Participant Handout #1 Instructions

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.

Participant Handout #1

Case Study 1: Natural Disaster in Gammalpha (based on UNFPA training scenario)

Situation Report

Two days ago, a category 5 cyclone, the worst storm ever recorded in the region, hit the island nation of Gammalpha. The storm was followed by a huge flood surge, which increased damage to coastal villages, roads and infrastructure.

The island nation Gammalpha, in the southwest Pacific Ocean, is spread over approximately 15,000 sq km. The cyclone-affected area is roughly 3,000 sq km on 10 islands, including the main island of Khron, the second largest island of Takri and 8 smaller islands. Most of these islands have steep terrain, with unstable soils and little permanent freshwater.

Early reports indicate that approximately 200 people were killed and more than 100,000 people were affected. A number of people are still missing. At the present time, according to the Gammalpha National Disaster Relief Offices, which are coordinating the humanitarian response, there are an estimated 50 000 people displaced and sheltering in ad-hoc camps, living in temporary shelter they have made from grass, branches, and banana leaves.

The largest of these displacement camps is near the coastal town of Brew on the remote east coast of the main island of Khron, where 30 000 people have built make-shift shelters. Another 10 000 people are displaced on the smaller island of Takri. Displaced people from nearby islands are trying to make their way to Brew and Takri and this influx of people has led to further stress on limited resources. Amongst those trying to make their way to Brew is 15 year old Seri and her 14 year old brother Amiri. They were separated from their parents who were at work on another part of the island when the cyclone struck their island. Seri recounts that “we were trapped in the house for more than 12 hours and then someone came with a boat and took us to the local school which was the closest evacuation centre. We stayed there overnight but it was so crowded and there was no sign of our parents. We found our neighbours in the evacuation centre and they told us that we would have more chance of finding mum and dad on the main island. I don’t know if this is the best decision- a lot of people are trying to get to Brew and I don’t know anyone, but what else can we do?”

There is currently no electric power on the affected islands and there are ongoing problems with telecommunications. Food, water and other necessities are urgent priorities, and the need for health services is increasing. Sanitation infrastructures are no longer functioning, even in the main camps. Women, men, girls and boys are using wooded areas around the camps for toileting and are collecting water for drinking and washing from streams and stagnant freshwater pools left by the torrential rains. Oxfam has been asked to access the most crowded areas to dig latrines and set up water distribution points but this has yet to be done.

Food supplies are becoming exhausted. Communities in less-affected neighbouring areas have been trying to help out, but this is clearly not enough and WFP has initiated food distribution to the larger displacement camps. Even with these food drops, food remains limited and there is concern amongst the displaced population about who is able to access these supplies. Cooking fuel is a problem but women and girls have been collecting firewood from the surrounding woods.

There are health centres and health posts scattered around the affected area, but they have sustained damage and do not have electricity or functioning sanitation facilities at this time. The provincial hospital of Khron is not affected, but it is 50 km away from the displaced settlement in Brew. The storm partly destroyed the smaller hospital in Brew (20 km away from the displacement camp) and damaged the small hospital on Takri. The hospital in Brew is much affected by increasing demands for services from the displaced. Fifteen smaller health facilities on Brew and Takri and the other affected islands are limited in their functionality. A training of Primary Health Care Workers (PHCW) was undertaken in Gammalpha several years ago, but not as many as needed have been trained and there has been significant attrition of female staff who have families to care for. Some TBAs received training about 10 years ago.

The Ministry of Health has sent out emergency medical teams to the 2 hospitals to support the local staff, some of whom are unaccounted for or have been displaced. Several humanitarian organizations are starting limited health services for the affected population (IRC, MSF, Gammalpha Red Cross,), but a lack of coordination and communication prior to the cyclone has meant that only one joint meeting has been convened by the Gammalpha National Disaster Relief Office and no further meetings are planned. Already a major shortage of drugs and supplies is looming.

Health problems in the area include malaria, measles, HIV, meningitis, diarrhoea, respiratory infections and skin conditions. Although no assessments have been completed, it appears that malnutrition may be a significant problem due to a long period of drought. There is an increase in trauma cases due to persons presenting with wounds and there are reports of rapes and sexual abuse of women, girls and boys by armed gangs looking for supplies. Obstetrical complications are common, and there have been reports of maternal and newborn deaths related to the emergency.

The flood surge destroyed airports and sea ports in the affected areas and cargo flights can no longer reach the islands. Transport to the affected islands area is possible by helicopter or smaller vessels. Depending on the island, either or both of these means of transport can be problematic.

Reproductive Health Indicators for Gammalpha

(Most figures date from the last DHS 2015)

Basic demographic indicators	
Total population	741 500
Sex Ratio (M:100 F)	90:100
% of women who are aged 15 – 49	25.2 %
Percentage <5 years of age	20.1 %
Total fertility rate (per woman)	2
Safe Motherhood indicators	
Crude birth rate (per 1000 population)	29.6
Neonatal mortality rate (0 – 4 weeks) (per 1000 live births)	26.5
Maternal mortality ratio (per 100.000 live births)	120
Lifetime risk of maternal death	1 in 180
Unsafe abortion	not applicable
Skilled attendance at birth	40 %
STDs, including HIV/AIDS	
Adults living with HIV/AIDS (%)	0.5 %
Gonorrhoea Prevalence Rate among all tested (%)	10%
Family planning indicators	
Contraceptive prevalence (all methods) (% of women 15 – 49)	30 % (2012)
Contraceptive method mix	
Pill	25 %
Injection	20 %
IUD	5 %
Female sterilization	2 %
Traditional methods	20 %
Others	28 %

Participant Handout #1

Case Study 2: Conflict in Gammaland (Based on CARE/IPPF Training Scenario)

Situation Report

Gammaland is a landlocked country. Since independence from the British it has been plagued by conflict in the southwest province of Alpha where **Moona** ethnic separatist groups have been clashing with the national army over land, natural resources and preserving their identity. The Army is made up of soldiers from the dominant **Sun** ethnic group. The population of Alpha Province is approximately 300,000, of which 70% are from the Moona ethnic minority and 30% from the Sun ethnic majority group.

The Moona and Sun ethnic groups speak different dialects of the same language.

The last 10 years have been relatively peaceful in Alpha Province as a ceasefire between the two sides was agreed.

In the last few months, tensions and small-scale clashes have been increasing in Alpha since rumours that the provincial government is planning to sell off land that is culturally significant for the Moona people to a neighbouring country for property development.

Things came to a climax last week when a small Moona separatist group set fire to a local police station killing 10 officers. Retaliation has been strong and over the last three days, 190 people including 100 men, 60 women and 30 children[1] were killed in the crossfire when trying to leave the area. A total of 110[2] people were critically injured, of which 80 were airlifted by the ICRC/National Red Cross to Beta Province due to inaccessible terrain. A total of 312[3] houses in Alpha Province have been burned. The growing violence has prompted thousands to flee the area and make their way to villages and towns in the province and to a neighbouring province.

1 Source: National Red Cross Society and local government official

2 Source: Local government official

3 Source: National Red Cross Society

The number of displaced has been estimated at 57,250 people, of which 45,550 (80%) have been displaced to informal and formal camps in Beta Province, while roughly 11,700 (20%) are being hosted in various villages and towns within Alpha Province. It has been estimated that the majority – approximately 80- 85% - of the displaced are women and children, with many of the women now heading up their households as men remained behind to join the separatists or to continue working the land. Amongst these displaced women is Sana, who recounts that she fled her home because the "constant threat of violence has been the scariest experience so far. I didn't know if my children, husband and I would live. My husband stayed to fight and I have witnessed so many dead bodies on our long run to safety. I have tried to shield my children from these things but there are just so many. And the gunshots, and the screams and yelling. We have encountered road blocks, military checkpoints…the demands of the soldiers…I cannot describe this to you".

As of now, it is not clear whether these newly-displaced people in Alpha Province will remain integrated with the host communities or end up in spontaneous camp settings. The 45,500 displaced to Beta Province are additional to 50,000 people who were already living in long-term camps since the previous conflict, bringing the total displaced in Beta Province to 95,500. Formal camps are currently being managed by local authorities who also use private security firms. While Beta is a well-developed province, this influx is likely to put great strain on the authorities and local people's resources. Already, water and sanitation facilities are being overwhelmed and women, men, girls and boys are making use of surrounding wooded areas for toileting, and small streams for bathing and collecting water. Host populations are increasingly restricting access to food as more people move into the area. Rumours of unfair distribution and the targeting of women and girls at food drop points have begun to circulate.

Tensions are ongoing and reports have emerged of increases in levels of gender-based violence (GBV) within the displaced and the host communities, including sexual violence, domestic violence, and sexual exploitation and abuse (SEA) of women, girls and boys.

There are five districts hospitals spread out across Alpha (2) and Beta (3) Provinces. Each hospital has BeMONC and CMR capacity but supplies are running low due to the increased demand. Most current staff are from the Sun ethnic group and not all healthcare providers are trained in the clinical management of rape (CMR). As a result of the supplies and capacity shortages, only 40% or so of health facilities seem to be fully functional.

The long-term and newly-displaced population are very conservative in their outlook on gender and social norms. Displacement has made them even more conservative, restricting mobility of women and girls and therefore further hindering their access to life-saving SRH services. There are reports of an increase in child marriage between displaced and host communities.

The Government of Gammaland (GoG), which sits in the nation's capital, Delta, which is 100km and 75km from Alpha and Beta Provinces respectively, is overwhelmed and is trying to cope with the security problem. They have called on the national and international humanitarian community present in country to provide urgent assistance to Beta and Alpha Provinces.

Participant Handout #1

Reproductive Health Indicators For GAMMA

(Most figures date from the last DHS 2010)

Basic demographic indicators	
Total population	7.5 million
Sex Ratio (M:100 F)	100
% of women who are aged 15 – 49	25.2 %
Percentage <5 years of age	20.1 %
Total fertility rate (per woman)	4.7
Safe Motherhood indicators	
Crude birth rate (per 1000 population)	39.6
Neonatal mortality rate (0 – 4 weeks) (per 1000 live births)	29
Maternal mortality ratio (per 100.000 live births)	700
Lifetime risk of maternal death	1 in 50
Unsafe abortion	not applicable
Skilled attendance at birth	18 %
STDs, including HIV/AIDS	
Adults living with HIV/AIDS (%)	10 %
Gonorrhoea Prevalence Rate among all tested (%)	15%
Family planning indicators	
Contraceptive prevalence (all methods) (% of women 15 – 49)	17.3 % (2015)
Contraceptive method mix	
Pill	20 %
Injection	17 %
IUD	0.2 %
Female sterilization	0.2 %
Traditional methods	40 %
Other (including condom)	12.7 %
Sexual Violence N/A	
In previous phases of the conflict, SV was reported to increase particularly in areas heavily patrolled by army. Other forms of GBV have also been reported to increase during conflict and in displacement. These include domestic violence and early marriage.	

