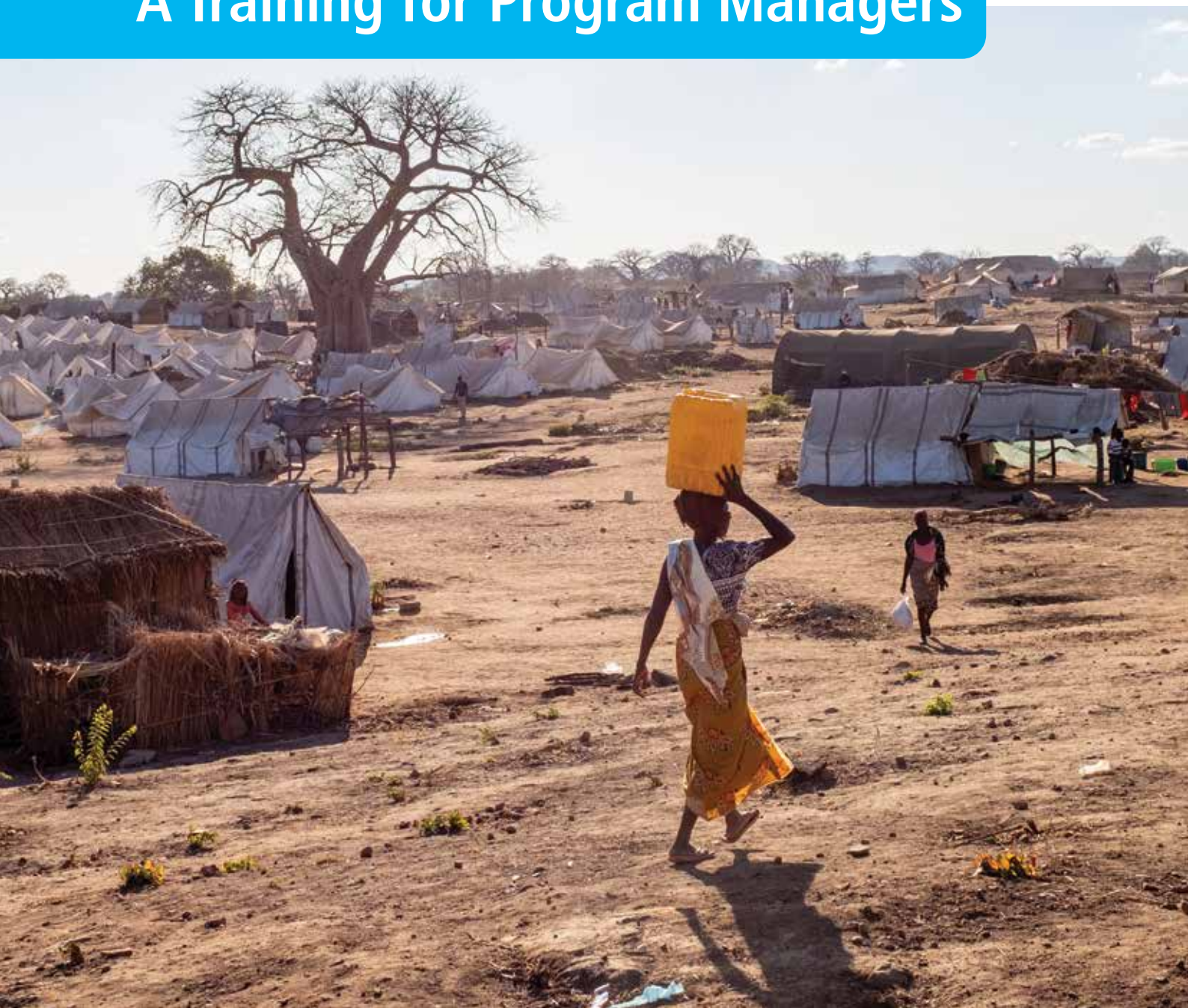
Inter-Agency Working Group on Reproductive Health in Crises

IPPF International Planned Parenthood Federation

Sexual and reproductive health in emergencies

An introduction to the Minimum Initial Service Package (MISP)

A Training for Program Managers



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Acknowledgements

This manual is inspired by the work of those around the world who fight every day to ensure Sexual and Reproductive Health (SRH) needs are met in humanitarian emergencies.

The International Planned Parenthood Federation (IPPF) led the development of the 2019 MISP for Program Managers Manual. Specific coordination and development was overseen by Keya Saha-Chaudhury (IPPF) and Dr. Kristen Beek (UNSW).

The content and structure is derived from various tools and guidelines developed by members of the Inter-Agency Working Group on SRH in Crisis Situations (IAWG), namely *The 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM).

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These materials are built on previous versions of the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises-A Course for SRH Coordinators Facilitator's Manual*, which was a result of collaboration between IPPF, the Humanitarian Response Branch of the United Nations Population Fund (UNFPA) and the University of New South Wales.

Our sincere gratitude also extends to the Australian Government for their commitment in safeguarding the rights and dignity of persons living in crises. Their commitment and support has led to the creation of the SPRINT Initiative, without which this manual could not have been developed.

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List of Acronyms

AIDS / HIV	Acquired Immune Deficiency Syndrome / Human Immunodeficiency Virus
ALNAP	Active Learning Network for Accountability and Performance
AMDD	Averting Maternal Death and Disability
ANC	Antenatal Care
AoR	Area of Responsibility (formerly Sub-Cluster)
ASRH	Adolescent Sexual and Reproductive Heath
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BEmOC / BEmONC	Basic Emergency Obstetric Care / Basic Emergency Obstetric and Newborn Care
CAP	Consolidated Appeal Process
CBO	Community Based Organisation
CEmOC / CEmONC	Comprehensive Obstetric Care / Comprehensive Obstetric and Newborn Care
CERF	Central Emergency Response Fund
CHS	Core Humanitarian Standard
CoC	Code of Conduct
CSO	Civil Society Organisation
DFAT	Department of Foreign Affairs and Trade (Australian Government)
DFID	Department for International Development (UK Government)
DRR	Disaster Risk Reduction
EC	Emergency Contraception
EmOC / EmONC	Emergency Obstetric Care / Emergency Obstetric and Newborn Care
FP	Family Planning
GBV	Gender based violence
GBV AoR	Gender based violence Area of Responsibility
GPC	Global Protection Cluster
HIV / AIDs	Human immunodeficiency virus / Acquired immune deficiency syndrome
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings
IARHK	Inter-Agency Reproductive Health Kit
IASC	[UN] Inter-agency standing committee
IAWG	Inter-Agency Working Group (on reproductive health in crises)
ICPD	International conference on population and development -1994
ICRC / IFRC	International Committee / Federation of the Red Cross / Crescent Societies
IDP	Internally Displaced Person
IEC	Information, Education, and Communication
IP	Implementing partner
IPPF	International Planned Parenthood Federation

LGBTQIA	Lesbian, gay, bisexual, transgender, queer, intersex & asexual
M&E	Monitoring and Evaluation
MA	[IPPF] Member Association
MISP (for SRH)	Minimum Initial Service Package for Sexual and Reproductive Health in Crises
MNH	Maternal and neonatal / newborn health
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MVA	Manual Vacuum Aspiration
NGO	Non-governmental organisation
OCHA	[UN] Organisation for the coordination of humanitarian affairs
PEP	Post-exposure prophylaxis
PLW	Pregnant and lactating women
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPH	Postpartum haemorrhage
PSEA	Protection from sexual exploitation and abuse
RH	Reproductive health
RHRC	Reproductive Health Response in Conflict Consortium
RMC	Respectful Maternity Care
SC	Sub-Cluster
SGBV	Sexual and gender based violence
SHRiE	Sexual and reproductive health in emergencies
SPRINT	Sexual Reproductive Health Programme in Crisis and Post-Crisis Situations
SRH/R	Sexual and reproductive health / and rights
STI	Sexually transmitted infections
SV	Sexual violence
TBA	Traditional Birth Attendant
ToT	Training of Trainers
UN	United Nations
UNFPA	United Nations population fund
UNHCR	United Nations high commissioner for refugees
UNICEF	United Nations Children's Fund
UNISDR	United Nations International Strategy for Disaster Reduction
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VAW	Violence against Women
VAWC	Violence against Women and Children
VAWG	Violence against Women and Girls
WASH	Water, sanitation and hygiene
WG	Working Group
WHO	World Health Organization
WRA	Women of Reproductive Age
WRC	Women's Refugee Commission

A note on Terminology

There is ongoing debate regarding certain terminology in relation to both sexual and reproductive health and in relation to humanitarian affairs. Whilst clearly defined and universally understood and agreed terms are crucial, training will not focus on the (often long-standing) debates around different terminologies. Here are outlined some of the interchangeable terminologies with a brief explanation of the debate and the language this training will use.

SRH **Sexual and Reproductive Health**
SRHR **Sexual and Reproductive Health and Rights**
RH **Reproductive Health**

Sexual health and reproductive health are clearly interlinked and interdependent. IPPF has always favoured use of SRH to emphasise the equal importance of sexual health, as stated by the International Conference on Population and Development in Cairo in 1994. In humanitarian settings, sexual health can be overlooked by focusing on reproductive health and in particular on maternal health alone. This preference for SRH over RH is now reflected in the 2018 Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, the key guidance document for SRH programming in humanitarian settings.

SRHR emphasizes the importance of SRH as a basic human right. In this training we will reference SRH, SRHR, and RH interchangeably. We will have to reference RH at certain points as this is the terminology used within some RH in Crises tools and guidelines.

The Minimum Initial Service Package (MISP)

The Minimum Initial Service Package for sexual and reproductive *health defines which SRH services are most important in preventing morbidity and mortality, while protecting the right to life with dignity in humanitarian settings*. The MISP was first articulated in the 1999 guidance document Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. Since that time, the MISP has undergone a series of revisions which have included technical updates and re-prioritisation. The most current version of the MISP is found in the 2018 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* referenced throughout this manual as IAFM 2018 (http://iawg.net/wp-content/uploads/2019/01/2018-inter-agency-field-manual.pdf). This manual serves as the authoritative source for SRH programming in humanitarian settings and is based on guidelines issued by key international organisations including the World Health Organization (WHO). It will provide the technical contents of this training.

Sub-Clusters (SCs)
Working Groups (WGs)
Areas of Responsibility (AoRs)

In accordance with the 2009 Health Cluster Guide, SRH is defined as an 'area' under health. It is the role of the Health Cluster to assign a partner agency in the Health Cluster to lead on SRH and generally form a working group. Sometimes these can be referred as sub clusters. In this manual the terms maybe used interchangeably. GBV sits under the Protection Cluster (PC) as opposed to the Health Cluster. GBV was previously designated a sub-cluster and is now designated an AoR.

It is important for participants to understand the differences between global cluster guidance and the structures present within their context. Wherever possible, reference nationally led clusters or sectors relevant to the implementation of the MISP for SRH.

SRH / RH Coordinator…Focal Points…Programme Managers

Within this training manual we refer to the individual responsible for SRH coordination in humanitarian settings as the SRH Coordinator. This is in line with the 2018 Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, which states that the SRH Coordinator *is responsible for supporting health sector/ cluster partners to implement the MISP and plan for the provision of comprehensive SRH services*. This person may be from the government, UNFPA or another agency, and will function within the health sector/ cluster and coordinate, communicate and collaborate between the health sector/ cluster and the GBV and HIV sectors/ clusters/ actors to ensure the prioritisation of SRH and the implementation of the MISP.

Individuals responsible for SRH response at the agency level are referred to in this manual interchangeably as focal points or programme managers.

GBV	**Gender-Based Violence**
SGBV	**Sexual and Gender-Based Violence**
SV	**Sexual Violence**
VAW	**Violence against Women**
VAWG	**Violence against Women and Girls**
VAWC	**Violence against Women and Children**

The different uses of terminology for GBV (often used interchangeably) are more than semantics, and represent a significant issue in relation to the scope of GBV, particularly in relation to how men and boys are included or not.

In 1993, the UN Declaration of the Elimination of Violence against Women offered the first official definition of the term "gender-based violence" (GBV) as "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life."

Gender-based violence has become an umbrella term for any harm that is perpetrated against a person's will and that results from power inequalities that are based on gender roles. Around the world, gender-based violence almost always affects women and girls. However, it is clear that sexual violence is also perpetrated against men and boys and so many organisations (notably, UNHCR) deliberately reference SGBV to include men and boys. Others (notably, DFID) clarify their programming position by specifically referencing VAWG – being very clear that particular funding streams, programmatic approaches, or policy commitments relate to violence perpetrated against women and girls. Some countries (for example, the Philippines), are keen to include boys and therefore reference Violence against Children (VAC).

Both IPPF generally and IAWG / MISP reference GBV, SGBV, or SV. The MISP explicitly references sexual violence in its second objective. As such, this training will use the term sexual violence (SV), except where broader reference is made to gender-based violence (GBV). The term 'survivor' of sexual violence is preferenced over other terms, including 'victim' of sexual violence.

EmOC	**Emergency Obstetric Care**
EmONC	**Emergency Obstetric and Newborn Care**
BEmOC	**Basic Emergency Obstetric Care**
BEmONC	**Basic Emergency Obstetric and Newborn Care**
CEmOC	**Comprehensive Emergency Obstetric Care**
CEmONC	**Comprehensive Emergency Obstetric and Newborn Care**

Signal functions[1] are used for monitoring emergency obstetric care (life-saving emergency interventions performed by skilled providers to manage the majority of maternal complications in pregnancy, childbirth and postpartum period).

The signal function of basic neonatal resuscitation using bag and mask to treat asphyxia, constitutes the only intervention for newborns among all the signal functions, and so while WHO, UNFPA, UNICEF and AMDD refer to the package as EmOC. Others feel that even though only one signal function is related to newborn care, it is critical enough to reference the care package as EmONC.

Revisions to the MISP and Inter-agency Field Manual on Reproductive Health in Humanitarian Settings have preferenced the terms EmONC (including BEmONC and CEmONC), and provided specific guidance on newborn care. This training will follow this guidance and the terms EmONC, BEmONC and CEmONC will be used throughout.

LGBTQIA **Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual**

The term LGBTQIA is used throughout this manual and its accompanying documents as per the IAFM and the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module* (Draft 2019). For more information on individual term definitions see Human Rights Campaign (HRC) Glossary of Terms. Assessed at: https://www.hrc.org/resources/glossary-of-terms

Note: many organisations may use other terms such as SOGI, LGBTIQ+, LGBT

1 Signal functions are a representative shortlist of key interventions and activities that address major causes of morbidity or mortality and that are indicative of a certain type and level of care. See Monitoring emergency obstetric care: a handbook, WHO 2009 (available at: https://www.unfpa.org/sites/default/files/pub-pdf/obstetric_monitoring.pdf); and Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors WHO, 2nd Ed., Geneva, (available at: https://www.who.int/maternal_child_adolescent/documents/managing-complications-pregnancy-childbirth/en/)

Purpose and Structure of the Manual

This Facilitators Manual will take you through the various steps necessary to facilitate a training workshop on sexual and reproductive health in emergencies and the MISP for SRH for program managers at a national level.

This training for program managers is one of three modules of the IPPF Training Package. The three components, which together form a comprehensive capacity development approach, are:

1. A workshop for policy makers on sexual and reproductive health in emergencies and the Minimum Initial Service Package for Sexual and Reproductive Health;

2. Training for program managers on the Minimum Initial Service Package for Sexual and Reproductive Health; and

3. Training for service providers on the Minimum Initial Service Package for Sexual and Reproductive Health.

In addition to covering the MISP for SRH objectives and activities, additional sessions are included on Day 4 which cover more programmatic aspects of MISP implementation such as adolescents, M+E, logistics etc.

This manual accompanies the **PowerPoint Slide Deck** titled *Sexual and Reproductive Health in Emergencies: Training for Program Managers*. In addition to covering the six objectives and other priority of the MISP for SRH it also covers topics such as adolescents, funding, inclusion, logistics and M+E which are considered important for implementation of the MISP for SRH and are also addressed in the IAFM.

The manual provides a daily agenda for training and a description of the **key messages** to cover while facilitating the training. All group work and discussion activities and their instructions, and **handouts for participants** are also provided in this manual.

Note to facilitators boxes are included throughout the manual. These contain suggestions on how to make the session more interactive, links to additional information or resources, or strategies to contextualise information on that slide.

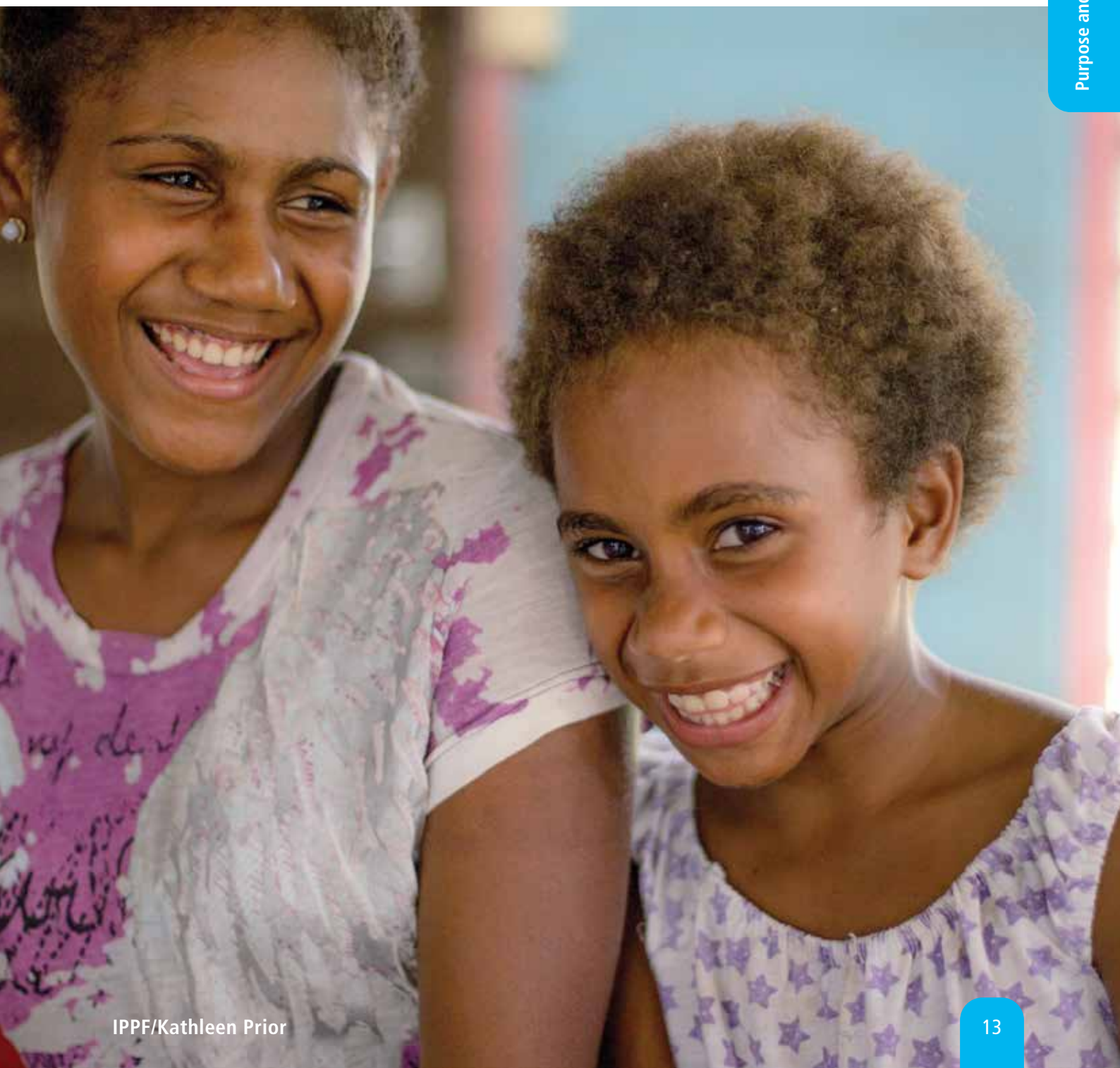
A **scenario** is introduced at the beginning of the manual and should be incorporated throughout the training. The use of a scenario will help participants visualise the discussions and practice the theory being discussed. A choice of scenarios is provided, or if you prefer, you can adapt to a scenario better suited to your context.

There are a number of **activities and group discussions** in this manual to make learning more interactive and progress preparedness. It is not intended or feasible to do all of these. Facilitators will need to select the activities for each session which are most relevant to their context.

The training concludes with a **mapping exercise** designed to support stakeholders in identifying gaps and next steps towards MISP implementation.

A **pre- and post-test** is included to provide insight into the base level of understanding so that facilitators can adapt the training or identify areas that may need emphasis. The pre-test should, therefore, be marked as soon as possible after the commencement of the training. In some instances, participants may wish to see their own scores on the pre- and post-tests. Consider allocating a number or a symbol so that trainees may see the differences in their scores without being identified.

Many of the **resources** used throughout this training were being updated at the time of writing this manual or may have been updated since. It is important for facilitators to refer to the latest versions of all resources online where possible to ensure that the latest information and guidance is provided to participants.



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Objectives of the Training

At the close of the training, all participants should:

1. Explain why it is important to address sexual and reproductive health in emergencies.
2. Define key terminology & concepts for planning for and responding to sexual and reproductive health needs in emergencies.
3. Describe the roles all sectors or clusters must play in planning for and responding to sexual and reproductive health needs in emergencies.
4. Outline the objectives and activities prescribed by the MISP for SRH.
5. Demonstrate skills in coordinating or supporting the activities necessary for MISP planning and implementation.
6. Identify the role they have in supporting preparedness for and implementing the MISP for SRH in emergencies.

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Planning and Conducting the Training

The intended audience for this workshop is representatives of relevant government agencies or national staff of an NGO, INGO, or United Nations (UN). They should be program coordinators or managers within their agencies, and be in a position to either lead the SRH response in emergencies (as SRH Coordinator), or support the assigned organisation and SRH Coordinator to ensure SRH needs are addressed in emergencies in their context. Participants should be familiar with SRH and involved in preparedness or response work in their country but are **not** expected to be clinicians/service providers.

Before planning a training, a basic needs assessment/discussion should be conducted to identify capacity development needs and whether training is the correct response. If it is decided that training is the appropriate tool for building the needed capacity in this context, a decision should be made about whether training on the MISP for SRH is the most appropriate, and which of the three modules (for Policy Makers, Program Managers or Service Providers) best fills gaps in capacity.

Inviting Participants

This workshop will require careful planning, particularly when it comes to making sure the right people attend. What is important is that those invited to attend the workshop for program managers are in a **position** to **implement** the knowledge and skills developed during the training and are likely to be involved in the event. The purpose of this training is to build knowledge and practical skills in coordination of MISP for SRH implementation and as such, participants should be in a position to integrate these knowledge and skills into their work roles for preparedness and in emergency response.

It is therefore vital that **the right people are invited** to the training.

This may require having clear participant criteria and inviting and reminding with sufficient time (approx. two to three months in advance) to ensure they can participate.

Participants may be identified by training organisers through a mapping of key stakeholders and/or partners who would be responsible for MISP implementation. Alternatively, it may be possible to identify volunteers by placing announcements for interested candidates to attend during working group meetings/events.

A Learner Profile Template is available in the handouts. Once participants are selected, this document will allow facilitators to understand the strengths and gaps in participants' knowledge and skills. This information can then be used to help shape the workshop contents. Please note that it is not a requirement for participants to come from a medical or clinical background. Participants are expected to be certified in the MISP Distance Online Learning Module (http://iawg.net/minimum-initial-service-package/) before attending the training.

Adaptation to local contexts

Note that as with any global training manual, this training must be adapted to local contexts. This means that if working days run to different hours, the training schedule as provided as a guide should be adapted. Any particular legal policy, or cultural or religious sensitivities should be respected. The training very heavily relies on participants being able to link each session to their own particular context. As facilitators, you need your participants to engage with the issue of SRH in emergencies so that they might meet the objectives of the training outlined above. For this to happen, it is important to remember that:

> *Each country, region or community has a different context … and they have different causes or symptoms of that issue. Being aware of this context is essential for effective communication, and it will help you make your case more relevant, legitimate and powerful* (UNAIDS, 2014)[2].

To ensure that the program managers you invite to the workshop see the relevance of the MISP for SRH to their contexts and are therefore motivated to take action with their new knowledge and skills, the contents of the workshop must be relevant and relatable. **At every opportunity, make sure to integrate national or local examples, statistics, policies, laws, case studies, and even pictures**. In preparation for facilitating the training, you will need to source specific information for your context. These are indicated throughout the Guide for Facilitators and a number of slides have been left blank throughout the presentation slidedecks as indications of when context-specific information should be added.

During the training, there are numerous opportunities to engage with your participants' prior knowledge and experience by asking questions, eliciting answers before showing slides, allowing for discussion and asking for input. Allowing participants to share their knowledge is excellent for both peer learning, and for placing the training contents in context. As a facilitator, you should be on the lookout for these opportunities and open to allowing your participants the time and space to share. The '**Note to facilitators**' boxes included throughout the manual often serve as a reminder of these opportunities for sharing and discussion.

To ensure contextualisation, it is important that participants from a range of key ministries, agencies and organisations can attend. The MISP requires inter-sectoral action and it is important that each sector relevant to implementation of MISP for SRH components is engaged in the training.

Contextualisation of the training materials and content is important to show that the MISP for SRH is a priority in any emergency setting. While this contextualisation is encouraged throughout this manual it must be stressed that the **MISP for SRH is an evidence-based life-saving package and as such, should be covered in full during the workshop**.

2 UNAIDS (2014) *ACT! 2015 Advocacy Strategy Toolkit*
http://www.unaids.org/sites/default/files/media_asset/advocacy_toolkit_en_0.pdf

Completion of the training

Depending on contextualisation training can be from three to five days. It is important to recognise the efforts of participants who commit this time and energy to the training.

Only those participants who participate in all days of the training and complete the pre- and post-tests should be considered as having completed the training.

Notes on Facilitators, Facilitation and Training Skills

Facilitators should be knowledgeable about SRH in emergencies and have expertise in one or more area covered by the MISP. Ideally, three or more facilitators should be engaged to conduct the workshop and they should, together have knowledge and experience across all objectives, including the other priority activity of the MISP for SRH. In addition, the facilitation team should be diverse and provide varying experience in preparedness and response. Previous experience in training on the MISP or other areas of SRH is valuable.

Inviting guest speakers is also important and will reinforce the messages of inclusion which run throughout the IAFM 2018 and this training.

A number of other people may also be invited to help strengthen the messages of your workshop:

- For the Stories of Accessing SRH in Emergencies activity it is suggested that you may invite one or two people who have lived experience of requiring or choosing to access sexual and reproductive health services in a humanitarian setting to speak. You could also ask those who have been involved in responding to sexual and reproductive health needs in emergencies to present to the group about their experiences and what they witnessed during those times. Other options are provided if this is not possible.

- When discussing national and/or sub-national coordination mechanisms, it may be valuable to have someone from relevant government departments or ministries to briefly present. Again, other options are presented if this is not possible.

- When discussing inclusion or youth it also may be good to bring a colleague from a relevant Community Based Organisation (CBO) to help share experience and co facilitate.

When facilitating, remember that people learn in different ways and it is important to use different methods to engage these different learning styles. This manual includes a variety of interactive approaches to aid your facilitation. Training and facilitation can be daunting at first. Notes to help with facilitation and training skills can be found at the end of this manual. Remember that practice is important and all trainers gain confidence and improve with time.

Remember: as a Facilitator, you are an SRH advocate. It is of critical importance that the delivery of this training supports and promotes sexual and reproductive rights, and clearly explains that the services identified within the MISP are necessary within humanitarian action and beyond. Women, girls, men and boys in all their diversity all have a right to these services regardless of any bias or personal beliefs of service providers, programme managers, or facilitators running this training. During the training facilitators should model the key messages in the manual.

Key resources for all participants

The **Inter-agency Field Manual on Reproductive Health in Humanitarian Settings** (2018) is the key resource document for this training. It is referenced throughout this manual as the **IAFM 2018**.

In addition to the various documents listed throughout the manual, provide all participants with a copy of the IAFM 2018 or Chapter 3: The MISP **as a minimum**. It would be helpful for participants to have access to the entire IAFM 2018 for reference.

Also provide the MISP for SRH Cheat Sheet and related advocacy documents (available at www.IAWG.net or on the accompanying USB). Key resources are provided on the accompanying USB however it is good to check the websites regularly for updates or latest materials.

IPPF/Peter Caton

Agenda

Day 1: Sexual & Reproductive Health in Emergencies

Session 1.1	Introduction to sexual & reproductive health in emergencies
Length	2 hours
Overview	This session will welcome participants to the training for program managers and provide an introduction to why it is important to address sexual and reproductive health needs in humanitarian settings from different perspectives.
Methodology	Pre-test Interactive presentation Video Case study Storytelling
Materials	Pre-test PowerPoint presentation Video: SRH in emergencies/ audio-visual equipment Participant handouts & supplies MISP for SRH Cheat Sheet

Break

Session 1.2	Inclusion: Leaving no one behind
Length	2 hours
Overview	This session will provide participants with an 'inclusion lens' which they should carry with them through the remainder of the training. It focuses on marginalisation and vulnerability, but also the capacities inherent in populations. Inclusion is an important crosscutting theme that emerges from the IAF (2018) and is a critical component of effective and equitable programming.
Methodology	Interactive presentation Group work & power walk
Materials	PowerPoint presentation Flipcharts/ paper & markers Participant handouts & group work supplies

Break

Session 1.3	MISP Objective 1: Ensure the Health Sector/ Cluster identifies an organisation to lead implementation of the MISP for SRH
Length	3 hours
Overview	This session will provide participants with an understanding of global and national coordination mechanisms for SRH in humanitarian emergencies. Participants will also develop skills in coordination and an appreciation of why coordination is so important for MISP implementation.
Methodology	Interactive presentation Group work & role play Presentation by government representative or other (if possible)
Materials	PowerPoint presentation Participant handouts & group work supplies

Day 1 Close

Day 2: The Minimum Initial Service Package: Objectives 2 & 3

Session 2.1	**MISP Objective 2: Prevent sexual violence & respond to the needs of survivors**
Length	4 hours
Overview	This session will develop program managers' knowledge and skills in preventing sexual violence & responding to the needs of survivors in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Video presentation Group work & role play
Materials	PowerPoint presentation Video: GBV/ SV in emergencies/ audio-visual equipment Handouts & group work supplies Flipchart & markers

Break

Session 2.2	**MISP Objective 3: Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs**
Length	2 hours
Overview	This session will develop program managers' knowledge and skills in preventing the transmission of & reducing morbidity & mortality due to HIV & other STIs, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Group work & role play
Materials	PowerPoint presentation Participant handouts & group work supplies Flipchart & markers

Day 2 Close

Agenda

Day 3: The Minimum Initial Service Package: Objectives 4, 5 & 6 & Other SRH Priority

Session 3.1	MISP Objective 4: Prevent excess maternal & newborn morbidity & mortality
Length	2 hours
Overview	This session will develop program managers' knowledge and skills in preventing excess maternal and newborn morbidity & mortality in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.
Methodology	Interactive presentation Group work Discussion
Materials	PowerPoint presentation Participant handouts & group work supplies

Break

Session 3.2	MISP Objective 5: Prevent unintended pregnancies
Length	2 hours
Overview	This session will develop program managers' knowledge in preventing unintended pregnancies in emergencies, with a focus on how the MISP for SRH addresses this serious SRH concerns.
Methodology	Interactive presentation Case study
Materials	PowerPoint presentation Participant handout & case study supplies Flipchart & markers

Break

Session 3.3	MISP Objective 6: Plan for comprehensive SRH services, integrated into primary health care as soon as possible
Length	1 hour
Overview	This session will provide participants with an overview and practical skills in planning for comprehensive SRH services integrated into primary health care as soon as possible, and working across the health systems building blocks to ensure sustained, improved and expanded SRH services.
Methodology	Interactive presentation Discussion Group work
Materials	PowerPoint presentation Participant handout & group work supplies

Break

Session 3.4	MISP Other SRH Priority: Safe Abortion Care to the full extent of the law
Length	1 hour
Overview	This session will explore the importance of providing safe abortion care in humanitarian emergencies, and context-specific laws and resources. Challenges and enablers to providing safe abortion care services will be considered.
Methodology	Interactive presentation Reflective exercise
Materials	PowerPoint presentation Participant handout & exercise supplies Flipchart & markers

Day 3 Close

Day 4: Supporting MISP Implementation

Session 4.1	Supporting MISP Implementation: Adolescent SRHR in emergencies
Length	1 hour
Overview	This session will require participants to consider the particular needs and strengths of adolescents in humanitarian settings.
Methodology	Interactive presentation Group work
Materials	PowerPoint presentation Participant handout & group work supplies If possible: copies of the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*

Break

Session 4.2	Supporting MISP implementation: Funding
Length	45 minutes
Overview	This session will provide participants with an understanding of global and national funding mechanisms for SRH in humanitarian emergencies.
Methodology	Interactive presentation Group work
Materials	PowerPoint presentation Group work supplies Flash Appeal documents Post its

Short Break

Session 4.3	Supporting MISP implementation: Logistics
Length	1 ½ hours
Overview	This session will develop program managers' knowledge and skills in logistic management for the implementation of SRH programs in emergencies.
Methodology	Interactive presentation Group work
Materials	PowerPoint presentation Participant handout & group work supplies Flipchart & markers

Break

Session 4.4	Supporting MISP implementation: Assessment, monitoring & evaluation
Length	1 hour
Overview	This session will develop program managers' knowledge and skills in assessment, monitoring & evaluation for the implementation of SRH programs in emergencies.
Methodology	Interactive presentation
Materials	PowerPoint presentation

Break

Session 4.5	Next Steps
Length	2-3 hours
Overview	This session will allow participants to practically apply their newly developed knowledge and skills to planning for next steps in preparedness and for response.
Methodology	Group work Post-test
Materials	Participant handout & group work supplies Post-test

Training close

Guide for Facilitators

Day 1

Sexual & Reproductive Health in Emergencies

Session 1.1 2 hours

Overview

This session has two purposes:

1. Welcome participants to the training for program managers and set the scene for the training
2. Provide an introduction to why it is important to address sexual and reproductive needs in humanitarian settings from different perspectives

Methodology

- Pre-test
- Interactive presentation
- Video
- Case study
- Storytelling

Materials

- Pre-test
- PowerPoint presentation
- Video: SRH in emergencies
- Audio-visual equipment
- Participant handouts #1 & #2 & supplies
- MISP for SRH Cheat Sheet

Slide #1: Day 1: Sexual and reproductive health in emergencies

Welcome your participants to 'Sexual and reproductive health in emergencies: Training for Program Managers'.

Introduce yourself and any co-facilitators or administrative support personnel.

Key Messages

- This training is one of three developed by IPPF. As well as this training for program managers, there is a workshop for policy makers and a training package for service providers. These may be available to you if useful and relevant in your context.
- Sincere appreciation goes to the Australian government for its continuous support of the SPRINT Initiative.

Note to facilitators Introduce your organization as relevant. You are also welcome to add your institution's logo on the slidedeck while also acknowledging IPPF.

Slide #2: Introductions

Now move to introductions. Have participants introduce themselves by name, position, organization, and involvement in the humanitarian sector and/or sexual and reproductive health. Consider having an icebreaker, depending on timing and audience.

Possible icebreaker Instead of asking participants to say their names, divide the group into pairs. Give each pair of participants a few minutes to interview each other and resume as a larger group. Each participant should then introduce her/his/their partner by name and share at least two unique characteristics about her/him/them. As is best practice for large group work, ask a woman participant to begin the partner introductions.

Pre-test Administer the pre-test when participants have finished introductions and/or the icebreaker exercise. Allow 15-20 minutes for participants to complete the test. After this time, collect tests and inform participants that you will present results later in the day or by tomorrow at the latest.

Facilitators should identify the weakest questions and ensure that these are covered carefully in the respective sections.

Note to facilitators This may be a good opportunity to discuss and level expectations and ground rules with participants.

Slide #3: Session 1.1: Introduction to sexual and reproductive health in emergencies

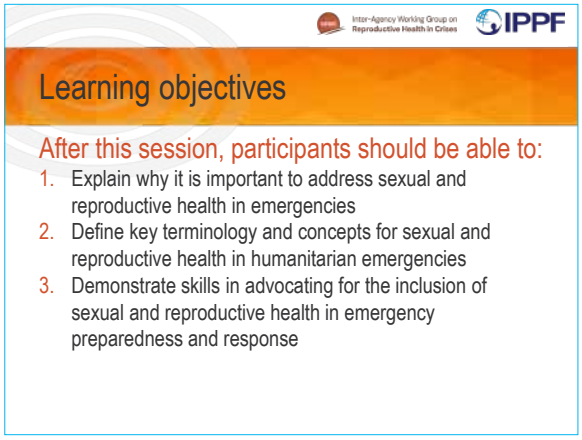
Explain that the first session of the day will be an introduction to sexual and reproductive health in emergencies.

Note to facilitators Encourage your participants to ask questions at any point, especially if something is unclear.

Slide #4: Learning objectives

Key Messages

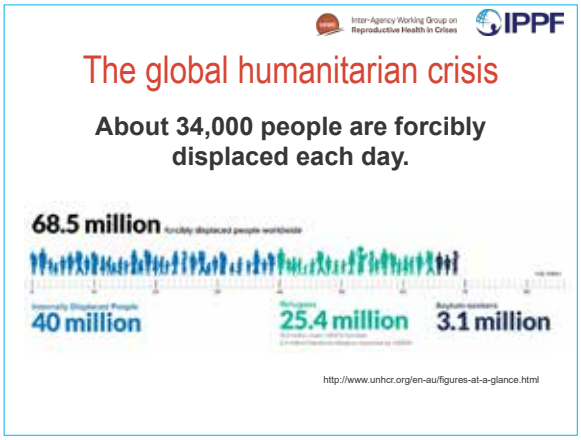
- There are 3 learning objectives for session 1.1



1. Explain why it is important to address sexual and reproductive health in emergencies
2. Define key terminology and concepts for sexual and reproductive health in humanitarian emergencies
3. Demonstrate skills in advocating for the inclusion of sexual and reproductive health in emergency preparedness and response

Slide #5: The global humanitarian crisis

Key Messages



- In 2018, the United Nations High Commissioner for Refugees (UNHCR) estimated that the global forcibly displaced population exceeded 68 million for the first time in history.
- This included over 25 million refugees, more than 40 million internally displaced persons, and more than three million asylum seekers.
- Approximately 34,000 people become displaced every day.
- Natural hazards are increasing- the IFRC estimate that 3,751 natural hazards have been recorded over the last 10 years, equating to more than one a day.
- Given the magnitude and increasing impact of disasters, if we do not address SRH needs during humanitarian emergencies, we are unlikely to meet our commitments under the Sustainable Development Goals and the gains made to reduce maternal mortality.

Note to facilitators Consider including information about regional, national, or setting-specific humanitarian issues.

Link For further statistics or updates, visit:

- http://www.unhcr.org/en-au/figures-at-a-glance.html
- https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/10/B-WDR-2018-EXECSUM-EN.pdf
- https://interactive.unocha.org/publication/globalhumanitarianoverview/
- https://www.unocha.org/story/us219-billion-needed-2019-average-length-humanitarian-crises-climbs

Slide #6: National or Regional Context

This slide has been left blank so that you may provide information on the humanitarian situation in your local, national and/or regional context.

Slide #7: Causes of the global humanitarian crisis

Key Messages

- Crises can be caused by various dangerous phenomena (hazards), and may also involve a combination of these hazards.
- Multiple causes of crises may be found in any one setting.

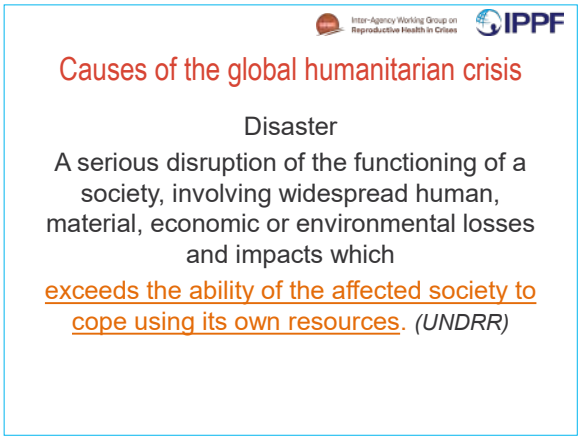
Note to facilitators Consider including information about regional, national, or setting-specific causes of humanitarian crises in your setting. You could also ask participants for their experience with various emergencies in your context.

For more information and definitions of hazards, visit:

- http://www.ifrc.org
- http://www.who.int/environmental_health_emergencies/complex_emergencies/en/
- http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/definition-of-hazard/complex-emergencies/
- http://www.unisdr.org/we/inform/terminology

Slide #8: Causes of the global humanitarian crisis

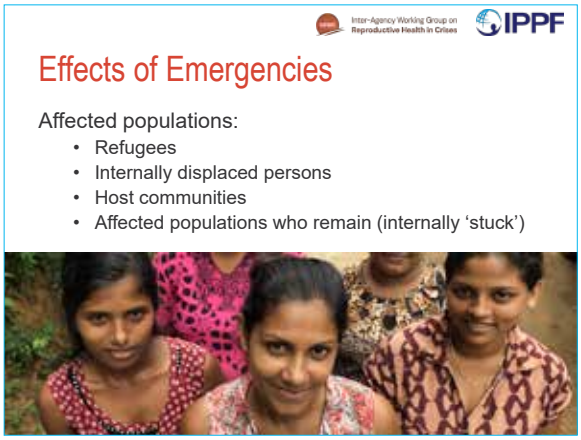
Key Messages



- This definition from UNDRR (formerly UNISDR) will guide our understanding of disaster throughout this training. In this definition, the focus is on a situation that is beyond the capacity of the local or national government to cope with.
- There are many definitions of 'disaster', 'emergency' or 'crisis'. In the context of this training when 'disaster', 'emergency' or 'crisis' is mentioned, it is the definition given on this slide that is being referred to. In this training, 'emergency', disaster and 'crisis' are used interchangeably.

Slide #9: Effects of emergencies

Key Messages



- Various populations are affected by emergencies:
  - Refugees: "people who have been forced to flee their homes by conflict or persecution. They are unwilling or unable to avail themselves of the protection of their own government, and must seek protection in another country" (UNHCR).
  - Internally Displaced Persons or IDPs have not crossed an international border to safety but have remained inside their home countries. Even if they have fled for similar reasons as refugees, IDPs legally remain under the protection of their own government (UNHCR).
  - Host communities include populations in the region/area to which refugees or internally displaced persons flee.
  - Affected populations who remain (internally 'stuck' populations) include people who remain in the area affected by the crisis as they are unable or unwilling to leave. This inability or unwillingness to leave may be due to poverty, the geographic limits of the affected area (remote, island or other areas), the scale of the hazard, insecurity or hazards in surrounding zones, and/or the continuation of some services within the affected area (such as in urban areas affected by disasters).

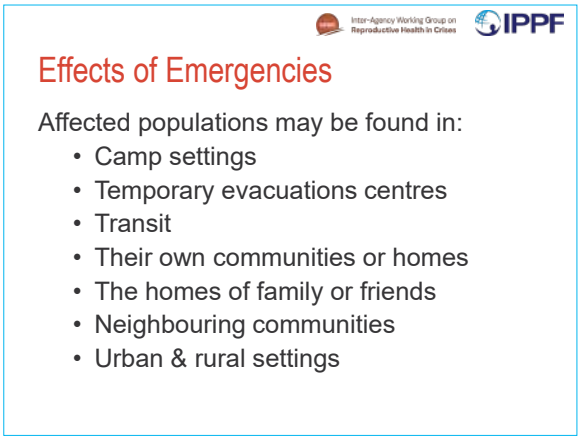
Note to facilitators For more information and definitions of affected groups, visit:

- http://www.unrefugees.org.au/?WT.mc_id=AWBRAND003&gclid=CLvSw-ur5a4CFQhLpgodcxi3xg
- http://www.unrefugees.org.au/what-we-do/who-we-help

Slide #10: Effects of emergencies

Key Messages

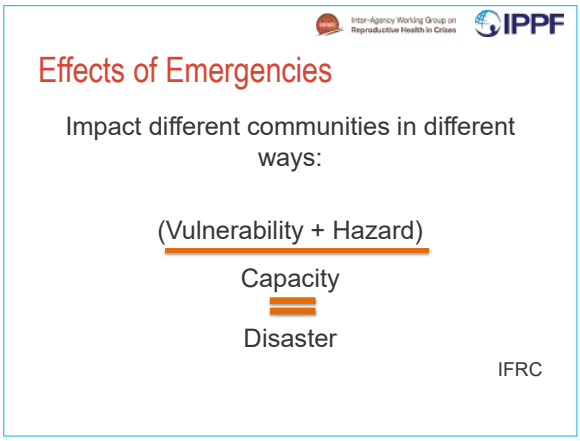
- It is important to recognize that affected populations can be found in many different locations, including but not limited to those on the slide. And that these locations may be present in both rural and urban settings.



Slide #11: Effects of emergencies

Key Messages

- Emergencies affect people in different ways.
- Vulnerability of the affected population, the magnitude of the hazard, and the capacity of individuals, households, communities and wider systems to cope with or resist a threat influence whether a hazard will become a disaster, and the impact that disaster may have on affected populations.



- This equation is a useful way to think about the variables which determine the real impact of hazards on an affected community. For the purposes of this training, 'disaster' refers to events arising from both natural and human induced hazards.

- Vulnerability in this context "can be defined as the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard. The concept is relative and dynamic. Vulnerability is most often associated with poverty but it can also arise when people are isolated, insecure and defenceless in the face of risk, shock or stress" (https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/).

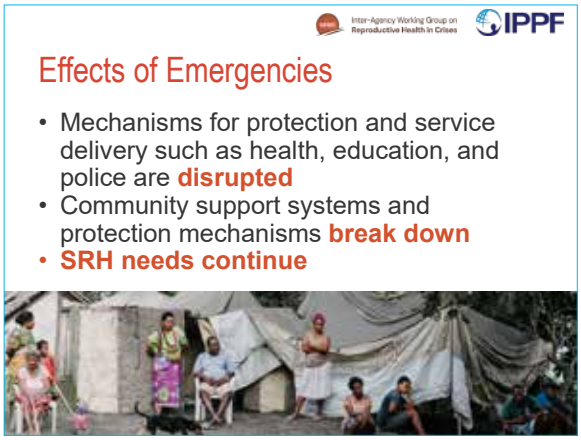
- "The reverse side of the coin is capacity, which can be described as the resources available to individuals, households and communities to cope with a threat or to resist the impact of a hazard. Such resources can be physical or material, but they can also be found in the way a community is organized or in the skills or attributes of individuals and/or organizations in the community" (https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/).

- This equation also shows where interventions may be directed before a crisis occurs-through action to *reduce the vulnerability of populations*, and *increase capacity* (the purpose of this training). Targeting these areas before a crisis occurs improves resilience.

Note to facilitators For more information on this equation and the different ways hazards affect populations, visit: https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/

Slide #12: Effects of emergencies

Key Messages



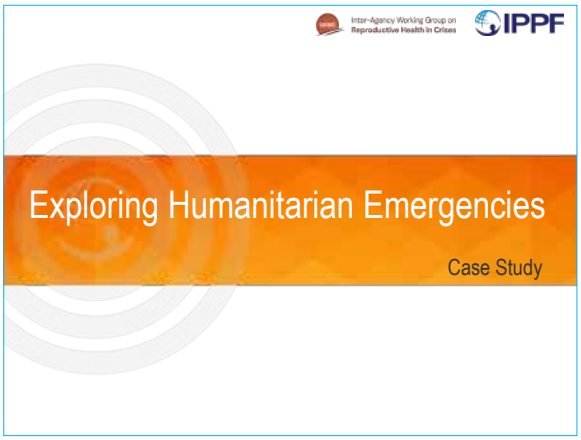
- The process of displacement results in changes to social structures and systems. For example:
  - Families and communities are separated.
  - Mechanisms for protection and service delivery such as health, education, and police are disrupted.
  - Community support systems and protection mechanisms break down.
  - Existing power dynamics (based, for example on age or gender) may become more prominent during a crisis and underserved groups can have less access to information and services.
  - The need for sexual and reproductive health information and services do not stop because of a crisis.

- These dynamics have a profound impact on SRH services and outcomes. For example:
  - Women and girls' risk of sexual violence may increase because of breakdown in societal structures, displacement overcrowding, and disruption of legal services.
  - The lack of access to information and services combined with high population density and increased risk of sexual violence can increase risk of unintended pregnancy, unsafe abortion, and STI/HIV transmission.
  - The inability to reach health facilities or skilled workers, and increased risk of malnutrition and communicable diseases during crisis can make delivery unsafe, and increase risk of pregnancy complications. Indeed, when health services are disrupted or impossible to access, complications in pregnancy/childbirth can quickly become deadly.
  - Crisis situations can lead to an increase in risk-taking behavior which increases risk of having unintended pregnancies and contracting STIs and HIV infection.
  - Crises have a disproportionate impact on people with disabilities.
  - Adolescent SRH needs and adolescents' access to SRH services can be particularly complicated in crisis and are often restricted in stable times.

Slide #13: Exploring humanitarian emergencies: Case Study

Case Study

This group activity will introduce participants to the case study scenario which will be used throughout the training. This first step to using the case study includes a background to an emergency situation to allow participants to better engage with the realities of humanitarian settings.



Time

15-20 minutes

Process

- Divide participants into groups of 3-5.
- Provide each group with copies of the chosen case study (see Participant Handout #1 and decide which case studies are most relevant to your group). Groups may be provided with the same or different case studies, depending on relevance to your context.

- Explain to participants they only have to read through the case study and highlight the key elements of the crisis. There will be a chance to go through it in more detail as the training progresses. As they are reading ask participants to think about:

  1. What is the cause of the crisis (hazard)?

  2. Who/where are the affected populations and what are their particular vulnerabilities, coping capacities and health determinants?

