example, who helps her?)**:**

B13. What are some very serious danger signs for health problems in a newborn baby?

B13a.Where can you take a baby to receive care for serious problems?

B13b. How can you get there?

B13c. How can you receive care at night, on a holiday or during the weekend?

B14. Do most women breastfeed their babies? **Yes No**

B14a. When do they start breastfeeding and for how many months do they usually breastfeed?

B15. What do women do in this society to prevent or postpone having babies?

B15a. Where do you find trusted sources of information about family planning?

B15b. Are there any costs for these services? **Yes No**

IF YES, please describe the costs:

B16. What do women in this community do when they think or know they are pregnant but do not want to be?

B17. Overall, how do you think health services for women and young people within this [camp/area] could be improved?

FOR ADOLESCENT WOMEN (15-24 YEARS) FGD ONLY

Now, I want to ask some questions about marriage

B18. What age do people usually marry?

B19. Has the common age of getting married changed for people who have been displaced from their homes? **Yes No**

IF YES, why has this change occurred?

C. Now I would like to talk about STIs/HIV/AIDS for a few minutes.

C1. What do you know about HIV/AIDS?

C2. Are people in this setting worried about getting AIDS? **Yes No**

C2a. IF YES, what do they do to prevent it?

C3. What would people do if they were taking medicine for HIV before they came here and they wanted to continue to take the medicine?

C4. Have you heard of any other diseases that you can get from having sex, for example, sexually transmitted infections (STIs)? (**PROBE:** Can you name any sexually transmitted infections [STIs]?)

C5. What would people do in this community if they thought they had a sexually transmitted infection (STI)?

C5a. Are there health services that they can use for treatment? **Yes No**

IF YES, how did you learn about these health services?

C6. Are there places in this camp where condoms can be found easily? **Yes No**

→**[IF answer is 'NO,' go to Q C6c]**

C6a. Are the condoms free? **Yes No**

C6b. How have women learned about where these condoms can be found?

C6c. If condoms cannot be found easily, what barriers prevent easy access to the condoms?

D. Now I would like to ask you some questions about how to get care if a woman has been a victim of violence.

D1. What options or services are made available to women to help them when they have been victims of violence in this [camp/area of the city]?

D1A. Should health services be made available to women who have experience violence? (**ONLY ASK IF NO HEALTH SERVICE MENTIONED IN D1**) **Yes No**

IF YES, what types of health services should be included**?**

If NO, why?

D1B. Would a woman feel comfortable using these health services? **Yes No**

IF NO, what are some reasons that she might not use these services**?**

D2. What has been heard about the quality of these health services? (**ONLY ASK IF HEALTH SERVICE MENTIONED IN D1**)

E. **Before we finish, I would like to invite you to speak up if there anything about health care services, especially as it relates to reproductive health care or care for women and young girls, that we have missed and you would like to discuss:**

We thank you for your time. You have all helped to provide a good understanding of the situation here. Your contributions are greatly appreciated. If you have any concerns, or think of additional information that should be shared, you can contact our organizations through the following contacts this week.

(Provide each participant with information about local contacts for complaints, concerns, or follow up.)

NOTES from anecdotal conversations or additional notes:

Appendix E. Acknowledgements

Amman Jordan Medical Association
Gynécologie Sans Frontières (GSF)
International Medical Corps (IMC)
International Relief and Development (IRD)
International Rescue Committee (IRC)
Institute for Family Health Noor Al Hussein Foundation (IFH)
Joint United Nations Programme on HIV/AIDS (UNAIDS)
Jordan Health Aid Society (JHAS)
Jordanian Ministry of Health
Jordanian Women's Union (JWU)
Marfraq Hospital
Medair
Médecins du Monde (MDM)
MISP Evaluation Note Takers and Translators
Moroccan Field Hospital (MFH)
Physicians Across Continents (PAC)
Royal Medical Services (RMS)
Save the Children