Participant Handout #2 Instructions

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. 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 group. Ask each small group or pair to read through and absorb the information provided.

- After 5 minutes or so, ask each small group or pair to discuss their story and how they feel their programming would (as it is), or could (with some changes) meet the individual's needs in this context.

Materials

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

Participant Handout #2

Stories of accessing SRH in emergencies: group work

1. Epi

Epi, 30, was eight months pregnant with her sixth child when a 7.5 earthquake occurred near her town in Palu, Indonesia on the 28 September 2018. She received prenatal care through IPPF's SRH mobile health tent which was located in the Internally Displaced Persons (IDP) camp where she was staying. The checkup confirmed the gestation of her pregnancy, she received vitamins and the IPPA nurse was able to work through her delivery plan with her. For Epi, this was the first time she had received prenatal care throughout any of her six pregnancies. She said, "I don't have any information about family planning. This is my first time getting a checkup during a pregnancy. I have never, ever been to a clinic throughout any of my pregnancies. I was scared! But today, when I heard [IPPF Member Association] IPPA were setting up a tent, my aunt and everyone really encouraged me to come to get prenatal care and not to be scared."

2. Amelia

Amelia, 19, has three daughters aged four, two and a one month old baby. She was married in 2013 when she was 14 years old. Her newest baby, Gifa, was born only seven days after a devastating 7.5 earthquake hit her home island in Indonesia. Amelia named her Gifa as it means 'earthquake' in the local language. She says, "For the moment, I still carry too much trauma after the earthquake to have more children. I remember so clearly how I was so heavily pregnant, and I had to push myself so hard to run away from the earthquake to reach a far place. That is so traumatizing to think about. Three children is enough for now. I won't have more until I feel safe and comfortable again. I am still scared of another earthquake". IPPA Midwife Anggnani was able to provide Amelia with a contraceptive injection in the mobile SRH tent located in her IDP camp.

3. PNG Highlands Earthquake

On the 26 February 2018, a 7.5 magnitude earthquake struck the Highlands Region of Papua New Guinea. The Papua New Guinea Family Health Association (PNGFHA) team did mobile outreach to the remote area villages where they heard about a 16 year old girl who had delivered her 1st baby and had a retained placenta. The PNGFHA midwife examined the mother and immediately transported her to the Nipa Health centre where she delivered the placenta. The following day the mother was discharged back to the village. The PNGFHA midwife did a home visit for follow-up postnatal care for the mother and baby the following day. She also provided family planning counselling to the couple. At first the husband was reluctant and didn't want his wife to start family planning, but after careful explanation about the family planning methods, they couple decided to start with oral contraceptive pills.

Participant Handout #3 Instructions

Challenges to Delivering Services in Emergencies

This group work will allow participants to understand the importance of developing flexible service delivery models in emergency contexts. The challenges and solutions raised will be important to keep in mind as you move through each of the clinical objectives.

Time

30 minutes

Process

- Break participants into small groups.
- Provide participants with one of the case studies outlined in Participant Handout #1. Also give each group a copy of Participant Handout #3.
- Ask each group to design a strategy to deliver SRH services, according to the conditions in the case study and by addressing the considerations and challenges outlined in Participant Handout #3. The MISP Cheat Sheet can be a good reference as participants have not yet been introduced to the MISP in detail.
- After 20 minutes, ask each group to present only key elements of their plan to the group.
- Ask groups to:
  - Share three key factors which affected their strategy
  - Share two main ways this differs from their delivery of services in stable times.
  - Share one strategy they would use to ensure populations were not 'left behind'
- If running short of time, ask other groups if there is anything additional they would add.

Materials

- Participant Handouts #1 and #3
- MISP for SRH Cheat Sheet
- Flip chart paper

Key Messages

- Flexible and adaptable service delivery models are need in emergency response.
- Quality and human rights are still essential in the delivery of services during emergencies.
- It is essential to consider the well-being of staff and volunteers providing services.

Challenges to delivering services in emergencies

Your task is to develop a strategy to deliver clinical SRH services, to the affected community, based on a case study context provided in Participant Handout #1.
Consider the challenges below and how these could be addressed taking into account the considerations below.
The lists below are not exhaustive and groups can add any other challenges and considerations.

Challenges

- Transport to and from the affected populations
- Mobility of populations
- Security and well-being of your field team
- Staffing/ human resources: who will go/who has been affected
- Availability/cost of supplies
- Types of services that can be provided in an outreach environment
- National laws and policies on provision of services outside of a facility
- Follow up of patients
- Deciding when to leave

Strategy Consideration:

- **Planning & coordination**
- **Environment- site location**
- **Mechanism for service delivery (mobile/static etc)**
- **Transportation**
- **Equipment**
- **Governance & human resources**
- **Safety & security**
- **Psychosocial support for staff**
- **Logistics & communication**
- **Supplies & power sources**
- **How to maintain quality of care**
- **Infection control in outreach clinic**
- **Community involvement**

Participant Handout #4 Instructions

Why did X Die?

Adapted from IPAS Values Clarification exercise (https://www.ipas.org/resources/abortion-attitude-transformation-a-values-clarification-toolkit-for-global-audiences):

- The purpose of this group work is to use a case study to explore how attitudes of service providers and barriers can affect access to health services for marginalized populations, and how these barriers, in turn, directly affect health outcomes.

- It may be necessary to change the names and certain elements of the story to be more culturally, geographically or organizationally appropriate for the audience and setting. You may want to adapt an actual story from your experience at your agency or from the media, making sure to change any potentially identifying information to protect people's privacy. It may be helpful to provide participants with more local information on stigma and criminalization to illustrate the barriers to access and care.

Time

25 minutes

Process

1. Warn your participants that the subject matter of this activity can be confronting.

Explain to participants that this activity features a case study that highlights the cultural context around sexual and reproductive healthcare for diverse LGBTQIA persons in humanitarian settings. Participants are confronted with the tragic consequences that can result when LGBTQIA persons face barriers to getting the care they need. Participants discuss one person's story and are asked to articulate their personal beliefs and professional responsibility to provide necessary medical care and avoid preventable deaths.

By the end of this activity, participants will be able to:

- Discuss the cultural context surrounding SRH care and sexual orientation and gender identity and expression.

- Explain the tragic outcomes that can result from restricting access to care for LGBTQIA persons.

- Articulate their personal beliefs and professional responsibility to promote health and prevent deaths for this population/

2. Ask for a volunteer (a participant) who will play the role of the woman and recount her story to other participants as realistically as possible from Participant Handout #4).

3. At the close of the story, ask participants the question, "Why did she die?" Facilitate a large group discussion. Suggested discussion questions to choose from are listed below. Be prepared to offer a couple of example answers to each question you pose, to get the discussion started if no one talks initially.

- How does this story make you feel?
- What choices did Amelia have?
- What could have been done to prevent her death? Who could have helped prevent her death?
- What could have made this situation better for Amelia?
- What information, resources and health-care services could have helped her avoid this situation?
- In addition to the woman, who else was directly affected by her death?
- What does this story tell us about our responsibility to ensure women have access to comprehensive medical care?
- What could you do, personally and professionally, to prevent deaths such as this one from occurring?
- Who has experienced or heard about a story like this woman's through their work that they would be willing to share? What happened, and was the woman able to access care? If yes, how? If not, why not? (This could be an emotional question for some participants and should be asked with careful consideration.)

4. Solicit and discuss any outstanding questions, comments or concerns with the participants. Thank the group for their participation.

Materials:

Copies of Participant Handout # 4

Key Messages:

- All persons have the right to access comprehensive sexual and reproductive health care regardless of sexual orientation & gender identity.
- Community and facility level stigma contribute to lack of access to care for LGBTQIA persons.
- The attitude and behavior of health care professionals and all staff at health facilities have a direct impact on the physical and mental health outcomes of the people who seek care.
- Confidentiality by all service providers is critically important. People may not openly share all of their identities and all health care staff must respect their decision and maintain confidentiality.
- As shown in Amelia's story, not all people may feel that they are able to reach health services. Service providers must be creative and innovative in delivering services in different ways to meet different needs

Participant Handout #4

Why did she die?

My name is Amelia. I was a student until recently and do hair in the evenings to make some money. I used to live with my family but was thrown out once they found out that I was transgender. I have been staying with friends, but don't have a home. Some nights I have to sleep on the street.

I am a transgender woman and face a lot of stigma from people in the community and my family does not accept me. In school, I was called bad names by my peers and even my teachers. They would scream "tranny" at me and sometimes throw rocks. I used to love going to school as a child and would get the highest grades in my math and science classes. I dreamed of becoming a doctor. The older I got, the harder it was to go to school as I could not handle the emotional and physical abuse. I had nobody to turn to as my family and teachers didn't accept me.

Sometimes the students in front of the school wouldn't even let me inside the building and would shout at me to "go kill myself".

When I was very young, my uncle raped me. Afterwards, I got sick and when I went to the doctor, I was diagnosed with HIV. Since then, I have been taking anti-retrovirals (ARVs). When I was 14 years old, I found a LGBTQIA community center in the city where I could access ARVs and sometimes hang out. Luckily, the doctor there was very nice and had a lot of trans clients, so I enjoyed going to him. I went every three months to refill my prescription.

One day, there was an earthquake in my town which injured and killed hundreds of people. Most of the buildings and homes were destroyed and many people had to stay in evacuation centers. The LGBTQIA center I used to go to collapsed. I couldn't get in touch with my friends and didn't know how to see my doctor. I had no home to sleep in and urgently needed to refill my ARVs.

I heard that there were evacuation centers where I could sleep and get some food. They had one specifically for women so they could feel safe. Men in our communities can be very aggressive and I would not feel safe sleeping in a building with men. When I got to the shelter, they asked for an identification card before they would register me and let me in. I'm a woman, but because of the law my gender ID still says that I am a man. They wouldn't let me in even after I explained that I'm a woman. They said that I stole the ID and didn't believe me and told me to "go stay with your freaks".

I slept on the street with nowhere else to go. By the next week, I had run out of my medicines. I heard there was a medical camp where you could get health services. When I got there, there were lots of men smoking cigarettes outside. I hated having to walk past them as they screamed at me. When I finally met the doctor, he did not want to see me. He told me that they do not serve "my kind" here.

I was so hungry and started to get sick as I didn't have my medicine anymore. I had nowhere to sleep, nobody to talk to and I was so unhappy. It didn't seem like I would get better or survive. I could not handle to live another day. I found a building nearby and decided to jump. I died and I'm not sure anyone misses me.

Why did Amelia die?