  3. What are the main health challenges people in crisis are facing?

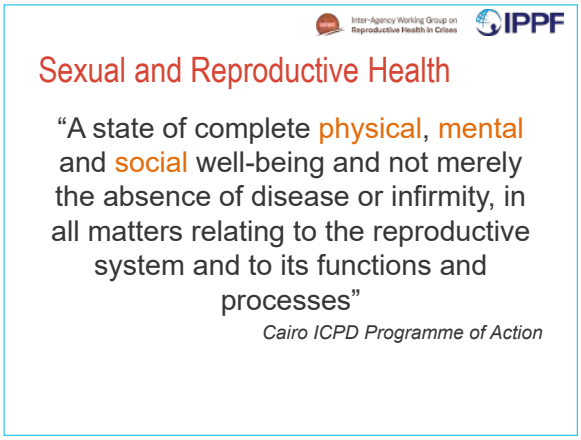
- At the close of 15 minutes, bring participants back for a general discussion of these key points and issues in the case studies. In the interests of time-keeping and in order to avoid repetition, you may ask participants to comment separately on different aspects of the crisis.

Materials

Participant Handout #1 contains both case studies. Select the one which will be distributed before proceeding.

Slide #14: Sexual and reproductive health

Key Messages



- The definition given on this slide was created at the International Conference on Population and Development held in Cairo in 1994. Stress the holistic nature of this definition.

- This was the first time that SRH was defined as a right and a matter of choice for individuals.

- SRH is not merely the absence of disease or infirmity.

- Refugee and internally displaced persons rights, including adolescents, were explicitly recognised in the ICPD Programme of Action.

Note to facilitators To download the ICPD Cairo Program of Action, visit http://www.unfpa.org/public/site/global/publications/pid/1973

Slide #15: Effects of emergencies on SRHR

Key Messages

- Women and girls are at particular risk in humanitarian settings.
- In any crisis-affected population, approximately 4% of the total population will be pregnant at any given time. Of these pregnant women and girls, approximately 15% will experience an obstetric complication such as obstructed or prolonged labour, pre-eclampsia/ eclampsia, infection or severe bleeding. The WHO estimates that 9% to 15% of newborns will require lifesaving emergency care (IAFM 2018). The first day of life is the highest risk for newborns.
- In humanitarian settings, it is essential to provide SRH services. Morbidity and mortality related to SRH is a significant global public health issue and those in humanitarian settings often face heightened risks and additional barriers to SRH services. Research from around the world has shown that conflict-affected and displaced women and girls are at increased risk of:
  - Rape and other forms of sexual violence
  - Early, child, and forced marriage
  - Human trafficking
  - Unintended pregnancy
  - Unsafe abortion
  - Complications during pregnancy and delivery
  - STI & HIV infection
- It is important to also consider the needs of male survivors of sexual violence who are at increased risk of things such as STI/HIV infection, human trafficking etc.

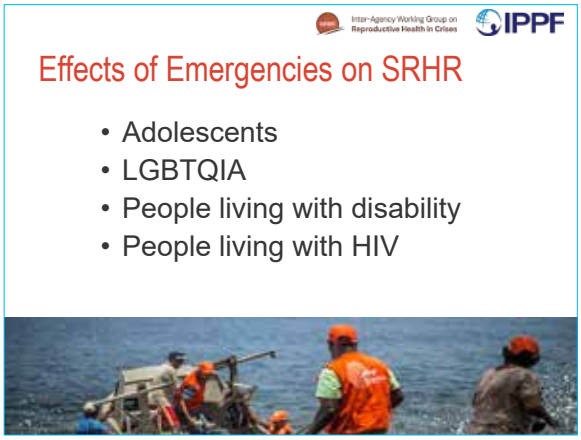
Note to facilitators Ask participants why they think women and girls are at particular risk in humanitarian settings and facilitate a brief discussion. For more information on this, visit:

- https://www.unfpa.org/sites/default/files/sowp/downloads/State_of_World_Population_2015_EN.pdf

- https://www.one.org/us/2015/03/16/why-we-must-invest-in-girls-and-women-in-humanitarian-crises/

Slide #16: Effects of Emergencies on SRHR

Key Messages

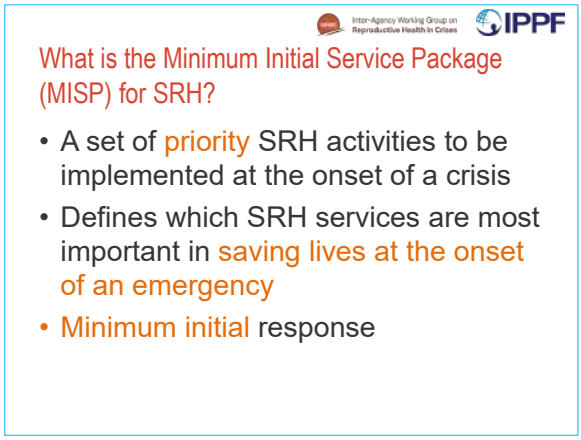


- Emergencies impact people in all their diversity. It is therefore important to consider the specific SRH needs of all populations.
- Adolescents are often forgotten during humanitarian crises but are at increased risk of threats to their sexual and reproductive health during emergencies. They are also a resilient and resourceful group who should be engaged with in a meaningful way.
- LGBTQIA individuals face a variety of risks and present with divergent sexual and reproductive health needs during emergencies. It is important to engage with LGBTQIA self-help or rights groups and make sure that service provision points are respectful of diversity.
- People living with disabilities and their caregivers have specific, and often increased, risks and sexual and reproductive health needs during emergencies. They also often face extreme discrimination by service providers. It is important to engage with disability rights organisations and ensure that SRH services are available and accessible to this often hidden or excluded population.

Note to facilitators Ensure that participants are familiar with and/ or understand the terms used on this slide. Ask participants to identify other marginalised groups in their context. When discussing the impact of emergencies on people in all their diversity, make sure to emphasise that each 'population' (such as people with disabilities, LGBTQIA individuals, adolescents etc.) are not homogeneous groups. Each individual has a multitude of attributes which intersect and make them, and their SRH needs, unique. This will be explored further in the section on Inclusion, as will strategies for working in respectful partnership with all groups.

Slide #17: What is the Minimum Initial Service Package for SRH?

Key Messages



- In response to the clear need for sexual and reproductive health services in humanitarian emergencies, the international community developed a set of minimum standards for response- the Minimum Initial Service Package or MISP for SRH.
- The MISP defines which SRH services are most life-saving, while protecting the right to life with dignity, particularly for women and girls, in humanitarian settings.
- All services should be in place within 48 hours of the onset of an emergency, and build to more comprehensive services as soon as possible, ideally within 3-6 months.
- The services included in the MISP are based on well-documented evidence of SRH needs in humanitarian settings and World Health Organization normative standards. **Thus, we do not need an in-depth needs assessment to tell us which SRH services to implement**. However, some initial situational, demographic and health information is needed to optimize delivery of the MISP.
- It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. Even where other components of SRH care are available, we should ensure that the MISP services are first implemented and available to all as they are most life-saving. As soon as possible, and certainly within 3 months, humanitarian stakeholders should expand services towards comprehensive SRH service delivery.
- The MISP is a 'package' as it is accompanied by a set of supplies that are defined by the Inter-agency Emergency Health Kits. These will be referred to and explored throughout the training.

Slide #18: What is the Minimum Initial Service Package for SRH?

Key Messages

- This slide shows the MISP for SRH Cheat Sheet.

Note to facilitators

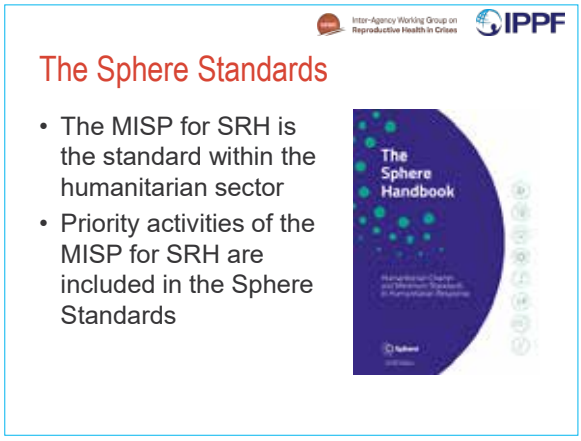
- Provide all participants with a copy of the MISP for SRH Cheat Sheet if they do not already have it.
- Explain that this is a very useful reference document and should be referred to throughout the training.
- Allow participants a few minutes to glance through the document.

IPPF/Hannah Maule-ffinch

Slide #19: The Sphere Standards

Key Messages

- The MISP for SRH is the standard within the humanitarian sector. SRH is included in the Sphere Minimum Standards in Humanitarian Response for Health, which outlines priority activities including MISP activities.
- MISP for SRH is also integrated into the global health cluster guidance.



Note to facilitators Make sure that participants are familiar with the Sphere Standards and Handbook.

The following description is taken from the Sphere website, at https://www.spherestandards.org/about/

"The Sphere movement was started in 1997 by a group of humanitarian professionals aiming to improve the quality of humanitarian work during disaster response. With this goal in mind, they framed a Humanitarian Charter and identified a set of humanitarian standards to be applied in humanitarian response.

"Initially developed by non-governmental organisations, along with the Red Cross and Red Crescent Movement, the Sphere standards have become a primary reference tool for national and international NGOs, volunteers, UN agencies, governments, donors, the private sector, and many others. Today, Sphere is a worldwide community which brings together and empowers practitioners to improve the quality and accountability of humanitarian assistance.

"Sphere's flagship publication, the Sphere Handbook, is one of the most widely known and internationally recognised sets of common principles and universal minimum standards in humanitarian response".

For more information on the Global Health Cluster Guide see: https://www.who.int/health-cluster/resources/publications/hc-guide/en/

Slide #20: Who is IAWG?

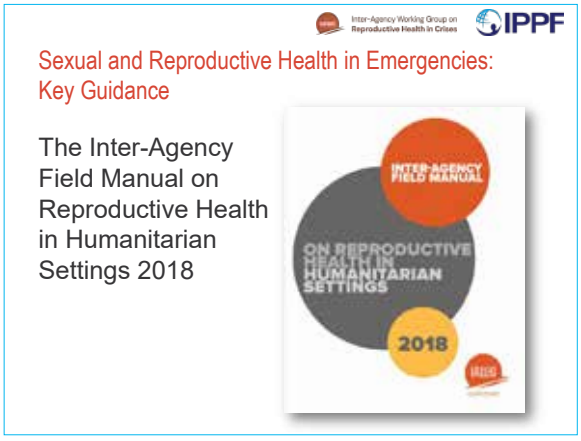
Key Messages

- The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) developed the MISP as part of the Inter-Agency Field Manual and Reproductive Health in Crises (IAFM). The most recent version was released in September 2018.
- The IAWG for RH in crisis is a broad-based, highly collaborative coalition representing United Nations, government, non-governmental, research, and donor organisations. Founded in 1995 and formerly known as the IAWG on Reproductive Health in Refugee Situations, the IAWG for RH in Crises works to expand and strengthen access to quality SRH services for people affected by conflicts, natural disasters and public health emergencies. The IAWG for RH in Crises is currently led by a 19-member Steering Committee comprising United Nations agencies and non-governmental humanitarian, development, research, and advocacy organisations. In 2018, it had more than 2,800 individual members from 450 agencies.

Note to facilitators Encourage your participants to look into IAWG and consider finding out if their organisations are members or if they are interested in joining. Participants can make a valuable contribution to IAWG by participating in sub-working groups. A link to the IAWG web page is provided on the slide. Make sure you allow enough time for your audience to write this down.

Slide #21: Sexual and reproductive health in emergencies: key guidance

Key Messages



- The MISP is contained within the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.
- This manual serves as the authoritative source for SRH programming in all humanitarian settings. The MISP focuses on the acute setting while other chapters provide more in-depth guidance on SRH in protracted or fragile settings.
- It provides much of the content of this training and will be a key reference document for your learning.

- Additional tools and resources related to MISP implementation are available on the IAWG website (www.IAWG.net) and will be references throughout the training.

Note to facilitators If participants have been provided with the 2018 IAFM, allow them a few minutes to flick through the document now. Briefly go through the structure of the document, highlighting relevant chapters, including Chapter 3: Minimum Initial Service Package.

Slide #22: SRH in emergencies: Video

Video Presentation

The video presentation will provide participants with an opportunity to engage with the realities of sexual and reproductive health needs in humanitarian emergencies and to see its importance.

Time

Dependent on video chosen. Suggest no longer than 10 minutes for this activity.

Process

- Choose a video that is most relevant to your context. The following are suggestions only. They are provided on the USB but many other options are available online.
- Project the chosen video.
- Video Discussion (optional): After showing the video, facilitate a large group discussion that addresses the following questions:

  1. What are your reactions to the content of the video?
  2. What does the video tell us about SRH in crisis?
  3. (Depending on the video shown) What do you see as the SRH priorities at the outset of a humanitarian emergency?
  4. What do you see as the facilitators and barriers to implementing those priorities?

- As is best practice for group work, call first on a woman to respond to the questions.

Materials

Audio-visual equipment (be sure to test the sound in advance)

Suggested videos (included on the USB):

- Women & War- UNFPA
- MISP in India- Government of India, UNFPA and partners
- Planning Sexual & Reproductive Health before Emergencies- WRC
- IPPF Humanitarian Slideshow- IPPF

Slide #23: Stories of accessing SRH in emergencies: Group work

Stories of Accessing SRH in Emergencies

Following from the video on SRH in emergencies, this activity will provide participants with the opportunity to hear and learn from people who have been directly affected by humanitarian crises.

Time

20 minutes

Process

You have a number of options for presenting stories of affected populations:

1. Invite one or more individuals from your context who have lived experience of requiring or choosing to access sexual and reproductive information and services in humanitarian emergencies. You could also ask those who have been involved in responding to sexual and reproductive health needs in emergencies to present to the group about their experiences and what they witnessed during those times.

2. Provide real life written accounts of people from your context who have lived experience of requiring or choosing to access sexual and reproductive information and services in humanitarian emergencies.

3. Provide the more generic written accounts included in this training module to participants from IPPF. Ideally, you will also have contextualized these for your particular workshop participants (Participant Handout #2).

If you choose to use options 2 or 3, divide the written accounts of people accessing SRH services in emergencies between the tables. Ask each small group or pair to read through and absorb the information provided.

After five minutes or so, ask each small group or pair to discuss their story and how they feel it highlights the need for SRH in crisis.

Materials

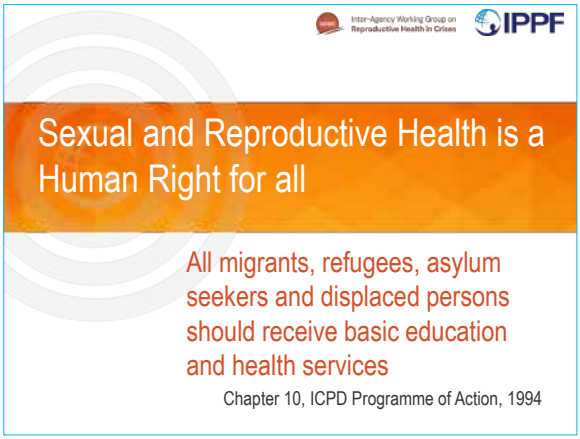
Participant Handout #2 if using option 3 (above).

Finish by revealing the rest of the slide and emphasise that addressing sexual and reproductive health in emergencies

- Prevents disease
- Prevents disability
- Saves lives

Slide #24: Sexual and reproductive health is a human right for all

Key Messages



- As well as being lifesaving, access to sexual and reproductive health is a human right and, like all other human rights, it applies to refugees, internally displaced persons, and others living in humanitarian settings.
- To realize this right, affected populations must have access to SRH information and services so they are free to make informed choices about their health and well-being.
- The global political community has made progress, especially in addressing the gravity of sexual violence in armed conflict. The United Nations Security Council Resolutions 1325, 1820, 1888, and 1889 on Women, Peace, and Security affirm the unique needs, perspectives, and contributions of women and girls in conflict settings. The Security Council has recognized sexual and reproductive health, with Resolution 1889 explicitly referencing the need to ensure women and girls' access to SRH services and reproductive rights to achieve better socioeconomic conditions in post-conflict situations.

Note to facilitators Present information on the human rights obligations of your context. This need only be brief but mentioning international commitments can be an important way to prompt action.

For more information on various human rights resolutions and statements in support of SRHR see Handout #2 of the Policy Makers manual.

Slide #25: Sexual and reproductive health is a human right for all

Key Messages

- All countries have signed up to various international protocols such as the Convention on the Rights of the Child, the Sustainable Development Goals (specifically SDGs 3 and 5), and the Sendai Framework of Action for Disaster Risk Reduction (specifically priority 3), and other legal instruments which require the provision of SRH services even in times of emergency in order to maintain the achievements and gains made during stable times

Slide #26: The continuum of an emergency

Key Messages

- The emergency continuum may run from emergency to post-emergency phase, but it is also possible that the post-acute and rehabilitation phases may become unstable and once again become acute.
- It is in the acute phase of the crisis that the MISP for SRH should be implemented.
- More comprehensive SRH services should then be built on the MISP and integrated into primary health care as soon as possible -because it is a right.

- Preparedness is key to ensure a timely and effective SRH response when a crisis occurs.

Slide #27: Respectful partnerships in coordination

Key Messages

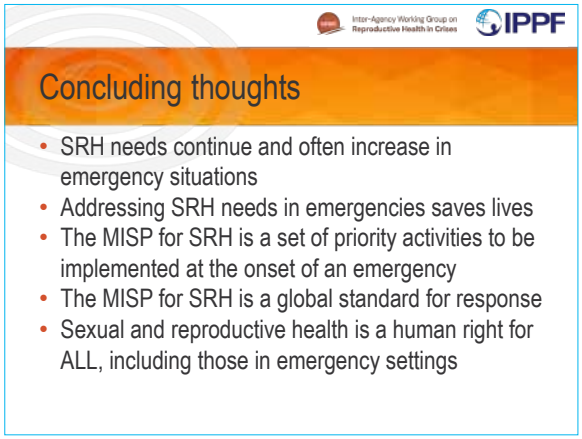
- Partnership is a strategic way of organizing working relationships that values collaboration and joint decision-making over hierarchy in order to achieve a desired result, in this case, improvements in SRH coverage and quality (IAFM 2018 p10).
- Partnerships can be among organisations, including government authorities and local and international NGOs (IAFM 2018 p10).
- Communities have strengths and assets and can also be a full partner in SRH programming, usually through village health committees and other service delivery organizations, civil society groups (women's groups, disabled persons organizations, groups for lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people), supportive faith-based organizations, or other local groups. These groups should represent the full range of community members, including men and adolescents. Their strengths and capacities should be acknowledged and engaged throughout the program cycle.
- Partnerships should also include culturally-sensitive approaches to identify strategic opportunities to advance SRH and challenge harmful practices (IAFM 2018 p10).

Note to facilitators If there is time, this is a moment to ask participants to view the back of their MISP for SRH Cheat Sheet and read through the fundamental principles. Facilitate a brief discussion on how coordination can support the fundamental principles.

Slide #28: Concluding thoughts

Before showing the list of concluding thoughts, ask participants what the **key messages** they got out of the preceding sessions were.

Reveal the list and allow participants to read through and ask any questions.



Day 1 continued

Inclusion: Leaving no one behind

Session 1.2 2 hours

Overview

This session will provide participants with an 'inclusion lens' which they should carry with them through the remainder of the training. It focuses on marginalisation and vulnerability, but also the capacities inherent in populations. Inclusion is an important crosscutting theme that emerges from the IAF (2018) and is a critical component of effective and equitable programming.

Methodology

- Interactive presentation
- Group work & power walk

Materials

- PowerPoint presentation
- Flipcharts/ paper & markers
- Participant handouts #3 & #4
- Group work supplies

Note to facilitators This is a crucial cross cutting issue. If you are new to this topic, it is very important for you to invite a more experienced facilitator to deliver this session.

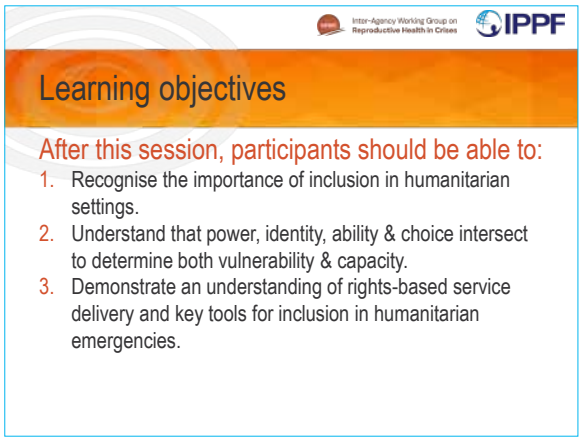
Slide #29: Session 1.2: Inclusion: Leaving no one behind

Welcome your participants back from their break and explain that you are now moving on to a cross-cutting issue: inclusion in humanitarian programming to ensure that no one is left behind.

Slide #30: Learning objectives

Key Messages

- There are three learning objectives for session 1.3:



1. Recognise the importance of inclusion in humanitarian settings.

2. Understand that power, identity, ability and choice intersect to determine both vulnerability and capacity.

3. Demonstrate an understanding of rights-based service delivery and key tools for inclusion in humanitarian emergencies.

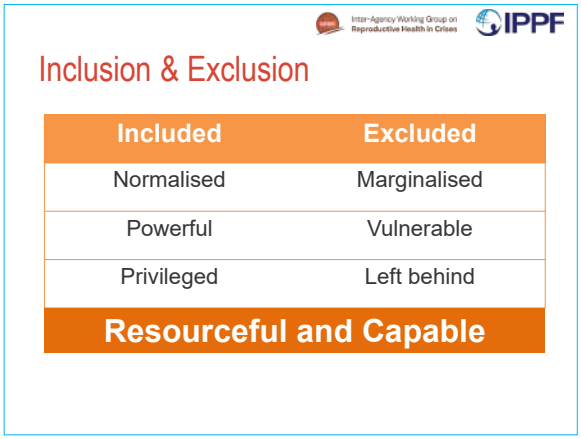
Slide #31: Inclusion and exclusion

Note to facilitators Ask participants to write down on a piece of paper who in their context fits in the left-hand column 'included', and who fits in the right-hand column 'excluded'. They can provide answers from stable or emergency settings.

Then ask participants to consider how these different groups of people may be differently affected by humanitarian emergencies.

Finally, reveal the final row of the table and make clear to participants that all of these groups, including those who are generally excluded, are both resourceful and bring capacity to the situation. Ask participants how they think these groups might fare in humanitarian emergencies if their resources and capacities were respected and engaged with?

Key Messages



- "In every human population some people are marginalised and as a result are often 'voiceless' within their communities and more vulnerable to crises" (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook)
- "One of the basic principles of effective participation is the representation of affected populations and the creation of spaces for participation. Working only with existing leaders and organised groups can reinforce the marginalisation of those who are not represented in these organisations and those who are not organised" (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook). Thus, it is important not to limit partnerships to organisations only.
- In this session we will look further into inclusive humanitarian programming that works to identify marginalized groups, ensure that their exclusion is not exacerbated by either the crisis or the crisis response, engage their resources, and actively contribute to the development of capacities in crises and beyond.

Slide #32: Inclusion and exclusion

Key Messages

- In every society, individuals and groups are accorded differential status and power, leading to the exclusion and marginalization of certain groups. The inclusion/ exclusion continuum is a dynamic, multi-dimensional process resulting from unequal power relationships at individual, household and community levels, and influencing an individual's access to resources, capabilities and rights.

- It is now well-recognised in humanitarian contexts that certain groups of individuals may be more at risk of protection concerns than others (e.g. adolescent girls, persons with disabilities, LGBTQIA persons).

- Certain attributes such as sex, age, gender identity, disability, race/ethnicity, religion, bodily diversity, and sexual orientation, and other factors including family structure and marital status, all intersect to impact the range of resources and opportunities these individuals can access, their vulnerability to risks, and their capacity to respond to protection concerns.

- Context is critical and "it is important to avoid basic, stereotyped or imported notions of ethnicity, religion, class, gender and generation, for example, and to be sensitive to the local dynamics, values and beliefs that emerge in relation to exclusion and social discrimination (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook).

- Keep in mind, however, that "[w]orking with standard categories such as ethnicity, religion, class, gender and age can mask other categories, such as social or marital status, which may enhance or diminish an individual's position within a particular group. This may lead to less participation on the part of marginalised or less powerful groups. Crises can lead to a loss of social cohesion, notably when communities are torn apart by conflict or separated by displacement. When traditional or established social structures break down, this can make collective action more difficult. Aid agencies can help to rebuild social structures and they can use this opportunity to try to encourage these to be more inclusive" (ALNAP 2009 Participation Handbook for Humanitarian Field Workers https://www.urd.org/Participation-Handbook).

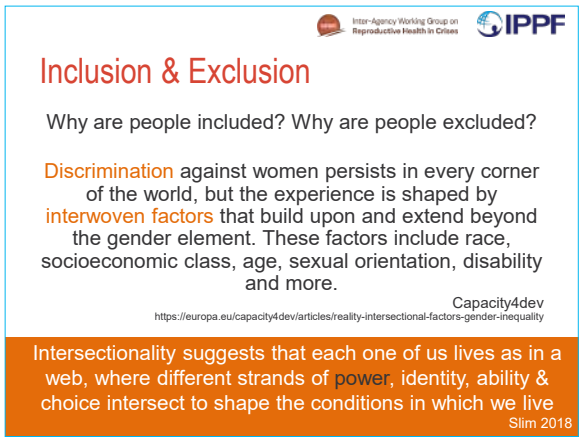
Note to facilitators Ensure that participants have a clear understanding of the key terms presented on this slide.

Ethnicity generally refers to belonging to a social group that has a common cultural or national tradition and indigeneity is often used to refer to people originating from or being the first peoples of a given place.

It may also be useful to provide examples to illustrate the complexity that is in all of our identities and how this connects to our vulnerabilities and capacities. An example may be the status of a married versus an unmarried adolescent in the eyes of their community, and how this determines her/ his/ their vulnerability, needs and capacities.

Slide #33: Inclusion and exclusion

Key Messages

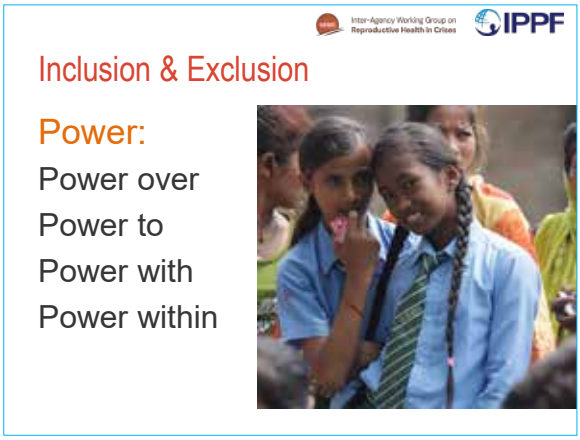


- As an example, and making clear that men, of course, face discrimination too, allow participants to read through the description of factors that intersect to result in discrimination against women.
- The quote focuses on discrimination against women but we have seen that discrimination happens to not all women, the intersectional approach allows us to understand which women, in all their diversity, are most vulnerable, as well as identifies their capacities.
- Intersectionality, as defined on the slide, emphasizes the complexity of human identity and power and how the many factors which make each person who they are combine and interact to contribute to their access to power and resulting opportunities.

Slide #34: Inclusion and exclusion: Group work

Key Messages

- This power takes various forms: power over, power to, power with, and power within. See below for examples and explanation of these terms.



Inclusion & Exclusion

Adapted from: Women's Refugee Commission & International Rescue Committee (2015) I see that it is possible: Gender Based Violence and Disability Toolkit (https://www.womensrefugeecommission.org/?option=com_zdocs&view=document&id=1173).

This brief activity will allow participants to become familiar with different forms of power.

Time

10 minutes

Process

- Write the following on flip charts or pieces of paper and position around the room:
  - Power Over
  - Power To
  - Power With
  - Power Within
- Read out the following quotes and ask participants to move to the sign that they think best reflects the type of power being demonstrated in relation to the girl in the exercise.
- Before starting the exercise make sure people are clear about what each term on the pieces of paper mean.

1. "My daughter with intellectual disabilities is safer if she stays inside the house. So I don't let her go out – I keep the door locked." A: (Power over – Other people are making decisions for her)

2. "She is very outgoing and enjoys being around other people. She is always following her sister to other activities, even though she can't participate." A. (Power to – she is actively seeking support)

3. "My sister is deaf, but she is very good at sewing. So she shows the other women in our group, using demonstrations, while I translate her instructions." A: (Power with – women working together)

4. "I can't work anymore, but I want to be useful again. Maybe I can share information with other people with disabilities." (Power within – growing self-agency)

5. "When I was talking to her mother about making a referral for a medical examination, Inaam became upset and started yelling. I think she may have behavioral problems." A. (Power over)

- At the close of the activity, explain that these examples specifically address power as it relates to people with disabilities but the concepts of power remain the same for other groups.

- If there is time ask participants to reflect on their own experiences and interactions with persons with disabilities. What kind of power relationship do they think they have with these individuals? What assumptions or stereotypes do they hold? What concerns or fears do they have about working with women and girls with disabilities?

- Reinforce to participants that it is important to work with people with disabilities to support them to develop their "power within" and "power to" make their own decisions about services and assistance. We must be careful not to reinforce negative power dynamics between persons with disabilities and others and/or to exercise "power over" them. We must also support spouses, caregivers and other service providers to share "power with" people with disabilities, as well as caregivers, to ensure their needs are met and that programs are made more friendly and accessible to them. A good way can be to work with PLWD organisations, particularly women led ones to learn how better to respond for PLWD.

Materials

Flip Charts or pieces of paper with the following words written on them:

- Power Over
- Power To
- Power With
- Power Within

Slide #35: Power walk: Group work

Power walk

Adapted from: Women's Refugee Commission & International Rescue Committee (2015) *I see that it is possible: Gender Based Violence and Disability Toolkit* (https://www.womensrefugeecommission.org/?option=com_zdocs&view=document&id=1173).

The Power Walk activity will further demonstrate how intersectional factors can contribute to risk and resilience.

Time

20 minutes

Process

- Ask two participants to volunteer to be the characters Alieva or Amina and stand in the front of room. Option: if the group is large, add 'mother', 'sister', 'father', 'aunt' and/or 'brother' who are also mentioned in the scenarios.
- Provide the rest of the group with slips of paper describing different scenarios experienced by each character (Participant Handout #3).
- Ask the group to read out what is on their paper one by one.

  The volunteers (as Alieva and Amina) take steps forward or steps backwards according to how the scenario promotes equality and opportunities for that individual. An individual may have both positive and negative things happening in each scenario, and so they may take multiple steps forward or backwards accordingly. There may also be events that affect the other women and girls in the family, and this may have additional impact on the individual. The group can help the volunteers decide if they should move forward or back.

- Encourage discussion throughout. If needed, try these key questions to facilitate discussion on whether each girl should move forward or backward:
  - What are the good and bad things that are happening in this scenario for the girl?
  - What skills, capacities and assets are they developing?
  - What opportunities are they missing?
  - What kind of power exists in the relationships around them? (e.g., power over/power within/ power to/power with)

- How does this affect their vulnerability or resilience?
- What power dynamics are happening here? How will you address these dynamics?
- When a disaster happens in this community, who will access services? Who may not?

6. Close the exercise by reinforcing that this exercise is an experiential way of highlighting the different impacts of disaster and humanitarian response. Gender identity and power dynamics influence how a person is able to exercise their rights to humanitarian assistance and protection, and these inter-relate with other social inclusion issues. It is therefore crucial to consider gender in emergencies, and to link this to gender inequities that existed before the emergency.

Materials

Participant Handout #3

Slide #36: Inclusion and exclusion

Key Messages

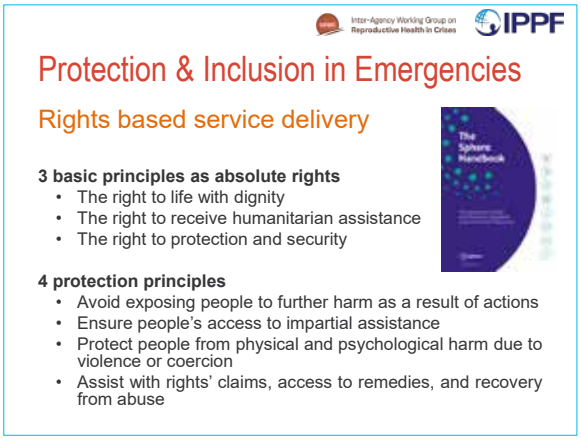
- We have seen the impact that unequal power relations can have on access to resources and opportunities for marginalized populations.
- It's also important to consider what can be done about this in humanitarian settings and in preparedness and development.
- Humanitarian preparedness and response programming must recognise and analyse the intersecting factors which can contribute to exclusion.

- Coordination mechanisms have a key role to play in ensuring that marginalized groups are included in a meaningful way at all stages of the emergency management cycle- from preparedness, to response and recovery.

Slide #37: Protection and inclusion in emergencies

Key Messages

- The Sphere Handbook contains a humanitarian charter, the principles of which should guide all humanitarian action. Following these supports inclusion.
- The charter includes three basic principles and four protection principles.
- Most importantly from these, all people have equal rights and the only way we can ensure everyone's access to impartial assistance and avoid doing further harm is by recognizing diversity in vulnerability and capacity.



Slide #38: Nothing for us without us

Key Messages

- The phrase 'nothing for us without us' is an important summary of the key concepts covered in this session on inclusion.
- Participants should keep this phrase in mind as they move through the training and use it as a framework in understanding effective implementation of the MISP for SRH for all.

Note to facilitators As facilitator, it is also important that you 'walk the talk' when it comes to inclusion during your training. Ensure practical efforts are taken to make the training as inclusive as possible. Consider things such as room accessibility, translators, colours and gender balance.

Slide #39: Tools for inclusion

Tools for Inclusion

Note This activity should only be conducted if time permits.

Gender differences can influence women's and men's exposure to risk factors or vulnerability, their access to and understanding of health information, differences in health status and the services they receive. When individuals do not conform to established gender norms, they may face discrimination or exclusion, with additional negative health impacts.

The Gender with Age Marker (GAM) is a tool which, based on a code, provide an automatic and objective calculation of the quality of humanitarian programming. The IASC GAM codes programs and projects on a 0-4 scale, based on responses to questions about twelve key gender quality measures.

Note there are different tip sheets for different sectors but today we are looking at the health Tip Sheet specifically.

Time

40 minutes

Process

Share handout Participant #4 with participants.

Take the case study issued in the previous session or alternatively, ask a participant to share a recent response (location important) to use as a case.

Option 1

- If internet is available: access: https://iascgenderwithagemarker.com/en/home/ . Go to "Access the Marker" and click on the "Play with the Marker"
- In plenary, fill out the different questions asked. Some sections will need some language added ("analysis based on etc"). It may be useful to have that language pre-prepared and cut and pasted in as the test proceeds. The purpose of going through the tool in plenary is to illustrate the type of questions we need to ask of ourselves as we design programs.
- Go through the exercise until a score is provided. Open up a discussion on how target groups need to participate in design of our programs. Mention that the tool does not adequately add a disability component and is something that needs to be integrated. (Note that upcoming IASC Guidelines on Disability Inclusion will facilitate this)

Note to facilatators It is recommended that the facilitator goes through the tool in advance to prepare some of the language to add.

Option 2

- Ask participants to look at the Gender with Age Marker Health Tip Sheet (Participant Handout #4).
- In small groups, ask participants to consider:
  - Which of the tips may be feasible in the early stages of an emergency?
  - Do you already collect/use this information- what are the sources for this information in your country?
  - What would be needed to implement these tips in emergency programming?
- Then ask the group to feed back key points to the plenary.

Materials

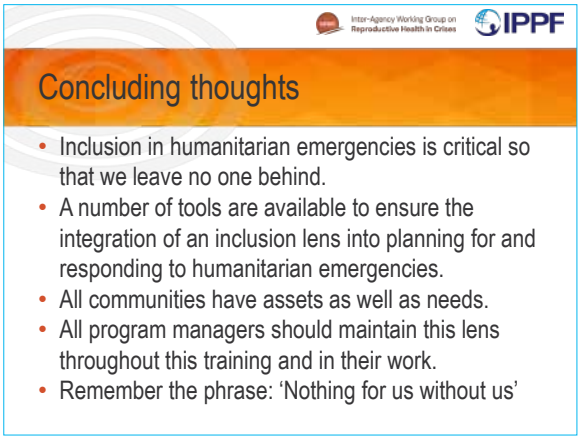
Internet access and projecting equipment or

Participant Handout #4

Slide #40: Concluding thoughts

Before showing the list of concluding thoughts, ask participants what the **key messages** they got out of the preceding sessions were.

Reveal the list and allow participants to read through and ask any questions.



Day 1 continued

MISP Objective 1: Ensure the Health Sector/ Cluster Identifies an Organisation to Lead Implementation of the MISP for SRH

Session 1.3 3 hours

Overview

This session will provide participants with an understanding of global and national coordination mechanisms for SRH in humanitarian emergencies. Participants will also develop skills in coordination and an appreciation of why coordination is so important for MISP implementation.

Methodology

- Interactive presentation
- Group work & role play
- Presentation by government representative or other (if possible)

Materials

- PowerPoint presentation
- Participant handouts #1, #5, #6 & #7
- Group work supplies

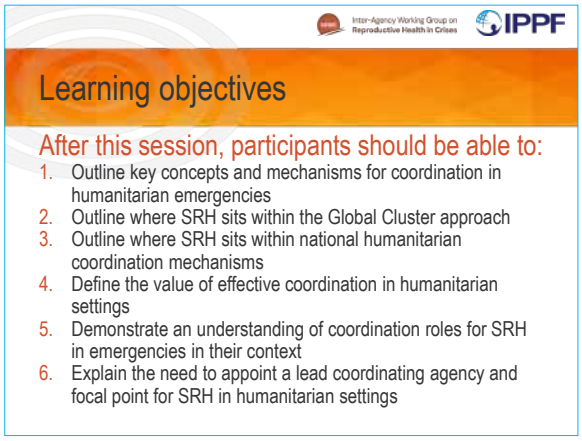
Slide #41: Session 1.3: MISP Objective 1: Ensure the Health Sector/ Cluster Identifies an Organisation to Lead Implementation of the MISP for SRH

Welcome your participants back and explain that you will now move onto a key component of the successful provision of life-saving SRH services in humanitarian emergencies- coordination.

Slide #42: Learning Objectives

Key Messages

- There are six learning objectives for session 1.2

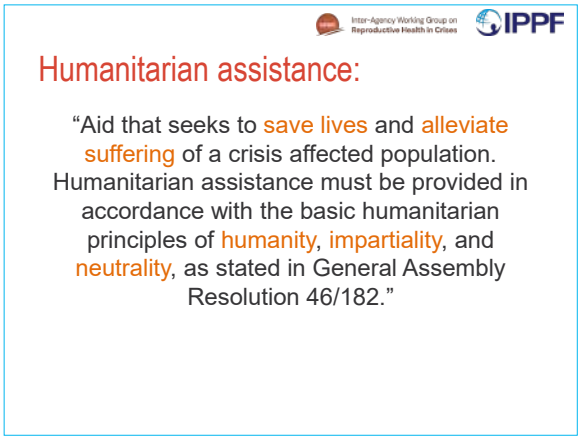


1. Outline key concepts and mechanisms for coordination in humanitarian emergencies
2. Outline where SRH sits within the Global Cluster approach
3. Outline where SRH sits within national humanitarian coordination mechanisms
4. Define the value of effective coordination in humanitarian settings
5. Demonstrate an understanding of coordination roles for SRH in emergencies in their context
6. Explain the need to appoint a lead coordinating agency and focal point for SRH in humanitarian settings

Slide #43: Humanitarian assistance

Key Messages

- This is the definition given by Sphere of humanitarian aid.
- Stress the life-saving nature of humanitarian aid and that each participant at the training has a role to play in this.
- Humanitarian principles of humanity, impartiality, neutrality and independence are highlighted in this definition. Operational independence is the fourth humanitarian principle.



Note to facilitators If your participants are interested in, or would like more information on the humanitarian principles, they can visit: https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf https://emergency.unhcr.org/entry/223864/humanitarian-principles

Slide #44: Humanitarian principles

Key Messages

- There are four humanitarian principles which must guide all action in this field: humanity, neutrality, impartiality and independence.
- These principles are "central to establishing and maintaining access to affected people, whether in a natural disaster or a complex emergency, such as armed conflict. Promoting and ensuring compliance with the principles are essential elements of effective humanitarian coordination" (from: https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf).

Slide #45: Game: The importance of effective coordination

Key Messages

- The humanitarian principles must underpin humanitarian action so that effective coordination is ensured.
- The following game will help participants understand why coordination is important.

The importance of effective coordination:

Game

Choose a game or icebreaker which emphasizes the importance of working together toward a common goal.

The purpose here is to provide participants with an interesting and practical experience of the importance of coordination. Many facilitators will already have a number of these activities on hand to energize their training participants.

Time

Restrict this activity to 10 minutes.

Example of a possible coordination game:

Process

- Give each participant a number. Ask them to write this number on two papers (pad size)
- Participants are asked to scrunch their papers into two balls
- Request participants to stand in a circle
- Place an empty box in the center of the circle made by participants
- Ask the participants to place/throw one ball with their number in the box
- Now play music for 15 seconds or the facilitator should count 1-15, and ask all participants to find the paper ball containing their number within 15 sec.
- Give them one – two minutes and count how many participants were successful in finding their own ball.
- Now repeat all of the above and ask participants to place their second paper ball in the empty box. This time, instruct them to help each other in finding their right numbers. Again, count the participants who can get the paper ball with their number back.

Reiterate The number of successful participants will be many more as all participants help each other to get the number back. This activity highlights the importance of working together and synergizing the work particularly for the MISP for SRH.

Materials

Box and paper and pens

Slide #46: MISP Objective 1: Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP

Key Messages

- Reiterate the importance of effective coordination for MISP for SRH implementation and explain that this session will focus on Objective 1 of the MISP and what constitutes effective coordination.

Slide #47: Managing emergency response

Key Messages

- Reiterate the importance of coordination- as seen in the game above. Explain that this session will now focus on how coordination fits into the management of humanitarian response and then look at the importance of MISP for SRH Objective 1, which focuses on coordination.

- In a majority of crisis situations, the humanitarian response will be managed and led by national, provincial and/or local government agencies.

- At times, the impact of a crisis situation may exceed the ability of the nation to cope using its own resources. In such situations, the national government may request or accept international assistance.

- Emphasise that it is the primary responsibility of states to respond to crises wherever this is possible.

Note to facilitators For more information on the role of states in humanitarian response, visit https://www.alnap.org/system/files/content/resource/files/main/alnap-26-meeting-concept-note.pdf

Slide #48: Humanitarian mechanisms

Key Messages

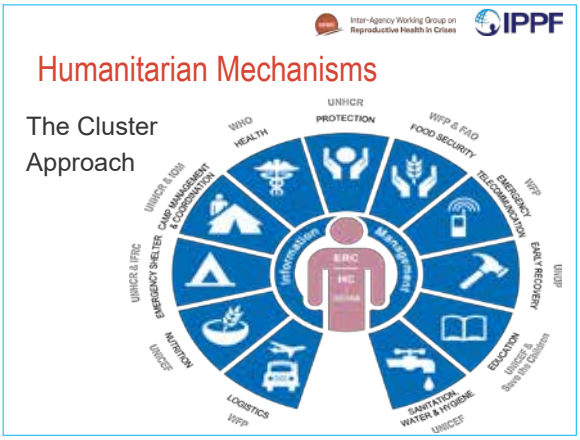
- If an international response is activated, the Inter-Agency Standing Committee (IASC) is the primary mechanism for inter-agency coordination of humanitarian assistance. It is a unique forum involving the key UN and non-UN humanitarian partners. The IASC was established in June 1992 in response to the UN General Assembly resolution on strengthening humanitarian assistance.
- Outside of the IASC system there are other standards and guidelines we use in humanitarian response.
- "Sphere standards" are globally recognised minimum standards for humanitarian work. The components of the MISP are integrated into these standards under health and protection.
- In 2014 the Core Humanitarian Standard (CHS) was launched. It sets out Nine Commitments that organisations and individuals involved in humanitarian response can use to improve the quality and effectiveness of the assistance they provide. The CHS places communities and people affected by crisis at the centre of humanitarian action.

Note to facilitators For more information on these mechanisms, visit:

- https://interagencystandingcommittee.org/
- https://www.spherestandards.org/
- https://corehumanitarianstandard.org/the-standard

Slide #49: Humanitarian mechanisms

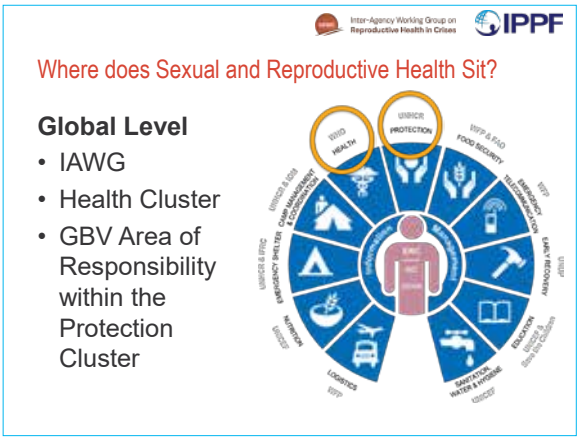
Key Messages



- As part of Humanitarian Reform in 2005, the "Cluster System" was established to ensure coordination per sector-area (i.e. there is a health cluster, a shelter cluster, an education cluster etc.).
- For the purposes of this training, the most important clusters are:
- Health: led by World Health Organization. SRH is a direct part of the Health Cluster and SRH lead agencies participate in the Health Cluster.
- Protection: led by UNHCR. The protection cluster also has 4 focus areas called Areas of Responsibility (AoRs). One of these sub-clusters is the GBV AoR. This is very important for the implementation of the MISP and is led by UNFPA.

Slide #50: Where does sexual and reproductive health sit?

Key Messages



- At the global level, SRH in emergencies is guided by the work of IAWG (outside of the formalised cluster system) and within the cluster system, is under the mandate of

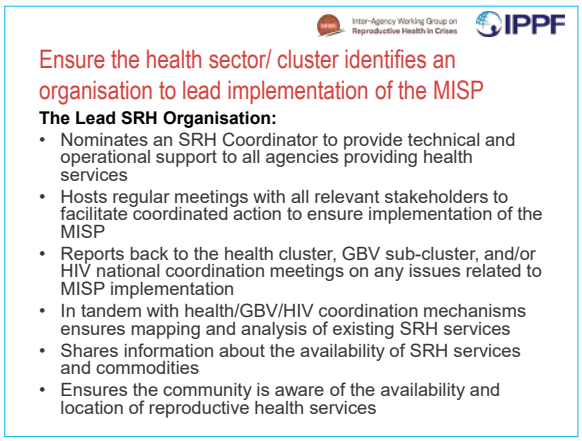
  1. the Health Cluster – all objectives
  2. the GBV AoR (Area of Responsibility) of the Protection Cluster for non-health components of SRH such as the GBV Referral Protocol.

- At field / country level, a Health Cluster will usually be established and an SRH lead agency appointed. There will also need to be coordination with the GBV AoR and GBV Cluster coordinators may be appointed.
- SRH sub-working groups may also be established.

Slide #51: MISP Objective 1: Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP

Key Messages

- Remind participants that the first objective of the MISP for SRH is to ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP.
- This slide contains the priority activities the lead organisation must initiate in the acute phase of the crisis as per the MISP for SRH. We will go through key points in the following slide but can ask participants to read and see if they have any questions.



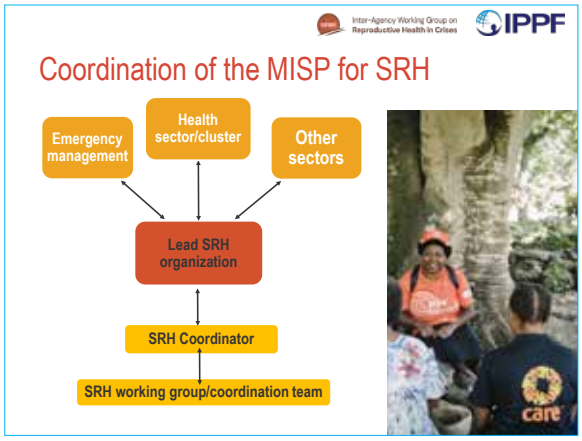
- Explain coordination is included as a MISP objective as it is not possible for one agency to implement the MISP, it requires coordination between SRH, health and humanitarian actors to ensure effective implementation.

Note to facilitators Ask participants to look at their MISP for SRH Cheat Sheet and locate the first MISP Objective and its priority activities.

Slide #52: Coordination of the MISP for SRH

Key Messages

- This slide provides an overview of the levels of coordination needed for MISP implementation.
- The lead SRH organization must work in collaboration with the national or sub-national health sector and/or global health cluster (whichever is operational), emergency management agencies, and other relevant sectors (such as those agencies responsible for protection).

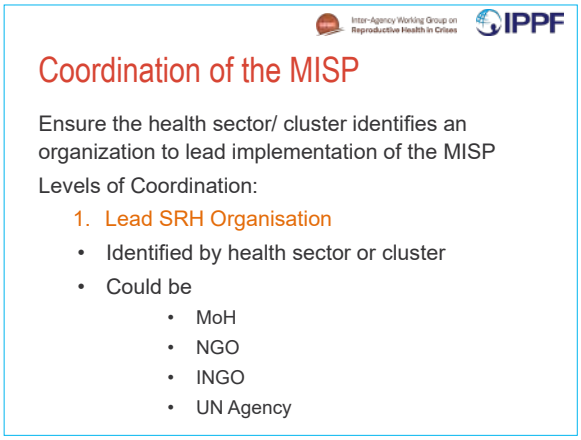


- The lead organization must also nominate an SRH Coordinator to provide technical and operational support to all agencies providing health services. The other roles of the SRH Coordinator will be discussed in detail in following slides.