Participant Handout #5 Instructions

Matrix Group Work: MISP for SRH Objective 2

Process

- Ask participants to briefly share their experience in addressing sexual violence in their work as clinical service providers. If they have not been directly involved in this work, ask them to share information on the kinds of services they are aware of for survivors in their setting.
- Share the table on Participant Handout #5 electronically or in hard copy. Note that a similar table will be given at the start of each objective.
- Explain there will be time at the beginning, throughout and at the end of the session to complete the matrix with colleagues in the room.
- The purpose of this matrix is to:
  - Discuss clinical skills needed to implement each action under the MISP Objectives;
  - Identify how these differ from the services provided during non-emergency times;
  - Map who can do what (individual and/ or organisations) in their context for each activity; and
  - Allow participants to understand the role service providers play and competencies needed to contribute towards each objective.
- Encourage participants to work in groups (such as table groups) to brainstorm and engage their existing knowledge and experience of this objective, filling in aspects of the matrix as they are able at this stage. Remind participants that they will have the opportunity to add to the matrix throughout and at the end of the session.

Materials

Participant Handout #5

MISP for SRH Objective 2: Prevent Sexual Violence & Respond to the Needs of Survivors in Emergencies				
Clinical skills as outlined in the MISP List Core Clinical competencies as outlined in the MISP	**Which Cadre of staff can perform these skills?** Identify who within the health workforce is permitted to provide these services (e.g. Doctors, Nurses, Midwives, Community Health Workers)	**Differences with Standard settings** Identify any existing health laws, policies, standards or resources that would impact how these services are delivered in Emergencies	**Skills/policy gaps?** Are there any current skills or policy areas that need to be addressed to ensure the SRH service can be provided timely and efficiently in emergencies	**What resources are available in your setting which could help build skills and fill gaps (consider existing partners, trainings, supplies etc)?** Where could someone access the resources needed to build their capacity in these areas

Participant Handout #6 Instructions

Code of Conduct against Sexual Exploitation and Abuse

This activity will allow participants to understand the importance of a Code of Conduct against Sexual Exploitation and Abuse, and what this might contain.

Time

15 minutes.

Process

- Ask participants to look at the sample codes of conduct provided on Participant Handout #6.
- Allow participants time to read through the documents and answer the following questions (also included on Participant Handout #6):
  - What principles are common to the documents?
  - How do these principles relate to sexual exploitation and abuse?
- Facilitate a brief discussion with the group, based on the above questions.
- Emphasise the importance of establishing and enforcing a code of conduct for all actors in the 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 #6

Participant Handout #6

Sample Codes of Conduct

Consider:

- What principles are common to the documents?
- How do these principles relate to sexual exploitation and abuse?

1. IASC Task Force on Protection from Sexual Exploitation and Abuse

6 core principles for inclusion in UN and NGO Codes of Conduct:

1. Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.

2. Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.

3. Exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes the exchange of assistance that is due to beneficiaries.

4. Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.

5. Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.

6. Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

2. IAFM 2010

Sample Code of Conduct

In accordance with the mission and practice of [ORGANIZATION] and principles of international law and codes of conduct, all [ORGANIZATION] staff, including both international and national, regular full- and part-time staff, interns, contractors and volunteers, are responsible for promoting respect for fundamental human rights, social justice, human dignity and respect for the equal rights of men, women and children. While respecting the dignity and worth of every individual, the [ORGANIZATION] worker will treat all persons equally without distinction whatsoever of race, gender, religion, colour, national or ethnic origin, language, marital status, sexual orientation, age, socioeconomic status, disability, political conviction or any other distinguishing feature.

[ORGANIZATION] workers recognize that certain international standards of behaviour must be upheld and that they take precedence over local and national cultural practices. While respecting and adhering to these broader frameworks of behaviour, [ORGANIZATION] specifically requires that [ORGANIZATION] workers adhere to the following Code of Conduct.

Commitment to [ORGANIZATION] Code of Conduct

(1) A [ORGANIZATION] worker will always treat all persons with respect and courtesy in accordance with applicable international and national conventions and standards of behaviour.

(2) A [ORGANIZATION] worker will never commit any act that could result in physical, sexual or psychological harm to the beneficiaries we serve.

(3) A [ORGANIZATION] worker will not condone or participate in corrupt activities or illegal activities.

(4) [ORGANIZATION] and [ORGANIZATION] workers recognize the inherent unequal power dynamic and the resulting potential for exploitation inherent in humanitarian aid work, and that such exploitation undermines the credibility of humanitarian work and severely damages victims of these exploitative acts and their families and communities. For this reason, [ORGANIZATION] workers are prohibited from engaging in sexual relationships with beneficiaries.*

Sexual activity with children (persons under the age of 18) is strictly prohibited.

(5) A [ORGANIZATION] worker must never abuse his or her power or position in the delivery of humanitarian assistance, neither through withholding assistance nor by giving preferential treatment, including requests/demands for sexual favors or acts.

(6) It is expected of all [ORGANIZATION] workers to uphold the highest ethical standard of integrity, accountability and transparency in the delivery of goods and services while executing the responsibilities of their position.

(7) A [ORGANIZATION] worker has the responsibility to report any known or suspected cases of alleged misconduct against beneficiaries to senior management (as outlined in the reporting pathway) immediately. Strict confidentiality must be maintained to protect all individuals involved.

I, the undersigned, hereby declare that I have read and understand this Code of Conduct. I commit myself to exercise my duties as an employee of the Gender-based Violence Programme in accordance with the Code of Conduct. I understand that if I do not conform to the Code of Conduct,

I may face disciplinary sanctions.

Employee's name, function and signature, date

Manager's name and signature, date

Participant Handout #7 Instructions

Stories of Survivors

This activity allows participants to engage with stories of survivors of sexual violence and reflect on how a survivor centred approach may contribute to better health and wellbeing outcomes.

Time

15 minutes.

Process

- Explain to participants that the stories they are about to explore contain emotional content and that they may take a break at any time during the exercise.
- Prepare 2 stories of survival relevant to sexual and gender based violence in your context.
- Add these as stories 3 and 4 on Participant Handout #7.
- The 2 stories given may be used if you feel they represent the situation in your setting. If not, you may also need to adapt or rewrite these. Stories should include women, children, adolescents and men. Stories should include a mix of good practice and bad practice. Elements of preventing sexual violence and caring for survivors should be incorporated into the narratives.
- Ask participants to read through some or all the stories by themselves.
- When they have finished reading, ask participants to discuss with the person next to them or in small groups:

  1. The situation which made the survivor vulnerable to sexual violence
  2. The care seeking behaviour of the survivor
  3. The care the survivor received (in story 2)

- Allow the discussion to unfold.

Key Messages

- Remind participants of the importance of protection mechanisms to try to prevent such violence and the guiding principles for the care of survivors that must always be followed.
- Highlight to participants the negative effects of victim-blaming. Explain the key role they have, as service providers, in being aware of this and acting to address any negative

comments or actions they come across in the care of survivors.

- This is a good opportunity for participants to learn through the mistakes of others and develop a deeper understanding of the principles at play in protecting vulnerable populations and caring for survivors with compassion and by adhering to the guiding principles.

Materials

Participant Handout #7

Participant Handout #7

Stories of Survivors

Story 1

(Adapted from: Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series, CARE on behalf of the Reproductive Health Response in Conflict Consortium).

Marie, a 13-year-old girl, is the oldest of 5 siblings, living with their mother in a settlement for people displaced by flooding. Her mother has been overwhelmed by grief since fleeing their home and is barely able to care for the youngest children in the family. Marie acts as the primary caretaker with responsibility for obtaining food, cooking and feeding the family. The settlement management provides regular rations of basic food stuffs but it is hard for Marie to compete with other residents of the settlement, and she often ends up with less than her family's allocated share. It distresses her to see her brothers and sisters so hungry.

One day, her 10-year-old brother, who often plays soccer in the late afternoons with some of the settlement management staff, told her that "the man who distributes the food" said he wanted to help Marie's family get more food and Marie should come talk to him the next day. He said she should come alone, because he did not want other people to know he was helping Marie's family. Marie went to the man, who was very kind. He asked her about her mother, her brothers and sisters, and told Marie to come with him to the warehouse, where he would give her some rations. When they got to the warehouse, the man pulled Marie into a dark corner and sexually assaulted her. When she wept, he told her not to cry, because he was doing this to help her, because he liked her very much. Then he gave her some extra rations and sent her away, warning her that she must keep this incident secret. He said she should come see him again whenever she needed more food.

Marie felt profoundly ashamed, and did not know what to do. Her family desperately needed the food, she was afraid someone as important and powerful as the "food man" could stop her family getting any food at all. The "food man" continued to ask her brother about her and finally she went to see him again.

Marie felt so anguished, she stopped attending the school in the settlement, even though she had almost completed primary school. Her teacher came to ask about her, and in a flood of tears, Marie told her what was happening. The teacher assured Marie it was not her fault, and that she would keep Marie's "secret" to herself.

Story 2

(Adapted from Caring for Survivors of Sexual Violence in Emergencies: Training Pack Medical Modules, IASC Gender SWG/GBV AoR, & Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series, CARE on behalf of the Reproductive Health Response in Conflict Consortium).

Cecile and her family have fled fighting in their home region and have just arrived at a camp for displaced persons. Cecile is 25 years old. She comes to a clinic in the camp and approaches the receptionist timidly to ask to see a doctor. She thinks to herself that it would be more comfortable if the doctor were a woman, but is afraid to say this to the receptionist, who is busy asking her a series of questions about her personal life and noting the answers on a chart. Cecile answers in a low voice, not wanting other waiting patients to hear. She doesn't disclose her real reason for attending the clinic. When the questions are finished, she receives a number and is told to wait her turn.

After an hour and a half, her number is called. She walks quickly into the consulting room, where she is relieved to find an older, woman doctor and female nurse. Her brave "Good morning doctor", is answered by kind, "How are you my child? Take a seat". The doctor and nurse continue a discussion that had been interrupted by Cecile's arrival. They are discussing a patient who has just left the consulting room, expressing their doubts that she will follow through with the treatment they prescribed. Eventually, the doctor reads the chart the receptionist filled out, turns her attention to Cecile and says, "How can I help you?"

Haltingly and through tears, Cecile explains: "I was raped by men in uniforms who came into my home 2 nights ago. It started at 1 a.m. We were all sleeping. I heard the noise and was the first to wake up. There were ten of them- I could see them and count them. They came into the compound. I wanted to hide but I couldn't".

The doctor immediately stands and asks Cecile to disrobe for examination. The doctor moves quickly through the examination, speaking to Cecile and the nurse in turn. Cecile is confused and does not understand many of the words the doctor uses. She is afraid to confess her confusion, but finally explains to the doctor that she is not sure about what is happening. The doctor pauses in her examination. In a kind voice, she assures Cecile that patients really just need to trust the clinic and medical staff, that she has seen cases just like Cecile's before, that she knows what she is doing and will do her best for Cecile.

After the examination, Cecile is given medication and told how to take the tablets. She is also provided with an appointment card for a follow-up visit to the clinic, and a copy of her medical certificate.

Participant Handout #7

Story 3

Participant Handout #7

Story 4

Participant Handout #8 Instructions

Providing Treatment for Survivors

This activity is designed to engage with participants' existing knowledge and experience and allow facilitators to identify any gaps in knowledge. These gaps should then be fully addressed in the session to follow.

Participants will work in groups to review their knowledge of treatment for survivors of sexual violence including special considerations.

Time

30 minutes

Process

- Advise participants that the subject matter may be upsetting and they can take a break at any time throughout the exercise.
- Divide participants into two groups.
- Ask participants to look at Participant Handout #8 and work through the case studies and treatment decisions as a group. Group 1 to review cases 1 and 2; Group 2 to review cases 3 and 4.
- Allow 20 minutes for participants to complete the exercise and then facilitate a brief discussion using the solutions provided below.

Materials

Participant Handout #8

Solutions

	PEP	EC	STI treatment	Which tests are required?	Referral
Case 1	Yes	Yes	Yes	None	With consent only: -VCT -Psychosocial support -Police
Case 2	No	Yes	Yes	None	With consent only: -Gynaecology -VCT -Psychosocial support -Police (maybe mandatory reporting of sexual abuse in minors)
Case 3	Yes	No	Yes	None	With consent only: -VCT -Psychosocial support -Police (maybe mandatory reporting of sexual abuse in minors)
Case 4	No (debatable)	No	Yes	None	With consent only: -VCT -Psychosocial support -Police

Participant Handout #8

Providing Treatment for Survivors

Case Study 1

An adult woman survivor comes to the clinic 36 hours after being sexually assaulted. She states she wants all available treatment. She states she has no allergies that she knows of.

The treatment offered to the woman should include:

Do you provide	Yes	No	Why?
PEP?			
Emergency Contraception?			
STI presumptive treatment?			
Which tests are required before you can prescribe the above treatment?			
To which other services would you refer her?			

Participant Handout #8

Case Study 2

Girl 11 years, was brutally raped by 5 soldiers 4 days ago. Her mother is very concerned about HIV and she wants all possible treatment. On examination you find multiple bruises on breasts, healing lacerations around the introitus and anal tears. When she takes off her skirt you see that she has wet (urinated on) herself.

Treatment offered to the girl should include:

Do you provide	Yes	No	Why?
PEP?			
Emergency Contraception?			
STI presumptive treatment?			
Which tests are required before you can prescribe the above treatment?			
To which other services would you refer her?			

Participant Handout #8

Case Study 3

A 5 year old boy comes to the clinic 70 hours after being sexually assaulted. His mother states she wants all available treatment. She states he has no allergies that she knows of.

Therefore, the treatment offered to the boy should include:

Do you provide	Yes	No	Why?
PEP?			
Emergency Contraception?			
STI presumptive treatment?			
Which tests are required before you can prescribe the above treatment?			
To which other services would you refer her?			

Participant Handout #8

Case Study 4

Woman 42, severely beaten and sexually abused by a soldier 2 days ago. The perpetrator was unable to achieve sufficient erection for vaginal penetration. The survivor was forced to perform oral sex on the perpetrator who did not achieve erection nor ejaculate. On examination she has multiple bruises around the face and legs and abdomen. There is a laceration on the forehead, and abrasions on the elbows. She is very emotional and very concerned about HIV and states she wants all possible treatment.

Treatment offered should include:

Do you provide	Yes	No	Why?
PEP?			
Emergency Contraception?			
STI presumptive treatment?			
Which tests are required before you can prescribe the above treatment?			
To which other services would you refer her?			

Timelines for the Care of Survivors

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

Key Discussion points

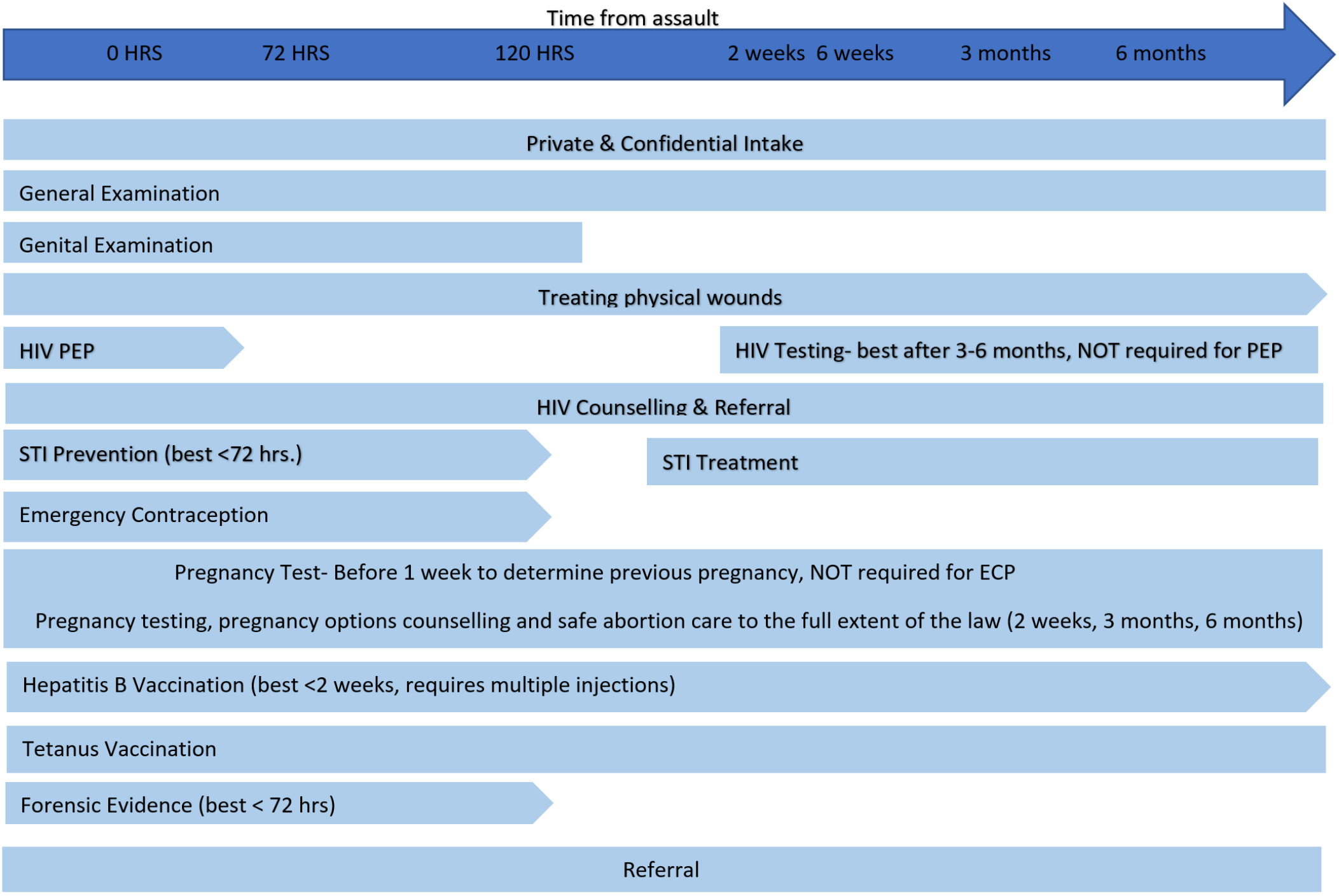
- CMR treatment should be available and accessible to all survivors soon as possible. The reality is that many survivors present many days, weeks or even months after the event and not all survivors wish to receive all treatments at the same time. It is important to understand which interventions have 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 #10 which provides a summary of treatment timelines.

Materials

- Participant Handout #9 (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

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

Solution: Timelines for the Care of Survivors



Providing Clinical Care for Survivors: Safe & Confidential Spaces

This activity will allow participants to explore the elements that make spaces safe and appropriate for survivors of sexual violence taking into consideration the guiding principles, particularly safety and confidentiality.

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. The activity is more impactful if the room can be set up 'a clinic' with the features outlined in the picture. If not, facilitators can draw/print the handouts for discussion.
- Ask the groups to take 2 minutes to work on the following scenario:
- During a monitoring visit, you as a provider are visiting a clinic that provider services and care for rape survivors.
- At the end you are expected to give your comments and recommendations for improvement.
- When inspecting the setup, also evaluate whether considerations for specific populations have been made.
- Have a reporter for each group share findings and facilitate a discussion based on the key messages below.

Materials

- Participant Handout #10
- Items as depicted in pictures

Key Messages

- Entrance sign: does not ensure confidentiality and safety, limited opening hours.
- Files: names should be coded and files put in a locked cabinet.

- Medicines: should be better organized with drugs in a separate cabinet.
- Latrine: it is important to have access to latrines but male and female latrines should be separate.
- Referral: clear information about other referral pathways and services are important to display for survivors.

Always remember the guiding principles

- Safety
- Confidentiality
- Respect
- Non-discrimination

Involving marginalised populations and CSO's working with marginalised groups such as adolescents, people living with disability, can help design spaces that are appropriate and acceptable.

Participant Handout #10

Providing Clinical Care for Survivors of Sexual Violence: Safe & Confidential Spaces

Observations

Participant Handout #11 Instructions

Matrix Group Work: MISP for SRH Objective 3

Process

- Ask participants to briefly share their experience in preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs in their work as clinical service providers. If they have not been directly involved in this work, ask them to share information on the kinds of services they are aware of for survivors in their setting.
- Share the table on Participant Handout #11 electronically or in hard copy. Note that a similar table will be given at the start of each objective.
- Explain there will be time at the beginning, throughout and at the end of the session to complete the matrix with colleagues in the room.
- The purpose of this matrix is to:
    - Discuss clinical skills needed to implement each action under the MISP Objectives;
    - Identify how these differ from the services provided during non-emergency times;
    - Map who can do what (individual and/ or organisations) in their context for each activity; and
    - Allow participants to understand the role service providers play and competencies needed to contribute towards each objective.
- Encourage participants to work in groups (such as table groups) to brainstorm and engage their existing knowledge and experience of this objective, filling in aspects of the matrix as they are able at this stage. Remind participants that they will have the opportunity to add to the matrix throughout and at the end of the session.

Materials

Participant Handout #11

MISP for SRH Objective 3: Prevent the transmission of & reduce morbidity & mortality due to HIV & other STIs				
Clinical skills as outlined in the MISP List Core Clinical competencies as outlined in MISP	**Which Cadre of staff can perform these skills?** Identify who within the health workforce is permitted to provide these services (e.g. Doctors, Nurses, Midwives, Commuinty Health Workers)	**Differences with Standard settings** Identify any existing health laws, policies, standards or resources that would impact how these services are delivered in humanitarian settings	**Skills/policy gaps?** Are there any current skills or policy areas that need to be addressed to ensure the SRH service can be provided timely and efficiently in emergencies	**What resources are available in your setting which could help build skills and fill gaps (consider existing partners, trainings, supplies etc)?** Where could someone access the resources needed to build their capacity in these area

Participant Handout #12 (A & B) Instructions

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 2 Group Work activities are designed to be conducted at the same time:

- Divide participants into 2 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.