- Finally, the SRH Coordinator will generally work with the SRH working group or coordination team to ensure MISP implementation. **All members of the SRH working group need to participate actively for it to be effective.**

Slide #53: Coordination of the MISP

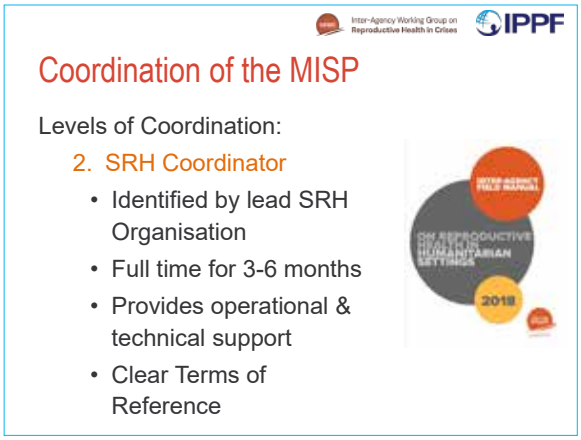
Key Messages



- From the beginning of the response to every humanitarian emergency, the health sector or health cluster (whichever is operational in your context) must identify a lead SRH organization.
- This organisation can be the Ministry or Department of Health, a United Nations Agency such as UNFPA, or an international or local NGO.
- The organization will work with other sectors or clusters to ensure the implementation of the MISP for SRH.
- The nominated organisation should be the one which has the greatest capacity to fulfil this role. They must then immediately dedicate a full-time SRH coordinator.

Slide #54: Coordination of the MISP

Key Messages



- The SRH Coordinator must take on this position full time, for a minimum of three to six months.
- They will provide operational and technical support to health partners and facilitate coordinated planning with all involved sectors/ clusters to ensure the prioritization of SRH and the effective provision of MISP services. Advocacy on SRH in coordination mechanisms, including protection and health clusters may be necessary if these do not prioritise SRH.
- Roles include:
  - Hosting regular meetings with relevant stakeholders to ensure coordinated action on MISP implementation.

- Reporting back to health and other sectors/ clusters on MISP implementation.
- Mapping and analysis of existing SRH services.
- Sharing information about the availability of SRH services and commodities.
- Ensuring the community is aware of services.

Slide #55: SRH coordinator terms of reference: Discussion

SRH Coordinator Terms of Reference

This brief activity will allow participants to become familiar with the roles and responsibilities of the SRH Coordinator. This is vital information for program managers who may assume this role themselves or work to support the individual assigned this responsibility.

Time

10 minutes

Process

- Provide participants with copies of the SRH Coordinator Terms of Reference from IAFM 2018 (pages 20-21).
- Allow some time for participants to read through these guidelines and then bring participants back to the group.
- Facilitate a guided discussion with the group about the roles and responsibilities of the SRH Coordinator, making sure to highlight the importance of the coordination principles discussed above (clear roles and responsibilities, information and management sharing, trust, communication, common goals and purpose, and respectful partnerships).

Materials

Participant Handout #5

Slide #56: Coordination of the MISP

Key Messages

- Just as the SRH Coordinator must work in collaboration with all relevant stakeholders working for SRH in emergencies, so too must these stakeholders work towards goals agreed to with the SRH coordinator.
- Stakeholders include organisations and individuals within the health sector/ cluster and other related sectors/ clusters (such as emergency management, social welfare, protection etc.) and affected populations.
- Support from involved organisations and individuals, working through respectful partnerships and upholding the principles of effective coordination is crucial in ensuring that the life-saving activities prescribed by the MISP are implemented in a timely and effective manner.

Slide #57: Coordination of the MISP

Key Messages

- Remembering the earlier discussion of respectful partnerships and the fundamental principles for SRH programming in humanitarian settings, reiterate to participants that it is important to ensure effective and meaningful participation of concerned persons and person-centred care that recognizes patients' autonomous decision-making power and choice for services and commodities (IAFM 2018).
- This should extend to coordination mechanisms. Affected communities are key contributors to MISP coordination mechanisms to ensure both upward and downward accountability.

Slide #58: Exploring coordination in context: Presentation

Exploring coordination in context

When discussing national and/or sub-national coordination mechanisms, it is valuable to have someone from relevant government departments or ministries address your training participants.

If this is not possible, make sure to source this information yourself and use this opportunity to make these mechanisms clear to participants. Consider using the Mapping Coordination in Context activity instead (Participant Handout #6).

Time

20 minutes

Process

- Allow a representative from your national disaster management organization or other relevant actor to present relevant contextual information to training participants. This should include:

  1. Over-arching disaster management/ coordination mechanisms

  2. Where SRH sits within these mechanisms

- Encourage participants to ask questions and get more familiar with the humanitarian architecture in their country

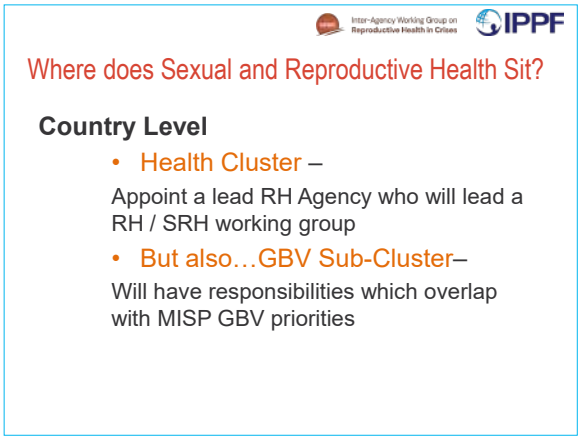
Materials

Presentation

Slide #59: Where does sexual and reproductive health sit?

Key Messages

- Provide a summary of the information presented by the government representative (above) or use this slide to present context specific information on where sexual and reproductive health sits within national and/or sub-national disaster risk management/ emergency preparedness and response mechanisms.



Slide #60: Mapping coordination in context: Group work

Mapping Coordination in Context

If time allows:

This activity will provide participants an opportunity to discuss and learn from each other about the key organisations involved in general humanitarian coordination and the coordination of MISP components in their context. This is designed to be a brief activity to engage with what participants know or have been exposed to in the above presentations. It will also be a useful document to refer to during the mapping exercise on the final day of the training.

Time

25 minutes

Process

- Break group into smaller groups
- Provide each group with a copy of Participant Handout #6.
- Allow participants 15 minutes to discuss and fill in the template. At the end of 15 minutes, facilitate a brief discussion and allow participants to share information on the involved organisations, how they function and coordinate, and to suggest contacts and follow up activities as appropriate.

- If it is not possible to make this activity specific to your participants' contexts, the scenarios introduced through Participant Handout #1 may be used as a basis for the mapping exercise.

Materials

Participant Handout #6

Slide #61: Coordination improves

Key Messages

- We now have an understanding of the key organisations involved in MISP for SRH implementation in your context. This knowledge is important but needs to be accompanied by skills in coordination.
- It is clear that the 'soft skills' of coordination are vital for successful implementation of the MISP for SRH.
- Coordination of reproductive health within the health sector/cluster and with other relevant sectors/clusters can improve efficiency, effectiveness and speed of response, enable strategic decision-making and problem solving and help avoid gaps and duplication in services.
- Coordination will help to deliver a standard package of life-saving SRH services throughout an area, making good quality SRH care accessible to all.
- Coordination can generate a multiplier effect that results in expanded coverage and efficient use of resources and can compensate for any single agency's limited expertise, staff, resources or range of activities.

Note to facilitators Ask participants what the benefits of good coordination are before revealing the list.

Slide #62: Effective coordination involves

Key Messages

- For effective coordination, it is important to:
  - Formally agree to share information, resources and responsibilities- with each organisation and individual working to their strengths.
  - Map, invest in and actively foster inter-agency relationships and trust, always with a view to providing the best possible SRH information and services to beneficiaries living in humanitarian settings.
  - Place the needs of beneficiaries at the foremost and use these to guide the development of common, agreed goals.

Slide #63: What does good coordination look like?

Key Messages

- This slide provides a summary of what is needed for MISP implementation in terms of coordination.
- Allow participants time to read through the list.

Note to facilitators Ask participants to describe the role they see for themselves in achieving this list. Emphasise that for MISP implementation to be effectively coordinated, all agencies participating in the training must be actively involved- not just the SRH Coordinator. This is clear in the SRH Coordinator Terms of Reference.

Slide #64: Challenges and solutions in coordination: Group work

Key Messages

- Remind participants of the Coordination Game played at the start of this session and reiterate the importance of good coordination explored above.
- Explain that although they now have a good understanding of the mechanisms for coordination of the MISP for SRH in emergencies, challenges to effective coordination will likely arise.

Challenges and Solutions in Coordination

Taken from the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module draft 2019.

This group work activity will allow participants to strategise advocacy messages to ensure that SRH is included in coordination mechanisms.

Time

40 minutes

Process

- Participants should work in their table groups. Provide each table group with a flipchart containing one of the following challenges:

  1. Sometimes a lack of understanding and/or prioritization of SRH by humanitarian actors can make implementation of the MISP for SRH within the overall health response difficult. How can one ensure that SRH and the MISP for SRH are prioritized and integrated appropriately?

  2. At the beginning of an emergency, UNFPA and other SRH specialist agencies may not yet be operational in the field. Security may be poor and capacity of staff may be weak. In such a setting, what can an agency do to address SRH?

  3. How can a local counterpart be identified to lead or co-lead the SRH coordination effort?

  4. How can marginalized populations be included in coordination initiatives?

- Allow groups five minutes to brainstorm and write down solutions to these challenges on the flipchart. After five minutes, ask groups to stand and move to the next flipchart.

- After each group has discussed solutions to all of the listed challenges, recap answers as a whole group and make sure that all of the suggested solutions in the **note to facilitators** (below) are covered.

Note to facilitators Reiterate the importance of coordination and that they can advocate for this in their contexts.

Materials

4 Flipcharts

Solutions to challenge 1

- Emphasize that the MISP for SRH is an accepted international minimum standard reflected in the Sphere handbook, the CERF life-saving criteria, the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings and the Health Cluster Guide.
- Encourage all technical and managerial staff involved in humanitarian response to complete the MISP for SRH distance learning module and share relevant resources such as the MISP for SRH advocacy and cheat sheets.
- Conduct trainings on life-saving SRH services and the MISP for SRH as part of preparedness efforts and collaborate with the MoH and other relevant governmental organizations prior to an emergency, if possible.

Solutions to challenge 2

- If your agency is involved in the health response, it should ensure the MISP for SRH is included in its programming. Your agency or another agency could volunteer in the health sector/cluster meetings to lead on SRH and to establish regular SRH working group meetings to facilitate implementation of the MISP for SRH.
- If your agency cannot provide all MISP for SRH recommended activities, assess other health/ SRH actors' service capacity and establish an effective referral system for the MISP for SRH services that your agency cannot provide.

Solutions to challenge 3

- If capacity exists, the MoH should lead or co-lead the coordination effort.
- The MoH could advise on existing local organizations and their capacities.
- Conduct a mapping of existing local actors implementing SRH programming.

Solutions to challenge 4

- With the SRH working group, identify representatives of local adolescents, women, people with disabilities, and LGBTQIA groups from among the crisis-affected populations. Extend an invitation for representation in the SRH working group meetings to these leaders.

Slide #65: Role play: Cluster coordination

Cluster coordination

This activity will allow participants to apply what they have learnt on humanitarian coordination and general coordination skills through role play. The role play is based on the on-going case study participants have been engaged with since session 1.1.

Time

40 minutes approx. (25 min role play- 15 min discussion)

Process

- Ask for 9 volunteers and assign each person a different role (try to identify those who have had some experience in coordination meetings before). See Participant Handout #7 for suggested name plates/ role cards. E.g.
  - One person should be allocated the role of WHO Health Cluster Coordinator.
  - One person should be allocated the role of UNFPA country coordinator.
  - One person should be allocated the role of Ministry of Health Representative.
  - One person should be the IPPF Program Manager.
  - Other people should choose to represent other organisations (either local organisations such as disabled persons organisations, LGBTQIA organisations, women's groups, faith-based groups etc.; youth- based organisations; and international NGOs such as CARE, Save the Children, Médecins Sans Frontières / Doctors without Borders).
- Read out the following instructions to the group:
  - It is the day after the emergency described in your case study occurred. The local IPPF MA/other organisation have called UNFPA or Ministry of Health or WHO to find out when the first cluster meeting will take place. There is a Health Cluster Meeting taking place today.

  - You will all now contribute to the Health Cluster meeting, it is the second meeting since the emergency.

- Give participants a couple of minutes to review their roles and think about how they want to play their characters. Will they be dictatorial, will they understand SRH etc. See guide.
- The other participants can act as observers.
- Allow up to 25 minutes for the role play, and then facilitate 15 minutes a discussion consider:
  - What was going on in the meeting? Who was leading? what were the priorities (ask observers)
  - Did people seem supportive of SRH? Ask the actors (e.g. MoH)
  - Ask IPPF/UNFPA how they felt trying to convince others?
  - Ask participants what they think worked- was there potential for collaboration
  - Ask what could be done in preparedness to improve coordination in response

Key Messages

- There can be a lot of competing priorities in health cluster and broad range of health actors
- Often many people will not know SRH- need to advocate for it
- It should be in an inclusive space for all
- It is not just about sharing what you are doing but it can be a space for problem solving and coordination

Materials

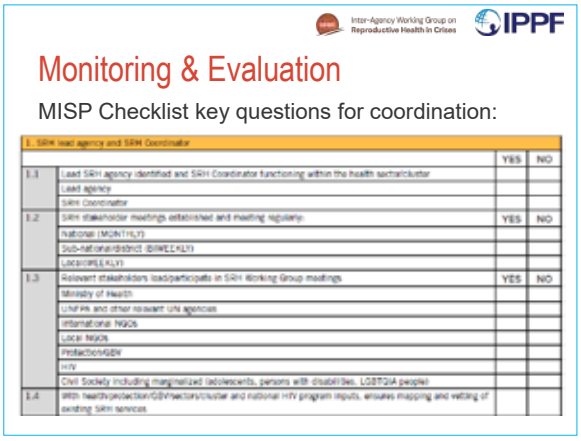
Participant Handout #7

Scenario from Participant Handout #1

Slide #66: Monitoring and evaluation

Key Messages

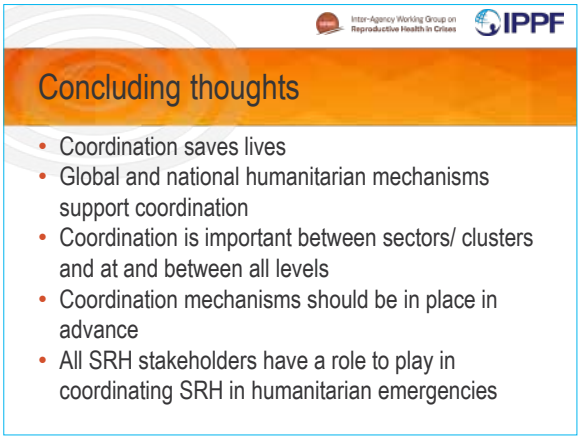
- The MISP checklist provides a useful tool for monitoring and evaluating the coordination objective of the MISP.
- It can also be used for preparedness to ensure that coordination mechanisms are identified and engaged before a crisis occurs.
- The checklist highlights both the important role of the SRH Coordinator in ensuring MISP implementation, and the role of other stakeholders in supporting this work.



Slide #67: Concluding thoughts

Before showing the list of concluding thoughts, ask participants what the **key messages** they got out of the preceding sessions were.

Reveal the list and allow participants to read through and ask any questions.



Day 1 Close

Day 2

MISP Objective 2: Prevent Sexual Violence & Respond to the Needs of Survivors

Session 2.1 4 hours

Overview

This session will develop program managers' knowledge and skills in preventing sexual violence & responding to the needs of survivors in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.

Methodology

- Interactive presentation
- Video presentation
- Group work & role play

*Time can be tight for this session so it is suggested to select the activities most suited to context

Materials

- PowerPoint presentation
- Video: GBV/ SV in emergencies
- Audio-visual equipment
- Participant handouts #1, #8, #9, #10 & #11
- Group work supplies
- Flipchart & markers

Slide #1: Day 2: The Minimum Initial Service Package (MISP)

Welcome your participants to their second day of training for program managers on sexual and reproductive health in emergencies. Ask if there are any outstanding questions and take care of any housekeeping matters before moving on.

Slide #2: Day 1 Review

Spend a few minutes revisiting the sessions from the day before.

Note to facilitators It is a good idea to ask participants to lead this review exercise. This review may be done in a standard question and answer format, or they may wish to do this in a more interactive way to energize your participants.

Slide #3: MISP objectives

Remind participants that we are now focusing on the service oriented objectives of the MISP.

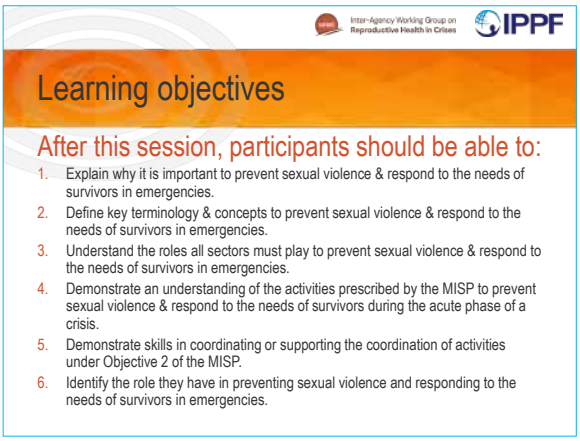
Slide #4: Session 2.1: MISP Objective 2: Prevent Sexual Violence & Respond to the Needs of Survivors

Highlight that you will now move on to the second objective- prevent sexual violence and respond to the needs of survivors.

Slide #5: Learning objectives

Key Messages

- There are six learning objectives for session 2.1:



1. Explain why it is important to prevent sexual violence and respond to the needs of survivors in emergencies.

2. Define key terminology and concepts to prevent sexual violence and respond to the needs of survivors in emergencies.

3. Understand the roles all sectors must play to prevent sexual violence & respond to the needs of survivors in emergencies.

4. Demonstrate an understanding of the activities prescribed by the MISP to prevent sexual violence & respond to the needs of survivors during the acute phase of a crisis.

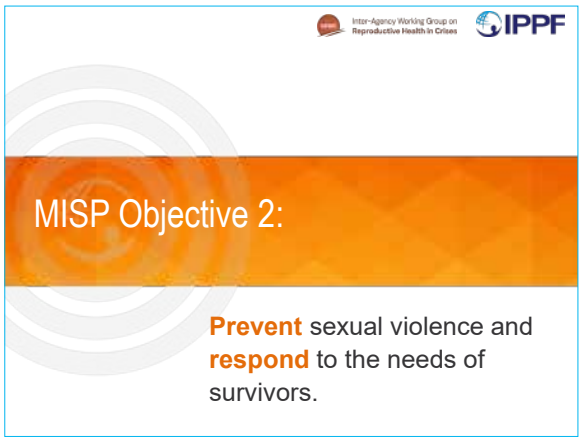
5. Demonstrate skills in coordinating or supporting the coordination of activities under Objective 2 of the MISP.

6. Identify the role they have in preventing sexual violence and responding to the needs of survivors in emergencies.

Slide #6: MISP Objective 2: Prevent Sexual Violence & Respond to the Needs of Survivors

Key Messages

- The second MISP Objective is to prevent sexual violence and respond to the needs of survivors.



Note to facilitators This is a good opportunity to ask participants what they think action towards this objective might entail. A short amount of time should also be given to allow any participants who have worked in the field to share from their experience.

Slide #7: GBV in emergencies: Video presentation

Video presentation

The video presentation will provide participants with important background information and allow an opportunity for engagement with the impact of gender based violence in emergencies. A video is provided in the presentation (available at https://youtu.be/lEDzl1dFGzk), or you may choose one impactful in your setting. Some additional suggested videos are listed below and provided on the USB, but others are available online.

Time

Dependent on video chosen. Suggest no longer than 10 minutes for this activity.

Process

- Explain to participants that the video may contain graphic or content that is distressing, particularly for some participants.
- Project the given video or choose a video more relevant to your context.
- At the close of the video, ask participants some broad questions about what they have just watched. These could include:
  - What factors increased the risk of sexual violence in the context shown in the video?
  - What were/ may be some barriers to seeking care in the setting shown in the video?

Materials

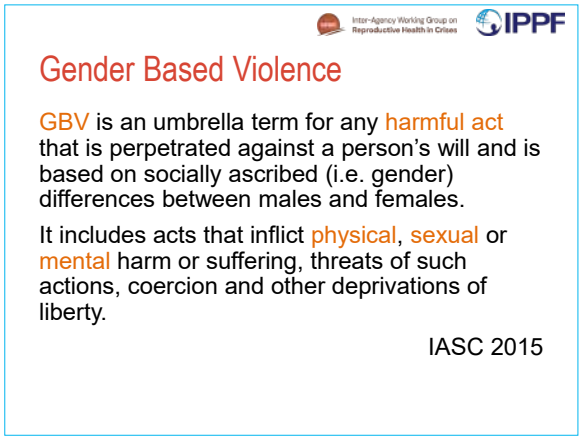
Projecting equipment

Suggested videos (included on USB):

- Our Bodies, Their Battleground- IRIN (now New Humanitarian)
- Iraqi Refugees in Jordan- Women's refugee commission

Slide #8: Gender based violence

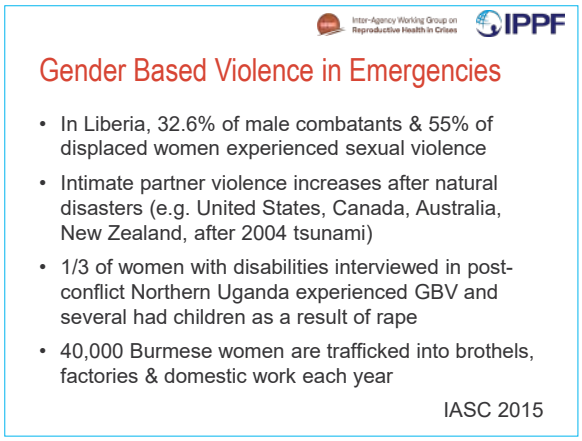
Key Messages



- GBV is complex and highly sensitive in both development and humanitarian settings.
- There is no common understanding of GBV. GBV, SGBV (sexual and gender-based violence), VAW (violence against women) or VAWG (violence against women and girls) are all used by different organisations. The differences are not just semantics, but reflect an underlying and fundamental disagreement, specifically in regard to whether GBV is violence perpetrated against women and girls, or whether it is violence perpetrated against anyone based on their gender.
- The 2015 IASC Guidelines on GBV state that it is "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females".
- This definition supports the view that whilst women and girls are the primary victims of GBV because of their subordinate status vis-à-vis men and boys worldwide, men and boys may also be victims of violence due to socially determined roles, expectations, and behaviours linked to ideas about masculinities.
- Increasingly GBV is also being used to describe violence perpetrated against LGBTQIA persons, motivated by drivers of homophobia and transphobia, and aimed at punishing those who seemingly defy gender norms.

Slide #9: Gender based violence in emergencies

Key Messages



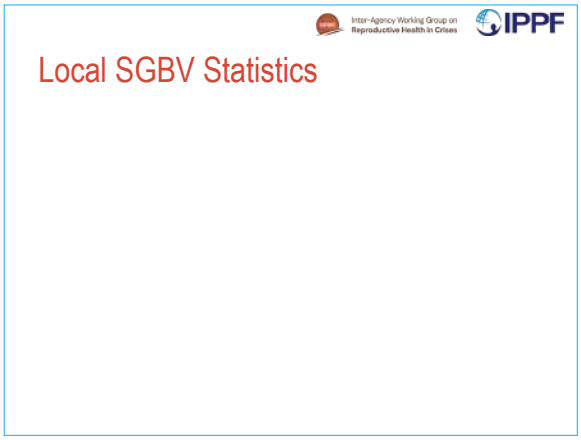
- Gender based violence is amongst the greatest health and protection challenges individuals, families and communities face during humanitarian emergencies.
- Gender based violence takes many forms in emergencies, as shown in the examples included on slide 9.
- As the situation stabilizes, humanitarian emergencies may also provide a window of opportunity to transform unequal gender relations and shift harmful gender norms.

Note to facilitators Provide statistics on the extent of gender based violence in emergencies for your settings or known examples of this occurring.

Slide #10: Local SGBV Statistics

Key Messages

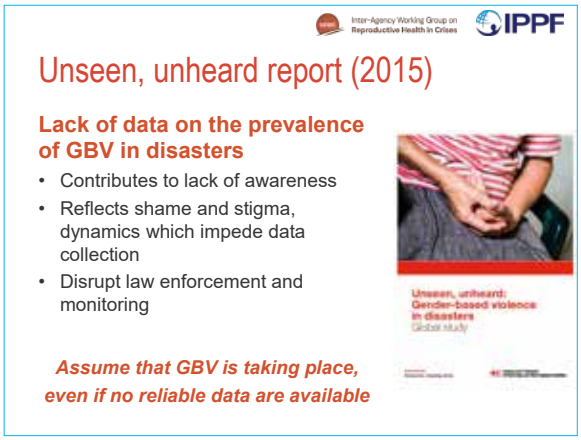
- This slide has been left blank so that you may provide information on sexual and gender based violence in humanitarian settings in your local, national and/or regional context.



Slide #11: Unseen, unheard report (2015)

Key Messages

- Sexual violence in humanitarian settings is often underreported. We must always assume that GBV is a risk for people in crisis settings and as such, reporting is not essential to start prevention and response activities outlined by the MISP.
- A 2015 report showed that this lack of data contributes to lack of awareness, both reflects and reinforces stigma and shame, and results from disrupted law enforcement and monitoring.



- It is critical to provide the sexual violence services outlined in the MISP even if there are no reliable data on GBV.

Note to facilitators For a copy of the IFRC report Unseen, unheard: Gender-based violence in disasters, visit https://www.ifrc.org/Global/Documents/Secretariat/201511/1297700_GBV_in_Disasters_EN_LR2.pdf

Slide #12: Gender based violence in emergencies

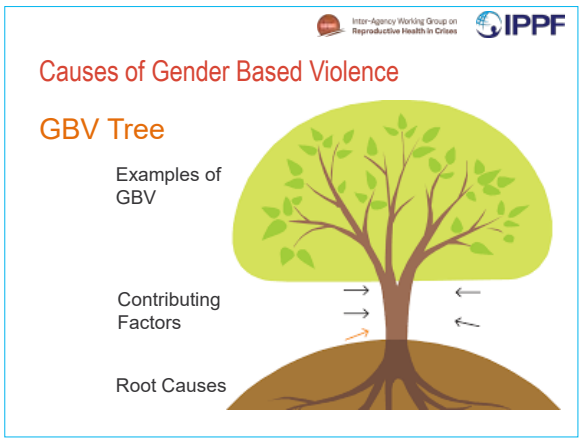
Key Messages

- Gender based violence occurs in all societies and cultures and in both stable and emergency contexts.
- Natural disasters, conflict and emergencies which result from other hazards often exacerbate violence, diminish means of protection and increase risks of trafficking and early marriage (IASC 2015).
- New threats or forms of gender based violence may emerge, such as those associated with the presence of armed forces or aid workers, overcrowding, separation from family and the breakdown of protective social and legal mechanisms. These will be looked at in more depth in the following slides.

Slide #13: Causes of gender based violence

GBV Tree

This exercise helps participants identify the different types of GBV and distinguish between contributing factors and root causes- also highlighting what can and can't be addressed during emergency responses.



Time

10 minutes.

Process

If time permits break group into two, to work on problem trees.

- Distribute post-it notes to the group.
- Show the slide and ask if anyone has seen or used a problem tree before.
- Explain that this is a blank problem tree. It shows a 'problem' (the tree) as being constructed of

1. The roots: denote underlying or root causes of GBV;
2. The trunk: represents the problem and contributing factors;

3. Branches: signify the effects (or consequences)/ examples of GBV.

- Ask participants to write examples of root causes, contributing factors and examples of GBV on separate post-it notes and place these on the blank problem trees.
- Facilitate a brief discussion about the participants' work, highlighting similarities and difference across their problem trees and explaining that the next slide will show an example GBV tree.

Materials

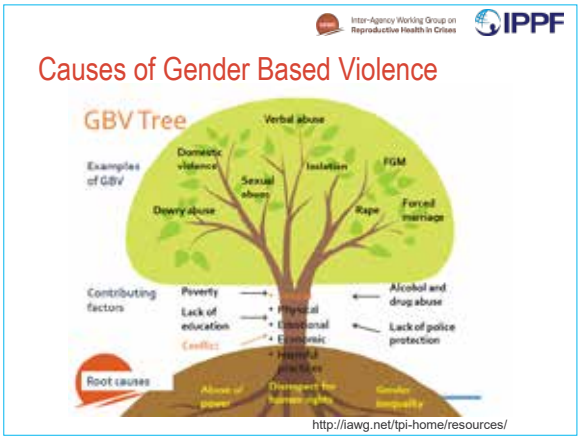
Two or more flipcharts (depending on the number of participants) with a blank problem tree drawn on each, Markers

Post-it notes.

Note to facilitators Remind participants to be mindful of persons with disabilities and their carers, LGBTQIA individuals, sex workers and other priority populations when presenting the problem tree. Revisit the importance of considering inclusion when addressing this issue.

Slide #14: Causes of gender based violence

Show the complete GBV tree and discuss if everything was captured by participants. Have a further short discussion on how this relates to the specific contextual factors for program managers in their own context.



Key Messages

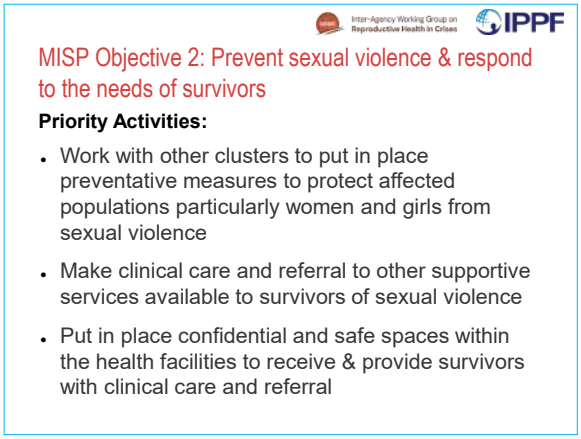
- The root causes of all forms of GBV lie in societal attitudes towards and practices of gender discrimination - the roles, responsibilities, limitations, privileges and opportunities afforded to an individual according to gender.
- Contributing factors are those that perpetuate GBV or increase the risk of GBV, and influence the type and extent of GBV in any setting. Contributing factors do not cause GBV although they are associated with some acts of GBV. War, displacement, and the presence of armed combatants are all contributing factors, but all soldiers do not rape civilian women. Poverty is a contributing factor, but not all poor women and girls will be sexually exploited. Many contributing factors can be eliminated or significantly reduced through prevention activities.
- Addressing the root causes through prevention activities requires sustained, long term action with change occurring slowly over a long period of time. Many contributing factors can be eliminated or significantly reduced through prevention activities.
- Remind participants that the MISP for SRH is to be implemented at the onset of a humanitarian crisis and it therefore addresses immediately life-threatening sexual violence. Work to address the root causes, contributing factors and other symptoms of GBV should be built upon the MISP for SRH as the situation allows. This will be discussed below.

Note to facilitators For more on the contributing factors and root causes of gender based violence in emergencies, see IASC (2015) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* page 10. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

Slide #15: MISP Objective 2: Prevent Sexual Violence & Respond to the Needs of Survivors

Key Messages

- Remind participants that the second objective of the MISP for SRH is to prevent sexual violence and respond to the needs of survivors.
- This slide contains the priority activities necessary to meet Objective 2 of the MISP. Ask participants to read aloud from slide and explain we will go through the key points in the following slides
- Activities under Objective 2 highlight the importance of working with actors from different sectors to prevent and respond to the needs of survivors, and putting survivors at the center of care.

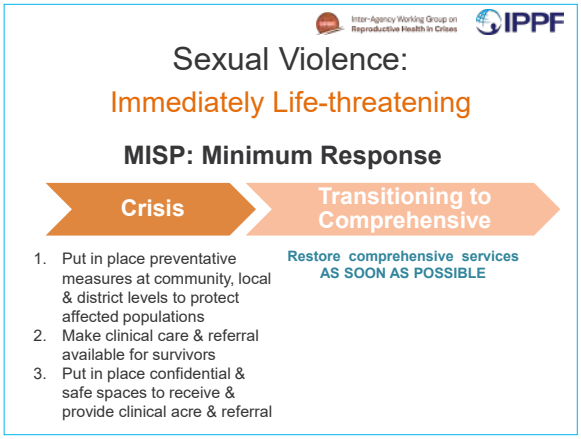


Note to facilitators Ask participants to look at their MISP for SRH Cheat Sheet and locate the second MISP Objective and its priority activities.

Slide #16: Sexual violence: immediately life-threatening

Key Messages

- GBV in all its forms is an issue in crisis settings. However, agencies agree that preventing sexual violence and responding to the needs of survivors of sexual violence is the minimum intervention that needs to take place in the early phase of an emergency because of the immediately life-threatening impact of this form of GBV.
- During the acute phase of an emergency, most reported GBV incidents are sexual violence.

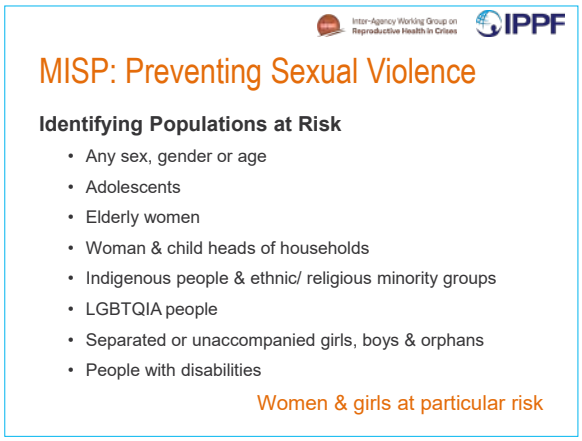


- Incidents of rape and other forms of sexual violence often increase in emergencies.
- The activities under MISP Objective 2 include both prevention and response. We will start with prevention and then move on to response.

Slide #17: MISP: preventing sexual violence

Note to facilitators Before revealing the answer, ask participants who is at risk of sexual violence in emergencies. Facilitate a brief discussion.

Key Messages

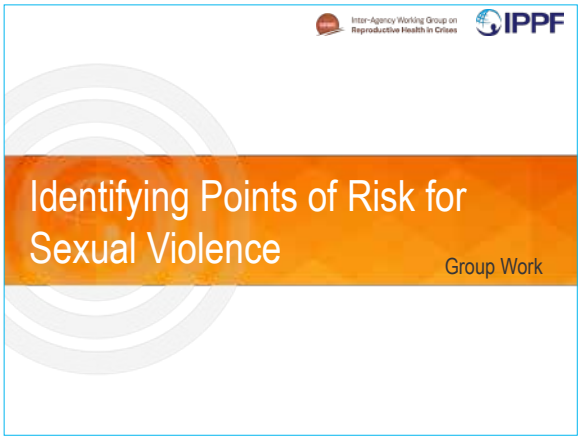


- Most reported cases of sexual violence among crisis-affected communities- and in most settings around the world- involve male perpetrators committing violent acts against females. It is important to remember that perpetrators may be known to the survivor and in many instances are family members or intimate partners.
- However, men and boys may also be at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture.
- While all women in crisis-affected settings are susceptible to sexual violence, adolescent girls are exceptionally vulnerable as they are often targeted for sexual exploitation and rape.
- People with disabilities and their caregivers are also disproportionately affected by sexual violence.
- In addition, sexual violence, even if exclusively perpetrated against women and girls, often affects and undermines the entire community- including the fathers, brothers, husbands and sons of the survivor. It is important to recognize that anyone can be a survivor of sexual violence (women, girls, boys and men of all ages) and to ensure that services are available and accessible to all.

Slide #18: Identifying points of risk for sexual violence: Group work

Identifying points of risk for sexual violence:

This activity will encourage participants to identify potential points (places and/or times) of risk for sexual violence in their on-going case study (Participant Handout #1).



Time

25 minutes.

Process

- Remind participants of their on-going case study.
- Ask participants to use the comprehensive description of the emergency context provided on day one (Participant Handout #1) and work with their small group to discover and discuss any potential points of specific risk for sexual violence. In addition to this, ask participants to identify the existence of anything in the case study that may serve to protect people from sexual violence.
- Facilitators should circulate around the room and provide advice and input as necessary.
- Facilitate a brief discussion at the close of 20 minutes.

Materials

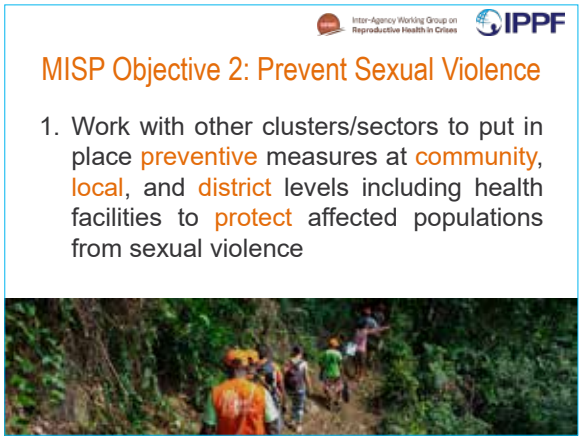
Participant Handout #1

Note to facilitators A useful tool for identifying and strategizing to overcome points of risk for sexual violence is the CARE Rapid Gender Analysis tool. Inform participants of this tool and encourage them to look at it in their own time. For more information on this, visit: https://reliefweb.int/sites/reliefweb.int/files/resources/RGA%20Mosul_SECOND%20UPDATE.pdf

Slide #19: MISP Objective 2: Prevent sexual violence

Key Messages

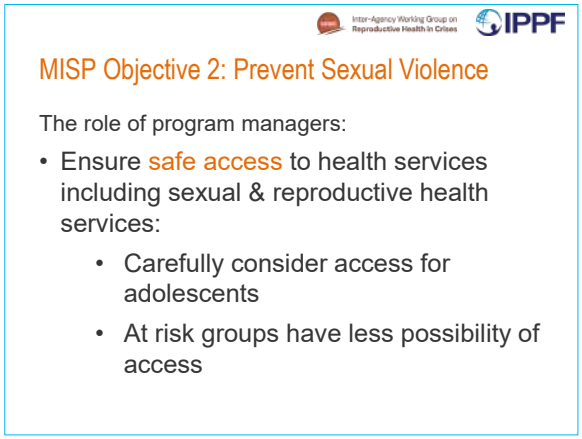
- This is the first part of the prevention component of MISP Objective 2.
- Highlight the importance of coordination to meet this activity.
- We will now work through the different activities needed to make this happen.



Slide #20: MISP Objective 2: Prevent sexual violence

Key Messages

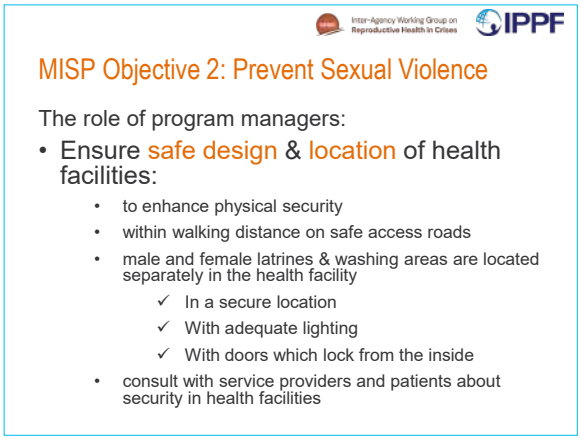
- ALL people require access to basic health services, including SRH services. This is an important component of preventing sexual violence in emergencies. Accessible health services contribute to community awareness of SRH issues, including the prevention of sexual violence
- Accessible sexual and reproductive health services make a difference in women's and girls' ability to reduce risks to their own and their children's health.



- It is very important for adolescents to be considered and specifically targeted for program interventions as the MISP is implemented. Adolescents at increased risk of sexual violence in crisis settings include orphans, separated adolescents, adolescent heads of households, marginalised adolescents, and children associated with armed forces and armed groups.
- Other at-risk groups should not be forgotten when ensuring access to basic heath services, including SRH services. The needs and access constraints of sex workers, LGBTQIA people and people with disabilities and their caregivers should also be carefully considered as they are more at risk and often have additional barriers to accessing health services including those for SRH.
- Consult with service providers and clients about security and safety concerns regarding access to health facilities.

Slide #21: MISP Objective 2: Prevent sexual violence

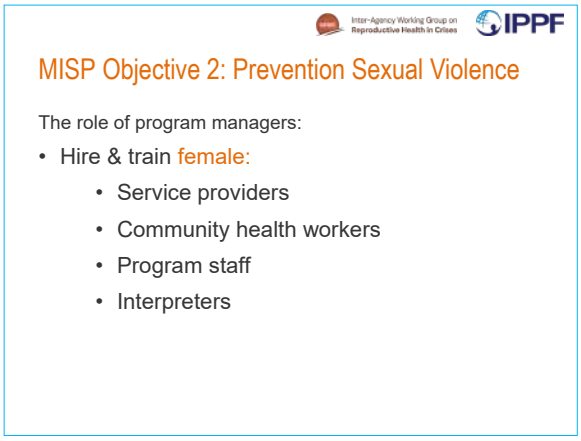
Key Messages



- Health facilities themselves must be designed and located in a way that does not place service seekers at increased risk.
- Important aspects of this include the proximity of the health centre to the affected population and safety of access roads, and the availability of separate and secure latrines and washing facilities in the centre.
- Health facilities must have adequate path lighting at night.
- Consider how entrance to a facility is monitored and controlled, such as by guards.
- Consider accessibility for people with disabilities, adolescents, and other marginalized people in consultation with these populations and groups representing them.
- Consult with service providers and clients about security and safety concerns within health facilities.
- In the preparedness phase, program managers can assess and address the accessibility of health and sexual and reproductive health facilities and connect with other organisations.
- Program managers can also involve women, adolescent girls and other at-risk groups in the design and delivery of health programming before a crisis hits (with due caution where this poses a potential security risk or increases the risk of GBV) (IAFM 2018).

Slide #22: MISP Objective 2: Prevent sexual violence

Key Messages



- Preventing sexual violence also requires the availability of female service providers, community health workers, program staff, interpreters and other key workers for accessibility and acceptability.
- In the preparedness phase, program managers can work to enhance the capacity of female health care providers.

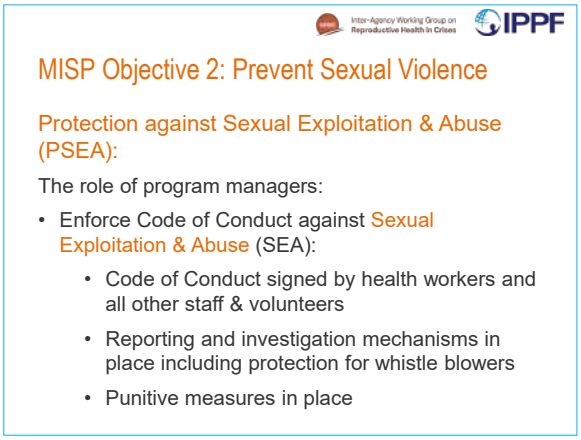
Slide #23: MISP Objective 2: Prevent sexual violence

Key Messages

- Ensuring accessibility and acceptability of health services, including sexual and reproductive health services, also requires ensuring that all ethnic subgroup languages are represented among service providers, or that male and female interpreters are available.
- Program managers should also inform service providers and all other facility staff of the importance of maintaining confidentiality, including protecting survivor information and data.

Slide #24: MISP Objective 2: Prevent sexual violence

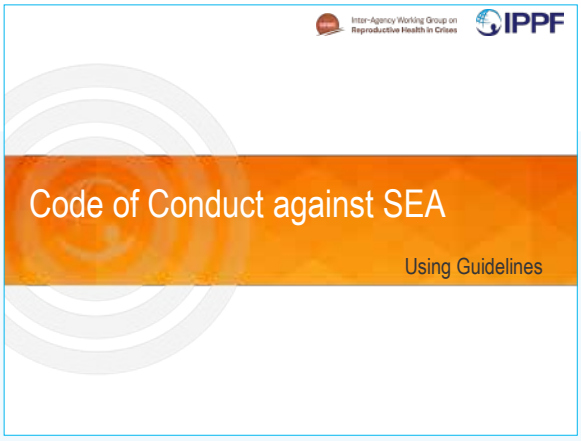
Key Messages



- Program managers should ensure that all health workers and other facility staff have signed and abide by a Code of Conduct against sexual exploitation and abuse (SEA). Most agencies will have their own policies and codes of conduct for preventing sexual exploitation and abuse.
- A Code of Conduct (CoC) against sexual exploitation and abuse (SEA) is a set of agency guidelines that promote respect by staff of the agency for fundamental human rights, social justice, human dignity and respect for the rights of women, men, adolescents and children. The CoC also informs staff that their obligation to show this respect is a condition of their employment
- Also ensure that codes of conduct and reporting mechanisms on SEA (which ensure whistle blower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct. An enforceable CoC is a critical component of humanitarian accountability to beneficiaries.
- Codes of Conduct are often part of a HR mechanism, not specific to SRH. However, links to GBV/ SV referral systems and services are of obvious importance.

Slide #25: Using guidelines: Code of conduct against SEA

Code of Conduct against Sexual Exploitation and Abuse:



Note to facilitators must familiarise themselves with the codes of conduct before conducting this exercise to ensure that they are able to support the discussion.

This activity will allow participants to analyse and understand the key components of codes of conduct against sexual exploitation and abuse.

Time

15 minutes.

Process

1. Ask participants to look at the sample codes of conduct provided on Participant Handout #8.

2. Allow participants time to read through the documents and answer the following questions (also included on Participant Handout #8):

   - What principles are common to the documents?
   - How do these principles relate to sexual exploitation and abuse?
   - How could a code of conduct help prevent sexual exploitation and abuse?

3. Facilitate a brief discussion with the group, based on the above questions.

4. Emphasise the importance of program managers establishing and enforcing a code of conduct for all team members working in a humanitarian space. This will require SRH coordinators and those working in SRH in these settings to advocate to and coordinate closely with representatives from all sectors/clusters involved in the crisis setting.

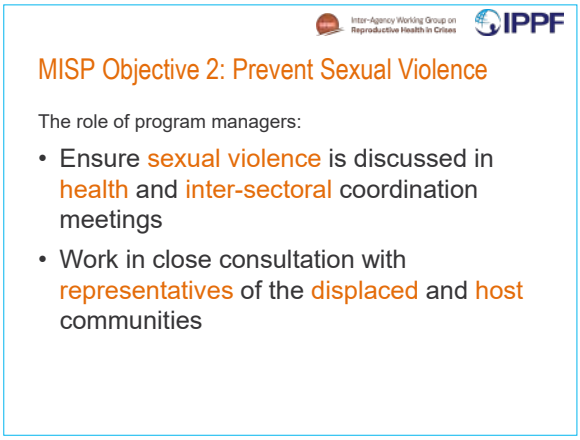
Materials

Participant Handout #8

Slide #26: MISP Objective 2: Prevent sexual violence

Key Messages

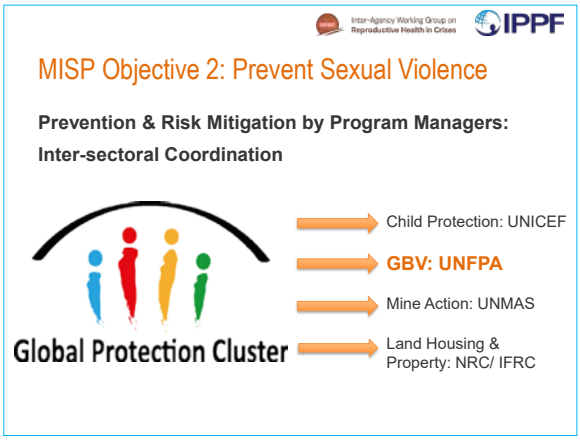
- Program managers will need to work with other clusters, especially the protection or GBV sub-cluster, to put in place the preventative measures outlined above at community, local and district levels.
- It is also important to genuinely engage and consult with members of the displaced and host communities, keeping in mind the diversity which exists across these populations.



Slide #27: MISP Objective 2: Prevent sexual violence

Key Messages

- At a global level, and sometimes translated into national mechanisms, The Global Protection Cluster is the main inter-agency forum for standard and policy setting as well as collaboration and overall coordination of activities supporting the protection response in complex and natural disaster humanitarian settings.
- The Global Protection Cluster has 4 Areas of Responsibility (AoRs).



- The GBV AoR advises and provides technical input by Regional Emergency GBV Advisors (REGA) as needed.

Note to facilitators This is a good opportunity to explain to participants how the components of the Global Protection Cluster translate to local mechanisms.

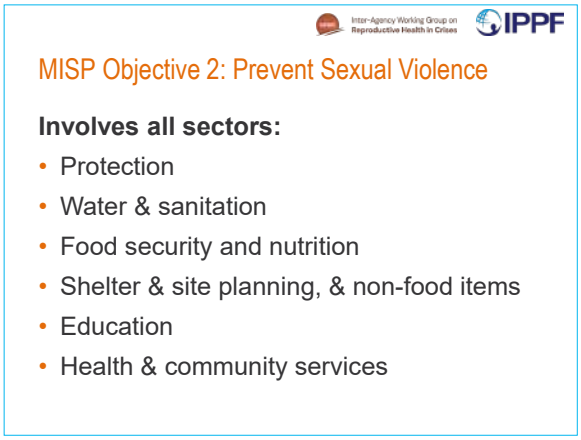
For more information on the Global Protection Cluster and its AoRs, visit http://gbvaor.net/what-is-gender-based-violence-area-of -responsibility/

For more information on REGA, visit gbvaor.net/who-we-are/regional-emergency-gbv-advisors-rega

Slide #28: MISP Objective 2: Prevent sexual violence

Key Messages

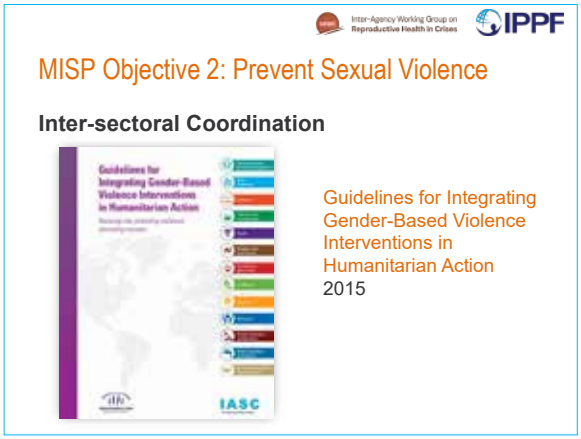
- As well as health and protection, a number of other sectors/ clusters have a role to play within this area of responsibility. All clusters have a duty to protect.
- These include water and sanitation, food security and nutrition, shelter and site planning, education, and health and community services.