Procedure

- 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.

Participant Handout #12 A

Standard Precautions

Participant Handout #12A: Health Post

You are conducting a supervisory visit to a health post:

- Look around and observe how well standard precautions are implemented.
- Give feedback to the nurse on the following standard precautions measures.

Standard Precaution components	Your comments
Hand washing set-up	
Safe use of needles	
Safe disposal of needles	
Standard Precaution protocols displayed	
House keeping	

Notes

Group Work B Standard Precautions: Challenges & Strategies

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

Procedure

- 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).

Participant Handout #12B: Challenges & Strategies

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

1. Identify three challenges to implementing standard precautions in your setting as it is now.

2. Identify three challenges to implementing standard precautions in your setting in the event of a crisis.

3. Discuss some strategies to overcome these challenges. How would you implement these strategies during a crisis?

4. In the event that your area is cut off from supply routes because of the crisis, and you are therefore unable to restock health posts with official supplies, suggest some simple, practical measure which could be taken as a first step using existing or local resources (remember- staff are resources too!).

Notes

Participant Handout #13 Instructions

Syndromic Diagnosis &Treatment of STIs: Adapting Algorithms

This activity will provide participants with a hands-on opportunity to adapt a standard algorithm for the treatment of STIs to a provided protocol.

Time

30 minutes

Process

- Divide participants into groups of between 5 and 6. Provide each group with a copy of the STI algorithm wall chart. This may be attached to a wall or in the centre of a table.
- Ask participants to review the algorithm on the wall chart.
- Ask participants to then write the appropriate national syndromic treatment on post-it notes and stick them in the correct place on the STI algorithm wall chart. Can refer to the example national protocol if needed.

Materials

- STI algorithm wall chart- 1 for each group of 5-6 (Available in resources folder). Print A3 or larger.
- Post-it notes for each group.
- Participant Handout #13 or an alternative national protocol from your context.

Key Messages

- Stress that algorithms must be adapted. Stress also that any antibiotics selected to treat STI syndromes must be tested to ensure that pathogens in the region have not become resistant to certain antibiotics over time.

Participant Handout #13

Syndromic diagnosis & treatment of STIs: Adapting algorithms

Example of a National Protocol

Syndrome	Treatment
Urethral discharge	Spectinomycin 400 mg IM single dose Doxycyclin 100mg, twice daily x 7 days
Abnormal vaginal discharge	Spectinomycin 400 mg IM, single dose Doxycyclin 100mg, twice daily x 7 days Metronidazole 500mg, twice daily x 7 days Clotrimazole 500mg, intra-vaginally, single dose
Genital ulcers	Benzathine penicillin 2.4 million units IM x2/1week
Inguinal bubo (swelling)	Cotrimoxazole 160/800 mg by orally twice daily for a minimum of 10 days
Scrotal swelling	Spectinomycin 400 mg IM single dose Doxycyclin 100mg, twice daily x 7 days
Lower abdominal pain	Spectinomycin 400 mg IM, single dose Doxycyclin 100mg, twice daily x 7 days Metronidazole 500mg, twice daily x 7 days
Neonatal conjunctivitis	Spectinomycin 40 mg/kg IM, single dose Doxycyclin 2.2 mg/kg orally 2x/day

Notes

Participant Handout #14 Instructions

Matrix Group Work: MISP for SRH Objective 4

Time

10 minutes.

Process

- Ask participants to briefly share their experience in preventing excess maternal and newborn morbidity and mortality in their work as clinical service providers. If they have not been directly involved in this work, ask them to share information on the kinds of services they are aware of for survivors in their setting.
- Share the table on Participant Handout #14 electronically or in hard copy. Note that a similar table will be given at the start of each objective.
- Explain there will be time at the beginning, throughout and at the end of the session to complete the matrix with colleagues in the room.
- The purpose of this matrix is to:
  - Discuss clinical skills needed to implement each action under the MISP Objectives;
  - Identify how these differ from the services provided during non-emergency times;
  - Map who can do what (individual and/ or organisations) in their context for each activity; and
  - Allow participants to understand the role service providers play and competencies needed to contribute towards each objective.
- Encourage participants to work in groups (such as table groups) to brainstorm and engage their existing knowledge and experience of this objective, filling in aspects of the matrix as they are able at this stage. Remind participants that they will have the opportunity to add to the matrix throughout and at the end of the session.

Materials

Participant Handout #14

MISP for SRH Objective 4: Prevent Excess Maternal & Newborn Morbidity & Mortality				
Clinical skills as outlined in the MISP List Core Clinical competencies as outlined in the MISP	**Which Cadre of staff can perform these skills?** Identify who within the health workforce is permitted to provide these services (e.g. Doctors, Nurses, Midwives, Community Health Workers)	**Differences with Standard settings** Identify any existing health laws, policies, standards or resources that would impact how these services are delivered in humanitarian settings	**Skills/policy gaps?** Are there any current skills or policy areas that need to be addressed to ensure the SRH service can be provided timely and efficiently in emergencies	**What resources are available in your setting which could help build skills and fill gaps (consider existing partners, trainings, supplies etc)?** Where could someone access the resources needed to build their capacity in these areas

Participant Handout #15 Instructions

Newborn Resuscitation

This activity will allow participants to become familiar with a standard checklist for newborn resuscitation and the Helping Babies Breathe Flow Chart.

Time

15 minutes.

Process

- Provide participants with Participant Handout #15. Briefly explain the concept of the "Golden Minute' as defined by the Helping Babies Breathe Initiative. This concept states that within one minute of birth, a baby should be breathing well or should be ventilated with a bag and mask. The Golden Minute identifies the steps that a birth attendant must take immediately after birth to evaluate the baby and stimulate breathing (from https://www.healthynewbornnetwork.org/partner/helping-babies-breathe/).

- Ask participants to break into small groups and discuss the following:

  1. Using the Helping Babies breath Flow chart, discuss what steps the birth should attendant take if the baby is breathing after birth/not breathing after birth. Follow through different scenarios on the flow chart. If possible, using equipment to act out steps in flow chart will be more impactful.

  2. How does this compare to standard practice in their context?

  3. What skills and resources are needed to successfully follow this flow chart?

- At the close of 10 minutes, ask participants to feed back to the group their thoughts on the documents and answers to the questions.

- Let participants know there is an IAWG Newborn resuscitation checklist (https://iawg.net/wp-content/uploads/2017/08/Newborn-resuscitation-checklist-2017.docx) and more resources at the Healthy Newborn Network https://www.healthynewbornnetwork.org/ if interested.

Materials

- Participant Handout #15/Golden Minute- Helping Babies Breath flowchart (resource folder)

- Equipment as described in flowchart (if possible)

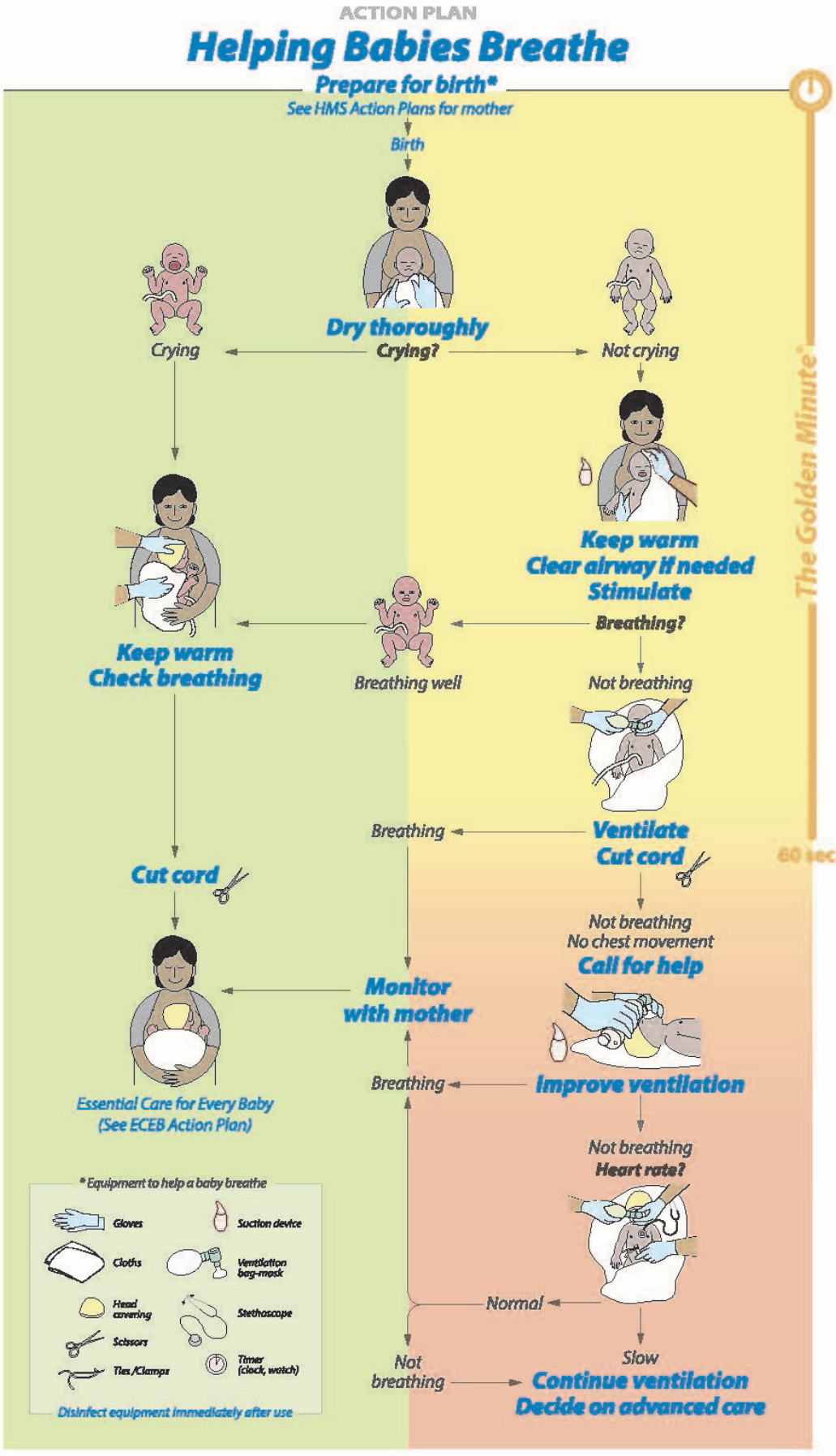
Key Messages

- In most cases, if a baby is born not breathing, respiration can be stimulated with tactile stimulation (rubbing back, thoroughly drying baby). These interventions should be performed to initiate and sustain breathing with the “Golden Minute” after Birth

- For a baby who is not breathing and does not responds to tactile stimulation, a bag and mask should be used to assist the baby breathe. (See New born Health in Humanitarian Settings Field Guide, 2018, IAWG)

Participant Handout #15

Helping Babies Breathe Flow Chart



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Clean Delivery Kits

This activity provides participants with practical experience in demonstrating the use of clean delivery kit items and strategizing for their distribution.

Time

20 minutes

Process

- Provide table groups with the materials contained within a standard clean delivery kit and ask them to role play a demonstration of the use of each article to a 'client' (partner from their table group). Monitor closely to ensure the correct information is being discussed and to ensure that participants re-iterate to their 'clients' the importance of facility-based delivery if possible.
- Ask participants to work through the discussion questions on the Participant Handout.
- At the close of 15 minutes, take 5 minutes to ask participants to report back on their discussion, and how they would work to distribute these kits in their case study context. Give constructive feedback.

Materials

- Contents of a clean delivery kit (1 or 2 for each table group).
- Participant Handout #16

Key Messages

- Clean delivery Kits need to be distributed to all visibly pregnant women and girls (6-9 months), even in flight, for use by birth attendant or herself. It should be emphasized that at the very least, women should receive supportive care during childbirth and should never be left unattended.
- Those provided with the kits should also be informed about the nearest facilities and the importance of delivering with a skilled attendant so that they can pass this information on to the women they visit.
- This is also a good opportunity for women providing clean delivery packages to identify and link pregnant adolescents with health services and encourage facility-based deliveries.

- Health providers can encourage women to take CDK's with them to health facilities in case there is a shortage of supplies at the facility.

- Because the materials included in a clean delivery package are often easily obtained locally, it is possible to assemble these packages on site. In fact, it may be possible to contract with a local NGO to produce the packages, which could also provide an income generation project for local women. -If the situation permits, assembling clean delivery packages locally may be a good opportunity to identify and organize women's groups and TBAs with whom you can then talk about encouraging all pregnant women to deliver in a health facility, and about recognition and referral of those suffering from obstetric complications.

- Clean delivery kits can also be ordered from UNFPA, which may sometimes be a quicker alternative- and the sooner the materials are available, the better it is for pregnant women. In addition, contacting UNFPA before the start of a crisis to establish a relationship and to ensure the availability of supplies will likely facilitate better emergency preparedness.

Participant Handout #16

Clean Delivery Kits Discussion Questions:

Discuss the following questions with your table group:

1. Who would you distribute the clean delivery kits to in your setting?
2. How would you distribute the kits in your setting?
3. Who could you partner with to provide clean delivery kits?
4. What other opportunities would local partnering allow?
5. What are some challenges in distributing the clean delivery kits in your setting?
6. What kind of preparedness activities could you undertake to overcome these challenges?
7. Would it be possible to assemble and store the kits locally?
8. Who are some partners you could work with to do this?

Remember that facility-based delivery and the support of EmONC and a 24/7 referral system should always be the priority. Clean delivery kits are a last resort for when facility based services and referral mechanisms are not yet in place or accessible.

Notes

Participant Handout #17 Instructions

Providing Post Abortion Care

Time

20 minutes

Process

- Ask participants to work through the discussion questions on the Participant Handout.
- At the close of 15 minutes, take 5 minutes to ask participants to report back on their discussion. Give constructive feedback using the solutions below.

Materials

Participant Handout #17

Key Messages and 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.

Participant Handout #17

Providing Post-Abortion Care

Discuss these questions with your group:

1. What is the difference between post-abortion care and abortion?

2. Why is post-abortion care so important in humanitarian settings?

3. At what levels of service (community, health post, health center, and referral hospital) can post-abortion care be provided? What kinds of services can be provided at each level?

4. How can these services be coordinated? How can we ensure that women have access to them? Think about referral within health facilities and between health facilities at different levels.

5. What other SRH health services should be available to women who present for post-abortion care?

Notes

Participant Handout #18 Instructions

Matrix Group Work: MISP for SRH Objective 5

Time

10 minutes.

Process

- Ask participants to briefly share their experience in preventing unintended pregnancies in their work as clinical service providers. If they have not been directly involved in this work, ask them to share information on the kinds of services they are aware of for survivors in their setting.
- Share the table on Participant Handout #18 electronically or in hard copy. Note that a similar table will be given at the start of each objective.
- Explain there will be time at the beginning, throughout and at the end of the session to complete the matrix with colleagues in the room.
- The purpose of this matrix is to:
  - Discuss clinical skills needed to implement each action under the MISP Objectives;
  - Identify how these differ from the services provided during non-emergency times;
  - Map who can do what (individual and/ or organisations) in their context for each activity; and
  - Allow participants to understand the role service providers play and competencies needed to contribute towards each objective.
- Encourage participants to work in groups (such as table groups) to brainstorm and engage their existing knowledge and experience of this objective, filling in aspects of the matrix as they are able at this stage. Remind participants that they will have the opportunity to add to the matrix throughout and at the end of the session.

Materials

Participant Handout #18

MISP for SRH Objective 5: Prevent Unintended Pregnancies				
Clinical skills as outlined in the MISP List Core Clinical competencies as outlined in the MISP	**Which Cadre of staff can perform these skills?** Identify who within the health workforce is permitted to provide these services (e.g. Doctors, Nurses, Midwives, Community Health Workers)	**Differences with Standard settings** Identify any existing health laws, policies, standards or resources that would impact how these services are delivered in humanitarian settings	**Skills/policy gaps?** Are there any current skills or policy areas that need to be addressed to ensure the SRH service can be provided timely and efficiently in emergencies	**What resources are available in your setting which could help build skills and fill gaps (consider existing partners, trainings, supplies etc)?** Where could someone access the resources needed to build their capacity in these areas

Rumours and Facts vs. Facts and Realities of LARCs

Adapted from LARC Learning Resource Package Jhpiego

This activity will allow participants to increase their understanding of long-acting reversible contraceptive methods and to build skills in providing correct information.

Time

15 minutes

Process

- Cut out all the cards for "Rumours and Misconceptions" and "Facts and Realities to address Rumours and Misconceptions" on Participant Handout #19.
- Divide participants into two groups. Give one group all of the "Rumours and Misconceptions" cards and the other group all of the "Facts and Realities to address Rumours and Misconceptions" cards.
- Ask the group that has the "Rumours and Misconceptions" cards to read one of the rumours out loud.
- Ask the other group to identify "Facts and Realities" that dispel the rumour or misconception.
- Continue in this way until matches have been identified and read aloud for all the rumours and misconceptions.
- Explain that participants can find all these rumours and misconceptions and the facts and realities to combat them from Adapted from LARC Learning Resource Package Jhpiego (http://resources.jhpiego.org/resources/Modular_LARC_LRP)

Materials

Participant Handout #19 cut into cards

Key Messages

Participant Handout #19

Rumors and Misconceptions about LARCs

The IUD might travel inside a woman's body to her heart or her brain.

A woman can't get pregnant after using an IUD.

If a woman with an IUD becomes pregnant, the IUD gets embedded in the baby's forehead.

The IUD deteriorates in the uterus after prolonged use.

An IUD can't be inserted until 6 weeks postpartum.

Implants cause infertility.

Implants move to other parts of the body like your heart or brain.

Implants stop monthly bleeding and dirty blood collects in your body.

Implant insertion is painful, and removal is difficult.

Implants cause abortion if you are pregnant at the time of insertion.

Implants and IUD's can't be used in humanitarian settings.

Participant Handout #19

Implants and IUD's are not suitable for adolescents as the hormones in the implant are not good for their bodies and both methods can make them infertile.

Facts and Realities to Address Rumors and Misconceptions About LARCs

There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and—unless it is accidentally expelled—stays there until a trained health care provider removes it. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus.

The provider can teach the client how to feel for the string, if the client is comfortable doing so.

A woman's fertility returns to normal very soon after the IUD is removed. Studies have shown that most women who discontinue the IUD become pregnant as rapidly as those who have never used contraception.

The baby is very well protected by the sac filled with amniotic fluid inside the mother's womb. If a woman gets pregnant with an IUD in place, the health provider will remove the IUD immediately due to the risk of infection. If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.

Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made of materials that cannot deteriorate. The client can keep it longer, if she desires, without any risk.

A trained provider can insert the IUD immediately after delivery (within 10 minutes of delivery of the placenta), or during a cesarean section, or up to 48 hours following delivery. Postpartum insertion of an IUD has been shown to be safe, effective and convenient for women, just like the regular or interval IUD. Postpartum insertion appears to have a lower chance of perforation as instrument used is blunt and uterine wall is thick just after the pregnancy.

Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made of materials that cannot deteriorate. The client can keep it longer, if she desires, without any risk.

After the 48-hour postpartum period, a Copper T 380A may be safely inserted at four or more weeks postpartum.

It has been shown that IUDs do not affect breastmilk and can be safely used postpartum by breastfeeding women.

If placed correctly it is highly unlikely that they can move. They remain where they are inserted until they are removed. In rare cases, a rod may start to come out of the skin, usually during the first four months after insertion.

Implants stop working once they are removed. Their hormones do not remain in your body. The implant will not affect your ability to have another child. You can become pregnant again once your implant is removed.

Changes in menstrual bleeding—like spotting, prolonged bleeding or no menstrual bleeding—are common. These side effects are normal and are not a sign of sickness. Blood does not build up in your body.

Implants do not cause an abortion. There is good evidence that the implant will not harm a baby if you are already pregnant when the implant is put in. Your provider will check carefully to make sure you are not pregnant before the implant is inserted.

Health providers who insert implants have been specially trained to insert them. The provider will give you a small injection in your arm so that you do not feel the insertion. The incision is very small and does not require stitches. Removal of implant is easy if it is inserted correctly. Women are advised to go to the trained provider who inserted it for removal.

Participant Handout #19

Implants and IUD's can be safely and effectively used in emergency settings and are in should be made available to clients as part of voluntary contraception services. Ensuring the availability of a range of long-acting and short acting contraceptive methods to meet demand is an activity under Objective 5 of the MISP.

Implants and IUD's are safe for adolescents to use and will not impact on their ability to get pregnant once removed.

Acknowledgments: This factsheet and its contents were referenced from the LARC Learning Resource Package from USAID's Maternal & Child Survival Program (MCSP) implemented by Jhpiego.

Transitioning to Comprehensive SRH: 3 Month Update to Case Study

This activity asks participants to consider priority areas that need to be addressed in transition planning.