Slide #29: MISP Objective 2: Prevent sexual violence

Key Messages

- A key tool which addresses the role these various sectors have in preventing and responding to gender based violence in emergencies is the IASC (2015) *Guidelines for Integrating Gender-Based Violence in Humanitarian Action*.
- This is one of the tools produced by the Global Protection Cluster GBV AoR.
- The guidelines are divided into Thematic Area Guides (TAGS). Each TAG is for one cluster.



Note to facilitators If you have internet connection, bring up the IASC GBV guidelines page: https://gbvguidelines.org/wp/wp-content/uploads/2016/10/2015_IASC_Gender-based_Violence_Guidelines_full-res.pdf

Show participants the sectors represented by the TAGs and that if you click on one of the tabs on the right, it will take you to that particular thematic area.

Slide #30: Coordination with other humanitarian sectors: Group work

Coordination with Other Humanitarian Sectors: (Optional activity)

This activity will build skills of participants in coordinating with other sectors to address the points of risk for sexual violence identified earlier in this session. This is an optional activity. It is designed to provide further coordination practice and to reinforce to participants that the prevention of sexual violence in humanitarian settings is everyone's responsibility and that coordination with other sectors or clusters is vital.

Time

25 minutes.

Process

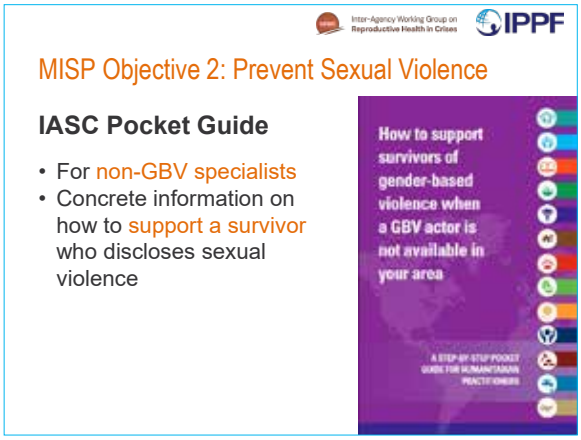
- Ask participants to think again about the points of risk for sexual violence in their case studies which they identified earlier in the session.
- Divide participants into two groups. The first group will play the role of SRH Coordinators. The second will be divided between the other relevant sectors/ clusters.
- Give participants in the first group a copy of the IASC Health TAG Excerpt (Handout #9). Allow them time to read through and identify what they will be seeking through the GBV working group meeting with other stakeholders in reference to their discussion on points of risk for sexual violence.
- Ask participants from the second group to take a role card identifying them as a representative of one of the other relevant sectors/ clusters and ask them to brainstorm potential priorities for each of these representatives.
- After approximately 10 minutes, convene the GBV working group meeting and ask group one to address each representative in turn and ask them how they might contribute to the prevention of sexual violence, based on the points of risk for sexual violence identified earlier in their case study. Group one should ensure that each action outlined for each sector in the IASC Health Tag Excerpt is discussed.
- Participants from the second group should push for their other priorities, compelling the SRH Coordination team to engage advocacy messages discussed on the first day and at the start of this session.
- At the close of the role play, facilitate a brief discussion with the group to ensure that advocacy messages and proposed strategies for coordination are on track.

Materials

- Participant Handouts #1 & #9
- Name tags

Slide #31: MISP Objective 2: Prevent sexual violence

Key Messages



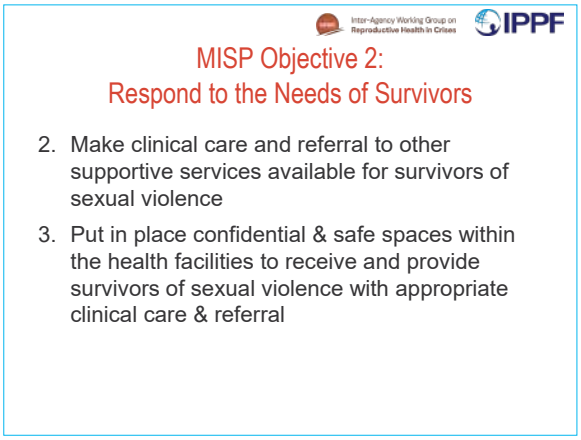
- As program managers, it is important for those in attendance to try to ensure that sexual violence is addressed in coordination with the sectors/ clusters explored above.
- In instances where there is no GBV focal point available in your area, the IASC Guide *How to Support Survivors of Gender-Based Violence when a GBV Actor is not Available in your Area: A Step-by-Step Pocket Guide for Humanitarian Practitioners* (or the Pocket Guide) is a useful document to make broadly available to humanitarian practitioners.
- The Pocket Guide is targeted towards non-GBV specialists who are on the frontlines of providing services to affected communities, including hygiene promoters, community health workers, camp managers, protection focal points etc. The guide provides information on how to support a survivor of gender-based violence who disclosed to you in a context where is no gender-based violence actor (including a referral pathway or GBV focal point) available in your area.
- The goal of the Pocket Guide is to provide all humanitarian practitioners with concrete information in an easy-to-follow and easy-to-carry-guide.

Note to facilitators The Pocket Guide is a useful tool and this may be a good opportunity to allow your participants to explore it further. It is available at https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_Background_Note021718.pdf or through Google Play or the iTunes store. Search for "GBV Pocket Guide."

Slide #32: MISP Objective 2: Respond to the needs of survivors

Key Messages

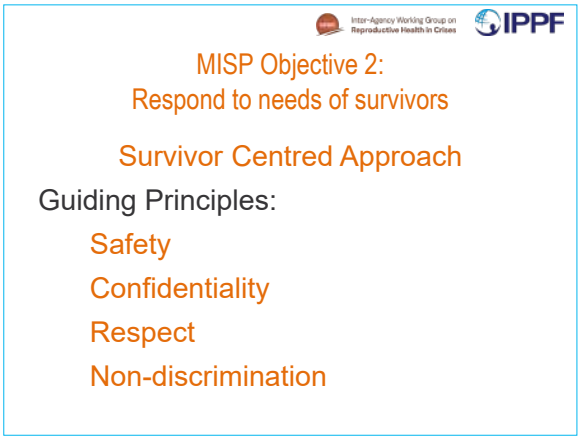
- We have now moved from prevention of sexual violence to responding to the needs of survivors.
- This has two parts. The first is making clinical care and referral to other supportive services available for survivors of sexual violence; and the second is putting in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.



Slide #33: MISP Objective 2: Respond to the needs of survivors

Key Messages

- A survivor-centred approach means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV related programming (IAFM 2018).
- The survivor-centred approach can guide professionals- regardless of their role- in their engagement with persons who have experienced SV. It aims to create a supportive environment in which survivor's rights are respected, safety in ensured, and the survivor is treated with dignity and respect (IAFM 2018).



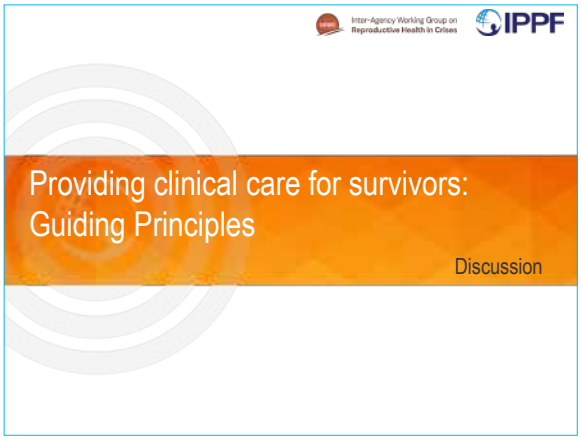
- The approach helps to promote a survivor's recovery and strengthen her or his ability to identify and express needs and wishes, it also reinforces the person's capacity to make decisions about possible interventions (IAFM 2018).
- The guiding principles of this approach are safety, confidentiality, respect and non-discrimination.

Note to facilitators For more information on the guiding principles, see IAFM 2018 pages 206-207

Slide #34: Providing clinical care for survivors: Guiding Principles: Discussion

Providing Clinical Care for Survivors: Guiding Principles

This activity will allow participants to see how the guiding principles must be translated into action when ensuring the provision of clinical care for survivors of sexual violence.



Time

10 minutes.

Process

- Divide participants into four groups (such as by table) and give one copy of Participant Handout #10 to each group.
- Explain the pictures: entrance sign, files, medicines, and latrine.
- Ask the groups to take two minutes to work on the following question:
  - As a program manager, you are evaluating a clinic that provides care to survivors of sexual violence. Give your comments and recommendations.
- Have a reporter for each group share findings and facilitate a discussion based on the solutions below.

Alternatively, you can set this up as a role play based on the pictures if have time.

Materials

Participant Handout #10

Solutions

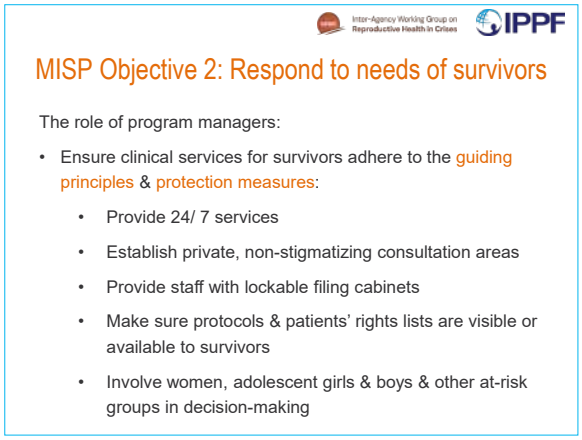
- Entrance sign: does not ensure confidentiality and safety and has limited opening hours;
- Files: names should be coded and files put in a locked cabinet;
- Medicines: should be better organised with drugs in a separate cabinet;
- Latrine: it is important to have access to latrines but male and female latrines should be separate.

Key message for participants

Health providers might be the first point of contact for the survivor, therefore referral is critical. Survivors of sexual violence and/or other forms of GBV may attend health services and must be provided with information, services and referral in a way which upholds the guiding principles. More on the role of service providers for this is available in the complementary training module *Training for Service Providers on the Minimum Initial Service Package for Sexual and Reproductive Health*.

Slide #35: MISP Objective 2: Respond to the needs of survivors

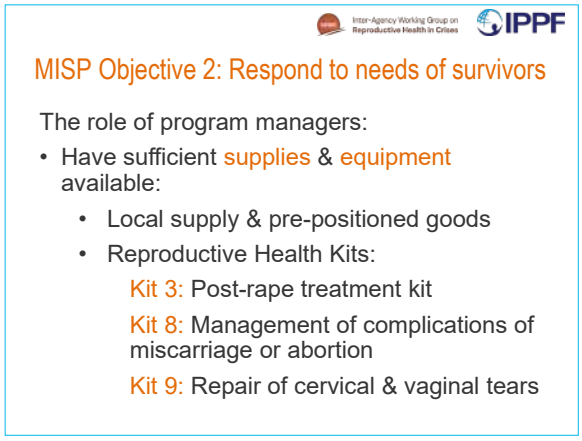
Key Messages



- The survivor's healing process should begin from the first visit to the clinic. This may be the first and only point of contact for survivors.
- In follow up to the discussion above, stress to participants that as program managers, they need to ensure:
  - 24/ 7 services for survivors are in place
  - Private, non-stigmatizing consultation areas are available in all health facilities
  - Protocols for treatment and patients' rights are visibly posted or are available to survivors in all relevant languages/ pictorially as needed
  - That at-risk groups are involved in decision-making as early as possible
  - Ensure access points for male and LGBTQIA survivors (who will not access SV care in maternity or women-friendly spaces).

Slide #36: MISP Objective 2: Respond to the needs of survivors

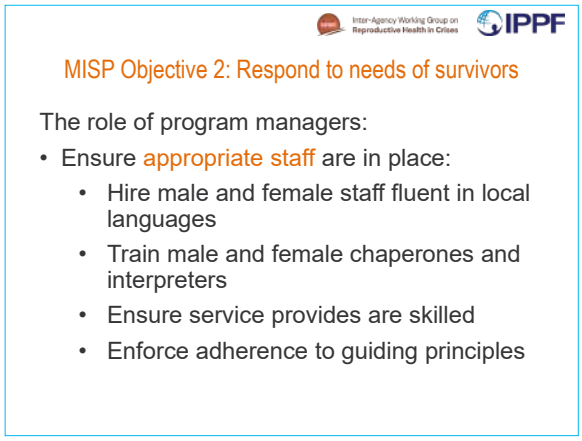
Key Messages



- Program managers are also responsible for ensuring a sustained supply of commodities and equipment to support clinical care for survivors of sexual violence.
- Program managers can work in the preparedness phase to support the pre-positioning of appropriate supplies to implement clinical care for survivors of sexual violence. These may include medical drugs, equipment, and administrative supplies. Partnerships with government or other agencies is critical for pre-positioning.
- When necessary, Reproductive Health kits may also be ordered to support the response in the acute phase of the crisis. Kits 3, 8 and 9 directly relate to the provision of health services for survivors of sexual violence.

Slide #37: MISP Objective 2: Respond to the needs of survivors

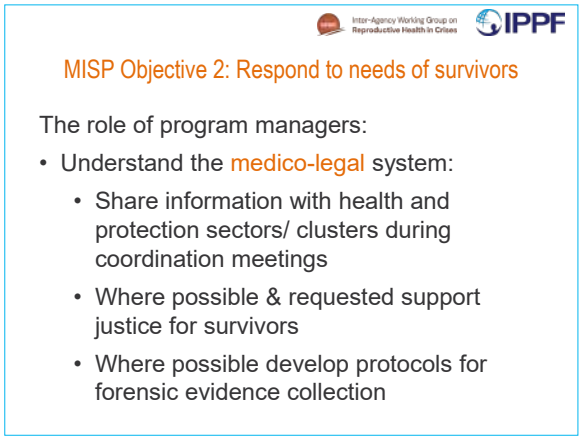
Key Messages



- A further responsibility of program managers is to ensure that appropriate staff are in place to provide clinical services to survivors or sexual violence and linkages to services to meet the needs of survivors such as justice/ legal resources, protection, security, psychosocial, and community services.
- Trained staff may be pre-positioned in the preparedness phase to provide clinical care and psycho-social support. In addition, mapping and rostering of staff with capacity in providing services for survivors will aid the speed of response when a crisis hits.
- Adequately trained male and female staff are required. A number of training resources are available to facilitate this. See, for example http://iawg.net/tpi-home/.
- Survivor-centred care should be guaranteed by program managers. This includes ensuring a clear focus on clinical and attitudinal competencies for child-friendly care and to promote access and recovery for both male and female survivors.

Slide #38: MISP Objective 2: Respond to the needs of survivors

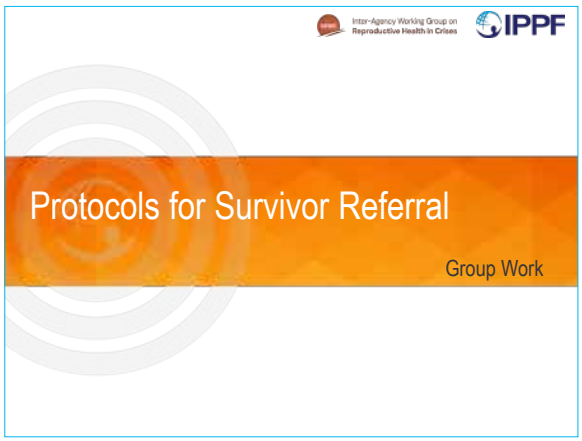
Key Messages



- An important part of the response to sexual violence is ending impunity of perpetrators and supporting justice for survivors.
- The SRH Coordinator and SRH program managers should determine the status of the national medico-legal system, including the relevant laws and policies about sexual violence. This can be done in the preparedness phase.
- This information should be shared with respective national and international stakeholders (including health providers, GBV experts, psychosocial workers, and civil society organizations addressing GBV, such as women's, youth, LGBTQIA, PWD, and ethnic minority community groups).
- In crisis settings, various aspects of an existing system(s) comprised of health and social services, forensic medicine, forensic lab services, police/investigative services, and the legal system could be compromised due to a lack of qualified personnel or insufficient/damaged facilities, equipment, supplies, and resources.
- Clinical management of survivors of sexual violence takes priority over the medico-legal process. However, if the survivor agrees, and where capacity exist to test and use the evidence, the exam and forensic evidence can be collected together. Collection of forensic evidence should only occur if that evidence can be tested, analyzed, and used.

Slide #39: Protocols for survivor referral: a survivor-centred approach: Group work

Protocols for Survivor Referral



The aim of this activity is for participants to understand the need for a coordinated referral system to ensure the guiding principles of survivor-centred care are respected and how Standard Operating Procedures (SOPs) can help with this. This activity is to be conducted before the in-depth discussion of SOPs as it will emphasise to participants the importance of coordination and maintaining survivor-centred care- the approach and mindset they should take with them into discussions about technical aspects of SOPs.

Time

30 minutes.

Process

Option 1

- Ask for a volunteer to play the part of a 17 year old survivor of SV. Put them in the middle of the circle.
- Distribute name tags for the other roles to volunteers. Tell them that they will be in the role of the person noted on their name tag.
- Ask the volunteers to stand in a circle, fairly close together around the survivor. Ask the remaining participants to stand outside the circle so that they can easily see the activity.
- Explain that the ball of yarn represents the journey of a 17 year old girl who was raped.
- Once everyone is in place start reading the story. Ask the survivor to hold on to a piece of the string and pass the rest to the next person mentioned in the story and so on. Each Actor who receives the ball of string will wrap it around a finger and then pass the ball to the next Actor as instructed.
- Let the activity speak for itself, unfolding before participants' eyes. Do not describe it or explain its purposes before completing the activity.

Story

A 17 year old girl was raped and tells her mother;

- Mother takes girl to Community Leader
- Community Leader refers the girl to the TBA
- TBA helps, but the girl needs more health intervention and TBA refers girl to the Midwife
- Midwife calls in the Doctor
- Doctor administers treatment and sends girl back to Midwife
- Midwife refers the girl to the Community Services Worker
- Community Services Worker provides emotional support and contacts the UNHCR Community Services Officer for assistance
- UNHCR Community Services Officer talks with the girl and discovers the girl wants to involve the police—refers the girl to the UNHCR Protection Officer
- UNHCR Protection Officer meets the girl, takes her back to the Doctor for a few more questions

- Doctor sends the girl back to the UNHCR Protection Officer
- UNHCR Protection Officer refers the girl to the Police
- Police contact the Doctor
- Doctor contacts Mother
- Mother takes girl to UNHCR Protection Officer
- UNHCR Protection Officer refers girl to a Lawyer
- Lawyer contacts Police
- Police contact Prosecutor to have him speak with the survivor
- Prosecutor discusses with Lawyer
- Lawyer discusses with Prosecutor
- Prosecutor calls the Doctor about the survivor to get information about the medical exam. Doctor asks to see the survivor again because she forgot to examine something
- The Doctor refers the survivor to a Social Worker
- The Social Worker then contacts the Police to give them some new information
- The Police contact the UNHCR Protection Officer to report the incident
- The Protection Officer contacts the mother to ask questions
- The Mother asks the survivor additional questions
- The survivor goes to talk with the Community Leader because she is confused about the process
- The Community Leader contacts the Prosecutor and the Judge to find out the status of the case
- They refer the Community Leader to the Police
- The Police refer the Leader to the UNHCR Protection Officer

Stop the activity when every Actor has taken part in at least two communication exchanges regarding the case. There will be a large web in the centre of the circle, with each Actor holding parts of the string.

Pause to look at the web. Ask some questions to generate discussion:

- What do you see in the middle of this circle?

- Was all of this helpful for the survivor? Traumatic?
- Might a situation like this happen in your setting?
- What could have been done to avoid making this web of string?
- Observers: How many times did the girl have to repeat her story?
- Actors: How many times did you talk with this survivor—or with others about her? Do you remember the details?

Actors should let go of the string and let it drop to the floor. Leave the red stringy chaotic mass sitting on the floor for all to see. Explain that SOPS are an important instrument to ensure that this scenario doesn't happen.

Option 2 (variation of Option 1)

Alternatively, you can help participants develop a scenario and story which would be more representative of their context. It is advised to keep the central character as a 17 year old who has been raped at the centre of the story.

Key Messages

- SOPs are important to stop this scenario happening.
- In most refugee/IDP contexts, the SV survivor has to interact with a vast number of resources and contacts that are often not well trained and not well coordinated. This can be very daunting and confusing to the survivor and may discourage incident reporting or negatively impact the survivor. It is important to set up a clear response system and to have someone act as a case manager for the survivor, helping her to navigate the system.
- Explain that roles and responsibilities can be divided into the nature/scope of the services provided by each organization. Referrals should be clearly defined to prevent unnecessary "back and forth" of the survivor which only delays medical attention and worsens his/her situation (as shown in thread game). A reporting mechanism should be in place in order to monitor the incidence of sexual violence and its trend for more targeted programs.
- Displaced communities should be a part of the SOPs and be aware of the response mechanisms in place for them. Community can be involved in peer-to-peer awareness on human rights, especially women's rights, establishing women committees, facilitating women support groups for survivors, engaging the women groups in identification of survivors, etc. Women and girls who are survivors of sexual violence should know where they can go to receive the necessary attention, assistance, support and care.

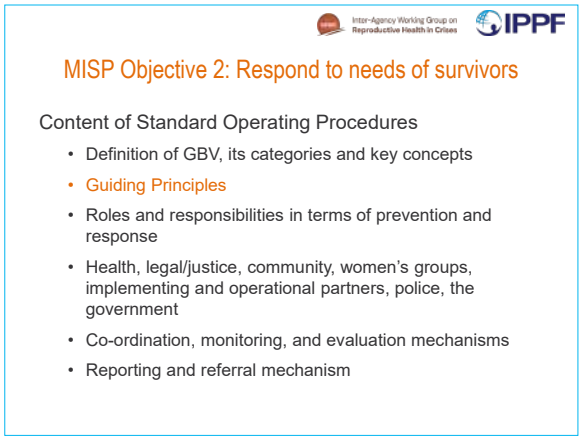
Slide #40: MISP Objective 2: Respond to the needs of survivors

Key Messages

- The importance of survivor-centred protocols was made clear in the above exercise.
- As discussed during the section on preventing sexual violence in emergencies, coordination and collaboration between the health and other sectors is critically important to ensure services are available to survivors.
- Part of this is ensuring that roles, responsibilities and referral mechanisms are clearly defined and widely known amongst involved agencies.
- One way of supporting this is to establish SOPs for inter-agency coordination at the camp or community level for individual survivors of sexual violence. (Note that the IASC Guidelines discussed earlier provide direction on coordinating prevention and response at the lead inter-agency level).
- SOPs facilitate a coordinated response to sexual violence amongst all of the agencies indicated in the diagram.

Slide #41: MISP Objective 2: Respond to the needs of survivors

Key Messages



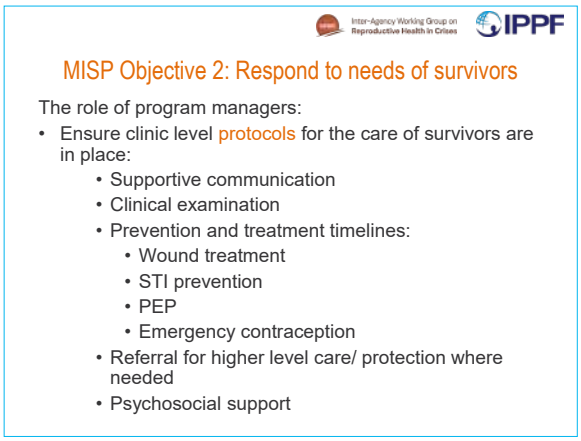
- SOPs must contain the information listed on the slide in order to be comprehensive and effective.
- A focal point must be identified in the SOP for each of the sectors listed.
- SOPs enhance coordination between partners by clarifying roles and responsibilities.
- SOPs facilitate a common and agreed understanding of what needs to be done and how it should be done (common definitions, reporting and monitoring).
- SOPs facilitate effective communication and ensure a timely response to survivors.

- SOPs also fill gaps and help avoid duplication in both prevention and response to sexual violence.

Note to facilitators This might be a good opportunity to provide participants with an example of a SOP document so that they may get a clearer understanding of what's included. Source an example relevant to your context.

Slide #42: MISP Objective 2: Respond to the needs of survivors

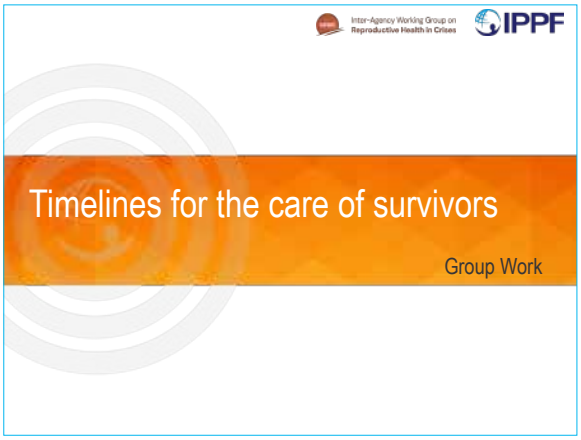
Key Messages



- As well as ensuring collaboration and coordination between agencies, program managers should ensure that clear protocols for responding to the needs of survivors are in place within health facilities too.
- These protocols should be in line with national and/or international standards.
- As part of preparedness, program managers can work to develop and/or standardize policies and protocols for SV related health programming, in partnership within Ministry of Health, as feasible, and civil society actors including women's rights groups, to ensure integrated, quality care for survivors (IAFM 2018).
- Also in preparedness, program managers can promote integration of available health services in GBV standard operating procedures and/or referral pathways.
- Protocols for responding to the needs of survivors must include:
  - Supportive communication
  - Clinical examination
  - Prevention and treatment timelines (to be explored in the group work below)
  - Referral for higher level care/ protection where needed
  - Psychosocial support

Note to facilitators For more on these aspects of responding to the needs of survivors, see IAFM 2018 from page 25.

Slide #43: Timelines for the care of survivors: Group work



This activity follows from the above discussion about treatment for survivors where participants made treatment decisions, partly based on consideration of the time of patient presentation after the incident. This activity will help to summarise guidance on treatment time frames and reinforce to participants the importance of providing timely services to survivors of sexual violence.

Note: National treatment guidelines may differ from the international guidance presented in this exercise. Be sure to source correct information for your context and present the differences between national and international guidelines at the close of the exercise. Explain to participants that any difference may be an important point for future advocacy work.

Time

30 minutes

Process

- Use a large space where participants can move around.
- Write/print out each treatment and time frame on an A4 piece of paper as in the following table (the notes are for your reference).
- Lay time frame numbers out on the floor (or stick them to the wall) in a time line.
- Ask participants to stand next to time line and give each participant an A4 piece of paper with a treatment option on it and ask them to hold it up.
- Ask participants to place the treatment option on the timeline where they think each treatment should happen.
- Discuss as a group where and why each treatment should be positioned and move participants/Papers to the correct place. Allow time for questions, discussions, reflections.

Time frame	Treatment	Notes
0 hours to 72 hours (3 Days)	-Forensic examination -HIV PEP -Tetanus vaccination	Only useful if there is forensic testing.
120 hours (5 Days)	Emergency Contraception	A pregnancy test is not required before giving EC.
2 weeks	-Pregnancy testing, pregnancy options counselling and safe abortion care to the full extent of the law. -Hepatitis B vaccination	Preferably A positive pregnancy test result up to 2 weeks following rape indicates a pre-existing pregnancy. Best to do as soon as possible after the event as per CMR guidelines
3 months	-Pregnancy testing, pregnancy options counselling and safe abortion care to the full extent of the law. -HIV Counselling and Referral -HIV Testing (between 3 – 6 months)	Same as pregnancy test. Best to do on first presentation to get existing HIV status but HIV sero conversion following rape will only be detected after 3-6mths.
6 months	Pregnancy testing, pregnancy options counselling and safe abortion care to the full extent of the law.	
Anytime	-Referral -Private Counselling -Presumptive STI Treatment -Medico-Legal Documentation -General examination -Wound management	All these should be done as soon as client presents of course but the key message is that survivors should be offered these services if rape was in the past mo. A survivor may not wish to have certain interventions until some time after the event Should be done with forensic testing within 72 hours but you should still always document a case of sexual violence even if client reports that it happened a long time ago

Materials

- Participant Handout #11 (Solution can be given after the exercise)
- A4 paper with treatment time frames printed and A4 paper with treatment options printed
- Marker pen, blue tack or tape to stick time line papers on floor or wall

Key Discussion points

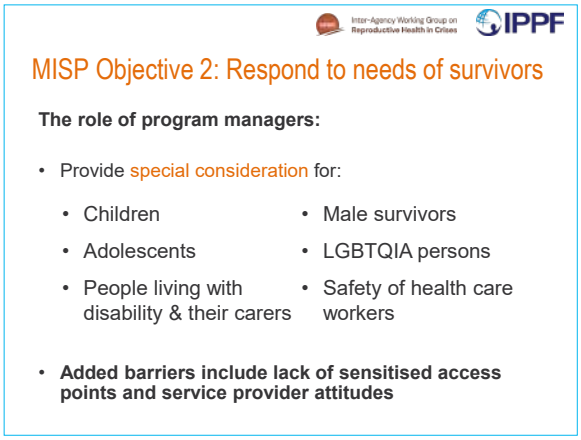
- CMR treatment should be available and accessible to all survivors soon as possible. The reality is that many survivors present many days, weeks or even months after the event and not all survivors wish to receive all treatments at the same time. It is important to understand which interventions have time limits for effectiveness.
- Emphasise the importance of the 72 hour deadline for PEP etc as well as 120 hour deadline for ECP.
- Note that this is international guidance. Provide participants with correct information for your country context. Explain any differences and that these may be important points for future advocacy efforts.
- Emphasise which treatments should be made available at any time and that all service agencies have a role to play in providing support to survivors of sexual violence (such as counselling and referral to other services), even if they are not directly providing clinical management of rape.
- Provide participants with Participant Handout #11 which provides a summary of treatment timelines.

* WHO/UNFPA CMR guidelines currently being updated. Please check guidelines for any updates needed.

Slide #44: MISP Objective 2: Respond to the needs of survivors: Discussion

Key Messages

- Program managers have a responsibility to ensure that special consideration is given to the needs of survivors from specific populations, including children, adolescents, people with a disability and their caregivers, male survivors, LGBTQIA persons and for the safety of health care workers.



Note to facilitators Remind participants of the principles of inclusion discussed during the first day of the training. Briefly review why inclusion is important and how the barriers to inclusion may present for specific populations of survivors of sexual violence.

Remind participants that considerations for male and LGBTQIA survivors are important. Negative and homophobic provider attitudes are a main barrier to care, as are destructive myths such as male rape survivors become gay. Another barrier at the service provision level is when providers and survivors don't recognise acts such as genital violence and the forced rape of others as sexual violence.

Confidentiality is often a primary concern and program managers must work to enforce this and provide sensitized access points, as these are often lacking.

Special Considerations for Specific Populations

This is an optional activity. It will allow participants to engage with a population in need of special consideration and bring their needs to the group.

Time

10 minutes

Process

- Ask participants to turn to page 35 of the IAFM.
- Divide participants into 5 groups (while remaining seated to save time) and allocate each group a population that requires special consideration.

- Ask participants to read through their allocated population and think of examples of needs, challenges and strengths of this specific population from their own experience or context. At the close of 5 minutes, as each group to report back on their specific population (from the IAFM and with examples from their own experience/ context) and then report back to the group.

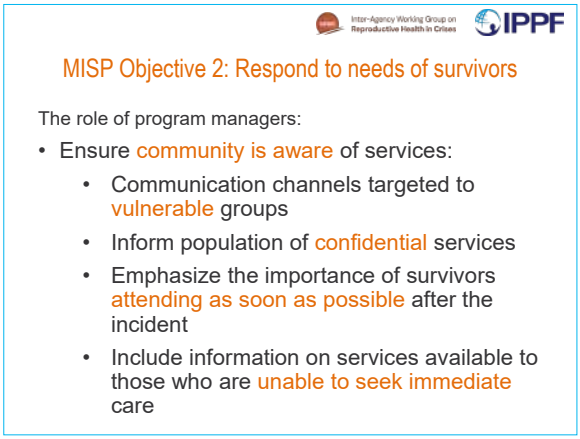
- Facilitate a brief discussion, re-enforcing to participants that specific populations require different considerations and that taking these into account makes humanitarian programming more survivor centred.

Materials

IAFM 2018 page 35

Slide #45: MISP Objective 2: Respond to the needs of survivors

Key Messages



- An important component of the program manager's role in providing survivor centred care is to ensure that the community is aware that these services are available, the benefits of seeking care, the location of the services and their hours of operation.

- SRH coordinators and program staff should inform the community about the importance of seeking immediate medical care following sexual violence, as highlighted in the above exercise.

- Affected populations should know that services are confidential and available to all people, regardless of age or marital status.

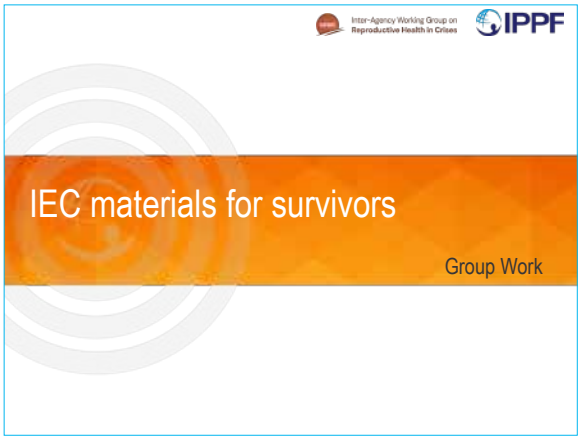
- Information should be provided in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (women, youth, and LGBTQIA and PWD groups) and other setting-appropriate channels (e.g., through schools, midwives, community health workers, community leaders, radio messages or informational leaflets in women's latrines) (IAFM 2018).

- Messaging should also include information about what health services are offered to survivors who are unable to seek immediate care (IAFM 2018).

Slide #46: IEC materials for survivors: Group work

IEC Materials for Survivors

- Participants will evaluate current IEC materials for survivors of sexual violence in terms of their relevance to local contexts and needs.



Time

25 minutes

Process

- Participants can remain in their table groups for this activity (alternatively, this activity can be done as home work for groups to engage with during the lunch break).
- Provide participants with a copy of the 2 IEC materials for survivors of sexual violence (Templates G & H) developed by IAWG, available at:
  - http://iawg.net/resource/template-g-forced-sex/
  - http://iawg.net/resource/template-h-health-center/
- There are a number of variations of these two templates- choose those which will require some alteration by participants.
- Ask participants to work with their table group to note how these templates could best be adapted for their setting or the context presented in their case study. They should consider the pictorial representation in the images of the template and levels of literacy.
- Ask participants to also consider whether the materials accurately reflect the objectives of the MISP for SRH.
- Encourage them to draw, write notes, or otherwise alter the given templates so that they make sense for local populations.
- Ask participants to present their work at the close of the activity. Check that the images are appropriate and provide enough detail, that they are pitched to the correct audience in an appropriate way considering levels of health literacy and general literacy, that information on how to access services and a depiction of chronology are included, and that they do not reinforce patriarchal norms, but work to empower women.

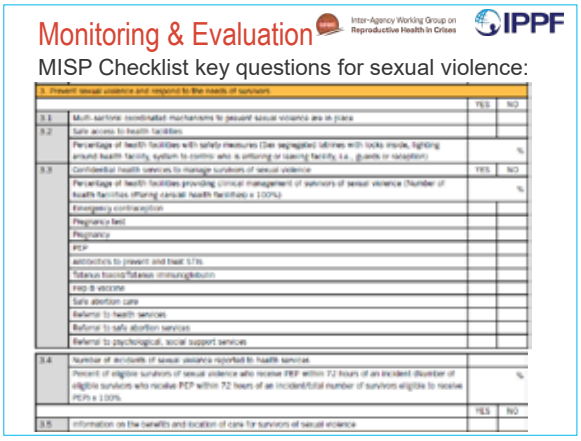
Materials

IEC templates G and H from the IAWG website.

Pens/paper for colouring

Slide #47: Monitoring and evaluation

Key Messages



- The MISP Checklist provides a useful tool for monitoring and evaluating the sexual violence objective of the MISP.
- This checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. The presence of staff with capacity to provide care to survivors should also be considered, and mapping and rostering conducted prior to the onset of an emergency.

Slide #48: Moving from MISP to comprehensive

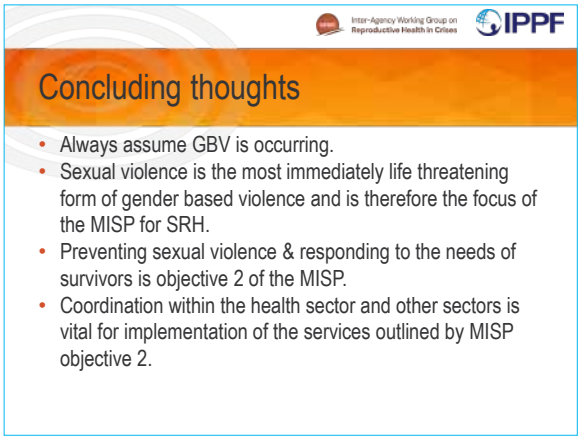
Key Messages

- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.
- It is critical to provide comprehensive services as soon as possible.
- For the sexual violence objective of the MISP, this entails expanding medical, psychological, social and legal care for survivors. It also involves addressing other forms of gender based violence, providing community education and engaging men and boys in GBV programming.
- Strong systems and programs in place before a crisis minimize the impact of hazards on sexual and reproductive health when a crisis hits. Steps to building comprehensive GBV services should, therefore be taken in the preparedness phase.

Note to facilitators If participants are interested in learning more about comprehensive GBV programming, refer them to the IAFM 2018 Chapter 10: Gender Based Violence.

Slide #49: Concluding thoughts

- Before showing the list of concluding thoughts, ask participants about the key messages they will take from this session.
- Reveal the list and allow participants to read through and ask any questions.



IPPF/Brenda Islas

Day 2 continued

MISP Objective 3: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Session 2.2 2 hours

Overview

This session will develop program managers' knowledge and skills in preventing the transmission of & reducing morbidity & mortality due to HIV & other STIs in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.

Methodology

- Interactive presentation
- Group work & role play

Materials

- PowerPoint presentation
- Participant handouts #12 & #13
- Group work supplies
- Flipchart & markers

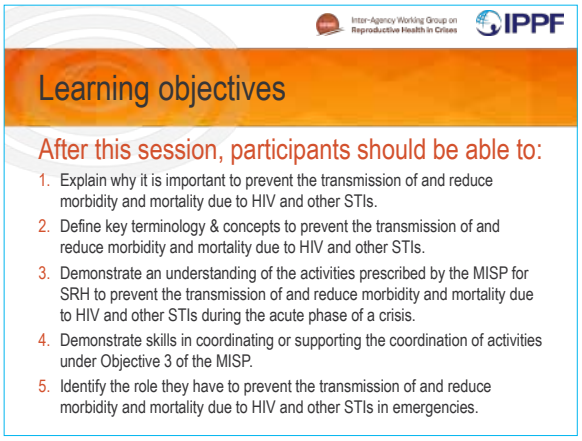
Slide #50: Sesssion 2.2: Objective 3: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Welcome your participants back and explain that you will now move on to addressing HIV and other STIs in emergencies.

Slide #51: Learning objectives

Key Messages

- There are five learning objectives for session 2.2:



1. Explain why it is important to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.

2. Define key terminology & concepts to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.

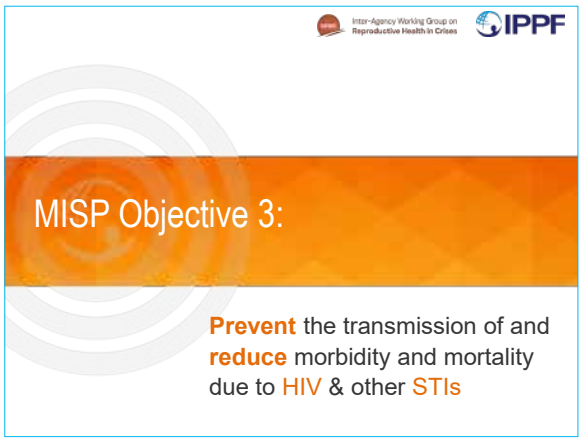
3. Demonstrate an understanding of the activities prescribed by the MISP for SRH to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs during the acute phase of a crisis.

4. Demonstrate skills in coordinating or supporting the coordination of activities under Objective 3 of the MISP.

5. Identify the role they have- to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs in emergencies.

Slide #52: MISP Objective 3: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Highlight that you are now going to look at MISP Objective 3: to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.



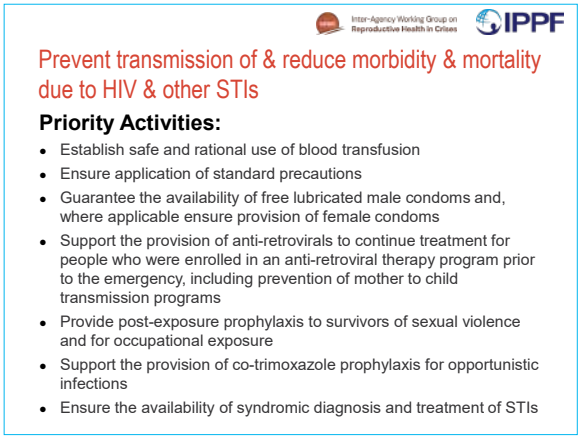
Slide #53: HIV & STIs in humanitarian settings

Key Messages

- HIV transmission in humanitarian settings is complex and is dependent on the dynamic interaction of a variety of factors. This includes HIV prevalence and vulnerability of some groups within the population in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement, and the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees) (IAFM 2018).
- The characteristics that define a complex emergency, such as conflict, mass displacement, loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV (IAFM 2018).
- As indicated on the slide, this increased vulnerability occurs through the breakdown of social structures; reduced access to HIV prevention, treatment and care services; exacerbated inequalities and stigmatization of PLWHIV; and an increase in GBV.
- Factors which may lead to decreased risk include reduced mobility, and the possibility of increased access to health and education services in host areas.
- In addition to this, refugees and internally displaced people are not usually included in national HIV programs, meaning that prevention and treatment services may not reach them.

Slide #54: MISP Objective 3: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Key Messages



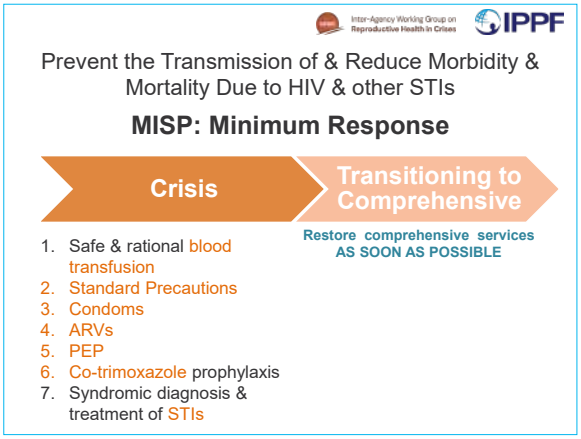
- Remind participants that the third objective of the MISP for SRH is to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
- This slide contains the priority activities necessary to meet Objective 3 of the MISP. These are:
  - Ensure safe and rational use of blood transfusion.
  - Ensure application of standard precautions.
  - Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms.
  - Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs.
  - Provide PEP to survivors of sexual violence as appropriate and for occupational exposure.
  - Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.
  - Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

Note to facilitators Ask participants to look at their MISP for SRH Cheat Sheet and locate the third MISP Objective and its priority activities.

Slide #55: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Key Messages

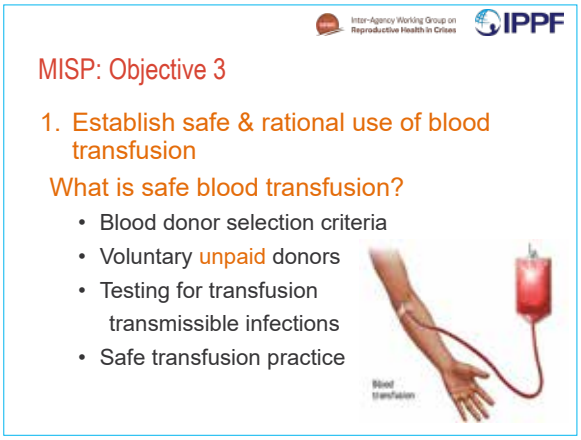
- This slide contains the priority activities necessary to meet Objective 3 of the MISP. Ask participants to read aloud from slide and explain we will go through the activities in the following slides
- These priority interventions should be provided in all humanitarian emergencies regardless of the local HIV epidemiology
- Overall activities under Objective 3 of the MISP for SRH highlight basic interventions that can be put in place to prevent transmission, and ensure people with HIV and or risk of STI are able to continue to receive care during emergencies.



Slide #56: MISP Objective 3: Prevent the Transmission of & Reduce Morbidity & Mortality Due to HIV & other STIs

Key Messages

- The first component of MISP Objective 3 is to ensure the safe and rational use of blood transfusion.
- Safe blood transfusion involves clear blood donor selection criteria, voluntary unpaid donors, testing for transfusion transmissible infections and safe transfusion practice.

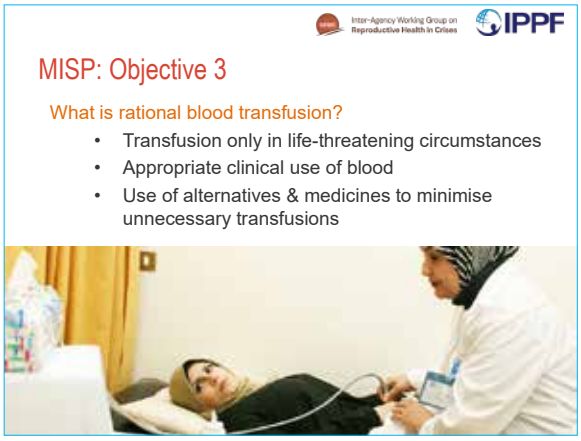


Note to facilitators Move quickly through this slide. Program coordinators will not need to know the clinical aspects of safe blood transfusion, but rather what clinical service providers are required to do from a management perspective. If participants require more information about these aspects of safe blood transfusion, refer them to IAFM 2018 pages 36-37.

Slide #57: MISP Objective 3: Rational blood transfusion

Key Messages

- Rational blood transfusion involves only transfusing blood in life-threatening circumstances, the appropriate clinical use of blood/ blood products/ substitutes and the use of alternatives and medicines to minimize unnecessary transfusions.

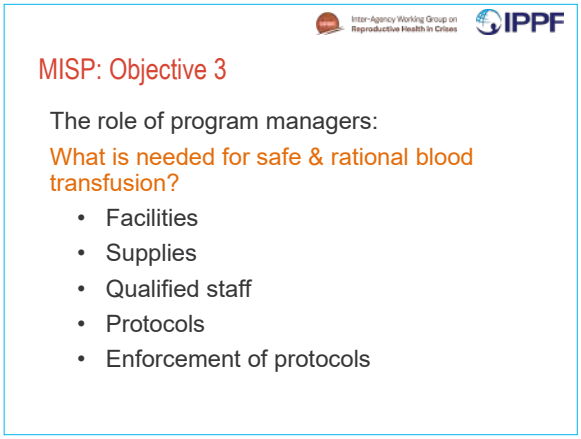


Note to facilitators Move quickly through this slide. Program coordinators will not need to know the clinical aspects of rational blood transfusion, but rather what clinical service providers are required to do from a management perspective. If participants require more information about these aspects of rational blood transfusion, refer them to IAFM 2018 pages 34-36.

Slide #58: MISP Objective 3: Rational blood transfusion

Key Messages

- The role of program managers is not to perform safe and rational blood transfusion but to ensure that the facilities, supplies and qualified staff are in place to ensure the availability of this life-saving intervention.
- The components of safe and rational blood transfusion mentioned above should be clearly explained in standard protocols. These protocols must be known and adhered to by clinic staff.

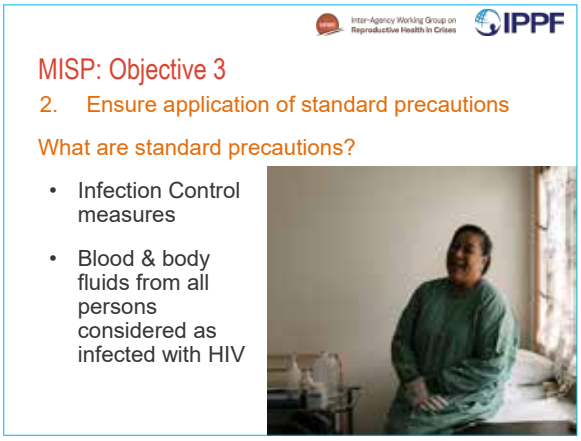


- Reproductive Health Kit 12 (for Referral Hospitals) provides supplies for safe and rational blood transfusion.

Slide #59: MISP Objective 3: Standard precautions

Key Messages

- Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health care workers (IAFM 2018).
- Under the "standard precautions" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person (IAFM 2018).

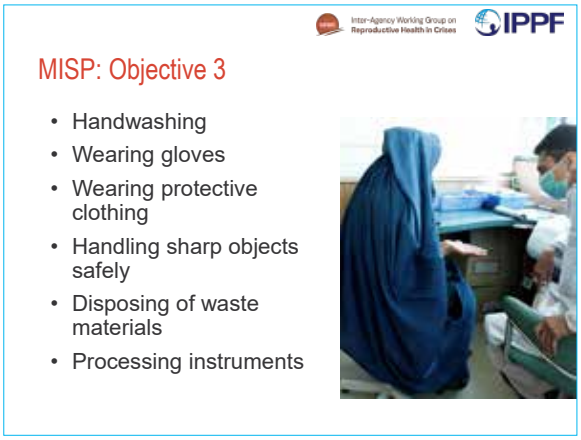


- Standard precautions prevent the spread of infections such as HIV, hepatitis B, hepatitis C, and other pathogens within health care settings.