Time

20 minutes

Process

- Break participants into small groups
- Remind participants of the case study they discussed earlier in 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) on Participant Handout #20.
- 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 identify two to three priority areas/activities which need to be integrated into the transition plans given the update.
- 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 & #20

Key points

- Planning for comprehensive should begin from the onset of crisis.
- Transition planning is an opportunity to build back better.

- Transition planning: Consider how to transition to stable supply system not reliant on kits; opportunity to consider capacity development needs; data collected in emergencies is important to use in planning for where supplies, facilities and staff should be, based on need.

TABLE 3.6: HEALTH SYSTEM BUILDING BLOCKS

HEALTH SYSTEMS BUILDING BLOCK	WHEN PLANNING FOR COMPREHENSIVE SRH SERVICES, COLLABORATE WITH ALL STAKEHOLDERS TO
Service delivery	• Identify SRH needs in the community • Identify suitable sites for SRH service delivery
Health workforce	• Assess staff capacity • Identify staffing needs and levels • Design and plan staff training
Health information system	• Include SRH information in the health information system
Medical commodities	• Identify SRH commodity needs • Strengthen SRH commodity supply lines
Financing	• Identify SRH financing possibilities
Governance and leadership	• Review SRH-related laws, policies, protocols • Coordinate with MOH • Engage communities in accountability

Table 3.6 From IAFM 2018

Participant Handout #20

Case Study 1: 3 Month Update: Natural Disaster in Gammalpha

Situation Report

It is three months after the disaster. Water has receded but still many people remain affected and in need of support. The government has estimated that it will be at least six months before things can fully return to normal.

All clusters have been asked by the NDMO to prepare a plan for the transition and recovery phase. The health cluster has requested the SRH working group to prepare their plan for the next six month focusing more on comprehensive SRH service delivery.

Considering the update below and the health systems building block prepare a brief transition plan to be presented back to the Ministry of Health and Emergencies.

- The camps near Brew remain the largest. Although people are now living in tents the area has become over crowded with more people from the smaller islands moving there.
- There are reports that members of the surrounding community are becoming upset by the number of handouts that people in the camps continue to receive
- The ports, communication and electricity have been restored, and Oxfam has rebuilt the sanitation infrastructure including latrines.
- Hospitals in Brew and Tarki are now fully functional. The smaller health centres continue to run but often face stock out of basic supplies, particularly since the supplies from the initial Interagency Reproductive Health Kits have run out.
- Many of the international agencies that arrived at the onset of the emergency are starting to pull out as their emergency funding runs out.
- Through the protection cluster GBV actors have set up an informal referral system sharing phone number of relevant actors- there is still some confusion though around when cases have to be reported to the police.
- Service providers have been reporting that women have really preferred the implant

methods, more than expected but there is a shortage of skilled staff to meet demand. This has been made more challenging as only nurses are allowed to provide implants according to the national guidelines.

- Gammalpha has committed to the meeting the sustainable development goals and has a large programme supporting MNCH programmes.

Participant Handout #20

Study 2: 3 Month Update: Conflict in Gammaland (Based on CARE/IPPF Training Scenario)

Situation Report

It has been three months since since the conflict in Alpha, Gammaland flared up. Fighting is more sporadic, but the risk remains and people fear they will not be able to go back to their old lives. The Government and humanitarian community estimate that 100,000 people remain in need

All clusters have been asked by the NDMO to prepare a plan for the next three to six months. The health cluster has requested the SRH working group to prepare their plan for the next six months focusing more on comprehensive SRH service delivery.

Considering the update below and the health systems building block prepare a brief transition plan to be presented back to the Ministry of Health and Emergencies after lunch.

- The camps in Beta province remain the largest displacement sites of this response. Although more than half of approximately 100,000 people have been living in these camps even before this conflict, the local populations are now restricting their access to food and other necessities. Most NGOs are focusing their efforts on Beta due to the lack of safety measures in Alpha.

- The hospitals are fully functional but they often face stock outs of basic supplies, due to disruption in the local supply chains and a shortage of in country vendors. Most of the commodities that were distributed from the initial Interagency Reproductive Health Kits have run out.

- Health service providers are reporting feeling overwhelmed by the number of the SV cases they are seeing, including types of cases they have not seen before. They were last trained 4 years ago.

- FGDs have been conducted with women to better understand the low demand for contraceptives. A common theme found was the need for permission from male partners first.
- In Beta province the emergency referral system for EMONC and CEMONC services is operating but only really in the day time, the lack of lighting and volunteers makes it difficult to operate in the evenings.
- Cluster members have been feeding into the Health Information Management system but not all service points and many find there is no place for the RH data they are collecting.
- Gammalpha has committed to the Sustainable Development Goals and the 2030 Agenda for humanity- 'leave no one behind' and wants to ensure plans are in line with these agendas.

Participant Handout #21 Instructions

Matrix Group Work: MISP for SRH Other Priority Activity

Time

10 minutes.

Process

- Ask participants to briefly share their experience in providing safe abortion care to the full extent of the law in their work as clinical service providers. If they have not been directly involved in this work, ask them to share information on the kinds of services they are aware of for safe abortion care to the full extent of the law.
- Provide participants with a copy of Participant Handout #21 and allow them to work in groups (such as table groups).
- Start with the section on laws regarding safe abortion care in the participants' context(s). Facilitate a brief discussion on participants' understanding of laws and protocols. You may use the Centre for Reproductive Rights World's Abortion Laws resources and maps as a guide to provide the correct information to the group (available at https://reproductiverights.org/worldabortionlaws).

Materials

Participant Handout #21.

MISP for SRH Other Priority Activity: Ensure Safe Abortion Care is available, to the full extent of the law, in health centres and hospital facilities				
Legal Context:				
Clinical skills as outlined in the MISP List Core Clinical competencies as outlined in the MISP	**Which Cadre of staff can perform these skills?** Identify who within the health workforce is permitted to provide these services (e.g. Doctors, Nurses, Midwives, Community Health Workers)	**Differences with Standard settings** Identify any existing health laws, policies, standards or resources that would impact how these services are delivered in humanitarian settings	**Skills/policy gaps?** Are there any current skills or policy areas that need to be addressed to ensure the SRH service can be provided timely and efficiently in emergencies	**What resources are available in your setting which could help build skills and fill gaps (consider existing partners, trainings, supplies etc)?** Where could someone access the resources needed to build their capacity in these areas

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: 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 #22 to each participant.
- Ask participants to work through Part A of Participant Handout #22, 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 #22) 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 #22 Parts A & B
- Copies of national and organisational laws and policies regarding safe abortion care

Participant Handout #22

Safe Abortion Care in Humanitarian Emergencies: Values Clarification Exercise

Participant Handout #22 Part A:

Please read each of the statements below about barriers to providing abortion care or supporting your agency's provision of abortion care. Check all that apply.

- ☐ I find abortion personally objectionable.
- ☐ I am concerned about my professional reputation.
- ☐ My colleagues are not supportive of abortion.
- ☐ My family is not supportive of abortion.
- ☐ People who are important to me and whom I respect oppose abortion.
- ☐ I am concerned about my personal safety or the safety of my loved ones due to the threat of violence from people who oppose abortion.
- ☐ I am concerned about risks to my agency due to safe abortion care provision.
- ☐ My agency's safe abortion care policies and procedures are not clear.
- ☐ I have not been adequately trained on safe abortion care relative to my role within my agency.
- ☐ I am not clear about how my agency's staff should respond if they have a problem related to providing safe abortion care.
- ☐ If there were a problem related to safe abortion care provision, I am not confident that my agency would handle it appropriately.
- ☐ I do not always support women's reasons for seeking an abortion.
- ☐ Abortion laws and policies don't authorize abortion in the contexts where I work.
- ☐ There are no reasons that would prevent me from providing or supporting my agency's provision of safe abortion care.

Please select all reasons that may facilitate your provision or support for your agency's provision of safe abortion care.

- ☐ All women should have access to safe abortion care.
- ☐ Many women seeking safe abortion care are not able to receive it.
- ☐ Refugees and displaced women have a disproportionate need for safe abortion care.

Participant Handout #22

- ☐ I am committed to preventing women's deaths and disabilities due to unsafe abortion.
- ☐ My agency has a medical responsibility to provide safe abortion care.

Participant Handout #22

Participant Handout #22 Part B:

Please select all statements that represent your responsibilities to women who seek safe abortion care.

- ☐ I have a responsibility to provide compassionate, factually-correct information about all pregnancy options to pregnant women, including safe abortion.
- ☐ I have a responsibility to encourage pregnant women not to have an abortion if they live in a country where abortion is legally restricted.
- ☐ Whenever I hear someone making false statements about abortion, I have a responsibility to offer correct information.
- ☐ I have a responsibility to refer women seeking an abortion to appropriate care.
- ☐ I have a responsibility to abide by the abortion laws of the country I am currently in.
- ☐ If I do not support safe abortion care, I have a responsibility to inform my agency about my position.
- ☐ I have a responsibility to provide women with the abortion information and referrals they need, even if abortion is legally restricted in that country.
- ☐ I have a responsibility to be informed about abortion laws and policies in the countries in which I am working.
- ☐ I have a responsibility to provide safe abortion care regardless of the laws and policies in the country where I work.
- ☐ I have a responsibility to support women in making abortion decisions according to their own values and beliefs, regardless of my personal beliefs.
- ☐ I have a responsibility to minimize my agency's organizational risks with regard to safe abortion care provision.
- ☐ I have no responsibilities to women with regard to safe abortion care.

Please select all statements that best represent your agency's staffs' responsibilities with regard to women who seek safe abortion care:

- ☐ My agency's staff have a responsibility to provide information to pregnant women about their pregnancy options, including abortion.
- ☐ My agency's staff have a responsibility to provide safe abortion care or support the provision of safe abortion care in a discreet manner.
- ☐ My agency's staff have a responsibility to refer women who request abortion to appropriate safe abortion care.

- ☐ My agency's staff have a responsibility to provide safe abortion care or support provision of safe abortion care to women who meet legal indications in that country.
- ☐ My agency's staff have a responsibility to provide safe abortion care or support the provision of safe abortion care to any woman who requests it.
- ☐ My agency's staff have a responsibility to be leaders in providing safe abortion care to refugees and displaced people.
- ☐ My agency's staff have no responsibilities to women with regard to safe abortion care.