Slide #60: MISP Objective 3: Standard precautions

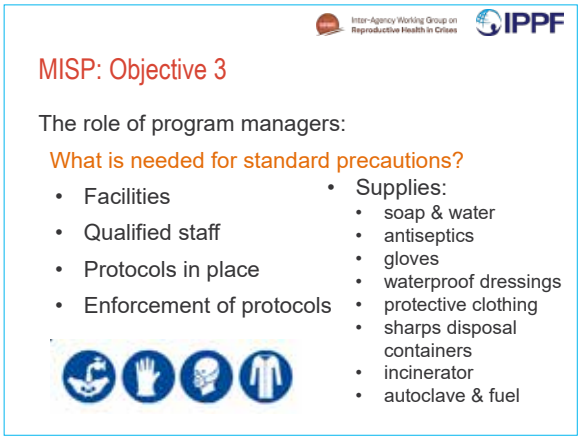
Key Messages

- Components of standard precautions include handwashing, wearing gloves and protective clothing, handling sharp objects safely, disposing of waste materials and processing instruments.



Slide #61: MISP Objective 3: Standard precautions

Key Messages



- The role of the program manager is to ensure that all standard precautions are adhered to.
- In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff (IAFM 2018).
- Protocols and enforcement of protocols through regular supervision can help to reduce the risk of occupational exposure in the workplace.
- Program managers should also ensure that facilities and qualified staff are in place.
- Supplies needed to support standard precautions include soap and water, antiseptics, gloves, waterproof dressings, protective clothing, sharps disposal containers, incinerators and autoclaves and fuel.
- There is no 'standard precaution kit'. Instead, RH kits include supplies, job aides and guidelines to ensure standard precautions as necessary. Many of these supplies can also be locally sourced.

Slide #62: Standard precautions: Group work

Standard Precautions

This activity will provide participants with the opportunity to practically apply their knowledge of the contents of standard precautions.

Time

45 minutes

Process

- The following two Group Work activities are designed to be conducted at the same time. Divide participants into two groups. One group will undertake **Group A Standard Precautions: Health Post** while the other group conducts **Group Work B Standard Precautions: Challenges & Strategies**.

- After 15-20 minutes, invite groups to conclude their first group work station and begin the alternate activity.

Group Work A Standard Precautions: Health Post

The key messages of this station are very simple and clear, but often overlooked by health workers. Having a practical station will help participants better remember and reinforce standard precautions in their project areas.

Process

- In a corner of the training room, set up a nurses' station where the items listed below are displayed (some of them inappropriately, as not to respect standard precautions). The hotel or training centre will have panels and curtains that you can use to build your station. Be creative and the participants will have fun learning!
- Instruct participants that they are conducting an inspection of the health post.
- A facilitator may take the role of a nurse or other service provider staffing the health post.
- Participants should conduct an inspection and be encouraged to give feedback directly to the 'service provider' as well as noting comments on the Participant Handout #12 (Part A).
- Also encourage participants to consult the IAFM, pages 37 and 38 for more on the breaches of standard precautions they are witnessing.

Materials for Group Work A Standard Precautions: Health Post

1 Sign 'Nurses' Station'
1 Wall protocol on safe injections
1 Mask
1 Apron
1 Pair of rubber gloves
1 Bucket
1 Mop
1 Injection table: Box of gloves; Needle in vial; Uncapped used syringe; Kidney basin
1 Water dispenser & soap
1 Nurse's table: Burn box full of syringes; Stethoscope; Blood pressure cuff; Trash can with recapped syringe inside; 5 Patient's files.

Participant Handout #12 (Part A)

If this activity is difficult to set up or the resources are not possible to obtain, provide participants with photos or pictures to analyse in a similar way.

Group Work B Standard Precautions: Challenges & Strategies

Adapted from HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers (Women's Commission & RHRC)

https://www.womensrefugeecommission.org/resources/document/603-hivaids-prevention-and-control-a-short-course-for-humanitarian-workers-facilitators-manual

Process

- Ask participants to work through the questions on their worksheet as a group.
- Encourage them to discuss, outline obstacles and strategise as a group to overcome these obstacles.

Materials for Group Work B Standard Precautions: Challenges & Strategies

Participant Handout #12 (Part B).

Slide #63: MISP Objective 3

Key Messages

- Condoms are key protection methods to prevent transmission of HIV, other STIs, and unplanned pregnancy.
- Program managers should ensure lubricated male condoms and, where applicable (already used by the population), female condoms, are available and promoted from the earliest days of a humanitarian response (IAFM 2018).


IPPF/Tom Pilston

Slide #64: MISP Objective 3

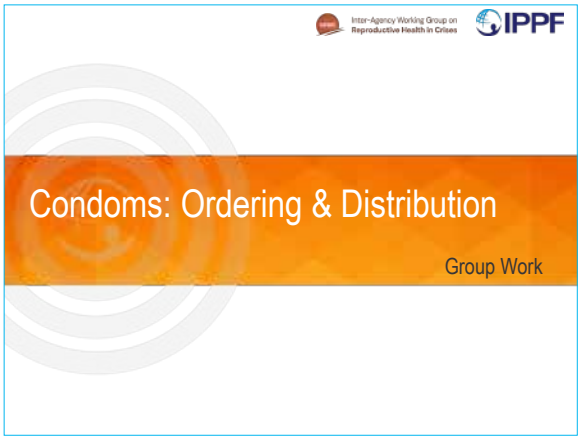
Key Messages

- Order sufficient supplies of good quality male condoms (and female condoms where appropriate) immediately.
- Condom supply in a humanitarian emergency should focus on the type of condoms used in the local context (IAFM 2018).
- RH Kit 1A (at the community/ health post) contains male condoms. Complementary RH Kit 1B contains female condoms.
- It is useful to discuss condom distribution with leaders and members of affected communities, so they understand the need and importance of condom use, to ensure that distribution takes place in a culturally appropriate manner, and to increase community acceptance of condoms (IAFM 2018).
- Ensure condoms are available on request at health facilities.
- Condoms should also be available in accessible private areas in the community. These include latrines, bars, coffee shops, non-food distribution points, and youth and community centres (IAFM 2018).
- Consult with local staff about how condoms can be made available in a culturally sensitive way, particularly for adolescents and other key populations (sex workers and their clients, men who have sex with men, persons using injectable drugs, and transgender persons).
- Ensure culturally appropriate messages are available to disseminate information on correct use and disposal of condoms.
- Condom uptake should be monitored by ensuring that regular checks are undertaken of distribution points.

Slide #65: Condoms: Ordering and distribution: Group work

Condoms: Ordering and distribution

This activity will provide participants with practical experience in ordering and planning for condom distribution.



Time

20 minutes

Process

- Provide participants with copies of Participant Handout #13 and ask them to work through the discussion questions and calculations.
- At the close of 15 minutes, ask participants to report back on their discussion in relation to the case study and calculations using the **key messages** below.

Materials

Participant Handout #13

Solutions

- Do not order female condoms for emergencies if the population has not been exposed to them.
- Condoms can be made available in many ways, but you must be creative and take cultural sensitivities into consideration.
- Program managers and health clinic staff should discuss with young men and women (separately) and ask them where the best place to pick up condoms would be if people need them. Male condoms (and if available, female condoms) should be available to adolescents free-of-charge at distribution points located in places that are discreet and convenient to access. Program managers and clinic staff should engage selected adolescents in the community to help identify adolescent-friendly distribution points and inform others that condoms are available. In addition, condoms should be offered to any person (regardless of sex, age or marital status) who requests them or who presents to the health facility with symptoms of STIs.
- Some examples are: making condoms available at registration sites; providing them in the non-food item distribution; putting them out during the food distribution, put supplies in the latrines, in schools, in clinics, through community leaders, community health workers or TBAs.

- Program managers must ensure that distribution sites are selected so that condoms can be displayed in such a way that they do not spoil, preferably in a cool shady spot and away from dirt and pests. Instruct "distributors" who are responsible for re-supply to check the quality from time to time by taking a condom out of its package and visually inspecting it.

- It is important to keep track of how many condoms are distributed. Check weekly how many condoms are taken from the distribution places.

- Monitoring distribution is different from monitoring usage rates: for this you need to do a behaviour survey.

Answer

30,000 x 20% = 6,000 sexually active men

6,000 x 20% = 1,200 men use condoms

1,200 x 12 condoms = 14,400 condoms needed per month

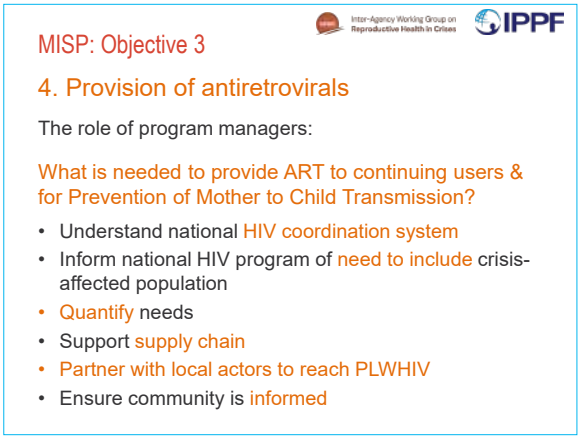
14,400 x 3 months = 43,200 condoms

43,200 x 20% wastage = 8,640 extra condoms.

43,200 + 8,640 = 51,840 condoms need to be ordered in total

Slide #66: MISP Objective 3: Antiretroviral treatment

Key Messages



- Antiretroviral drugs prevent the transmission of HIV and excess mortality and morbidity from opportunistic infections and AIDS-defining illnesses.

- Antiretrovirals should be continued for people who were enrolled in an ART program prior to the emergency, including women who were enrolled in PMTCT of HIV and Syphilis programs

- Program managers should understand the HIV coordination system in the country. This is an activity which can be undertaken in the preparedness phase. HIV coordination mechanisms are usually led by the national HIV program, UNAIDS, the UN HIV coordination team and civil society organisations. In high prevalence countries and in countries with an important proportion of people living with HIV (PLWHIV) taking ARV, the "Inter-Agency Task Team to Address HIV in Emergencies" convened by UNHCR and the World Food Program should also provide support to the health coordination mechanism and/or the HIV country team (IAFM 2018).

- A further role for program managers is to ensure that the effected population is included in the national HIV program, including the national ART program. This will involve close coordination and collaboration with national level partners.

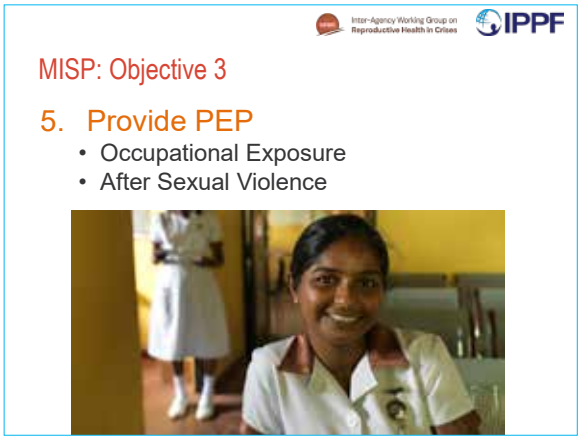
- Rough total population estimates and pre-crisis statistics of prevalence and treatment rates can help to quantify needs. This data can be collected and maintained in the preparedness phase.

- The SRH coordinator and program managers should advocate within the health cluster/ sector to ensure a sufficient supply of ARVs for continuing users in the crisis-affected population.

- An important component of ensuring that ART is available for continuing users during the acute phase of an emergency is partnering with local actors to ensure PLHIV are reached and ARV supplies are safely and confidentially reestablished. The identification of NGOs, CBOs and CSOs active in care and advocacy for PLHIV should be included in preparedness planning. This will further help in informing the community of available services.

Slide #67: MISP Objective 3: Post Exposure Prophylaxis (PEP)

Key Messages



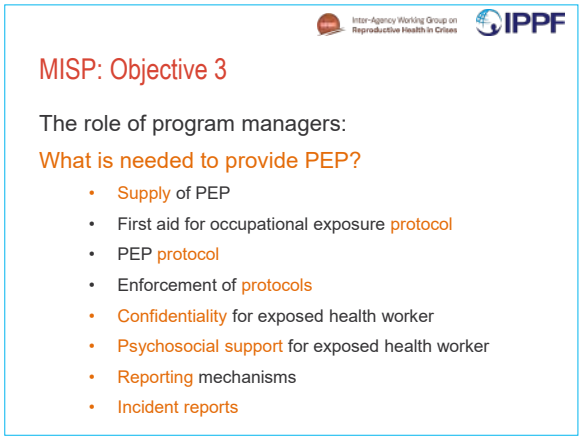
- Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. Ensure PEP is available within the health sector as part of a comprehensive standard precautions package to reduce staff exposure to infectious hazards at work. Post first aid measures in relevant workspaces and inform all staff how to access treatment for exposure (IAFM 2018).

- Provision of PEP to survivors of sexual violence is part of providing compassionate and confidential treatment and counseling.

Slide #68: MISP Objective 3: Manual Post Exposure Prophylaxis (PEP)

Key Messages

- Program managers should advocate to ensure a sufficient supply of drugs to support PEP.
- It is also important that standard protocols for occupational exposure and the provision of PEP are in place, known by staff and enforced by managers.
- These protocols should include confidentiality for the exposed health care workers and the person who is the source of the exposure; clinical response; psychosocial support; reporting mechanisms and incident reporting.



Note to facilitators More information on the specifics of protocols for providing PEP can be found in the IAFM 2018 page 38.

Slide #69: MISP Objective 3: Co-trimoxale

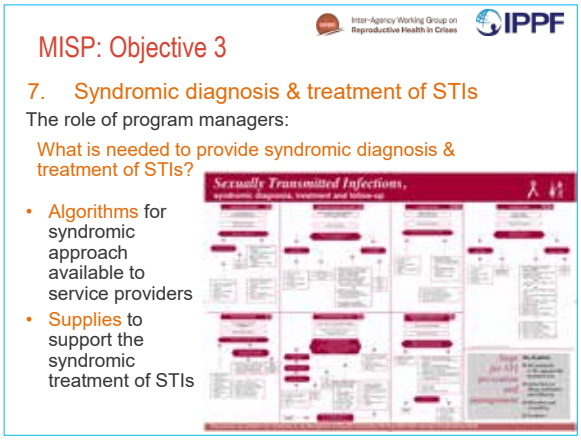
Key Messages

- Co-trimoxazole prophylaxis is a life-saving, simple, well tolerated, and cost-effective intervention for people living with HIV.
- It should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy care.

Slide #70: MISP Objective 3: Sexually Transmitted Infections (STIs)

Key Messages

- The transmission of HIV and STIs are closely linked.
- The syndromic management of STIs is an approach which is currently implemented in many countries and therefore might exist before the crisis. It is a method built from algorithms (decision trees, such as those included on the slide) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols.

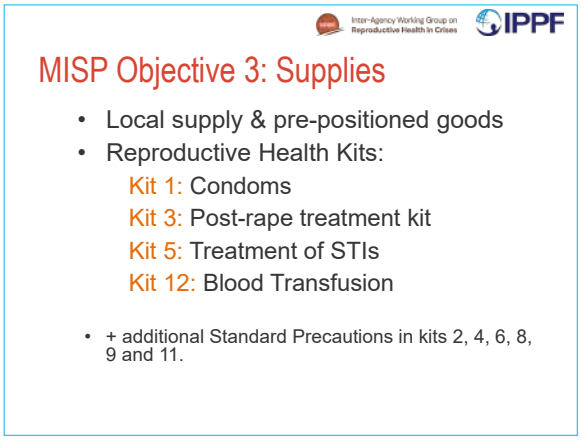


- Antibiotics recommended by WHO for syndromic treatment of STIs are available in the Inter-Agency Reproductive Health Kits.

Slide #71: MISP Objective 3: Supplies

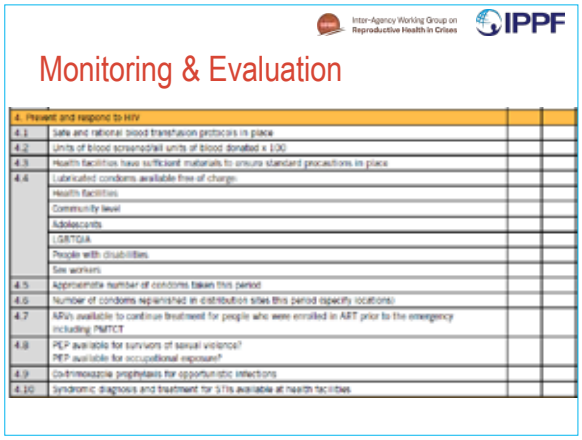
Key Messages

- Supplies to support the third objective of the MISP for SRH may be procured and stored in the preparedness phase. Local supply mechanisms may also be engaged where possible.
- If necessary, commodities to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs can be found in RH Kits 1, 3, 5 and 12, with additional Standard Precautions in kits 2, 4, 6, 8, 9 and 11.



Slide #72: Monitoring & evaluation

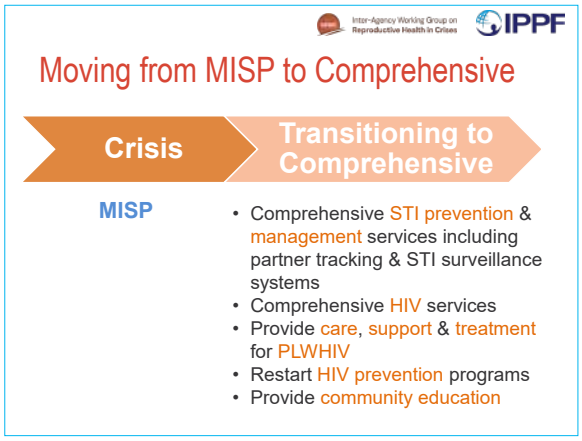
Key Messages



- The MISP checklist provides a useful tool for monitoring and evaluating the HIV and other STIs objective of the MISP.
- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. Partnerships with organisations working with PLHIV and mechanisms that coordinate national HIV programs should also be established in the preparedness phase. These relationships will also support the collection of data to inform MISP implementation and the development of protocols.
- The presence of staff with the capacity to provide HIV and other STI services should also be considered, and mapping and rostering conducted prior to the onset of an emergency.

Slide #73: Moving from MISP to comprehensive

Key Messages



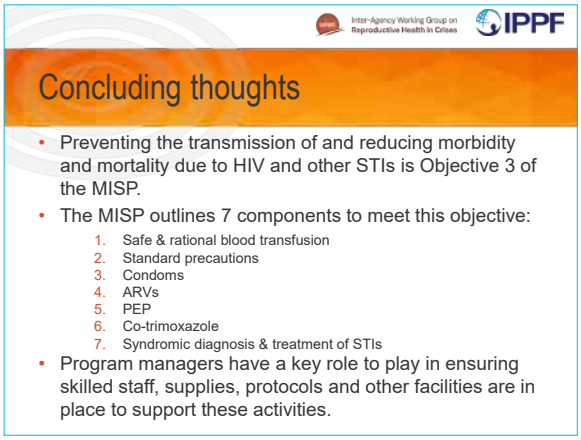
- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.
- It is critical to provide comprehensive services as soon as possible.
- Comprehensive HIV and STI care includes: HIV voluntary counseling and testing, partner tracking and STI surveillance systems; providing care, support and treatment for PLHIV; and expanding community education programs.

Note to facilitators If participants are interested in learning more about comprehensive HIV and other STI programming, refer them to the IAFM 2018 Chapter 11: HIV.

Slide #74: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



Day 2 Close

Day 3

MISP Objective 4: Prevent Excess Maternal & Newborn Morbidity & Mortality

Session 3.1 2 hours

Overview

This session will develop program managers' knowledge and skills in preventing excess maternal and newborn morbidity and mortality in emergencies, with a focus on how the MISP for SRH addresses these serious SRH concerns.

Methodology

- Interactive presentation
- Group work
- Discussion

Materials

- PowerPoint presentation
- Participant handout #14
- Group work supplies

Slide #1: Day 3: The Minimum Initial Service Package (MISP)

Welcome your participants to their third day of training for program managers on sexual and reproductive health in emergencies. Ask if there are any outstanding questions and take care of any housekeeping matters before moving on.

Slide #2: Day 2 Review

Spend a few minutes revisiting the sessions from the day before.

Note to facilitators This review may be done in a standard question and answer format, or you may wish to do this in a more interactive way to energize your participants and get them ready to engage in the sessions to follow.

Slide #3: MISP objectives

Remind participants that we are now focusing on the objectives of the MISP.

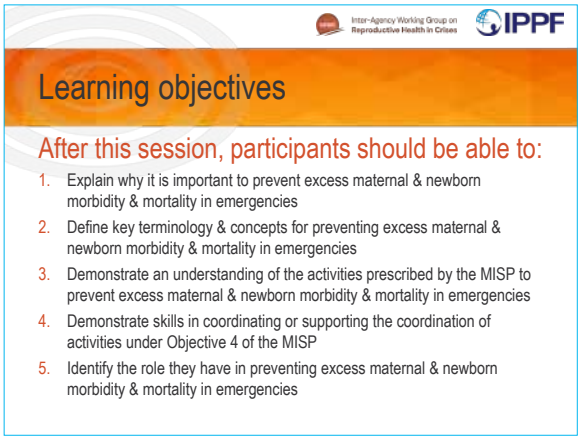
Slide #4: Session 3.1: MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

Highlight that you will now move on to the fourth objective- preventing excess maternal and newborn morbidity and mortality.

Slide #5: Learning objectives

Key Messages

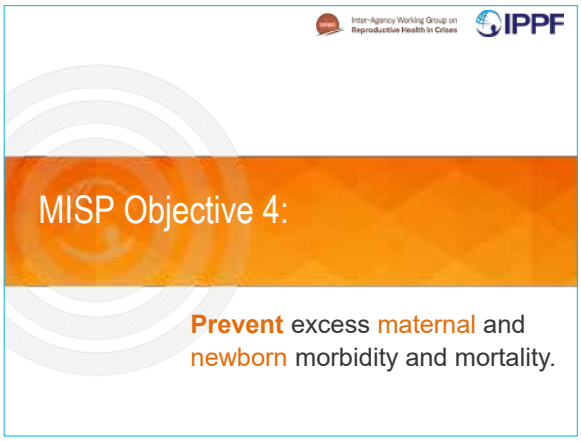
- There are five learning objectives for session 3.1



1. Explain why it is important to prevent excess maternal & newborn morbidity & mortality in emergencies
2. Define key terminology & concepts for preventing excess maternal & newborn morbidity & mortality in emergencies
3. Demonstrate an understanding of the activities prescribed by the MISP to prevent excess maternal & newborn morbidity & mortality in emergencies
4. Demonstrate skills in coordinating or supporting the coordination of activities under Objective 4 of the MISP
5. Identify the role they have in preventing excess maternal & newborn morbidity & mortality in emergencies

Slide #6: MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

Highlight that you are now going to look at MISP Objective 4: prevent excess maternal and newborn morbidity and mortality.



Note to facilitators This may be a good opportunity to ask participants to share any experience they have had in addressing maternal and newborn health in their settings. You could also ask participants what they think may be involved in a minimum response during the acute phase of an emergency compared to standard settings.

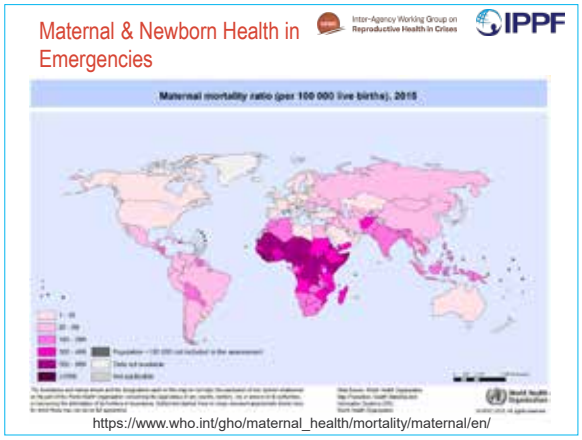
Slide #7: Maternal & newborn health in emergencies

Key Messages

- "Every woman has the right to decide whether or when she will become pregnant, and the right to give birth safely and live free from violence. Yet every day, millions of women and girls whose lives have been upended by wars, conflicts or natural disasters are denied these rights. When we speak of leaving no one behind and reaching the furthest behind first, there can be no more compelling example of exactly whom we are speaking about. More than 500 women and girls die in emergency situations every day from complications due to pregnancy and childbirth. Sexual and gender-based violence also increase in such settings, with devastating – and often deadly – consequences. The unprecedented frequency, intensity and scope of humanitarian emergencies in the past year has dramatically amplified these risks for millions of women and girls" (Dr Natalia Kanem UNFPA Executive Director 2018 https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2018_Jan_31_ONLINE.pdf).

Slide #8: Maternal & newborn health in emergencies

Key Messages

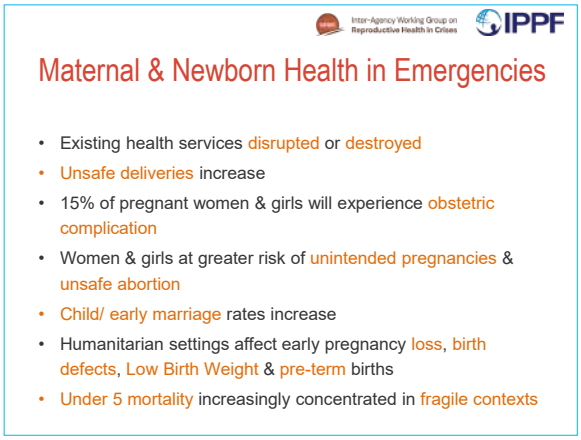


- This map shows rates of maternal mortality by country. Darker colours represent higher rates of maternal mortality.
- In the year represented by this map, 2015, about 830 women died EVERY DAY due to complications of pregnancy and child birth. Almost all of these deaths occurred in low-resource settings and fragile states affected by conflict or disaster, and most could have been prevented (https://www.who.int/gho/maternal_health/mortality/maternal/en/)

Slide #9: Maternal & newborn health in emergencies

Key Messages

- Humanitarian emergencies disrupt and sometimes destroy health services, increasing vulnerability for pregnant women, newborns and children.
- Unsafe deliveries often increase in these settings as skilled maternal and newborn care providers become unavailable.
- Emergencies also expose women and girls to greater risk of unintended pregnancies and unsafe abortion practices.

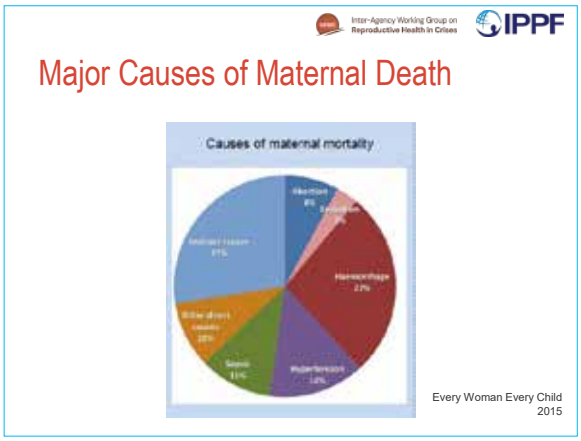


- Growing evidence shows that child, early and forced marriage rates increase in crisis settings, including after natural disasters or during conflict (https://www.girlsnotbrides.org/resource-centre/child-marriage-in-humanitarian-crises/). Child marriage is often accompanied by early and frequent pregnancy which results in higher maternal morbidity and mortality rates (https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/ChildMarriage.aspx).
- Humanitarian emergencies affect early pregnancy loss, birth defects, low birth weight and pre-term birth (https://reliefweb.int/report/world/maternal-newborn-and-child-health-emergency-settings).
- Under five mortality is becoming geographically concentrated in fragile contexts and demographically concentrated in the newborn period (https://reliefweb.int/report/world/maternal-newborn-and-child-health-emergency-settings).

Slide #10: Major causes of maternal death

Key Messages

- Most maternal and newborn deaths occur around the time of labour, delivery, and in the immediate post-partum phase. This is why the MISP focuses on care at time of delivery and immediately post-partum and does not include ante-natal care or pre-natal care.
- The leading causes of maternal death are haemorrhage, hypertension, sepsis and complications of unsafe abortion.

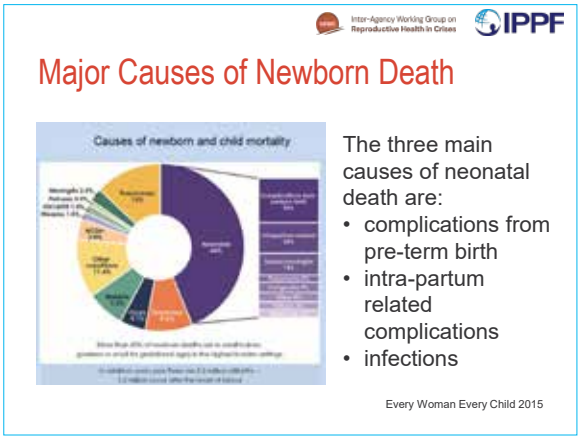


- Many of these causes are preventable or could be managed by skilled providers with adequate resources at the facility level.

Slide #11: Major causes of newborn death

Key Messages

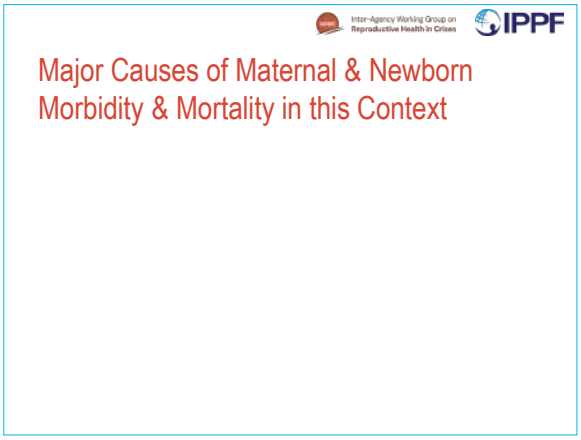
- The three main causes of neonatal death are complications from pre-term birth, intra-partum related complications and infections.
- Many of these causes are preventable or could be managed by skilled providers with adequate resources at the facility level.



Slide #12: Major causes of maternal & newborn morbidity & mortality in this context

Key Messages

- This slide has been left blank to allow you to provide national/ context specific information on causes of maternal and newborn mortality for your setting. Consider adding separate slides for maternal mortality and newborn mortality as needed. You could also combine the slides and provide a column with global maternal mortality statistics next to a column with national maternal mortality statistics on one slide, and then do the same for newborn mortality on the next slide.



Slide #13: The 3 delays

Key Messages

- While we can not always predict complications, we can address the three delays which contribute significantly to maternal morbidity and mortality.

- The 3 delays are:

1. Decision to seek care: the first delay involves a delay in recognizing that there is a problem and deciding to seek medical care. Some reasons for this delay can include the low status of women and that they are not in a position to make decisions; poor understanding of pregnancy complications and risk factors and when it is important to seek help; financial constraints, previous poor experience with health services; and acceptance of maternal deaths.

2. Time to reach the health facility: the second delay in reaching the health facility once the decision has been made to seek care. This delay is primarily caused by physical and financial barriers to accessing health services. These include the distance to health service points; transport availability and cost; problems with geography, roads and infrastructure; and the need to wait for someone to accompany the woman to the facility.

3. Time to receive appropriate care at the facility: The third delay refers to the time it takes to initiate treatment once the patient reaches the health facility. This delay may occur due to a lack of equipment, staff, supplies and drugs; discriminatory attitudes of staff (remind participants of the importance of inclusion and providing services for all); and weak referral systems.

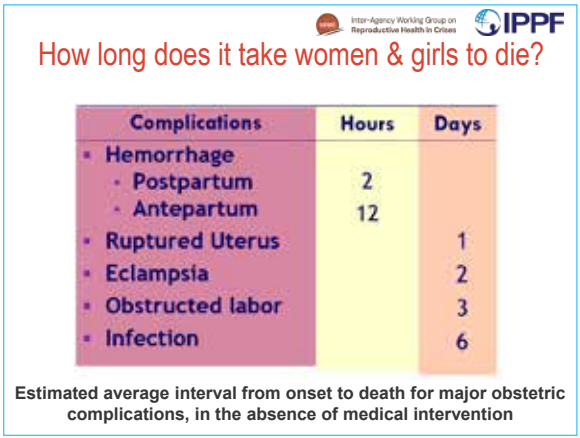
Note to facilitators Ask participants to provide examples of the 3 delays from their own setting. As a group, discuss what might contribute to more delays in crisis settings.

Briefly discuss some ways that these delays may be addressed.

Slide #14: How long does it take women & girls to die?

Key Messages

- It is so important to address the 3 delays- especially in emergency settings- as it takes such a short time for women and girls to die.



Estimated average interval from onset to death for major obstetric complications, in the absence of medical intervention

Note to facilitators Ask participants to now consider what may be done to address the 3 delays in emergency situations.

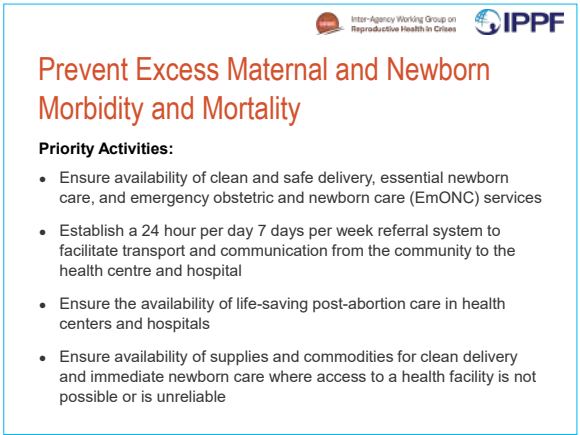
Strategies might include:
Delay 1: informing traditional birth attendants, women, girls and men about danger signs that need emergency treatment.
Delay 2: MISP-referral system, communication system, transportation, clean delivery kits for when the second delay cannot be overcome.
Delay 3: ensuring facilities have the right staff and equipment.

Slide #15: MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

Key Messages

- Remind participants that the fourth objective of the MISP for SRH is to prevent excess maternal and newborn morbidity and mortality.

- This slide contains the priority activities necessary to meet Objective 4 of the MISP. Ask participants to read aloud from slide and explain we will go through the activities in the following slides



  - Ensure availability of clean and safe delivery, essential newborn care, and emergency obstetric and newborn care (EmONC) services including:

- At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage;
- At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC);
- At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

- Establish a 24 hour per day seven days per week referral system to facilitate transport and communication from the community to the health centre and hospital
- Ensure the availability of life-saving post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or is unreliable

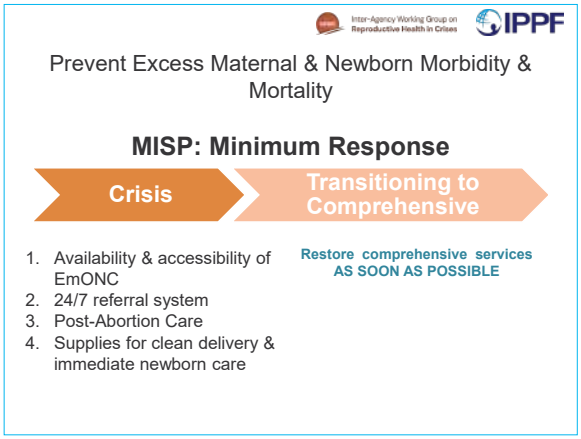
- This slide contains the priority activities necessary to meet Objective 3 of the MISP. Ask participants to read aloud from slide and explain we will go through the activities in the following slides
- The activities prescribed by Objective 4 of the MISP for SRH explain the need to establish referral systems, from community to health facilities, to ensure women and newborns can receive the care they need at time of delivery; and provide basic supplies where this is no possible,

Note to facilitators Ask participants to look at their MISP for SRH Cheat Sheet and locate the fourth MISP Objective and its priority activities and the associated kits.

Slide #16: Prevent excess maternal & newborn morbidity & mortality

Key Messages

- Due to the ongoing and often increased threats to maternal and newborn health in emergency situations, the fourth life-saving objective of the MISP is for maternal and newborn health.



- The evidence-informed activities that support this objective include the availability and accessibility of Emergency Obstetric and Newborn Care (EmONC), a referral system that is available 24 hours a day, seven days a week, post-abortion care services, and supplies for clean delivery and immediate newborn care.

- These activities form an absolute minimum of response during a crisis. They should be expanded and comprehensive maternal and newborn health services made available as soon as possible.

Slide #17: MISP Objective 4: BEmONC

Key Messages

- The first activity of Objective 4 of the MISP is to ensure the availability and accessibility of clean and safe delivery, essential newborn care and emergency obstetric and newborn care services.

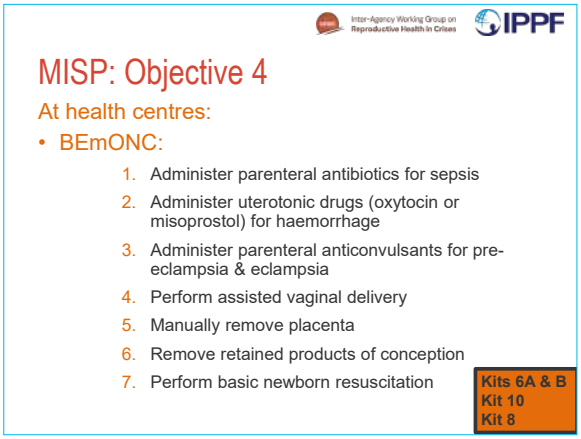
- This activity has a number of parts and these are divided along the level of service delivery. We will look at the services required to meet this activity first at referral hospitals, next at the health facility level and then at the community level.

Slide #18: MISP Objective 4: BEmONC

Key Messages

- The second level of activities for ensuring the availability and accessibility of EmONC is that of the health centre.

- Basic Emergency Obstetric and Newborn Care (BEmONC) services should be available at the health centre level. These services include all of those outlined on the slide.



- To address the third delay (the delay in receiving appropriate treatment), it is useful for clinical service providers (nurses, midwives, doctors) to follow priority interventions called 'signal functions' (the first seven signal functions are required for BEmONC and are on this slide). These procedures undertaken by clinical staff at the health centre are to address clinical issues or to stabilize the patient before referral to the hospital level.

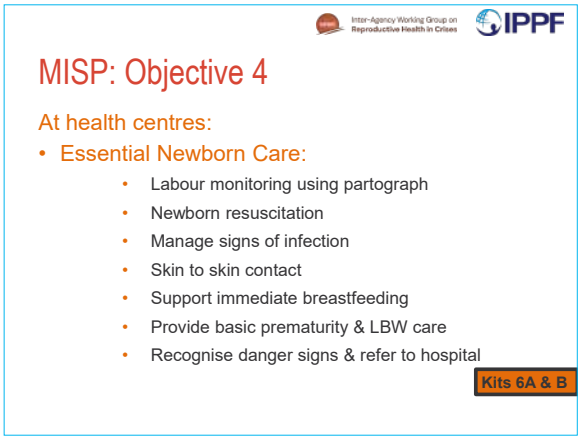
Note to facilitators Allow participants to read through the list of clinical service which must be available at the health centre level from the start of an emergency. Highlight to participants that it is their role, as program managers to ensure that these services are available as they are lifesaving, not to develop a clinical understanding of each component. If participants are interested in learning more about these, refer them to the following resources:

- https://resourcecentre.savethechildren.net/sites/default/files/documents/newbornhealthbook-production2017-v4b-press.pdf
- IAFM 2018 Chapter 9.
- Ask participants to consult their MISP for SRH Cheat Sheet and review the kits associated with this activity of Objective 4.

Slide #19: MISP Objective 4: BEmONC

Key Messages

- This slide contains the elements of essential newborn care which should also be available at all health centres.



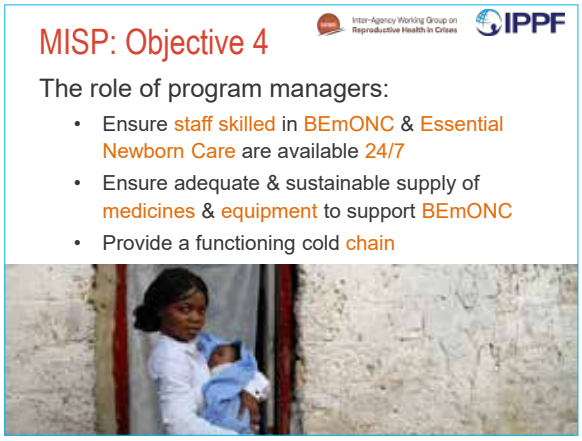
Note to facilitators Again, allow participants to read through the list of clinical service which must be available at the health centre level from the start of an emergency. Once again, highlight to participants that it is their role, as program managers to ensure that these services are available, not to develop a clinical understanding of each component.

For more on each of these components of essential newborn care and why they are an essential component of services at all health centres, consult and refer participants to the IAFM 2018 page 45.

Ask participants to consult their MISP for SRH Cheat Sheet and review the kits associated with this activity of Objective 4.

Slide #20: MISP Objective 4: BEmONC

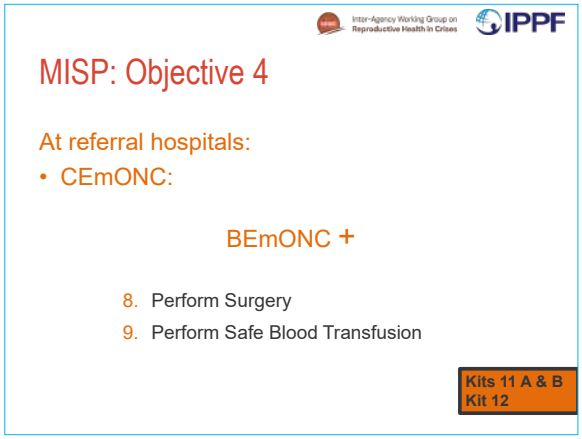
Key Messages



- Program managers and coordinators have a crucial role to play in ensuring these basic emergency maternal and newborn care services are available at the health centre level.
- Staff skilled in BEmONC and Essential Newborn Care must be available at health centres 24 hours a day, seven days a week. These staff must also be competent in the provision of confidential, non-judgmental services to adolescents, people with disabilities and LGBTQIA populations.
- It is also the role of program managers and coordinators to ensure adequate supplies to support BEmONC and a functional cold chain.
- Supplies for BEmONC at the health centre level are available in Inter-agency Reproductive Health Kit 6 (A & B). It is also possible for program managers to procure these goods through local or regional supply chains and pre-position them as necessary.

Slide #21: MISP Objective 4

Key Messages



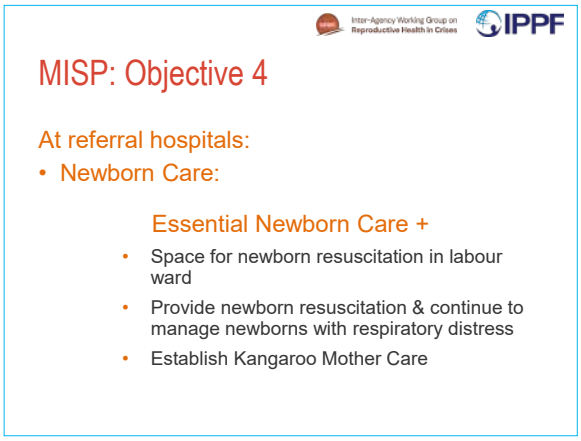
- The third level of service provision to prevent excess maternal and newborn morbidity and mortality in humanitarian emergencies is the referral hospital.
- Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services must be available from the onset of a crisis, not only when a situation stabilizes.
- CEmONC includes all of the seven signal functions provided by Basic Emergency Obstetric and Newborn Care (BEmONC) and adds the capacity to perform surgery such as caesarean section and the ability to perform safe blood transfusion observing universal infection prevention precautions.

- Where feasible, host-country hospital should be supported. "If this is not feasible because of the host-country hospital's location or inability to meet the increased demand, the SRH Coordinator should work with the health sector/ cluster and an agency such as the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross and Red Crescent Societies (IFRC), or Medicins Sans Frontieres (MSF) and other NGOs to provide CEmONC, such as establishing a temporary field or referral hospital close to the affected population" (IAFM 2018 p44).

Slide #22: MISP Objective 4: CEmONC

Key Messages

- At the referral level hospital, more comprehensive newborn care services should be available.
- All of the essential newborn care interventions discussed for the health centre level must be available and the following services added: space for newborn resuscitation in the labour ward; management of newborns with respiratory distress and kangaroo mother care.



- Complementary Kit from UNICEF for newborn care at hospital level contains supplies to support this work.

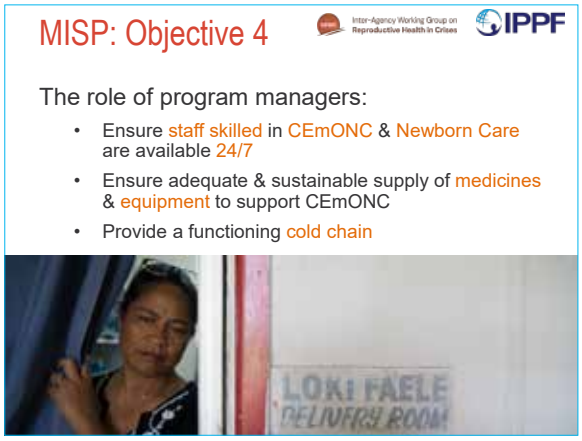
Note to facilitators As with the health centre level, allow participants to read through the list of clinical services for CEmONC but remind them that they do not need to develop a clinical understanding of these. They do, however, need to be aware of what is required and their role as program manager in seeing that these services are accessible.

For more on each of these components of essential newborn care and why they are an important component of services at the referral level hospital, consult and refer participants to the IAFM 2018 pages 45 and 46.

Ask participants to consult their MISP for SRH Cheat Sheet and review the kits associated with this activity of Objective 4.

Slide #23: MISP Objective 4: Program manager's role

Key Messages



- Once again, it is vital that program managers and coordinators work to support the provision of Comprehensive Emergency Maternal and Newborn Care at the referral hospital level.

- This can be done by ensuring staff skilled in CEmONC and Newborn Care are available 24 hours a day. seven days a week. There is no time to train new staff in the acute phase of an emergency. Surge capacity of skilled staff from other parts of the country or other international health agencies need to be considered if local staff are not available. Mapping of capacities and establishing a roster of skilled staff can be done by program managers in the preparedness phase.

- Supplies for CEmONC at the referral hospital level are available in Inter-agency Reproductive Health Kit 11 (A & B). It is also possible for program managers to procure these goods through local or regional supply chains and pre-position them as necessary.

Slide #24: MISP Objective 4: BEmONC & CEmONC Facilities & Roles

This activity is designed to engage participants in thinking about the contextual realities of providing BEmONC and CEmONC and referral services in emergencies in their setting.

Time

10 minutes

Process

- Ask participants to work in their table groups to consider who might provide BEmONC and CEmONC services in their setting during an emergency.

- Encourage groups to discuss who would need to be involved in referral from community to health centre, and between health centre and referral hospital level. Ask any participants with experience in facilitating referral in emergency settings in their context to share their challenges and successes in doing so.

- Remind participants that the facilities and referral mechanisms they have discussed can be planned for and engaged in preparedness and planning work.

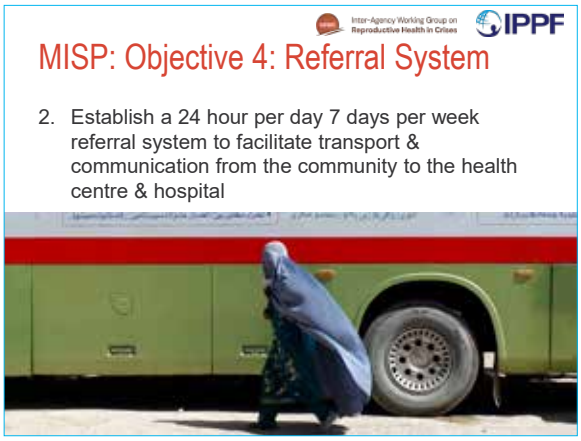
Materials

This slide has been left blank so that you might summarise participants' discussions and share experiences from different table groups with the whole room.

Slide #25: MISP Objective 4: Referral system

Key Messages

- The second key activity under MISP Objective 4 is to establish a referral system for the management of maternal and newborn complications.
- The referral system includes means of communication and transport. Both of these components must be available at all times and the referral system is to be established as soon as possible after the onset of the crisis.



Slide #26: MISP Objective 4: Referral system

Key Messages

- The referral system must be available 24 hours a day, seven days a week and ensure that women, girls and newborns who need emergency care are referred from the community to a health centre where they can access BEmONC.
- Patients with obstetric complications and newborn emergencies that cannot be managed at the health centre must be stabilized and transported to a hospital with CEmONC services.

- Transport and communication must be available to facilitate the referral of patients.

Note to facilitators

Transport (from IAFM 2018 pages 178-179)
For every logistician working in emergency response and every MNH program manager, there are few things worse than needing transportation for a person in need of urgent health care but being unable to find it. Be it due to a lack of planning, a lack of resources, or the context, transportation seems to always top the list of programming needs just after staffing. However, there is one area that is often overlooked until there are tragic consequences: transportation for referral systems. These referral systems do not need to rely on the purchase of a brand new hard top vehicle, but should be as locally contextualized and reliable as possible. In some areas due to security, rented vehicles may be the most appropriate approach, while in others a system of donkey carts or even stretchers to hand carry women to the main road may be suitable.

What matters is that that SRH Coordinators and health program managers begin planning at the beginning of any MNH programmatic response whichever transportation referral system works the quickest and ensures access to emergency care within the resources of the program.

Several forms of transportation may need to be connected in order to get a woman to the hospital. For example, the woman may be carried by stretcher to the main road where the ambulance meets her and takes her the remaining distance to the hospital.

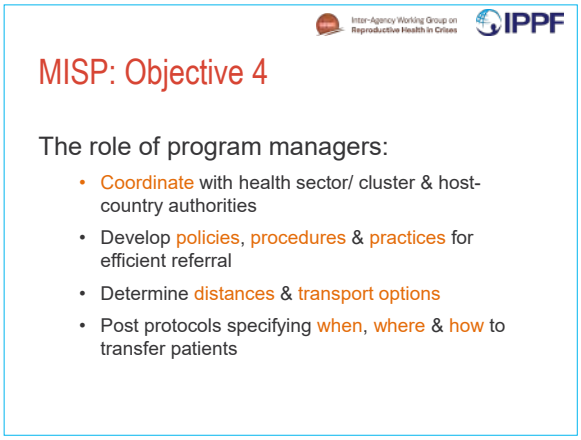
Communication

"Quality referral systems and counter referral systems require clinical, communication, and transport protocols, as well as trust and understanding between the community, service providers, health center, and the hospital. As a rule, health staff must understand that the further away the referral facility is, the earlier they must make a decision to refer women with obstetric complications" (IAFM 2018 page 169).

Importantly, communication for referral may also involve calling or contacting skilled care for advice when referral systems are not available or not functioning.

Slide #27: MISP Objective 4

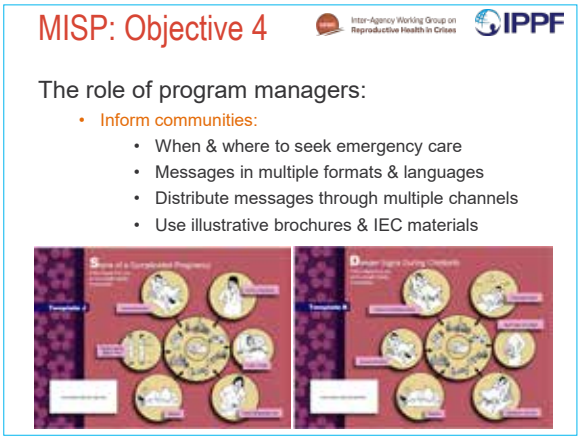
Key Messages



- Program managers can support the referral system by:
  - Coordinating with the health sector or cluster and host-country authorities to ensure the referral system is place and functioning (both transport and communication).
  - Developing policies, protocols and practices to be followed by clinic staff in health centres and referral hospitals.
  - Determining distances from the affected community to functioning health centres and hospitals.
  - Determining transport options for referral.
  - Establishing communication channel from community to health facility/ hospital.
  - Posting protocols in every health centre and hospital which include when, where and how to refer patients with obstetric and newborn emergencies.

Slide #28: MISP Objective 4: Role of Program Manager

Key Messages



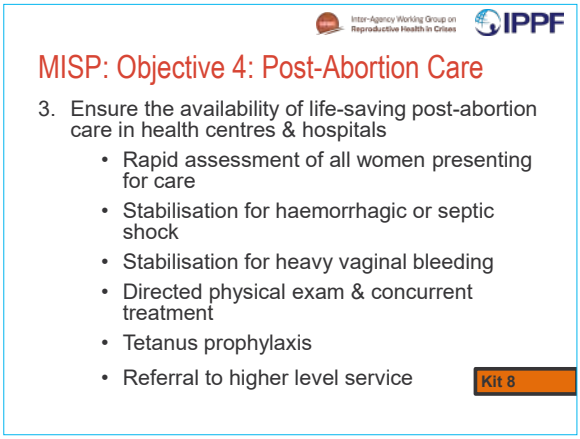
- Program managers should also work with local organizations to "inform communities when and where to seek emergency care for complications of pregnancy and childbirth. Messages should be shared in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictorial formats) and in discussion groups through community-led outreach (with women's, LGBTQIA, and PWD groups) and other setting-appropriate channels (e.g., midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines)" (IAFM 2018 p47).

- "Meet with and inform community leaders, traditional birth attendants, and others to distribute illustrative brochures or undertake other creative information, education, and communication (IEC) approaches" (IAFM 2018 p47).

Note to facilitators The IEC materials on this slide are available from www.iawg.net and can be adapted to different contexts.

Slide #29: MISP Objective 4: Post-abortion care

Key Messages



- Post-abortion care is part of BEmONC and is always legally available.

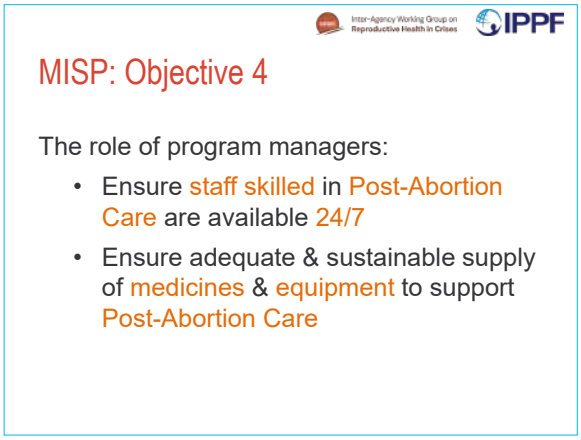
- "Deaths and injuries from unsafe abortion continue to be a serious public health problem that affects women, girls, families and entire communities…Women and girls in humanitarian settings may be at increased risk of unintended pregnancy and unsafe abortion" (IAFM 2018 p48).

- Post-abortion care is treatment given to a woman who has complications due to an incomplete abortion or miscarriage. These complications are usually bleeding or infection. Medical care can include medication or surgery given to the woman to evacuate the uterus and to save her life.

- Clinical service providers in health centres and hospitals should perform the series of interventions displayed on this slide.
- Highlight to program managers that this list is the minimum requirement for post-abortion care in emergencies.

Slide #30: MISP: Post-abortion care

Key Messages



- As with each aspect of preventing excess maternal and newborn death in humanitarian settings, program managers have a key role to play in ensuring life-saving post-abortion care services are in place.
- This can be done by ensuring staff skilled in post-abortion care are available 24 hours a day, seven days a week. Mapping of capacities and establishing a roster of skilled staff can be done by program managers in the preparedness phase.
- Supplies for post-abortion care are available in the BeMONC kits discussed above. It is also possible for program managers to procure these goods through local or regional supply chains and pre-position them as necessary.

Slide #31: Providing post-abortion care

Providing Post Abortion Care

During this activity, participants will have the opportunity to clarify the difference between abortion and post-abortion care and understand the importance of post-abortion care in humanitarian settings.

Time

20 minutes

Process

Ask participants to work through the discussion questions on the Participants' Handout.

At the close of 15 minutes, take five minutes to ask participants to report back on their discussion. Give constructive feedback using the solutions below.

Materials

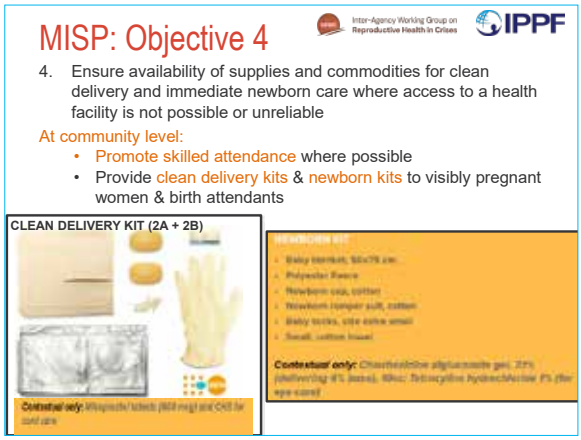
Participant Handout #14

Solutions

- Post-abortion care (PAC) is the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. The elements of PAC include:
  - Emergency treatment of incomplete and unsafe abortion and potentially life-threatening complications (sepsis, excessive bleeding, tetanus).
  - Post-abortion family planning counselling and services to help women prevent unwanted pregnancy or practice birth spacing.
  - Linkages between post-abortion services and other SRH services (for example, if rape is found to be the reason for unsafe abortion, provide/refer to post-rape management services).
- Post-abortion care involves all levels of service, including education in the community about prevention of unsafe abortion and availability of services.
- Death and suffering from the complications of unsafe and spontaneous abortion are avoidable. Governments, UN agencies, and humanitarian organizations have an obligation to ensure that health services are able to respond to complications from unsafe and spontaneous abortion.

Slide #32: MISP Objective 4: Clean delivery kit

Key Messages



- The fourth activity of MISP Objective 4 is to ensure the availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable.
- In all humanitarian settings, there are women and girls in the later stages of pregnancy who will give birth during the emergency. At the onset of a humanitarian emergency and in settings with high levels of home deliveries before the emergency, births may take place outside of health facilities without the assistance of skilled birth attendants.

- **The ideal situation would be for 100% of pregnant women and girls to deliver with skilled attendance, but this may not be possible, particularly in an emergency.**
- Clean, safe delivery and newborn care kits should be made available to all visibly pregnant women to improve birth practices when access to a health facility is not possible. In themselves, they do not make deliveries safer, but do provide a cleaner environment.
- Instructional materials explaining what is in the kit, and how to use these items should be provided and explained at time of distribution
- Clean delivery kits for birth attendants may also be distributed and these include all of the items listed above, together in a shoulder bag with the additions of a flashlight, gloves, apron and wet weather protection.
- "In settings with national protocols for advanced distribution of misoprostol tablets for PPH prevention, this essential life-saving commodity should be included in all kits. Decades of research have proven the safety and efficacy of using misoprostol as a prophylactic uterotonic to reduce post-partum hemorrhage when taken immediately after birth of a newborn. The World Health Organization recommends the administration of misoprostol by community health workers and lay health workers where skilled birth attendants are not present and oxytocin is not available. Recent evidence from both stable and crisis-affected settings suggests that self-administration of misoprostol can be done safely and effectively. In particular, misoprostol has the potential to reach women who give birth, by choice or by necessity, at home or in health facilities that lack electricity, refrigeration, and/or skilled health providers" (IAFM 2018 p170).
- Newborn kits for immediate newborn care should also be distributed to visibly pregnant women. These often include a blanket, fleece, cap, clothing and socks for thermal protection and can be procured from UNICEF.

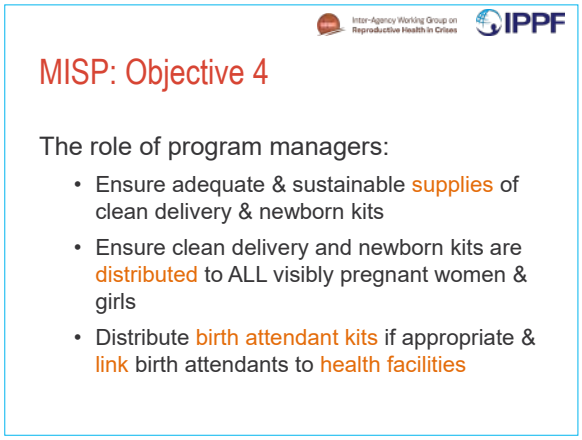
Note to facilitators Ask participants to consult their MISP for SRH Cheat Sheet and review the kits associated with this activity of Objective 4.

Clean delivery kits (Kit 2A) include:

- One sheet of plastic for the woman to deliver on;
- Bar of soap;
- Pair of gloves;
- One clean razor blade or other cutting instrument, new and wrapped in its original paper (to cut the umbilical cord);
- Three pieces of umbilical tape (to tie the umbilical cord);
- Two pieces of cotton cloth (to dry and use as a nappy).
- Contextual only: Misoprostol tablets (600mcg) and CHX for cord care

Slide #33: MISP: Objective 4: Role of Program Manager

Key Messages



- Program managers have a key role to play in ensuring the availability of these life-saving supplies. Clean delivery and newborn kits can be ordered or locally assembled and pre-positioned and may be a source of income for local groups.
- Program managers should also work with local organisations to ensure that clean delivery and newborn kits are widely distributed.
- Engaging with birth attendants through kit delivery is an opportunity to link these providers to more formal health facilities.

Slide #34: MISP: Quality & respectful maternal & newborn care in humanitarian settings

Key Messages

- The quality of maternity care and mistreatment of women in maternity care is linked to the third delay. It is not enough that services are available, they must also be acceptable and of good quality.
- Mistreatment of women in maternity care is a global issue and undermines ongoing efforts to increase skilled attendance at birth.
- Quality of care should underpin all components of maternal and newborn care, including in humanitarian settings.
- Providing respectful maternity care is integral to improving quality of care.
- This slide lists some of the key components of the Universal Rights of Childbearing Women, recognized in the Respectful Maternity Care Charter (see below for more on these).

Note to facilitators (From IAFM 2018 pages 182-183)

Respectful maternity care (RMC) in humanitarian settings is a woman's right, not a luxury. Ensuring that women are not only satisfied with their experiences of care but have a good birth experience can be the catalyst to ensuring they survive and thrive. Women's experiences with maternal and newborn health services can empower and comfort them, or can inflict lasting damage and emotional trauma.

Mistreatment of women in maternity care is a global issue and undermines ongoing efforts to increase skilled birth attendance. Mistreatment is complex with many drivers, including the health system itself and gender inequities.

Efforts to reduce mistreatment and advance RMC are integral to improving quality of care.

Respectful maternity care is a universal human right that is due to every childbearing woman in every health system and setting. The Universal Rights of Childbearing Women recognized in the Respectful Maternity Care Charter include:

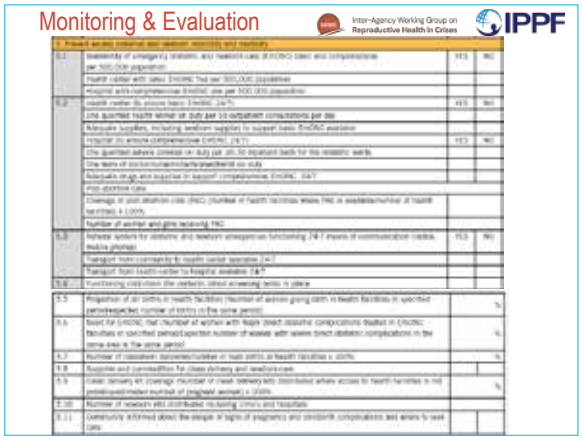
- The right to be free from harm and ill treatment before, during, and after childbirth
  The right to information, informed consent and refusal, and respect for her choices and preferences (including the right to her choice of companionship during labour and delivery, where possible)
- The right to privacy and confidentiality before, during, and after childbirth
- The right to be treated with dignity and respect before, during, and after childbirth
- The right to equality, freedom from discrimination, and equitable care before, during, and after childbirth
- The right to healthcare and the highest attainable level of health including access to antenatal, delivery, and postpartum care for all mother-baby pairs and all necessary measures to reduce preventable maternal and perinatal mortality and morbidity
- The right to liberty, autonomy, self-determination, and freedom from coercion

The fulfilment of other human rights, such as the right to adequate food, shelter, clean water, information and education, are also key to ensuring the survival and health of mother and child.

For more information on respectful maternal and newborn care, visit
https://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf
https://reliefweb.int/report/world/rmc-not-luxury-case-respectful-maternity-care-humanitarian-settings

Slide #35: Monitoring & evaluation

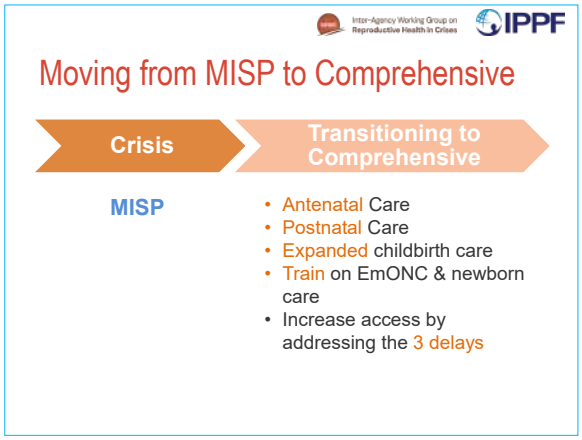
Key Messages



- The MISP checklist provides a useful tool for monitoring and evaluating the maternal and newborn health objective of the MISP.
- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. The presence of staff with the capacity to provide maternal and newborn care at the three levels detailed in the MISP (community, health centre and referral level hospital) should also be considered, and mapping and rostering conducted prior to the onset of an emergency.
- It is important to review staffing structure, roles, responsibilities, protocols and scopes of practice to map who is able to contribute what during an emergency. This will also highlight gaps in capacity and provide opportunities to work on developing capacity.

Slide #36: Moving from MISP to comprehensive

Key Messages



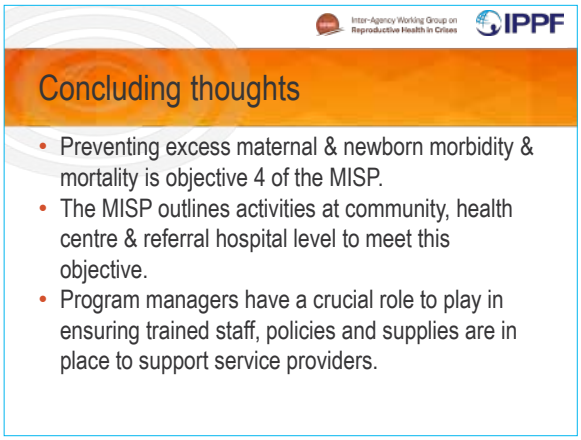
- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.
- It is critical to provide comprehensive services as soon as possible.
- For the maternal and newborn health objective of the MISP, this includes providing antenatal and postnatal care. It also entails the expansion of childbirth care, training new workers on EmONC and working to comprehensively address the three delays.
- Strong systems and programs in place before an emergency minimize the impact of hazards on sexual and reproductive health when a crisis hits. Steps to building comprehensive maternal and newborn health services should, therefore, be taken in the preparedness phase.

Note to facilitators If participants are interested in learning more about comprehensive maternal and newborn health programming, refer them to the IAFM 2018 Chapter 9: Maternal and Newborn Health.

Slide #37: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions. Emphasise the key points, highlighting any issues that were raised during discussions.



Day 3 continued

MISP Objective 5: Prevent unintended pregnancies

Session 3.2 2 hours

Overview

This session will develop program managers' knowledge in preventing unintended pregnancies in emergencies, with a focus on how the MISP for SRH addresses this serious SRH concern.

Methodology


Interactive presentation


Case study

Materials


PowerPoint presentation


Participant handout #15


Case study supplies

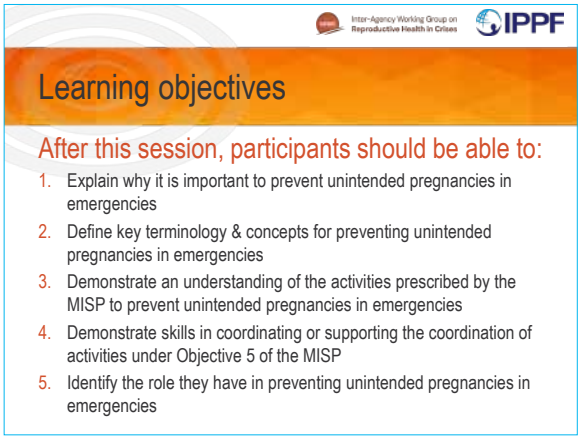

Flipchart & markers

Slide #38: Session 3.2: MISP Objective 5: Prevent unintended pregnancies

Welcome your participants back and explain that you will now move on to addressing the prevention of unintended pregnancies in emergencies.

Slide #39: Learning objectives

Key Messages

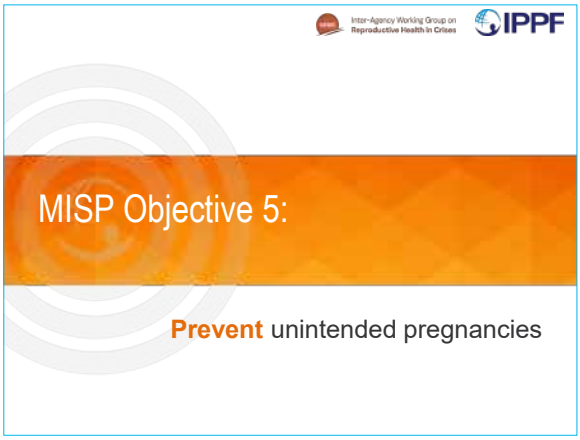


- There are five learning objectives for session 3.2

1. Explain why it is important to prevent unintended pregnancies in emergencies
2. Define key terminology & concepts for preventing unintended pregnancies in emergencies
3. Demonstrate an understanding of the activities prescribed by the MISP to prevent unintended pregnancies in emergencies
4. Demonstrate skills in coordinating or supporting the coordination of activities under Objective 5 of the MISP
5. Identify the role they have in preventing unintended pregnancies in emergencies

Slide #40: MISP Objective 5: Prevent unintended pregnancies

Highlight that you are now going to look at MISP Objective 5: prevent unintended pregnancies



Note to facilitators This may be a good opportunity to ask participants to share any experience they have had in family planning programming in their settings. You could also ask participants what they think may be involved in a minimum response during the acute phase of an emergency compared to standard settings.

Slide #41: Case studies: Contraception in humanitarian emergencies

Contraception in Humanitarian Emergencies

Participants will explore case studies to highlight the importance of providing contraception to prevent unintended pregnancies in emergencies. These case studies are from *Family planning saves lives and promotes resilience in humanitarian contexts* available at:

https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf

Explain to participants that the case studies included in this document are from protracted settings. They do, however, highlight some important challenges and solutions to providing contraception in emergencies.

An alternative exercise may be to provide an example or case study from the acute phase of an emergency in your setting and discuss the challenges to providing contraception in that instance. Include information such as challenges to availability, access and supplies (of a variety of methods); provider bias; lack of trained staff; community stigma; transportation or other barriers in the case study.

Time

25 minutes

Process

- Ask participants to read through the case studies provided in Participant Handout #15.
- When they have read through these, as a group, ask participants to point out some good practices and some challenges in providing family planning which were discussed in the case studies.
- **Note** These challenges and good practices on a flipchart to refer to in the coming session.
- Allow some time for a general discussion and ask participants whether these good practices and challenges would apply to their setting.
- Finally, explain to participants that you are now going to work through the activities prescribed by the MISP to support the prevention of unintended pregnancies and as you do, they should keep in mind the good practices and challenges discussed here.

Materials

Participant Handout #15

Flipchart and markers

IPPF/Tom Pilston

Slide #42: Preventing unintended pregnancies in humanitarian emergencies

Key Messages

- At the onset of an emergency it is important to ensure contraceptives are available to prevent unintended pregnancies.

- Contraception is one of the most effective ways to prevent maternal death. "It is estimated that if unmet need for contraception were fulfilled, an additional 104,000 maternal deaths could be prevented- a 29% reduction in global maternal mortality" (https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf).

- Making a range of long-acting reversible and short-acting methods of contraception available is a life-saving intervention in humanitarian settings. It is also empowering and cost-effective but a gap in the provision of contraception during emergency response remains due to a lack or prioritization and funding.

- "Strong evidence demonstrates that family planning services can and should be integrated into each stage of humanitarian interventions, from preparedness, to response and recovery" (https://www.rescue.org/sites/default/files/document/1728/familyplanningwhitepapercompletespreadina4web.pdf).

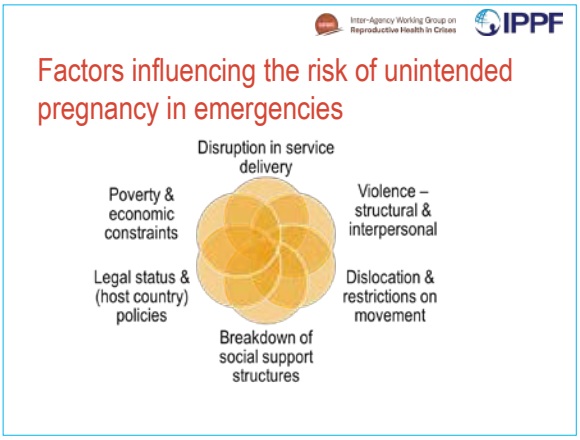
- The need for family planning services and supplies becomes more acute in emergency settings. Women and girls affected by armed conflict and natural disasters are at increased risk of unintended pregnancy, maternal morbidity and mortality, including unsafe abortion (see http://iawg.net/wp-content/uploads/2017/07/FP-in-humanitarian-contexts-IAWG-.pdf).

Note to facilitators If participants are interested in learning more about family planning in emergencies, encourage them to explore:

- http://iawg.net/wp-content/uploads/2017/07/Family-planning-white-paper-complete-spread-in-US-LETTER-WEB.pdf
- http://iawg.net/wp-content/uploads/2017/07/FP-in-humanitarian-contexts-IAWG-.pdf

Slide #43: Factors influencing the risk of unintended pregnancy in emergencies

Key Messages

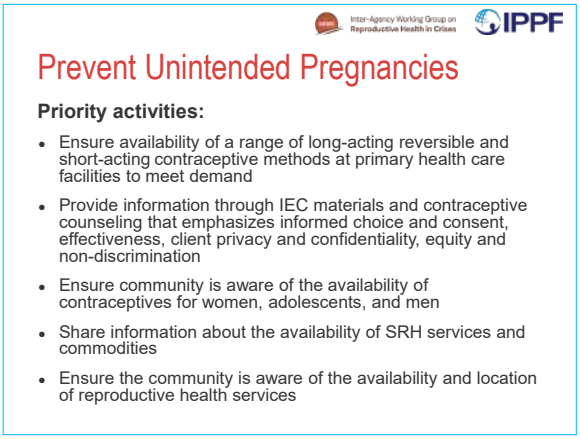


(From IAWG Workshop Presentation Guide for IAFM draft 2019)

- Access to contraception decreases during emergencies as health systems are compromised.
- New barriers to access come at a time when many people's desire and need for birth spacing and pregnancy prevention increase. Evidence shows that many recently displaced couples have no desire to become pregnant for two or more years.
- Additionally, the loss of social structure and protective mechanisms during emergencies increase the risk of forced sex, risk-taking behaviours, and exposure to high-risk situations, highlighting the critical role of the availability of contraception.
- The factors on this slide are amongst those which place thousands of women and girls at risk of unintended pregnancy, unsafe abortion, and related morbidity and mortality.

Slide #44: Prevent unintended pregnancies

Key Messages



- Remind participants that the fifth objective of the MISP for SRH is to prevent unintended pregnancies.
- This slide contains the priority activities necessary to meet Objective 5 of the MISP. Ask participants to read aloud from slide and explain we will go through the activities in the following slides
- These are:
  - Ensure availability of a range of long-acting reversible and short-acting contraceptive methods at primary health care facilities to meet demand
  - Provide information through IEC materials and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity and non-discrimination

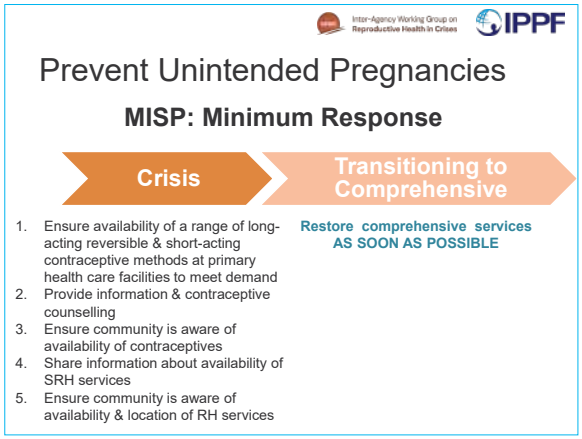
- Ensure community is aware of the availability of contraceptives for women, adolescents, and men
- Share information about the availability of SRH services and commodities
- Ensure the community is aware of the availability and location of reproductive health services

- The activities under the fifth Objective of the MISP for SRH emphasise the provision of a range of contraceptive methods including long term methods, to enable informed choice, and to ensure the community is aware of services.

Note to facilitators Ask participants to look at their MISP for SRH Cheat Sheet and locate the fifth MISP Objective and its priority activities.

Slide #45: Prevent unintended pregnancies

Key Messages

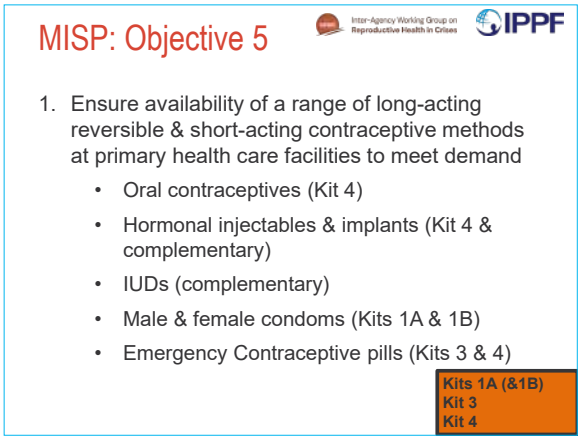


- Due to the life-saving nature of contraceptive provision in emergency situations, the fifth objective of the MISP is for the prevention of unintended pregnancies.
- The evidence-informed activities that support this objective include ensuring the availability of a range of long-acting reversible and short-acting contraceptive methods to meet demand, provision of information and contraceptive counselling to users, and ensuring that the community is aware of services.
- These activities form an absolute minimum of response during a crisis. They should be expanded and comprehensive family planning services made available as soon as possible.

Slide #46: MISP Objective 5: Contraceptive method

Key Messages

- "A range of oral contraceptives, hormonal injectables and implants, IUDs, male and female condoms and emergency contraceptive pills should be available immediately to meet demand in the affected population where providers are trained and skilled to provide, and in the case of long-acting reversible contraceptive, remove the method" (IAFM 2018 p50).



- Emphasise the need for a wide range of long-acting and short-acting contraceptive methods at primary health care facilities to meet demand. Program managers must ensure the presence of skilled staff to provide these contraceptive information and services.

Slide #47: Contraceptive methods

Key Messages

- This slide shows possible contraceptive methods from most effective to least effective.

Slide #48: MISP Objective 5: Role of Program Manager

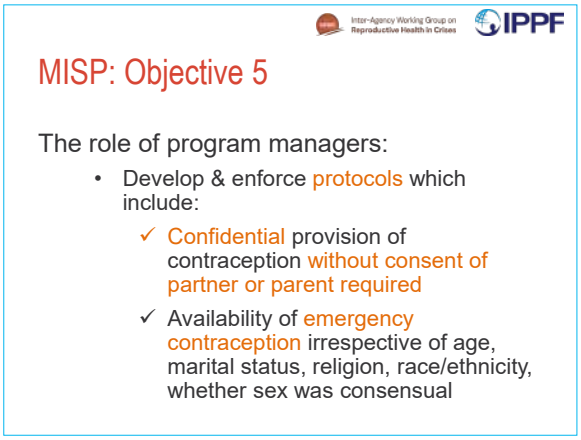
Key Messages

- Program managers can support the fifth MISP Objective, first by ensuring that service providers with competency in the provision of family planning services are in place to begin services at the onset of the crisis.
- Adequate and sustainable supplies are also required to support the work of service providers. Oral and injectable contraceptives are available in Reproductive Health Kit 4 and male and female condoms are contained in Kit 1A & B.

Slide #49: MISP Objective 5: Role of Program Manager

Key Messages

- All forms of contraception should be provided on a confidential basis and without requiring the consent of a partner, parent, relative or other caregiver in line with the law of the country.
- "Emergency contraception should be made available to all women and girls irrespective of age, marital status, religion, race/ethnicity, or whether or not the sex was consensual" (IAFM 2018 p51).

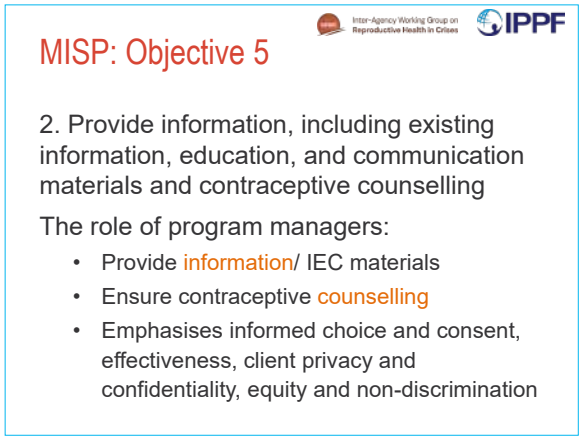


- Ensuring that these protocols are in place and that staff follow these protocols is an important component of program management for this objective of the MISP.

Note to facilitators Where possible, provide context-specific information on the provision of contraceptives to different population groups in your context. Where these differ from the information on the slide, reiterate the importance of providing contraception as a life-saving intervention in humanitarian settings and the lessons on inclusion discussed during the first day of the training.

Slide #50: MISP Objective 5: Information

Key Messages

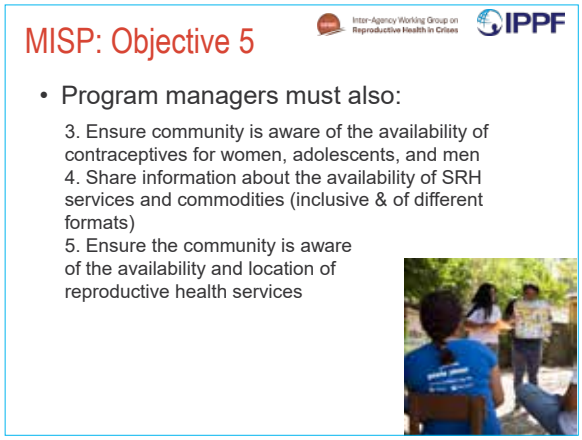


- Program managers should ensure that information, including existing IEC materials in local language and contraceptive counselling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity and non-discrimination is available.

- Protocols should be developed and enforced to ensure that providers maintain "quality of care that emphasizes clients' confidentiality and privacy, clients' voluntary and informed choice and consent, method eligibility, effectiveness, possible side effects management, follow-up, and guidance on method removal as appropriate for women of all ages, including adolescent girls" (IAFM 2018 p51).

Slide #51: MISP Objective 5: Information

Key Messages



- Program managers should also ensure "the community is aware of where and how to seek access to contraception, including unmarried and adolescent community members. Information should be communicated in multiple formats and languages to ensure accessibility (e.g., Braille, sign language, pictograms and pictures). Engage community leaders to disseminate information about availability of contraceptive services" (IAFM 2018 p51).

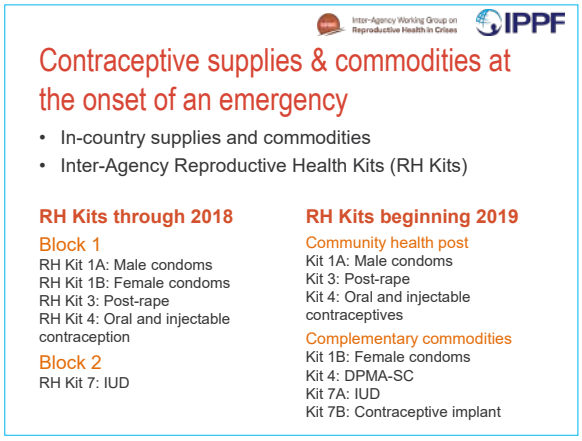
- The final two priority activities for the fifth Objective of the MISP for SRH are to: share information about the availability of SRH services and commodities and ensure the community is aware of the availability and location of reproductive health services

Note to facilitators Think back to the discussion on inclusion. Ask participants what suggestions they might have in making these information materials more inclusive.

Slide #52: Contraceptive supplies and commodities at the onset of an emergency

Key Messages

- Reliable and sustainable supplies of contraceptives need to be available to support this life-saving MISP Objective.
- In-country supplies and commodities and engagement with/ strengthening of supply chains is important prior to an emergency and, to meet Objective 6 of the MISP, planning to integrate comprehensive SRH services into primary health care.



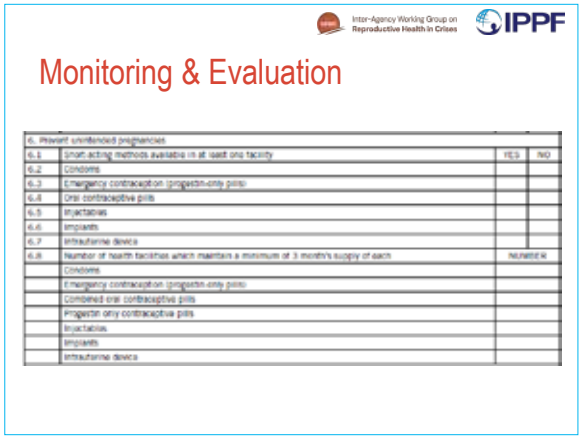
- As mentioned above, commodities are available in RH Kits to be ordered as required at the onset of an emergency.

Note to facilitators Refer participants to their MISP for SRH Cheat Sheet to review where these commodities and supplies are found within the kits.
Explain that we will look into these commodities in more detail on the final day of the training.

Slide #53: Monitoring & evaluation

Key Messages

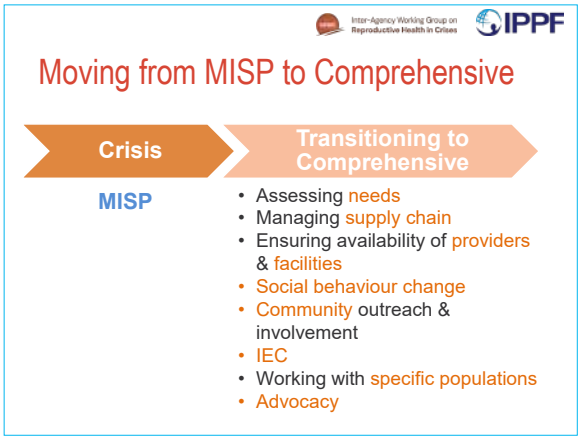
- The MISP check list once again provides a useful tool for monitoring and evaluating Objective 5 of the MISP.
- The checklist can also be used in the preparedness phase to ensure that supplies are in place (prepositioned) or that supply chains are established through relationships with other actors. These relationships will also support the collection of data to inform MISP implementation and the development of protocols.



- The presence of staff with the capacity to provide a range of contraceptive methods should also be considered, and mapping and rostering conducted prior to the onset of an emergency.

Slide #54: Moving from MISP to comprehensive

Key Messages



- The MISP is the absolute minimum that needs to be provided in the very early days of an emergency.
- It is critical to restore or build comprehensive services as soon as possible.
- Planning for comprehensive initiatives to prevent unintended pregnancies would include conducting needs assessments, managing the supply chain, further ensuring the availability of providers and facilities, social behavior change interventions, further IEC campaigns, working with specific populations and advocacy.

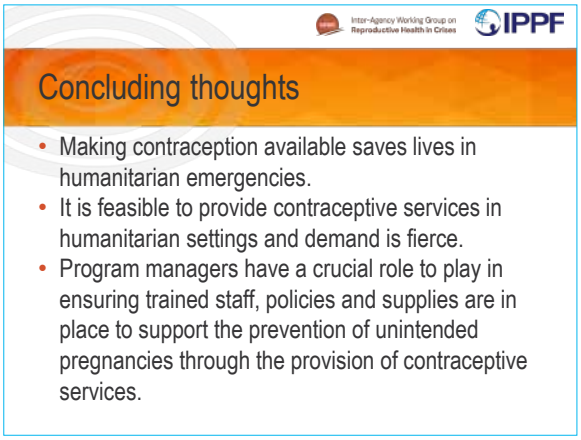
Note to facilitators If participants are interested in learning more about comprehensive contraception services, refer them to IAFM 2018 Chapter 7: Contraception.

IPPF/Hannah Maule-ffinch

Slide #55: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



Day 3 continued

MISP Objective 6: Plan for comprehensive SRH services, integrated into primary health care as soon as possible

Session 3.3 1 hour

Overview

This session will provide participants with an overview and practical skills in planning for comprehensive SRH services integrated into primary health care as soon as possible, and working across the health systems building blocks to ensure sustained, improved and expanded SRH services.

Methodology

- Interactive presentation
- Discussion
- Group work

Materials

- PowerPoint presentation
- Participant handout #16
- Group work supplies

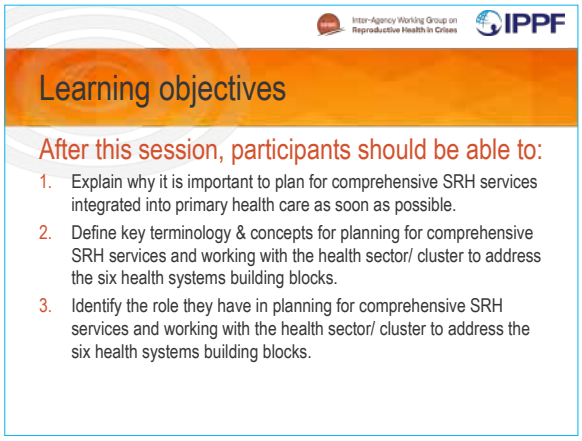
Slide #56: Session 3.3: MISP Objective 6: Plan for comprehensive SRH services, integrated into primary health care as soon as possible

This session will look at moving towards comprehensive SRH programming and building back better.

Slide #57: Learning objectives

Key Messages

- There are three learning objectives for session 3.2

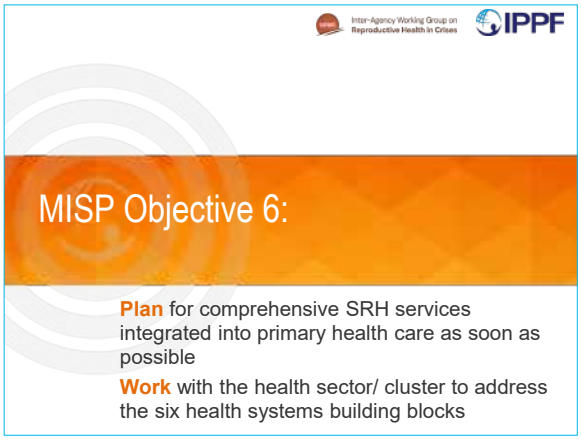


1. Explain why it is important to plan for comprehensive SRH services integrated into primary health care as soon as possible.
2. Define key terminology & concepts for planning for comprehensive SRH services and working with the health sector/ cluster to address the six health systems building blocks.
3. Identify the role they have in planning for comprehensive SRH services and working with the health sector/ cluster to address the six health systems building blocks.

Slide #58: MISP: Objective 6

Key Messages

- The sixth objective of the MISP is to plan for comprehensive SRH services integrated into primary health care as soon as possible, or between three and six months, and to work with the health sector/ cluster to address the six health systems building blocks.



Slide #59: Comprehensive SRH Services

Key Messages

- The MISP for SRH is the minimum response in any crisis. Its activities must be in place in every humanitarian setting- from acute to protracted- as they are life-saving and address the highest priority SRH concerns in crisis contexts. The MISP for SRH must be in place first as a minimum. It can then be built upon with additional comprehensive SRH activities as the situation allows.

- "The MISP is designed to form the starting point for SRH programming. It was developed based on well-documented evidence of SRH needs in humanitarian settings, and therefore, the four "clinical service delivery" components of the MISP …can be put in place without an in-depth SRH needs assessment among the affected population" (IAFM 2018 p52).

- Start planning for the integration of comprehensive SRH activities into primary health care at the onset of the humanitarian response. Failure to do so may unnecessarily delay the provision of these services.

- "When planning for the delivery of comprehensive SRH, the clinical services put in place as part of the MISP should be sustained, improved in quality, and expanded upon with other comprehensive SRH services and programming throughout protracted crises, recovery, and reconstruction. After the situation stabilizes and while preparing for comprehensive SRH services, plan to obtain input from the community on the initial response in order to identify gaps, successes, and avenues for improvement" (IAFM 2018 p52).

- Participatory planning is important among national stakeholders and international partners when the MISP indicators are reached and when humanitarian appeals processes and agencies start longer term planning.

- Ensuring that vulnerabilities and capacities are addressed in humanitarian settings will enable better access to services, an increased opportunity for marginalized people to have a voice in decision-making, build the capacity of these groups for action post-crisis, and minimize the chance of exacerbated vulnerabilities and further harm.

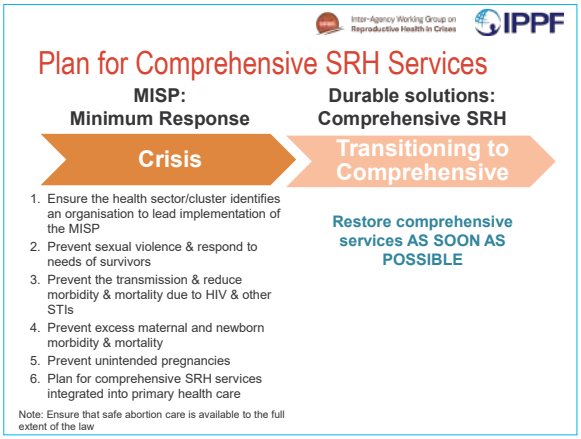
- Note that crises seldom take a linear path from emergency, stability, recovery to development. They are often complex with ongoing and varying degrees of improvement and deterioration. The provision of SRH services must take into account the non-linear trajectory of a crisis.

Slide #60: Plan for comprehensive SRH services

Key Messages

- Remind participants of the transition between the MISP for SRH and more comprehensive SRH services. This transition has been discussed for each of the objectives of the MISP and should be reiterated now.

- Examples of comprehensive SRH activities can be found in the IAFM 2018 chapters.



Note to facilitators This is an opportunity to discuss components of comprehensive SRH services with participants. It is also important to reiterate that many of these are not possible during the acute phase of the crisis and this is why the MISP for SRH focuses on priority life-saving activities.

At the end of the discussion, choose one or two objectives and highlight the differences between what is in the MISP and what should be built upon the MISP for comprehensive programming.

Slide #61: Plan for comprehensive SRH services

Key Messages

- The health systems building blocks are a useful tool for understanding and comprehensively considering the different components that interact to form a health system. All elements are needed to deliver health services effectively through the health system.
- When planning for comprehensive SRH services, there are a number of activities that can be taken across the building blocks to sustain, improve and expand SRH services.

Note to facilitators

Health Systems Building Blocks

Allow participants time to read through the table on the slide and ask for any questions or discussion points.

Ask participants to reflect on their own contexts or the scenarios they have followed throughout the training and how each health system building block may be addressed. Ask participants to briefly discuss the challenges they see to addressing each of the health systems building blocks in transitioning towards comprehensive SRH services, who they may engage with to overcome these challenges, and what strategies they could put in place to do so.

After around 10 minutes, ask participants to feed back to the group about the challenges and strategies they discussed for each of the health system building blocks.

Make sure that participants mention the importance of working with all stakeholders, including the community, when planning for comprehensive services. Highlight the roles different actors may play planning for comprehensive SRH services.

For further information on these components for either yourself or your participants, and to facilitate the above discussion refer to IAFM 2018 pages 54-55.

Slide #62: Transitioning to comprehensive SRH: Group work

Transitioning to Comprehensive SRH:

3 Month Update to Case Study

This activity asks participants to develop a transition plan for the health cluster based on a three month update to the case study introduced on day one of the training (Participant Handout #1).

Time

20 minutes

Process

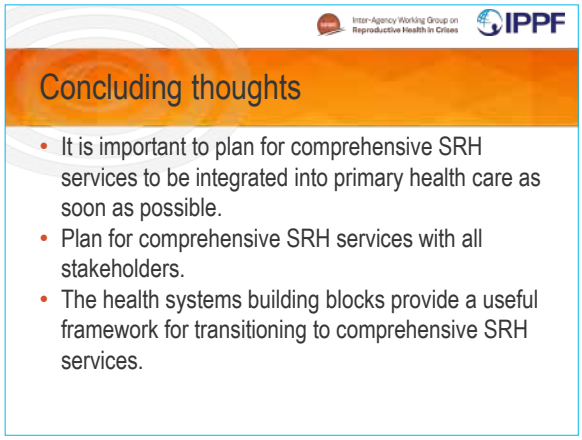
- Break participants into small groups
- Remind participants of the case study they have been working with throughout the training and explain that it is now three months after the event.
- Provide each group with the update notes relevant to their case study (Gammalpha or Gammaland). Handout #16.
- Alternatively, participants could be provided with a context-specific case study to discuss how transition planning was done after a recent crisis in their setting.
- Ask participants to work in groups, using the health systems building blocks as a guide, to prepare a brief transition plan to be presented to the Ministry of Health and Emergencies.
- Explain to participants that part of transition planning is to note the strengths and assets that have been identified and can be built upon as they plan for comprehensive SRH services/ recovery.
- Ask groups to share back one or two key points from their plan and facilitate a discussion on key considerations. Volunteers can pretend to be MoH to be more interactive.

Materials

Participant Handouts #1 & #16

Slide #63: Concluding thoughts

- Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.
- Reveal the list and allow participants to read through and ask any questions.



IPPF/Kathleen Prior

Day 3 continued

MISP for SRH Other Priority Activity: Safe Abortion Care to the Full Extent of the Law in Emergencies

Session 3.4 1 hour

Overview

This session will explore the importance of providing safe abortion care to the full extent of the law in humanitarian emergencies, and context-specific laws and resources. Challenges and enablers to providing safe abortion care services will be considered.

Methodology

- Interactive presentation
- Reflective exercise

Materials

- PowerPoint presentation
- Participant handout #17
- Exercise supplies
- Flipchart & markers

Note to facilitators This can be a very sensitive topic to facilitate. People will often bring divergent views to the subject of Safe Abortion Care. It is important that everyone remember the ground rules (including respect and confidentiality) and that participants are reminded not to judge other people's views and to respect their opinions.

The point of this session is not to change anyone's personal belief systems but to recognise the expectations for program managers under the Other SRH Priority Activity

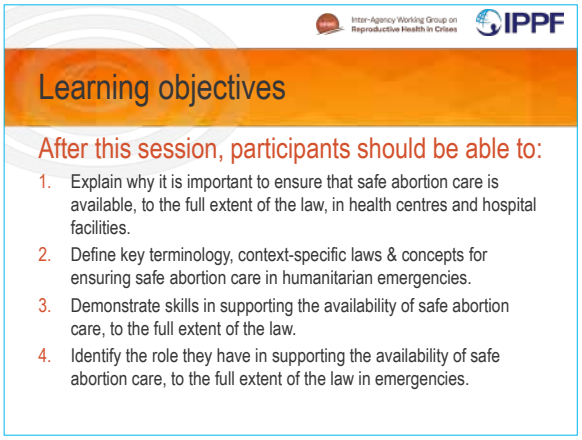
Slide #64: Session 3.4: Other SRH Priority Activity: Safe Abortion Care to the Full Extent of the Law in Emergencies

Welcome your participants back and explain that you will now move on to addressing the other priority activity- safe abortion care to the full extent of the law in emergencies.

Slide #65: Learning objectives

Key Messages

- There are four learning objectives for session 3.4



1. Explain why it is important to ensure that safe abortion care is available, to the full extent of the law, in health centres and hospital facilities.