- Final small group discussion questions:

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

Pre- and Post-Test

Pre- and Post-Test From: Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations: A Distance Learning Module (Draft 2019)

Circle all correct answers for each question (there may be more than 1 correct answer):

1. What are the four clinical services provided under the MISP for SRH?

   a. Prevent unintended pregnancies
   b. Prevent excess maternal and newborn morbidity and mortality
   c. Plan for comprehensive SRH services
   d. Prevent sexual violence and respond to the needs of survivors
   e. Ensure the health cluster/working group identifies an organization to lead implementation of the MISP for SRH
   f. Prevent the transmission of and reduce the morbidity and mortality of HIV and other STIs

2. The SRH Coordinators role is to:

   a. Coordinate, communicate and collaborate within the health, GBV, HIV cluster/sectors/actors
   b. Support health partners to seek SRH funding through humanitarian planning processes and appeals
   c. Active case identification and case management of HIV and procurement of ARVs for first or second-line treatment and co-trimoxazole
   d. Utilize the MISP for SRH Check List for monitoring MISP for SRH services

3. The guiding principles of responding to the needs of survivors of sexual violence include:

   a. Safety
   b. Confidentiality
   c. Service Delivery
   d. Non-discrimination
   e. All of the above

4. Which are components of clinical care for survivor of sexual violence?

   a. History and thorough medical exam following survivor consent
   b. Compassionate and confidential care and counselling with survivor consent
   c. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care, to the full extent of the law
   d. Forensic examination and collection- this must be done for every survivor
   e. Psychosocial or mental health services

5. What should be offered to all crisis-affected individuals living with advanced HIV who were on ARVs prior to the emergency?

   a. ARVs
   b. Penicillin prophylaxis
   c. Condoms
   d. All of the above

6. The syndromic management of STIs is a method to treat STIs based on multiple visits to the clinic using standardized treatment protocols?

   a. True
   b. False

7. If a woman presents for post abortion care the first thing a skilled health provider should do is refer her to a hospital.

   a. True
   b. False

8. Which is not a newborn danger sign?

   a. Fits or convulsions
   b. Reduced activity or lack of movement
   c. Breastfeeding
   d. Fast breathing (more than 60 breaths per minute)
   e. Very small size at birth

9. What essential services should skilled birth attendants understand in order to provide EmONC and essential newborn care?

   a. Provision of post-abortion care
   b. Management of newborn illness and care for preterm/low birth weight babies
   c. Prevention and management of intrapartum and postpartum haemorrhage (PPH)
   d. Provision of assisted delivery with vacuum extraction
   e. Thermal protection (drying, warming, immediate skin-to-skin contact and delayed bathing)
   f. All of the above

10. What information should be provided to all clients during contraceptive counselling?

   a. Effectiveness of the method
   b. Common side effects of the contraceptive method
   c. Antenatal counselling
   d. How the method works
   e. STI protection
   f. All of the above

11. Contraceptive counselling and provision of a method should be a priority in all abortion services.

   a. True
   b. False

12. Which information or data should be collected to plan for comprehensive SRH services?

    a. Individual organizations' protocols for standardized care
    b. MISP for SRH service indicators that are monitored and evaluated
    c. General health data and statistics on non-communicable and communicable diseases, malnutrition rates, etc.
    d. Chronic disease prevalence and health knowledge of the affected population
    e. All of the above

13. Which is **not** a WHO health system building block?

    a. Financing
    b. Medical Commodities
    c. Service Delivery
    d. Marketing
    e. Governance and Leadership

14. When transitioning to comprehensive SRH services, it is important to continue to order the pre-packaged IARH Kits.

    a. True
    b. False

ANSWER KEY: Pre- and Post-Test

1. What are the four clinical services provided under the MISP for SRH?

a. Prevent unintended pregnancies
b. Prevent excess maternal and newborn morbidity and mortality
c. Plan for comprehensive SRH services
d. Prevent sexual violence and respond to the needs of survivors
e. Ensure the health cluster/working group identifies an organization to lead implementation of the MISP for SRH
f. Prevent the transmission of and reduce the morbidity and mortality of HIV and other STIs

Why is this correct: While all objectives of the MISP only four are clinical. There is also another clinical component which is not mentioned here and that is to make safe abortion car to full extent of law.

2. The SRH Coordinators role is to:

a. Coordinate, communicate and collaborate within the health, GBV, HIV cluster/sectors/actors
b. Support health partners to seek SRH funding through humanitarian planning processes and appeals
c. Active case identification and case management of HIV and procurement of ARVs for first or second-line treatment and co-trimoxazole
d. Utilize the MISP for SRH Check List for monitoring MISP for SRH services

Why is this correct: The SRH Coordinators role is to coordinate, communicate and collaborate within the health, GBV, HIV cluster/sectors/actors, support health partners to seek SRH funding through humanitarian planning processes and appeals and utilize the MISP for SRH Check List for monitoring MISP for SRH services. Hence A, B, and D are the correct answers.

3. The guiding principles of responding to the needs of survivors of sexual violence include:

a. Safety
b. Confidentiality
c. Service Delivery
d. Non-discrimination
e. All of the above

Why is this correct: The missing is Respect

4. Which are components of clinical care for survivor of sexual violence?

a. History and thorough medical exam following survivor consent
b. Compassionate and confidential care and counselling with survivor consent
c. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care, to the full extent of the law
d. Forensic examination and collection- this must be done for every survivor
e. Psychosocial or mental health services

ANSWER KEY: Pre- and Post-Test

Why is this correct: Refer to updated CMR guidelines- Forensic Evidence collection may not be feasible in all cases.

5. What should be offered to all crisis-affected individuals living with advanced HIV who were on ARVs prior to the emergency?

   a. ARVs
   b. Penicillin prophylaxis
   c. Condoms
   d. All of the above

Why is this correct: Syndromic management of STIs is standardized treatment protocols based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions on a single visit.

6. The syndromic management of STIs is a method to treat STIs based on multiple visits to the clinic using standardized treatment protocols?

   a. True
   b. False

Why is this correct: Syndromic management of STIs is standardized treatment protocols based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions on a single visit.

7. If a woman presents for post abortion care the first thing a skilled health provider should do is refer her to a hospital.

   a. True
   b. False

8. Which is not a newborn danger sign?

   a. Fits or convulsions
   b. Reduced activity or lack of movement
   c. Breastfeeding
   d. Fast breathing (more than 60 breaths per minute)
   e. Very small size at birth

ANSWER KEY: Pre- and Post-Test

9. What essential services should skilled birth attendants understand in order to provide EmONC and essential newborn care?

a. Provision of post-abortion care
b. Management of newborn illness and care for preterm/low birth weight babies
c. Prevention and management of intrapartum and postpartum haemorrhage (PPH)
d. Provision of assisted delivery with vacuum extraction
e. Thermal protection (drying, warming, immediate skin-to-skin contact and delayed bathing)
f. All of the above

10. What information should be provided to all clients during contraceptive counselling?

a. Effectiveness of the method
b. Common side effects of the contraceptive method
c. Antenatal counselling
d. How the method works
e. STI protection
f. All of the above

11. Contraceptive counselling and provision of a method should be a priority in all abortion services.

a. True
b. False

12. Which information or data should be collected to plan for comprehensive SRH services?

a. Individual organizations' protocols for standardized care
b. MISP for SRH service indicators that are monitored and evaluated
c. General health data and statistics on non-communicable and communicable diseases, malnutrition rates, etc.
d. Chronic disease prevalence and health knowledge of the affected population
e. All of the above

13. Which is not a WHO health system building block?

a. Financing
b. Medical Commodities
c. Service Delivery
d. Marketing
e. Governance and Leadership

Why is this correct: Marketing is not one of the six WHO health system building blocks

14. When transitioning to comprehensive SRH services, it is important to continue to order the pre-packaged IARH Kits.

a. True
b. False

ANSWER KEY: Pre- and Post-Test

Why is this correct: When transitioning to comprehensive SRH services, avoid continual ordering of the pre-packaged IARH Kits to avoid incurring costs and wastage. Ordering SRH supplies based on demand will help ensure the sustainability of the SRH program and avoid shortages of particular supplies as well as the wasting of others not typically used in the setting.

Evaluation

Participant Feedback Form

	1	2	3	4	5
How would you rate the training overall? (1 = poor to 5 = very good)	○	○	○	○	○
How would you rate the content? (1= poor to 5 = very good)	○	○	○	○	○
How would you rate the facilitator(s)? (1= poor to 5 = very good)	○	○	○	○	○

Please give your impressions of the course using the below rating scale:

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree

Questions	Rating	Comments
A. The course fulfilled its goal and objectives		
B. The course content – including the role plays, job aids, handouts and activities – were useful and relevant to my needs.		
C. The course content was organized with appropriate allocation of time.		
D. The course content was an appropriate level for service providers.		
E. The trainers clearly presented the material in a way that was easy to understand and allowed me to ask questions when I did not understand.		

Evaluation

5. What session did you find most useful (refer to agenda) – and why?

6. What session did you find least useful (refer to agenda) and why?

7. Please list three things that could be improved in the course

8. Now that I have completed this course, I feel (circle the most appropriate statement for you):

a. Confident to support MISP implementation

b. That I need further support and guidance before I can support MISP implementation

c. Not comfortable at all to support MISP implementation

d. Other (please describe)_____

Evaluation

Any other comments?

Evaluation

Logistics

1	Accommodation	1	2	3	4	NA	
2	Food	1	2	3	4	NA	
3	Travel arrangements	1	2	3	4	NA	
4	Meeting arrangements	1	2	3	4	NA	
5	Administrative support	1	2	3	4	NA	
6	Any other comments/ suggestions for future trainings						

Evaluation

Staying in touch

1. On a scale of one to 10, with one being not at all likely and 10 being very likely, how likely are you to stay in touch with your cohort after today's training?

1 2 3 4 5 6 7 8 9 10

2. If you would like to stay connected, which communication channel do you prefer?

email ◯ Facebook Messenger ◯ Google Hangout ◯

GroupMe ◯ iMessage ◯ Slack ◯

Viber ◯ WeChat ◯ WhatsApp ◯

Other please list:

_____

3. Would you like to connect with others who have completed this training during different sessions?

a. Yes ◯ b. No ◯

4. Do you have any other ideas about how remain in touch with your cohort from today's training?

_____

_____

_____

_____

_____

Thank you!

Learner Profile template[1]

This document can assist in the selection of participants and/or help with tailoring the training to participant needs.

Name of training	
Name of applicant	
Gender	Female ◯ Male ◯ Other ◯
Age Range	18-25 ◯ 26-40 ◯ 41+ ◯
Name of Institution	
Participant's Role/Title	
Duty station/location (city, country)	
Nationality	
Contact information of applicant (please tick preferred method)	e-mail Phone Skype Other
Curriculum Vitae (CV)	Please attach a copy of your CV with this form
Name and title of supervisor	
Contact information of supervisor	e-mail Phone Fax

1 Questions may need to be adapted if conducting a ToT

Learner Profile template

1. What expectations do you have of the training?

2. Please describe your qualifications/experience in SRHiE and any previous MISP training experience

3. How do you plan to apply the knowledge and skills received during the training?

4. Special requirements or learning considerations?

Please share any personal or learning needs that should be considered or they will impact your attendance and/or performance.

5. Would you be willing and available to be contacted to facilitate MISP trainings in x?