2. Define key terminology, context-specific laws and concepts for ensuring safe abortion care in humanitarian emergencies.

3. Demonstrate skills in supporting the availability of safe abortion care, to the full extent of the law.

4. Identify the role they have in supporting the availability of safe abortion care, to the full extent of the law in emergencies.

Slide #66: Other SRH priority activity

Key Messages

- Access to safe abortion care, to the full extent of the law, in health centers and hospital facilities is defined as an 'other priority activity' in the IAFM 2018.
- As an other priority, the SRH lead coordinator, implementers and service providers should ensure that these services are available at the onset of a crisis when the capacity already exists to offer them.
- These services should be included/ advocated for when transitioning to comprehensive SRH services, based on their critical contribution to protecting the lives and dignity of women and girls. (IAFM 2018 p60)

Slide #67: Safe abortion care in humanitarian emergencies

Key Messages

- As discussed during our session on maternal and newborn health, unsafe abortion contributes significantly to maternal deaths worldwide. We do not know the extent of maternal deaths due to unsafe abortion in humanitarian settings.
- "Access to safe abortion care (SAC) to the full extent of the law should be facilitated from the onset of an emergency by direct service provision or referral to trained providers. In most countries, induced abortion is legally permitted in at least some circumstances, particularly for early abortion. In many countries abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest. Programs should identify the conditions under which national policies, signed international agreements and international humanitarian and human rights law permit the provision of SAC" (IAFM 2018 p60).

Slide #68: Safe abortion care in humanitarian emergencies

Key Messages

- Evidence demonstrates that access to safe abortion for all women and girls is critical to saving their lives, given that unintended pregnancies and unsafe abortions are major causes of maternal mortality.
- Medical care for abortion is not a difficult procedure.
- Global data indicate that unsafe abortion is present in countries where safe abortion care is not accessible to all women and girls and that the need for safe abortion services likely increases in humanitarian settings. As sexual violence is associated with war and acute crises, the trauma resulting from sexual violence may be exacerbated if the incident results in a pregnancy. Because of this, many international agreements and human rights expert bodies support the provision of SAC for women who are raped in crises; international human rights law supports access to SAC across all settings" (IAFM 2018 p60).
- While abortion is restricted in many places, it is only completely prohibited in very few: Dominican Republic, El Salvador, Nicaragua, Vatican City, Holy See and Malta.
- Abortions still occur in places where it is illegal, often in unsafe conditions.

Slide #69: Safe abortion care in humanitarian emergencies

Key Messages

- This slide has been left blank for you to provide national data on maternal deaths attributable to abortion (if such data is available), and to present relevant national and/or state laws on safe abortion care.

Note to facilitators If not done beforehand, ask participants to share their understanding of laws regarding safe abortion care, restrictions and exemptions.

For more information on this, refer to the Centre for Reproductive Rights Abortion Map, available at: https://reproductiverights.org/worldabortionlaws

Slide #70: Safe abortion care in humanitarian emergencies exercise: Values clarification exercise

Safe Abortion Care in Humanitarian Emergencies: Values Clarification Exercise

The following activity is from IPAS and is available at: www.ipas.org/humanitarianVCAT

This activity is intended to help participants assess where their personal beliefs are in alignment or in conflict with their professional responsibilities to provide or support provision of safe abortion care. It emphasizes the responsibility of medical-humanitarian organizations to ensure women have access to reproductive health care, including safe abortion care, to reduce maternal morbidity and mortality linked to unsafe abortion.

Note to facilitators This exercise can bring up strong beliefs, emotions and experiences amongst participants and should be guided by an experienced facilitator.

Time

45 minutes

Process

Step 1: Facilitate a short discussion using the introduction below:

- When a woman or girl is determined to end her pregnancy, she will usually seek out an abortion regardless of the safety of the procedure. Even in places where safe abortion care is available, she may be reluctant to seek professional medical help and will risk her life to terminate the pregnancy through unsafe means.

- This reluctance is often due to perceived or actual stigma she fears she may face from health-care providers or non-medical support staff for wanting to end her pregnancy. A refugee or displaced woman may face even greater barriers to accessing safe abortion care due to lack of freedom of mobility, income, language barriers and limited knowledge of services. As a result, she may seek an unsafe abortion and face one of the many complications, such as severe bleeding, infection, trauma to the vagina and uterus, and death.

- This example highlights how conflicts between personal beliefs and professional responsibilities among medical or support staff concerning safe abortion care provision can affect a woman's ability to obtain appropriate medical care and avoid death or injury.

Ask participants the following questions:

- Reflecting on the example just shared, what kind of conflicts do you think may influence a health-care provider's willingness to provide safe abortion care to a woman or girl? What about non-medical support staff's willingness?

- What other factors do you think might affect your agency's staff's willingness to provide safe abortion care?

Step 2: Divide participants into groups of four to six people each. Distribute Participant Handout #17 to each participant. Ask participants to work through Part A of Participant Handout #17, checking each statement that applies regarding their personal beliefs. Highlight that this is confidential and that there are no right or wrong answers.

When participants have finished filling out Part A of the Participant Handout, ask the whole group the following questions and facilitate a brief discussion about personal beliefs:

- What were your reasons for providing or supporting access to the provision of safe abortion care?

- What people and life experiences have influenced these reasons?

Step 3: Still in small groups, ask participants to complete Part B of their worksheet.

After participants have completed Part B, ask the whole group the following questions and facilitate a brief discussion about professional responsibilities:

- How would you describe your responsibilities to women seeking safe abortion care, relative to your job?
- How would you describe your responsibilities to refugee or displaced women seeking safe abortion care in humanitarian settings?
- How would you describe your agency's responsibilities to provide or support refugee or displaced women seeking safe abortion care in humanitarian settings?
- What factors influence your sense of professional responsibility to provide safe abortion care to a woman or girl who requests it?
- Have there been any situations in which you did not act in accordance with your perceived responsibilities? What were the reasons for this?
- What consequences do women face when your agency's staff do not follow safe abortion care policies?

Step 4: Finally, ask participants to discuss the following questions (also available on Participant Handout #17) in their small groups. This final step is to allow participants to discuss and resolve any outstanding issues within their peers, without input from the facilitator.

An alternate activity is to discuss the following questions in plenary using the facilitator.

Allow 10 minutes for this discussion and then bring the activity to a close.

- Please discuss what you interpret as your professional responsibilities with regard to safe abortion care.
- Please discuss what you interpret as your organisation's responsibilities with regard to safe abortion care.
- What are some ways we can maintain our personal beliefs about abortion, while adhering to our professional responsibilities?

To close the session, summarise the discussion and highlight the responsibility of medical-humanitarian organizations to ensure women have access to reproductive health care, including safe abortion care to the full extent of the law, to reduce maternal morbidity and mortality linked to unsafe abortion.

Materials

Participant Handout #17 Parts A & B

Copies of national and organisational laws and policies regarding safe abortion care

Slide #71: Safe abortion care in humanitarian emergencies

Key Messages

- As discussed in the above exercise, program managers have a responsibility to understand relevant laws and look for entry point to provide these life-saving services in humanitarian contexts. They must also ensure that all staff involved in the provision of services understand these laws.
- Program managers also have an advocacy role in questioning reasons that safe abortion care is not provided.
- The other SRH priority activity in the MISP explains that it is important that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities. Safe abortion care includes the following activities by service providers (from the IAFM 2018 page 60):
  - Provide medically accurate information about abortion services in a form women can understand and recall;
  - Explain any legal requirements for obtaining safe abortion care;
  - Explain where and how to obtain safe, legal abortion services and their cost;
  - Provide medication abortion, with mifepristone/ misoprostol if available or misoprostol-alone if mifepristone is unavailable, vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by WHO;
  - Provide information and offer counseling to women on post-abortion contraceptive use and provide contraception to women who accept a method;
  - Consider providing presumptive treatment for gonorrhea and chlamydia in settings with a high prevalence of STIs;
- Program managers should also ensure that referral systems are in place in case of complications and that staff are appropriately trained and resourced.

Slide #72: Other SRH priority activity: Supplies

Key Messages

- Supplies to support the Other SRH Priority Activity may be procured and stored in the preparedness phase. Local supply mechanisms may also be engaged where possible.
- Supplies to support MVA and misoprostol alone for postabortion care are included in the Inter-Agency RH Kit for managing complications of miscarriage and abortion. These supplies can also be used for safe abortion care.

- The mifepristone/misoprostol regimen is the global gold standard for medication abortion and should be provided in settings where mifepristone is registered and available.

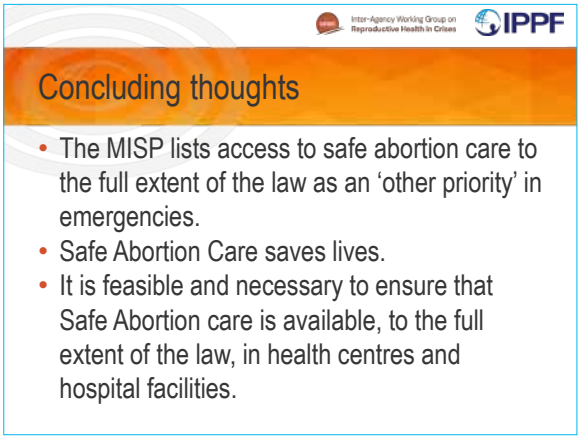
In 2019, misoprostol and mifepristone will be available in the RH Kits as complementary commodities to complement Kit 8 (and misoprostol to also complement Kit 6B and 2B).

Note to facilitators Ask participants to review the reverse side of their MISP for SRH Cheat Sheet and locate the kits and complementary commodities listed.

Slide #73: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



Day 3 Close

Day 4

Supporting MISP Implementation: Adolescent SRHR in Emergencies

Session 4.1 1 hour

Overview

This session will require participants to account for the particular needs and strengths of adolescents in humanitarian settings.

Methodology

- Interactive presentation
- Group work

Materials

- PowerPoint presentation
- Participant handout #18
- Group work supplies
- If possible: copies of *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* for each participant (https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf) (in 2019 under revision)

Slide #1: Day 4: Supporting MISP implementation

Welcome your participants to their fourth and final day of training for program managers on sexual and reproductive health in emergencies. Ask if there are any outstanding questions and take care of any housekeeping matters before moving on.

Explain that today's sessions will look into programmatic aspects of MISP implementation, starting with the special needs and capacities of adolescents in humanitarian settings.

Many of the things discussed today are relevant for both the acute phase and when transitioning to comprehensive SRH.

Note to facilitators If participants are interested in a more in-depth understanding of adolescent SRHR, please refer them to the E-Learning Course on Adolescents and SRH in Humanitarian settings, available at: http://iawg.net/resource/e-learning-course-adolescent-srh-humanitarian-settings/

This session refers to the Adolescent SRH toolkit for humanitarian settings, which was in the process of being updated at the time of writing this manual. Please check back on the IAWG website for the latest version when facilitating this session.

Slide #2: Day 3 Review

Spend a few minutes revisiting the sessions from the day before.

Note to facilitators This review may be done in a standard question and answer format, or you may wish to do this in a more interactive way to energize your participants and get them ready to engage in the sessions to follow.

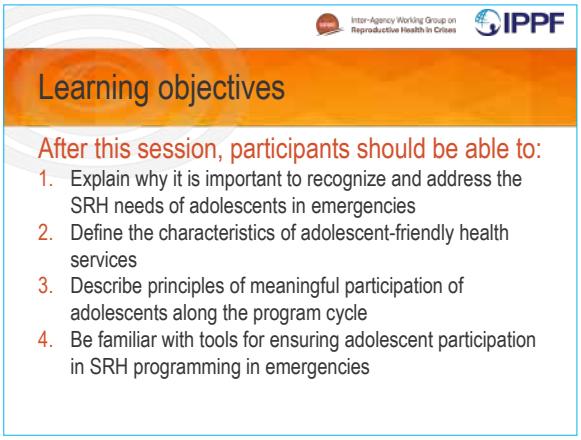
Slide #3: Session 4.1: Adolescent SRHR in Emergencies: Training for Program Managers

Explain again that you will now look into programmatic aspects of ensuring adolescents have access to SRH information and services in emergencies.

IPPF/Kathleen Prior

Slide #4: Learning objectives

Key Messages



- There are four learning objectives for this session:

1. Explain why it is important to recognize and address the SRH needs of adolescents in emergencies
2. Define the characteristics of adolescent-friendly health services
3. Describe principles of meaningful participation of adolescents along the program cycle
4. Be familiar with tools for ensuring adolescent participation in SRH programming in emergencies

Slide #5: Adolescent SRH

Key Messages

- Humanitarian emergencies present inherent risks for adolescents.
- As seen in the statistics represented on this slide, adolescents are in need of sexual and reproductive health services:
  - There are approximately 1.2 billion adolescents globally — making up 16% of the world's population (UNICEF, 2018)
  - AIDs is now the leading cause of death among young people aged 10-24 years in Africa (AVERT 2018 https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people).
  - Every day in developing countries, 20,000 girls under age 18 give birth https://www.unfpa.org/adolescent-pregnancy)
  - From 2009-2012 proposals for ASRH through humanitarian funding streams constituted less than 3.5% or all health proposals. Most were unfunded. (IAFM,108)

- As with any population, SRH needs do not stop for adolescents in emergency situations. The final point on the slide shows that despite this, these needs are being neglected in humanitarian programming (IAFM, 108).

- Adolescent SRH care in emergencies is not just needed, it is a right. The SRH of young people is protected by international law,

Note to facilitators This is a good point to adapt the statistics to highlight the situation in your context.

Slide #6: Adolescent SRH

Key Messages

- The different stages of adolescents include very young, middle and older adolescents.

- Adolescence is a period of biological, physical, and cognitive changes and is accompanied by unique sexual and reproductive health (SRH) needs.

- Adolescents are a heterogeneous group. It is important for program managers and service providers to recognize that adolescents' "needs vary by age, sex, education, marital status, local and cultural context, gender, gender identity, bodily identity, sexual orientation, and disability status" (IAFM 2018).

- "Sub-groups have unique needs and risks. Design and implementation of all programming, including provision of health services and behavior change communication strategies, should be tailored to their specific needs and be age and sex appropriate" (IAFM 2018). It may not be feasible to identify the unique needs of sub-groups of adolescents and work with them in the timeframe of the MISP for SRH. However, it is important to do so as soon as possible and ensure this approach is taken in comprehensive SRH programming.

Slide #7: Adolescent SRH in emergencies

Key Messages

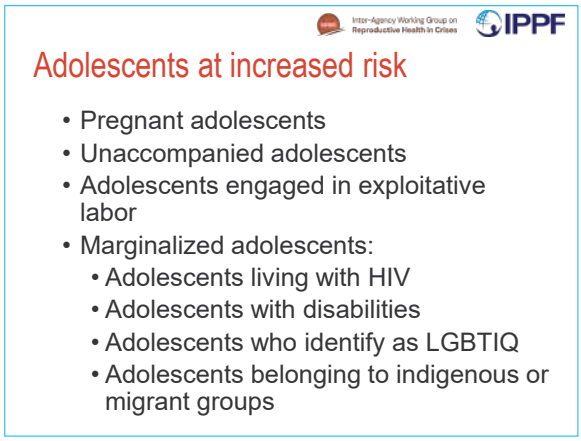
- "Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse, and exploitation. These factors can disrupt protective family and social structures, peer networks, schools, and religious institutions and can greatly affect the ability of adolescents to protect themselves and practice safe SRH behaviors. Their new environment can be violent, stressful, and/or unhealthy. Adolescents (especially adolescent girls) who live in crisis settings are highly vulnerable to sexual coercion, exploitation, and violence, and may engage in high-risk or transactional sex for survival" (IAFM 2018).

- "At a critical and vulnerable time of life, crisis may dramatically shift the individual's view on life. It may lead to increased risk-taking, such as violence, substance use, and/or unsafe sexual activity" (IAFM 2018).

Note to facilitators For more detail on the increased risks to adolescents in emergencies, see IAFM 2018 Chapter 6: Adolescent Sexual & Reproductive Health.

Slide #8: Adolescents at increased risk

Key Messages



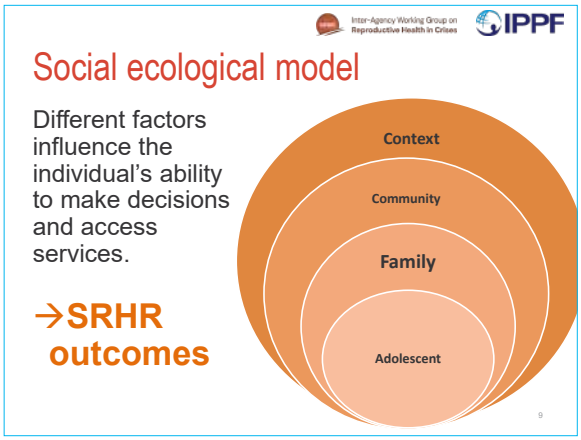
- Program managers should consider the needs of particularly vulnerable adolescents. Remind participants that many of these categories on slide apply to girls and boys in their diversity.

- Especially vulnerable adolescents includes those on the slide. Go through the groups and discuss briefly discuss why some of these may be more at risk/vulnerable.

Note to facilitators Once again remind participants of the importance of inclusion in SRH programming for emergencies and that the principles described on the first day of the training apply equally to adolescents, in all their diversity and intersecting identities.

Slide #9: Social ecological model

Key Messages



- Adolescents are surrounded by important influences and it is critical to acknowledge and work with these in order to create an environment which enables and supports access to SRH information and services.
- The social ecological model shown on this slide illustrates the ecosystem in which adolescents are situated. There are different factors that can hinder or enable young people's sexual and reproductive health. For example, the adolescent's immediate surroundings (parents, siblings, peers etc.), may be supportive of the adolescent accessing SRH services, but the adolescent may be very shy. Or the adolescent may want to seek help but there may be no services available for them to access. The combination of all of these factors will contribute to the SRH outcomes of the adolescent (adapted from: *ASRHR in Humanitarian Settings* https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf).
- Individual factors, family factors, community factors and contextual factors all have a role to play. For example, school-based comprehensive sexuality education promotes positive development; it is possible to work with parents to promote positive, stable emotional connections with their adolescent children; and community initiatives can reduce early marriages and support youth to seek for health services.
- There are promising approaches to build protective factors and address risk factors at all of these levels. For example, at the individual level by building individual assets; at the relational level by working with parents and peers; at the community level by challenging and changing community norms; and at the societal level by formulating and applying enabling laws and policies, and increasing investment.
- It is important that these promising approaches are adapted to the realities of different contexts, using a multilevel approach.

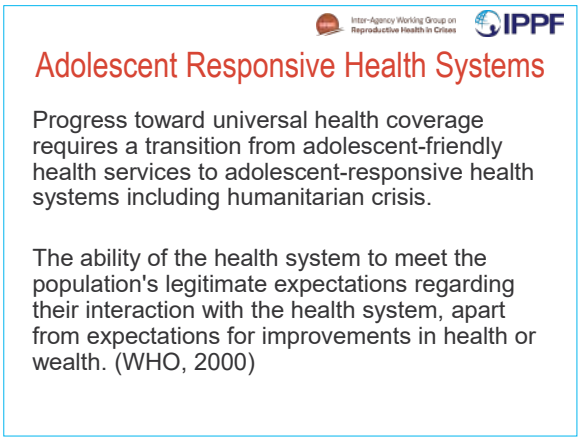
Slide #10: Adolescent SRH in humanitarian settings

Key Messages

- *The Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* (available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf) provides information and guidance to advocate for ASRH and implement adolescent-inclusive SRH interventions.
- It is designed to accompany the IAFM and contains a number of useful tools to encourage meaningful adolescent participation.
- The ASRH Toolkit has been designed to help program managers ensure that SRH needs of adolescents are addressed during an emergency.
- In order to ensure that services are adolescent-inclusive, and to capitalize on the capacities of young people in emergencies, program managers and implementing agencies should follow the principles of adolescent-responsive health services, and meaningful engagement with adolescents. The rest of this session will explore these two sets of principles.

Slide #11: Adolescent Responsive Health Systems

Key Messages



- Adolescent Responsive Health Systems is a holistic term that refers to the ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth. (WHO, 2000)
- Adolescent Responsive Health Systems move beyond addressing the barriers to uptake of services by proactively responding to the health and development needs and priorities of adolescents.
- Though the term refers to a development context it is relevant for humanitarian programs especially in protracted crisis and as soon as the crisis has stabilized and a comprehensive program design is possible to implement

- Adolescent friendly services explained in the next few slides is part of adolescent responsive systems and more pertinent to consider in acute settings and when thinking about the MISP implementation.

Slide #12: Adolescent-friendly services

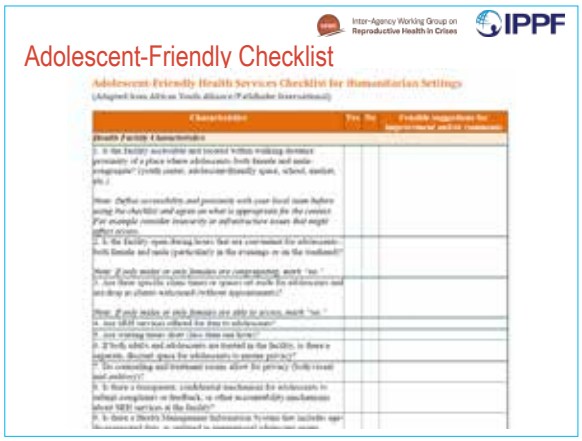
Key Messages

- Adolescents face a number of barriers to accessing SRH information and services, even in stable settings. Some of these barriers include lack of knowledge about SRH issues, lack of information about available services and where they are located, insecurity, limits to freedom of movement, physical barriers, cultural norms, lack of privacy and confidentiality, and a lack of same-sex SRH healthcare providers.
- It is also important to remember that these barriers will differ for different groups of adolescents and from culture to culture.
- To overcome these barriers, program managers should work to ensure that adolescent SRH services are acceptable, accessible, affordable, appropriate, equitable, effective and efficient.
- Ensuring services are adolescent friendly is a part of ensuring health systems are adolescent responsive.

Slide #13: Adolescent-friendly checklist

Note to facilitators Provide participants with a copy of the Adolescent-Friendly Health Service Checklist for them to refer to during your presentation of this slide. Handout #18.

Key Messages



- One of the main ASRH facility tools we have is the adolescent-friendly SRH services checklist.
- This tool is used at the health facility to measure how friendly the health facility is in responding the SRH needs of adolescents.
- There are three main sections of this checklist: the characteristics of the health facility, the characteristics of the service provider, and the characteristics of the programs/services provided at the health facility.
- The supervisor/manager will fill out the checklist and check yes or no for each question. There is space for providing comments, as some questions are difficult to provide an easy yes or no response. This space is also useful for writing recommendations or next steps in response to the observation.
- Some of the examples of responsive SRH services or activities that programs can implement and track using this checklist include:
  - Involve adolescents in program design & implementation
  - Hire youth in community health programs
  - Meaningful participation of adolescents in design and implementation of the health services.
  - Engage adolescents in supervision activities of health services
  - Strengthen referrals between the facility and other adolescent services that might be available in the area (schools, youth centers, girl friendly spaces, child friendly spaces, etc.)

Note to facilitators Now that participants have this in their handout and could go over to see how this may be useful in their context

Slide #14: Adolescent SRH in humanitarian emergencies: identifying good practice: Exercise

Adolescent SRH in Humanitarian Emergencies: Identifying Good Practice

This activity will allow participants to apply the Adolescent-Friendly Checklist to a case study of family planning for adolescents (based on a protracted setting). Alternatively feel free to use a case study from your context or an acute setting.

20 minutes

Process

Part 1

- Provide participants with a copy of Participant Handout #18 and allow them time to read through with their group, identifying aspects of good practice for providing SRH services to adolescents in emergencies. Participants may use the copy of the Adolescent-Friendly Checklist also included in Participant Handout #18 to check off any positive characteristics described in the case study.

- After people have shared their comments facilitate a brief discussion on what they think would be particular challenges or approaches that could be used in their context to deliver quality adolescent services.

Materials

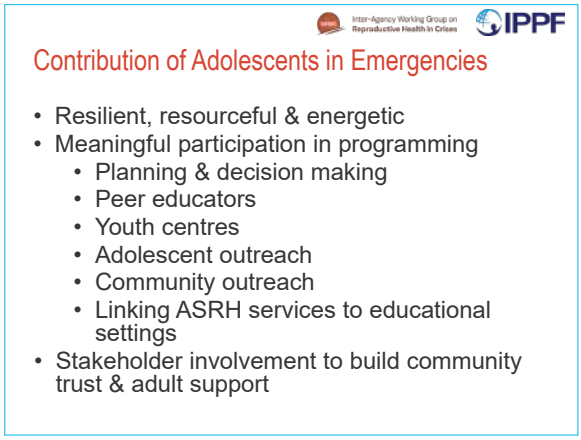
Participant Handout #18

Slide #15: Contribution of adolescents in emergencies

Note to facilitators Before showing the contents of this slide, ask participants to recount any contributions made by adolescents to SRH programming in the case study they have just read through.

Note any answers on flipcharts or a whiteboard to refer to in the following section.

Key Messages



- As demonstrated in the case study discussed above, adolescents are resilient, resourceful and energetic- all capacities which may be put to effective use in an emergency.

- Adolescents can play an integral role throughout the disaster risk management and humanitarian program cycles. For this to happen, program managers must work to meaningfully engage with adolescents throughout the program cycle- including design, implementation, monitoring and evaluation.

- Some methods of meaningful participation may include the representation of young people in decision making and planning bodies, including through coordination mechanisms; through youth centres; and by adolescent and community outreach activities. Adolescents may also work to refer from ASRH services to education, livelihood, mental health and/or other programming as available.

- In this way, program managers should make efforts to "offer opportunities to build on their capacities to promote their empowerment in the process. For example, they can serve as first responders in emergencies through activities such as assisting health providers as volunteers and community-based distributers. They can expand access to quality SRH services for the wider community as well as for their peers at the community level. In addition, they can play a critical role in coordination mechanisms to ensure that adolescent needs are considered from the outset of the emergency" (IAFM 2018 pages 107-108).

- "Understanding the cultural context and creating a supportive environment is critical to advancing SRH services for adolescents, as they may be affected by community values regarding ASRH…Community members, including parents, guardians, teachers, health care providers, and religious leaders, must be consulted and involved in developing programs with and for adolescents" (IAFM 2018 page 113).

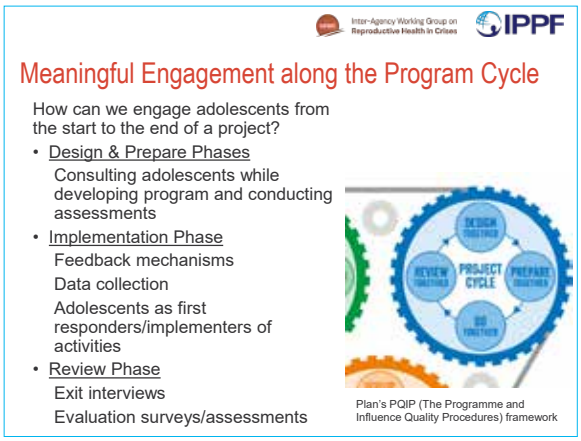
Note to facilitators A number of stories and videos of adolescents contributing to ASRH programs during humanitarian response are available online. If time permits and you feel it is appropriate, source one of these stories or videos and present it to your participants here.

As an example, a short video which shows the contribution of youth volunteers in Indonesia can be found at: https://www.youtube.com/watch?v=aZKSRZCh1Us

Other useful resources include CARE's Community Scorecard for ensuring adolescent-friendly services (an example of which can be found in the IAFM in relation to CARE's work in Democratic Republic of Congo: IAFM 2018 page 111).

Slide #16: Meaningful engagement along the program cycle

Key Messages



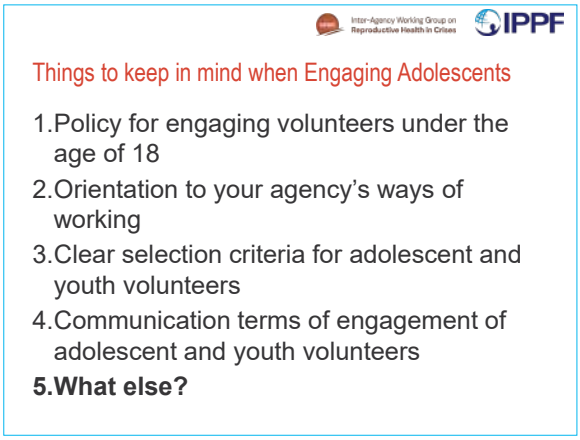
- As explained above, it is important to engage adolescents in a meaningful way throughout the program cycle. This will help to ensure that SRH services meet their needs and are acceptable, accessible, affordable, appropriate, equitable, effective and efficient.
- This includes inclusion of adolescents as decision makers in coordination mechanisms, integrated into camp management/ health development committees and others.
- Reiterate that in addition to program management cycle adolescents should also be included in process' across the development to emergency continuum, such as preparedness and recovery activities, to support acceptance of their role during emergencies.
- This slide provides information on engaging adolescents during MISP implementation and in the transition to comprehensive services. It is taken from the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings* (available at: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf).

Note to facilitators If time allows, ask participants to go through the examples on the slide and ask if there are others they can think of.

Slide #17: Engaging Adolescents

Key Messages

- These are a few things to keep in mind when engaging adolescents, but you will gain additional lessons learned as you continue working with this population.



Note to facilitators Some of these things to consider include (taken from Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings available at: https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf):

- Policy on engaging youth volunteers: Make sure your agency has a policy on engaging volunteers under the age of 18 years old. For example, the agency's HR and child safeguarding policies have clear guidelines on how volunteers under the age of 18 years will be reimbursed through non-cash incentives, the maximum number of hours they are allowed to volunteer per day and per week and minimum supervision requirements in order to engage young people.

- Ways of working: Regardless of the stage of the emergency, all youth volunteers should be properly orientated on the agency's ways of working, including undergoing orientation on child safeguarding, sexual assault and exploitation (SEA) and reporting incidents.

- Selection criteria: Program managers should have clear selection criteria for adolescent and youth volunteers to ensure a diverse range of age, gender, demographics and sub-groups are represented.

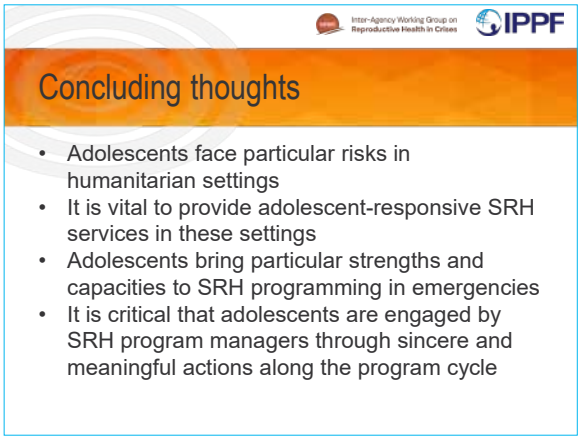
- Terms of Engagement: The TOR for the adolescent and youth volunteers are communicated not just with the volunteers but also with program staff of other sectors for them to understand their role and their terms of engagement. This is to both allow the opportunity to coordinate with other sectors but to also protect the volunteers from not being burdened by tasks from other sectors as they come to be seen as an easily available resource. So for example adolescent volunteers being engaged to do awareness sessions on where adolescents can access health services are not pulled into distribution of NFI kits because the NFI team is short-staffed. Any work beyond the scope of the TOR, should be first discussed approved by the supervisor before engaging adolescents.

  If participants have not been provided with a copy of the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*, encourage them to engage with the text in their own time.

Slide #18: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



Day 4 continued

Supporting MISP Implementation: Funding

Session 4.2 45 minutes

Overview

This session will provide participants with an understanding of global and national funding mechanisms for SRH in humanitarian emergencies.

Methodology

- Interactive presentation
- Group work

Materials

- PowerPoint presentation
- Flash Appeal documents
- Group work supplies
- Post its

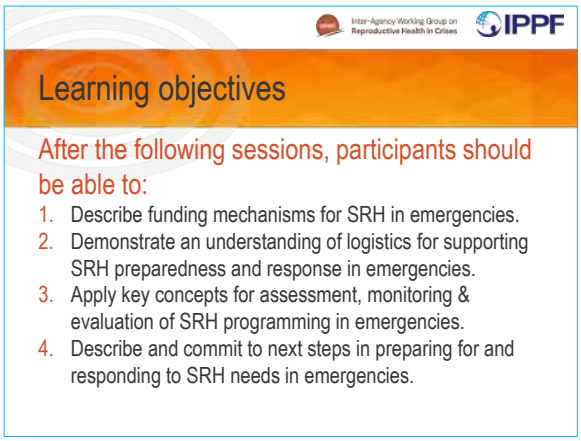
Slide #19: Session 4.2: Supporting MISP Implementation: Funding

Explain to participants that we will now work through the important components of funding, logistics, assessment, monitoring and evaluation, and next steps in support of the MISP for SRH.

Slide #20: Learning objectives

Key Messages

- There are five learning objectives for the following sessions on funding, logistics, and assessment, monitoring and evaluation:



1. Describe funding mechanisms for SRH in emergencies.
2. Demonstrate an understanding of logistics for supporting SRH preparedness and response in emergencies.
3. Apply key concepts for assessment, monitoring and evaluation of SRH programming in emergencies.
4. Describe and commit to next steps in preparing for and responding to SRH needs in emergencies.

Slide #21: Session 4.2: Funding

An essential component for supporting MISP implementation is funding.

Slide #22: Humanitarian funding mechanisms

Key Messages

- We will discuss global and national funding mechanisms for humanitarian action, and specifically for SRH in emergencies.

Note to facilitators Take this opportunity to ask participants for their experience in accessing funding for humanitarian preparedness and response generally, and for SRH in particular. Note any terms they say on a white board or flip chart and make sure to refer to these as they come up throughout the presentation.

Slide #23: Global humanitarian funding mechanisms

Key Messages

- The Flash Appeal, Central Emergency Response Fund (CERF), Consolidated Appeals Process (CAP), and Country Based Pooled Funds are humanitarian funding mechanisms. Each is slightly different, with funds allocated, dispersed and monitored in different ways and at different times through the Humanitarian Appeals Process.

- NGOs can apply for this funding from 1) UN agencies at country level and 2) International government humanitarian aid departments either at country or HQ level. Government aid departments depend on the CAP/CERF/Flash objectives to decide how/who/what to fund. It is therefore important to be active in the country coordination mechanisms. For smaller NGOs the best approach is usually to partner with larger NGOs/UN agencies.

- We will go through each in some detail but the most important thing to know is that the MISP for SRH meets the life-saving criteria for humanitarian funding. Two of the four priority areas under CERF submissions and Country Based Pooled Funds are directly relevant to the MISP for SRH and SGBV specifically:

  - Support for women and girls, including tackling gender based violence, reproductive health and empowerment;

  - Programs targeting people with disability. (https://cerf.un.org/sites/default/files/resources/USG_ERC_mail_RC_HC_Four_Priority_Areas.pdf)

- The way to access these funding sources is to attend cluster or sector meetings and advocate for the inclusion of the MISP.

Slide #24: Global humanitarian funding mechanisms

Key Messages

- The Flash Appeal is a framework of coordinated strategic response. It contains an analysis of the context, along with specific sectoral response plans to address acute humanitarian needs. The appeal should include priority programs from all key humanitarian organisations. Flash Appeals will generally require funding from multiple sources, including the CERF which we will come to next.
- The Flash Appeal is to be used in any major sudden onset disaster that requires a response beyond the capacity of the government or a single UN agency.
- It should be used within five to seven days of a sudden onset emergency.
- It can be more difficult to apply a Flash Appeal to slow onset emergencies as it may be more difficult to prove the acute worsening of the situation.
- The Resident Coordinator/Humanitarian Coordinator triggers the Flash Appeal, in consultation with the humanitarian country team. Cluster leads will feed into the development of Flash Appeal so it is essential that the SRH Coordinator liaise with the health and protection cluster leads to ensure MISP is included.

Slide #25: Flash Appeal proposals: Exercise

Flash Appeal Proposals: Group Work

This activity will allow participants to become familiar with a Flash Appeal and the place of SRH within the document. This will also allow participants to review each objective of the MISP as they analyse the documents for the inclusion of SRH.

If time permits, it may also be useful to ask participants to consider the Gender and Age Marker (introduced during Day 1: https://iascgenderwithagemarker.com/en/home/) and how it relates to the flash appeal documents provided.

Time

25 minutes

Process

- Divide participants into groups, such as by table. Provide each group with copies of 2 Flash Appeal documents. These are widely available online, with the following only suggestions. Choose those that are most relevant to your context:

  https://reliefweb.int/sites/reliefweb.int/files/resources/mosul_flash_appeal_final_web.pdf

  https://reliefweb.int/sites/reliefweb.int/files/resources/-PE-Flash_Appeal_ENG_1000_hrs_%28PUBLIC%29-20170410-CV-20519.pdf

  https://reliefweb.int/sites/reliefweb.int/files/resources/SIRT%20Flash%20Appeal_16Sept_En.pdf

- Ask participants to look through the Flash Appeal documents and note on a post-it note which MISP Objective is mentioned in the Flash Appeal. The post-it should then be attached to the relevant part of the document.

- After approximately 25 minutes, facilitate a general discussion of where SRH was mentioned in the documents. Highlight any gaps or overlaps and the roles of different agencies.

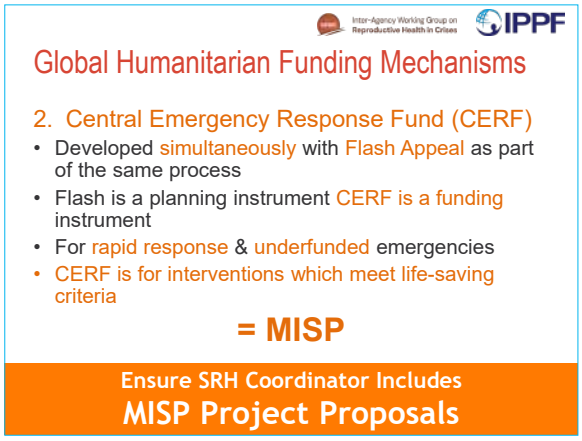
Materials

Flash Appeal documents

Post-it notes

Slide #26: Global humanitarian funding mechanisms

Key Messages



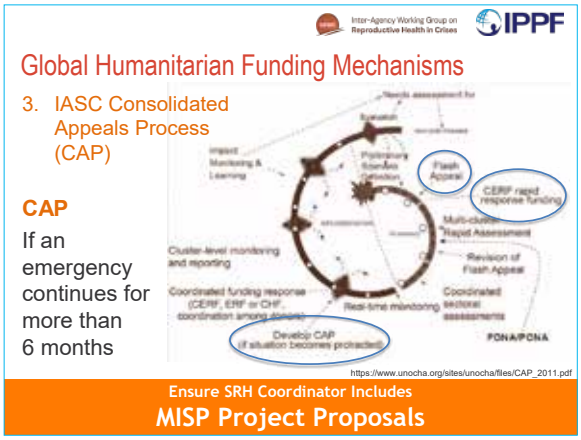
- CERF is a stand-by fund established by the UN to enable more timely, reliable and equitable humanitarian assistance to people in humanitarian settings.
- The Flash Appeal is the strategic plan and the CERF is the funding mechanism to support the plan.
- "CERF is intended to complement- not substitute for- flash appeals. The CERF acts as a donor and the Flash Appeal is the strategic plan and a list of projects that CERF (and other donors) should fund. Flash Appeals are necessary to form a framework of coordinated strategic response, and to obtain funding after and beyond the CERF (which cannot fully fund the humanitarian response in most situations). CERF can provide seed funds to jump-start critical operations planned in the appeal (The CERF may also allocate further funds in a second tranche if needed)" (https://www.humanitarianlibrary.org/sites/default/files/2014/02/Guidelines_for_Flash_appeals.pdf).
- CERF can be used for rapid response and underfunded emergencies.
- The MISP meets the life-saving criteria of CERF. It is crucial for the MISP to be included in CERF applications.

Note to facilitators If participants request more information on the Flash Appeal and CERF, direct them to:

- https://www.unocha.org/sites/dms/CAP/FAs_What_you_need_to_know.pdf
- https://www.humanitarianlibrary.org/sites/default/files/2014/02/Guidelines_for_Flash_appeals.pdf
- https://interagencystandingcommittee.org/system/files/guidelines_for_flash_appeals.pdf

Slide #27: Global humanitarian funding mechanisms

Key Messages

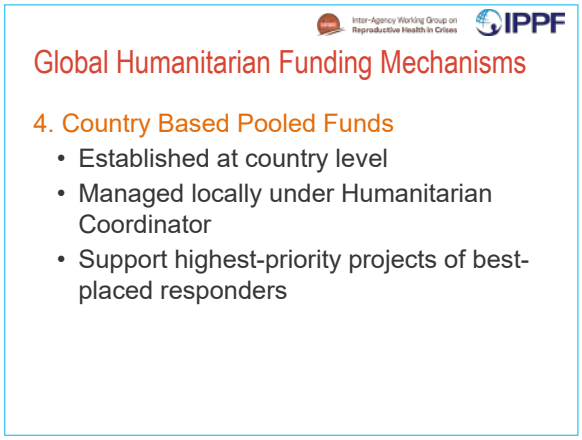


- The (Consolidated Appeals Process) CAP is the main tool for coordination and strategic planning in complex emergencies.
- The CAP is the strategic planning process, during which humanitarian partners develop a Common Humanitarian Action Plan (CHAP) to outline strategic priorities, to express the requirements needed to meet these priorities and to ensure a comprehensive, strategic response to the crisis by all partners. Attached to the CHAP are the funding requirements to implement the response, outlined for donors' consideration
- CAPs are usually annual and are used in cases of ongoing complex crises.
- Many NGOs participate in CAPs, either through clusters or through direct participation,
- As seen on the slide, "the Consolidated Appeals Process (CAP) is a program cycle for aid organisations to plan, coordinate, fund, implement, and monitor their response to disasters and emergencies, in consultation with governments" (https://interagencystandingcommittee.org/consolidated-appeals-process-cap).
- The Flash Appeal can later become a consolidated appeal. A CAP should be developed if the situation continues for more than 6 months.
- Again, it is vital to ensure that the SRH Coordinator includes proposals that address the MISP to comprehensive SRH services in the CAP.
- It may be possible to also consider other entry points for funding such as GBV funding or development funding.

Note to facilitators For more information on pooled appeals processes see and NGO engagement see: https://assets.publishing.service.gov.uk/media/57a08b0640f0b652dd000a50/funding-leaflet.pdf

Slide #28: Global humanitarian funding mechanisms

Key Messages

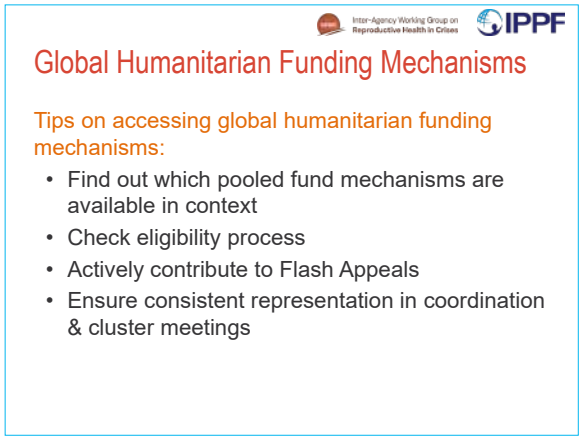


- Country Based Pooled funds provide another possible source of humanitarian funding. These are established at a country level for complex emergencies.
- Contributions are collected into single, unearmarked funds and managed locally under the leadership of the Humanitarian Coordinator.
- The funds support the highest-priority projects of the best-placed responders (including international and national NGOs and UN agencies) through an inclusive and transparent process that supports priorities set out in Humanitarian Response Plans (HRPs). This ensures that funding is available and prioritized locally by those closest to people in need.
- Country Based Pooled Funds are established when a new emergency occurs or when an existing crisis deteriorates. They are managed by OCHA under the leadership of the Humanitarian Coordinator and in close consultation with the humanitarian community.

Note to facilitators For more information on Country Based Pooled Funds, see OCHA humanitarian financing: https://reliefweb.int/sites/reliefweb.int/files/resources/CBPF%20Factsheet%20March%202017_EN.pdf

Slide #29: Global humanitarian funding mechanisms

Key Messages



- Tips on accessing global humanitarian funding mechanisms include:
  - Finding out what pooled fund mechanisms are available in each context (in consultation with OCHA);
  - Checking the eligibility process (done at the country office level);
  - Actively contributing to Flash Appeals; and
  - Ensuring consistent representation in coordination and cluster meetings.

Slide #30: National humanitarian funding mechanisms

Note to facilitators It is very important for your participants to understand national level funding mechanisms for humanitarian response and SRH in humanitarian settings. Please provide information here on the national/ sub-national funding context and the role your participants can have in engaging with these mechanisms.

Be sure to highlight any funding opportunities that can be accessed in collaboration with or through relevant organisations, agencies, institutions etc.

Also emphasise that working in the preparedness phase to ensure MISP is included in disaster response plans can allow access to potential funding for implementation. Provide examples of this for your context.

If applicable to your setting, also provide details on potential funding from the private sector.

After this presentation of national humanitarian funding mechanisms, ask participants to provide details on any other funding mechanisms or collaborations they have used or may be aware of.

Note these on a flipchart and encourage participants to take note of these.

Slide #31: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.

Day 4 continued

Supporting MISP Implementation: Logistics

Session 4.3 1 ½ hours

Overview

This session will develop program managers' knowledge and skills in logistics for the implementation of SRH programs in emergencies.

Methodology

- Interactive presentation
- Group work

Materials

- PowerPoint presentation
- Participant handout #19
- Group work supplies
- Flipchart & markers

Slide #32: Session 4.3: Logistics

This session will look at the logistics necessary to support MISP implementation.

Slide #33: Logistics

Key Messages

- This session is designed as an introduction to logistics necessary to support the MISP. We will look at products, essential program information and briefly at supply chain management.

Note to facilitators If participants are interested in a more in-depth understanding of logistics processes, refer them to:

- https://www.unfpa.org/procurement-and-supply-chain
- https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_Delivering_Supplies_When_Crisis_Strikes.pdf
- JSI: Lessons in Logistics Management for Health Commodities (through https://elearning.jsi.com/)

This session refers to the RH Kit Booklet, which was in the process of being revised at the time of writing this manual. Please check back on the IAWG website for the latest version when facilitating this session.

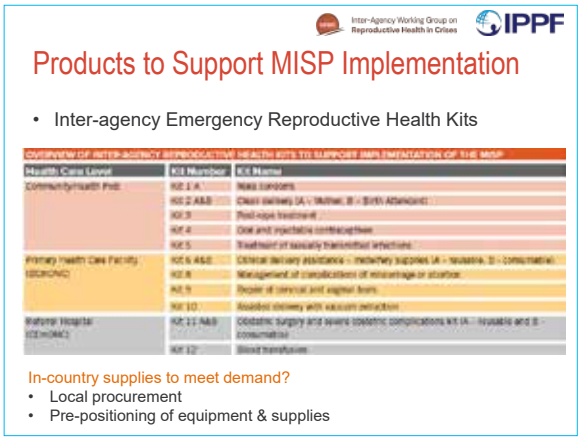
Slide #34: The 6 'RIGHTS' of logistics

Key Messages

- "A strong supply chain is a critical component of sexual and reproductive health (SRH) service delivery. When SRH supplies – from contraceptive methods, to antibiotics for sexually transmitted infections, to medicines that prevent maternal death and basic supplies for small and sick newborns – are not available, SRH services cannot be effective. In short, no product, no program" (IAFM 2018 p69).
- This slide shows the six principles, or 'rights' of logistics. These include the right goods in the right quantities, in the right condition, delivered to the right place at the right time, for the right cost.
- We will work through some of these principles in the following presentation.

Slide #35: Products to support MISP implementation

Key Messages



- The first 'right' involves products, goods or commodities.
- In emergencies, we need to assess/ consider what health facilities are functioning and how the supply chain has been disrupted
- Inter-agency Emergency Reproductive Health (IARH) Kits are one possible source of SRH goods for humanitarian response and are designed specifically to implement the MISP.
- As well as these kits, however, SRH agencies should determine whether it is possible to obtain SRH supplies locally to meet the SRH needs of affected populations. "When supplies are not already in-country, agencies will often procure IARH Kits from the Procurement Services Branch of the United Nations Population Fund (UNFPA). The IARH Kits can also be procured from regional warehouses where they have been pre-positioned" (IAFM 2018 p72)
- Not every context will require procurement of IARH Kits, or all of the available kits.

- Agencies and program managers should coordinate with government clusters and other agencies to ensure SRH supplies are part of the health cluster/ sector core commodity pipeline.

Note to facilitators This is a good opportunity to provide participants with information on any pre-positioning of supplies in-country or regionally.

If participants are interested in further information about IARH Kits, refer them to IAFM 2018 Chapter 3: The MISP

Ask participants to look again at their MISP for SRH Cheat Sheet to review the kits and their associated MISP for SRH objectives.

Note that IARH Kit guidance was in the process of being updated at the time of writing this manual. Facilitators should check online for these updates.

Slide #36: Products to support MISP implementation

Key Messages

- The Inter-agency Emergency Reproductive Health Kits are categorized by level of service delivery. They contain SRH supplies for the relevant number of people for each level, for three months, after which further needs should be calculated based on monthly consumption.

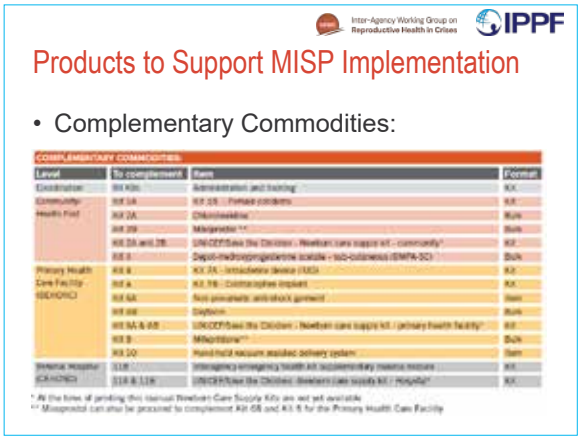
- Further supplies should be ordered through the usual supply systems of the ministry or organization implementing the services. Kits can be re-ordered, if needed, but this is not recommended.

- Program managers must also consider the level of training required by service providers to use commodities contained within the kits. If staff are not available at the level needed for kit use, or plans are not in place to engage these staff, the kits should not be ordered, as they can be wasted.

- Calculations for kits in the manual have been based on estimates of who will present using population calculations- not on how many survivors.

Slide #37: Products to support MISP implementation

Key Messages



- As well as the IARH Kits, there are a series of 'complementary commodities' kits (available late 2019).
- "Complementary commodities are disposable and consumable items that can be ordered under specific circumstances to complement the main kits:
  - Where providers or the population are trained to use the commodity
  - Where the supplies were accepted and used prior to the emergency
  - In protracted or post-emergency settings, (although effort must be directed to procuring from more stable procurement channels); and
  - Where the use of the supplies is allowed to the fullest extent of the national law" (IAFM 2018).
- Complementary Commodities in KITS are procured based on the same catchment populations as the standard kits. Complementary Commodities in BULK can be procured for a population of 10,000 or a multiple of 10,000 people.
- "Complementary Commodities with specific agency names can be ordered through the respective organizations including:
- Interagency Emergency Health Kit Supplementary Malaria Module – WHO
- UNICEF/Save the Children Newborn Care Supply Kits – UNICEF

Additionally, it is important to keep in mind that other pre-packaged emergency medical kits for various interventions (Non-Communicable Diseases (NCD), Cholera, Severe Acute Malnutrition (SAM), etc.) can be procured from other partner organizations or may have been brought in by health partners already" (IAFM 2018 p59).

Slide #38: Other supplies

Key Messages

- Other supplies to be distributed during the SRH response include hygiene or dignity kits.
- These are not part of the MISP as they are not immediately life-saving, but provide important basic supplies so that affected populations, particularly women and girls, can continue engaging with daily activities.

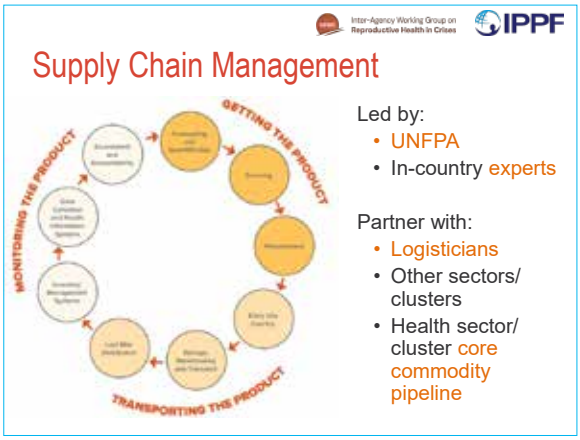
- UNFPA have devised a standard dignity kit (picture on slide) but generally it is best if these are adapted to local cultural needs including communities in the adaptation process.
- Hygiene supplies are important products for the population but should not be implemented in lieu of the life saving components of the MISP.
- The need for other supplies such as tents, beds, cabinets to deliver MISP services should also be considered.

Note to facilitators Ask participants what they believe would be appropriate in hygiene kits for women in their context. It is also important to consider that people living with disabilities, members of LGBTIQA community may need dignity kits and so should be included in the consultation process.

Slide #39: Supply chain management

Key Messages

- Supply chain management for SRH supplies in humanitarian contexts are generally led by UNFPA, national government and other experts.

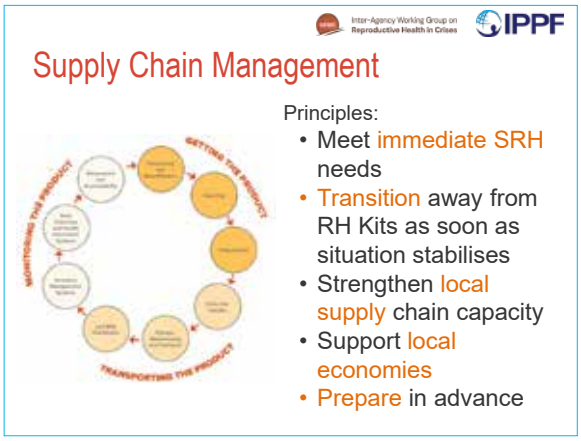


- "Establishing effective supply chains requires people to engage with each other across the entire supply management system, including the logistician, the procurement officer, the customs agent, the provider in the clinic, the facility's pharmacy manager, and the end user" (IAFM 2018 p76).

- As mentioned above, it is critical that SRH supplies are integrated into the health sector/ cluster core commodity pipeline.

Slide #40: Supply chain management

Key Messages



- "The principles underlying successful SRH supply chain management in emergency settings include:
  - Meet the immediate SRH needs of the affected population, including marginalized sub-groups, by distributing SRH supplies as soon as possible after the onset of the crisis
  - As soon as the situation stabilizes, transition away from reliance on Inter-agency Emergency Reproductive Health Kits and support a more sustainable, consumption-driven supply chain system at all levels
  - Strengthen local capacity to be able to maintain a robust, sustainable supply chain over time
  - Support local economies throughout the supply chain system, by sourcing locally as much as possible, when possible
  - Prepare in advance to be able to meet SRH supply needs as soon after the onset of an emergency as possible
  - Prevent stock outs while minimizing wastage
  - Ensure provision of quality assured products" (IAFM 2018 p71).

- Program managers should work to understand the legal requirements and customs requirements in the preparedness phase. At this stage, pre-arrangements and agreements can be established.

Slide #41: Supply chain management

Key Messages

- The first step in supply chain management is getting the product. This involves the following components:
  - Forecasting and quantification involve estimating the quantities and costs of products required to provide SRH services to a population in humanitarian settings. "It also encompasses determining when the products should be delivered to ensure an uninterrupted supply for the program. The term "quantification" is sometimes used interchangeably with "forecasting" " (IAFM 2018 p76). Quantification experts can be deployed in the preparedness phase to inform pre-positioning work. "In the acute phase of an emergency, the number of the affected population and catchment area will be the most critical information for quantification. Agencies planning to order the RH Kits can use the IAWG RH Kit Calculator to forecast need. Note that forecasting for the RH Kits should not be done solely based on the number of functioning health facilities; forecasting must include population numbers" (IAFM 2019 pages 76-77).
  - Sourcing is the process of determining the brand or manufacturer of each product. "Sourcing can vary significantly from the acute to recovery phases, but should always start with consideration to the potential for sourcing high-quality, local products" (IAFM 2018 p77).
  - Procurement involves purchasing the right product, including submitting and financing orders. "The most important step is obtaining all needed product detail and order specifications to procure exactly the right products. The relationships among the logisticians, procurement teams, and health teams are critical to the success of this process. The health team needs to provide precise information to the logistics team, specifically anyone managing procurement, to make the order accurately reflect factors such as the correct dosage and formulation of each medication, including different dosages and formulations needed for special populations like children and/ or adolescents. Before procuring products, make sure that all products requiring importation are registered for use in the country where you are programming (or that a waiver is in place), and that the agency is authorized to import them" (IAFM 2018 p78).

Slide #42: Supply chain management

Key Messages

- The second step in supply chain management is transporting the product. This involves the following components:
  - Entry into to country via customs and clearances. "It is important to plan and prepare for this phase by knowing the mode of transportation by which the supplier will send the product through to its arrival (air, ship, etc.), exactly when and where the arrival is scheduled, and having staff on the ground ready (and waiting) to receive the shipment. It is also important to be flexible as challenges often emerge, given that there are numerous policies and processes (from customs to laboratory inspections) that must be cleared as part of the product's entry into the country " (IAFM 2018 p79).
  - "Proper warehousing and transportation ensure that products reach their final destination and remain in good quality. Conduct a needs assessment (see IAFM 2018 Section 4.4.1) to learn what goods need to be stored in what conditions (including cold chain), what storage areas are used/available at ports of entry, warehousing options available at each leg of the journey including the last mile, and the best transport options" (IAFM 2018 pages 79-80).
  - This involves:
    - Identifying the dimensions of products and their warehousing needs;
    - Understanding if and how a cold chain can be established and possible gaps;
    - Reviewing options for contracting with local vendors for storage and transportation;
    - Being aware of context-specific issues such as the possibility that products may be confiscated during transportation and/or used for other purposes;
    - Identifying warehouses that can be used/borrowed for medical purposes and reaching out to partners;
    - Verifying that warehouses are temperate, dry and protected against pests and theft;
    - Exploring secure/safe transportation options and considering speed, cost and seasonal conditions;
    - Developing and implementing stocking/warehousing procedures;
    - Planning for outgoing distribution to health facilities; and

- Managing waste disposal.

Slide #43: Last-mile delivery

Key Messages

- Last mile delivery is an important component of the second step in the supply chain management process.

- "Last-mile delivery is a crucial but often overlooked aspect of supply chain management. It involves moving goods from regional hubs to often remote program sites, such as health facilities, refugee or internally displaced person (IDP) camps, and even into homes. Engaging health staff, communities, and affected populations can increase the reliability of last-mile delivery, particularly utilizing participatory monitoring and accountability approaches" (IAFM 2018 p81).

- "Agencies should develop storage and transportation plans all the way to the end-point, where the products will be distributed to clients. These plans should be shared with other agencies through the cluster mechanisms, including the Logistics Cluster. It is important to ensure that all goods can be stored properly once they reach their final destination (i.e., in health facilities). Consider both amount of space needed and cold chain requirements. It is also important to make sure health facility staff are aware of storage requirements, and impose stock keeping for all products. Investing in reliable store keepers will improve efficiency and reliability" (IAFM 2018 p81).

Note to facilitators For more information on last-mile delivery, see IAFM 2018 p81.

Slide #44: Supply chain management

Key Messages

- The third step in supply chain management is monitoring the product. This involves the following components:
  - "Establishing data collection tools to track products and stock levels in health facilities and warehouses is critical to an effective supply chain system. This data informs quantification and procurement processes to meet commodity needs, avoid stock-outs, and minimize wasted products. A variety of tracking systems and reporting tools exist, from basic spreadsheets to powerful LMIS software that optimizes quantification and planning. The tools used often differ from the acute to recovery phases of a crisis, becoming more robust and more coordinated with national systems as the situation stabilizes" (IAFM 2018 p82).
  - For tracking and tracing, a variety of staff will need to collect a range of data, input these into the system and send them to those responsible for forecasting and procurement. Program managers will need to train their "teams on the critical nature of each person's role, the data points and information needed, key indicators to monitor, how often they should gather the necessary data, at what stock levels in their clinics/programs they need to reorder, and when will they be in danger of stock-outs, as well as monitor losses" (IAFM 2018 p83).
  - "To continuously improve supply chains and ensure accountability to clients, conduct periodic analyses of the data collected through these processes. Conducting an audit of physical inventories to compare actual holdings to stock reports and records is essential for accountability. Ideally, community representatives and health center staff would conduct monthly (full or partial) physical inventories to verify/correct stock records accordingly. In addition, a monthly review of data on loss and waste can suggest where bottlenecks, seasonality barriers, or other challenges are occurring" (IAFM 2018 pages 83-84). A feedback mechanism, such as client exit interviewing, should also be established so that beneficiaries, staff, partner agencies and others can provide feedback to the service.

Note to facilitators Refer participants to Chapter 4 of the IAFM 2018 for more information on logistics, including steps in supply chain management.

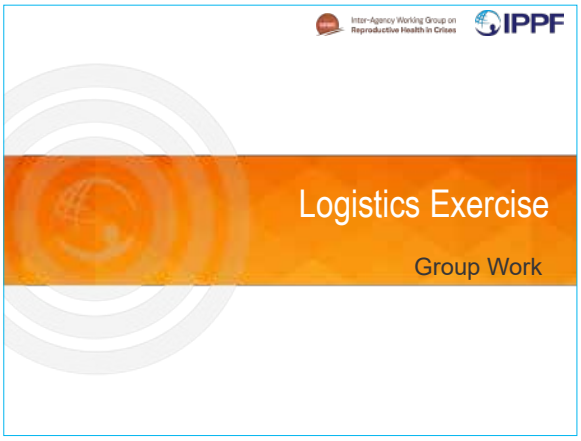
Slide #45: Supply chain management

Key Messages

- This slide shows some examples of warehousing and in-country transportation and distribution to indicate the size of some products/ kits and their warehousing requirements.

Slide #46: Logistics exercise: Group work

Logistics Exercise: Group Work



There are two exercises in this Group Work. Depending on available time and group size, facilitators can select one part or split the group into two, and do the activities simultaneously.

Part 1:

The first part of the logistics exercise will allow participants to strategise on overcoming challenges in supply chain management in humanitarian settings. It relies on the experience of participants and their previous involvement in providing services in humanitarian contexts. The experience level of participants should be considered when deciding whether to conduct this part of the logistics exercise.

Time

30 minutes

Process

- Divide the group into 3 (or multiples of 3, depending on the size of the group). Assign each group one of the three major steps in supply chain management, reminding them that for every major step in the supply chain, there are three sub-steps:
  - Group 1: Getting the product: forecasting; sourcing; and procurement;

  - Group 2: Transporting the product: entry into country; storage, warehousing and transport; and last mile distribution;
  - Group 3: Monitoring the product: inventory management systems; data collection and health information systems; and assessment and accountability.

- Ask the groups to use their experience/ strategise based on their knowledge, to explain how they may overcome challenges for each sub-step during the preparedness, acute response, and transition to comprehensive SRH phases.
- Ask participants to write their responses on flipcharts.
- At the close of 20 minutes, ask participants to present their results and elicit questions and comments from the group.

Materials

Flip charts and markers for each group.

Part 2:

The second part of the logistics exercise is a way for participants to apply the key principles of logistics discussed during this session.

Time

60 minutes

Process

- Divide participants into groups of five to eight people.
- Distribute copies of Participant Handout #19 and ask participants to refer once again to the case study introduced on day 1 of the training (Participant Handout #1).
- Explain the exercise (instructions are on the handout), stressing that each group needs to present their work on flip charts at the end of the exercise.
- Let the groups start the exercise on their own.
- Facilitate the group work and by gentle probing and constructive feedback, ensure that the groups keep to the allocated time as to address all the questions required.
- After 40 minutes of group work, take 20 minutes for presentation. Each group will take turn to present their work and receive your feedback (in total, five to 10 minutes per group depending on the number of groups).

Materials

Participant Handout #19

Flip charts and markers for each group

Case study introduced on Day 1 of the training (Participant Handout #1).

The following answers will help you to facilitate and provide guidance during and after Part 2 of the logistics exercise.

1. **Which assessments need to be made?**
   None, except an estimate of the number of affected population and an assessment of the location of health care facilities and staff.

2. **Which priority RH interventions will you put in place immediately?**
   The components of the MISP

3. **Which Kits will you order and how many?**
   The handout 'RH Indicators for___' is aimed to confuse participants.
   Clue: there is no need for calculating Kits based on these DHS indicators, but they can be used to compare the affected population with the "standard" population assumptions used to calculate the supplies in the Kits. They also give an indication of what not to order (low use of IUDs, and no exposure to female condoms).
   The RH Kits are already pre-calculated based on population assumptions. These assumptions can be found on the last page of the Inter-Agency RH Kits Manual.

4. **How much will this cost?**
   Use the UNFPA revised price list to make the calculations.

5. **Calculate your storage requirement (in cubic meter)**
   Note: One extra cubic meter is needed for staff to move around the Kits. Kits should not be stacked more than two meters high.

Inform participants that the following resources for calculating RH kit needs are also available:

1. MISP Calculator: A spreadsheet which calculates the reproductive health statistics necessary for the implementation of the MISP (Minimum Initial Service Package).

2. RH Kits Calculator: A spreadsheet which calculates dimensions of the reproductive health kits required according to site-specific data.

Both of these resources are available at: http://www.iawg.net/resources/calculator.html

For more information on the RH kits and to keep up to date with changes to guidance and kit contents, the coordination team should consult: http://www.iawg.net/resources/rhkits.html

Slide #47: Essential program information for logistics

Key Messages

- Supply chain infrastructure will often be severely damaged or completely incapacitated after an emergency. As a minimum, it is important to have an idea of the number and scope of functioning health facilities and the size of the population catchment area.

- "In the initial stages of an acute emergency response it may not be appropriate to utilize the time, resources, and staffing to conduct a full coordinated logistics needs assessment. Instead, information collected pre-crisis such as any relevant secondary data, analysis of existing supply chains, historical data, and supplies that currently exist in country, as well as continuous collaboration with technical staff, can provide critical information for initial supply chain planning and implementation. Pre-crisis data and rapid situation overviews can help in fine-tuning supply orders. Use this information in combination with existing tools, such as the Inter-agency Emergency Reproductive Health Kits (IARH Kits) Calculator developed by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, to guide initial SRH logistics and supply activities" (IAFM 2018 p71).

- "Remember, just as the MISP does not need an assessment to begin implementation the same is true for the supply chains that support initial MISP implementation" (IAFM 2018 p71).

- "Pre-existing relationships and agreements, transportation plans, and other pre-crisis systems are also essential to planning and implementing supply chains in crises. The plans you make in your preparedness and planning activities are crucial to the success of any emergency response programming" (IAFM 2018 p71).

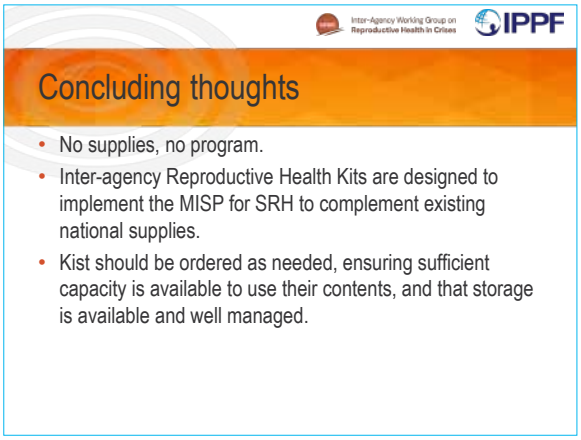
- Once possible and appropriate, multi-sector rapid/initial needs assessments will typically be performed by technical staff. This will be discussed in the next session.

Note to facilitators Ask participants what of this list of essential program information for logistics could be gathered in the preparedness phase? Lead a brief discussion highlighting what can be done before an emergency hits.

Slide #48: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



IPPF/Kathleen Prior

Day 4 continued

Supporting MISP Implementation: Assessment, Monitoring & Evaluation

Session 4.4 1 hour

Overview

This session will develop program managers' knowledge and skills in assessment, monitoring & evaluation for the implementation of SRH programs in emergencies.

Methodology

Interactive presentation

Materials

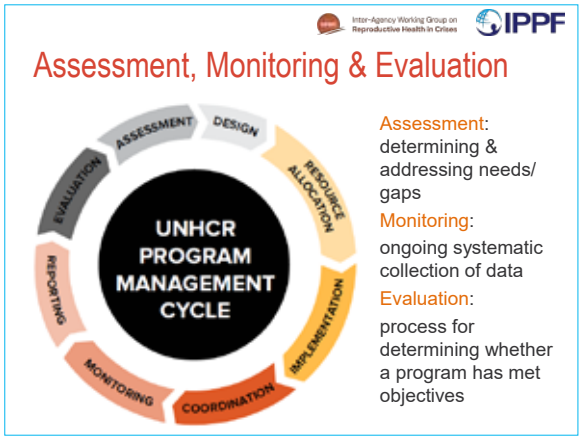
PowerPoint presentation

Slide #49: Session 4.4: Assessment, Monitoring & Evaluation

This session will look at assessment, monitoring and evaluation of the MISP across the program cycle.

Slide #50: Assessment, monitoring & evaluation

Key Messages

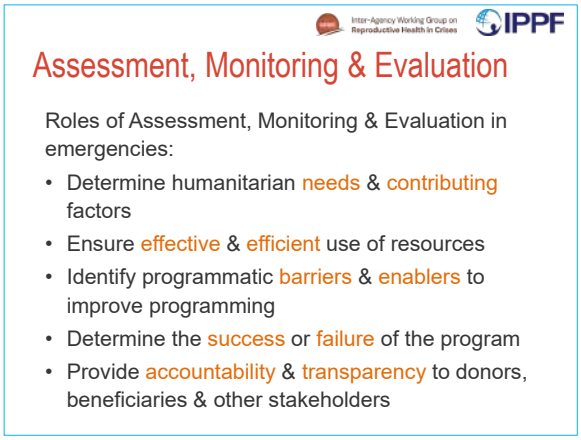


- Key terms for this process can be defined as follows (from IAFM 2018 p93):
  - Assessment: is a process for determining and addressing needs or 'gaps' between current conditions and desired conditions and contributors to those gaps.
  - Monitoring: is the on-going, systematic collection and analysis of data as a project progresses. It is aimed at measuring progress towards the achievement of program milestones and objectives.
  - Evaluation: Is a process for determining whether a program has met expected objectives and/ or the extent to which changes in outcomes can be attributed to the program.
- The UNHCR program management cycle shown on this slide is a useful way of visualizing these processes. It shows a feedback loop and the important role data can play throughout a humanitarian response in informing, monitoring, and evaluating SRH programming.

Slide #51: Assessment, monitoring & evaluation

Key Messages

- Sexual and reproductive health services must be responsive to the needs of the population, and to ensure that this is the case, it is important to assess, monitor and evaluate the program. Program managers have a key role to play in this work.



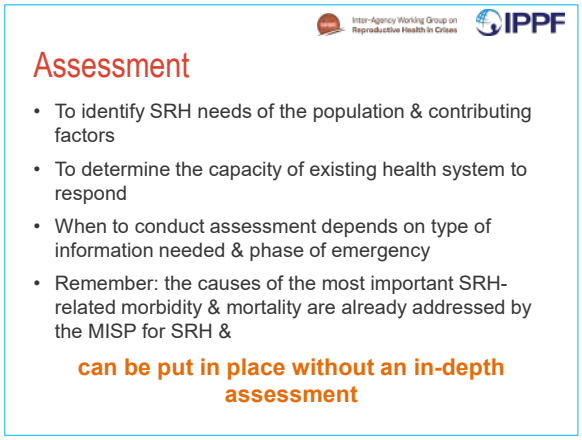
- The roles of assessment, monitoring and evaluation listed on the slide show the importance of integrating these approaches throughout programming activities. These roles include to:
  - Determine humanitarian needs & contributing factors
  - Ensure effective & efficient use of resources
  - Identify programmatic barriers & enablers to improve programming
  - Determine the success or failure of the program
  - Provide accountability & transparency to donors, beneficiaries & other stakeholders

Note to facilitators Ask participants to briefly discuss what SRH information may exist/ could be collected before a disaster which could help at the onset of a response

Probe: Examples include demographic and health survey data; routine surveillance or health facility data; SDG reports, national strategic plans and/or UN Development Assistance Framework/Humanitarian response plans, Gender Analysis and SRH reports.

Slide #52: Assessment

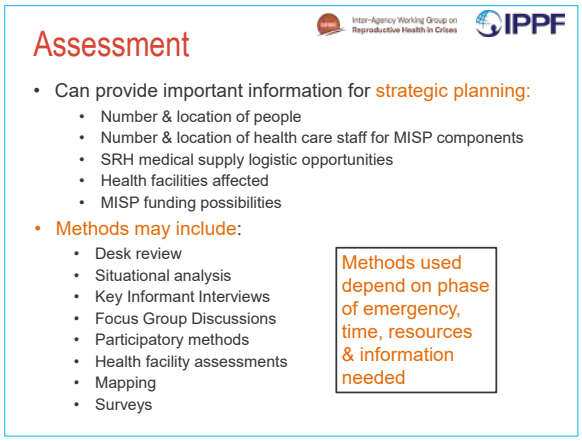
Key Messages



- The purpose of assessment is to identify the SRH needs of the population and contributing factors and to determine the capacity of the existing health system to respond to those needs. Assessments can be undertaken throughout the life of a program to evaluate its progress towards achieving objectives (IAFM 2018 p94).
- When to conduct an assessment depends on the type of information needed and the phase of the emergency.
- An assessment team will generally include people with clinical, research, management, and public health skills. Gender, age, ethnicity, and social status should also be considered. "For example, in some cultures, it may be inappropriate for a man to ask a married woman questions about her reproductive history. In general, it is good practice to include members of the affected population in the assessment teams, unless participants will be less comfortable disclosing sensitive information to data collectors of the same demographics" (IAFM 2018 p94).
- At the beginning stages of a crisis, many people may want to assess the community which can cause disruption. Consider where possible working with other SRH actors to collect the information needed and avoid duplication.

Slide #53: Assessment

Key Messages



- Some types of assessments, such as situational analyses and rapid assessments are often conducted during the acute phase of a humanitarian crisis when time and resources may be limited. Desk assessments may be used in the acute phase to avoid duplication of effort and can also be used throughout the emergency. Other methods that require more resources, such as surveys or some participatory methods, may be more appropriate in later phases of an emergency (IAFM 2018 p94) when planning for more comprehensive programming.

- A MISP calculator is available to help in the calculation of reproductive health statistics necessary for the implementation of the MISP for SRH. It enables you to input site specific data.

Note to facilitators If time permits, ask participants to access and try using the MISP calculator through http://iawg.net/resource/misp-rh-kit-calculators/

Explain that it can be used, not just for supplies, but also with program design.

Key terms to explain methods of assessment are included below:

- Rapid assessments: "At the onset of the humanitarian response, humanitarian partners carry out an initial rapid assessment. While the causes of the most important SRH-related morbidity and mortality are already addressed by the MISP and do not need to be assessed at the onset of the humanitarian response, there is nonetheless important information to be gathered with a rapid assessment to ensure appropriate strategic planning" (IAFM 2018 p94). This information must include: "the number and location of people needing access to minimum SRH services; the number and location of health-care staff providing, or capable of providing, the service components of the MISP; SRH medical supply logistic opportunities; and MISP funding opportunities" (IAFM 2018 p94).

- Desk review: a review of secondary data sources on existing SRH information for the affected population should be conducted. This information could include demographic and health survey data; routine surveillance or health facility data; availability of SRH services, their location and functionality; and national strategic plans and/or UN Development Assistance Framework. These data will be available from government organisations, UN agencies and NGOs (IAFM 2018 p95).

- Situational analysis: "should be conducted to understand the legal, political, cultural, and socio-economic context of the locale and how this might impact the SRH needs and availability of services for affected populations" (IAFM 2018 p95). This should also include an understanding of how different subpopulations might be differently affected.

- Key informant interviews: may be used to generate qualitative data from a range of individuals. They can be used to collect views of "pre-existing conditions and SRH practices, the current situation, changes in practice since the onset of the emergency, adequacy of current SRH services, and priority SRH needs of the population" (IAFM 2018 p95).

- Focus group discussions: "are particularly useful in generating information representative of a specific sub-group in the population, such as women of reproductive age or adolescent males" (IAFM 2018 p95).

- Participatory methods: aim to "make the assessment process as inclusive as possible of the target communities. Community organisations led by members of the affected population and informal groups of different subpopulations within the affected population should be engaged and involved throughout the process" (IAFM 2018 p95). Community members may be involved in all stages of the assessment process, including design, data collection, analysis and dissemination.

- Health facility assessments: are inventories "of the places where health care is provided and the types and quality of services provided at these sites" (IAFM 2018 p95).
- Mapping: "can often be done in conjunction with the health sector/ cluster to include health facility assessments. Mapping of relevant stakeholders and service providers includes both those currently providing SARH services to affected populations and those who potentially could..." (IAFM 2018 p95).
- Surveys: "can be useful for gathering population-based information from a sample that can be representative of the larger population of interest" (IAFM 2018 p96).

Slide #54: Assessment

This slide has been left blank so that you provide information about context specific assessment and monitoring tools. An example may be integrated national assessment tools used during emergency response. If no context-specific examples are available, you can provide participants with a link to the following site: https://www.humanitarianresponse.info/en/programme-cycle/space/page/assessments-tools-guidance which shows some general rapid assessment tools for humanitarian settings.

Slide #55: Assessment

Key Messages

It is not just about collection of data but also analysis:

- Data should be analysed as soon as possible after collection.
- Results of an assessment must be as specific as possible so that timely decisions on interventions can be made.
- Assessment reports should be shared with all organisations involved in the humanitarian response, "including the Ministry of Health (MOH), through the health sector/ cluster coordination mechanism, as well as with logistics teams and procurement officers" (IAFM 2018 p98).

- Findings and decisions should also be communicated to the community in a way that ensures the confidentiality of participants.

Slide #56: Monitoring MISP implementation

Key Messages

- "Regularly collecting, reporting, and analyzing SRH data is essential for monitoring the performance and quality of health service delivery/ SRH program and for identifying changes in the health status of the affected population" (IAFM 2018 p98)

- "At the onset of a humanitarian response, a simple information system that collects minimal SRH data is required to monitor implementation of the MISP. As the response evolves and more comprehensive SRH service components are introduced, the monitoring requirements of SRH programs must adapt accordingly" (IAFM 2018 p98).

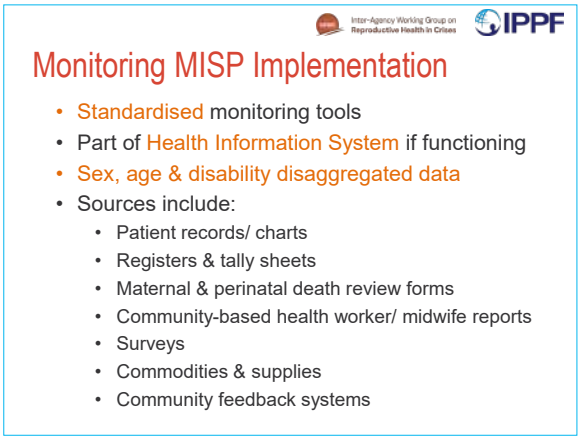
- The timing of monitoring (whether it is conducted daily, weekly, or monthly) will depend on the phase of the humanitarian crisis and the needs of each organization. "At least monthly data should be made available to inform regular programming decisions, through more frequent data reports may be necessary depending on the stage (e.g., acute) and type of emergency (e.g. outbreak)" (IAFM 2018 p98).

- SRH service providers are responsible for the routine collection and reporting of data. Community based health staff should also be involved in collecting community-level data. All staff collecting data should receive training on the correct use and application of data collection tools to ensure that data is comparable across programs.

- The clinical supervisor must then aggregate reports and send these to the SRH or health program manager for computer entry and analysis. The clinical supervisor should also conduct checks to ensure the quality and consistency of data collection.

Slide #57: Monitoring MISP implementation

Key Messages

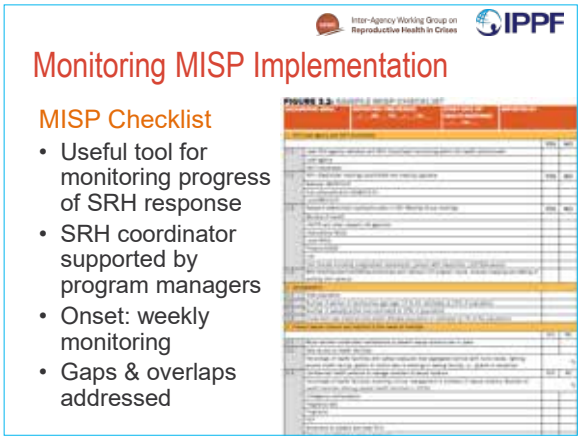


- All health partners should use the same monitoring tools to ensure that data are standardized, of good quality and comparable across programs and locations.
- If functioning, health data can be collected as part of the national Health Information System. Where such a system does not exist or has been interrupted by the emergency, "the health sector/cluster will implement an emergency monitoring system in order to support program management and coordination." (IAFM 2018 p99).
- Sex, age and data on disabilities should always be collected from health facility and community-based sources to enable disaggregated analysis. Sex, age and disability disaggregated data is vital for monitoring as it allows more specific, and therefore more effective programming.
- Sources of routine data can include (from IAFM 2018 p99):
  - Individual patient records and charts;
  - Daily registers and tally sheets;
  - Maternal and perinatal death review forms;
  - Community-based health workers/ midwife reports;
  - Weekly and/or monthly reporting forms;
  - Repeated surveys;
  - Commodities/ supplies.
  - Community feedback systems

Note to facilitators For more information on the importance of sex, age and disability disaggregated data, refer participants to:
https://360degreesaccess.org/saddd-the-devil-is-in-the-detail-or-are-they/
http://asiapacific.unwomen.org/en/focus-areas/humanitarian-action-and-disaster-risk-reduction/mainstreaming-gender-into-data-analysis-and-advocacy

Slide #58: Monitoring MISP implementation

Key Messages



- The MISP checklist provides a useful tool for monitoring the progress of the SRH response in humanitarian settings.
- The SRH Coordinator, supported by program managers, should implement the MISP checklist. "In some cases, this may be done by verbal reporting from SRH managers and/or through observation visits" (IAFM 2018 p61).
- At the onset of the emergency, weekly monitoring should be implemented, and once services are established, an agreed upon, routine monitoring and evaluation should be put in place. This is to understand progress towards quality MISP and more comprehensive services are available as possible.
- Program managers should also ensure that any gaps and/or overlaps in service delivery are discussed in SRH and other coordination meetings and strategies developed to overcome these.
- Where they are in existence or still functioning after an emergency, data should be coordinated and/or shared with existing health information management systems.

Note to facilitators Remind participants that they have been consulting the MISP checklist throughout the training. Ask them to look once again at their copy of the MISP checklist and briefly review the indicators included under each MISP for SRH objective. Inform participants that more details on SRH indicators and tools for monitoring are available in the individual IAFM chapters 2018.

Slide #59: Monitoring MISP implementation

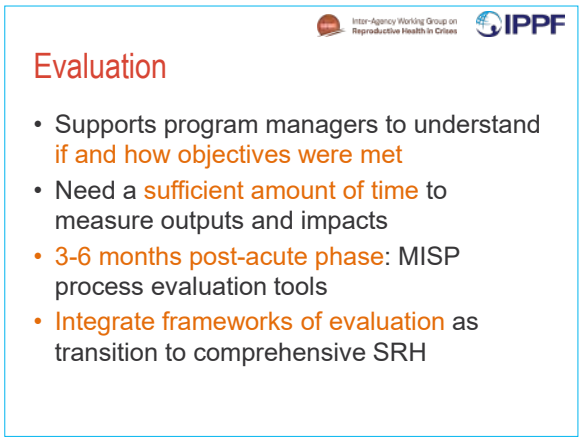
Key Messages

- "Monitoring results enable program managers to analyse trends of specific indicators over time to determine whether the program is adequately serving the affected population. When indicators fall short of their targets, program managers need to use this information to make course corrections so as to achieve the intended objectives" (IAFM 2018 p100).

- Effective use of data requires the correct choice of indicators to ensure that higher level managers do not experience information overload.
- The effective "use of data also requires regular feedback to lower-level managers and SRH staff." (IAFM 2018 p100). Analysis and results should be discussed with field staff and volunteers to ensure effective solutions.

Slide #60: Evaluation

Key Messages

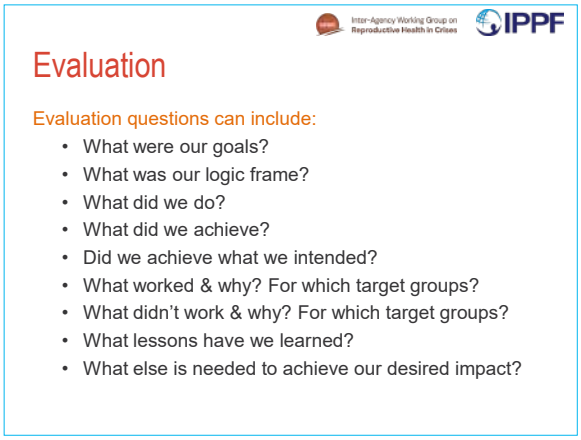


- Evaluation supports program managers to understand if and how programs met defined objectives. "It compares program activities and services (outputs) with benefits (outcomes) and public health impact (goals)" (IAFM 2018 p100).
- Evaluations need a sufficient amount of time so that they can measure program outputs and impacts. "Therefore, evaluations are not appropriate in acute situations where assessments and monitoring can provide feedback on emergency actions. However, three to six months post-acute phase, a comprehensive package of MISP process evaluation tools are available" (IAFM 2018 p101).
- It is vital to build in frameworks for evaluation as more complex and comprehensive SRH programming is planned.
- Ideally, external evaluators should be engaged as they are most likely to generate objective and unbiased evaluations.

Note to facilitators The MISP for SRH process evaluation tools are available at: http://iawg.net/resource/misp-process-evaluation-tools-2017/

Slide #61: Evaluation

Key Messages

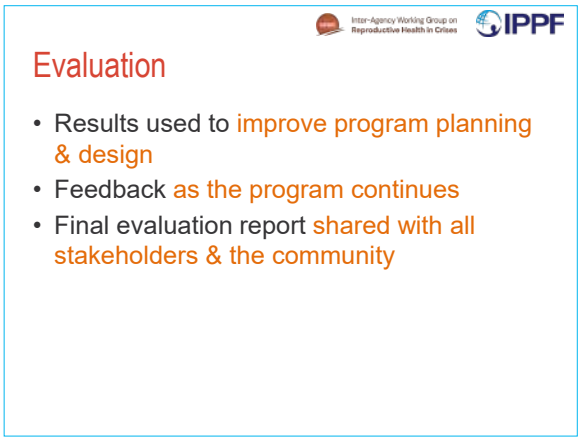


- Questions to be asked during an evaluation often include (from IAFM 2018 p101):
  - What were our goals?
  - What was our logic frame?
  - What did we do?
  - What did we achieve?
  - Did we achieve what we intended?
  - What worked and why? What target group(s) did it work best for and why?
  - What didn't work and why? What target group(s) did it work least for and why?
  - What lessons have we learned?
  - What else is needed to achieve our desired impact?

Some organisations may do after action reviews to reflect on how they can improve their preparedness work moving forward.

Slide #62: Evaluation

Key Messages



- Evaluation results are used to improve program planning and design. They should, therefore, reflect both what is working well and what is not.
- Feedback should be provided to service providers and program managers "as the program continues and not just at the end to ensure that issues identified in the evaluation are dealt with promptly before they become problems or risks" (IAFM 2018 p101).
- The final evaluation report should be shared with all stakeholders, including the Ministry of Health, health cluster, involved organisations, and the community. It can be useful for advocacy, learning and resource mobilization purposes.

Slide #63: Participatory methods

Key Messages

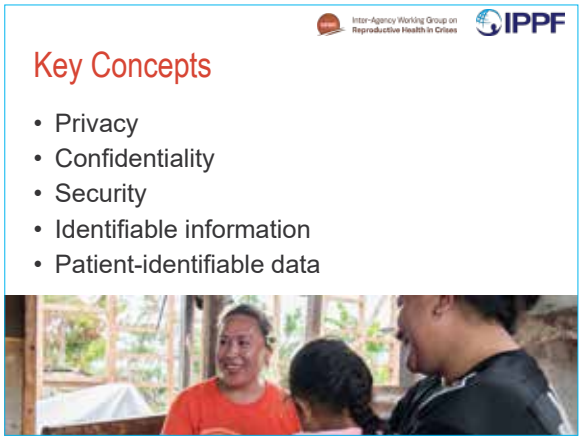
- Remind participants that it is important that the assessment, monitoring and evaluation process is inclusive. This may not always be feasible during the acute phase of an emergency but should be considered as soon as possible and when building towards comprehensive SRH services.

Note to facilitators If your participants would like more information about participatory methods of data collection, direct them to https://www.researchgate.net/publication/292963306_good-enough-guide-book-en and IAFM 2018 pages 102-103 for ethical considerations of data collection.

Slide #64: Key concepts

Key Messages

- "Privacy risks in data collection relate to identifiability or participants and the potential harms they, or groups to which they belong, may experience from the collection, use and disclosure of personal information- particularly sensitive SRH information" (IAFM 2018 p102).



- To safeguard against this, a number of key concepts should inform and guide the assessment, monitoring and evaluation process at all times. These include (from the IAFM 2018 pages 101 to 103).
  - Privacy: an individual's right to be free from intrusion or interference by others.
  - Confidentiality: the obligation of an individual or organization to safeguard entrusted information.
  - Security: measures used to protect information. Security includes physical, administrative and technical safeguards.

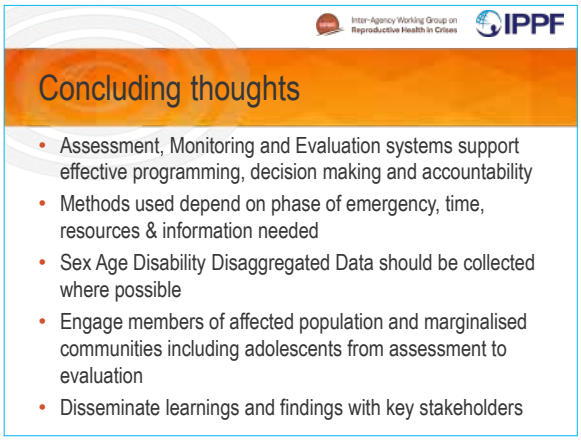
- Identifiable information: where researchers seek to collect, use, share and access different types of information or data about participants, they are expected to determine whether the information or data proposed in research may reasonably be expected to identify an individual.

- Patient-identifiable data: refer to any personal data that can be used directly or indirectly to identify an individual.

Slide #65: Concluding thoughts

Before showing the list of concluding thoughts, ask participants about the **key messages** they will take from this session.

Reveal the list and allow participants to read through and ask any questions.



Day 4 continued

Next Steps

Session 4.5 2-3 hours

Overview

This session will allow participants to practically apply their newly developed knowledge and skills to planning for next steps in preparedness and for response.

Methodology

- Group work
- Post-test

Materials

- Participant handout #20
- Group work supplies
- Post-test

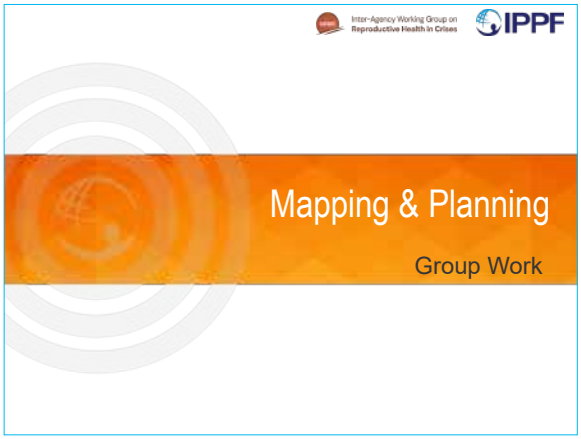
Slide #66: Next Steps

This session will look at next steps and evaluate participants' learning during the training.

Slide #67: Mapping and planning: Group work

Mapping and Planning

This activity will allow participants to consolidate their learning from the previous 4 days and discuss concrete steps to take their work as program managers for sexual and reproductive health in emergencies forward.



Time

1 hour to 90 minutes

Process

- Provide participants with Participant Handout #20 and briefly go through the contents of the template. Ask participants if they have any questions.
- Depending on the audience, you may want to break participants into small groups.
- Give participants a good amount of time to work together to complete the mapping and discuss which actions they would like to prioritise.
- Explain to the group that the mapping is an opportunity to identify what exists in their current system to help prepare for MISP implementation and identify what gaps remain. Emphasise that without preparedness MISP implementation at the time of response can be very difficult.
- Participants should be encouraged to think about how they can work together to follow up on the gaps identified.
- Let participants know they will have a chance to share some key actions and priorities at the end of the activity.

- For ideas on preparedness activities refer participants to the list of suggested activities at end of template
- Circulate around the room to ensure that the mapping and planning is progressing, to answer any further questions, and to encourage participants to think about practical, concrete steps they can take.

Note to facilitators If participants are interested in doing more in depth mapping of their MISP capacity to identify preparedness activities, refer them to the MISP Readiness Assessment tools (currently being updated) which can be found on the IAWG website.

Materials

Participant Handout #20 (electronically)

Slide #68: Post-test

Before final presentations, administer the post-test. This is the same test provided on the first day of the training. Allow participants 20 minutes to answer the questions. Collect answer sheets and then work through the questions and field any additional questions or comments.

Slide #69: Final presentations

This is an opportunity for participants to present and discuss their mapping and planning work. This is an important follow up to the group work activity so ensure that adequate time is left to allow for presentations and questions/ discussion.

Day 4 & Training Close

This is an opportunity to celebrate the achievements of your participants. Plan for a closing ceremony and/or presentation of certificates in line with cultural preferences.

Annex 1: Facilitation & Training Skills

For your session to be successful:

- Be prepared, and have extensively reviewed all of the training materials, notes, exercises and links before the training starts
- Know what the learning outcomes are that you want the learners to achieve for every exercise, session and period of learning.
- Constantly focus on the learners, and adapt the pace to the needs of the group, whilst recognising that time keeping is critical. Training should always start and finish on time.
- Remember that your role is to facilitate discussion and learning. You are not expected to be the font of all knowledge. Participants also have a wealth of knowledge and experience to share and it is important that they also accept responsibility for their own learning. Ensuring that you have a team of facilitators with different backgrounds, skills and experience will also bring different perspectives and knowledge to the training.
- Enable the learners to generate self-motivation for the learning and provide clear input explaining the subject being covered and how to apply it.
- Reflect on your own performance, tracking the responses from the learners and then assessing these responses in order to generate improvements to future sessions. Collect informal feedback from participants at the end of the day to assess how future sessions can be adapted or improved.

Adult Learning Principles

There are six generally understood characteristics of adult learning[3] which are important for trainers to understand. Adult learners are:

1. Autonomous and self-directed
2. Experienced and knowledgeable which they want to draw on
3. Goal orientated
4. Relevance orientated
5. Practical
6. Need to be shown respect

3 Identified by Malcolm Knowles, a pioneer in the field of adult learning, in 1970

Common concerns for New Trainers

Public Speaking

Tips:

- Everyone gets nervous about public speaking, the only difference is that some people are more experienced, or can hide their nervousness more. But it is very normal to be nervous!
- Be prepared: make sure you have read through the materials and facilitator notes a few times and are very familiar with the content; this will help reduce nervousness.
- Take a deep breath before starting. Normally, the first few minutes are the most difficult and then it becomes easier.
- Enjoy! If participants can see that you are passionate and engaged in the course, they will be too.

Having participant ask difficult questions that you don't know the answer to

Tips:

- Sincerity shows. If you don't know the answer, admit it and work together with the participants to decide where, collectively, you might find the answer to this.
- Remember: being a facilitator does not make you the font of all knowledge.

Controlling the room

Tips:

- Occasionally there will be a participant that is deliberately disruptive and undermining. If this happens, always remain calm. Try to adopt an open listening style and try not to get too defensive. If questions and interruptions are hostile, deflect them back to the group to answer which will often help calm the situation.
- Sometimes people read emails, don't engage, are late back from lunch or breaks etc. It is important to remember that this is adult learning, and adults generally do not respond well to being treated like children. Assertive is always better than aggressive. Try to keep calm, and explain to participants that not engaging or being late is detrimental to the whole group. Ask the group to come up with ideas for how this behaviour should be addresses.

Remember: the more times you facilitate training or orientation, the better it will get. After each training, reflect on what went well and what could have gone better, and document this to ensure continual learning and improvement. Share your reflections with others. Consider engaging with the IAWG Community of Practice (CoP) for this. Advocate internally for a facilitator CoP forum to share experiences.

Annex 2: Using this manual to conduct a Training of Trainers

The purpose of this training package is to increase the knowledge and skills for the MISP for SRH among key individuals and agencies with responsibility for collaboratively planning and managing SRH programs during crisis situations. If it is decided that there is a gap in training capacity on MISP for SRH (for program managers) in your setting, it is possible to use this manual to conduct a training of trainers (ToT) course.

When deciding to conduct a ToT, the objectives of training others to train using the curriculum contained in this manual must be very clear.

- Will ToT participants then be engaged to roll-out trainings in their own contexts (nationally, sub-nationally, or more locally)?
- Who will the participants at their trainings be?
- Are there more appropriate trainings for these potential participants (such as program manager or clinical skills trainings)?

If it becomes clear that a ToT is needed, the following section will provide guidance on preparing, conducting and following up after a SPRINT ToT.

Goal and objectives of conducting a ToT

The goal of the ToT is to provide new trainers with the knowledge, skills and experience necessary to conduct a Training for program managers on the Minimum Initial Service Package for Sexual and Reproductive Health using this manual.

On completion of the ToT, participants should demonstrate:

- Working knowledge of the contents of this manual and accompanying resources;
- Effective instructional methods, based on adult learning principles, to deliver the contents of the training;
- Willingness and ability to fulfil all responsibilities of a SPRINT trainer (pre-, during, and post-training).

ToT Participant selection

ToT participants should already have some experience in training and/or adult education, as well as knowledge and experience of SRH and/or humanitarian response to build on. Potential trainees will need to demonstrate their availability for involvement in future training events. It may be necessary for ToT facilitators to confirm this with supervisors or advocate for availability before the ToT begins.

Using this manual to conduct a ToT

This facilitator's manual contains materials and resources necessary for conducting the Training for program managers on the Minimum Initial Service Package for Sexual and Reproductive Health. If you plan to conduct a ToT you need to factor additional time in the agenda. Consider at least half a day to full additional day for this so the content is not rushed.

Resources needed to adapt this manual for use in a ToT include:

- Resources on adult learning and facilitation (source externally);
- Trainer competency checklists (for use by ToT facilitators- source externally).

For training skills to be assessed, participants will need to demonstrate their capacity by facilitating a segment of the training course. To this end, ToT facilitators will need to provide ToT participants with training resources well ahead of the scheduled workshop and assign sections to facilitate or co-facilitate.

During the ToT it is important for ToT facilitators to be open, approachable and provide support and guidance to ToT participants during their presentation sessions. Facilitators should complete a trainer competency checklist for all participants and provide constructive feedback in one-on-one interviews at the close of the training day. It is also important to engage participants in planning for future trainings at this time.

After the ToT, it is important that ToT facilitators work closely with ToT participants to plan future training courses.

It may be necessary for ToT facilitators to continue their mentoring role, and this may extend to co-facilitating trainings with ToT participants until their confidence and competence increases.

IPPF/Jon Spaull

Our sincere appreciation extends to the Australian Government for their commitment in safeguarding the rights and dignity of persons living in crises, particularly of women and girls.